UNIVERSIDADE DE LISBOA

FACULDADE DE PSICOLOGIA

Estudo de Caso: Programa de Gestão do Stress Organizacional enquanto projeto de Promoção de Saúde Ocupacional num contexto empresarial Português

Liliana Marisa de Pinho Dias

MESTRADO INTEGRADO EM PSICOLOGIA
(Secção de Psicologia Clínica da Saúde/Núcleo Psicologia da Saúde e da Doença)

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Dissertação orientada pelo Prof. Dr. Fernando Fradique

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Resumo

Atendendo à crescente necessidade de desenho e implementação de programas de promoção de bem estar nas organizações, a consultoria na área da Psicologia da Saúde Ocupacional necessita oferecer soluções cada vez mais integradas, estratégicas e sustentáveis.

O presente trabalho apresenta um estudo de caso de um Programa de Gestão do Stress Organizacional, desenvolvido entre 2007 e 2010 numa empresa multinacional portuguesa do setor energético.

O programa destinou-se a duas populações, a equipa de atendimento a cliente que incluía os colaboradores das lojas nacionais da empresa (N=339), e a equipa de gestão da dívida (N=32).

Foi aplicado presencialmente um questionário antes de cada intervenção constituindo-se uma linha de base comparativa, das percepções de stress e bem-estar dos colaboradores.

A intervenção primária foi desenhada de forma a avaliar os níveis de stress e bem-estar dos colaboradores e determinar os fatores de stress e bem-estar, através de uma metodologia de *focus group*. Depois de realizada a análise qualitativa e quantitativa dos resultados gerados pela intervenção primária, foram definidos os objetivos e os conteúdos programáticos da intervenção secundária.

Os resultados demonstram uma redução significativa das percepções de exigências emocionais e quantitativas do trabalho, particularmente nos gestores. Igualmente, verificou-se um incremento significativo da utilização de estratégias de *coping* positivas, tais como o suporte social através do aumento significativo da perceção de reciprocidade na relação com os colegas. Para além do enfoque inicial na redução dos níveis de stress, este programa envolveu igualmente, numa segunda fase os

técnicos de serviço social e de segurança, saúde e higiene no trabalho da empresa nas ações de formação, de forma a facilitar a referenciação para intervenções terciárias.

É apresentado igualmente um projeto de investigação que dá continuidade ao estudo inicial, adotando melhorias no desenho e metodologias usados, e garantindo uma avaliação mais controlada da abordagem colaborativa e integrada proposta.

Palavras-chave: Gestão do Stress, Saúde Ocupacional, Intervenções de Promoção de Saúde, Bem-Estar no Trabalho

Abstract

Given the increasing need for the design and implementation of promotion of wellness in organizations, consulting in the area of occupational health psychology needs to offer integrated, strategic and sustainable solutions.

The present mixed method study explores outcomes of a Stress Management Program that was developed in a Portuguese multinational company within the energy sector, between 2007-2011.

The program was destined for two populations, the first being the front office team including the employees in all owned stores nationwide (N = 339), and the second the back office debt management team (N = 32).

A paper-pencil stress questionnaire was applied before any intervention as a baseline measurement of employee's perceptions of the stress and well-being at work dimensions.

The primary intervention was designed to evaluate the levels of stress and well-being of the employees and determine the stress and wellness factors, using a focus group methodology. After analyzing the qualitative and quantitative outputs generated from the primary intervention, the objectives and program content of the second phase sessions were designed.

The results show significantly reduced perceptions of emotional demands and quantitative demands, especially for managers. Also, a significant increment of use of positive coping strategies, such as social support by increased perception of reciprocity in the relationship with colleagues. Focusing primarily on reducing perceived stress levels of the employees, and increasing positive coping strategies and empowerment, this Program also integrated, on the second phase of intervention, social workers and

occupational health providers in the delivery of the training sessions in order to facilitate tertiary intervention referrals.

This research also presents a project design for a subsequent study, that intends to address limitations from the first study, and which improvements in design and methodology will evaluate multiprofessional integrative collaboration approach, in a more controlled way.

Key words: stress management, occupational health, health promotion interventions, well-being at work

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Enquadramento Inicial

Respondendo ao desafio proposto pelo processo de equivalência ao Mestrado Integrado em Psicologia para Licenciados Pré-Bolonha, o trabalho aqui apresentado surge no contexto de valorização e análise crítica da atividade profissional que desenvolvi nos últimos 9 anos, com especial enfoque nos últimos 5.

Procurei, neste relatório, escolher um dos projetos mais representativos que desenvolvi no contexto da outCOme – Clínica Organizacional, empresa com a qual colaboro desde maio de 2006, e que se destina à promoção de saúde e bem-estar nas organizações, através de soluções de apoio ao colaborador (*EAP – Employee Assistance Program*) e de formação e desenvolvimento de recursos humanos.

No entanto, o percurso de aprendizagem deste ano letivo foi mais extenso do que a investigação-ação que irei descrever neste relatório, atendendo que esta reinscrição na Faculdade de Psicologia impeliu-me a um questionamento de várias iniciativas, atividades e projetos já desenvolvidos.

Desde Outubro de 2011 que procurei perspectivar e apresentar de forma científica vários projetos profissionais implementados, entre eles: Programas de Apoio ao Colaborador, Programas de Gestão de Incidentes Críticos, Programas de Gestão de Doença, e Programas de Equilíbrio Trabalho-Família.

Alguns trabalhos, até por indicação e sugestão do meu orientador, resultaram em apresentações em congressos científicos, entre eles o Congresso da ISMA-BR

(International Stress Management Association – Brasil), o III – Workshop em Saúde e Segurança Comportamental ISCTE-IUL que se realizaram em Junho de 2012, e o VII Simpósio de Comportamento Organizacional ISCTE a realizar-se em Setembro de 2012.

Enquanto profissionais distanciamo-nos muitas vezes da exigência científica em prol de condicionantes financeiras, comerciais e de tempo. Por outro lado, consideramos que existe entre a academia e a profissionalização um hiato enorme, e um diálogo quase impermeável.

Esta experiência permitiu-me valorizar, avaliar e redefinir a minha prática profissional futura, e incrementar a atualização científica como forma de potenciar a inovação e desenvolvimento de novos serviços que enderecem as necessidades prementes de promoção de saúde mental em contexto de trabalho.

A estrutura deste relatório apresenta numa primeira seção a descrição realizada em formato *paper*, e redigida em inglês, de um programa de gestão de stress implementado entre 2007 e 2010 numa empresa do setor energético portuguesa.

O resultado da valorização da experiência profissional foi assim materializado pela redação de um artigo incluído nos procedimentos de uma Conferência realizada na Eslovénia em 7 e 8 de Junho de 2012 (*"5th International Scientific Conference QUALITY HEALTH CARE TREATMENT IN THE FRAMEWORK OF EDUCATION, RESEARCH AND MULTI PROFESSIONAL COLLABORATION – TOWARDS THE HEALTH OF INDIVIDUALS AND THE SOCIETY")*, e apresentado numa comunicação científica por um recém colaboradora da outCOme – Clínica Organizacional, a Maja Furlan.

A segunda parte deste relatório implica uma reflexão crítica sobre o projeto desenvolvido e uma proposta de continuidade em termos de investigação e intervenção, que procure contornar as limitações e dificuldades encontradas neste primeiro estudo.

Parte I - Estudo de Caso

Title: Stress Management Programs as an Occupational Health Project in a Portuguese Organizational Setting.

Abstract

Given the increasing need for the design and implementation of organizational stress management and promotion of wellness in organizations, consulting in the area of occupational health psychology needs to offer integrated, strategic and sustainable solutions. Traditionally, the delivery of Stress Management Programs is developed by consulting providers, extremely focused on individual competences and perceptions, and with scarce connection to internal occupational health care and social work providers.

The present mixed method study explores outcomes of two sessions of a Stress Management Program that was developed between 2007 and 2010 in a Portuguese multinational company within the energy sector.

371 participants participating in the program were at the time employees of the company. The program was destined for two populations, the first being the front office team including the employees in all owned stores nationwide (N = 339), and the back office debt management team (N = 32) as a second group.

A paper-pencil stress questionnaire was applied before any intervention as a baseline measurement of employee's perceptions of the following dimensions: Job Demands, Well-being, Relationship with clients and colleagues, Relationship between Work and Family, and Coping strategies.

The primary intervention was designed to evaluate the levels of stress and well-being of the employees and determine the stress and wellness factors, using a focus group methodology. After analyzing the qualitative and quantitative outputs generated

from the primary intervention, the objectives and program content of the second phase sessions were designed, which involved training sessions with a similar duration.

The program responded to the company's urgent need of reducing the levels of emotional exhaustion, which were manifested by employees to their managers and deputy directors. The results show significantly reduced perceptions of emotional demands and quantitative demands, especially for managers. Also, a significant increment of use of positive coping strategies, such as social support by increased perception of reciprocity in the relationship with colleagues. Focusing primarily on reducing perceived stress levels of the employees, and increasing positive coping strategies and empowerment, this Program also integrated, on the second phase of intervention, social workers and occupational health providers in the delivery of the training sessions. The goal was to connect the employees to their internal occupational and social work providers more directly in order to facilitate tertiary intervention referrals.

This research highlights the need for further improvements of the design, tools and methodologies used, and proposes a multiprofessional integrative collaboration approach, that needs to be corroborated in future investigations of stress management interventions in organizational settings.

Key words: stress management, occupational health, health promotion interventions, multiprofessional collaboration

Literature Review

Occupational health psychology aims to develop, maintain and promote the health of employees and the health of their families. The primary focus is the prevention of illness, injury and distress through the creation of a safe and healthy work place environment (Quick, Nelson, & Hurrel, 1997; Sauter, Hurrel, Fox, Tetrick, & Barling, 1999). The challenge is promoting healthy organizations and healthy people by integrating several disciplines (e.g., organizational psychology, social psychology, health psychology, clinical psychology, public health, preventive medicine) (Scheider, Camara, Tetrick, & Stenberg, 1999).

Several authors consider that a prevention model is highly appropriate in occupational health psychology since it is systemic in nature and recognizes the life history of a person and multifaceted complexity of many health problems (Ilgen, 1990; Quick, Quick, Nelson, & Hurrel, 1997).

Organizational-level occupational health interventions can be defined as planned, behavioral, theory-based actions to remove or modify the causes of job stress (i.e., stressors) at work and aim to increase the health and well being of participants (Giga, Cooper, & Faragher, 2003; LaMontagne, Keegel, Louie, Ostry, & Landsbergis, 2007; Richardson & Rothstein, 2008). These interventions seem to have the best effectiveness to achieve a significant impact if they follow a structured and participatory intervention process.

The Psychosocial Taskforce developed by the consortium of Danish labour inspectors identified seven criteria to describe the methods used in organizational-level interventions (cit. by Nielsen, Randall, Holten, & González, 2010):

- Interventions should focus on organizational-level solutions (primary interventions) aimed at changing the work and they should be designed, organized and managed;
- Participatory principles should be the core component of the intervention;
- Methods of conducting interventions should systematically consider all phases during an interventions project, from planning to evaluation;
- Intervention methods should include considerations of how organizational-level occupational health programs can be integrated with existing procedures and organizational cultures and the management of occupational safety and health within the organization.
- Communication/education in and raising awareness of the risks posed by features of work design, organization and management should constitute part of the methods;
- Methods should take into account the organization's existing experiences with dealing with psychosocial risk factors;
- Small and medium-sized companies (SMEs) should be able to use the method.

Individual/worker level interventions are usually directed at changing characteristics of the individual/job interface, such as perceptions, attitudes and behaviors, with the aim of improving workers' well being. Examples of these interventions are: stress management, time management and conflict resolution seminars (Murphy & Sauter, 2004).

Commonly, stress management interventions include training designed to reduce the symptoms of stress, with a wide assortment of techniques, such as: meditation, biofeedback, muscle relaxation and cognitive behavioral skills training (Murphy &

Sauter, 2004). The authors also consider that stress management training could be considered primary prevention if the training includes components that help employees change negative lifestyle habits and/or manage inaccurate perceptions of work organization factors.

Considering the effectiveness and sustainability of stress management programs, interactive and individually tailored health intervention programs seem to lead to higher levels of sustained behavior change than social marketing, but there seems to exist some difficulties in recruiting participants (Swerissen & Crisp, 2004).

Most of these interventions destined for individual behavior change make use of provision of information through education and social marketing in order to change knowledge, attitudes and beliefs, which are the precursors of behavior change. In the absence of other measures, even well designed programs seem to have relatively low success rate in producing the desired behavioral change intentions for most common behavioral health risks (Mittlemark et al., 1993; Winkleby, 1994; Fortman et al., 1995; van der Klink, et al., 2001; Richardson & Rothstein, 2008).

Accordingly to Nytroet al. (2000) and Saksvik et. al. 2002) the implementation of a stress management program should: (1) create a social climate of learning from failure and motivate participants; (2) provide opportunities for multi-level participation and negotiation in the design of interventions; (3) acknowledge tacit and informal behaviors (4) clearly define roles and responsibilities before and after the intervention and (5) existence of competing projects and reorganization.

The present study intends to evaluate the impact of a multi-level, participatory, and interactive Well Being program designed and implemented in a Portuguese organizational context. According to the literature we expect that stress perceptions of

employees, both managers and attendants, will be altered, and positive attitudes and positive coping skills will be reinforced through the participation on primary and secondary intervention sessions.

Method

Participants. Participants of this study were employees of an energy sector company in Portugal, who were involved in a Well Being Program designed specifically for them. The Well Being program addressed two different samples, the first the front office team that worked in stores of the company all over the country and the second the back office debt management team.

The primary intervention with the front office team, occurred by the end of 2007, involving 339 employees, among them 51 were store managers (47.1% females and 52. 9% males) and 288 attendants (46.9% females and 53.1% males). The secondary intervention, developed one year after, with the same population involved 288 employees, 58 store managers (29.3% females and 70.7% males), but 9 store managers were not included in the study because they were outsourced employees that didn't participate in the primary intervention. Only 224 attendants participated on the secondary intervention (43.3% females and 56.7% males).

The debt management back office team participated in the Well Being program in 2009 for the primary intervention, with 4 managers (all of them males) and 28 employees (57.1% females and 42.9% males). In 2010, on the secondary phase of intervention, only 3 managers (all of them males) and 29 employees participated (65.5% females and 34.5% males), because a new member was added to the team, which was not included in the analysis of this study.

Program design. The program was customized and proposed to the company in order to address the need to reduce the perceived stress levels already reported to the managers by the front-office team, and later by the back office debt team. With the aim to evaluate perceived stress and promote well being, training sessions were developed for the primary and secondary interventions.

The primary intervention included a 6-hours training session with the managers, and 3-hours training session with the employees in the real work context (store or office department). This first session had the main goal to evaluate stress factors and well being factors in each team unit (e.g., store or office team) but also already existing individual and group coping strategies that need improvement or development by using a focus group methodology. A positive, participative and learning from failure context was facilitated and the main goal was to actually train participants in identifying stress factors, wellness factors and positive individual and group coping strategies.

On the second training session the goal was to develop the positive coping skills that they identified, on the first session, as crucial for their stress management, and also to include in the session the presentation, and participation of internal social services professionals in order to facilitate tertiary referrals. The main themes addressed on the secondary interventions were for the managers: Managing Team Stress; Emotional Work and Emotional Management; Leadership Strategies to Promote Well Being at Work; And for the employees: Individual Well Being and Team Well Being; Work-Life Balance and Stress; Emotional Work and Emotional Management; Coping Skills; Social Support and Stress. Several active training methodologies were used such as case study, group dynamics, role-play, group work and discussion forum. The group was invited to learn and create different ways to address work-life balance demands, and to

individually and cooperatively address the identified stress factors and increment the wellness factors promoters on site.

Study Instrument. To measure the perceived stress and coping resources of the population a paper-pencil questionnaire was applied to all participants at the beginning of the first sessions of the program, just after the presentation of the facilitators, and before any training or information about stress at the workplace. In such way, a baseline was generated in order to measure impact of the different interventions. A second measure was made just before the second session, and the results of the study will analyze the impact of the primary intervention, because no third measurement was possible due to the company decision of not to proceed with a third moment of measurement.

Several demographic variables were measured, namely gender, level of qualification, marital status, age of children and working spouse, in order to explore significant differences in the sample concerning stress perception and coping skills.

The instrument consisted of a Portuguese tested version and was created using several international scales used in other studies of a research team unit at the Faculty of Psychology University of Lisbon led by Prof. Maria José Chambel that collaborated in the present project (Castanheira & Chambel, 2009, 2010; Chambel, Oliveira & Cruz, 2010; Salanova, Lorent, Chambel & Martinez, 2011)

Measured Dimensions

Emotional demands. Emotional dissonance and the requirements to express positive emotions and to express negative emotions were assessed using a Portuguese translation of the Frankfurt Emotion Work Scales (Zapf, Vogt, Seifert, Mertini, & Isic,

1999). Emotional Dissonance included 4 items about the requirement to display unfelt emotions (e.g., *"How often in your job do you have to display emotions that do not agree with your true feelings?"*). The requirement to express positive emotions included 4 items (e.g., *"How often in your job do you have to display pleasant emotions towards customers?"*). Finally, the requirement to express negative emotions included 3 items (e.g. *"How often do you have to display unpleasant emotions towards customers?"*). Items were scored on a five-point Likert scale, ranging from *Very Rarely/Never* (1) to *Very Often* (5). All scale scores presented good internal reliability (Cronbach's alpha of emotional dissonance 0.76; Cronbach's alpha of requirement to express positive emotions 0.69; Cronbach's alpha of requirement to express negative emotions 0.79).

Quantitative demands and Autonomy. Quantitative demands and Autonomy were assessed using a Portuguese translation of Karasek et al. (1998) instrument. Quantitative Demands included 5 items about time pressure and workload (e.g. *"To what extent does your job require your working hard?"*). Autonomy included 4 items related to the employee's autonomy to make job-related decisions (e.g. *"To what extent do you have the freedom to decide how to organize your work?*"). Items from both scales were scored on five-point Likert scale, ranging from *Never* (1) to *Very Often* (5). All scale scores presented good internal reliability (α Quantitative demands = 0.77; α Autonomy = 0.81).

Burnout. Burnout was measured using two core dimensions, emotional exhaustion, and professional efficacy subscale of the Maslach Burnout Inventory – general version (Schaufeli, Leiter, Maslach & Jackson, 1996) using 4 items to measure emotional exhaustion (e.g., *" I am emotionally exhausted by my work."*) and 6 items for professional efficacy (e.g., *"At my work, I am confident that I am effective at getting things done."*). Participants were asked to rate the frequency of each statement on a

seven-point scale, ranging from *Never* (1) to *Every Day* (6). All scale scores presented good internal reliability (α emotional exhaustion = 0.74; α Professional efficacy = 0.77).

Engagement. Engagement was measured using the two core dimensions, vigor, dedication subscales of the Utrecht Work Engagement Scale – general version (Schaufeli, Salanova, Gonzalez-Roma & Baker, 2002). Vigor was measured with 9 items (e.g., *"At my job, I feel strong and vigorous."*), dedication with 8 items (e.g., *"I am enthusiastic about my job."*). Participants were asked to rate the frequency of each statement on a seven-point scale ranging from *Never* (0) to *Every day* (6). All scale scores presented good internal reliability (α vigor = 0.76; α dedication = 0.90).

The questionnaire also included questions that aimed to evaluate the *Relationship with Clients* (3 items) and *Colleagues* (3 items), particularly the reciprocity perception in those relationships (e.g., Clients *"How often do you feel that you give more to your clients than you receive?"*; Colleagues *"How often do you feel that you invest more in the relationship with your colleagues than you receive in return?"*). The questions were inspired on Hobfoll's (1988, 1989, 1998) Conservation of Resources (COR) theory, in which resource loss is the primary operating mechanism driving stress reactions. Participants were asked to rate the frequency of each statement on a Likert scale, ranging from *Never* (1) to *Almost Everyday* (several times an hour). Both scales presented a good internal consistency (α reciprocity with clients = 0.78; α reciprocity with colleagues = 0.91).

Three open questions were used in order to explore the work-life balance perception (e.g., *"What aspects of your professional life are making conciliation with your family life more difficult?"*; *"What factors of your family life make your*

performance at work more difficult?"; *"How do you successfully overcome the challenges of work-life balance?"*).

Finally, three coping strategies at the workplace were assessed. Problem Solving was assessed on 4 items (e.g., *"I try to establish a strategy on what to do."*), Denial on 5 items (*"I turn to my work or other activities in order to not think on the subject."*) and Social Support on 4 items (e.g., *"I look for advice and help from others about what to do."*). All scales presented a good internal reliability (α problem solving = 0.69; α denial = 0.67; α social support = 0.76).

Control Variables. Gender was controlled since it can be related to individual's stress management abilities (Schaufeli & Buunk, 2003), Age couldn't be controlled due to the need to preserve participants identity in the program.

Data analysis. Data was analyzed using SPSS - Statistical Package for Social Sciences, and a descriptive analysis of each variable: confirmation of values and missing data, mean responses, standard deviation, minimum and maximum values. In addition, we carried out a frequency analysis in order to characterize each sample. For quantitative data we used Oneway ANOVA and Scheffe's as a post hoc test, in order to evaluate the statistical significance of means differences between Managers and Attendants, and a Paired Sample T-Test to evaluate differences between Primary and Secondary Interventions.

For the open-response questions, we performed a content analysis to categorize the responses. The categories shown correspond to the answers with higher frequency to each question.

Results

Front Office. The results show in Table 1 that significant differences were found between managers and the attendants on the first measurement. Managers revealed higher expression of negative emotions ($F(337)$=11.17, p<.05), higher emotional dissonance ($F(334)$=5.77, p<.05), higher quantitative demands ($F(327)$=4.57, p<.05), higher autonomy ($F(333)$=29.22, p<.05) and higher use of problem solving ($F(333)$=9.99, p<.05) compared to attendants. No differences were found on the secondary interventions between managers and attendants.

(Table 1)

Comparing the first and second measurements shop managers perceived a reduced requirement to express positive emotions in their work ($t(47)$=2.15, p<.05), reduced emotional dissonance ($t(48)$=2.61, p<.05), and reduced work load perception ($t(48)$=2.73, p<.05). In the attendants sample also a significant reduction of requirement to express positive emotions ($t(223)$=3.11, p<.05) and increased perception of reciprocity with colleagues ($t(218)$=3.49, p<.05) were found after the primary intervention.

Back Office. No statistically significant difference was found between managers and attendants of the debt management team, on both measurement moments. The results show (Table 2) a significant decreased in the need to express negative emotions at work after the primary intervention ($t(26)$=2.17, p<.05), and an increased perception of emotional dissonance ($t(26)$=4.04, p<.05).In line with the results of the front office team there was also an increased perception of colleague's reciprocity ($t(26)$=2.52, p<.05).

Table 1 – Front Office Results Primary and Secondary Intervention

	Primary Intervention (I)					*Secondary Intervention (II)*					*Means Comparison I &II*	
Dimension	$M_{Managers}$	*SD*	$M_{Attendants}$	*SD*	*F*	$M_{Managers}$	*SD*	$M_{Attendants}$	*SD*	*F*	*Managers*	*Attendants*
											t	*t*
Positive Emotions	*4.09*	*0.53*	*4.03*	*0.61*	*0.38*	*3.82*	*0.69*	*3.84*	*0.64*	*1.05*	***2.15***	***3.11***
Negative Emotions	*1.87*	*0.66*	*1.55*	*0.63*	***11.17***	*1.76*	*0.68*	*1.58*	*0.63*	*0.57*	*1.07*	*0.20*
Emotional Dissonance	*3.38*	*0.66*	*3.05*	*0.93*	***5,77***	*2.90*	*1.05*	*3.07*	*0.87*	*1.35*	***2.61***	*0.52*
Quantitative Demands	*3.70*	*0.64*	*3.49*	*0.63*	***4.57***	*3.33*	*0.69*	*3.50*	*0.69*	*0.58*	***2.73***	*0.32*
Autonomy	*3.93*	*0.67*	*3.25*	*0.84*	***29.22***	*3.90*	*0.67*	*3.22*	*0.79*	*0.44*	*0.12*	*0.54*
Emotional Exhaustion	*3.31*	*1.41*	*3.43*	*1.44*	*0.30*	*3.06*	*1.46*	*3.29*	*1.42*	*0.79*	*1.03*	*1.41*
Professional Efficacy	*5.34*	*0.52*	*5.21*	*0.75*	*1.28*	*5.23*	*0.63*	*5.10*	*0.80*	*1.05*	*0.81*	*1.39*
Vigor	*4.90*	*0.68*	*4.66*	*0.84*	*3.56*	*4.79*	*0.65*	*4.5*	*0.90*	*1.31*	*0.72*	*1.31*
Dedication	*5.15*	*0.78*	*4.88*	*1.06*	*3.05*	*4.98*	*0.88*	*4.73*	*1.08*	*0.57*	*0.96*	*1.28*
Reciprocity with Clients	*3.50*	*0.78*	*3.62*	*0.75*	*0.95*	*3.65*	*0.75*	*3.66*	*0.73*	*0.69*	*0.74*	*1.02*
Reciprocity with Colleagues	*2.55*	*0.84*	*2.62*	*0.98*	*0.23*	*2.83*	*0.89*	*2.86*	*0.83*	*0.65*	*1.71*	***3.49***
Problem Solving	*3.34*	*0.43*	*3.07*	*0.58*	***9.99***	*3.34*	*0.42*	*3.11*	*0.58*	*0.91*	*0.02*	*0.55*
Denial	*1.93*	*0.57*	*1.95*	*0.61*	*0.06*	*1.98*	*0.70*	*1.98*	*0.62*	*1.04*	*0.38*	*0.291*
Social Support	*2.60*	*0.69*	*2.43*	*0.65*	*2.67*	*2.50*	*0.71*	*2.50*	*0.69*	*0.55*	*0.80*	*0.80*

** p value <.05*

(Table 2)

Control Variables. Significant differences were found considering the gender of participants for the front-office team. In the management population men seemed to reveal higher professional efficacy than women at the front office management team (*F(50)*=4.37,*p*<.05) and lower use of problem solving when coping with stress (*F(50)*=4.17,*p*<.05). In the front-office attendant sample, women showed a significant increase in the expression of positive emotions (*F(287)*=7.40 *p*<.05) and a higher significantly use of denial (*F(282)*= 20.13; *p*<.05) and social support (F=(280)=7.04, p<.05) compared to men. Considering the total sample of the front-office women revealed a significantly increase in expression of positive emotions (F(337)=9.11, p<.05), in use of problem solving (F(333)=5.75, p<.05), denial (F(333)=17.62, p<.05) and social support (F(331)=9,244, p<.05) coping strategies compared to men. No significant differences were found at the back office debt sample considering gender.

Qualitative Analysis. In terms of qualitative outputs (Table 3) our aim was to identify the three higher frequency categories of answers considering aspects of professional life that difficult conciliation with family life, aspects of family life that difficult work performance, and finally the main strategies to achieve work-life balance.

(Table 3)

Work Factors. The higher percentage of participants referred time and workload as a major stress factor for work-life balance, with higher frequency on the back office team (75,0% managers and 46,4% attendants).

Table 2 –Back Office Debt Team Primary and Secondary Intervention

	Primary Intervention (I)					*Secondary Intervention (II)*					*Means Comparison I &II*				
Dimension	$M_{Managers}$	*SD*	$M_{Attendants}$	*SD*	*F*	$M_{Managers}$	*SD*	$M_{Attendants}$	*SD*	*F*	$M_{Total\ Sample(I)}$	*SD*	$M_{Total\ Sample\ (II)}$	*SD*	*t*
Positive Emotions	*3.56*	*0.69*	*3.69*	*0.24*	*0.27*	*3.17*	*0.38*	*3.58*	*0.66*	*1.05*	*3.65*	*0.54*	*3.57*	*0.69*	*0.35*
Negative Emotions	*2.67*	*0.72*	*2.83*	*1.50*	*0.15*	*2.78*	*0.51*	*2.03*	*0.77*	*1.64*	*2.58*	*0.93*	*2.02*	*0.80*	****2.17***
Emotional Dissonance	*1.69*	*0.85*	*1.56*	*0.52*	*0.21*	*2.25*	*0.25*	*2.94*	*0.87*	*1.35*	*1.99*	*0.82*	*3.02*	*0.81*	****4.04***
Quantitative Demands	*3.90*	*0.48*	*3.69*	*0.59*	*1.78*	*3.53*	*0.23*	*3.81*	*0.68*	*0.69*	*3.93*	*0.74*	*3.80*	*0.69*	*0.68*
Autonomy	*3.38*	*0.43*	*4.13*	*0.60*	*2.32*	*3.42*	*0.63*	*3.50*	*0.65*	*0.20*	*3.59*	*0.66*	*3.49*	*0.66*	*0.61*
Emotional Exhaustion	*2.75*	*1.06*	*1.81*	*0.61*	*5.96*	*2.56*	*0.19*	*3.03*	*1.60*	*0.50*	*2.57*	*1.07*	*3.11*	*1.56*	*1.52*
Professional Efficacy	*5.54*	*0.37*	*5.62*	*0.13*	*0.42*	*4.83*	*1.26*	*5.14*	*0.55*	*0.82*	*5.16*	*0.64*	*5.14*	*0.56*	*0.12*
Vigor	*5.00*	*1.10*	*5.36*	*0.11*	*0.80*	*4.20*	*0.81*	*4.72*	*0.70*	*1.21*	*4.75*	*0.78*	*4.70*	*0.70*	*0.19*
Dedication	*4.63*	*2.27*	*5.63*	*0.23*	*0.86*	*3.79*	*1.09*	*4.76*	*0.87*	*1.80*	*5.03*	*0.73*	*4.76*	*0.89*	*1.16*
Reciprocity with Clients	*3.58*	*0.69*	*4.17*	*0.33*	*1.17*	*3.11*	*0.19*	*3.25*	*0.79*	*0.30*	*3.33*	*0.70*	*3.37*	*0.67*	*0.22*
Reciprocity with Col-leagues	*2.42*	*1.29*	*2.08*	*0.17*	*0.49*	*2.89*	*0.19*	*2.68*	*0.70*	*0.51*	*2.35*	*0.57*	*2.72*	*0.68*	****2.52***
Problem Solving	*3.63*	*0.14*	*3.56*	*0.38*	*0.40*	*3.00*	*0.00*	*3.13*	*0.47*	*0.47*	*3.38*	*0.41*	*3.18*	*0.42*	*1.79*
Denial	*1.55*	*0.30*	*1.65*	*0.25*	*0.27*	*1.40*	*0.40*	*1.72*	*0.57*	*0.94*	*1.97*	*0.62*	*1.74*	*0.57*	*1.34*
Social Sup-port	*2.31*	*1.14*	*2.50*	*1.08*	*0.23*	*2.08*	*0.76*	*2.40*	*0.62*	*0.84*	*2.47*	*0.75*	*2.48*	*0.57*	*0.03*

** p value <.05*

Table 3 – Qualitative Results | Frequency of Answers

	Front Office				Back Office			
Questions	*N* valid	Managers	*N* valid	Attendants	*N* valid	Managers	N valid	Attendants
"What aspects of your professional life are making conciliation with your family life more difficult?"	48	Time & Work Load (37%) "Particularly the time schedule and the excessive amount of work."	184	Time & Work Load (15%) "The accumulation of work for the next day."	4	Pressure (75%) "Working with a lot of pressure with no time to perform the tasks."	18	Time & Work Load (46,4%) "A lot of work, and little dialogue, few time to perform the tasks in order to achieve the goals."
		Traveling (21%) "The fact that I have to travel more than 140 KM to get to work."		Traveling (10%) "The distance between home and work."		Traveling (25%) "Work meetings far a way from home."		High professional dedication (10,7%) " Total dedication even after hours"
		High professional dedication (6%) "The scarce time to be with our family"		Emotional Exhaustion (6%) "Our work is very exhausting."				Traveling (7,2%)
"What factors of your family life make your performance at work more difficult?"	48	Family Support (25%) "Sometimes health problems in the family."	184	Family Support (13%) "When there is some family problem is difficult to put it aside".	2	Family Support (25%) "To accompany my wife in some doctor appointments."	28	Family Support (21,4%) "If I have a family member ill of dependent."
		Child Care (8%) "Give attention to my child, his development and problems."		Personal Problems (8%) "Sometimes due to personal problems."		Child Care (25%) "The disease of my children"		Child Care (10,7%) "Missing work because of children disease."
		Domestic Management (6%) "Some everyday worries and home work."		Child Care (6%) "The behavior of children on every level."				Absence of spouse understanding (7,2%) "When our spouse doesn't understand the demands of work"

"How do you successfully overcome the challenges of work-life balance?"	47	Planning & Organization (25%) "With organization and method."	170	Planning & Organization (12%) "With specific rules and time management."	4	Motivation & Optimism (50%) "With time and will everything is possible."	28	Separation of Work & Family (42,9%) " I complete separate work from family."
		Conciliation (25%) "Trying to dialogue and achieve the best negotiation possible."		Conciliation (11%) "There exists a lot of comprehension and help in house work."		Conciliation (25%) "To manage intelligently the demands of both sides"		Conciliation (21,4%) "Trying to conciliate the professional and family aspects"
		Motivation & Optimism (8%) "With dedication and commitment."		Motivation & Optimism (9%) "With high spirits and good will."		Sports & Hobbies (25%) "We have a lot of ludic activities together as a family."		Motivation & Optimism (17,9%) "With a lot of persistence, energy and optimism, and luckly I have a solid family and a job I love."

Traveling also seemed to be a frequent factor that creates difficulties in terms of conciliation with personal and family life, present in both populations between 7,2% (Back-Office Attendants) and 25,0% (Back-Office Managers).

Family Factors. The main category found in terms of family factors that impact on performance at work was family support (frequencies ranging from 25,0% to 13,0%) and child care (frequencies from 25,0% of managers, to 6,0% of back-office attendants).

WLB Strategies. The front office team referred planning and organization as an important strategy of conciliation (25,0% of managers and 12,0% of attendants).

Both populations referred conciliation of needs and role demands as an important coping skill and only the back office attendants revealed a higher use of total separation of work life from family life, which seems, in their statements, related to denial and avoidance stress coping strategies.

Discussion

The program revealed to have an impact on stress perceptions of both populations, particularly on emotional work demands (i.e., positive emotions, negative emotions and emotional dissonance), perception of reciprocity with colleagues, and in front-office managers' perception of quantitative work demands.

The results also show that in the front-office population the stress perceptions and coping skills of managers and attendants were more homogeneous after the primary intervention than before.

We believe that the impact was particularly potentiated by the customized design of the training sessions, particularly the involvement of participants in the design of the program on the first session. A second important feature of the program was the fact that

social work internal professionals were invited to participate on the second sessions, which facilitated future tertiary referrals, reducing 'resistance towards counseling for stress' (Gyllensten, Palmer e Farrants, 2005) thus promoting rehabilitation of individuals already with burnout symptoms in the population.

Limitations. Our study presented several limitations that must be considered. Firstly, all quantitative measures of the study were self-reported which raises the question of the results to be contaminated by the common method variance. Nevertheless, the methodology seem adequate because the main aim of the program was to influence the perceptions of employees and reinforce their stress coping techniques in order to improve well being and resiliency at work.

The sampling of participants was not entirely in our control, and some changes in the composition of the samples happened. Although we excluded the participants that clearly didn't participate in the first session, it was not possible to control that samples were totally comparable because anonymity was a requisite of the program. Due to the confidentiality requirement it was also not possible to explore intra individual results in this study.

The methodology of the first sessions in the program raises some questions considering the term primary intervention, which accordingly to the literature focus on people who are not at risk, usually used in health education campaigns (Schmidt, 1994), and are operationalized as organizational-level solutions aimed at changing how work is designed, organized and managed (Nielsen, Randall, Holten and González, 2010). The fact that participants were called to a session entitled *Well Being Program*, that addressed discussion topics with managers about job re-design, task distribution and time management, also, in our opinion, corroborates the primary focus of this program.

Future program designs and research should use more rigorous research designs, and try to investigate the long-term effectiveness of organizational and individual strategies to enhance well being at work, that includes in the design the participation of health and social work professionals of the organization.

Nota: *A bibliografia específica do artigo apresentado está integrada nas referências bibliográficas finais.*

Parte II - Análise Crítica e Proposta de Reformulação

Atendendo à necessidade profissional de dar continuidade a estas intervenções de gestão do stress em contexto organizacional, revela-se fundamental num projeto de investigação-ação subsequente procurar contornar as limitações, e adoptar um desenho mais controlado na avaliação da eficácia do programa.

Algumas limitações já identificadas no primeiro estudo foram: a exclusividade da utilização de auto-relato, ausência de total controlo sobre a amostragem dos participantes nas diferentes fases de intervenção (i.e., decorrentes de despedimentos e novas contratações, na maior parte dos casos em outsourcing), a impossibilidade de avaliar os percursos individuais dos participantes estabelecendo comparações intra-indivíduo, a ausência de grupo de controlo e de mais um momento de avaliação de forma a medir o impacto da intervenção secundária.

Seguidamente descreverei os elementos fundamentais do projeto a implementar num novo contexto organizacional e que procurará contornar as limitações do estudo anterior.

Projeto "Programa de Bem-Estar numa Empresa de Transportes"

Uma das organizações com a qual já foram iniciados contatos no sentido de desenvolver um estudo aplicado é uma empresa portuguesa do setor dos transportes com cerca de 1200 colaboradores. Algumas das unidades funcionais da organização estão particularmente propensas a riscos de acidentes, agressões físicas e/ou verbais por parte dos clientes e assistência a acidentes de viação de elevada gravidade.

Sendo que já desenvolvemos junto desta organização um Programa de Gestão de Incidentes Críticos e de apoio aos colaboradores, que apoia psicologicamente as

vítimas, testemunhas e seus familiares de *incidentes*, revela-se necessário o desenho e implementação de uma resposta mais preventiva da gestão do stress particularmente para estas equipas operacionais.

Atendendo às limitações orçamentais, a proposta de intervenção não envolverá quaisquer custos financeiros para a organização, permitindo assim que se estabeleçam grupos de controlo para cada população, em que a intervenção passa apenas pela aplicação do instrumento de medição ao longo do tempo.

Problema

Na continuidade do estudo anterior revela-se crucial avaliar a efetiva eficácia do *Programa de Bem-Estar*, desenhado com uma abordagem multinível, participativa e interativa, e envolvendo a participação de profissionais de saúde e serviço social da própria organização na dinamização das ações de formação secundárias.

A utilização de grupo de controlo na referida população permitirá avaliar de forma mais precisa o efeito do programa nas percepções individuais de stress e bem-estar dos colaboradores, bem como nas estratégias de *coping* utilizadas (i.e., Resolução de Problemas, Negação e Suporte Social).

Estado da Arte

De acordo com a literatura, a eficácia e a sustentabilidade dos Programas de Gestão de Stress parece estar intrinsecamente relacionada com a concetualização, planificação e desenvolvimento de programas de intervenção e promoção de saúde que sejam interativos e customizados ao indivíduo e à organização. De facto verificou-se que estas características dos Programas resultam numa mudança comportamental mais sustentável comparativamente ao marketing social, verificando-se no entanto, dificuldades no recrutamento de participantes (Swerissen & Crisp, 2004).

A maior parte das intervenções de gestão do stress destinadas à mudança comportamental individual utilizam abordagens de educação/formação ou marketing social de forma a alterar o conhecimento, atitudes e crenças dos destinatários da intervenção. No entanto, a maioria dos programas, mesmo quando bem desenhados parecem apresentar níveis de sucesso relativamente baixos quanto à efetiva mudança de intenções e atitudes face aos riscos de saúde mais comuns (Mittlemark et. al., 1993; Winkleby, 1994; Fortman et al., 1995; van der Klink, et. al., 2001; Richardson & Rothstein, 2008).

Segundo vários estudos de meta-análise a avaliação da eficácia e resultados dos Programas de Gestão de Stress carece ainda de estudos que avaliem as variáveis organizacionais e não só individuais (e.g., psicológicas e fisiológicas) (van der Klink et al., 2001, Murphy & Sauter, 2003, Richardson & Rothstein, 2008).

Objetivos/Hipóteses

O estudo pretenderá avaliar de forma controlada o impacto de um Programa de Bem-Estar que implica uma intervenção multinível, participativa, interativa e multiprofissional numa empresa portuguesa do setor dos transportes.

O estudo terá como principais objetivos:

a) Avaliar a efetiva eficácia do Programa de Bem-Estar na redução dos níveis de stress no grupo, o incremento dos níveis de bem-estar e a adoção de estilos de coping mais positivos em contexto laboral;
b) Avaliar o impacto da participação de técnicos de saúde e de serviço social da própria organização nas ações secundárias, na referenciação terciária de colaboradores que já evidenciam sinais e sintomas de *distress*, alterações de desempenho ou de doenças relacionadas com o stress.

Atendendo à revisão bibliográfica já realizada, e aos resultados do primeiro estudo aplicado, espera-se que o Programa de Bem-Estar implique uma redução significativa dos níveis de stress percebido dos colaboradores do grupo experimental face aos do grupo de controlo, e um aumento significativo nos níveis de bem-estar em contexto laboral.

Esperamos igualmente que os participantes das sessões em que estarão presentes profissionais da área da saúde e serviços sociais apresentem um maior número de referenciações de colegas ou colaboradores que necessitem de apoio no âmbito do Programa de Apoio ao Colaborador (*EAP*) já disponibilizado na organização (Fase Terciária).

Método

A amostra envolverá duas populações da organização: a primeira a que se encontra no contato direto com o cliente (i.e., cobranças e área comercial); e a segunda as equipas que prestam apoio rodoviário. Atendendo ao elevado número de rescisões amigáveis de contratos no último ano nesta organização, não dispomos do número total de colaboradores que poderão ser alvo de intervenção, mas rondará cerca de 350 no total.

Os colaboradores serão convidados a participar num programa de bem-estar que implicará o envolvimento em 3 sessões breves de intervenção que se realizarão ao longo de 3 anos. A população para além das 2 áreas funcionais específicas será, tal como no estudo anterior, subdividida em chefias e colaboradores, sendo ainda controlada a variável género.

Serão constituídos aleatoriamente 2 grupos experimentais e 1 grupo de controlo a partir da base de inscritos no Programa. Os participantes do grupo de controlo serão

convidados a participar de sessões onde será apenas aplicado o questionário e agradecida a participação no levantamento das necessidades de intervenção que a Direção de Recursos Humanos pretende realizar anualmente nos próximos 3 anos.

Os dois grupos experimentais participarão no programa e nas 2 fases de intervenção, sendo que, para além da aplicação do instrumento, a primeira envolverá a metodologia de *focus group* com cada unidade funcional/regional, e a segunda o desenho customizado da sessão formativa que abordará os mesmos temas abordados no estudo anterior.

O grupo experimental 2 difere relativamente ao grupo experimental 1 pelo envolvimento na ação de formação secundária dos técnicos de saúde e serviço social da própria organização, que apresentam os serviços que disponibilizam internamente (e.g., âmbito, tipo de acompanhamento, forma de contato e referenciação, questões de confidencialidade) facilitando os seus contatos diretos e a sua disponibilidade para responder a qualquer questão que os colaboradores apresentem.

O instrumento a aplicar será idêntico, sendo que a aplicação será realizada *online*, estando para o efeito disponíveis computadores na sala para os participantes utilizarem. Será possível codificar o número do questionário com uma palavra chave que apenas o próprio participante define e utiliza sempre que responder ao instrumento, garantindo assim a anonimidade e a recuperação da palavra-passe, o que permitirá na análise dos dados estabelecer comparações intra-indivíduo.

Será ainda acrescentada uma dimensão core do *Engagement* à análise, a Absorção, que é avaliada na Utrecht Work Engagement Scale – versão geral através de 6 itens (“Esqueço tudo o que se passa à minha volta quando estou concentrada(o) no

trabalho.”). Os participantes serão convidados a responder com que frequência cada afirmação se verifica numa escala de 7 pontos, que varia entre Nunca (0) até Todos os dias (6).

Assim, as variáveis dependentes de auto-reporte do estudo serão: Exigências Emocionais (i.e., Emoções positivas, Emoções negativas, Dissonância Emocional); Exigência quantitativas e autonomia (i.e., Pressão de Tempo, Quantidade de trabalho, Autonomia); *Burnout* (i.e., Exaustão Emocional, Eficácia Profissional); *Engagement* (i.e., Vigor, Dedicação e Absorção); Relacionamento com clientes e colegas; Relação entre trabalho e família; e Estratégias de *Coping* (i.e., Resolução de Problemas, Negação e Suporte Social). Estas variáveis serão avaliadas anualmente durante um período de 3 anos, de forma medir o impacto de cada fase interventiva.

De forma a incluir neste estudo uma variável que não fosse alvo de auto-relato, será ainda medido em cada ano o volume de referenciações realizadas pelas chefias, por pares de colaboradores e pelo próprio (após feedback e encaminhamento realizado pela chefia) para os serviços de medicina no trabalho, serviços sociais e Direção de Recursos Humanos por apresentarem sinais e sintomas de exaustão emocional e alterações no seu desempenho profissional.

Em conjunto com a Direção de Recursos Humanos, que agrega toda a informação interna relativa a estes pedidos, poderemos registar o número de referenciações para o programa já em curso de apoio aos colaboradores, e será possível emparelhar com o grupo controlo/experimental 1/experimental 2 a que o “referenciador” e “referenciado” pertenceu no âmbito do Programa de Bem-Estar.

Estratégias previstas de discussão e conclusão

Na discussão procurar-se-á avaliar primeiramente o real impacto do Programa de Bem-Estar, com um desenho colaborativo e interativo, na redução dos níveis de stress e no incremento do bem-estar da população alvo, avaliando diferenças significativas, entre os grupos experimentais e de controlo, e intra-indivíduo.

Atendendo à existência de 3 momentos de medição será ainda possível acompanhar ao longo do tempo a utilização de diferentes estratégias de *coping*, mas igualmente as diferentes percepções e estratégias de conciliação vida-trabalho na população, que serão exploradas de forma qualitativa aprofundada.

Outra conclusão importante a procurar retirar será a efetiva facilitação da referenciação terciária de colaboradores pela participação nas sessões formativas secundárias de interlocutores internos da organização (i.e., Técnico(s) de Segurança, Saúde e Higiene no Trabalho e Técnico(s) de Serviço Social), face ao grupo experimental em que essa participação não ocorreu.

No final deste estudo ficará mais clara a contribuição efetiva do desenho multi-nível, colaborativo e interativo do Programa de Bem-Estar, e ainda do envolvimento de interlocutores internos na facilitação da referenciação para a fase terciária de intervenção.

Possivelmente serão identificadas novas limitações neste estudo, que orientarão o desenho de projetos subsequentes com maior rigor e controlo científico. Por exemplo, poderemos em futuras investigações incluir variáveis organizacionais com efeitos diretos nos níveis de stress percebidos dos colaboradores e que não são passíveis de serem controlados no âmbito de um programa de Bem-Estar conforme o proposto neste estudo (e.g., reestruturação organizacional, redução de custos, *lay-offs*, e *turnover*).

Considerações Éticas Finais

Atendendo à existência de um grupo de controlo no desenho de projeto de continuidade proposto, e dando resposta a evidentes preocupações éticas, propomos que os elementos do grupo de controlo sejam envolvidos após a avaliação e análise dos resultados dos 3 momentos de avaliação, num formato de intervenção primária e secundária semelhante ou eventualmente melhorado.

Desta forma, garantimos que todos os participantes da referida empresa são envolvidos em condições de relativa igualdade aos conteúdos, atividades e dinâmicas que envolvem o Programa de Bem-Estar. Por outro lado, os participantes dos grupos experimentais poderão ser de novo envolvidos nesta segunda fase de intervenção, agora como grupo de controlo, permitindo avaliar a estabilidade dos resultados obtidos pela intervenção ao longo do tempo.

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Anexo I – Instrumento Utilizado no Estudo

outCOme
CLÍNICA ORGANIZACIONAL

Questionário

Este questionário tem como objectivo recolher informação sobre o modo como as pessoas vêem a sua vida profissional. Não existem respostas certas ou erradas a este questionário, queremos apenas saber a sua visão pessoal sobre os assuntos abordados ao longo do mesmo. Não demore muito tempo a pensar sobre cada questão, as primeiras reacções são geralmente as melhores. Assinale as suas respostas na escala que se encontra à direita de cada item.

As respostas são confidenciais, pelo que ***em nenhuma situação*** os seus dados individuais serão dados a alguém.

Todos os questionários serão tratados, exclusivamente, pela Outcome-Clínica Organizacional e destruídos depois de consolidados.

A - Dados Pessoais

É importante para nós sabermos alguns dados pessoais sobre si, para podermos comparar as opiniões de diferentes grupos profissionais.

Sobre si

1. Género: Mulher ..... ☐ Homem ..... ☐	**2.** Habilitações: Básico ..... ☐ Secundário ..... ☐ Ensino Superior ..... ☐

3. Estado civil: Solteiro ..... ☐ Casado ou união de facto ☐ Separado/viúvo..... ☐	**4.** Idade dos filhos (em sua casa): _____anos _____anos _____anos _____anos ☐ Não tem filhos	**5.** O cônjuge trabalha? Sim ..... ☐ Não ..... ☐

B - As Exigências da sua Função

As questões que se seguem dizem respeito às **emoções** (positivas ou negativas) **que exprime quando lida com um cliente** nas situações gerais de atendimento. Para cada uma das situações descritas, indique a frequência com que demonstra essa emoção. Pense naquilo que acontece e não no que acha que devia fazer.

1. Muito raramente
2. Raramente (uma vez/semana)
3. Às vezes (uma vez por dia)
4. Frequentemente (várias vezes por dia)
5. Muito Frequentemente (várias vezes por hora)

Com que frequência no seu trabalho lhe acontece ter de exprimir emoções agradáveis aos seus clientes (ex. simpatia)?	1 2 3 4 5
Com que frequência no seu trabalho lhe acontece ter de mostrar emoções desagradáveis aos seus clientes (ex. firmeza ou agressividade quando as regras não são respeitadas)	1 2 3 4 5
Com que frequência no seu trabalho lhe acontece ter de fazer os clientes sentirem-se bem dispostos?	1 2 3 4 5
Com que frequência na sua função lhe acontece ter de pôr os clientes com um humor negativo (ex. ameaçar o cliente?)	1 2 3 4 5
Com que frequência lhe acontece ter de mostrar diferentes tipos de emoções positivas para com os clientes em função da situação (ex. simpatia e entusiasmo)?	1 2 3 4 5
Com que frequência lhe acontece ter de mostrar diferentes tipos de emoções negativas para com os clientes em função da situação (ex. agressividade, firmeza)?	1 2 3 4 5
Com que frequência lhe acontece ter você própria(o) que mostrar boa disposição, quando lida com os seus clientes (ex. alegre)	1 2 3 4 5
Com que frequência lhe acontece ter você própria(o) que mostrar mau humor quando lida com os seus clientes (ex. agressividade?)	1 2 3 4 5
Com que frequência na sua função lhe acontece ter que mostrar emoções que não estão de acordo com o que está a sentir em relação ao cliente, no momento?	1 2 3 4 5
Com que frequência na sua função lhe acontece ter que mostrar emoções agradáveis (ex. cortesia, simpatia) ou desagradáveis (ex. ser inflexível) quando o que está a sentir é diferente?	1 2 3 4 5
Com que frequência no seu trabalho lhe acontece ter que mostrar emoções que não estão de acordo com aquilo que realmente sente?	1 2 3 4 5

Pedimos-lhe agora que descreva algumas **características do seu trabalho**. Por favor responda a todas as questões assinalando com um X a resposta que melhor descreve o seu trabalho

	Nunca	Poucas vezes	Algumas vezes	Muitas vezes	Quase sempre
O meu trabalho exige que eu trabalhe depressa	1	2	3	4	5
No meu trabalho, tenho uma grande quantidade de coisas para fazer	1	2	3	4	5
Não tenho tempo para fazer todo o meu trabalho	1	2	3	4	5
Tenho demasiado trabalho para fazer	1	2	3	4	5
Sinto que não tenho tempo para terminar o meu trabalho	1	2	3	4	5
Tenho a possibilidade de decidir como organizar o meu trabalho	1	2	3	4	5
Tenho controlo sobre o que acontece no meu trabalho	1	2	3	4	5
O meu trabalho permite-me tomar decisões por mim própria(o)	1	2	3	4	5
No meu trabalho é-me pedido que tome as minhas próprias decisões	1	2	3	4	5

C – O Seu Bem-Estar

Na secção seguinte encontram-se 33 afirmações sobre **sentimentos relacionados com a sua actividade profissional**. Por favor leia cada frase atentamente e pense se alguma vez se sentiu dessa forma face ao seu trabalho. Se já teve esse sentimento, escreva o número (de 0 a 6) que melhor descreve *com que frequência* se sente dessa forma**.**

0. Nunca
1. Algumas vezes por ano
2. Uma vez, ou menos, por mês
3. Algumas vezes por mês
4. Uma vez por semana
5. Algumas vezes por semana
6. Todos os dias

Sinto-me feliz quando estou a realizar tarefas relacionadas com o trabalho.	0	1	2	3	4	5	6
Sinto-me desgastada(o) ao fim do dia de trabalho.	0	1	2	3	4	5	6
Esqueço tudo o que se passa à minha volta quando estou concentrada(o) no trabalho.	0	1	2	3	4	5	6
Sinto-me fatigada(o) quando acordo de manhã e tenho de enfrentar mais um dia de trabalho.	0	1	2	3	4	5	6
Estou imersa(o) no trabalho.	0	1	2	3	4	5	6
Ter actividades de trabalho todo o dia é realmente uma pressão para mim.	0	1	2	3	4	5	6
O trabalho satisfaz-me.	0	1	2	3	4	5	6
Lido muito eficazmente com os problemas do meu trabalho.	0	1	2	3	4	5	6
O meu trabalho é desafiante para mim.	0	1	2	3	4	5	6
Quando me levanto de manhã apetece-me ir para o trabalho.	0	1	2	3	4	5	6
Sinto que dou um contributo válido para o trabalho desta empresa.	0	1	2	3	4	5	6
O trabalho inspira-me coisas novas	0	1	2	3	4	5	6
Estou entusiasmada(o) com o trabalho	0	1	2	3	4	5	6
Em minha opinião sou uma(um) boa (bom) profissional.	0	1	2	3	4	5	6
No final do dia ainda tenho energia para outras actividades	0	1	2	3	4	5	6
Para mim é estimulante atingir os meus objectivos no trabalho.	0	1	2	3	4	5	6
Nas minhas tarefas neste emprego não paro, mesmo que não me sinta bem.	0	1	2	3	4	5	6
Realizei muitas coisas que valem a pena nesta profissão.	0	1	2	3	4	5	6
Dedico muito tempo às minhas tarefas ligadas com o trabalho.	0	1	2	3	4	5	6
Quando estou no trabalho não gosto que me incomodem com outras coisas.	0	1	2	3	4	5	6
As minhas tarefas no trabalho não me cansam.	0	1	2	3	4	5	6
O tempo passa a voar quando estou a realizar as minhas tarefas no trabalho.	0	1	2	3	4	5	6
"Deixo-me ir" quando realizo as minhas tarefas no trabalho.	0	1	2	3	4	5	6
No trabalho sinto que sou capaz de finalizar as minhas tarefas eficazmente.	0	1	2	3	4	5	6
Sou uma pessoa com força para enfrentar as minhas tarefas no trabalho.	0	1	2	3	4	5	6
Sou capaz de tomar iniciativas pessoais em assuntos relacionados com o trabalho.	0	1	2	3	4	5	6
É difícil para mim desligar-me das tarefas do trabalho.	0	1	2	3	4	5	6

Creio que o trabalho tem significado.	0	1	2	3	4	5	6
Sinto-me envolvida(o) no trabalho.	0	1	2	3	4	5	6
Sinto-me com força e energia quando estou a participar no trabalho.	0	1	2	3	4	5	6
Sinto-me motivada(o) para fazer bem o trabalho.	0	1	2	3	4	5	6
As minhas tarefas no trabalho fazem-me sentir cheia(o) de energia	0	1	2	3	4	5	6
Estou orgulhosa(o) por ter este emprego.	0	1	2	3	4	5	6

D - A sua Relação com os Clientes e Colegas

Nesta secção pedimos-lhe que avalie as relações que estabelece com os seus clientes e com os seus colegas **no dia-a-dia do trabalho. Por favor responda a todos os itens assinalando com um X a resposta que melhor o descreve na sua actividade profissional.**

	Nunca	Raramente	Às Vezes	Frequentemente	Quase sempre
Com que frequência sente que investe mais na relação com os **clientes** do que recebe em troca?	1	2	3	4	5
Com que frequência sente que dá muito de si comparativamente com o que recebe dos **clientes**?	1	2	3	4	5
Com que frequência sente que dedica aos seus **clientes** muito tempo e atenção, mas recebe pouco reconhecimento e apreciação deles?	1	2	3	4	5
Com que frequência sente que investe mais na relação com os **colegas** do que recebe em troca?	1	2	3	4	5
Com que frequência sente que dá muito de si comparativamente com o que recebe dos **colegas**?	1	2	3	4	5
Com que frequência sente que dedica aos seus **colegas** muito tempo e atenção, mas recebe pouco reconhecimento e apreciação deles?	1	2	3	4	5

E - A Relação entre o seu Trabalho e a Família.

Nesta secção pedimos-lhe que reflicta sobre a **relação entre a sua vida profissional e a sua vida familiar.** Por favor, responda às questões seguintes considerando a sua experiência pessoal.

1. Que aspectos da sua vida profissional dificultam a conciliação com a sua vida familiar?

_____
_____
_____
_____
_____
_____

2. Que factores da sua vida familiar dificultam o bom desempenho das suas funções profissionais?

_____
_____
_____
_____
_____
_____

3. De que forma consegue ultrapassar, com sucesso, os desafios colocados pela relação entre os aspectos do trabalho e da família?

_____
_____
_____
_____
_____
_____

F – Acções para Enfrentar o Stress

Nesta secção pedimos-lhe que indique **o que geralmente faz quando no seu trabalho** se defronta com acontecimentos difíceis ou geradores de stress, não esquecendo que diferentes acontecimentos provocam reacções, de alguma forma, diferentes.

	Não faço isto de todo	Faço um pouco isto	Faço isto moderadamente	Faço muito isto
1. Concentro os meus esforços em fazer alguma coisa quanto à situação em que me encontro.	←	↑	→	↓
2. Tento definir uma estratégia sobre o que fazer.	←	↑	→	↓
3. Tento ver as coisas de outra perspectiva para que pareçam mais positivas.	←	↑	→	↓
4. Aceito a realidade do que acontece.	←	↑	→	↓
5. Digo piadas sobre o assunto.	←	↑	→	↓
6. Procuro obter apoio emocional de outras pessoas.	←	↑	→	↓
7. Procuro encontrar conforto na minha religião ou nas minhas crenças espirituais.	←	↑	→	↓

8. Procuro obter conselhos ou ajuda de outras pessoas sobre o que fazer. ← ↑ → ↓
9. Volto-me para o trabalho ou outras actividades para não pensar no assunto. ← ↑ → ↓
10. Digo a mim própria(o) "isto não está a acontecer". ← ↑ → ↓
11. Exprimo os meus sentimentos negativos. ← ↑ → ↓
12. Desisto de tentar lidar com a situação. ← ↑ → ↓
13. Critico-me a mim própria(o). ← ↑ → ↓
14. Faço tentativas adicionais para tentar que a situação melhore. ← ↑ → ↓
15. Penso muito sobre quais os passos a dar. ← ↑ → ↓
16. Procuro encontrar algo de bom no que está a acontecer. ← ↑ → ↓
17. Aprendo a viver com o que me acontece. ← ↑ → ↓
18. Faço troça da situação. ← ↑ → ↓
19. Rezo ou medito. ← ↑ → ↓
20. Procuro obter conforto e compreensão de alguém. ← ↑ → ↓
21. Procuro ajuda e conselho de outras pessoas. ← ↑ → ↓
22. Faço coisas para pensar menos no assunto, como ir ao cinema, ver TV, sonhar acordada(o), dormir ou fazer compras. ← ↑ → ↓
23. Recuso-me a acreditar que isso aconteceu. ← ↑ → ↓
24. Digo coisas que ajudem a libertar as minhas emoções desagradáveis. ← ↑ → ↓
25. Desisto da tentativa de lidar com a situação. ← ↑ → ↓
26. Culpo-me a mim mesma(o) pelo que aconteceu. ← ↑ → ↓

Muito obrigado pela sua colaboração!

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Stress Management Programs as an Occupational Health Promotion Project in a Portuguese Organizational Setting

Liliana Dias
Maja Furlan

Abstract

Theoretical background: Given the increasing need for the design and implementation of organizational stress management and promotion of wellness in organizations, consulting in the area of occupational health psychology needs to offer integrated, strategic and sustainable solutions. Traditionally, the delivery of Stress Management Programs is developed by consulting providers, extremely focused on individual competences and perceptions, and with scarce connection to internal occupational health care and social work providers.

Method: The present mixed method study explores outcomes of two sessions of a Stress Management Program that was developed between 2007 and 2010 in a Portuguese multinational company within the energy sector.

371 participants participating in the program were at the time employees of the company. The program was destined for two populations, the first being the front office team including the employees in all owned stores nationwide (N = 339), and the back office debt management team (N = 32) as a second group.

A paper-pencil stress questionnaire was applied before any intervention as a baseline measurement of employee's perceptions of the following dimensions: Job Demands, Well-being, Relationship with clients and colleagues, Relationship between Work and Family, and Coping strategies.

The primary intervention was designed to evaluate the levels of stress and wellbeing of the employees and determine the stress and wellness factors, using a focus group methodology. After analyzing the qualitative and quantitative outputs generated from the primary intervention, the objectives and program content of the second phase sessions were designed, which involved training sessions with a similar duration.

Results: The program responded to the company's urgent need of reducing the levels of emotional exhaustion, which were manifested by employees to their managers and deputy directors. The results show significantly reduced perceptions of emotional demands and quantitative demands, especially for managers. Also, a significant increment of use of positive coping strategies, such as social support by increased perception of reciprocity in the relationship with colleagues. Focusing primarily on reducing perceived stress levels of the employees, and increasing positive coping strategies and empowerment, this Program also integrated, on the second phase of intervention, social workers and occupational health providers in the delivery of the training sessions. The goal was to connect the employees to their internal occupational and social work providers more directly in order to facilitate tertiary intervention referrals.

Discussion: This research highlights the need for further improvements of the design, tools and methodologies used, and proposes a multiprofessional integrative collaboration approach, that needs to be corroborated in future investigations of stress management interventions in organizational settings.

Key words: stress management, occupational health, health promotion interventions, multiprofessional collaboration

1 Literature Review

Occupational health psychology aims to develop, maintain and promote the health of employees and the health of their families. The primary focus is the prevention

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of illness, injury and distress through the creation of a safe and healthy work place environment (Quick, Quick, Nelson and Hurrel, 1997; Sauter, Hurrel, Fox, Tetrick and Barling, 1999). The challenge is promoting healthy organizations and healthy people by integrating several disciplines (e.g., organizational psychology, social psychology, health psychology, clinical psychology, public health, preventive medicine) (Scheider, Camara, Tetrick and Stenberg, 1999).

Several authors consider that a prevention model is highly appropriate in occupational health psychology since it is systemic in nature and recognizes the life history of a person and multifaceted complexity of many health problems (Ilgen, 1990; Quick et al., 1997).

Organizational-level occupational health interventions can be defined as planned, behavioral, theory-based actions to remove or modify the causes of job stress (i.e., stressors) at work and aim to increase the health and well being of participants (Giga, Cooper and Faragher, 2003; LaMontagne, Keegel, Louie, Ostry and Landsbergis, 2007; Richardson and Rothstein, 2008). These interventions seem to have the best effectiveness to achieve a significant impact if they follow a structured and participatory intervention process.

The Psychosocial Taskforce developed by the consortium of Danish labour inspectors identified seven criteria to describe the methods used in organizational-level interventions (cit. by Nielsen, Randall, Holten and González, 2010):

- Interventions should focus on organizational-level solutions (primary interventions) aimed at changing the work and they should be designed, organized and managed;
- Participatory principles should be the core component of the intervention;
- Methods of conducting interventions should systematically consider all phases during an interventions project, from planning to evaluation;
- Intervention methods should include considerations of how organizational-level occupational health programs can be integrated with existing procedures and organizational cultures and the management of occupational safety and health within the organization.
- Communication/education in and raising awareness of the risks posed by features of work design, organization and management should constitute part of the methods;
- Methods should take into account the organization's existing experiences with dealing with psychosocial risk factors;
- Small and medium-sized companies (SMEs) should be able to use the method.

Individual/worker level interventions are usually directed at changing characteristics of the individual/job interface, such as perceptions, attitudes and behaviors, with the aim of improving workers' well being. Examples of these interventions are: stress management, time management and conflict resolution seminars (Murphy and Sauter, 2004).

Commonly, stress management interventions include training designed to reduce the symptoms of stress, with a wide assortment of techniques, such as: meditation, biofeedback, muscle relaxation and cognitive behavioral skills training (Murphy and Sauter, 2004). The authors also consider that stress management training could be considered primary prevention if the training includes components that help employees change negative lifestyle habits and/or manage inaccurate perceptions of work organization factors.

Considering the effectiveness and sustainability of stress management programs, interactive and individually tailored health intervention programs seem to lead to higher levels of sustained behavior change than social marketing, but there seems to exist some difficulties in recruiting participants (Swerissen and Crisp, 2004).

Most of these interventions destined for individual behavior change make use of provision of information through education and social marketing in order to change knowledge, attitudes and beliefs, which are the precursors of behavior change. In the absence of other measures, even well designed programs seem to have relatively low success rate in producing the desired behavioral change intentions for most common behavioral health risks (Mittlemark, Hunt, Heath and Schmid, 1993; Winkleby, 1994; Fortman et al., 1995; van der Klink, Blonk, Schene and van Dijk 2001; Richardson and Rothstein, 2008).

Accordingly to Nytré, Saksvik, Mikkelsen, Bohle and Quilan (2000) and Saksvik, Nytré, Dahl-Jorgensen and Mikkelsen (2002) the implementation of a stress management program should: (1) create a social climate of learning from failure and motivate participants; (2) provide opportunities for multi-level participation and negotiation in the design of interventions; (3) acknowledge tacit and informal behaviors (4) clearly define roles and responsibilities before and after the intervention and (5) existence of competing projects and reorganization.

The present study intends to evaluate the impact of a multi-level, participatory, and interactive Well Being program designed and implemented in a Portuguese organizational context. According to the literature we expect that stress perceptions of employees, both managers and attendants, will be altered, and positive attitudes and positive coping skills will be reinforced through the participation on primary and secondary intervention sessions.

2 Method

Participants. Participants of this study were employees of an energy sector company in Portugal, who were involved in a Well Being Program designed specifically for them. The Well Being program addressed two different samples, the first the front office team that worked in stores of the company all over the country and the second the back office debt management team.

The primary intervention with the front office team, occurred by the end of 2007, involving 339 employees, among them 51 were store managers (47.1% females and 52. 9% males) and 288 attendants (46.9% females and 53.1% males). The secondary intervention, developed one year after, with the same population involved 288 employees, 58 store managers (29.3% females and 70.7% males), but 9 store managers were not included in the study because they were outsourced employees that didn't participate in the primary intervention. Only 224 attendants participated on the secondary intervention (43.3% females and 56.7% males).

The debt management back office team participated in the Well Being program in 2009 for the primary intervention, with 4 managers (all of them males) and 28 employees (57.1% females and 42.9% males). In 2010, on the secondary phase of intervention, only 3 managers (all of them males) and 29 employeesparticipated (65.5% females and 34.5% males), because a new member was added to the team, which was not included in the analysis of this study.

Program design. The program was customized and proposed to the company in order to address the need to reduce the perceived stress levels already reported to the managers by the front-office team, and later by the back office debt team. With the aim to evaluate perceived stress and promote well being, training sessions were developed for the primary and secondary interventions.

The primary interventionincluded a 6-hours training session with the managers, and 3-hours training session with the employees in the real work context (store or office department). This first session had the main goal to evaluate stress factors and well being factors in each team unit (e.g., store or office team) but also already existing individual and group coping strategies that need improvement or development by using a focus group methodology. A positive, participative and learning from failure context was facilitated and the main goal was to actually train participants in identifying stress factors, wellness factors and positive individual and group coping strategies.

On the second training session the goal was to develop the positive coping skills that they identified, on the first session, as crucial for their stress management, and also to include in the session the presentation, and participation of internal social services professionals in order to facilitate tertiary referrals. The main themes addressed on the secondary interventions were for the managers: Managing Team Stress; Emotional Work and Emotional Management; Leadership Strategies to Promote Well Being at Work; And for the employees: Individual Well Being and Team Well Being; Work-Life Balance and Stress; Emotional Work and Emotional Management; Coping Skills; Social Support and Stress. Several active training methodologies were used such as case study, group dynamics, role-play, group work and discussion forum. The group was invited to learn and create different ways to address work-life balance demands, and to individually and cooperatively address the identified stress factors and increment the wellness factors promoters on site.

Study Instrument. To measure the perceived stress and coping resources of the population a paper-pencil questionnaire was applied to all participants at the beginning of the first sessions of the program, just after the presentation of the facilitators, and before any training or information about stress at the workplace. In such way, a baselinewas generated in order to measure impact of the different interventions. A second measure was made just before the second session, and the results of the study will analyze the impact of the primary intervention, because no third measurement was possible due to the company decisionof not to proceed with a third moment of measurement.

Several demographic variables were measured, namely gender, level of qualification, marital status, age of children and working spouse, in order to explore significant differences in the sample concerning stress perception and coping skills.

The instrument consisted of a Portuguese tested version and was created using several international scales used in other studies of a research team unit at the Faculty of Psychology University of Lisbonled by Prof. Maria José Chambel that collaborated in the present project (Castanheira and Chambel, 2009, 2010; Chambel and Oliveira-Cruz, 2010; Salanova, Lorente, Chambel and Martinez, 2011)

Measured Dimensions

Emotional demands. Emotional dissonance and the requirements to express positive emotions and to express negative emotions were assessed using a Portuguese

translation of the Frankfurt Emotion Work Scales (Zapf, Vogt, Seifert, Mertini and Isic, 1999). Emotional Dissonance included 4 items about the requirement to display unfelt emotions (e.g., *"How often in your job do you have to display emotions that do not agree with your true feelings?"*). The requirement to express positive emotions included 4 items (e.g., *"How often in your job do you have to display pleasant emotions towards customers?"*). Finally, the requirement to express negative emotions included 3 items (e.g. *"How often do you have to display unpleasant emotions towardscustomers?"*). Items were scored on a five-point Likert scale, ranging from *Very Rarely/Never* (1) to *Very Often* (5). All scale scores presented good internal reliability (Cronbach's alpha of emotional dissonance 0.76; Cronbach's alpha of requirement to express positive emotions 0.69; Cronbach's alpha of requirement to express negative emotions 0.79).

Quantitative demands and Autonomy. Quantitative demands and Autonomy were assessed using a Portuguese translation of Karasek et al. (1998) instrument. Quantitative Demands included 5 items about time pressure and workload (e.g. *"To what extent does your job require your working hard?"*). Autonomy included 4 items related to the employee's autonomy to make job-related decisions (e.g. *"To what extent do you have the freedom to decide how to organize your work?"*). Items from both scales were scored on five-point Likert scale, ranging from *Never* (1) to *Very Often* (5). All scale scores presented good internal reliability (α Quantitative demands 0.77; α Autonomy 0.81).

Burnout. Burnoutwas measured using two core dimensions, emotional exhaustion, and professional efficacysubscale of the Maslach Burnout Inventory – general version (Schaufeli, Leiter, Maslach and Jackson, 1996) using 4 items to measure emotional exhaustion (e.g., *" I am emotionally exhausted by my work."*) and 6 items for professional efficacy (e.g., *"At my work, I am confident that I am effective at getting things done."*). Participants were asked to rate the frequency of each statement on a seven-point scale, ranging from *Never* (1) to *Every Day* (6). All scale scores presented good internal reliability (α emotional exhaustion 0.74; α Professional efficacy 0.77).

Engagement. Engagement was measured using the two core dimensions, vigor, dedicationsubscales of the Utrecht Work Engagement Scale – general version (Schaufeli, Salanova, González-Romá and Baker, 2002). Vigor was measured with 9 items (e.g., *"At my job, I feel strong and vigorous."*), dedication with 8 items (e.g., *"I am enthusiastic about my job."*). Participants were asked to rate the frequency of each statement on a seven-point scale ranging from *Never* (0) to *Every day* (6). All scale scores presented good internal reliability (α vigor = 0.76; α dedication = 0.90).

The questionnaire also included questions that aimed to evaluate the *Relationship with Clients* (3 items) and *Colleagues* (3 items), particularly the reciprocity perception in those relationships (e.g., Clients *"How often do you feel that you give more to your clients than you receive?"*; Colleagues *"How often do you feel that you invest more in the the relationship with your colleagues than you receive in return?"*). The questions were inspired on Hobfoll's (1988, 1989, 1998) Conservation of Resources (COR) theory, in which resource loss is the primary operating mechanism driving stress reactions. Participants were asked to rate the frequency of each statement on a Likert scale, ranging from *Never* (1) to *Almost Everyday* (several times an hour). Both scales presented a good internal consistency (α reciprocity with clients 0.78; α reciprocity with colleagues 0.91).

Three open questions were used in order to explore the work-life balance perception (e.g., *"What aspects of your professional life are making conciliation with your family life more difficult?"*;*"What factors of your family life make your performance at work more difficult?"*; *"How do you successfully overcome the challenges of work-life balance?"*).

Finally, three coping strategies at the workplace were assessed. Problem Solving was assessed on 4 items (e.g., *"I try to establish a strategy on what to do."*), Denial on 5 items (*"I turn to my work or other activities in order to not think on the subject."*) and Social Support on 4 items (e.g., *"I look for advice and help from others about what to do."*). All scales presented a good internal reliability (α problem solving 0.69; α denial 0.67; α social support 0.76).

Control Variables. Gender was controlled since it can be related to individual's stress management abilities (Schaufeli and Buunk, 2003), Age couldn't be controlled due to the need to preserve participants identity in the program.

Data analysis. Data was analyzed using SPSS - Statistical Package for Social Sciences, and a descriptive analysis of each variable: confirmation of values and missing data, mean responses, standard deviation, minimum and maximum values. In addition, we carried out a frequency analysis in order to characterize each sample. For quantitative data we usedOneway ANOVA and Scheffe's as a post hoc test, in order to evaluate the statistical significance of means differences between Managers and Attendants, and a Paired Sample T-Test to evaluate differences between Primary and Secondary Interventions.

For the open-response questions, we performed a content analysis to categorize the responses. The categories shown correspond to the answers with higher frequency to each question.

3 Results

Front Office. The results show in Table 1 that significant differences were found between managers and the attendantson the first measurement. Managers revealed higher expression of negative emotions ($F(337)$=11.17, p<.05), higher emotional dissonance ($F(334)$=5.77, p<.05), higher quantitative demands ($F(327)$=4.57, p<.05), higher autonomy ($F(333)$=29.22, p<.05) and higher use of problem solving ($F(333)$=9.99, p<.05) compared to attendants. No differences were found on the secondary interventions between managers and attendants.

Comparing the first and second measurements shop managers perceived a reduced requirement to express positive emotions in their work ($t(47)$=2.15, p<.05), reduced emotional dissonance ($t(48)$=2.61, p<.05), and reduced work load perception ($t(48)$=2.73, p<.05). In the attendants sample also a significant reduction of requirement to express positive emotions ($t(223)$=3.11, p<.05) and increased perception of reciprocity with colleagues ($t(218)$=3.49, p<.05) were found after the primary intervention.

Back Office. No statistically significant difference was found between managers and attendants of the debt management team, on both measurement moments. The results show (Table 2) a significant decreased in the need to express negative emo-

Table 1 – Front Office Results Primary and Secondary Intervention

	Primary Intervention (I)					Secondary Intervention (II)					Means Comparison I &II			
											Managers		Attendants	
Dimension	$M_{Managers}$	SD	$M_{Attendants}$	SD	F	$M_{Managers}$	SD	$M_{Attendants}$	SD	F	t		t	
Positive Emotions	4.09	0.53	4.03	0.61	0.38	3.82	0.69	3.84	0.64	1.05	***2.15**		***3.11**	
Negative Emotions	1.87	0.66	1.55	0.63	***11.17**	1.76	0.68	1.58	0.63	0.57	1.07		0.20	
Emotional Dissonance	3.38	0.66	3.05	0.93	***5,77**	2.90	1.05	3.07	0.87	1.35	***2.61**		0.52	
Quantitative Demands	3.70	0.64	3.49	0.63	***4.57**	3.33	0.69	3.50	0.69	0.58	***2.73**		0.32	
Autonomy	3.93	0.67	3.25	0.84	***29.22**	3.90	0.67	3.22	0.79	0.44	0.12		0.54	
Emotional Exhaustion	3.31	1.41	3.43	1.44	0.30	3.06	1.46	3.29	1.42	0.79	1.03		1.41	
Professional Efficacy	5.34	0.52	5.21	0.75	1.28	5.23	0.63	5.10	0.80	1.05	0.81		1.39	
Vigor	4.90	0.68	4.66	0.84	3.56	4.79	0.65	4.5	0.90	1.31	0.72		1.31	
Dedication	5.15	0.78	4.88	1.06	3.05	4.98	0.88	4.73	1.08	0.57	0.96		1.28	
Reciprocity with Clients	3.50	0.78	3.62	0.75	0.95	3.65	0.75	3.66	0.73	0.69	0.74		1.02	
Reciprocity with Colleagues	2.55	0.84	2.62	0.98	0.23	2.83	0.89	2.86	0.83	0.65	1.71		***3.49**	
Problem Solving	3.34	0.43	3.07	0.58	***9.99**	3.34	0.42	3.11	0.58	0.91	0.02		0.55	
Denial	1.93	0.57	1.95	0.61	0.06	1.98	0.70	1.98	0.62	1.04	0.38		0.291	
Social Support	2.60	0.69	2.43	0.65	2.67	2.50	0.71	2.50	0.69	0.55	0.80		0.80	

* p value <.05

Table 2 –Back Office Debt Team Primary and Secondary Intervention

	Primary Intervention (I)					Secondary Intervention (II)					Means Comparison I &II				
Dimension	$M_{Managers}$	**SD**	$M_{Attendants}$	**SD**	**F**	$M_{Managers}$	**SD**	$M_{Attendants}$	**SD**	**F**	$M_{Total\ Sample(I)}$	**SD**	$M_{Total\ Sample\ (II)}$	**SD**	**t**
Positive Emotions	3.56	0.69	3.69	0.24	0.27	3.17	0.38	3.58	0.66	1.05	3.65	0.54	3.57	0.69	0.35
Negative Emotions	2.67	0.72	2.83	1.50	0.15	2.78	0.51	2.03	0.77	1.64	2.58	0.93	2.02	0.80	*2.17
Emotional Dissonance	1.69	0.85	1.56	0.52	0.21	2.25	0.25	2.94	0.87	1.35	1.99	0.82	3.02	0.81	*4.04
Quantitative Demands	3.90	0.48	3.69	0.59	1.78	3.53	0.23	3.81	0.68	0.69	3.93	0.74	3.80	0.69	0.68
Autonomy	3.38	0.43	4.13	0.60	2.32	3.42	0.63	3.50	0.65	0.20	3.59	0.66	3.49	0.66	0.61
Emotional Exhaustion	2.75	1.06	1.81	0.61	5.96	2.56	0.19	3.03	1.60	0.50	2.57	1.07	3.11	1.56	1.52
Professional Efficacy	5.54	0.37	5.62	0.13	0.42	4.83	1.26	5.14	0.55	0.82	5.16	0.64	5.14	0.56	0.12
Vigor	5.00	1.10	5.36	0.11	0.80	4.20	0.81	4.72	0.70	1.21	4.75	0.78	4.70	0.70	0.19
Dedication	4.63	2.27	5.63	0.23	0.86	3.79	1.09	4.76	0.87	1.80	5.03	0.73	4.76	0.89	1.16
Reciprocity with Clients	3.58	0.69	4.17	0.33	1.17	3.11	0.19	3.25	0.79	0.30	3.33	0.70	3.37	0.67	0.22
Reciprocity with Colleagues	2.42	1.29	2.08	0.17	0.49	2.89	0.19	2.68	0.70	0.51	2.35	0.57	2.72	0.68	*2.52
Problem Solving	3.63	0.14	3.56	0.38	0.40	3.00	0.00	3.13	0.47	0.47	3.38	0.41	3.18	0.42	1.79
Denial	1.55	0.30	1.65	0.25	0.27	1.40	0.40	1.72	0.57	0.94	1.97	0.62	1.74	0.57	1.34
Social Support	2.31	1.14	2.50	1.08	0.23	2.08	0.76	2.40	0.62	0.84	2.47	0.75	2.48	0.57	0.03

** p value <.05*

tions at work after the primary intervention (*t(26)*=2.17, *p*<.05), and an increased perception of emotional dissonance (*t(26)*=4.04, *p*<.05).In line with the results of the front office team there was also an increased perception of colleague's reciprocity (*t(26)*=2.52, *p*<.05).

Control Variables. Significant differences were found considering the gender of participants for the front-office team.In the management population men seemed to reveal higher professional efficacy than women at the front office management team (*F(50)*=4.37,*p*<.05) and lower use of problem solving when coping with stress (*F(50)*=4.17,*p*<.05). In the front-office attendant sample, women showed a significant increase in the expression of positive emotions (*F(287)*=7.40 *p*<.05) and a higher significantly use of denial (*F(282)*= 20.13; *p*<.05) and social support (F=(280)=7.04, p<.05) compared to men. Considering the total sample of the front-office women revealed a significantly increase in expression of positive emotions (F(337)=9.11, p<.05), in use of problem solving (F(333)=5.75, p<.05), denial (F(333)=17.62, p<.05) and social support (F(331)=9,244, p<.05) coping strategies compared to men. No significant differences were found at the back office debt sample considering gender.

Qualitative Analysis. In terms of qualitative outputs (Table 3) our aim was to identify the threehigher frequency categories of answers considering aspects of professional life that difficult conciliation with family life, aspects of family life that difficult work performance, and finally the main strategies to achieve work-life balance.

Work Factors. The higher percentage of participants referred time and workload as a major stress factor for work-life balance, with higher frequency on the back office team (75,0% managers and 46,4% attendants).

Traveling also seemed to be a frequent factor that creates difficulties in terms of conciliation with personal and family life, present in both populations between 7,2% (Back-Office Attendants) and 25,0% (Back-Office Managers).

Family Factors. The main category found in terms of family factors that impact on performance at work was family support (frequencies ranging from 25,0% to 13,0%) and child care (frequencies from 25,0% of managers, to 6,0% of back-office attendants).

WLB Strategies. The front office team referred planning and organization as an important strategy of conciliation (25,0% of managers and 12,0% of attendants).

Both populations referred conciliation of needs and role demands as an important coping skill and only the back office attendants revealed a higher use of total separation of work life from family life, which seems, in their statements, related to denial and avoidance stress coping strategies.

4 Discussion

The program revealed to have an impact on stress perceptions of both populations, particularly on emotional work demands (i.e., positive emotions, negative emotions and emotional dissonance), perception of reciprocity with colleagues, and in front-office managers' perception of quantitative work demands.

The results also show that in the front-office population the stress perceptions and coping skills of managers and attendants were more homogeneous after the primary intervention than before.

Table 3 – Qualitative Results | Frequency of Answers

	Front Office				Back Office			
Questions	**N valid**	**Managers**	**N valid**	**Attendants**	**N valid**	**Managers**	**N valid**	**Attendants**
"What aspects of your professional life are making conciliation with your family life more difficult?"	48	Time & Work Load (37%) "Particularly the time schedule and the excessive amount of work."	184	Time & Work Load (15%) "The accumulation of work for the next day."	4	Pressure (75%) "Working with a lot of pressure with no time to perform the tasks."	18	Time & Work Load (46,4%) "A lot of work, and little dialogue, few time to perform the tasks in order to achieve the goals."
		Traveling (21%) "The fact that I have to travel more than 140 KM to get to work."		Traveling (10%) "The distance between home and work."		Traveling (25%) "Work meetings far a way from home."		High professional dedication (10,7%) "Total dedication even after hours"
		High professional dedication (6%) "The scarce time to be with our family"		Emotional Exhaustion (6%) "Our work is very exhausting."				Traveling (7,2%)
"What factors of your family life make your performance at work more difficult?"	48	Family Support (25%) "Sometimes health problems in the family."	184	Family Support (13%) "When there is some family problem is difficult to put it aside".	2	Family Support (25%) "To accompany my wife in some doctor appointments."	28	Family Support (21,4%) "If I have a family member ill of dependent."
		Child Care (8%) "Give attention to my child, his development and problems."		Personal Problems (8%) "Sometimes due to personal problems."		Child Care (25%) "The disease of my children"		Child Care (10,7%) "Missing work because of children disease."
		Domestic Management (6%) "Some everyday worries and home work."		Child Care (6%) "The behavior of children on every level"				Absence of spouse understanding (7,2%) "When our spouse doesn't understand the demands of work"
"How do you successfully overcome the challenges of work-life balance?"	47	Planning & Organization (25%) "With organization and method."	170	Planning & Organization (12%) "With specific rules and time management."	4	Motivation & Optimism (50%) "With time and will everything is possible."	28	Separation of Work & Family (42,9%) " I complete separate work from family."
		Conciliation (25%) "Trying to dialogue and achieve the best negotiation possible."		Conciliation (11%) "There exists a lot of comprehension and help in house work."		Conciliation (25%) "To manage intelligently the demands of both sides"		Conciliation (21,4%) "Trying to conciliate the professional and family aspects"
		Motivation & Optimism (8%) "With dedication and commitment."		Motivation & Optimism (9%) "With high spirits and good will."		Sports & Hobbies (25%) "We have a lot of ludic activities together as a family."		Motivation & Optimism (17,9%) "With a lot of persistence, energy and optimism, and luckly I have a solid family and a job I love."

We believe that the impact was particularly potentiated by the customized design of the training sessions, particularly the involvement of participants in the design of the program on the first session. A second important feature of the program was the fact that social work internal professionals were invited to participate on the second sessions, which facilitated future tertiary referrals, reducing 'resistance towards counseling for stress' (Gyllensten, Palmer and Farrants, 2005) thus promoting rehabilitation of individuals already with burnout symptoms in the population.

Limitations. Our study presented several limitations that must be considered. Firstly, all quantitative measures of the study were self-reported which raises the question of the results to be contaminated by the common method variance. Nevertheless, the methodology seem adequate because the main aim of the program was to influence the perceptions of employees and reinforce their stress coping techniques in order to improve well being and resiliency at work.

The sampling of participants was not entirely in our control, and some changes in the composition of the samples happened. Although we excluded the participants that clearly didn't participate in the first session, it was not possible to control that samples were totally comparable because anonymity was a requisite of the program. Due to the confidentiality requirement it was also not possible to explore intra individual results in this study. The methodology of the first sessions in the program raises some questions considering the term primary intervention, which accordingly to the literature focus on people who are not at risk, usually used in health education campaigns (Schmitt, 1994), and are operationalized as organizational-level solutions aimed at changing how work is designed, organized and managed (Nielsen et al., 2010). The fact that participants were called to a session entitled *Well Being Program*, that addressed discussion topics with managers about job re-design, task distribution and time management, also, in our opinion, corroborates the primary focus of this program.

Future program designs and research should use more rigorous research designs, and try to investigate the long-term effectiveness of organizational and individual strategies to enhance well being at work, that includes in the design the participation of health and social work professionals of the organization.

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Organizacijske ovire pri zdravljenju odvisnikov od prepovedanih drog in alkohola

Organizational Barriers in Treating Drug and Alcohol Abusers

dr. **Tonka Poplas Susič**

Izvleček

Teoretična izhodišča: V Sloveniji je obravnava odvisnikov od psihoaktivnih substanc (PSA) urejena na različnih nivojih zdravstvenega varstva. Zanimalo nas je, kako bi lahko s primerno organizacijo izboljšali dostopnost in zdravljenje odvisnikov, zlasti ko le-ti prvič vstopajo v zdravstveni sistem.

Metoda: Kvalitativna raziskava s fokusnimi skupinami v okviru evropskega projekta IATPAD je vključila 18 zdravnikov. Pogovori so bili posneti, prepisi pa kvalitativno analizirani.

Rezultati: Organizacijske ovire so: pomanjkanje strokovnjakov; pomanjkanje multidisciplinarnih timov; predolge čakalne dobe; preslabo poznavanje organizacije zdravljenja bolezni odvisnosti na sekundarnem nivoju in zato neustrezno napotovanje; pomanjkanje znanja in veščin pri zdravnikih na primarni ravni; oddaljenost centrov za preventivo in zdravljenje odvisnosti od prepovedanih drog ter vezanost na javni prevoz; odvisniki s pridruženimi duševnimi boleznimi in tisti, ki so odvisni od več psihoaktivnih substanc (PAS); pomanjkanje programov za preprečevanje recidiva, zavarovalni status.

Razprava: Zaradi obremenjenosti osebni zdravniki ne obravnavajo odvisnikov od PAS načrtno in zato tudi ne kažejo interesa, da bi na tem področju pridobili dodatna znanja. Potrebno je opredeliti, kje naj se zdravijo odvisniki, ki imajo pridružene še duševne bolezni, ali tisti, ki so odvisni od več PAS (dvojna diagnoza). Na oddelkih za zdravljenje odvisnosti od drog tako v Sloveniji kot tudi v drugih državah kot pogoj za vstop v program zdravljenja zahtevajo prenehanje uživanja drog. V primeru bolnikov z dvojno diagnozo je to resna ovira. Pri metadonskem nadomestnem zdravljenju pogosti obiski v centrih predstavljajo oviro, zlasti če imajo osebe še stroške z javnim prevozom. Za vstop v proces zdravljenja je potrebno imeti urejeno zdravstveno zavarovanje in osebno izkaznico, kar je lahko ovira, ker mnogi tega nimajo.

Ključne besede: psihoaktivne snovi, organizacijske ovire, kvalitativna raziskava, zdravljenje, odvisnik

Abstract

Introduction: The treatment of people with alcohol or drug dependency depends on organizing ability of the health care institutions. Adopted organizational structure can improve the management of these patients.

Methods: Qualitative research with focus groups included 18 physicians. Transcribed text was analysed.

Results: From the organizational standpoint, one of the most important obstructing factors is the lack of experts and multidisciplinary teams and, consequently, the long waiting periods. In regard to the medical staff, the obstacles are due to the fact that there is still an insufficient amount of knowledge on addiction diseases and organization of treatment. If the addiction appears as a secondary disease in combination with mental illness, treatment is much more demanding. The same situation arises regarding combined addictions to several psychoactive substances. The distance towards health centre is also an obstacle and so is not having assurance card.

Discussion: Family physicians are very burdened with a number of patients and therefore they do not manage patients with drug/alcohol dependency systematically. It is necessary to define the place, where patients with dual diagnosis (dependency and psychosis or dependency on two substances) should be managed. The distance of the centre to the place of living could present obstacles, while patients have to spend money for bus/train tickets and visiting the centre is usually relatively frequent. To enter the treatment, patients must have settled their health insurance status and personal identification card and for this kind of people that could be a problem.

Key words: drugs, organizing obstacles, qualitative research, treatment, drug dependence

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