

# Occupational Stress Management Intervention: An Informative Perception

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## Abstract

This article provides an overview of stress management interventions (SMIs) and the evidence that they improve employee well-being. The objective of this study is to identify the individual-level stress (personal) and stress at an organisational level (workplace) and to suggest certain intervention techniques at primary and secondary levels to reduce it. To begin, we create a classification system for SMI, as it is taught in accordance with degree (i.e., the personal stage or the organisational stage) and recognition (i.e., a 'number one' focus on changing the causes of stress or a 'secondary' or 'tertiary' attention on lowering stress itself). Relaxation methods, cognitive behavioural treatment (CBT) and mindfulness training are all examples of secondary character-stage SMI (such as implementing new organisational policies and procedures) and are subcategories of SMI based on how widely they have been proven to work (e.g., process redesign, adjustments to running time schedules). There is a lot of data to support these two SMI techniques, but the study concludes by strengthening the evidence base for SMI treatments requiring a good methodological design, as well as improved knowledge on the context and people in which SMIs are most successful, how SMIs are administered and long-term effects of SMIs. Therapy for mental health issues, stress management and CBT study was carried out from June to August 2022.

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**Keywords**

Stress management intervention, relaxation method, cognitive behavioural treatment. mindfulness training and cognitive behavioural therapy

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**Introduction**

From boosting productivity to lowering absenteeism, companies may benefit from increasing employee health and reducing stress in many ways (De Neve et al., 2013). Employee well-being may be improved and stress reduced by using a variety of activities that can be used by companies to either treat stress's root causes or decrease its impact on an individual's personality. This chapter examines the efficacy of various stress management strategies for bettering one's mental health. There are three key elements to this essay. Stress management interventions (SMIs) come in a variety of forms, and we will demonstrate how they may be used in real-world situations. We will speak about the evidence for the efficacy of SMI after we first quickly discuss the methodological problems that are used when evaluating therapies in order to provide the reader some reasons for knowing about the best evidence in this field. A summary of what we have found works best to complete our conversation is provided below.

According to this wide definition, we include studies on such topics as burnout, stress and depression as well as more recent efforts to measure the current state of well-being in people's subjective perceptions of well-being. Studies on physical fitness or interest attitudes or on the effects of well-being at the organisational level, such as illness and absenteeism, are not included in our analysis. Be aware that bettering one's psychological well-being may also improve one's physical health, sense of accomplishment in the workplace and frequency of absences. While briefly discussing the methodological issues that are used when assessing treatments in order to offer the reader with some grounds for understanding the best evidence in this subject, a summary of what we have found works best to complete our conversation is provided below.

**Stress Management Interventions: Categorisation and Description**

It is a typical practice in stress management literature to classify stress management tactics based on the attention they get and the extent to which they are used (DeFrank & Cooper, 1987). Depending on how much focus is placed on stress control, basic, secondary and tertiary treatments may be categorised. Prevention of stress is the goal of primary interventions, which aim to remove and enhance factors that contribute to it. As quickly as possible, secondary interventions are used to lessen the intensity or duration of stress, as well as to avoid the amount of stress from becoming overwhelming. Third-level interventions are aimed at improving and enhancing the lives of those who are already suffering from or afflicted by mental illness.

Individual and organisational levels of intervention are relatively uncommon and simple to distinguish. When it comes to stress management, both individual and organisational treatments concentrate on helping employees learn how to better cope with the pressures of their jobs and how to better manage, deal with and decrease stress. There is a third type that is used in certain classifications: individual–organisational stage interventions. This kind of intervention is characterised by its emphasis on improving the interaction between individuals and organisations, such as peer support groups. For simplicity's sake, we will stick to identifying treatments at the personal and organisational levels as the line between them has not been blurred much recently. SMIs may be categorised into primary, secondary and tertiary levels based on their recognition and degree of implementation. Throughout the remainder of this section, we will discuss the various SMIs and their usefulness.

### *Individual-level Interventions*

The main goal of intervention is to alleviate any existing stress that an employee may be experiencing. Selection and assessment techniques that pick candidates with abilities to control the process's requirements and filter out those who are more likely than not to experience stress in the desired job, particularly in very upsetting professions, are one way to achieve this goal (Bartone et al., 2008). However, despite the fact that such treatments might help manage stress and promote well-being, they are not always implemented (Giga et al., 2003).

Interventions at the secondary level aim to provide workers with stress management skills and competences; additionally, there are opportunities for stress-reducing hobbies. Meditation, cognitive behavioural therapy (CBT) and mindfulness training are just a few of the strategies that may be used in conjunction with relaxation and exercise programmes to improve mental health. The goal is to decrease or eliminate the sources of stress and to lower the level of stress that individuals feel; these tactics concentrate on emotion legislation procedures and reaction-focused emotion control strategies. The use of rest, CBT) and mindful sports activities are all examples of multimodal treatment at the individual level. With a wide range of skills that can be used in extraordinary situations, such an approach has the potential to develop and enhance both antecedent- and response-focused emotional control strategies, which will benefit both individuals and the company. Individual effectiveness of SMIs in general has been supported by a substantial body of literature on secondary person treatments, for example.

Stress (i.e., heightened horrible states of well-being including worry, anxiety and wrath) and relaxation are thought to be mutually exclusive (Russell, 1979). Relaxation and stress cannot exist at the same time; therefore, boosting rest requires lowering stress levels as well. Stress-relieving techniques exist in a variety of shapes and sizes, but they may all be grouped under the umbrella term 'response-based emotion law therapies'. To achieve progressive muscular relaxation, a certain set of muscles is tense and then relaxed in a predetermined order during the length of the video. In order to get your forearm muscles to relax,

begin by clenching and unclenching your hands one after the other, and so on. Workers may rapidly achieve a deep level of muscular relaxation by engaging in physical activity, which can last anywhere from minutes to hours (Murphy, 2003).

Another relaxing method is meditation; however, this one focuses more on the mind than on the body. To maintain a passive intellectual condition free of intruding thoughts, several techniques call for the practitioner to sit quietly and repeat a phrase or sound. There are secular and standardised procedures that may be used for research despite the fact that meditation has its origins in a non-secular practice (Carrington et al., 1980). The inhalation and exhalation of the breath may be used in conjunction with relaxation methods such as muscle relaxation and meditation, but breathing techniques alone can also be used.

Patients who get CBT for mental health issues such as anxiety and depression as a result of stress may benefit from the use of techniques that target maladaptive thinking patterns. This is addressed through CBT, which aids the individual in uncovering and refuting erroneous beliefs they may have regarding stress and how it manifests in their lives. CBT's behavioural specificity encourages the user to practice new habits in addition to promoting new behavioural responses in stressful circumstances. Precedent-centred emotion approaches are used to assist individuals to reassess and rebuild their knowledge of their stress and worrying behaviours in accordance with CBT (Hofmann & Asmundson, 2008). Csiernik (2011) conducted an intervention with teachers that included three phases: an approach to dealing with stress and its causes; ability to detect and replace illogical thinking with sensible ones; and development and practice of new cognitive, emotional, and behavioural capacities. Compared to a passive listening group and a peer guide organisation, the CBT intervention was shown to be more effective in reducing stress. Henrich et al.'s (2023) study explains the effectiveness of training in CBT appraisal to address present gaps in the prose by focusing on the explanation of the exact training mechanism and their related costs, as well as exploratory therapist-level predictors of training effectiveness.

The practice of cultivating one's awareness of the present moment is becoming more popular awareness (i.e., it is the goal of the SMI that I am referring to [non-judgmental, compassionate, accepting, non-reactive]) along with brand-new, more flexible responses to dreadful ideas and emotions (Kuyken et al., 2010). Individuals who practice mindfulness are encouraged to separate their negative thoughts and feelings from their unhelpful behaviour and emotional reactions in order to improve their mental health. To put it another way, a mindfulness approach might be thought of as a tool for honing focus on certain emotional reactions. Bredero et al.'s (2023) study meant to inspect the effectiveness of mindfulness-based cognitive therapy (MBCT) for tumbling weariness in patients with IBD in reduction of stress. Mindfulness is a response-targeted emotion regulation method, but it has foremost dissimilarity from other response-targeted strategies, such as relaxation and meditation. Developing new and more adaptable responses is a primary goal of mindfulness training, rather than suppressing unpleasant thoughts and studies (which might have detrimental consequences for the well-being) (Richards & Gross, 1999).



Acknowledgement-based psychotherapy (ABT) and MBCT are two forms of mindful psychotherapy (Segal et al., 2002). The latter approach in particular is commonly used in groups, which incorporates a wide range of techniques including frame scanning and yoga and meditation exercises. The first step of MBCT is to focus on creating a state of awareness. More and more focus is placed on understanding how negative thoughts lead to maladaptive actions, in future training levels, encouraging the person to adopt more adaptive answers while also helping the person accept his or her emotions. Despite the rising popularity and universal acceptance of mindfulness training, there has been little empirical study conducted in business settings. However, to make an exception, Hülshager et al. (2013) were able to undertake a week-long self-directed mindfulness intervention with employees from many different professions using MBCT protocols. Participants' daily diaries, used to compile the study's findings, revealed that those in the mindfulness approach group had more daily mindfulness and less daily emotional fatigue than those in the control group.

There have also been advancements in supplementary individual therapies. Stress management programmes and fitness merchandising jobs are two prominent projects that educate workers about the effects of stress and how it may be alleviated, as well as the need of maintaining a healthy lifestyle (such as increasing physical activity and eating a more balanced diet; Anger et al., 2015). It is the purpose of any stress-relieving training to help personnel avoid high-stress circumstances like excessive workloads. As a final point, therapies at the tertiary-person level concentrate on persons who are suffering from excessive or chronic stress, which may be impairing their ability to perform. In order to help those who are struggling with stress or mental health difficulties, irrespective of the nature of their work or occupation, counselling and assistance is offered (Csiernik, 2011).

### *Organisational-level Interventions*

To alleviate stress in the workplace, primary organisational-level treatments are designed to alter organisational practices and regulations, including those relating to leadership and running time (Anger et al., 2015). Worker well-being is a major focus of job redesign interventions. Research studies of activity layout that reveal that process parameters (e.g., workload, ergonomic design) is one of the most significant factors in determining employee stress and well-being according to the study literature (Demerouti et al., 2001). The breadth of work redesign interventions varies, with some focusing on only one activity function, such as job discretion, while others aim to change a few job features in the hope that this would lead to bigger changes in well-being (Bond & Bunce, 2001).

The goal of secondary organisational-level treatments is to help workers deal better with difficult studies by making organisation-wide changes. The construction of peer support groups and the development of communication skills, as well as training aimed at improving all workers' capacity to cope with difficult circumstances via, for example, advanced conflict management, are some examples of such interventions (Ghazavi et al., 2010). Social aid treatments that may reduce stress

(such as the loss of social support) as well as boost the capacity of workers to deal with stressful situations are not always clearly differentiated in this exercise between primary and secondary organisational actions.

Complex and inflexible interventions at the organisational level may be difficult to implement. These kinds of organisational-level interventions, particularly those that are aimed at boosting the performance of the organisation, rely heavily on effective execution. To be precise, there are four critical elements to a successful organisational-level intervention: pre-planning, screening and implementation (figuring out the psychosocial risks), movement planning (creating trade jobs) and implementation (embedding alternate jobs in the organisation). Additionally, in organisational initiatives, worker participation is essential. Only managers and consultants were engaged in the design and implementation of job reshaping modifications during a process redesign intervention by Morgeson et al. (2006). Rather than relying only on managers to implement process redesign interventions, employees were actively engaged by suggesting and carrying out their own efforts to decrease workloads, as well as by changing their own working practices. The quality of trade projects can be improved by tapping on workers' own expertise to make them more contextually relevant, and they may boost their commitment to executing change projects since they feel more like they have a stake in the result when employees are participating (LaMontagne et al., 2007). A feeling of duty and engagement that is healthy in and of itself may be gained via involvement. There are certain drawbacks to integrating additional stakeholders in the intervention process, such as increasing complexity, increasing discontent with the intervention system and increasing costs by customizing the intervention system.

Some multimodal SMIs incorporate both individual- and organisational-level therapies. Integrating health and safety programmes at the organisational level with individual-level fitness programmes is known as 'whole worker health interventions' (see Anger et al., 2015, for an assessment). There are advantages to this method, such as lessening factors that cause stress and enhancing workers' capacity to cope with it. It may be especially important for those who are more vulnerable, because they are more inclined to indulge in unhealthy habits (Anger et al., 2015). In terms of a business, other multimodal approaches are also possible. For example, changes to various organisational practices were made in conjunction with job redesign interventions, with the hope that this would enhance the impacts of the job redesign intervention (Daniels et al., 2017). Multimodal techniques have the potential to increase implementation complexity and lower the efficacy of one intervention at the expense of the other.

## **Evaluating the Effectiveness of Stress Management Interventions**

Individual efficacy in stress reduction and well-being promotion must be considered while making the decision to use SMI. Secondary- and primary-level therapies for SMI are examined in this chapter, which include data from previous studies. In order to begin, we must first discuss the difficulties associated with

assessing treatments, because it gives a clearer picture of the types and levels of data that are readily accessible.

RCT designs have historically been regarded as the best way for comparing treatments in the natural science paradigm. The participants in a randomised controlled trial (RCT) are divided into two groups at random and given either an intervention or a sham therapy. Companies are assessed both before and after the intervention for changes in the main outcome. A randomisation assumption is that if an experimental group's transaction differs considerably from that of a control group, the intervention is to blame. Therefore, RCTs are considered to be more conclusive proof of an intervention's causal effects than methods that do not randomise participants to groups, do not involve a manipulative institution and do not evaluate individuals before the intervention.

In addition to character research, multiple research studies may be evaluated quantitatively using meta-analyses. The different studies considered in a meta-analysis provide an overall duration of the effects. False positives are less likely to occur if there is a bigger sample size, and the entire analysis takes into account the flaws of individual studies. Consequently, meta-analytic conclusions may be accepted with more confidence. It is possible that the results of a single study may be unexpected or encouraged by something that was no longer researched. Even though meta-analyses are more likely to provide accurate findings since they combine information from several research, they are not without their limitations. When doing a meta-analysis, the methodological quality of the research that is included (e.g., RCT studies only) has a significant impact on how confident one may be in the conclusions.

In recent years, several researchers have questioned whether RCTs are an acceptable and relevant strategy for conducting evaluations of treatments (Cox et al., 2007). Researchers stated that RCTs cannot be carried out in contexts where randomisation is not practicable or ethical or if a comparable management organisation (comprising people who are similar to those in the experimental institution) cannot be found, specifically. Employees' views of the intervention and individual reports may be influenced by the randomisation process itself (Nabe-Nielsen et al., 2015). The quality of the implementation technique and the organisational environment are not examined in RCTs, which tend to focus on alterations in effects. Opportunity intervention assessment frameworks were created in response to these problems. Both intervention outcomes and implementation techniques should be included in the paradigm proposed by Cox et al. (2007). Managers' support for the intervention, workers' involvement in the intervention and the availability of implementation assets are all examples of implementation method variables. According to Cox et al., taking system factors into account makes it possible to identify the processes responsible for determining the outcomes of interventions. In fact, if procedural factors are not taken into account, it is possible that an intervention may be deemed ineffectual while its execution was really erroneous. In order to determine how each stage of the intervention may impact following stages and eventually the final results of the intervention, as previously described, a longitudinal assessment framework has been presented that evaluates each intervention 'level' individually. Because these

changes may only become visible in unusual situations (such as when people are unable to run), they advocate for various levels of intervention in order to achieve a variety of outcomes (such as changing attitudes, running habits and general well-being).

In light of the significance of intervention techniques and RCTs' limitations in organisational contexts, according to a number of experts, SMIs' effectiveness should be evaluated using rigorous quantitative and qualitative evaluations, as well as research studies that do not follow the 'gold trend'. Unlike character SMI, which tends to use well-established strategies (e.g., CBT), organisational SMIs vary in form and may be customised to the corporate firm, increasing the possibility of repercussions being triggered by manner and context factors. Organisational SMI evaluations benefit greatly from this method. This makes character SMI particularly important. In light of these issues, criticisms of SMI research techniques are more prominent than ever.

## **Evidence for Primary Organisational-level Interventions**

SMIs implemented at the main level of an organisation, according to available meta-analyses, do not help employees relax or cope with stress. Study after study has shown that RCT-based treatments at the primary and secondary organisational levels have minor but significant effects ( $d = 0.08$  (Van der Klink et al., 2001);  $d = -0.31$ , well-being, and mental fitness (Richardson & Rothstein, 2008)).

SMI evaluations conducted at the organisational level, on the other hand, use qualitative methods, for a more sophisticated understanding of how well-designed organisational interventions function, such as quasi-experiments without randomisation (Bhui et al., 2012; Daniels et al., 2017; LaMontagne et al., 2007). Furthermore, other studies have shown that activity redecoration and social guide interventions have positive effects on employee well-being (Ahola et al., 2012). Researchers have shown that activity redesign interventions may promote worker well-being by altering the characteristics of tasks (e.g., process discretion, comments), which in turn affects the well-being of those who do them (Bond et al., 2008). These studies, then, support the theory that process redesign interventions have an impact on employee well-being via altering employees' activity attributes. Other studies have shown that process redesign interventions may have a long-term impact. Following a one-year and three-year follow-up, Kawakami et al. (1997) discovered that the well-being and activity parameters of the intervention group had improved. They all come to the same conclusion: multimodal organisational-stage SMIs may be beneficial (Anger et al., 2015; Daniels et al., 2017). The more complex organisational treatments may be more successful than less-complex interventions that focus on enhancing a single activity, but it is unclear whether or if their unique features have combined or cumulative benefits on well-being (i.e., a simplest task layout).

Organisational interventions have been shown to have positive effects on well-being, but a few studies have found no effect and a few have found negative effects (Ghazavi et al., 2010), and this must be taken into account because of the persistence of heterogeneity in their outcomes (Dahl-Jørgensen & Saksvik, 2005).

It has been suggested that the efficacy of organisational SMI is affected by implementation strategies and contextual variables, which may account for some of this variation. More and more study in organisational SMI is evaluating and documenting the implementation system's characteristics. According to Dahl-Jørgensen and Saksvik (2005), an activity redesign study on two separate sites found that six months after the intervention ended, emotional weariness increased in the experimental organisation on one of the sites. Some employees found the intervention burdensome, and other concurrent adjustments, such as increased workload, may have negatively affected worker stress, according to the qualitative method evaluation, which found that the best implementation technique was low (in part because of excessive work demands and coffee management aid).

A review of intervention implementation literature suggests this model of implementation approaches stated above has generally been supported by empirical evidence (Cox et al., 2007). Increasing the intensity of implementation tactics reduce stress (i.e., more time spent on intervention sports) and providing guidance for personnel (e.g., education in exchange procedure and verbal exchange ability). The quality of implementation methods may be enhanced by attending and helping with manner-related activities at critical levels (e.g., education and support-gathering, psychosocial hazard screening, action planning and implementing; LaMontagne et al., 2007).

SMIs' effectiveness may also be influenced by organisational and participant characteristics, according to the evidence. SMI participation may be hampered if an organisation has a downsizing, has strained ties with management and employees or has unworkable HR rules. As a result, increasing interventions with broader improvements in HR policies may reduce the likelihood of the organisational setting impeding a SMI (Daniels et al., 2017). SMI is influenced by organisational context, but the absence of study prevents clear conclusions from being drawn. According to SMI's theory, an individual understand the nature of change in demographic, social, and cultural factors, few studies have examined this issue in a systematic manner (Egan et al., 2007). Individuals are more open and willing to trade, have greater positive value determinations of the intervention itself and have previous experience of participating in selection-making processes when they are involved in work redesign interventions (Bond & Bunce, 2001). In order for a company-level SMI to succeed, it must have motivated and competent people who are willing to participate in alternative methods. This is due to the fact that these people are more likely to implement or respond favourably to the forms of change that are the basis of these therapies.

## **Evidence for Secondary Organisational-level Interventions**

In recent years, meta-analyses and systematic reviews of secondary individual therapies for stress and well-being have been carried out (see Bhui et al., 2012, for an evaluation of these reviews). The following two meta-analyses are among the most comprehensive: Van der Klink et al. (2001) and Richardson and Rothstein (2008). Everyone on the team has access to CBT and relaxation therapy,



regardless of their position. Unlike the Van der Klink et al. analysis, which includes unpublished papers (accounting for guide bias towards full-size results) and spans an extra decade of research, the Richardson and Rothstein meta-evaluation includes only RCT-based studies because of its tighter inclusion criteria. Character interventions are also covered by Kuoppala et al. (2008). In contrast to the meta-analysis conducted by Conn et al. (2009), which solely examined health marketing treatments, their review focuses on psychological and health promotion interventions including training and biofeedback, such as the promotion of healthy eating habits, in particular workout and bodily interest, which are the primary focus of their study. Businesses that employ workers are specifically targeted in this meta-analysis. While Regehr et al.'s (2014) study focuses on individual-level therapies for doctors, the study by Ruotsalainen et al. (2014) focuses on CBT and relaxation tactics for health-care workers.

For secondary character-level intervention, impact sizes are large in meta-analytic investigations ( $d = 0.48$  (Van der Klink et al., 2001);  $d = 0.60$  and 0). Richardson and Rothstein (2008) counted 42. Since the impact sizes of multimodal secondary individual-level SMIs and single secondary individual-stage SMIs are so similar, there is no longer an obvious benefit to using both. Richardson and Rothstein (2008) discovered the multimodal SMI's effects intensify with time, and their long-term repercussions are more. Stress management measures in multimodal SMI might be difficult to acquire at first, but their long-term benefits are greater and more enduring once learned. Aside from the fact that the comparison by Richardson and Rothstein included absenteeism and physiological reactions, this finding should be taken with a grain of salt for gift-giving reasons.

Research on secondary individual-degree SMI is very important because of the variety and range of effect magnitude that may be found. Even though impact sizes vary widely, virtually all outcomes are of excellent quality in direction, despite their small size. This is the best we can tell at this time. It was shown that CBT and relaxation therapy's effect sizes varied between zero and two, with 22 of 35 research showing non-significant results, like Van der Klink et al. (2001). A broad variety of effect sizes have been found via prior studies of SMI and mindfulness instruction. As a consequence, however, even if secondary individual-level SMIs are not harmful to worker well-being, their favourable benefits are not attained in all working environments. Because of this, it is possible that other factors, such as how the SMI is implemented or the setting in which it is taking place, may also have an influence on its efficacy. It is difficult to make meaningful conclusions regarding the effects of context and implementation method on secondary individual-stage SMI efficacy due to a paucity of research and inconsistent data (Richardson & Rothstein, 2008; Van der Klink et al., 2001).

## **Managerial Implication**

In this study primary-level and secondary-level intervention techniques are used on individual- and occupational-level stress. A few studies have proved that



primary-level intervention techniques are more effective than secondary-level intervention techniques when the stress level of an individual is low. However, many studies have proven that secondary-level intervention techniques are more effective than primary-level intervention techniques when the stress level of an individual is high. It should be helpful for the management to identify and provide the exact intervention programme for their employees, which helps to improve their efficiency in work.

## Conclusion

A broad variety of stress management therapies are available for businesses, according to our investigation. CBT, Registered Massage Therapist and Model-Integrated Evidence, which are all at the secondary level of SMI treatment, have a solid evidence base, but the evidence for organisational-level treatments like job redesign is still increasing. Our knowledge of why interventions work is improving as we learn more about the finer implementation methods and employee involvement, according to the findings of studies. These findings may be influenced by the effect of book bias, as well as the fact that they are based on studies with a wide variety of methodological limitations, so it is crucial to keep that in mind. In reality, more research, not only RCTs, is needed to strengthen the evidence basis for SMI. This study should use more rigorous methodology. SMI findings and the impact of various intervention strategies on their quantitative and qualitative quality will instead be assessed using extensive assessment frameworks. When it comes to character-stage SMI, for example, we do not know much about the settings when SMIs are most effective, and we do not know how effective treatments are since studies do not use the same metrics of well-being. If SMI is aware of these difficulties, it may be able to better direct its efforts and give aid as required. Since just a few studies have looked at the long-term benefits of SMI, doubts remain about its influence. It is clear that this has significant consequences for SMI control. Do firms do SMI on a regular basis and reap the long-term benefits, or do they have to persist and persevere to ensure that well-being stays high?

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