18 Measuring caregivers' perceived work-based stress in nursing homes for the elderly – a concept considering residents suffering from dementia

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Research aim: to emphasize that a suitable research concept is required to analyze “the extent to which a certain care concept counteracts subjectively perceived stressors during everyday care and support”.

Methods used: summative evaluation design – more precisely, a semi-experimental design with a control group and an experimental group, collecting data at two waves (“before and after” measurements). It permits the simultaneous evaluation of the experimental group (in which a new concept is introduced) in one or more care homes and the control group (in which the specific concept is not implemented) in comparable care homes. Changes over time can thus be studied under controlled conditions.

Lessons learned: the implementation of a care concept in nursing homes depends on the people involved, from the management to the caregivers. Even if the background conditions (e.g., legal regulations) and the characteristics of the home or the organization running it (e.g., mission statements) are identical, the way in which this type of concept is dealt with personally evidently plays a key role in its effect, or at least this is the only explanation for the identified differences. Moreover, the initial starting point is important when measuring the effect of a new concept. The level of improvement (as in a positive effect) will be minimal when a high level of caregiver motivation, or of nursing and care, is already reached, before a new concept is introduced.

Introduction

Caregivers in nursing homes for the elderly are currently facing changes to their nursing tasks. This is due on one hand to rising life expectancies and societal change, which is giving rise to individualization, changing family structures and rising female employment rates. Subsequently, there is rising demand for professional nursing services, which increasingly fall under the remit of public-sector or private providers (Glaser and Höge 2005). On the other hand, the proportion of elderly people with dementia is rising ever higher. Estimates by the Austrian Ministry of Health and Women's Affairs suggest that 115,000 to 130,000 people living in Austria currently suffer from some form of dementia (Bundesministerium für Frauen und Gesundheit, 2017). According to projections, by 2050 that number will have increased to 260,000 people with dementia (Höfler et al., 2015). These developments are also altering the population structure in nursing homes, creating new challenges for caregivers. The amount of care required is constantly rising as residents are entering

homes at an older age, with higher support needs and frequently, as described, advanced dementia; longer life expectancies mean that they are also staying there longer (Engels and Mehlan, 2008). Today, people suffering from dementia already make up the largest group of elderly people living in homes, which has a considerable effect on everyday life there. There are also different expectations of what comprises “good care”. The trend is shifting from functional “keep them warm, fed and clean” care toward full-service care and support, taking into account users’ quality of life (Leichsenring, Schulmann and Gasior, 2015). Providing care and support, especially for dementia sufferers, is a challenging task which requires caregivers to display a great deal of specialist knowledge, physical abilities and, above all, social and emotional skills (Dietrich et al., 2015; Glaser and Höge, 2005; Engels and Mehlan, 2008; Zimmer, Rudolf and Teufel, 2001).

People suffering from dementia thus need more intensive support and care than those who only need care due to their physical condition (Höfler et al., 2015). The law states that the minimum number of caregivers required must be based on the average number of residents per care level (Öö. *Alten- und Pflegeheimverordnung* [Upper Austrian Care Home Ordinance], 1996). In Austria, there are seven levels of care, based on the amount of care required per month. For dementia sufferers, since 2009 an additional 25 hours per month have been factored in as extended care needs (Pensionsversicherungsanstalt, 2017). According to the Austrian Dementia Report, however, the levels of care do not adequately reflect the intensive degree of care required for dementia sufferers, and the additional workload is currently not taken into sufficient account in nurse–patient ratios (Höfler et al., 2015). As a result, work-based stress in homes is rising along with the proportion of dementia sufferers. For this reason, care concepts are required which not only meet the needs of such residents in care homes, but also reduce the stress affecting caregivers and nurses.

A research project was carried out to examine how successful such concepts are; its findings form the basis of this piece. The focus was on the caregivers’ and nurses’ subjective perception of stressors, the subjective results of that stress and any consequences affecting their health and career. One point is clear: a suitable concept is required to analyze the extent to which a certain care concept counteracts subjectively perceived stressors during everyday care and support. The goals of this type of survey are to:

- record subjectively perceived work-based stress among caregivers and nurses looking after residents suffering from dementia;
- take background conditions into account;
- determine the factors influencing the perceived level of stress; and
- compare the findings based on various care concepts.

On this basis, we developed a theoretical model (the second section of the chapter), the theoretical framework of which is presented before – building upon this – we go into further detail on the measurement concept and thus on the operationalization (the third section of the chapter). Finally, the findings are summarized and possible limitations indicated.

Concept for recording perceived work-related stress in an experimental group and a control group

Where the aim is to compare different nursing and care concepts to identify differences in people’s subjective perception of work-related stressors, a summative evaluation design

should be selected. Where, as in this case, the intention is to evaluate the effect of introducing a new concept, an experimental design is required: a simple comparison of perceived work-based stress among different care homes would be inadequate. A semi-experimental design with a control group and an experimental group, collecting data in at least two waves ("before and after" measurements) serves this purpose. It permits the simultaneous evaluation of the experimental group (in which a new concept is introduced) in one or more care homes and the control group (in which the specific concept is not implemented) in comparable care homes. Changes over time can thus be studied under controlled conditions.

The first step is always to select the experimental and control homes. As well as featuring comparable care concepts, these should also have similar background conditions, especially with regard to:

- the number of residents in proportion to the number of full-time equivalent caregivers,
- the availability of care and nursing services (short-term care, all-day care, etc.),
- the building (age of the building, whether or not people can withdraw into their own private areas, etc.).

A research design that meets the needs of the above project requires a combination of qualitative and quantitative surveys studying different actors. This combination of methods (triangulation) enables researchers to make the most of each approach's advantages while at the same time compensating for its disadvantages. The research design's different approaches insure that the sometimes varied viewpoints of different actors, nursing managers, psychologists and caregivers can be taken into account.

On this basis, this type of research design is made up of several stages (Figure 18.1), as described in further detail below.

The first stage is an exploratory preliminary study in the form of qualitative expert interviews or focus groups. These are used to record the subjectively perceived background conditions and various work-based stressors, discuss the factors which increase and reduce work-based stressors and note their consequences. For this purpose, guidelines were developed (see Appendix 1). The findings thus obtained not only provide a comprehensive insight into the current situation but also serve as the basis for developing (or refining) the quantitative survey instrument (see Appendix 1). In other words, a quantitative questionnaire was developed to measure impacts, based on the theoretical model (see Figure 18.2, below) and taking into account the qualitative findings. This questionnaire must still be validated for further use.

During the second stage, the quantitative questionnaire is tested. This can be done using a pre-test with staff in nursing and care facilities who are comparable to the control and experimental groups, to find out whether any adaptations are necessary.

In the third stage, a standardized assessment of the current situation is carried out, i.e., a survey of caregivers and nursing staff in "Wave 1" (before the implementation of a new concept). A whole-population survey (asking all staff) is advised if there are not many staff at each institution. In the fourth stage, the standardized impact assessment is carried out: a survey in Wave 2 (roughly one year after the implementation of a new concept in the experimental homes). This ends with the validation of the findings, e.g., in the form of a findings workshop.

Figure 18.1 Research design.

Theoretical framework and measurement concept

Theoretical model

Based on the modified stress-strain concept (Metz and Rothe, 2017), a theoretical model was developed to measure the influences upon and consequences of subjectively perceived work-based stressors among people working in nursing and care. This took into account the subjective evaluations and assessments of working conditions and situations, and whether and to what extent people saw themselves as individually capable of coping with these situations and circumstances (see Figure 18.2).

Validation of the findings

Similarly to the stress-strain concept, the theoretical model is based on external influences which (may) affect the working person. In the theoretical model (Figure 18.2), these external influences are located in the background conditions of the nursing and care facility (A) or in the staff's subjective perception thereof (B).

People's subjective perception of the background conditions and stressors (D) are influenced by personal characteristics. It is assumed that on one hand personal characteristics (C1) and on the other hand personal resources (C2) play a role in people's perception of working conditions and work-based stressors. Meanwhile, various consequences for their health and career (E) may indicate that the stress has repercussions. Below is a description of the concept used to measure these dimensions.

Measurement concept

In the field of nursing and care for elderly people, when the topic of dementia sufferers comes up, the two issues highlighted are, first, information about the symptoms of dementia, support schemes and services, and, second, the quality of nursing and care (see Höfler et al., 2015; Juraszovich et al., 2015). Work on dementia frequently focuses on the development and implementation of nursing interventions designed to improve the dementia sufferers' situation, e.g., reminiscence work, Snoezelen environments, dementia care mapping (DCM), "understanding diagnostics" and assessment tools (Palm et al., 2013). As far as we are aware, as yet there have been no studies concentrating on the specific working conditions and work-based stressors in dementia nursing and care. For this reason, we examined general models for measuring work-based stressors and studies in the context of residential care for the elderly.

In the following, the individual dimensions of the theoretical model are described and set out as operationalized for the research project. This includes outlines of findings from other studies and results of the exploratory preliminary study which played a role in the development of the theoretical model.

Figure 18.2 Theoretical model of subjectively perceived work-based stressors.

Implications for caregivers' health and career (E)

During the project, because of the interest in the nurses' and caregivers' subjective perceptions, the subjective consequences of the stress were investigated and operationalized as implications for their health and career. Evaluations in the context of nursing and care for the elderly come up with the following consequences of stress on an individual level: somatization, back pain, emotional or mental exhaustion, job dissatisfaction and a lack of intrinsic motivation, fearfulness, depression, social dysfunction, reactive distancing, irritation and aversion to clients (Dietrich, Kirch and Rößler, 2014; Glaser and Höge, 2005; Maier and Kälin, 2015; Ziegler et al., 2016; Zimmer, Rudolf and Teufel, 2001). During the qualitative surveys, the topic was also addressed of the psychological or social burden increasing while the physical burden tends to become less important.

In other words, work-based stressors can affect the state of people's physical, mental and/or social condition. They can have an effect on their ability to work and identify with their job (see Table 18.1).

Subjectively perceived work-based stressors (D)

The stressful situations recognized by Glaser, Lampert and Weigl (2008) include organizational stressors (problems caused by absences, staffing changes, etc.), social stressors (stressful work with colleagues, superiors, residents and relatives), resident-related stressors (stress caused by demented, dying, depressed residents), being rushed, being given contradictory tasks or tasks outside one's field of responsibility, being uninformed, work being interrupted and an unfavorable working environment (physical spaces, noise, lighting, long distances to travel, etc.) (see also Becker and Prümper, 2016; Brunner and Jenull, 2009; Dietrich, Kirch and Rößler, 2014; Dietrich et al., 2015; Engels and Mehlan, 2008; Glaser and Höge 2005; Ziegler et al., 2016; Zimmer, Rudolf and Teufel, 2001). Meyer-Kühling, Wendelstein and Pantel (2015) point to another aspect, namely the different perceptions of collaboration between the nurses and doctors.

Accordingly, the exploratory preliminary study addressed the subject of stress caused by work with residents suffering from dementia (frustration, despair, making monotonous noises, constantly demanding attention, retrogenesis, the urge to wander, confusing day and night, mental illness and addictions), work with relatives (insufficient knowledge about dementia symptoms, differing expectations with regard to care and nursing, insufficient appreciation of work done, conflict among relatives), and internal and external collaboration. Other perceived sources of stress included conflict among residents of the kind which occurs frequently when residents with or without dementia live in close spatial proximity. The interviews and focus group also showed that the care home staff frequently felt rushed. A lack of time and low staffing levels were seen as the main cause of stress in their daily work, as dementia sufferers in particular require more time for care and nursing.

Based on the above findings, the indicators for work-based stressors derived for the research project were office management, work with residents suffering from dementia, interaction among residents, work with relatives and internal and external collaboration (see Table 18.1).

To assess the level of perceived work-based stress in the field of office management, the study gathered data on perceptions of being rushed in nursing and care, on work being interrupted, the feeling of not having enough time to respond to residents' wishes and needs which could otherwise be fulfilled, and the perceived fairness of how tasks were distributed.

Table 18.1 Dimensions, indicators and example items

<i>Area</i>	<i>Dimension</i>	<i>Indicators</i>	<i>Example items</i>
Implications (E)	Toll on health	Social, mental, physical toll	Looking back on the last 3 working weeks, how much of a toll do you feel your work took on your health? ...
	Identification with work	Choosing same job and thoughts of career change	social stress (social contacts, relationships, conflicts etc.) If you could go back in time, would you choose your current occupation again?
	Ability to work	Ability for future professional practice	Can you imagine still being able to do your job in 5 years' time?
Subjectively perceived work-based stressors (D)	Office management	Task distribution, being rushed, intensity vs. interruptions, lack of time	During the last 3 working weeks, how often have you felt rushed in your daily work?
	Work with residents	Psychological impairment, challenging behaviors, activities, communication among dementia sufferers	Please now think about the following behaviors which occur when working with dementia sufferers. I find ... challenging behaviors (constantly demanding attention, uncooperative behavior ...) very stressful to not at all stressful.
	Interaction among residents	Conflict among residents caused by certain behaviors found in dementia sufferers	How often do you find the following types of interaction among residents stressful (e.g. including among residents suffering and not suffering from dementia)? Conflict due to psychological impairments (depression, panic attacks, paranoid ideas ...)
	Work with relatives	Insufficient knowledge, false expectations, lack of appreciation, family conflicts among relatives	Please now think about the following aspects of working with relatives of dementia sufferers. To me, ... false or unfulfillable expectations are very to not at all stressful.
	Internal and external collaboration	Effectiveness of collaboration with superiors, colleagues and outsiders	How often do you find working with others to be stressful? Specifically, with ... direct superiors

continued

Table 18.1 Continued

Area	Dimension		Indicators	Example items
Subjectively perceived background conditions (B)	Tasks/content	Confrontation with dementia	Proportion of dementia patients, work in the field of dementia	Thinking of all the residents you take care of, how high would you say is the proportion of dementia sufferers?
		Residents' behaviour	Frequency of mental impairment, challenging behaviors, activities, communication among dementia sufferers	How often do the following aspects occur in residents suffering from dementia? Challenging behaviors (constant demand for attention, aggressive behavior, uncooperative behaviour ...) I really enjoy work.
		Work as enriching	Enjoying work, drawing strength from work, feeling of enrichment	
		Opportunities to be creative	Variety, self-determination	The work I do when nursing and caring for dementia sufferers is: varied – monotonous (5-step scale)
		Coping requirements	Coping during day or night shift activity, strength	I cope well with daily nursing and care for residents during the day. I draw strength from my work.
	Organization	Time management	Planning shifts and holidays	My wishes and needs are considered as far as possible when making up the duty roster.
		Allocation of work	Information, suitability of assigned activities, too many or too few demands made	Looking back on the last 3 working weeks, how often ... were you given all the information you needed to do your job well?
		Sphere of responsibility	Taking on responsibility, task assignment	Looking back on the last 3 working weeks, how often ... did you feel you had been given too much responsibility?
		Working environment	Suitability of the physical space, equipment and subjective well-being	The premises' physical spaces (living areas, corridors, rooms, the garden, etc.) are well suited to work with dementia sufferers.

	Training and CPD	Sufficient selection	There is a sufficient selection of training and CPD schemes available.
Atmosphere	Leadership culture	Transparent expectations, appreciation, support, participation, leadership style	I know exactly what she/he expects of me regarding my work
	Atmosphere among staff	Support, collaboration, getting on together	If necessary, I get help and support from my colleagues.
	Interdisciplinary collaboration	Collaboration with external occupational groups	Members of other occupational groups come to me for my specialist knowledge in nursing/care.
	Demographic characteristics	Age, gender, mother tongue	I am ___ years old.
Pers. characteristics (C1)	Occupational characteristics	Working hours, occupational group, years of service	I have been working in nursing and care for elderly people for about ___ years.
	Salary	Appropriateness of pay	My salary is appropriate.
	Care concept	Institution's care concept, seen as a resource (evaluation of professionalism, practices and supportive schemes for dementia sufferers)	Thinking about your daily work nursing and caring for residents suffering from dementia, how helpful are the following aspects for you? ... the institution's care concept.
Resources (C2)	Professional resources	Training, work experience, validation approach, internal and external CPD	... internal and external CPD attended (e.g. lectures, workshops, seminars).
	Occupational resources	Supervision, team discussion, discussion with colleagues	... discussion among colleagues in the institution.
	Leisure as a resource	Team activities, recreation/relaxation in free time	... recreation/relaxation in free time.

To assess perceived work-based stress, the study also took into account the extent to which challenges were experienced as stressful in the specific case of nursing and care for residents suffering from dementia (depression, panic attacks or paranoid ideas, challenging behaviors and activities such as constantly demanding attention, refusing to cooperate, the urge to wander about, confusing day and night, lack of drive and demanding communication such as constantly repeating things or making monotonous noises). Mental disorders and specific behaviors specific to dementia sufferers are also often the cause of conflict among residents, which can be stressful for caregivers and nurses. The aim was to make the perceived work-based stress measurable, including stress during work with relatives (see above), internal collaboration (with superiors and colleagues) and external collaboration (with members of external occupational groups).

Subjectively perceived background conditions (B)

During the explorative preliminary study carried out for the project described above, stressful situations were sometimes connected to organizational aspects, physical spaces or the working atmosphere. Long shifts, for example, can play a role in whether certain behaviors in residents are perceived as stressful, if caregivers are exposed to them for hours on end. The roster and holiday planning can be adjusted to reduce the stress. Other important background situations addressed are the staff's scope for action and decision-making and whether they are given an appropriate level of responsibility. Other relevant aspects which emerged were the level of appreciation the management show the staff, and the working atmosphere. Last but not least, the premises or architecture of the institution can make everyday life with dementia sufferers easier or more difficult (long corridors, lifts with glass walls, an open-plan support center with no private areas, etc.). Whether or not the building makes people feel at ease is an important factor not only for the residents but also for the staff.

Based on this, the dimensions developed during the operationalization process were allocated to three areas: working tasks/content, office management and working atmosphere. Under working tasks/content, data was gathered on how strongly staff felt confronted with dementia, whether they felt equal to the requirements of their job, whether they saw their work as enriching and whether they were given opportunities to be creative. The indicators under office management include a needs-based roster and holiday planning, whether work and responsibility are suitably allocated and the amount of training and continuous personal development on offer. The working atmosphere was operationalized via the dimensions of the leadership culture (transparent expectations, leadership style, appreciation, support and involvement by direct superiors), the atmosphere among staff (support, collaboration, how well they get on) and interdisciplinary collaboration with external occupational groups (see Table 18.1).

Personal characteristics and resources (C)

Various studies (Becker and Prümper, 2016; Glaser and Höge 2005; Ziegler et al., 2016; Zimmer, Rudolf and Teufel, 2001) compare the requirements and stress experienced in nursing with the resources which are available. The resources which are available play an important role in coping with requirements and stress. Resources may be found in terms of the organization (scope for action, opportunities to influence the way work is allocated, whether staff can plan and allocate work independently, feedback from superiors), the

social environment (positive atmosphere, effective communication with colleagues, superiors and residents) and the individuals themselves (professional skills, social skills, organizational skills and personal skills).

In the exploratory preliminary study, emphasis was placed on the fact that people working (or wanting to work) in nursing and care for dementia sufferers require well-developed social skills and a "stable" personality. Professional training and internal and external CPD were considered to be of great importance. Training in validation was often brought up as central to everyday communication and dealing with residents suffering from dementia. Other resources mentioned were supervision and a good working atmosphere, and leisure activities (i.e., a successful work-life balance) were attributed a key role in combating stress and stressful situations in everyday working life.

On this basis, the potentially relevant resources used in the theoretical model which was developed were the institution's care concept, professional resources (training, work experience, validation approach, internal and external CPD), occupational resources (supervision, team discussions, discussion with colleagues) and leisure time as an occupational resource (team activities, recreation/relaxation during free time). The personal characteristics on which data was gathered included on one hand demographic characteristics (gender and age), and on the other hand occupational characteristics (working hours, occupational group, years of service) and perceived appropriateness of pay (see Table 18.1).

Measuring instruments: establishing dimensions and testing reliability

As mentioned above, guidelines were developed for the qualitative preliminary study (see Appendix 1). Their content, and that of the quantitative questionnaire based on the findings, reflect the model of subjectively perceived work-based stressors (see Table 18.2). Statistically, the individual dimensions were based on exploratory factor analysis (e.g., see Brachinger and Ost, 1996). To check the internal consistency (reliability) of the scales, Cronbach's alpha was calculated. The analyses were carried out using SPSS (IBM SPSS Statistics 24).

Table 18.2 offers an overview of the dimensions established and their internal consistency, which is satisfactory apart from three aspects ("collaboration", "sphere of responsibility" and "professional resources"). For the sake of completeness, individual items are also listed. For details see also Table 18.1.

Conclusion

The work-based stressors affecting caregivers in nursing homes are a subject of increasing public discussion due to the rising number of residents suffering from multiple morbidities or dementia. Data from a repeated survey of caregivers in Austrian nursing homes were studied to analyze how caregivers actually subjectively perceive work-based stressors and what factors cause this. Particular attention was paid to the effect of having a defined care concept. To analyze the influencing factors, a theoretical causal model was developed taking into account multiple factors at different levels. The correspondingly high level of complexity posed a challenge, not only when analyzing the data, but also when presenting the findings. One aspect which became clear was that with such complex models in particular, appropriate methodological knowledge is a must (especially for analyzing data over time).

Moreover, the complexity of the identified causes and effects made them difficult for the research commissioners to follow, raising the question of whether knowledge can be transferred from empirical studies to (care) practice.

Table 18.2 Individual items and established dimensions, including explained variance, Cronbach's alpha

Area	Dimensions	Number of items	Explained variance (%)	Cronbach's alpha
Implications for health and career	Toll on health	3	—	—
	Identification with work	2	75.22	0.641
	Ability to work	1	—	—
Subjectively perceived work-based stressors	Office management	4	67.39	0.838
	Work with residents	4	69.65	0.849
	Interaction between residents	4	74.34	0.883
	Work with relatives	4	58.85	0.764
	Collaboration	4	52.41	0.525
Subjectively perceived background conditions	Confrontation with dementia	2	—	—
	Frequency of residents' behavior	4	70.17	0.853
	Work as enriching	3	63.33	0.706
	Opportunities to be creative	2	70.70	0.582
	Coping	2	82.22	0.783
	Requirements	2	—	—
	Time management	2	81.91	0.778
Organization	Allocation of work	3	52.98	0.548
	Sphere of responsibility	2	60.60	0.349
	Working environment	3	64.93	0.723
	Training and CPD	1	—	—
Working atmosphere	Leadership culture	5	73.64	0.908
	Atmosphere among staff	4	76.52	0.894
	Interdisciplinary collaboration	3	—	—
	Demographics	3	—	—
Person	Occupational characteristics	3	—	—
	Salary	1	—	—
	Care concept ^a	3	—	—
	Professional resources	4	48.35	0.635
	Occupational resources	3	61.98	0.667
	Leisure as a resource	2	—	—
	Resources	—	—	—

Notes

The findings are based on the data from the second survey ($n = 131$). Two filter questions were used (confrontation with dementia, language skills) which were not considered separately. Four open-ended questions were not taken into account in this overview.

a In addition, questions were asked about six items specific to the care concept, which must be adapted to the care concept used. Cronbach's alpha increases, *ceteris paribus*, along with the number of items (e.g. see Tavakol and Dennick, 2011). Some of the scales used comprised only two to three items. Accordingly, on scales with up to three items the internal consistency was tolerated as (just) acceptable at values of roughly 0.4 to 0.5, and considered good at 0.6 to 0.7, and very good from 0.8 and higher.

The sometimes rather low questionnaire response rate suggests that caregivers are only willing to take part in surveys of this kind to a limited extent. When it comes to putting the model into empirical practice, this can be especially problematic if they drop out at one of the two waves ("panel mortality"). However, an interval of six months between the two waves has proven effective, the maximum recommended interval being one year. In retrospect, three waves would be ideal to calculate the effects optimally. It would not be recommendable, in contrast, to include nursing homes in the study which implement more than two different care concepts. In the case described here, six nursing homes were studied, using two concepts (three homes per concept). An analysis of the long-term effects of one specific care concept on perceived work-based stress among caregivers remains an almost impossible undertaking, among other things due to staff turnover.

There is no doubt that the implementation of a care concept in nursing homes depends on the people involved, from the management to the caregivers. Even if the background conditions (e.g., legal regulations) and the characteristics of the home or the organization running it (e.g., mission statements) are identical, the way in which this type of concept is dealt with personally evidently plays a key role in its effect, or at least this is the only explanation for the identified differences. Another aspect which is important when measuring the effect is the initial starting point. In homes which start out with a high level of caregiver motivation, or of nursing and care, before a new concept is introduced, the level of improvement (as in a positive effect) will be minimal compared with other homes.

Finally, it can be said that the theoretical model for empirically assessing subjectively perceived work-based stressors among caregivers can generally be effectively transferred to other countries. This is mainly true of their subjective assessment of work-based stress, whereas in the case of basic structural conditions (staff qualifications, labor law, etc.), country-specific features must be taken into account.

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