Initial evaluation of patients reporting a work-related stress or bullying.

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Sir,

Psychological disorders linked with working conditions are internationally recognized as an emerging clinical entity (1–3). They have potentially serious consequences and may even be responsible for work-related suicide (4). Work-related stress is an impairment of mental, physical or social functioning induced either by difficult working conditions, or by organizational and relational factors in the company. The clinical features of stress (including bullying at work) are heterogenous, but have in common their relationship with occupational factors.

Occupational physicians are often on the front line in the diagnosis of these mental disorders and in the management of patients. To our knowledge, no documents are yet available to help practitioners identify clinical syndromes of work-related stress and bullying**,** then optimize referral of patients to either medical (general practitioners and/or psychiatrists) or non-medical specialists (psychologists, social workers, and lawyers).

The purpose of this work was to review the key elements of a first consultation for a patient presenting with symptoms of work-related stress or bullying.

The assessment includes several stages. The first part of the consultation focuses on the severity of symptoms and the identification the clinical syndrome. Medical findings observed in cases of work-related stress and bullying are nonspecific. The disorder may correspond to a *de novo* diagnosis or to the aggravation of a pre-existing condition. Treatments prescribed and taken by the patient need to be noted down. Chronic delusional illnesses, depression, can be identified as well as anxiety, adaptation and personality disorders. Burn-out is a suggestive syndrome (5). The physician should look for psychiatric comorbidities such as a personal or family psychiatric history, addictions and other risk factors for self- or hetero-aggressive acts: suicide attempts, self-inflicted injuries (e.g. scarification), etc. During the interview, it is also important to look for elements indicating a risk of suicidal or homicide attempts.

The next one needs to evaluate the working and social environment, including the job history and chronology of events. The present episode must then be analysed, into three phases: first the initial (so-called “serene”) phase, during which the patient does not report any particular difficulty; then the (“problem” phase) during which obstacles and conflicts gradually appear; and finally the third or “crisis” phase, for which the patient will generally see a doctor. Analysis of transitional elements (“what has changed?”) and elements of personal and collective resistance should be described in detail. Other work factors need to be listed (table 1). Mechanisms procedures of relay and support by occupational health and prevention teams or trade union representatives must be looked into. The patient’s social and family environment may reveal the existence of protective or aggravating factors. A precarious social situation often forces patients to stay in the same job, which delays the diagnosis and limits the range of options offered. On the other hand, a protective family environment helps maintain the patient in his job. Any legal action already undertaken by the patient is also useful to know for the practitioner.

Table 1 summarizes the different stages of the patients care. They may help general practitioners to distinguish between psychiatric cases requiring urgent management, a simple conflict situation with no psychological repercussions, and intermediate cases. It may be necessary to remove the patient from the working environment (sick leave) and try a medical treatment together with a workplace intervention. Re-evaluation after appropriate medical attention is always useful.

Occupational physicians are increasingly involved in dealing with complex situations of work-related stress or bullying and play a key role in their management after a first consultation in order to improve multidisciplinary work.

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TABLE 1

Clinical Workup of a Patient Consulting for Work-Related Psychological Distress or Bullying

	Proposed Investigation (Main Points)	Referral (Main Points)
Medical stage	Clinical context: personal history, family personal, comorbidity Interview Suicide or homicide risk	Psychiatric cases requiring urgent management (eg delusional states, depression with a marked suicide/homicide risk) => referral to a psychiatrist followed by a review of the situation.
Occupational and social stage	Job history and diplomas training before (until) the current position Current job history: with "serene, problem, crisis" phases. Company organization and risk factors: pressure, conflict of values, effort/rewards, work environment (management, fellow workers), overload or insufficient workload, collective cases, economic environment.	Intermediate cases (adaptation disorders, anxious depression with or without an associated personality disorder, burnout) requiring a more global approach => mixed team management with referral to a psychiatrist and multidisciplinary work.
	Elements of discrimination, threats, verbal or physical violence, abuse and sexual harassment Social and financial difficulties Family support and attitudes Legal context	No psychological repercussions => referral according to work characteristics, for which legal advice or group support are sufficient.