[Report]

The Effects of a Mental Health Training Program for Manufacturing Company Managers

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Abstract : We practiced interventional approaches for the promotion of occupational mental health in a manufacturing company with approximately 2,000 workers, between 2005 and 2007. We investigated the long term effects of our mental health training program - including Active Listening (AL) training for managers - on perceived job stressors, stress reactions and social supports of workers, and mental sick leave. We conducted the mental health training program with AL training for all managers in order to improve their communication skills and support for workers. The investigation was conducted using the Brief Job Stress Questionnaire (BJSQ). In addition, we surveyed the number of workers taking sick leave due to mental problems from 2003 to 2007. Among the categories of “job stressors” in the BJSQ, the scores for “quantitative workload,” “qualitative workload” and “physical demands” improved significantly after our interventional approaches. The number of workers taking sick leave had been increasing gradually from 2003 to 2005, but this decreased by approximately half in 2006 and 2007. Our mental health training programs for managers were successful in decreasing some job stressors, stress reactions, and workers’ sick leave due to mental problems.

Key words : active listening, brief job stress questionnaire, managers, mental health training program, sick leave.

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Introduction

Since 1997, about 60% of workers in Japan experience strong anxiety, worry, and stress in their work life, according to a national survey conducted every five years by the Ministry of Health, Labor and Welfare (MHLW) [1]. In fact, the proportion of companies reporting that “the number of workers with mental disorders has increased in the last three years” has been gradually increasing and reached 61.5% in 2006 [2]. Also in 2006, the number of large-scale companies with workers who took sick leave for longer than one month due to mental disorders reached 97.3% [3].

In this situation, the MHLW in Japan has promoted various plans for the implementation and reinforcement of mental health programs, and has published “Guidelines for the Promotion of the Mental Health of Workers in Companies” in 2000 [4], and a new “Guidelines for the Maintenance and Promotion of the Mental Health of Workers” in 2006 [5]. These guidelines emphasized the importance of promoting systematic and continuous “self-care by the workers themselves,” “care by line managers,” “care by occupational health care staff” (occupational physicians and industrial hygienists), and “care by special facilities outside of companies” (medical institutes, organizations with employee assistance programs or other institutes for occupational health), to improve the working conditions and support workers with psychological distress or workers who returned to work after sick leave due to mental disorders. In these four concerns, “care by line managers” is very important for workers, because managers’ listening to and supporting their subordinates reduces workers’ stress and has positive effects on their mental health.

Some large-scale companies reported effective results after trying mental health training for managers or supervisors [6–8]. We reported the effectiveness of Active Listening (AL) training for managers on better communication and reinforcement of supervisor support by an assessment 3 months after the training [9]. AL training seems to be a good practical method for improving managers’ listening attitudes and managing job stress by improving human relations between managers and workers in companies [10–13]. AL is expected to be useful as a participatory systematic interventional approach for work improvement, with positive effects on well-being by increasing social support and role harmony and reducing job stress. However, because many of these attempts were temporary and evaluated the effects on the listening attitudes or mental health of only managers, the long-term effects of AL training on workers were unclear. We have been engaged since 2004 in mental health promotion at an electronics manufacturing company with approximately 2,000 workers. We have planned and conducted the mental health training program for all managers since 2005. The main part of the program is AL training for “improving communication” and “reinforcement of supervisor support” in worksites. The purpose of this study is to introduce our interventional approaches for mental health promotion and to investigate the long-term effects of these approaches on job stressors, stress reactions and social support, and occurrences of sick leave due to mental disorders. Baseline data before the interventional approaches were used as a control to investigate the effects, because this was an uncontrolled interventional study.

Methods

We conducted a new mental health training program for supervisors, including AL training, in a Japanese electronics manufacturing company with approximately 2,000 workers. The number of supervisors, such as sub-sectional chiefs and sectional or department managers, was approximately 250, and most of the workers in the company were technicians and engineers working in the production line or in Research & Development. The observation term was three years, from the 2005 through 2007 fiscal years. In Japan, the fiscal year starts on the first day of April and ends on the last day of March.

Contents of mental health training program for managers

We constructed a new mental health promotion plan and evaluation for the plan, which began referencing these investigations in 2005. Table 1 shows our mental health training program, which was conducted twice, from October to December, 2005. The “reinforcement of supervisor support” was chosen as the main purpose of the organizational mental health promotion. The new mental health training programs, including the AL training [12–15] for managers on the worksite, were provided to all supervisors, including the sub-sectional leaders and sectional or department managers. In order to evaluate the effects of these interventional approaches and promote these activities, the results of the Brief Job Stress Questionnaire (BJSQ) were feed-backed to the manager of each division. Then we conducted follow-up and review programs of previous mental health training for the participants, which included consultation and advice for managers, from October to December in 2006.

Table 1. Mental health training program for managers

Contents	Time required (min.)
<i>First training</i>	
1. Purpose of the first training (policy of the company, importance of performing mental health care and so on)	10
2. Thinking about care in line of worksite using actual cases #1 Realization and follow up for subordinates with psychological distress (for secondary prevention) #1	100
3. Communication and support for subordinates (Explanation of the method of Active Listening)	40 (Total 150)
<i>Second training</i>	
1. Purpose of the second training (policy of the company, importance of performing mental health care and so on)	10
2. Thinking about care in line of worksite using actual cases #2 Realization and follow up for subordinates with psychological distress (for secondary prevention) #2 Supports for subordinates who return to work from leave of absence because of psychological distress	40
3. Communication and support for subordinates (Training of Active Listening)	100
4. Methods of work improvement (for primary prevention)	30
5. Methods of rational therapy as self-care	20
6. Review of the training	10 (Total 210)

Active Listening

AL was originally an important element of the client-centered therapy developed by C.R. Rogers [16, 17]. AL is also used as a basic skill of counseling in many different fields. AL is a way of listening and responding to another person that improves mutual understanding.

In this study, we used the AL training newly developed by Mishima and Kubota, which consists of two parts: role-play and over-all discussion [13, 14]. In the AL training, participants are divided into groups of five or six people. In the role-play, one person plays the role of a speaker, one plays a listener, and the others are observers. The speaker talks about any topic, not necessarily a problem. The role of the listener is to have the speaker talk about their topics for as long and spontaneously as possible. Trainers do not explain how to achieve that before the training starts. After one session of role-play ends, usually within 20 min, one of the observers chairs a group discussion in which they discuss what tactics for listening help the speaker to talk comfortably. After a few sessions of the role-play exercise, each group summarizes their findings about AL. After the group exercises, an overall discussion begins. In this session, representatives from the groups present detailed reports on their findings, and the trainer listens actively to them. The trainer not only summarizes their findings, but also demonstrates in front of the participants how they should listen actively. In these sessions, participants themselves learn how to listen actively, so that they can put to practical use at their workplace what they learned in the AL training. The effects of this AL training program on the listening attitude and listening skills of managers were confirmed by the investigation, using the Active Listening Attitude Scale (ALAS) at one and three months after training [14].

Procedure of investigation on Job stressors, psychological distress, social support and sick leave of workers

We used the BJSQ, a 57-item, multi-dimensional job stress questionnaire using a four-point Likert-type response option (from "strongly agree" = 4 to "strongly disagree" = 1) to measure the job stressors, worksite support, and psychological distress of workers [18]. For job stressors, we calculated scores of quantitative job overload (three items), qualitative job overload (three items), physical demands (one item), job control (three items), skill underutilization (one item), interpersonal conflict (three items), poor physical environment (one item), suitable job (one item), and rewarding job (one item), as well as scores for the individual items constituting these scales. For psychological distress, we calculated scores of vigor, hostility, fatigue, and anxiety, measured using three-item scale scores, and depression, measured by a six-item scale. High values on these scales of psychological distress, except for vigor, indicated high psychological distress. Supervisor support and coworker support were measured using three-item scale scores, for which a higher value was indicative of greater supervisor or coworker support.

The BJSQ analyses were conducted every year in May, from 2005 to 2007. The 2005 BJSQ data were used as the baseline, because the new interventional approaches began after the survey. To collect the responses, we used either online or paper questionnaires that respondents filled out independently. The number of respondents was 1,822 (male: 1,529, female: 293; mean age $\pm$ SD: 33.3 ± 7.2) in 2005, 1,843 (male: 1,549, female: 294; mean age $\pm$ SD: 33.9 ± 7.9) in 2006,

and 1,961 (male: 1,662, female: 299; mean age $\pm$ SD: 34.9 ± 8.3) in 2007. This investigation solicited responses from more than 90% of all workers in each year, excluding workers on sick leave, maternity leave, or away on long business trips.

We investigated the number of workers with sick leave of longer than a month due to mental disorders in each year from 2003 to 2007, as well as the number of workers who resigned after sick leave due to mental disorder without reinstatement.

Our procedures were reviewed and approved by the Human Ethics Committee for Epidemiological Research at the University of Occupational and Environmental Health, Japan. All workers were informed that our purpose was to evaluate job stress and to improve the work environment, and that participation was entirely voluntary and also that the data was to be used solely for the purpose mentioned.

Statistical analysis

We used the data of 1,420 workers (male: 1,196, Female: 224; Mean age $\pm$ SD: 35.2 ± 7.3), who were able to provide data through all periods from 2005 to 2007. We analyzed the BJSQ scores of subscales and items as dependent variable and each investigation period (IP) as independent variable, using repeated analysis of variance (ANOVA). For multiple comparisons, we used the *t*-test with the Bonferroni correction. The statistical analysis was conducted using the SPSS 15.0J statistics package (SPSS Inc., Chicago, USA).

Regarding sick leave, we investigated the number of workers with sick leave due to mental disorder for longer than a month and the ratio of that number to all workers, in addition to the number of workers who resigned after mental-disorder sick leave from 2003 to 2007.

Results

Change of subscales regarding job stressors, worksite support and stress reaction in the BJSQ

Statistically significant changes were observed in "quantitative workload," "qualitative workload," "job control," "physical demands," "poor physical environment," "suitable job," and "rewarding job" in the job stressor scales by analysis of the main effects during the investigation periods. These four scales were analyzed with multiple comparisons (Table 2). The scores of "quantitative work load," "qualitative workload," and "physical demands" in 2006 and 2007 significantly decreased compared to those of 2005. The score of "poor physical environment" significantly improved in the periods of 2006 and 2007 compared to that of 2005. However, "suitable job" and "rewarding job" scored highest in 2005.

Significant changes were observed in four items regarding job overload: "Large amount of work (Item No.1)," "Requires working hard (Item No.3)," "Requires concentration (Item No.4)," and "Complex job which requires a high level of knowledge and skills (Item No.5)"; particularly, the scores of Items No.3, 4, and 5 improved more in 2006 and 2007 compared to those of 2005 in multiple comparisons. In other items, significant changes were observed for "Can work at own pace (Item No.8)," "Interpersonal conflict within a workgroup (Item No.12)," "Conflicts with other workgroups (Item No.13)," and "Friendly atmosphere in a workgroup (Item No.14)." Items

Table 2. Comparison of the scores of scales and items for job stressors, psychological distress and social support among each year

Scales / Items	2005		2006		2007		IP		Multiple comparisons by IP
	M (SD)		M (SD)		M (SD)		F-value		
<i>Job stressors</i>									
Quantitative job overload	8.19 (1.86)		8.01 (1.86)		8.03 (1.81)		6.84 **		2005>2006**, 2005>2007**
No.1 Large amount of work	2.73 (0.77)		2.68 (0.72)		2.68 (0.71)		3.61 *		
No.2 Not enough time to get job done	2.45 (0.83)		2.39 (0.83)		2.40 (0.81)		0.91		
No.3 Requires working hard	3.02 (0.64)		2.94 (0.66)		2.95 (0.65)		12.82 ***		2005>2006***, 2005>2007***
Qualitative job overload	8.03 (1.69)		7.90 (1.79)		7.94 (1.69)		8.37 ***		2005>2006***, 2005>2007**
No.4 Requires concentration	2.90 (0.69)		2.85 (0.70)		2.86 (0.67)		4.50 *		2005>2006*, 2005>2007*
No.5 Complex job which requires high level of knowledge and skills	2.56 (0.77)		2.52 (0.77)		2.52 (0.74)		9.74 ***		2005>2006**, 2005>2007***
No.6 Requires always thinking about job during work hours	2.57 (0.71)		2.54 (0.73)		2.57 (0.72)		2.54		
Physical demands (No. 7 a lot of physical work)	1.89 (0.85)		1.87 (0.88)		1.83 (0.86)		9.22 ***		2005>2007*, 2005>2007***
Job control	8.15 (1.57)		8.23 (1.58)		8.27 (1.58)		3.16 *		
No.8 Can work at own pace	2.59 (0.77)		2.63 (0.77)		2.67 (0.75)		9.58 ***		2005>2007*, 2005>2007***
No.9 Can decide order and ways to do jobs	2.90 (0.64)		2.92 (0.64)		2.91 (0.63)		0.43		
No.10 Can express opinion of worksite policy	2.67 (0.65)		2.68 (0.62)		2.70 (0.62)		1.23		
Skill underutilization (No.11 requires less skill and expertise than I have)	2.18 (0.68)		2.20 (0.67)		2.19 (0.66)		0.09		
Interpersonal Conflict	6.99 (1.05)		7.03 (1.03)		7.01 (0.99)		1.29		
No.12 Interpersonal conflict within a workgroup	2.12 (0.71)		2.19 (0.69)		2.18 (0.67)		9.58 ***		2005<2007***, 2005<2007***
No.13 Conflicts with other workgroups	1.85 (0.63)		1.91 (0.62)		1.88 (0.60)		5.91 **		2005<2007**, 2005<2007*
No.14 Friendly atmosphere in a workgroup	1.98 (0.66)		2.07 (0.66)		2.05 (0.63)		14.81 ***		2005<2006***, 2005<2007***
Poor physical environment (No.15 Not good to workplace environments)	2.21 (0.83)		2.26 (0.84)		2.24 (0.84)		6.69 **		2005<2006**, 2005<2007*
Suitable Job (No.16 Contents of job that suit oneself)	2.76 (0.65)		2.76 (0.64)		2.71 (0.63)		4.33 *		2005>2007*
Rewarding job (No.17 rewardable job)	2.75 (0.70)		2.67 (0.69)		2.68 (0.67)		14.72 ***		2005>2006***, 2005>2007***
<i>Psychological distress</i>									
Vigor	6.47 (2.06)		6.32 (2.03)		6.33 (1.96)		9.55 ***		2005>2006***, 2005>2007**
Hostility	5.93 (2.07)		5.85 (2.10)		5.88 (2.04)		0.07		
Fatigue	6.32 (2.12)		6.20 (2.12)		6.09 (2.04)		6.61 **		2005>2007**
Anxiety	5.32 (1.97)		5.35 (2.03)		5.19 (1.90)		5.47 **		2005>2007*
Depression	9.66 (3.30)		9.91 (3.52)		9.57 (3.29)		6.53 **		2005<2007**
Physical complaint	17.63 (4.81)		17.89 (4.84)		17.78 (4.81)		4.08 *		2005<2006**
<i>Social support</i>									
Supervisor support	7.31 (1.86)		7.34 (1.87)		7.30 (1.87)		2.39		
Coworker support	8.40 (1.78)		8.24 (1.80)		8.21 (1.78)		8.24 ***		2005>2006**, 2005>2007***
Family and friends support	10.02 (1.87)		10.02 (1.94)		9.92 (1.96)		5.54 **		2005>2006**, 2005>2007**
<i>Others</i>									
Satisfaction of work or family life	5.92 (1.08)		5.91 (1.08)		5.94 (1.07)		0.34		

IP: Investigation period; *. $P<0.05$. ** $P<0.01$. *** $P<0.001$. n=1420

IP, Investigation period; *, $P<0.05$, **, $P<0.01$, ***, $P<0.001$

n=1420

No.8 and 14 in 2006 and 2007 improved significantly compared to those of 2005. Particularly, the score of Item No.14 significantly increased in 2006 over that in 2005, and remained in 2007 at the 2006 level (Table 2).

The score of "coworker support" in the worksite support scale for 2006 and 2007 decreased significantly compared to that of 2005 in multiple comparisons in each period. The score of supervisor support increased slightly but not significantly in 2006. Significant changes were observed for "Vigor," "Fatigue," "Anxiety," "Depression," and "Physical complaint" in the scale of stress reactions. The scores for "Fatigue" and "Anxiety" in 2007 significantly decreased compared to those of 2005 in multiple comparisons. In addition, the scores of "Depression" and "Physical complaint" for 2006 showed significant increases over 2005, but decreased in 2007. The score of "Vigor" in 2006 and 2007 significantly decreased compared to that of 2005 (Table 2).

Changes in the number of workers with sick leave due to mental disorder

The number of workers with sick leave absence due to mental disorders had been increasing gradually from 2003 to 2005. However, their number decreased by about half in 2006 compared to the peak in 2005, and slightly decreased in 2007 compared to 2006. There was a significant difference in the occurrences of workers with sick leave between the total numbers in 2003 and 2004 and those in 2006 and 2007. We removed the data for 2005, because our mental health activities started in September in 2005 and ended in March in 2006, so that the effect of our mental health activities would be only partial in 2005. There was no dismissal by restructuring or downsizing in these three years. The number of workers who resigned due to personal circumstances after mental-disorder sick leave was less than three persons through all the years. The ratio of the workers who could be reinstated after sick leave was in a range from 87.5 to 100% in each year (Table 3).

Table 3. Changes in the number of workers with sick leave

Year	The number of workers	Workers with sick leave due to mental disorder	Workers resigned after sick leave due to mental disorder ^a
	N	N (%) ^b	N (%) ^c
2003	1852	27 (1.46)	1 (3.70)
2004	1944	29 (1.49)	1 (3.45)
2005	1957	31 (1.58)	3 (9.68)
2006	2000	16 (0.80)	2 (12.5)
2007	2001	14 (0.70)	0 (0.00)

^a: The number of "Workers resigned after sick leave due to mental disorder" is included in the number of "Workers with sick leave", ^b: Workers with sick leave due to mental disorder (N) / The number of workers (N) *100 (%) in each year, ^c: Workers resigned after sick leave due to mental disorder / Workers with sick leave due to mental disorder *100 (%) in each year

Discussion

It is desirable to reduce job stressors or stress reactions by reinforcement of worksite support [19] with good communication between managers and subordinates, and to improve the workload as reflected in high job demands or low job control [20–22]. Previous research has shown that supervisor support moderated the effects of both objective and perceived workload and has a beneficial effect on worker health [23–25].

We conducted a mental health training program for all levels of managers on worksite mental health, including AL training, to improve the communication between supervisors and workers, and to reinforce supervisor support. Mental health training only for section heads may be insufficient for worksites, because they have too many subordinates and can not always work on the production lines or in the research laboratories. Therefore, it is difficult for them to respond to the needs of each worker. Sub-section leaders have more opportunities to work directly with their subordinates than do section heads, and they can correspond to various consultations from subordinates regarding problems in the workplace, such as work overload, poor worksite environment, and personal conflicts or troubles.

Evaluation of the mental health training

The company started a new business project in 2005 and continued it through 2007. Therefore, it was possible that actual job stress and the number of workers with mental problems might increase. In reality, our mental health promotion program resulted in a decrease of workers with mental problems. However, we observed that the scores of “quantitative workload,” “qualitative workload,” and “physical demands” in job stressor scales significantly decreased in 2006 and 2007 compared to the 2005 baseline. In these results, one of the reasons for these changes may be that the supervisor and subordinates cooperated together to reduce job stress by applying the techniques of our mental health promotion program. For example, systematic support for subordinates was promptly provided by supervisors for a task involving a heavy workload or the need for advice and support for troubles and anxiety in work. The other reason may be related to the workers’ adaptation to the new working conditions and new interpersonal relationships in the workplace, which started during a new business project in 2005.

We observed a statistically significant decrease of “coworkers support” and no significant change of “supervisor support.” These results may be attributable to the reorganization caused by the new business project in the company. Large-scale reorganization occurred in 2005 and resulted in many workers moving to new sections. Many workers who moved to new sections had to form new inter-personal relationships, but “supervisor support” remained stable. The effect of the mental health training program may have been mainly in maintaining supervisor support under changed working conditions. In our other study for managers in this company, there were increases in the score of attitude and methods of listening as measured by the ALAS [26] and the score of supervisor support in BJSQ comparing before and 3 months after AL training for sub-sectional leaders [9]. Additionally, in our other investigations after the AL training, “much more increasing of opportunities for conversation with their subordinates than

before” was cited by approximately 50% of all the respondents, and “the same as before” was the response of approximately 40%. “Becoming better at proceeding with conversations” or “becoming better at selecting time to select timing and place for conversations” were each cited by approximately 70%, and “as good as before without change” was reported by approximately 27%. Based on such results, we found that our mental health promotion program was effective for improving communication and reinforcing of supervisor support. On the other hand, our approach to mental health promotion for regular non-managerial employees may be insufficient. It was difficult for us to conduct mental health promotion programs for all workers because of the scant occupational health staff resources available to provide education or training for all workers.

It should be noted that “Friendly atmosphere in a workgroup” significantly increased in 2006 and 2007 compared to 2005. There is a close relationship between building and maintaining a friendly atmosphere in the worksite and supervisor support, and the role of supervisor is one of the most important factors [27–29]. We speculated that the reason for improvement of this item might have been the mental health training program since 2005.

Reduction of workers taking sick leave due to mental disorder

Some studies show a relationship between supervisor support and sick leave. Ishizaki *et al.* reported that there was significant negative correlation between the increase of supervisor or coworker supports and the number of workers taking sick leave [30]. Otsuka *et al.* reported that there was significantly low supervisor support in the group of workers who took leaves of absence from duties in excess of five days because of their physical health problems [31].

In our investigation, the number of workers taking sick leave in 2006 and 2007 reduced to about half of the number before 2005 despite the changing working conditions caused by the new business project. Such a drastic decrease in workers taking sick leave may have occurred because of our interventions in mental health promotion, because the number of workers, the total number of products, and the business environment were almost the same during these three years. Our mental health promotion might have strengthened attention from supervisors and communication between supervisors and subordinates, so that supervisors could be consulted by subordinates at an early stage of stress reactions, and supervisors could arrange their workload and prevent them from becoming ill and requiring mental distress sick leave. Supervisors performed interviews with their subordinates or dealt with the reduction of workload for subordinates, if it was necessary. We also recognize that supervisors and occupational health care staff implementing preventive approaches for workers with health problems or high job stressors might have some effects on the decline of workers’ sick leave, because of early detection and measures for workers with physiological or psychological distress.

Limitation of our study and future direction

In this study, we conducted various approaches, from primary to tertiary interventions for mental health promotion in worksites, and we evaluated our systematic mental health activities quantitatively, using questionnaires and the number of workers taking sick leave in this study.

However, it was not possible to clarify how or how much our activities affected the decrease in job stressors or psychological demands on all workers, nor which of our activities affected them. There are several reasons for these uncertainties. First, we should have conducted research with control groups to evaluate the effect of each intervention appropriately [6, 7]. However, we were unable to carry out such a research model because both managers and employees in charge of this project rejected it. The top managers insisted that our interventions be carried out for all workers. Second, many other stressors also affected the workers, such as change of working conditions due to the new business project during our investigation period. Many workers were exposed to stressors from outside of their core responsibilities; e.g., relations with an associated company and demands from clients, influences of the market or economic conditions – influences we can neither measure nor ignore.

The data may also be affected by subjects dropping out our research or those who did not reply to the questionnaire voluntarily, were on sick leave, transferred for personnel changes, or retired. Still, our research was carried out for most workers of the company each year, and we did obtain data for three successive years, with responses from 1,420 of a possible 2,000 workers in the company. That proportion of workers may also limit the success of this research in the company.

In conclusion, our mental health training program for managers with AL training were successful in reducing some job stressors and workers taking sick leave. We will continue these activities for mental health promotion and should develop a more practical and more scientific stress management and evaluation system in the near future.

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製造事業場における管理監督者メンタルヘルス研修の効果

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要 旨： 我々は2005年から2007年にかけて、従業員数約2000人の精密機器製造事業場において、労働者のメンタルヘルスの増進に取り組んだ。特に上司の部下への支援強化を目的とした積極的傾聴を取り入れたメンタルヘルス研修プログラムを全管理者を対象に実施し、職場や従業員への効果を評価した。全従業員を対象に職業性ストレス簡易調査票による調査と経年的な休職者数の変動を調査した。職業性ストレス簡易調査票の「仕事のストレス要因」を構成する9つの下位尺度のうち「仕事の量的負担」、「仕事の質的負担」および「身体的要求」の3尺度の得点が、我々の介入後有意に改善した。また休職者数は2005年まで増加傾向であったが、2006年と2007年は、2005年の約半数に減少した。我々の管理者を対象としたメンタルヘルス研修は職業性ストレスを軽減させると同時に休職者数を減少させることで、職場のメンタルヘルスの増進に有用であった。

キーワード： 積極的傾聴, 職業性簡易ストレス調査票, 管理者, メンタルヘルス研修プログラム, 休職。

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