

Fatigue and psychological distress in the working population Psychometrics, prevalence, and correlates

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Received 11 October 2000

Abstract

Objective: The purposes of this study were: (1) to explore the relationship between fatigue and psychological distress in the working population; (2) to examine associations with demographic and health factors; and (3) to determine the prevalence of fatigue and psychological distress. **Methods:** Data were taken from 12,095 employees. Fatigue was measured with the Checklist Individual Strength, and the General Health Questionnaire (GHQ) was used to measure psychological distress. **Results:** Fatigue was fairly well associated with psychological distress. A separation between fatigue items and GHQ items was shown. No clear,

distinct pattern of associations was found for fatigue vs. psychological distress with respect to demographic factors. The prevalence was 22% for fatigue and 23% for psychological distress. Of the employees reporting fatigue, 43% had fatigue only, whereas 57% had fatigue and psychological distress. **Conclusions:** The results indicate that fatigue and psychological distress are common in the working population. Although closely associated, there is some evidence suggesting that fatigue and psychological distress are different conditions, which can be measured independently. © 2002 Elsevier Science Inc. All rights reserved.

Keywords: Epidemiology; Fatigue; Psychological distress; Working population; Prevalence; Psychometrics

Introduction

Community and primary care studies have repeatedly shown that fatigue is a common complaint [1–6], and that fatigue may accompany physical [1] as well as psychiatric disorders [1,5,7]. Fatigue that becomes prolonged is reported to be associated with impairments comparable to chronic medical conditions [7], and may affect the individual's performance and functioning in the occupational as well as in the home setting.

The concept and the assessment of fatigue have been subjects of controversy for many years [8,9], and there are still more questions than answers with respect to the status of fatigue. For example, is fatigue conceptually, operationally, and etiologically distinct from psychological distress, or is the overlap between the two constructs so large as to

throw in doubt the usefulness of having two separate concepts? Is the natural history of the two different? Are different prevention and treatment strategies applicable? At present, these questions cannot be adequately answered. We do know that studies conducted in the general population [3] and in the primary care setting [5] have shown that fatigue is associated with psychological distress, with observed correlations of .62 and .51. However, the relationship between fatigue and psychological distress may vary across different populations. With respect to the working population, previous research of fatigue and psychological distress was restricted to a specific occupational setting [10], with an observed correlation of .54. Hence, one key issue is whether the available measures of fatigue and the existing measures of psychological distress assess highly similar or sufficiently different underlying concepts in the general working population.

The Maastricht Cohort Study of “Fatigue at work” contributes to this research field with a large-scale epidemiological study in a heterogeneous working sample, in which not only the etiological factors in the onset and

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natural history of fatigue and psychological distress will be investigated but also the measures of fatigue and psychological distress and the constructs themselves will be examined. Within the Maastricht Cohort Study, fatigue is measured with the self-report Checklist Individual Strength (CIS) [11–13]. The General Health Questionnaire (GHQ) is used to assess psychological distress [14,15].

In the present study, we used the baseline data from the Maastricht Cohort Study to describe the relationship between fatigue and psychological distress in the working population, to examine associations with demographic and health factors, and to determine the prevalence of fatigue and psychological distress.

Methods

Study population

In May 1998, a total of 26,978 male and female employees, aged 18–65 years, from 45 Dutch companies and organizations received a letter at home inviting participation

and the baseline questionnaire. The letter explained the purpose and the general outline of the cohort study, described how the data would be used, and guaranteed anonymity of responses. The voluntary nature of participation was emphasized. Nonrespondents received a written reminder 2 weeks later. After 6 weeks, a random sample of 600 persistent nonrespondents was asked to complete a brief questionnaire about the reasons for nonresponse; 168 (30%) of the nonrespondents returned this questionnaire.

A total of 12,161 employees completed the baseline questionnaire. Written consent was obtained from all participants. The overall response rate was 45%. Twenty-one questionnaires were discarded from the analysis because of technical reasons; another 45 questionnaires were excluded because an inclusion criterion was not met. The final study population at baseline consisted of 12,095 employees: 8840 (73%) men and 3255 (27%) women. The mean age of the total cohort was 41.0 years (S.D. 8.9) — 42.0 years (S.D. 8.8) in men and 38.0 years (S.D. 8.8) in women. Table 1 shows demographic and health factors for the total cohort at baseline. In a nonresponse analysis, no significant differences were found between respondents and nonrespondents

Table 1
Demographic and health factors for the total cohort (N=12,095)

| | Total (N=12,095) | | Men (N=8840) | | Women (N=3255) | |
|-----------------------------------|------------------|------|--------------|------|----------------|------|
| | n | % | n | % | n | % |
| <i>Age group (years)</i> | | | | | | |
| 18–25 | 488 | 4.0 | 253 | 2.9 | 235 | 7.2 |
| 26–35 | 3049 | 25.2 | 1924 | 21.8 | 1125 | 34.6 |
| 36–45 | 4530 | 37.5 | 3318 | 37.5 | 1212 | 37.2 |
| 46–55 | 3510 | 29.0 | 2905 | 32.9 | 605 | 18.6 |
| 56–65 | 518 | 4.3 | 440 | 5.0 | 78 | 2.4 |
| <i>Educational level</i> | | | | | | |
| Primary school | 522 | 4.4 | 446 | 5.1 | 76 | 2.5 |
| Lower vocational education | 1833 | 15.6 | 1524 | 17.6 | 309 | 10.1 |
| Lower secondary school | 1526 | 13.0 | 932 | 10.8 | 594 | 19.4 |
| Intermediate vocational education | 2805 | 23.9 | 2044 | 23.6 | 761 | 24.8 |
| Upper secondary school | 1009 | 8.6 | 641 | 7.4 | 368 | 12.0 |
| Upper vocational education | 2705 | 23.1 | 2047 | 23.6 | 658 | 21.5 |
| University | 1335 | 11.4 | 1035 | 11.9 | 300 | 9.8 |
| <i>Living alone</i> | | | | | | |
| Yes | 1227 | 10.2 | 840 | 9.5 | 387 | 11.9 |
| No | 10,852 | 89.8 | 7989 | 90.5 | 2863 | 88.1 |
| <i>Dependent children</i> | | | | | | |
| Yes | 6459 | 53.9 | 4922 | 56.2 | 1537 | 47.7 |
| No | 5522 | 46.1 | 3835 | 43.8 | 1687 | 52.3 |
| <i>Presence of disease</i> | | | | | | |
| Yes | 2839 | 24.2 | 1987 | 23.1 | 852 | 26.9 |
| No | 8914 | 75.8 | 6604 | 76.9 | 2310 | 73.1 |
| <i>Health status</i> | | | | | | |
| Excellent | 1144 | 9.5 | 844 | 9.6 | 300 | 9.3 |
| Very good | 2653 | 22.1 | 2002 | 22.8 | 651 | 20.1 |
| Good | 6437 | 53.6 | 4661 | 53.1 | 1776 | 55.0 |
| Moderate | 1648 | 13.7 | 1187 | 13.5 | 461 | 14.3 |
| Bad | 124 | 1.0 | 81 | 0.9 | 43 | 1.3 |

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