

# Evaluating brief therapy

## within an Employee Assistance Programme (EAP)

**Dr Kevin Wright** reflects on his PhD research exploring gender differences with regard to cost-effectiveness and work-stress coping strategies

**A**s a newly qualified chartered counselling psychologist, in 1995 I found a job with an EAP provider in London. I was very pleased to have found this position as it seemed quite a new area of work, which I found very rewarding. It was through this role I realised that the brief therapy model was effective and helpful and the provider was promoting this service on the basis of these claims. But I also realised they had no evidence to validate their claims other than the very subjective use of client satisfaction questionnaires. I approached the company's managing and clinical directors, who agreed with me, and I offered to research the effectiveness of the EAP, including its cost-effectiveness.

### Mapping and measuring

I was keen to study clients who were seeking counselling within a local authority contract. I wanted to use a scoring measurement system meaningful to me at different stages of their therapeutic journey; before they arrived for therapy, at the end of therapy and, because I was interested in how stable any change might be, I also wanted to look at their scores six months after therapy. However, I faced a problem. Apart from wanting to use scales that may not have been used before in such settings (as I wanted them to be relevant) I was carrying out the research in a commercial field where using randomised control trials (RCTs) might not have been regarded as ethically or commercially acceptable. So I pondered over who I should 'research' against my counselling client population, ie my 'control' group.

I came up with an idea: as the contract was with an organisation with a large number of employees, I would design the questionnaire to go out to a random sample of all the employees from the departments who had signed up to the EAP contract and from which the counselling clients would be coming. Thus the whole population would represent this baseline and I would examine the counselling clients and their changes against this baseline. However, while my expected research base of the education and social services departments was large, as I set out to plan this strategy, the rest of the council got wind of what I was planning and wanted

to be involved in the baseline measure research. So with the support of the authority, and its help in the distribution and collection of the questionnaires, I sent out over 5,000 questionnaires (comprising some 30 questions with five measurement scales plus demographic info, etc) to a random sample of the 17,500 workforce (random using their employee numbers for large departments and sent to all employees if a department had less than 250 employees). I was amazed that 2,300 completed questionnaires were returned. I ended up with an extremely valid baseline normative score which could be broken down into age, professional status and gender difference without compromising the validity of the mean scores. This was totally unexpected and gave me, according to Professor John McLeod, my tutor, perhaps one of the largest stress audits in the country.

### Coping strategies

My research design was 'postmodernist' in that it was based on my experiences as a therapist. I would see many clients whose primary presenting issue was 'stress'. So I searched for a measure for work stress and thus was given permission by Professor Cary Cooper to use his OSI (Occupational Stress Inventory)<sup>1</sup>. As this contained over 100 questions, I abstracted those that were more relevant to the kinds of questions I would explore in the therapy and still maintained enough in each of Cooper's six stress factors; and found from the baseline measure that each factor within my reduced OSI of 30 questions had very good internal validity. I had other measures that I was interested in, but because of space restrictions I will omit them here as I was most interested in clients' coping strategies and how these might change as a result of the brief therapy. Coping strategies, I believe, are what many brief therapists focus on in their work, ie how to change the client's coping strategies for dealing with the stresses that they are experiencing<sup>2</sup>.

I looked at six different coping strategies:

- *rational actions* – taking positive actions to deal with stress
- *palliative responses* – using hobbies etc to distract from stress being experienced

**Dr Kevin Wright**, a chartered counselling psychologist, works part time as a high-intensity IAPT integrative therapist in primary care in Lewisham for SLaM (South London and Maudsley Mental Health Trust). For the last 15 years he's been an EAP affiliate for a number of providers. kevin\_wright\_k@yahoo.com

- *social support* – using friends and family to gain support for dealing with stressful feelings
- *depressive response* – feeling powerless to do anything about the causes of one's stress
- *emotive response* – shouting at those around to release tension but doing nothing to change the situation
- *passive response* – taking no action or taking to drink hoping the problem will go away on its own.

I was also keen to examine various demographic differences and whether these had any effect on responses to stress. Also, there was not much in the literature on the particular issue of gender differences, as it was often said that the data did not lend itself to such comparisons<sup>3</sup>.

Furthermore, I was aware that many organisations examined stress levels and the effectiveness of stress responses via the examination of sickness absence levels. But I considered this to be an overly rudimentary construct as many people could be very stressed yet not absent from work – they might still drag themselves into work yet show limited or no effectiveness at their work. Thus we have the concept of 'presenteeism' ie a measurement of effectiveness at work. Finally I was interested in the cost of stress, sickness and 'presenteeism' to the organisation and in particular the cost benefits attributable to changes as a result of the counselling (using employee pay grades).

## Discoveries

The findings from the baseline normative measure became known by the council as the Wellbeing study. I had so much information from each department that I had to write 25 separate reports on the stress levels and types of stress experienced by each department. As a result, the council set up focus groups to deal with the levels of stress within each of its own departments. Another spin-off benefit from my research was identifying that teachers represented a very highly stressed group, which led to the setting up of the Teachers' Support Network, which now serves over 13,000 schools across the country<sup>4</sup>.

## Gender response differences

Of the 2,300 responders, 36 per cent were male, which was representative of the organisation as a whole (compared with figures provided by the HR department); 39 per cent were professionals, (37 per cent of the males, 38 per cent of the females). Twenty-four per cent of the respondents were part-timers (41 per cent of the females, nine per cent of the males). Professional males earned significantly more than the females ( $t = 5.908$ ,  $p < .1$  per cent;  $df = 820$ ). Non-professional males earned significantly

more than non-professional females ( $t = 13.122$ ,  $p < .1$  per cent;  $df = 1059$ ). Professional employees rated themselves as working at 10 per cent lower level of 'presenteeism' than non-professionals (ie working at lower levels of efficiency). The weekly intake of alcohol for the males was 2.5 times more than that of the females. The females took 1.4 times more days of sick/year than the males. The professional males took 1.1 times more sick leave than non-professional males. Non-professional females took 1.3 times more days off sick than professional females.

## Stress levels

On the issue of the amount of stress experienced, professionals were significantly more stressed than non-professionals. Overall the males experienced significantly more work stress than the females in all the stress factors except the factor referred to as 'home/work interface', where there were no gender differences, suggesting that getting this balance right was as much a concern for the males as it was for the females and overall this was the main cause of concern for this sample. Furthermore, work stress correlated with alcohol consumption and with lower levels of 'presenteeism', especially for the males, and the females' stress levels correlated with the number of days off sick. This suggests that under stress males may drag themselves into work but may not be working that effectively when under stress, whereas the females will use time off sick to try to deal with their stress. Further, it was also found that alcohol intake correlated particularly with the cause of stress factor known as 'career and achievement' for the professional males who were living with someone.

However, the most interesting finding for me was that full-time staff experienced significantly more stress than part-time staff, irrespective of age and gender, even in the more highly stressed professions, eg social workers, teachers, etc. This might not be accounted for by the fact that they were only working part time as this applied also to those who were working full time but in two different roles eg retained firemen who worked as part-time firemen while also working in another job in the council. Firemen were amongst the higher stress professions, but the part-timers showed considerably lower stress levels. This might offer some ideas about how to design jobs to reduce stress.

**‘The most interesting finding was that full-time staff experienced significantly more stress than part-time staff, irrespective of age and gender’**

### Cost of stress

In this study it was calculated that the total number of days off sick for the sample was 13,310 a year. Based on this figure, an extrapolation for the whole workforce (17,614) would equate to 106,564.7 days lost per year. Compared with the CBI estimates, this works out at 60,500 days lost a year for a workforce of 10,000 compared with the CBI estimate of 73,000 days per year<sup>5</sup>. This would suggest that this local authority compared well or better than the estimates in the private sector. The estimated cost of sickness absence for the sample was nearly £647,000 (equivalent to £866,000 in 2008). If this was extrapolated to the whole workforce, this would give a figure of nearly £5.8 million (or £6.9 million corrected to 2008 – InflationData.com). If the estimated proportion of the cost due to stress-related disorders was considered to be 60 per cent of the cost of sickness<sup>6</sup>, then the individual cost of stress would be £198 per employee, and if 71 per cent of that stress-related sickness was attributed to work as suggested by Cooper and Davidson<sup>7</sup>, this would work out at £140 per employee, which is larger than the estimated figure of £100 per employee estimated by the CBI<sup>5</sup>. The Mental Health Foundation-estimated stress-related sick leave costs the UK economy £93 billion every year<sup>8</sup>.

However, as suggested above, I considered the level of sickness to be a very limited way of measuring the cost of stress as it did not include those 'guilty' of presenteeism. Thus for my sample I calculated that the cost of lowered effectiveness was nearly £1.99 million (£2.66 million in 2008) and if extrapolated to the whole organisation, this would equate to £33.2 million in 1996 (£44.5 million in 2008). This was calculated by examining the subjects' self-reported percentage effectiveness in the workplace (using 80 per cent as the norm), equating this to lost productivity and quantifying it from their exact pay levels. In this sample, the percentage experiencing levels of effectiveness below the considered norm of 80 per cent was 27 per cent of the Wellbeing sample (33 per cent of the males and 23 per cent of the females). Thus the estimated total cost of stress to the organisation was estimated at 42.6 per cent of the cost of sickness and the cost of the reduced level of presenteeism £2 million for this sample (or £2.68 million in 2008). If extrapolated for the whole workforce then the total cost of stress to the organisation was estimated at £35.2 million per year (£47.1 million in 2008).

From the data it was also found that women estimated that they took more sick leave than the men and so they cost the organisation 4.4 per

cent more in sickness costs, though the differences in the costs for sickness for both genders were not significant. But the cost of presenteeism was higher in men, costing the organisation 21.6 per cent more than the women. Thus the total stress for the men cost the organisation 16.2 per cent more than the stress costs for the females. The males' costs for presenteeism and hence total stress costs were significantly different from that of the females ( $p < .01$  and  $.05$  respectively).

These figures were of significance because the objective had been to examine how and in what ways the EAP counselling service was cost-effective in reducing the stress experienced by the subjects and to be able to put a cost to the productivity saving produced by reducing the stress experienced by the subjects. To this end it was important therefore to have some concept of what stress was costing the organisation as a whole, and to use the figures obtained as a measure of what was being saved by the counselling, not directly in terms of financial cost but by implication in terms of improved productivity either by reducing sickness levels and/or lowering the level of 'presenteeism'.

### Coping strategies

In the Wellbeing baseline it was seen that males used 'rational actions' and 'passive responses' significantly more than the females, whereas the females tended to use 'social support', 'depressive responses' and 'emotive responses' more than the males as a way of coping with their stresses. It was also found that it was only with the males that alcohol consumption correlated significantly with the 'passive response' to coping with stress. Furthermore, for the males the use of 'emotive response' correlated significantly with days off sick whereas, for the females, 'depressive, emotive and passive' responses correlated significantly with levels of sickness.

### Results

Over the period of the research a total of 368 clients were seen, representing 2.94 per cent of the total workforce who were eligible to use the counselling service (ie education and social services departments). Three hundred and five different clients responded at some point to the research, representing an 82.9 per cent response rate. Fifty-eight per cent filled out a post-treatment questionnaire and 29 per cent filled out the follow-up questionnaire. The level of attrition was considered to be what one would normally expect in many studies and there was no significant difference in the pre-treatment scores between those who did not respond to either the post-treatment or follow-up questionnaires. These clients were seen by 22 therapists, who had all

been vetted and accepted to work in a brief therapy mode as affiliates for the EAP provider.

The gender split using the service was fairly representative of the proportion of each gender who had responded to the Wellbeing study, which was in itself fairly representative of the organisation as a whole (36.2 per cent males and 63.8 per cent females in the Wellbeing study compared with 27.0 per cent males and 73.0 per cent females in the counselling sample). The 19-35-year-old males were slightly underrepresented in those who came to counselling. The majority of the users of the service tended to be the 36-55 year olds who were professionals and were 'living alone'. They also drank more alcohol and had more time off than the norm. There were no gender differences in the counselling clients for 'days off sick' even when measured by age, but the highest levels of sickness came from females aged 36-64 living alone. The counselling subjects on average cost significantly more in sickness and presenteeism than the baseline normative subjects, and the higher sickness and presenteeism costs and alcohol consumption were amongst the professionals, independent of gender.

### Changes in stress levels through EAP counselling

All the counselling subject groups presented with significantly greater stress levels than the baseline norm. But it is when we start looking at the change process as a result of the counselling that the results become interesting and somewhat surprising. For example, the males produced reliable change, for their 'total stress' (mean for all the stress factors as described above for Cooper's OSI measure<sup>1</sup>) at the post-treatment stage and the 46-55 year old males (when comparing age groups) seemed to benefit the most. It was also of interest to note that at the post-treatment stage, while the females had shown some change, that change was not clinically significant or reliable. But by the six months' follow-up stage, the mean score for the males had fallen towards the pre-treatment level, while the mean for the females had continued to improve such that, at this stage, the change was now clinically significant and reliable and showed good effect size for that change. This was especially true for the 46-55-year-old females and those who were 'living together' with someone (see figure 1).

### Was the counselling cost effective?

In this study in 1996 it was found that by the post-treatment stage, using only those with effect sizes for the change that were over 0.5 and after subtracting the cost for the provision of the

counselling service (calculated as being £32 per head in 1996), the reduction in total stress costs was calculated as being £127 per client (or £180 in 2010) for all the subjects together. This was however different for each gender. The saving for the males was equivalent to £116 (£160 in 2010) and for the females it was £131 (£180). But because, for the males, some of the gains were lost by the follow-up stage (as stated above) and the females continued to improve to that stage, the savings were equivalent to £260 per subject as a whole (at 2010 value) or £160 for the males and £300 for the females. If the service was used by 10 per cent of the workforce, this saving would equate to £320,000 over the year or if calculated from the three per cent who used the service in its first year, the figure would be at the 2010 equivalent of £97,000. Thus it was seen the counselling saved 5.6 times the cost of the service, if just examining the reduction in stress levels. However, if just measuring the increased levels of presenteeism, the saving was 6.6 times the cost of the counselling.

### Changes in coping strategies

Like the baseline sample, the males in the counselling sample attended with significantly higher use of the coping strategy labelled rational actions than the females but the difference disappeared by the post-treatment and follow-up stages, suggesting this was

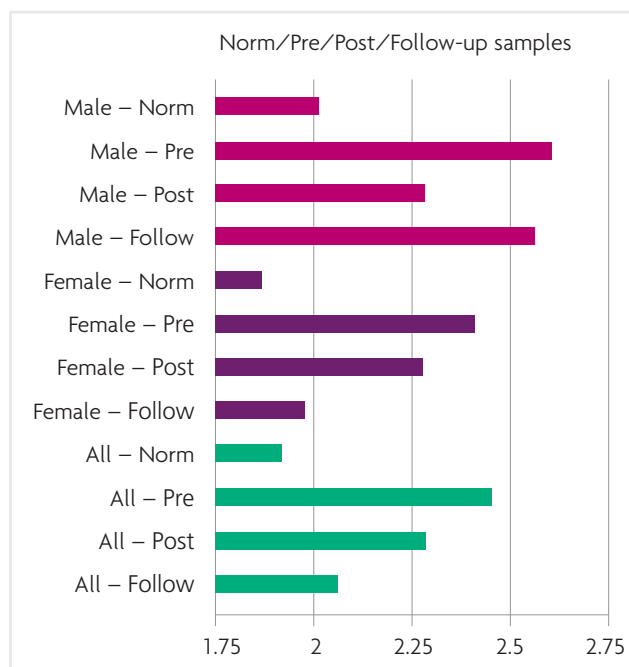


Figure 1. Mean score for total stress x gender (subjects responded on a scale of 1-5 (Not at all/A little bit/Moderately/Quite a lot/Extremely) – responses to 37 statements where they rated how each of the statements was true for them)

an area of change that the females found most helpful within their counselling. In fact, the females produced clinically significant and reliable change for this coping strategy at both the post-treatment and follow-up stages. Even more interesting was that both genders came to counselling with significantly higher mean scores for the use of social support than the norm, and both improved on this mean at the post-treatment and follow-up stages. This suggests that being able to use social support as a strategy for coping with stress was a reason why the counselling subjects could think about using counselling to help them deal with their stresses. So what does this mean for those who have difficulties using social support? On the issue of the coping strategy social support, as with the baseline sample the female counselling subjects came with mean scores for this coping strategy which were significantly higher than those for the males. But unlike many of the other measures, this was the one measure where the males not only showed improvement at the post-treatment stage but the mean for the males continued to improve to the follow-up stage such that at both stages the mean for the males was not significantly different than that for the females. For both genders, the groups that showed the most improvement for this strategy were the 36-45-year-olds and those who were in the 'professional' group.

When I examined the coping strategy called depressive response, I found that both genders came, as one might expect, with mean levels that

were significantly higher than the norm and the level for this strategy correlated significantly with the overall stress experienced by the subjects. As with other measures, the males produced clinically significant change for this coping strategy by the post-treatment stage, but by the follow-up stage, the change was no longer clinically significant. However, by the follow-up stage at six months after treatment, the females' mean for this strategy showed clinically significant and reliable change, meaning that, for example, the mean score for this coping strategy for the females was no longer significantly different from the norm.

For the coping strategy called emotive response, eg shouting at people, the females came with significantly higher levels for using this strategy but were able to produce clinically significant change after counselling. With respect to the coping strategy of passive response, eg having a drink or hoping the stress would go away, the males came with significantly higher mean scores than the females, though the difference disappeared at post-treatment but returned at the follow-up stage. The mean level for the females for this strategy was not significantly higher than the norm. The 16-35-year-olds came with significantly higher mean scores for this strategy when compared with the 36-64 plus age group. Unfortunately, it was found that the brief therapy, as offered by the EAP counselling, had limited effect in promoting change in the coping strategy of 'passive response', particularly for the males. The gender differences in responses can be seen clearly in figure 2.

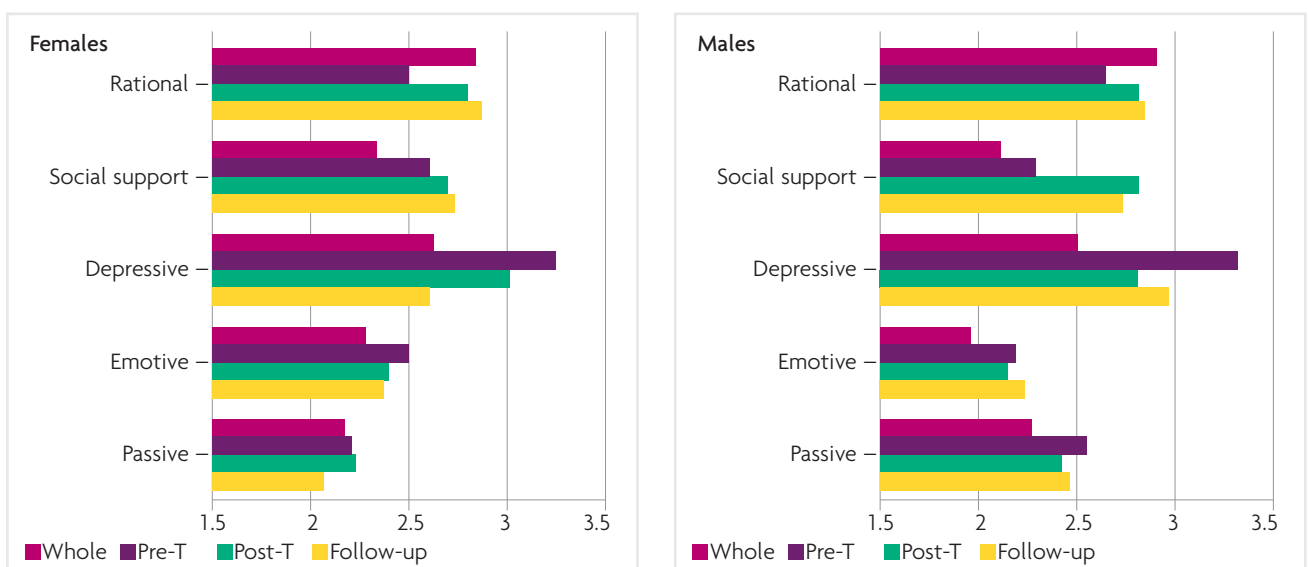


Figure 2. Mean scores for coping strategies x gender (subjects responded on a scale of 1-5 (Not at all like me to Very much like me) – in answer to the statement: When I am under a lot of stress I... (Responses to 37 questions)

## Summary

The key interesting findings were:

- The level of stress experienced varied with gender, age, and work, marital and professional status.
- Stress increased with age.
- Stress factors affected the genders differently.
- Males experienced more stress than the females.
- There were no gender differences for the stress factor known as home/work interface.
- Females took more days off sick.
- Males functioned with significantly lower levels of presenteeism than the females.
- Cost of stress to the organisation in lost productivity through sickness and lower presenteeism was considerable.
- Part-time staff were considerably less stressed than their full-time colleagues even when they worked the equivalent of a full-time job but in two different occupations.
- Males favoured using rational action and passive responses as ways of coping with stress.
- Females favoured depressive and emotive responses and the use of 'social supports' as ways of coping with stress.
- The proportion of males seeking counselling matched the proportion of males to females in the organisation and those who responded to the baseline normative measure.
- Older subjects were more likely to seek out counselling as a way of dealing with their stress.
- Males came with significantly higher mean score for rational actions than the females but by the follow-up stage there was no significant difference.
- Both genders came with significantly higher mean scores for the use of social support as a coping strategy than the baseline normative sample, and they continued to improve on this to the follow-up stage.
- At the start of counselling the males scored a mean for the use of social support that was significantly lower than that for the females, but by both the post-treatment and follow-up stages the differences between genders was not significant, and for both genders the mean for this coping strategy continued to be significantly better than the baseline norm.
- Counselling is cost effective in reducing stress and changing coping strategies especially for females.
- Finally, and for me the most interesting result, raising important questions. The males improved with counselling to post-treatment, but for most measures (eg stress measures and coping strategies other than social support) their mean scores moved back towards their pre-treatment levels by the follow-up stage; the females continued improvement to the follow-up stage such that the change was now significant whereas by the post-treatment stage the change for the females was not clinically significant.

## The question

My question from the last finding is why was there such a difference in the gender responses to EAP brief therapy or could this be applied to all brief therapy in whatever setting it is used? Could the difference be due to therapist differences and does the gender of the therapist matter in brief therapy? There was a slight suggestion in the study that the male therapists fared better in effecting more permanent change in both their male and female clients. But as there were only two male therapists out of the 22 involved, this cannot be used as evidence.

But there is another question that could be raised and that is, is the model of therapy that is taught and used in all settings, too female oriented, as the profession is female dominated and hence less functional for male clients? I put this as a suggestion for debate, acknowledging along with many others, that males and females are different. My results, concerning coping strategies, somewhat bears this out. So maybe we should think more deeply about working differently with male clients as compared with how we might work with our female clients. Or do I, as a male therapist, work differently with my male clients without consciously being aware of it? This presents an area for future study, particular with respect to EAP counselling, as males are clearly more stressed at work and therefore need more sustainable support. Their higher stress may be related also to the apparent fact that males frequently only use work as a means of gaining self value/worth and often lack effective work/life balance, whereas women tend to be better at gaining their sense of self-worth through a greater variety of activities.

Thus it is with these final thoughts that I leave you to ponder the effectiveness of EAP brief therapy. ■

## References

- 1 Cooper CL, Sloan SJ, Williams S. Occupational stress indicator: management guide. ASE; 1988.
- 2 Hammond S, Lewis AM, Viera P. Stress at work: a survey of the Chichester Health Authority workforce. Department of Psychology, University of Surrey, Guildford; 1992.
- 3 Bunce D. What factors are associated with the outcome of individual-focussed worksite stress management interventions? *Journal of Occupational and Organizational Psychology*. 1997; 70(1):1-17.
- 4 Nash P. Teamwork: the Newsletter for supporters of the Teacher Support Network. Spring 2006.
- 5 CBI Conference. Promoting mental health policies in the workplace. In: Jenkins R, Warman D. (eds) *Developing mental health policies in the workplace*. London: HMSO; 1993.
- 6 Kearns J. Stress at work: the challenge of change. BUPA series: The management of health: 1 Stress and the city. BUPA. 1986.
- 7 Cooper CL, Davidson M. High pressure: working lives of women managers. London: Fontana; 1982.
- 8 Mental Health Foundation. *Fundamental facts*. London: Mental Health Foundation; 2005.