The self-reported well-being of employees facing organizational change: effects of an intervention

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The objective of this study was to investigate the self-reported well-being of employees facing organizational change, and the effect of an intervention. It was a controlled intervention study. Subjects were allocated to study and control groups, and brief individual counselling was offered to the subjects in the study groups. Questionnaire measures were administered before and after counselling (a 3-month interval), and non-counselling subjects also completed questionnaires at the same times. The setting was 15 estate offices in an urban local authority Housing Department. Subjects comprised the total workforce of the Housing Management division: 193 employees, male and female, aged 22–62 years, facing compulsory competitive tendering between 1994–97. Main outcome measures were baseline and comparative measures of psychological morbidity, including the General Health Questionnaire (GHQ) and the Occupational Stress Indicator (OSI). Questionnaire response rates were 72% and 47% on first and second occasions respectively. The uptake of counselling was 37%. In comparison with (1) the UK norms for the OSI and (2) the norms for a similar occupational group, this group of workers were under more work-related pressure and their self-reported health was markedly poorer. They were not however at a disadvantage in terms of coping strategies. Those accepting the offer of counselling were subject to greater levels of work stress, had poorer self-reported health and markedly lower levels of job satisfaction than those who did not. Questionnaire scores were not significantly different before and after counselling, giving no evidence of treatment effects on symptomatology. However, almost all subjects rated counselling as having been extremely helpful. This study suggests that adverse effects on staff facing organizational change may be ameliorated by improved management practice.

Key words: Counselling; cognitive analytic therapy; intervention; organizational change; redundancy; well-being.

INTRODUCTION

The association of unemployment with ill-health is a major concern for society, reflected increasingly in the media and in the literature on occupational stress, occurring against the background of widespread unemployment in the UK and elsewhere, under market and political influences which affect both private and public enterprises. As part of this picture, local authorities throughout Britain have followed a comprehensive programme of compulsory competitive tendering (CCT) of their services, with resultant job insecurity and prolonged periods of uncertainty for their employees. Meeting employees' needs in this situation provides a challenge to occupational health practitioners, whose responsibilities extend to employees who are at risk of losing their jobs.\(^1\) Previous research\(^2\)\(^3\) has demonstrated a higher morbidity in the unemployed but few studies have determined measures of health and well-being in those who are threatened with redundancy. This study addresses the problems of employees facing organizational change and job insecurity associated with CCT. The paper is concerned solely with medical and psychosocial effects of the downsizing process and their management; organizational and political considerations are outside its scope.

Job insecurity and resultant employee stress pose a serious problem for organizations in a world of rapid and difficult change. In the UK, time off work due to
stress-related illnesses is estimated to have increased by 500% since the mid-1950s. In 1985, 80 million working days were lost due to sickness certified as mental illness. The cost to business is estimated at £3.7 billion each year. Organizations cannot compete successfully when they are experiencing diminished workforce performance.

Work stress may be defined as an imbalance between perceived demand (at work) and the perceived ability to meet that demand. Challenge is healthy; it is only when an individual feels the pressure to be excessive that potentially damaging effects may occur. Problems that may motivate organizations to tackle sources of job stress include high turnover, absenteeism, poor employee relations, high accident rates, decreased performance, low morale and increasing litigation.

Sources of stress at work were identified by Sutherland and Cooper as including factors intrinsic to the job: poor working conditions, work overload, time pressures and responsibilities; the role of the individual in the organization, the individual’s image of that role and role ambiguity and conflict; relationships with managers and colleagues, participation in decision-making and effective consultation within the organization. A sense of satisfac-tory career development is essential, and lack of job security is identified as a major stressor.

Job insecurity can be dysfunctional for both individuals and organizations, and research suggests a relationship between perceptions of the job being at risk and lowered satisfaction with a range of job and organizational features. Those who are more insecure are more likely to report lower job satisfaction, lower trust in management, lower organizational commitment and greater interest in leaving the organization. Insecure employees are also more likely to report psychosomatic symptoms and to feel depressed.

This study addresses these issues as they impinge on the downsizing process within a large organization.

According to Hartley the probability of job loss will depend on three factors: first, the organizational and industrial relations climate, embracing issues of trust in management, unions and standard employment procedures; second, individual characteristics such as health, age and seniority, ethnic background, experience and qualifications, relationships and indispensability at work; and thirdly, personality characteristics, including internal-external control and optimism-pessimism. Perception of potentially controllable but dysfunctional forces, such as poor management, may negatively affect commitment to the organization.

Following Hartley, we may summarize by saying that individuals may cope with job insecurity by active measures, seeking to change their situation, for example by job-seeking; by withdrawing psychologically from their work, or by avoidance and denial of the situation. Commitment to the organization in general declines, though individuals may increase their efforts if they feel their prospects depend on their performance in the run-up to privatization.

There have been studies of employees experiencing an extended period of organizational uncertainty. For instance, Firth-Cozens studied the personality attributes relevant to job stress, using the 12-question General Health Questionnaire (GHQ) in a longitudinal investigation of junior doctors, followed from when they were students. A main predictor of job stress was a well-developed tendency to self-criticism, and those who suffered parental loss or separation when young were more likely to reach a clinical level of symptoms. Self-reported health status, in relation to anticipated job change or job loss, was reported by Ferrie from the Whitehall II Study of white collar civil servants. Questionnaire data on self-reported health status were obtained at initial screening and four years later, during the period when employees of the department faced privatization. In comparison to the remainder of the cohort, the profile of health-related behaviours of cohort members who faced privatization was more favourable. Self-reported health status, however, tended to deteriorate among employees anticipating privatization when compared with that of the rest of the cohort, and this could not be accounted for by changes in health-related behaviours. This study showed that anticipation of job loss may affect health before employment status has changed. Anticipation of job change has often been considered to have effects on health similar to actual unemployment, but few studies have gathered adequate prospective data on this topic. The consequences of such changes would seem to be relevant not only to the civil service but to the privatization of other public services.

Nelson, Jackson and Cooper in a longitudinal study of a UK regional water authority, surveyed employees over three stages during the organization’s transition from a public to a private company. Measures of well-being were obtained using the Occupational Stress Indicator (OSI) scales for job satisfaction, mental health and physical health. Workers also completed a scale designed to assess uncertainty regarding the workplace (e.g., organizational climate, role ambiguity, etc.) in addition to three personality scales (focus of control, Type A behaviour and neuroticism). Changes in well-being were tracked as the organization made two major transitions, privatization and subsequent structural reorganization. Job satisfaction declined after privatization but recovered somewhat after reorganization. Less marked changes in mental and physical health were also reported, seemingly of a decline but with little sign of a recovery. Each of the measures of well-being at the two later stages was related to the corresponding measure at the previous stage, albeit moderated in different ways by uncertainty, locus of control and neuroticism. Nelson et al. concluded that major organizational change such as that associated with privatization may be stressful for those concerned unless managed properly.

In the UK, legislation exists which states the employers’ duties for the health and safety of their employees, notably the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1992. Employers are required to carry out risk assessments of hazards in the workplace, including psychiatric factors. Recently, the question of stress at the workplace has been germane in several cases which have come to Court. Much of the most recent concern has stemmed
from the case of Walker vs. Northumberland County Council (1994) in which the plaintiff, a social worker, was able to prove that his employer was liable for his psychiatric injury, with financial implications. Bad management appears common in recent cases; it is incumbent on employers to recognize and act on the major causes of stress at work.

MATERIALS AND METHODS

The council, housing management, CCT

The Council developed an externalization programme which was extended over time to all departments of the Council. Staff in all 17 estate offices comprising the Housing Division faced a programme of compulsory competitive tendering extending from 1994 to 1997. Tenders were arranged in pairs, i.e., two offices at a time, at intervals over this period. The first pair of offices took part in a pilot exercise for CCT in 1993–94 and won their in-house bids; their contracts started in August 1994.

The tendering process proved time-consuming and anxiety-provoking for those involved. Staff would only retain their council jobs if the office won the tender, and they saw themselves as disadvantaged in competition with outside organizations perceived as better resourced and having more expertise in the tender process. There was concern about possible staff reductions even in advance of the tender result, notably for residential staff in 'tied' accommodation at risk of loss of home as well as job, and about inferior terms and conditions of work in any new arrangement.

Occupational health experience

The Council's Occupational Health staff have in the course of their work encountered many employees experiencing high levels of stress directly attributed to their job situations, and job insecurity has been consistently reported as a major stressor. Over a 5-month period in 1994, a stress-related factor was identified by the first author as contributing to the presenting problem in 45% of Council employees referred by management. In 1994–95, 21% of ill-health retirements had a definite work-related stress aspect, and in a further 13% of retirements this was a possible factor.

An even higher prevalence of these kinds of adverse effects on health was anticipated in association with the tendering process. This study was developed as an investigation into this matter, and to determine the place of psychological assistance for staff involved in the process.

Subjects

The population. We worked with staff in 15 estate offices. The number of employees in the offices ranged from 12–20, average = 13; each office comprised a similar mix of different occupations: estate manager and housing officers, team support officers, surveyors, estate services assistants and wardens. As the pilot pair of offices had already won their contracts before the start date, they were excluded from the programme.

Control and study groups. The staff of one estate office from each pair as organized for tendering, was chosen to be a control group by random sampling (coin toss). The staff of the remaining estate office in each pair comprised the study group able to choose to receive psychological support.

Procedure

Subjects were given a questionnaire booklet which included (1) the Occupational Stress Indicator (OSI); (2) the 12-question General Health Questionnaire (GHQ) and (3) a biographical section. The questionnaires were administered before and after psychological intervention.

At meetings with estate staff a description of cognitive analytic therapy counselling was given, following which questionnaire booklets were distributed for completion immediately or later if preferred. Two versions of the questionnaire were prepared, with and without an offer to receive brief counselling; the study group received a questionnaire with the offer whilst the control group did not. Employees who took up the offer of counselling received up to four sessions of individual counselling from either NK or GS (the authors). Questionnaires were re-administered to both groups after three months, but this time the control group's questionnaire had the offer of brief counselling whilst the study group's did not. The questionnaire data of those who took up this later offer of counselling were discarded for the purposes of this present report.

The procedure was repeated for each pair of estate offices, starting each pair at 6–8 week intervals. The study was carried out between October 1994 and January 1996.

The control group subjects were informed that they would be offered counselling at a later date and therefore approximated a 'waiting list control' group. Questionnaires were not named, but each bore a hand-written number corresponding to a name on a list known and held only by the first author. This was required in order to contact those requesting counselling. Individuals were strongly assured of the confidentiality of both the data and the counselling content. Any subject found during data collection or counselling to be suffering from possible psychiatric illness (suggested, for instance, by a high GHQ score), would be referred back to the author for assessment. Consideration was given as to whether the three month delay in the offer of counselling to the subjects in the control groups raised ethical concerns, given the stressful circumstances prevailing. The project was approved by the Lewisham and North Southwark Committee on Ethical Practice.

Measures

General Health Questionnaire (GHQ). This is an established instrument which has been validated as
a sensitive measure of general dysphoria, and allows an estimation of 'caseness', or a probability estimate of that individual being a psychiatric case. The 12-item version used here has been found useful for measuring non-psychotic minor psychiatric morbidity in the community and has been used frequently as a measure of perceived stress in many occupational settings. A longer (e.g., 28-item) version was considered too intrusive to use in this setting.

Retest using the GHQ tends to lead to a slight drop in mean population score and it is not generally usually used as a change measure; however there is precedent (see Firth-Cozens, above) for its use in this context. It may possibly underestimate chronic cases of stress with its wording 'more than usual/less than usual'. The GHQ has been found to have high sensitivity and specificity in different cultural settings.

**Occupational Stress Indicator (OSI).** Developed by Cooper, Sloan and Williams in 1988, this measure consists of 167 questions which take about 45 minutes to answer. There are seven separately scored subscales: sources of pressure in the job (61 items); coping skills (28 items); type A behaviour pattern (14 items); job satisfaction (22 items); locus of control (12 items); mental health (18 items) and physical health (12 items). Scores may be compared to norms developed for a variety of UK populations, including both blue- and white-collar workers.

The counselling

Clients were offered four counselling sessions. Sessions took place weekly either at or away from the workplace and lasted 50 minutes each. Four initial sessions were funded by the organization and any additional sessions were funded by the client. A review, by both practitioner and client, after the initial four sessions determined any further counselling.

Methods followed those of cognitive-analytic therapy. Briefly, these involve an assessment of the 'target' problem, individual 'roles' and traditional coping procedures, a realistic aim of therapy and the replacement of 'dysfunctional' patterns with more 'functional' ones.

**Outcome measures**

In summary, individual outcomes were measured in three ways: (1) baseline measures of psychological well-being compared with UK population norms; (2) comparison of baseline measures in those subjects requesting counselling with those not requesting counselling and (3) change in measures after counselling.

**Statistical analysis**

The OSI questionnaire responses were scored semi-automatically, using special-purpose software based on Quattro Pro for Windows, 5.0 (Borland International, 1993). The scores so produced were analyzed statistically as described below, making use of the Biomedical Package (BMDP) statistical program.

Changes occurring during the time-scale of the project

It is perhaps inevitable that a study extending over 16 months in an organization undergoing rapid change would itself be subject to changing circumstances. Four points are noted.

**Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE).** At the outset of the project it was believed that in those offices where the bids were lost, the employees would be made redundant. However, just before the programme started, TUPE was deemed to apply to Housing CCT with the result that staff would be transferred to any new employer. This does not confer permanent protection of terms and conditions of employment as the new employer can change these, and there is continuing uncertainty about pension rights. It is therefore seen as removing an immediate redundancy threat but exacerbating long-term insecurity. Although it was apparent that staff would not be at immediate risk of redundancy if their bids failed, the anxiety-generating effects of TUPE were so great that the circumstances of the project had not materially altered. No change in project design was therefore deemed necessary at this stage.

**Methodology.** As the project progressed beyond the first few pairs of offices, the delivery of the introductory talk became more polished. It was noted that there was an increase in response and interest by staff after the decision was taken to leave the text of the introductory talk with the estate manager in advance of the staff meeting. The staff were then better informed about the purposes of the programme and more receptive. It was particularly noticeable that interest quickened when the programme was described as a workplace counselling programme in addition to the CCT support; staff recognized that CCT was a major concern but they also wanted acknowledgement of the place of other work and personal issues in their counselling.

**Variation in uptake of counselling.** Marked variation was found in the rates of uptake of counselling between offices. The increase was most marked from the third pair onwards, and by the fifth pair in September 1995, 90% of subjects of one study group accepted the offer. It was now felt to be unethical to withhold the offer from those in the control groups, and the matter was referred back to the Ethical Committee. It was jointly agreed that from then on counselling should be offered to all staff, and the control groups were therefore discontinued. Thus, although at the outset of the project it was intended to include 15 offices, at the end it comprised only 10. This part of the study was therefore designated Phase I, and the second, with no control group was designated Phase II.

**Restructuring of Housing Department.** In mid-September 1995 a new Director of Housing took up post and announced major changes in the structure of the Housing Department, with consequent effects on morale, due to the further implications for individuals' job security and...
role over and above the effect of CCT. This should be remembered in interpreting the results of the second half of the study.

RESULTS

Response rates
Overall, 72% of all subjects completed Questionnaire 1, 47% of all subjects completed both Questionnaires 1 and 2 and 37% of subjects completing Questionnaire 1 accepted counselling (Table 1).

Demographic summary
Full demographic information was available for 129 individuals. There were 70 men and 59 women with an average age of 37 years (range 22–62). Slightly less than half of them were educated to degree level (49%); 24% were single, 64% married or living with a partner and the remaining 12% were separated, divorced or widowed; 34% had at least one child under 18 years, and they had worked for the council for an average of 5.9 years.

Summary statistics for OSI Questionnaire, first administration (Q1)
The means and standard deviations of the scores obtained at the first administration of the adjusted OSI questionnaire with all 139 subjects were compared with two normative datasets. The first comparison was with the norms published in the OSI test manual aggregated from 7–8,000 individuals in 22 studies, which offers baseline measures of occupational stress; we also compared our data with the OSI norms for ‘Health authority workers in the South of England’ (n = 530). We refer to these below as, respectively, ‘OSI’ and ‘HA’ norms. In our analyses we compared our sample means with normative ones treated as point estimates. The experimental and control groups were compared on 28 OSI variables using t-tests. There were significant differences (p = 0.05 or 0.01) on 14 variables. (Detailed tables of the original data and the analyses are available on application to the first author.) The OSI generates three main groups of work-related measures, each with six sub-categories: Sources of Pressure, Job Satisfaction, and Coping Strategies. Compared with the OSI norms, our sample had significantly higher scores, indicating more stress, for ‘pressures intrinsic to the job’, ‘the managerial role’, ‘work relationships’, ‘career and achievement’ and ‘organizational structure and climate’, but not for the ‘home-work interface’. The largest difference was for ‘career and achievement’, where the present sample mean was more than half a standard deviation greater than the OSI mean; this difference (but for no other ‘sources of pressure’ scales) was also found in comparison with HA norms.

‘Job Satisfaction’ means were significantly less (indicating more dissatisfaction) than means for both OSI and HA norms for five of six subscales — ‘achievement’, ‘job satisfaction’, ‘organizational processes’, ‘relationships’ and overall; only for ‘organizational design and structure’ was there no difference.

The OSI ‘Coping Strategies’ scales point to ways in which respondents respond to and deal with work stresses. In the case of ‘task strategies’, home-work relationships, ‘time management’ and ‘involvement’ there were no differences between sample means and OSI norms. There was a significantly greater self-reported reliance on ‘social support’ for coping among the study sample; this was confirmed in comparison with HA norms.

Overall, these data show that the individuals who took part in this study experienced considerable levels of the various kinds of work stress commonly reported in the literature, and were experiencing relatively little job satisfaction.

The efficacy of counselling: study and control groups compared
Effects of counselling were assessed in what is described as phase 1 of this study. Units were randomly offered immediate counselling or delayed counselling; within each group individuals choosing counselling (C) or no counselling (NC). The OSI was completed twice, when counselling was offered (Q1) and when counselling in the study group had been completed (Q2) (also the time when counselling became available to ‘deferred’ units). Hence counselling effects could be discerned from different Q1–Q2 differences between C and NC individuals in units offered counselling, while passage-of-time effects (which would include organizational or policy changes) would be reflected in Q1–Q2 differences in individuals from the deferred units. Any such differences would be expected to be similar to the corresponding values in the NC individuals from units offered immediate counselling. Any C–NC differences in Q1 responses might point to reasons for choosing or not choosing counselling.

In the study group 23 individuals chose counselling (C) and 24 did not (NC); in the control (deferred) group, there were 10 who chose counselling and 20 who did not. Univariate analyses of variance (ANOVAR) were conducted for each of the 28 OSI variables and the GHQ-12 measure, taking into account two between-subject factors (study vs. control; and counselling accepted vs. not accepted), and one within-subject factor (Q1 vs. Q2). All of the main and interaction effects in the following ANOVAs share the same degrees of freedom (1, 73) and so this information will not be reported for each F-ratio below. The critical significance level for the ANOVAs was set at a more conservative level than is common,
namely 0.025, because of the large number of analyses and significance tests. For example, there were 116 main and interaction effects involving the Q1-Q2 factor. In fact, none of them was significant at the 0.025 level, though three were (marginally so) at the 0.05 level. Two of them were for the Time Management variable, Q1-Q2 x study-control ($F=4.28; p=0.042$) and Q1-Q2 x counselling accepted–not accepted ($F=3.97; p=0.050$). The third was for the Organization Design subscale of the Job Satisfaction test, Q1-Q2 x counselling factor (accepted vs. not accepted) ($F=4.97; p=0.029$).

We are inclined to treat these three interactions as spurious. It is difficult to see any meaning or material significance attached to them and they will not be discussed further.

It remains to consider the main effects and interaction for the study-control and counselling factors. There were no main effects for study-control, but there were several interactions between study-control and counselling. The two interactions were for the relations with people scale of the Sources of Pressure test, and for the GHQ12 test (in both cases $F=5.66; p=0.020$) and corresponded to a somewhat bigger difference in each case for the control group than for the study group between those accepting counselling and those not doing so. This seems likely to be a minor difference in the composition of the units, who were of course assigned by the organization’s recruitment system to the various offices involved. More germane are the overall differences between those coming forward for counselling and those not taking up the offer, on a range of measures. For the Sources of Pressure test, the counselling-accepted subjects scored higher than those not accepting counselling on the managerial role, relations with people and organizational structure/climate scales ($F=5.59, 5.83, 9.06$; and $p=0.021, 0.018, 0.004$, respectively).

On all measures of job satisfaction, the counselling subjects scored higher than non-counselling individuals (i.e., they expressed more dissatisfaction); this difference was significant for achievement at work, satisfaction inherent in the job, organizational design, organizational processes and work relationships as well as the total job satisfaction score ($F=16.04, 10.71, 16.14, 17.38, 18.11$, respectively; $p<0.01$). On two health measures, the counselling-accepted subjects scored higher than the counselling-not-accepted subjects (i.e., they reported poorer health); this was so for the Physical Health scale of the OSI ($F=7.74; p=0.006$) and the GHQ12 ($F=22.07; p=0.00001$). Finally, it is of interest that there were no differences in the reported incidence of the various coping strategies about which the OSI inquires.

Opinions of counselling

Taking phases 1 and 2 together, 51 individuals received counselling during the course of this study. The number of sessions was agreed case-by-case; 26 subjects had four sessions, five had three, nine had two and 11 had a single session. Ten subjects requested additional counselling later, and had between one and eight sessions.

Information about the counselling was obtained from 50 of the 51 counselled subjects. This was done by conversation at the end of counselling by both authors NK and GS. Comments were noted and collated. We did this in view of the lack of evidence of counselling efficacy in terms of OSI changes. Forty-nine (98%) subjects found the counselling helpful. The basis for this was reported as ‘helps positive thinking and confidence’ (29 subjects); ‘helps recognition and legitimization of feelings’ (19); ‘helps clarification of issues’ (13); ‘a chance to express anger’ (eight); ‘increased well-being and relaxation’ (seven) and ‘to find out how someone else thinks (s)he was coping’ (seven).

Despite some initial managerial concerns that the availability of counselling might increase worker unrest and create difficulty by encouraging talk about work stress and organizational pressures, managers were in general supportive of the programme and aware of stress among the workforce. Indeed, the programme would have been impossible without the positive support of managers.

DISCUSSION

The questionnaire response rates compare most favourably with those generally experienced in large studies; in the study group, Phase 1, 80% of subjects completed the first questionnaire. This can be seen to reflect a high perceived level of stress in the study population. Undoubtedly, compliance was encouraged by the active efforts made to disseminate information and counter anxieties about the study. The generally enthusiastic uptake of counselling, 37% both in the study group and overall, can be hoped to reflect a general trust in the good intentions of the programme. The variation in uptake between offices appeared to be due to the influence of complex organizational factors, for example group dysfunction in one office. It was noteworthy that in the control group the counselling uptake after 3 months was lower (21% of those subjects completing Questionnaire 1), suggesting that for counselling to be acceptable an immediate offer carries more conviction. Of further interest is the way in which changing circumstances forced a radical alteration of study design, demonstrating how difficult it can be to maintain a lengthy project ‘in the real world’.

The researchers were constantly reminded of the subjects’ great concern regarding confidentiality. Safeguarding this was crucial to the success of the project. Also at times, prior knowledge of management difficulties was in itself a problem for the researchers, who needed to make a conscious effort to prevent this knowledge from affecting their objectivity in the conduct of the study. By the same token, the study afforded an opportunity for a much closer understanding and involvement with the Division and its staff, leading to further collaboration on other workplace issues.

There is no evidence that those taking up the counselling opportunity were different on most of the demographic factors, with the notable exception of educational level. Almost twice as many graduates than non-graduates took advantage of the opportunity (56% vs. 29%). This may mean that they know more about
counselling, have a higher expectation of it or find it more accessible. Alternatively this may be a more desperate sign — that work pressures are greater for them and that career limitations are more severe. At any rate, this difference in behaviour may represent a significant biasing factor for the study.

The effectiveness of counselling

Thematic analysis of the comments made by counselled subjects shows graphically their perceived improvement in well-being and coping skills. Examples of comments include:

'Counselling has been effective because it has helped me collect my thoughts on feelings of helplessness. I'm now feeling philosophical. I feel much more involved in the change process.'

'As a result of talking things through in counselling I am now acting like an adult instead of a rejected child.'

'This whole project has enabled me to air my views about how I feel: anxiety, change, being ignored. This has made me feel valued. Counselling should be available at work.'

'This has helped me look at my options and see what I can do.'

Other studies have demonstrated subjective improvement. For example, Rogers et al., in a study in a British Social Services Department assessed client satisfaction following brief counselling. There was fair agreement between clients and counsellors that outcomes were satisfactory; around two-thirds of problems belonged in the personal domain.

Highley (personal communication) describes an unpublished, Health and Safety Executive-funded, longitudinal project which studies the effectiveness of workplace counselling programmes. The data from nine companies showed that general and context-specific mental and physical health improved whilst job satisfaction and perceived sources of pressure remained unchanged. The interpretation is that counselling is helpful, despite persisting sources of pressure, and the onus is on the organization to tackle the stressors.

The present study used a combination of quantitative and qualitative methods to assess the effects of counselling on employees facing organizational change. The quantitative results plainly suggest that there was little or no change in any of the indices of stress of the OSI, or in the relevant health measures, including the GHQ12 test. Moreover, there were no evident benefits from counselling (as indicated by the absence of Q1–Q2 effects). Juxtaposed with this, however, and in apparent contrast with it, is the near unanimity on the part of those who received counselling that it was helpful. The explanation for this apparent anomaly would seem to be that while counselling was not associated systematically with stress and symptom reduction, it facilitated the possibility of change in subjects' cognitions; what they thought about themselves and their work. It is not surprising that the OSI did not pick up phenomena in these areas. Other quantitative instruments, for example, measuring self-esteem, might have shown changes reflecting the increases in 'positive thinking and self-confidence' reported by counselled subjects. The combination of quantitative and qualitative methods is evidently advantageous, a conclusion also reached by Pernice (1996) in connection with unemployment research.

In the light of our finding of relatively little systematic effect from counselling, comment should be made about the possibility that more intensive therapy (more sessions) might have been more effective. This is of particular importance since many organizations offer more sessions of counselling in certain circumstances. We can only comment that while our work cannot directly answer this question, the subjective opinion of benefit without systematic improvement is even more striking if symptomatic relief could have been achieved by further intervention.

Our results suggest that a majority of the workforce was coping with the work pressure inherent in their present and changing work organization, but it is an uncomfortably small majority. The results draw attention to individual differences; it is apparent that some individuals were resistant to the form of organizational pressure to which the present employees were quite clearly exposed. Many more than would be expected felt subject to control by external factors. While this is likely to be a risk factor in relation to health, it may be tempting to dismiss it as a matter of a minority of workers who were seriously ill-fitted to the job, and hence to attribute this as a matter of an inefficient selection process. In fact, the picture is not of a small number of misfits but of a population in general, expressing high levels of occupational stress, reporting much poorer health, and substantially lower levels of job satisfaction than the population as a whole and than comparable workers. The potential accumulating threat to the health of these workers is a matter on which expert opinion might now be sought.

Cooper has commented: 'What is important to understand is that privatization is a potentially stressful event for all concerned unless properly managed. Those who initiate the process may have staked their personal careers on the successful outcome, those responsible for managing and implementing the change process face an exhausting and often time-urgent challenge to make it work, but for the vast majority of ordinary employees the adjustment and uncertainty which is often suddenly and unexpectedly thrust upon them is also likely to have adverse implications. Furthermore, for most of those affected, privatization will have been an unprecedented event in their lives, and they are unlikely therefore to have developed any effective way of coping with the stress of the experience.'

REFERENCES
