GENDER DIFFERENCE IN THE LONG-TERM OUTCOME OF BRIEF THERAPY FOR EMPLOYEES

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Few studies have assessed the effectiveness brief therapy as offered by Employee Assistance Programmes (EAPs) in the U.K. The present longitudinal study firstly identified normative coping strategy scores in a sample of 2300 participants, and then examined gender differences in the changes in coping strategies in 305 participants in brief therapy, from pre- to post-treatment, and at 6-months follow-up. There was a sex difference in the mean scores for clinically significant and reliable change, with men showing improvements in the short term (pre- to post-treatment), but women showing improvements in the long term (at 6-months follow-up). This study demonstrates the importance, for therapists and researchers, of recognising sex differences in psychological outcomes.

Keywords: workplace stress; therapy; sex difference; gender difference; Employee Assistance Programme (EAP).

INTRODUCTION

The development of EAPs, it has been argued, has passed through three distinct phases: occupational alcoholism programmes (1939-1962); broad-brush employee assistance programmes

(1962-present) and occupational health promotion (1980s to present) (DeGroot & Kiker, 2003). Part of the development was also as a result of the various research studies that indicated that EAPs could save companies money while promoting the health of employees (Brody, 1988, Csiernik, 2004). In Europe a number of factors prompted the rapid growth of EAPs, probably the most important of these has been the growing tendency from health and safety regulators and courts to recognise that the employer has a duty of care in relation to the workforce (Csciernik, 2005) (e.g. the Walker Case Walker v Northumberland County Council, 1995) and therefore to hold the employers responsible for the mental as well as physical health of their employees; the potential financial benefits (such as reductions in costs and insurance premiums) for the employers, and the advantage of EAP provision in employee compensation claim cases (Hoskinson & Reddy, 1993). This growth is illustrated by the fact that by 2006 more than 1000 organisations in the UK made use of EAPs covering more than two million employees (around 10% of the UK working employee population) (EAP Assocation, 2006).

EAPs provide a package of services including free legal, financial and careers advice. However, the focus here is on the counselling part of such packages. The goal of an EAP is to facilitate the resolution of a client's problems via brief therapy. McLeod (1993) describes the emergence of brief therapy as arising from social needs and client demands for shorter, problem-focused therapies. Given that most purchasers of mental health services (including individual clients as well managers of mental health services) have constraints of time and/or money, time-limited therapy is now the treatment of choice, and is becoming a quickly expanding option in mental health provision. The model of brief therapy as used by EAPs is 3-8 sessions irrespective of the type of therapy used.

This study was carried out as it was seen that there were a number of gaps in EAP evaluation. As Cayer and Perry (1988) pointed out, most research focused on private sector EAPs and was primarily descriptive or promotional without much rigor in evaluation methodology or design. In the public sector, there was even less written on EAPs, and almost no evaluation materials were available. In addition, Klarreich et al. (1985) also criticised the field for its lack of independent objective research, with almost all EAP research taking place within EAP provision, with the exception of the Kent study (Worrall, 1999). Many studies show significant satisfaction with respect to perceived benefit from EAP e.g. improved work performance or having helped

them with their concerns and whether subjects would recommend it to others (e.g. McClellan, 1989; Park, 1992). Furthermore, benefits were mainly described in testimonials or in cost-benefit terms, with individual measures mainly focusing on client satisfaction until more recently when the use of C.O.R.E. (Clinical Outcomes Routine Evaluation) has become more established and is widely used within the NHS and by a number of EAP providers as a way to quantify the change process. However, the more important question with respect to workplace counselling is not so much whether it is found to be helpful, but with what and whom does it does it work best.

This study sought to independently evaluate an EAP service using various tools to measure objectively the process of change. There are many ways to measure the effectiveness of an EAP and though the overall study focussed on a variety of measures, this report will focus on the changes in coping strategies. From a therapist point of view, it is of interest to know how effective EAP therapy services may be in producing psychological change by seeking improvements in coping strategies. Some studies have shown that work-related counselling can have a positive impact on psychological symptoms (Firth & Shapiro, 1986; Harris et al, 2002; Selvik et al, 2004, Gardner et al, 2005). Much of the work involved in brief therapy, particularly that which is offered within EAPs, concentrates on helping clients look at ways they think about a particular situation or problem and getting them to try to perceive it differently via Cognitive Behaviour Therapy (CBT) and/or to take more appropriate actions to resolve the problem/problems (solution/problem focussed therapy – de Shazer, 1985; de Shazer et al, 1986). The focus of such therapy frequently involves helping clients look at and change their coping strategies for dealing with stress, yet there seems to have been little interest in examining the clients' changes in coping strategies within the research around EAPs. The reasons may lie in the difficulties in finding useful tools with which to examine this, and this in turn may be because it has been difficult to date to find agreement with respect to defining the concept of coping. Lazarus (1991) defined coping as, 'cognitive and behavioural efforts to manage specific external or internal demands (and conflicts between them) that are appraised as taxing or exceeding the resources of a person'. However Lazarus noted that it was somewhat difficult to distinguish between cognitive appraisal of a situation and coping, as he observed, 'coping refers to what a person thinks or does to try to manage an emotional encounter and appraisal is an evaluation of what might be thought or done in that encounter.' His view is in support of his perception that coping relates to transactional phenomenological stress theory, i.e. a person's experience of stress is not necessarily in the

situation itself but in their perceptions and processing of that situation. Thus, a situation may be stressful for one person but manageable or enjoyable to another (e.g. riding a roller-coaster!). All the scales and measures suffered from trying to resolve the complexity of coping with respect to: dispositional versus situational complexity in coping assessment; real-life versus hypothetical scenarios design methods; multi-dimensionality versus hierarchy modelling and social versus non-social constructs of the concept of coping (Klauer et al, 1989; Filipp et al, 1993).

Notwithstanding these problems, an EAP therapist, more often than not, will focus on facilitating change in the client's coping strategies for dealing with their stresses, because, for example, it has been found that problem solving coping strategies are a significant negative predictor of both anxiety and depression (Sprangenberg & Campbell, 1999). Subjects with deficient social networks were found likely to experience events more stressfully than those with high social support networks, (Maynard, 1986; Van Dierendonck et al, 1998). Thus it can be seen that the examination of coping strategies is important in researching the effectiveness of the brief therapy within EAPs but it is hard to find a tool that meets all the requirements of research and has empirical and face validity. The scale measuring coping strategies used in this study was taken from a large study on stress amongst health workers and was derive from the basic structure as formulated by Lazarus & Folkman (1984). This scale formulated six factors (rational actions; palliative response; social support; depressive, emotive and passive responses) as derived from factor analysis, but it focused on responses as opposed to appraisal in order to measure the change process (Hammond et al, 1992). Though this tool will have limitation, the reasons for those limitation can be seen both in the difficulties in defining such a multidimensional concept as coping, and therefore in designing a tool with which to measure such a concept, and also in the difficulties that the definition and design make in the methodology or application of such designs within research.

Many studies have produced useful information or findings but many if not all have some methodological problems that make the conclusions rather less than clear cut or make for certain difficulties in using the measure. This is especially true for any studies that are in a naturalistic setting as the ability to control all variables is somewhat limited. On the other hand if all variables were completely controlled other than that which was being tested then the findings would tend to be of little use to the practitioner in the field who may work in an integrative way with clients

who have multiple problems. Thus in any piece of research there has to be a trade off between scientific rigour and making it relevant to the practitioner in the field (e.g. must have a degree of realism). It is, for the most part, difficult to be scientifically rigorous and to reflect the conditions of everyday working practice. Further there are a number of other difficulties that generally present themselves when trying to provide research into EAP effectiveness. Firstly there is the fear of the providers showing effectiveness when in competition with each other; or union reactions if staff is seen to be stressed. Researchers, therefore, often use satisfaction studies to avoid any critical research which might require access to clients. In reality the client satisfaction studies make only a very minor contribution to the evidence for effectiveness as they say very little with respect to what the therapy has been effective in changing, i.e. they bear little or no relationship to whether it helped to change anything (McLeod, 2001 & 2007, Reynolds, 1997). Often the research into EAPs is seen as being too brief, with no longitudinal collection of data (Giga et al, 2003) and rarely employs control groups. Arthur (2000) concluded that studies into the effectiveness of EAPs fail to deliver in relation to organizational outcomes because they are 'superficial' and do not reflect the complex, interactive nature of work stress.

Also much of the research into the effectiveness of EAP counselling has the difficulty that ethically or practically; control groups cannot easily be created and then be measured. In this study a form of control was set up by carrying out a large stress audit via a "Well-being" questionnaire and which randomly sampled the total work force and the result would provide a baseline or norm against which the sample of clients who sought counselling could be compared. Strictly speaking the 'Well-being' study was not a control group as they were not necessarily a group that matched those who were seeking help. What this study set out to look at was how effective the counselling work was in changing coping strategies to such a point where the counselling subjects' mean scores were no longer significantly different from that of the normative baseline population. There lies here an assumption of health within the normative population, but given that population defined the baseline, no value judgements as to what constituted health was involved, all that was to be examined was how much after therapy and at the six month follow-up period had the counselling client group moved their scores for the measures towards those of the norm created by the 'Well-being' study.

Thus, as with most research studies in the effectiveness of brief therapy via an EAP, this research had its methodological short-comings or limitations as its aim was to explore issues that would be directly relevant to the practitioner on the ground, thus is was a naturalist study. However, it was felt valid to accept those limitations in order that the research outcomes might be more informative to the practitioner in the field within the realities of the problems presented, etc., in workplace counselling or even to the practitioners in other settings where brief therapy is the required model of work e.g. in primary care. The studies that were seen as most helpful to this research were those of Cooper & Sadri, (1991), Alker, (2000) and Worrall, (1999) as they used tools that were similar to those used in this study.

In summary Employee Assistance Programmes (EAPs) in the UK have developed to the point where they now focus on occupational health promotion and broad-brush employee assistance programmes. The main focus of this report on the study was an examination of the effectiveness of the brief therapy in an EAP particularly with reference to gender differences in changes of coping strategies.

METHODOLOGY AND METHOD

Design

This study used a repeated measures design, meaning that the same questionnaires were used at each stage of the research with the same participants and response differences across time were examined. The core focus of the study was to look at the effectiveness of the therapy being offered to those subjects who came for counselling from the Education and Social Services departments of a large local authority. The baseline response norm was formulated from the responses from a random sample of the whole of the organisation's work force. The random sampling was achieved using random sampling tables and employee numbers. The counsellors who offered the service was a group of twenty-three therapists who were registered affiliates with the company who provided the service. There was no control with respect to their therapeutic orientation. The criteria used for their recruitment was that they were required to hold a recognised accreditation qualification and that they were comfortable working within a brief therapy model. Once the study had been designed, the organisation took on the role of randomly circulating the questionnaires for the 'Well-being' part of the study. There was no selection of the counselling subjects for this study; all who agreed to participate were accepted as subjects. If the

subjects agreed with the telephone counsellor with whom they had their first contact that they did not mind participating in the study they were then told they would be sent a pre-treatment questionnaire to fill out prior to seeing their therapist and they were asked to hand those questionnaires to the therapist when they first met. The researcher was a chartered counselling psychologist in the employ of the provider so was given free access to the company's data and records but was not employed at the head office and was not a provider of the counselling that was offered to the employees of the county council involved. Ethical approval was given by the University of Keele and the University of Abertay, Dundee. All participants gave their informed consent.

Questionnaire structure

Different versions of the questionnaire were used at the different stages of the research. Four stages were planned in the research in which questionnaires were used: the 'Well-being'/baseline normative measurement stage (stage 1); client assessment stage (pre-treatment, i.e. just prior to counselling – stage 2); post-treatment stage (stage 3: immediately after counselling) and follow-up stage (stage 4: 6 months after closure). The questionnaire first asked demographic questions, such as age, sex, occupation, marital, etc. The respondents were then asked to respond to five scaled questionnaires, only one of which will be examine here, that of the Coping Strategies measures. The coping strategy scales looked at the ways in which the subjects responded to their stress. This measure was taken from a large study on stress amongst health workers (Hammond et al, 1992). The coping strategy questionnaire consisted of 37 items where respondents were asked to score themselves on a 5 point scale where 1 = Not all like me to 5 = Very much like me; asking them to respond for each item to the question: 'When I am under a lot of stress I…'. The original coping model scale of 37 items was devised by Lazarus & Folkman (1984), it suggested a variety of coping strategies/styles: Rational actions (6 items) (this reflected a style that involved coping with stress by adopting a strategy of rational actions to solve the problem and which may be considered a healthy process); Palliative actions (5 items) (this option may be less healthy since it does not involve a direct attempt to approach the source of the stress and may involve displacement activities like taking up a hobby); Social support (10 items) (this is possibly a more healthy strategy and may include such actions as involving fellow workers in the problem or talking things over with a friend); Depressive response (6 items) (in this case the problem becomes internalised or 'bottled up' and the individual develops a feeling of

powerlessness or not feeling in control); Emotive response (4 items) (suppression of emotion or excessive emotional expression is associated with psychological or physical illness/problems (Grossarth-Maticek et al, 1985, Smith & Pope, 1991), not to mention the effect that this might have on peers at work or family or spouses); Passive response (6 items) (this is an unhealthy strategy as the individual simply accepts the stressful situation and lets things happen without attempting any intervention e.g. taking to drink hoping the problem will go away). All items in each factor were tested and were shown to have good internal reliability.

Procedure

The questionnaires were distributed as follows: *Stage 1* (July 1996), the 'Well-being' questionnaire was distributed prior to the main study to a random sample of the work force of the organisation; *Stage 2*, pre-treatment questionnaire, this stage focussed on the clients from the organisation who had purchased the service who were requesting counselling via the call centre of the EAP provider and at that point they were asked if they would agree to participating in the research. The majority of the clients during the research period agreed to participate in the research. It could have been possible for the counselling clients to have participated in the original 'Well-Being' study but the number would have been small given that the number of clients requesting counselling represented less than 2% of the total number that was randomly sampled in the 'Well-Being' study. The clients were sent this questionnaire prior to treatment by the EAP provider company's HQ Office/Call-centre; *Stage 3*, post-treatment questionnaire, this questionnaire was either given to the clients by their counsellor when they finished seeing them, or if the clients did not return for their final session, the questionnaire was sent to their homes from the provider's HQ office when the counsellors had sent in the closed case papers; *Stage 4*: follow-up questionnaire, this questionnaire was sent out by the provider's HQ office to all clients 6 months after their case notes had been sent in as being officially closed. All the questionnaires were distributed with letters of explanation and which emphasised the anonymity of the data. These letters were sent out from the EAP provider HQ office.

Statistics

Questionnaire data were analysed using repeated measures t-tests and Pearson's correlations. Significance values were two-tailed. SPSS Version 12 (IBM) was used.

RESULTS

The issue focussed on in this report of the study was whether there were gender differences in the effectiveness of the therapy to produce change in the coping strategies used by the clients. The first table presents each of the variables within the coping strategies showing the mean scores for that variable for the group as a whole and for each of the genders separately. The second table indicates whether there has been significant change at the various stages and the level of that significance again for the group as a whole and for each gender separately. The baseline norms were based on the findings analysed from the 2291 completed 'Well-being' questionnaires received back from the total of 5295 which was a random sample of the 17,614 total work force of organisation being studied. This represented a mean return rate of 43% with no department response falling below 27%. With respect to the counselling sample, 241 (79%) of total responding counselling clients sent in pre-counselling questionnaires, 58% of those filled out a post-treatment questionnaire and 29% filled out the follow-up questionnaire. In stage 1, 36.2% of the respondents were male and in stage 2 the proportion was 27% so was fairly representative though the males were slightly unrepresented. The response rates for stage 3 and 4 did raise the question whether there were any characteristic differences in the pre-treatment mean scores between those who filled out all the questionnaires or at least one of the post-treatment or follow-up questionnaires and those who only filled out the pre-treatment questionnaire. There were no significant differences in the pre-treatment means for either group, whether treated as all the subjects together or the genders separately (for demographics of responses at stages 1 & 2 see tables 1-4 below).

The baseline scores of coping strategies was of particular interest as it will be against this data that changes within the counselling group were matched. This was because the baseline acted as the normative measure for the counselling group in order to examine for clinically significant change i.e. to examine whether the mean for a particular strategy moved during the process of treatment such that it was no longer significantly different from the baseline norm or whether it remained significantly different. If the latter was the case then the change was not clinically significant if the treatment starting point was significantly different from the norm. In this study the baseline acted as the norm where as in other studies the norm would be taken from studies of completely different populations, thus as the counselling group was coming from the same population as those measured in the 'Well-Being' study which produced the baseline norm

then the norm produced had greater validity. In the baseline sample the males produced significantly higher means than the females for 'Rational actions' and 'Passive response' ($p<0.05$ for both) and the females produced significantly higher means than the males for all the other coping strategies ($p<0.001$ for all). Within the counselling sample, the males came with significantly higher means than the females for 'Rational action' and the females came with a significantly higher mean for the use of 'Social support' ($p<0.001$).

Both the males and females came, as might be expected, with considerably higher levels for 'Depressive' response than the baseline population. The females came to counselling with much higher levels for 'Emotive' response and the males with a significantly higher mean for 'Passive' response than the baseline norm. The male & females who came for counselling had means for use of 'Social support' as a coping strategy which were significantly higher than the baseline mean, and the counselling continued to improve on this response for both genders throughout stage 3 & 4. Thus the mean was not only higher than the baseline norm but continued to be significantly higher than the norm for both genders through post-treatment and up to the follow-up stage.

Further it was observed that for the variables Depressive, Emotive & Passive responses the mean for the males had improved to stage 3 but had fallen back again by stage 4 suggesting that the males had trouble holding onto the benefits they had gained from the therapy whereas the females generally continued to improve from stages 3 to stage 4. The exception for the males was for Rational action and the use of Social support where they were able to hold onto or even improve on their post-treatment means by the follow-up stage (see Tables 5 and illustrated in Figures 1-3 below).

Table 1: Number of returned questionnaires in Stage 1 x gender

Gender	Frequency	Percent
Male	829	36.2
Female	1461	63.8
Missing Values	1	0.0
Total	**2291**	**100**

Table 1 shows that nearly 2/3 of the respondents were female.

Table 2: Professional status of respondents in Stage 1 x gender

	Professional	Non-professional	Total
Male	329 (41%) (37%)	477 (59%) (35%)	806 (36%)
Female	551 (38%) (63%)	887 (62%) (65%)	1438 (64%)
Total	880 (39%)	1364 (61%)	2244

Table 2 shows that the proportions of professionals to non-professionals in the sample in each of the genders and overall were fairly similar and the proportion of males to females in each of the professional status groups were also fairly similar. The surprise was perhaps that nearly 2/3 of the respondents were female in both of the professional status groups.

Table 3: Age sub-grouping of sample in Stage 1

Age Group	Male Frequency	Valid Male Percent	Female Frequency	Valid Female Percent	'Well-being' Frequency	Valid 'Well-being' Percent
16 - 18	3	.4	2	0.1	5	0.2
19 - 25	58	7.1	88	6.1	146	6.4
26 - 35	179	21.9	242	16.8	421	18.4
36 - 45	247	30.2	477	33.2	724	31.6
46 - 55	263	32.2	491	34.1	754	32.9
56 - 64	65	8.0	135	9.4	200	8.7
65 +	2	0.2	3	0.2	5	0.2

Table 3 shows that the majority of the respondents fell in the 36 – 55 age bracket both for the men and for the women.

Table 4: Age grouping of sample in Stage 1

	Age Groupings		
	16-35	**36-64+**	**Total**
Male	240 (29%) (42%)	577 (71%) (34%)	817 (36%)
Female	332 (23%) (58%)	1106 (77%) (66%)	1438 (64%)
Total	**572 (25%)**	**1683 (75%)**	**2255**

Table 4 shows that a fairly similar proportion of males to females were represented in each age group. In the younger age group a higher proportion of males responded than in the older age group and within the overall sample.

Table 5: Means x gender at all stages for changes in Coping Strategies

		All			Males			Females		
Coping Strategy	**Stage**	**mean**	**N**	**sd**	**mean**	**N**	**sd**	**mean**	**N**	**sd**
Rational actions	1	2.85	2258	0.75	2.89	821	0.72	2.82	1436	0.76
	2	2.56	233	0.71	2.71	62	0.68	2.51	171	0.72
	3	2.75	164	0.70	2.80	36	0.67	2.76	112	0.72
	4	2.81	68	0.59	2.83	16	0.43	2.86	46	0.64
Palliative response	1	2.82	2254	0.82	2.66	821	0.82	2.91	1432	0.80
	2	2.73	234	0.76	2.67	62	0.69	2.75	172	0.78
	3	2.87	155	0.77	2.87	36	0.58	2.87	113	0.83
	4	2.73	68	0.70	2.75	16	0.42	2.75	46	0.75
Social support	1	2.25	2257	0.64	2.12	819	0.64	2.33	1437	0.64
	2	2.57	234	0.67	2.29	62	0.64	2.66	172	0.65
	3	2.76	154	0.64	2.81	36	0.74	2.77	112	0.62
	4	2.75	68	0.64	2.73	16	0.70	2.81	46	0.59
Depressive response	1	2.61	2256	0.91	2.51	822	0.87	2.66	1433	0.92
	2	3.29	234	0.79	3.34	62	0.79	3.28	172	0.78
	3	2.98	154	0.86	2.82	36	0.90	3.03	112	0.85
	4	2.74	68	0.81	2.98	16	0.93	2.65	46	0.78
Emotive response	1	2.13	2247	0.82	1.92	819	0.71	2.26	1427	0.86
	2	2.64	233	0.81	2.19	62	0.86	2.81	171	0.78
	3	2.30	154	0.74	2.13	36	0.63	2.38	112	0.76
	4	2.28	68	0.87	2.23	16	0.86	2.32	46	0.87
Passive response	1	2.20	2252	0.58	2.25	821	0.59	2.17	1430	0.57
	2	2.35	233	0.64	2.57	62	0.65	2.28	172	0.62
	3	2.29	154	0.59	2.40	36	0.91	2.26	112	0.59
	4	2.19	68	0.63	2.47	16	0.69	2.08	46	0.57

Table 5 shows that for the first three coping strategies i.e. Rational actions; Palliative response & Social support, the higher the figure in the mean column the more that group of subjects are using the positive coping strategies. The higher means for the last three coping strategies indicates a greater use of the negative coping strategies of Depressive, Emotive & Passive responses.)

Figure 1: Coping Strategies – Females

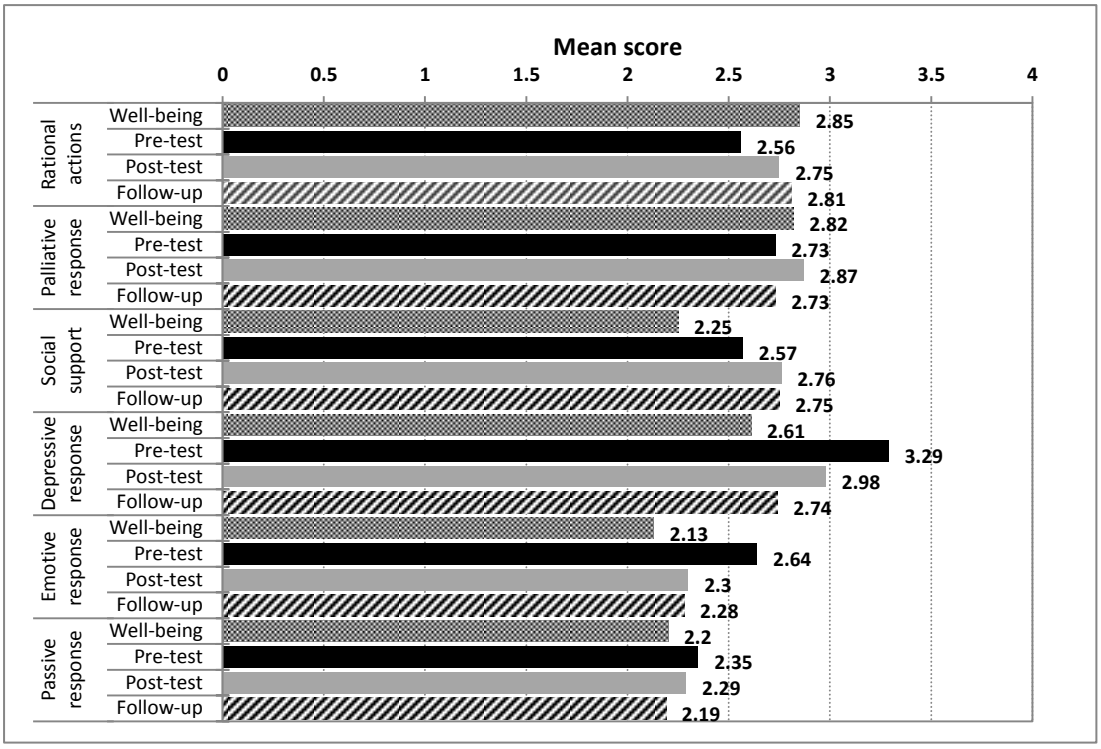


Figure 2: Coping Strategies - Males

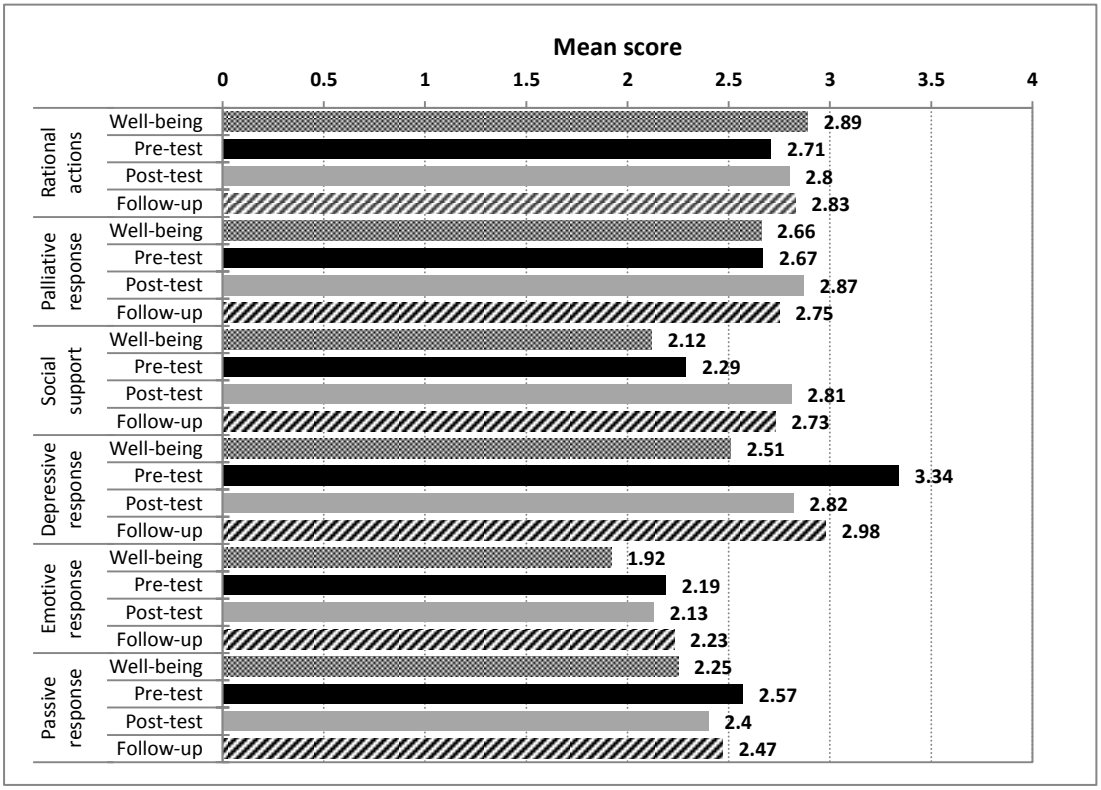
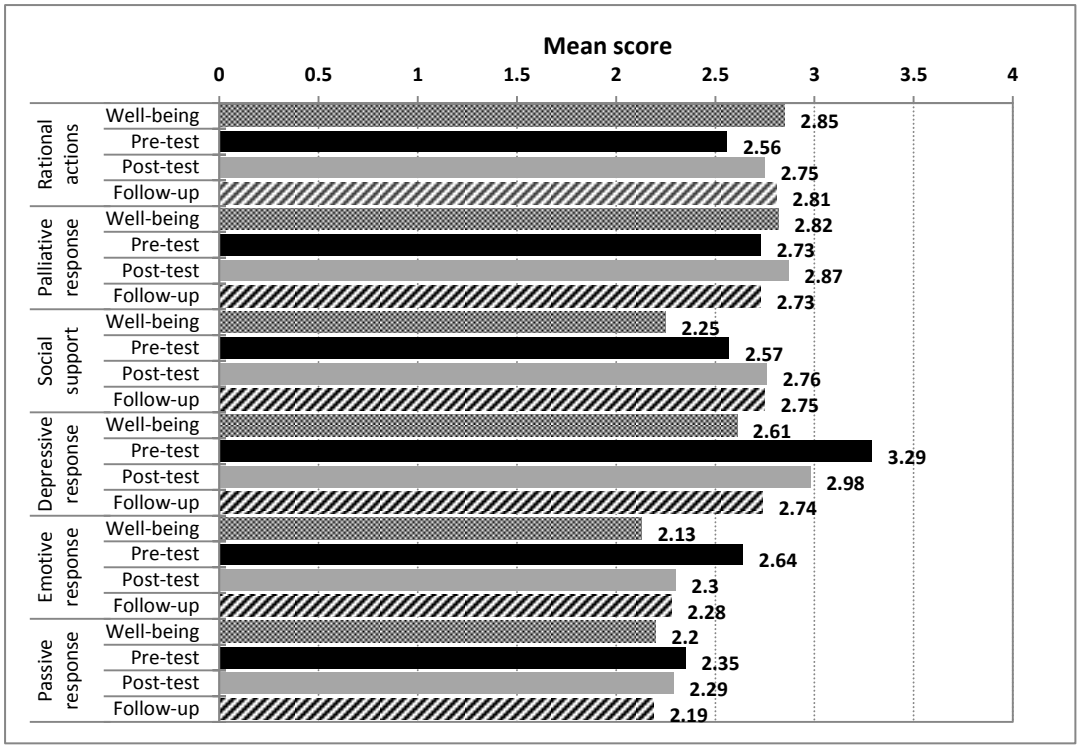


Figure 3: Coping Strategies – All Subjects



DISCUSSION

This study produced a variety of interesting outcomes. The core investigation, reported here was concerned with whether the brief therapy as offered by an E.A.P. was effective in producing change. The measurements presented here examined six forms of coping strategies with which to manage work stress. However, as the data was examined it became clear that gender was a significant variable with respect to the results. This was not the aim of the study but demographic data was taken with the thought that there may be differences in responses.

Looking at how males and females reacted under stress, from the baseline normative sample, overall it was seen that there were significant differences between the genders in their likelihood of responding using the various coping strategies. Etzion & Pines (1981) noted that women tended to seek help and social support more effectively than men. In this study, the males were significantly more likely to respond to stress using 'Rational action' or 'Passive' responses whereas the females respondents would cope with stress more than the males using 'Palliative' response, 'Social support', 'Depressive & Emotive' response. This last would support the idea that women report more symptoms of emotional distress and depression than men (Rosenfield, 1980; Haynes & Feinleth, 1980; Aneshenel et al, 1981; Cleary & Mechanic, 1983; Gove, 1979; Cooper &

Davidson, 1982; Karasek et al, 1981; Levenson et al, 1983); and used social supports significantly more than the males (Etzion & Pines, 1981). The 'Passive' response that the males were more likely to use, is to increase their consumption of alcohol as their stress goes up. Johnson (1982) noted that men have higher rates of problem drinking. Jick & Mitz (1985) suggested that there were clear differences between the genders in styles of coping and this study shows that for some coping strategies these differences were significant. This pattern of responses was echoed in those coming for counselling, though those coming for counselling differed from the baseline sample population in some very clear ways. In the counselling sample, both genders came to counselling with significantly lower levels for 'Rational actions' than the baseline sample. As with the baseline sample, the males came with a significantly higher mean for 'Rational action' than the females, at the pre-treatment stage. This suggests that for both the baseline and counselling samples the males were more likely to take positive actions to deal with their stress than the females. Lazarus (1966) has argued that the person usual employs both task and emotional focused coping strategies. The former attempts to form an action directly targeted towards dealing with the source of stress: adaptation of the environment, while the latter attempts to attenuate the emotional experience associated with that stress (Lazarus, 1966; Lazarus and Folkman, 1984). These results suggest that the males in both samples employed more task focused strategies for dealing with their stress.

Males and females were said by some to differ very little in the way they appraise potentially stressful events (Folkman & Lazarus, 1980; Karasek et al, 1981); but men were said to more often possess better psychological attributes or employ more effective methods of responding for controlling stress. However, after counselling the gender differences disappeared. The males came with a mean level for the coping strategy of 'Rational actions' that was only just significantly different from the baseline norm and thus they showed no significant improvement, overall. The change for the females was such that their mean for this coping strategy was no-longer significantly different from the males or the norm at both the post-treatment and follow-up stages. Thus the proposition can perhaps be challenge here, that men possess better psychological attributes or employ more effective methods of responding for controlling stress and that women were said to be socialized in a way that equips them less adequately for effective coping (Folkman & Lazarus, 1980; Karasek et al, 1981). It may be that the females are socialised in a non-rational action responses to dealing with stress, but were certainly able to significantly change, as a result

of the counselling, such that there were no-longer gender differences. So maybe the suggested socialisation was not so well engrained as previously proposed in that change was promoted for the females for the coping strategy of 'Rational actions', by the counselling process, and the change was at least maintained or improved on by the females up to the six month follow-up stage unlike the males who has lost much of their gains by the follow-up stage in many of the coping strategies.

The changes for the females suggest that, irrespective of earlier findings concerning gender differences in styles of coping, that at least the females, can be trained to develop healthier coping strategies by, for example, learning time, stress and anger management, assertiveness training and developing better work/life balance. Murphy (1989) reinforced this saying that learning to manage stress was more effective where it was seen as part of health promotion, i.e. learning improvements in coping strategies, rather than specific stress reduction methods.

There were certain interesting issues involving the coping strategy of 'Social support'. Use of social support is seen as a positive coping strategy allowing for a deflection of focus from the working environment to the development of better work/life balance, by way of interacting with different groups of people who reflect for the individual a greater variety of his/her self-value or self-worth than one that is only focussed on their worth and value at work. Etzion & Pines (1981) and others have suggested that women tended to seek help and social support more effectively than men (Pearlin & Schooler, 1978; Rosenfield, 1980; Rees & Cooper, 1990; Etzion & Pines, 1981; Jick & Miz, 1985). From the author's own experiences in the counselling setting it would seem to be apparent that females tend to be better at building and maintaining good life balance than the males. This was certainly the case in the findings from the baseline sample in that the females scored a significantly higher mean for the coping strategy of 'Social support' than the males. However, while the females in both the baseline and the counselling samples had significantly higher means for the use of 'Social support' than the males; both genders came at the pre-treatment stage with significantly higher means for this coping strategy than the baseline mean and though improvements were seen through the different stages of the study, the subjects mean response level (irrespective of gender) stayed significantly higher than the baseline mean. This finding was somewhat surprising as it seems to indicate that for this coping strategy that those coming for counselling, both the males and females, scored significantly higher means than the

baseline sample and hence were healthier in their use of this response than the normative population. Though the females who came for counselling had a mean score for 'Social support' which was significantly higher than the males at the pre-treatment stage, by the post-treatment and follow-up stage there was no-longer a significant difference between the genders. This would suggest that at least for this coping strategy, unlike most of the other variables, the males were able to benefit from the counselling to improve on this strategy and to continue to improve up to the follow-up stage. Thus, whereas, for 'Rational actions' the females were able to learn to bring their means up to that of the males such that there was no longer any significant differences between the genders, the reverse was true for 'Social support' where it was the males who gain most and had developed the skill and were able to reach a point at both the post-treatment and the follow-up stages where their means were no-longer significantly different from the females. It can perhaps be said that the counselling produced little effective change with respect to this coping strategy for the females as they were already better skilled with using this strategy than the males. The question here was: why was it that those with higher 'Social support' levels than the norm would seek out counselling help? It could be suggested that counselling may be seen as an extension of their skills in using this strategy. This suggestion would tend to agree with research finding that brief therapy would tend to be successful where there is a history of successful social interactions (Burlinggame & Fuhriman, 1987; Steenbarger, 1992; Lambert et al, 1986).

Within the baseline sample it was seen that the females were significantly more likely to use 'Depressive' responses as a coping strategy, such as bottling up feelings, and feel powerless to effect change or take control of one's situation. This is supported by many other findings that showed females were significantly more likely to cope with stress using depressive responses than males (Rosenfield, 1980; Haynes & Feinleth, 1980; Aneshesel et al, 1981; Cleary & Mechanic, 1983; Gove, 1979; Cooper & Davidson, 1982, Karasek et al, 1981; Levenson et al; 1983; Pearlin & Schooler, 1978; Etzion & Pines, 1981). However, this was not the case for the males in this counselling sample, for although the males came with higher levels for 'Depressive' response than the females the difference was not significant, and the differences were not significant at any of the stages of the study. Yet in other studies females were seen as having significantly poorer mental health than males (Kessler & McRae, 1981; Weinstein & Zappert, 1980). It could be that in the counselling subjects there may not be differences between the genders in depression or mental health, but there may be in the general population, or as found here, in the baseline sample. However, like

many of the other variables, there was a mean improvement for the males to post-treatment for 'Depressive' response but this was apparently lost by follow-up, whereas the females continued to improve to follow-up. This may be because, as suggested by others, males tend to use coping strategies which may be only effective in the short-term (looking for the quick fix – solution focussed (Jick & Miz, 1985}), and in fact this strategy, it has been suggested by Jick & Miz, may be the cause of them being more prone to serious illness. This certainly underlines the contention that gender is an important moderator with respect to coping responses to stress (Beehr & Schuler, 1980), but does not support the view that males possess better psychological attributes as suggested by Folkman & Lazarus (1980) and Karasek et al (1981).

In the baseline sample the females were more likely to use 'Emotive' response than the males, for example, shouting at colleagues, spouse or family when upset and stressed. This was also the case at the pre-treatment and post-treatment stages, but at the follow-up stage there was no significant difference between the genders. The females started at a higher mean level for this response and while the males were also able to reduce their levels of responding with this coping strategy, the females benefit most from the counselling in reducing their mean level to that of the baseline population and to maintain and improve on that by the follow-up period. These findings would tend to show, with counselling, that the females had a capacity for significant change in their coping strategies both after counselling and to maintain or improve on that change at least up to six months later, e.g. with 'Rational actions', 'Depressive & Emotive' responses. It is difficult to compare these findings to those of previous research because so little has been done on gender differences in coping strategies and change.

The opposite effect was found for the coping strategy of 'Passive' response, an example of which may be to have a drink and hope the problems will go away. The opposite effect was that, in both sample groups (the baseline & counselling samples), the males were significantly more likely than the females to cope using this response. This would suggest that males' coping strategies also include non-focussed or non-constructive coping methods to deal with stress. Johnson (1982) noted that it was indeed an observation that males have higher rates of problem drinking. Unfortunately while the males did improve with respect to 'Passive' response coping strategy at the post-treatment stage, but this was hard to sustain through to the follow-up stage. Thus the

counselling process was not particularly successful in promoting change at least to the follow-up stage, especially for the males for the coping strategy of 'Passive' response.

A possible criticism of the study was the issue of attrition. Kazdin (1994) indicated that anything up to 50% of the clients who begin treatment may drop out. Thus, the level of attrition in this study was within the expected range. Also this study found, as with a previous similar study (Worrall, 1999), that there were no significant differences in the pre-treatment means between the responders and the non-responders at stages 3 or 4. Further, when the gender proportions of respondents were examined it was seen that the proportion of males who came for counselling was fairly equivalent to the proportion of males who responded to the baseline questionnaire (stage 1) and to the proportion of each gender in the organisation as a whole. Thus this would tend to concur with those who found no gender differences with respect to utilization rates for EAP provided counselling services (Gerstein et al, 1993; Milne et al, 1994; West & Reynolds, 1995). Many studies grouped subjects altogether as it was considered that the samples were often statistically unsuitable to investigate sex differences (Kiev & Kohn, 1979; Jick & Miz, 1985). Yet gender was seen as affecting how people experienced stress and the coping strategies used to deal with those stresses (Beehr & Schuler, 1980; Ivancevich & Matteson, 1980). Others suggest that men and women differ very little in their appraisal of stressful events (Folkman & Lazarus, 1980; Karasek et al, 1981). This study does not appear to agree with this view. These differences were seen in the baseline 'Well-being' study. It would seem many studies on the effectiveness of therapy seem to have ignored the issue of gender differences (Bunce, 1997).

CONCLUSION

This study highlights some important issues, firstly the importance of examining the gender differences within counselling data and that follow-up studies can produce very differing results. However, the gender differences also raised the issue that males and females clearly not only react to stresses differently but also respond to counselling differently. Thus, these results would seem to suggest that the 'one size fits all' concept of therapy might not be appropriate, and that males may need to receive a different form of counselling that meets their needs, such that they might be able to sustain improvements over longer periods. It is thus suggested that there needs to be some work that looks into whether different methods of working or different focus models of therapy work better with males as compared with females. It is seen that the idea that different

models of working may be needed for different groups of subjects such as males and females has major implications not only on how data is collected but also on the work of counselling/clinical psychologists and counsellors generally in EAP work and also in other settings where brief therapy is the model expected to be used such as in primary care. This study also suggests that using an organisational baseline norm may facilitate the use of more naturalistic studies into the effectiveness of the therapy being offered but it is seen as important to ensure that at least the data for different groups, such as males and females, are analysed separately and longitudinally. Nevertheless overall the findings indicated that the model of brief therapy as used by this EAP was effective in promoting change.

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