Occupational Health Psychologist

Incorporating the Newsletter of the Academy

A publication of the European Academy of Occupational Health Psychology

Europe's leading body for individuals and institutions with an active involvement in research, professional practice and education in occupational health psychology

At a glance

Editorial

Welcome to the first 2006 issue of the *Occupational Health Psychologist* (*OHPist*). Building on the success of the three issues published in 2005 we bring you the latest news from the Academy, along with some interesting articles relating to OHP research and practice.

Information on the 7th EA-OHP conference can be found on page 3 of this issue. We have already received a number of excellent submissions for the conference, reflecting current OHP research, practice, and education. There is still time to submit an abstract for the conference (deadline 31st March), so if you have not yet submitted your work then now is the time to do so (see page 3 for details). The event in Dublin promises to be the largest and most successful EA-OHP conference to date – an event not to be missed!

In addition to this conference information, and the latest news from the Work and Stress journal, we are delighted to present two research articles from the UK and Sweden. In the first of these articles, David Ellard (Coventry University) evaluates an intervention that was designed to improve the quality of working life for employees with long-term medical conditions. Following this, Carina Bildt (National Institute for Working Life) compares the health and work characteristics of three groups of workers with varying degrees of exposure to bullying and harassment at work. Many thanks to David and Carina for sharing their work with us.

Following these research articles, Jan Hill-Tout reflects on some of the issues that she has faced as an internal consultant within the UK National Health Service. Jan provides a set-by-step guide to consulting within organisations, along with some of the core competencies required by organisational consultants.

We also bring you our regular section that summarises research papers that were published in recent issues of relevant journals (JAP, JOHP, and Work & Stress). Our thanks go to Victoria Friedman for taking the time to review this research.

As always, the success of the *OHPist* depends on our readers' willingness to send us articles describing their work. We therefore strongly encourage you to use the *OHPist* to disseminate your work to your fellow occupational health psychologists both in Europe and beyond. As you will see from the guidelines on page 17, we welcome many different types of articles. Please do not hesitate to contact me if you have any questions about submitting an article (email address below).

The next issue of the *OHPist* is due to be published in August/September of this year. In that issue, we are hoping to present interviews with prominent occupational health psychologists from across the globe, alongside further articles that reflect the work of fellow members of the Academy. We are also planning to distribute copies of the next issue at the Dublin conference to help raise the profile of this publication.

So, until the next issue, I wish you all a productive and healthy few months of work.

Best wishes,

Paul Flaxman
On behalf of the Editorial team
Email: P.Flaxman@gold.ac.uk

The UK-based members of the EA-OHP Executive Committee at a recent meeting at Birkbeck College, University of London. From left to right: Frank Bond, Tom Cox, Paul Flaxman, Peter Kelly, Phil Dewe, Jonathan Houdmont, and Patricia Murray

European Academy of Occupational Health Psychology

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7TH CONFERENCE OF THE
European Academy of Occupational Health Psychology

ABSTRACT SUBMISSION DEADLINE: 31 MARCH 2006

DELEGATE REGISTRATION DEADLINE: 1 OCTOBER 2006

Dublin, Ireland, 8-10 November 2006

For further information visit
http://www.ea-ohp.org/Conferences/index.asp

Announcement of pre-conference workshop:
"How to survive your PhD life"

Tuesday 7th November, 17:00-19:00, followed by optional dinner
Venue: to be confirmed

At the Academy's Dublin 2006 conference there will be a 'pre-conference' workshop especially designed for PhD-students. Annet de Lange and Josje Dikkers will present relevant and useful information for PhD students in all phases of their project. In addition, 1-2 students will be given the opportunity to present the findings of their research. Afterwards, they will receive feedback on their presentations.

The general aims of this workshop are to i) gather researchers who are working on a PhD-project in the Occupational Health field, ii) address important topics related to completing one's PhD project and finding work in the scientific arena, and iii) give feedback on some presentations to be held during the EA-OHP conference. More specifically, the workshop convenors will discuss the skills and competencies needed to finish one's project, coaching possibilities, career prospects, presentation skills, and the launch of a PhD page on the EA-OHP website.

Of course, there will also be time for informal discussion with the participants on the information presented, and an exchange of experiences between students. With this workshop, the European Academy wishes to value and recognize the contribution of young researchers to the field of Occupational Health Psychology.

Attendance is free for all registered conference delegates.

Annet de Lange is Associate Professor at the Department of Organizational Psychology, University of Groningen (RUG) contact: alange@feweb.vu.nl

Josje Dikkers is Assistant Professor at the Department of Management & Organization, Vrije Universiteit (VU) Amsterdam contact: jdikkers@feweb.vu.nl

The Dublin 2006 EA-OHP conference is generously sponsored by the following organisations:

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Work & Stress

From the editorial team

Tom Cox and Mary Tisserand
Work & Stress, Nottingham, UK

Editorials invited

We are keen to provide a forum for discussion and to stimulate debate. *Work & Stress* therefore welcomes offers of editorials, or commentaries. These provide an opportunity for the writer to express an informed opinion that may not be shared by the journal, in a way that is not possible in a scientific paper.

Editorials should be relevant to the journal's concern for issues in occupational health and work-related health psychology. Ideally they should focus on an issue that is of current interest to a substantial proportion of the journal's readers. Editorials may suggest potentially interesting avenues for future research and/or practice, be critical of current ideas, shed new light on established findings, or comment on previously published papers. We especially seek contributions that are soundly based as well as stimulating and challenging, that make specific points and, most of all, that inspire thought by the reader.

If you would like to contribute an editorial please contact the editorial team.

Forthcoming papers

A variety of interesting papers will be included the next edition of *Work & Stress* (volume 20 part 1). In the first paper, using a large dataset from two phases of the Whitehall II study, Leif Rydstedt (Sweden) and colleagues find little support for the assumption that long-term relationships between psychosocial work characteristics and mental wellbeing are curvilinear. This study, which was supported by the UK Health and Safety Executive, thus challenges the common assumption that these relationships are J or U-shaped. This has implications for stress management interventions and support the adoption of a population rather than individual approach

Studies using the Job Demand-Control (-Support) model are usually confined to the impact of job characteristics. In a study of some 700 health care staff, Akerboom and Maes (The Netherlands) investigate the additional contribution of organizational risk factors (ORFs, such as the availability of staffing resources and training opportunities). They found that ORFs explained important parts of the variance on negative outcomes, over job characteristics alone. This suggests that assessing ORFs in addition to JDCS constructs provides a more valid and complete measure of the quality of work and its effects on psychological wellbeing.

There has been surprisingly little research on PTSD in firefighters – the subject of a paper by Del Ben and colleagues from the US. They used the Posttraumatic Stress Disorder Checklist (PCL), a measure that is consistent with DSM-IV criteria for the diagnosis of PTSD, together with other instruments, to determine the prevalence of PTSD in firefighters and to assess the association between distress and the types of calls to which the firefighters responded.

In another paper from the US, Stetz et al investigate the moderating effects of social support on stressor-strain relationships, using the stressor organisational constraints. Using a sample of military police soldiers, they found that the moderating effects of social support were further moderated by self-efficacy.

A study on wellbeing in call centre work is reported by Wegge (Germany) et al. The authors examined the associations between the Motivating Potential of Work and organisational identification on the one hand, and indicators of satisfaction and wellbeing (including burnout and Organizational Citizenship Behaviour) on the other. They found that workers who identified with their organisation and who held a job with a high motivational potential reported better wellbeing.

In the final paper in this forthcoming edition, Rau (Germany) examines the association between blood pressure and work-related stress, measured in terms of overtime work and "disturbed unwinding" (i.e., an inability to relax after work). A diagnosis of high blood pressure is usually made on the basis of the diastolic pressure, or the systolic and diastolic pressures combined. However this study, which used ambulatory blood pressure monitoring over 24 hours, together with assessments of work characteristics and the ability to unwind, indicates that in studies of work-related stress it may be the systolic pressure alone that should be measured.

Publication alerting

To be alerted when these and future papers are published, you can sign up to the free SARA (Scholarly Articles Research Alerting) service: visit www.tandf.co.uk/sara

To contact the editorial team please e-mail: Mary.Tisserand@nottingham.ac.uk

Self-Management of Long Term Medical Conditions for NHS employees: Evaluation of the Improving Working Lives Pilot Project

By
Dr David R Ellard, Research Fellow
Prof. Julie H Barlow, Director of Research Centre

Interdisciplinary Research Centre in Health, Coventry University

Introduction

There is a paucity of research examining the impact of a Long-term Medical conditions (LTMC) on working life (Munir, Leka, & Griffiths, 2003). Munir et al., (2003) found that a half of the participants in their survey reported that their illness affected their work on a daily basis, with some stating that work made their condition worse. One UK study found that amongst people with ankylosing spondylitis, (a form of arthritis with an early age of onset), fatigue was the main challenge to working life (Barlow, Wright, Williams, & Keat, 2001). Other factors were the unpredictability of the condition, pain, and limited mobility. Strategies used to cope with these factors included reducing working hours, changing to less physical jobs, working from home, becoming self-employed, or taking early retirement. It is noteworthy that none of these strategies focused on developing better management of symptoms in the work environment.

The self-management of a LTMC implies monitoring and managing symptoms, adhering to treatment regimes, maintaining a healthy lifestyle, and managing the impact of the illness on daily functioning, emotions, and social relationships (Holman & Lorig, 2000). Self-management of LTMCs occurs throughout daily life regardless of setting. Thus, people have to manage their condition not only in the home environment but also in the workplace.

In contrast to the lack of published research evidence for workplace interventions, there is a growing body of evidence to support the effectiveness of community-based self-management programmes for LTMC (e.g. Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002; Lorig et al., 2001; Lorig et al., 1999; Wright, Barlow, Turner, & Bancroft, 2003). The Chronic Disease Self-Management Course (CDSMC) is a cornerstone of the UK Department of Health's Expert Patient Programme (EPP) and is based on the notion that people with chronic disease face similar issues in the daily management of their condition, its treatment and the psychosocial consequences and is a much more 'holistic' approach. The EPP is a lay-led programme delivered to groups of 10-16 people in 6-weekly sessions of 2.5 hours each. Topics covered include goal setting, communication, and exercise.

The Improving Working Lives Pilot Project aimed to deliver the EPP to UK National Health Service (NHS) employees. The aim of this exploratory study was to examine whether EPP is of benefit to people with LTMCs working in the NHS in terms of improving the quality of their working lives, and providing support. The Improving Working Lives Pilot Project was piloted in two NHS Workforce Development Confederation (WDC) areas (Bedfordshire & Hertfordshire, and Cheshire & Merseyside). The evaluation comprised two phases: Phase I focused on EPP participants; Phase II focused on managers.

Phase I: Employees with LTMCs

Participants & procedure
Sixteen people with LTMCs (8 from each area) were interviewed by telephone at baseline; 15 were female (age range 31 – 58 years; median age 51). Follow-up interviews were conducted with 14 participants approximately 2-months after course attendance (7 from Bedfordshire & Hertfordshire; 7 from Cheshire & Merseyside); 1 participant did not respond to follow-up; and 1 provided a brief verbal explanation of reasons for non-attendance on the course. Due to time constraints, the EPP in Cheshire & Merseyside was delivered over three rather than six weeks.

Two participants did not attend the course (1 due to the distance from the venue). One participant failed to complete the course due to work pressures and another felt that EPP was not appropriate as he viewed his condition as curable and short-term.

Results

Baseline
Participants reported that several aspects of their LTMCs interfered with working life. These included limited mobility, pain, fatigue and the unpredictability of many conditions. Symptoms were aggravated by use of equipment such as computers. Most had taken time off work due to the LTMC. The overwhelming impression given by participants was that rather than managing their condition, they were ignoring it in the workplace and were 'just getting on with it'.

Managers were viewed as supportive although some participants felt their managers were not sure how they could be of assistance. Others had encountered difficulties in obtaining equipment or workplace assessments. Three participants felt the organisation, as a whole, was less supportive than their line managers.

> "Anything to improve things that I do and make life a lot easier I think is welcomed by my manager." (ID13)

Self-management was viewed as a means of empowering people to take control of their LTMC.

After the course
Most participants felt that the course was well run and beneficial. They enjoyed being with similar others who had LTMCs and valued being able to take time away from the workplace to focus on their own health needs. After the course, many participants were more accepting of their condition and felt less guilty about having a LTMC that interfered with their working life (e.g. needing to take time off or reduce working hours). Acceptance was associated with feeling less 'guilty' about not being able to cope at times, being more in control and having the skills to successfully self-manage. Participants were using many of the self-management techniques learned on the course (e.g. visualisation, deep breathing).

A key theme to emerge was that the course was believed to be more about **living** with a LTMC rather than **working** with a LTMC. Indeed, many participants expressed a desire for more time to be spent on strategies directly connected with work such as feeling confident when discussing their workplace needs with line managers.

> "...ways of getting and talking to your boss and such like so that you felt more empowered really, rather than a victim, you know. If you were ill again or something, but, yeah I'd like to have had more, I think more of sort of help with that I think."(ID6)
>
> *"I think it would be quite handy to put more about managing things...each individual person with each, sort of, with their manager. I think that would be very helpful" (ID11)*

Components of the course mentioned as being particularly useful were the exercise sessions and relaxation. The latter was being used to assist stress management and sleep. Action planning received a mixed response with some participants finding it useful and others expressing a strong aversion to it. Some participants found the course to be too 'rigid' with insufficient time for discussion. This was particularly evident among participants attending the 3-week course with many finding two sessions a week to be exhausting and not allowing them sufficient time between sessions to practice the techniques learned. The 'buddy system', where participants were asked to be supportive of each other and check on each other's progress, was not liked by a number of the participants, as they felt it was too intrusive.

> "I've gone into sort of relaxation pretty big style… I've used in sort of every day for relaxing and … I use relaxation tapes for deep sleep and it's wonderful" (ID7)
>
> "I'm not taking as many painkillers because I'm relaxing more" (ID16)

Participants praised the tutors who were viewed as appropriate role models who fully understood the issues associated with LTMCs. Most participants would recommend the course to others.

Phase II: Managers' views

Participants & procedure
Twelve National Health Service (NHS) managers were identified: 6 participated in telephone interviews and 1 provided feedback via email (2 from Bedfordshire & Hertfordshire, 5 from Cheshire & Merseyside); the remaining 5 either could not be contacted or were not willing to participate.

Results
Only two managers knew about EPP and the 'Improving Working Lives' initiative. Several managers recognised the term 'expert patient' and associated this with a patient with expert knowledge of their condition who assists in improving standards of care. Once informed about the EPP and Working Lives project, all managers expressed qualified support for staff with LTMCs to either attend the EPP or to train as tutors. Managers were clear that any support had to be balanced against the need to ensure that service provision could be maintained, and had to take account of timing, staffing levels, and cost.

> "I would like to support it, but if we were in a situation that we were very short staffed and I couldn't provide a service, if this person wasn't available then I would have problems with that."

Perceived benefits of the course were viewed in terms of empowering staff to better manage their LTMCs, disseminating information, and reducing sick leave. In turn, these benefits would result in greater productivity, improved morale and a happier workforce. Perceived disadvantages of EPP revolved around professional concern about the context of information being disseminated by lay tutors, the danger of it being seen as a way to get people off long-term sick leave, and once again, issues of cost and maintaining staffing levels.

> "Ultimately a more comfortable employee because they've got their condition under control, whatever it is. Therefore, happier, happier worker!"
>
> "The fact is that you have people with these conditions and you don't want them disappearing all the time."

In order to improve the support offered to staff with LTMC, managers wanted a pool of easily accessible information about a range of conditions including the typical limitations and restrictions that individuals have to manage in the workplace. The need for a culture change in the initial selection process for jobs was called for with increased support for middle managers that make such decisions. Again, the need to balance services provision with additional support for staff was raised.   Finally, confidentiality issues around disclosure sometimes hindered managers' level of understanding regarding employees' needs and thus provision of support.

> "To be perfectly blunt, sometimes you think well, are they actually pulling the wool over our eyes, are they ill or whatever, because this person is always off sick what's going on? And because you're not being given that information, it's very difficult sometimes to really understand what's going on."

Conclusion
In conclusion, this study has illustrated how an intervention designed for delivery in the community can be successfully transferred to the workplace setting. Employees attending the Programme described a number of ways in which they had benefited and how they now felt more in control of their condition. Managers were broadly supportive of extending the Improving Working Lives initiative with the proviso that staffing levels and costs would have to be balanced with the need to maintain satisfactory service provision.

A copy of the full report and more information about the Expert Patient programme (EPP) can be found at: http://www.expertpatients.nhs.uk/

If you would like more information about the Interdisciplinary Research Centre in Health (IRCH) it can be found at:http://www.coventry.ac.uk/index.jsp (see Research and Consultancy).

Biography
Dr David Ellard joined the Interdisciplinary Research Centre in Health (IRCH) in 2002 as a Research assistant where he was involved with a number of projects, including a review of self-management for those with mental illness. In 2004 he was appointed as a Research Fellow and now manages a number of projects.

David's research interests include the psychological and physical impact of cardiovascular disease and its treatments, patient education, self-management in mental health and self-management for chronic disease.

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Psychosocial working conditions in relation to violence, threats and sexual harassment: Health consequences

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Abstract

In the present study the aim was to examine whether the occurrence of bullying, sexual harassment and threats about violence at work differed between groups in the population, and, if such groups could be identified, also to examine in what ways they differed according to their psychosocial working conditions, work organisational conditions and health. Questionnaire data were analysed with cluster analysis on bullying, sexual harassment and of threats of violence at work. Three clusters were identified, one low exposed, one exposed and one high exposed for the studied harassment aspects. Regarding the security of employment and other work characteristics, as well as musculoskeletal health, the individuals in the high exposed cluster were far worse off than the others.

Introduction

In the general population, demanding ergonomic working conditions are common, as are health consequences from those conditions (Bernard 1997, Vingård 2000). During the last decade, psychosocial working conditions, such as monotonous work, time pressure, poor job satisfaction and lack of control in the working situation have been found to be reliably associated with, for example, low back pain (Frank, Kerr et al. 1996, Vingård 2000). In other words, psychosocial working conditions include the individual's perception of the contents and organisation of work, as well as of the social relations at work. Work organisation also links to the occurrence of harassment at work, a phenomenon that has increasingly been included in the framework of work stress (Bildt 2003). Outcomes from sexual harassment, such as leaving work and reduced job satisfaction, have been studied (Goldenhar, Swanson et al. 1998, Gutek and Koss 1993, Piotrkowski 1998). Harassment, not only sexual harassment, has been recognized as a continuing, chronic occupational health problem in many of today's working environments (Bell, Quick et al. 2002). Since harassment of various types can cause reduced job satisfaction and other dissatisfactory psychosocial working conditions, if could be important to examine the relation between harassment, psychosocial working conditions, and work organisation. In Sweden, an extensive research project has been conducted, where individuals were grouped according to their working characteristics, rather than grouping variables to form factors, or being included in various types of multivariate analyses, which is a common way to study relationships (Härenstam 2001). A conclusion from that study was that such an approach provides valuable information about groups of individuals - information that can be used in intervention studies aimed at improving working conditions and health among the working population. In the present study, such a person-oriented approach has been applied.

The aim of the present study was to examine whether the occurrence of bullying, sexual harassment and threats about violence at work differed between groups in the population, and, if such groups could be identified, also to examine in what ways they differed according to their psychosocial working conditions, work organisational conditions and health.

Method

The data analysed in the present study emanate from a questionnaire-based study performed in Sweden in 2002. Cluster analysis was performed on the three variables that in the present study related to harassment – namely bullying, sexual harassment, and threats of violence at work - with the aim of finding groups of individuals with similar conditions. After the clusters had been determined, the harassment characteristics of the individuals belonging to the clusters were examined, as well as other variables of interest (such as psychosocial working conditions, work organisational factors, poor health). The analysis was performed in SPSS. In the analysis, where a similarity/dissimilarity measure was used, the measure was the average Squared Euclidean distance calculated on standardised variables. As a clustering method, the average linking method was used. This is a hierarchical method, which in each step links together the two clusters whose mean distance between all individuals within the two

Carina Bildt earned her PhD in 1999, and an associate professorship in 2004. Carina's main research interest focuses on women and men's working conditions and health. In the last few years, Carina has also focused on the effects of such aspects as ethnicity, class, and sexual orientation on working conditions and health. Carina is particularly keen on employing interactive research methods, to take her research one step further toward actual improvement of working conditions and health in society.

Table 1. Prevalence of violence and harassment; per cluster and gender (%)

	Cluster 1	2	3	Diff.
Women (n=)	(1774)	(192)	(67)	
Bullying	0	100	100	*
Threat of violence	21	33	34	*
Sexual harassment	2	6	15	*
Men (n=)	(1589)	(139)	(38)	
Bullying	0	100	100	*
Threat of violence	11	21	29	*
Sexual harassment	1	4	8	*

Diff=Chi2 statistically significant at 0.95 or not

proportion also exposure to threats of violence. The proportion of individuals reporting exposure to sexual harassment was higher among the individuals in cluster 3 than in cluster 2. Out of that result, the clusters were titled Low exposed, Exposed, and High exposed, to reflect the occurrence of harassment.

Some background information about the women and men (table 2) belonging to the different clusters are presented. The tables show that the individuals in the three clusters are distributed in many occupations and many types of employers, thus more of the High exposed cluster were employed by the government, and among women, more were employed by the county council.

Results

Poor psychosocial working conditions were much more common among the individuals in cluster 3 than among the others (table 3). For example, poor job satisfaction and low expectancies of the future were dramatically more common in cluster 3 than in cluster 1, and more common in cluster 2 than in cluster 1. Also, the occurrence of poor social support from superiors differed dramatically, with 80 per cent of the women and 76 per cent of the men in cluster 3 reporting this unfavourable work characteristic. Poor social support from colleagues was somewhat less

clusters is the smallest. We had the criteria that the distribution of bullying, sexual harassment, and threats of violence at work should be separated between the clusters. In this case, a 6-cluster solution was chosen. Of these six clusters, three had three or fewer participants (in total 7 individuals) and only the three largest clusters are presented in the results. The distribution of bullying, threat of violence and sexual harassment among women and men in the three clusters are presented in table 1. All individuals in cluster 2 and 3 reported exposure to bullying and a high

Table 2. Background information; per cluster for women

(%)	Women			Men		
	Cluster			Cluster		
	1	2	3	1	2	3
(n=)	(1774)	(192)	(67)	(1589)	(139)	(38)
Age						
< 25 years	9	7	4	9	7	4
25-34 years	20	25	13	20	25	13
35-44 years	27	31	28	27	31	28
45-54 years	28	28	36	28	28	36
55 >	16	10	18	16	10	18
Type of occupations						
Technical occupations	4	6	3	4	6	3
Educational (teachers)	15	21	16	15	21	16
Health care occupations	32	26	38	32	26	38
Administrative occupations	22	19	16	22	19	16
Commercial occupations	10	8	2	10	8	2
Farming	1	1	0	1	1	0
Transportation (drivers)	3	6	5	3	6	5
Manufacturing occupations	4	7	9	4	7	9
Service occupations	9	8	12	9	8	12
Type of employer						
Privately owned company	31	22	24	31	22	24
Government	10	17	37	10	17	37
Municipality	35	39	35	35	39	35
County council	11	12	25	11	12	25
Non-profit organisation	2	1	25	2	1	25
Other	8	7	8	8	7	8
Number of years in the occupation						
< 4	37	40	35	37	40	35
6-10	14	17	9	14	17	9
11-20	25	21	22	25	21	22
> 20	24	22	35	24	22	35

common, but the trend was the same, with higher occurrence in cluster 2 than in cluster 1, and a much higher occurrence in cluster 3 than in cluster 1. The individuals in cluster 3 had also experienced more negative changes in work organization, had a more insecure employment, and were more often working in large companies/organizations (table 4).

Also, worker health differed between the clusters, with the individuals in cluster 3 being worse off than the individuals in cluster 1, and somewhat more worse off than the individuals in cluster 2, with the exception of general health, where the men in cluster 2 were worse off (see table 5). As many as 63 per cent of the women, and 68 per cent of the men in cluster 3 reported low back symptoms, which is a very high proportion.

Table 3. Psychosocial working conditions; per cluster and gender (%)

	Cluster 1	2	3	Diff.
Women (n=)	(1774)	(192)	(67)	
Poor job satisfaction	31	49	56	*
Very high job centrality	22	23	25	ns
Low expectancies of the future	25	44	53	*
High demands	33	51	63	*
Low decision latitude	28	27	36	ns
Poor social support from superiors	34	62	80	*
Low social support from colleagues	20	31	71	*
Men (n=)	(1589)	(139)	(38)	
Poor job satisfaction	26	42	73	*
Very high job centrality	26	24	24	ns
Low expectancies of the future	18	37	67	*
High demands	30	44	47	*
Low decision latitude	28	23	13	ns
Poor social support from superiors	40	63	76	*
Low social support from colleagues	28	45	57	*

Diff=Chi2 statistically significant at 0.95 or not

Table 4. Work organisational factors; per cluster and gender (%)

	Cluster 1	2	3	Diff.
Women (n=)	(1774)	(192)	(67)	
Insecure employment	19	16	34	*
Work organisation changed negatively	21	34	47	*
Female dominated work place	72	70	66	ns
Male dominated work place	13	16	16	ns
Work as a supervisor	12	16	13	ns
Work place part of larger organisation	76	84	81	*
More than 50 employees	16	33	27	*
Men (n=)	(1589)	(139)	(38)	
Unsecure employment	18	18	35	*
Work organisation changed negatively	17	34	49	*
Female dominated work place	12	18	14	ns
Male dominated work place	71	62	68	ns
Work as a supervisor	25	23	29	ns
Work place part of larger organisation	69	82	74	ns
More than 50 employees	19	32	24	*

Diff=Chi2 statistically significant at 0.95 or not

Table 5. Health outcomes: per cluster and per gender (%)				
		Cluster		
	1	2	3	Diff.
Women (n=)	(1774)	(192)	(97)	
Reduced psychological wellbeing	24	27	31	ns
Shoulder symptoms	35	32	42	ns
Upper back symptoms	19	19	38	*
Lower back symptoms	45	44	63	*
General health	20	26	46	*
Men (n=)	(1589)	(139)	(38)	
Reduced psychological wellbeing	22	23	40	*
Shoulder symptoms	17	24	37	*
Upper back symptoms	10	15	13	ns
Lower back symptoms	37	48	68	*
General health	16	32	24	*
Diff=Chi2 statistically significant at 0.95 or not				

Conclusion

It was possible to identify groups of individuals that differed regarding their exposure to harassment. The most vulnerable group had a very high occurrence of bullying, threats of violence, and sexual harassment, and had very poor psychosocial working conditions, experiences of insecure employment, and negative changes of work organization. Their health status was much poorer than the other groups, both regarding musculoskeletal health and other aspects of health. Since these results are based on cross-sectional data, it is not possible to say anything about cause and effect, but some support can be found in other studies of harassment causing reduced job satisfaction, for example. The results in the present study can at least form the basis for intervention studies, with a longitudinal approach.

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Organisational Development Consultancy: A View From the Inside

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1. INTRODUCTION

Organisations generally employ external consultants when they have a task that needs to be undertaken in the organisation and do not have the appropriate resources to complete it. The consultant will bring with them specific knowledge and expertise and are briefed to get the job done within a circumscribed time frame, unconstrained by other organisational commitments. In time, it might become clear that these skills need to become a permanent part of the organisation, and full time employees may be recruited for this purpose.

Organisational Development (OD) consultants are in the same position in many respects. They are brought in from the outside because senior staff have identified a problem and do not have the expertise to solve it. OD consultancy may be slightly different however in that one of the pivotal contributions it makes is in reframing the organisation's view of the problem. The reframing can be challenging for senior staff and it can transpire that senior staff who thought the problem was 'out there' discover that it is 'here'. Maintaining a good relationship during this process is the mark of a good OD consultant and where relationships break down, it is at least possible for the external consultant to leave.

Sometimes organisations decide that having the skills of an OD Consultant available *internally* would be beneficial, or more likely approach staff who appear to have these skills to undertake this role on a temporary basis. This can be developmental for all concerned, but there are constraints because as an employee, there

may be things that it is very difficult to say to senior staff, or because when you are part of and close to an organisation it can be difficult to 'see' it clearly.

In this article, I share some of the lessons I have learned while working as an internal OD/occupational health psychology consultant for the UK National Health Service (NHS). Firstly, I have provided a step by step guide to the consulting process, followed by a description of the skills I believe an OD consultant can bring to an organisation. Subsequently there is strength/needs analysis of the internal consultancy role, and a summary of guidance for consultants in this position.

2. STEP BY STEP GUIDE TO ORGANISATIONAL DEVELOPMENT CONSULTING

Huffington *et al.* (1997) describe the key stages of Organisational Development Consulting from negotiating entry to the organisation (scouting, entry and contracting), making sense of the organisation (data gathering and diagnosis), taking action (planning intervention and evaluation), and withdrawal. These can be summarised as 'Going In', 'Finding Out', 'Intervening', and 'Leaving' and some detail on each of these activities is given below.

Going In
Requests for help can be framed in a variety of ways: 'We have massive sickness problems in one of our teams'…'A bullying manager is causing us problems'…'I've tried everything to get this team to perform'…'We need an away day to plan our strategy'. Deciding whether or not to 'go in' will rest on initial judgements about the organisation's capacity to change. If the organisation shows signs of not being ready to embrace the challenge of change, or in terms of the stages of change model (Prochaska *et al.*, 1992) is in the pre-contemplation or contemplation phase, then it may be that they are not ready to engage with the intervention that is being requested. For such organisations, a consultant saying no to a request may in itself contribute to internal reflections and possible movement. For the OD Consultant to be effective there needs to be some choice about whether to 'go in' or not.

Finding Out
OD Consultants need to have sophisticated process skills and need to be credible. However, naivety and ignorance about the detailed inner workings of an organisation are important in the 'Finding Out' stage. Staff will have to explain things, no assumptions can be made about pre-existing knowledge, and, as a newcomer, the customs, discourses, and culture will be novel and noticeable. In this role, it is easier for the consultant to ask the 'unaskable' and say the 'unsayable' in a non-judgemental way, without being perceived to take sides. From this position it is more likely that a diagnosis will be developed which includes all the factors and not just those that individuals have grown used to taking into account.
The consultant needs to work on finding out what is happening in an organisation, and this needs to be completed in conjunction with key players so that there is ownership of the diagnosis and subsequent commitment to any actions. This requires a consultant to identify official and unofficial leaders fairly rapidly, and to build trusting relationships that underpin the process. I believe that developing this shared understanding is a crucial part of the organisational intervention and may well require several meetings and conversations so that a shared view can be reached. I have found that this takes time but will pay dividends later on.

Intervening
Planning what to do and then doing it is the next work phase, and there will usually be a broadening out of involvement so that those who are responsible for implementing plans can be consulted and involved. The senior team will need to develop a general strategic plan, but anything more detailed needs to incorporate the knowledge and expertise of a wide variety of people in the organisation. The OD Consultant may by now be in a position to advise senior staff on the process of involving others so that they feel part of what is being decided. It is also crucial at this stage to set up achievable mechanisms for evaluating interventions. These may be internal feedback loops or agreed times in the future when the consultant will step back in and take a snap shot of how things are going.

Leaving
If the intervention process has gone well, then the organisation will be feeling confident about managing change and the consultant can leave. Action plans sometimes require continued input from the consultant, often in terms of evaluation, and sometimes relating to particular team development or facilitation projects. The consultant needs to be prepared for this change from a 'meta' role to one which is more focused, and understand that 'moving in' can sometimes make it hard to 'move out' again in the future. It may be advisable for someone else to do the more detailed action in order to retain the valuable outsider status.

3. CORE COMPETENCES OF AN ORGANISATIONAL DEVELOPMENT CONSULTANT

OD consultants may of course specialise in different work areas, for example non-governmental organisations (NGOs) or industry, but I believe that there are some core competences that underpin this work, wherever they are applied, and these are described below.

Values
An OD Consultant needs to hold a respected position in relation to an organisation and all the staff within it. This will entail taking a fairly uncompromising stance on certain values like accessibility, equity of involvement, confidentiality, process transparency and joint decision making. A strong value base also helps the consultant to discriminate between those projects which are achievable and those which are not.

Evidence base
An OD Consultant will be able to draw on a wide range of underpinning theories and research to support problem solving and understanding. It is important to be able to use a variety of models until the right one is found, rather than a 'one size fits all' approach. I believe that being up to date with research is a crucial for organisational problem solving, as is the ability to incorporate it into the consultancy process without mystifying people.

Evaluation
For the Consultant, measuring outcomes is good practice, not only so that the client can see if change has happened, but also so that the consultant can learn about, and develop, their practice. A good grasp of quantitative and qualitative research approaches is therefore another core competency, along with the ability to translate and implement some of these approaches in busy work place settings.

Interpersonal skills
A primary competency of an OD Consultant is the ability to build trusting relationships quickly and to be able to communicate with people in a language that they can understand. This does not only mean jargon-free communication, but also understanding the internal discourse of an organisation and adopting it as a vehicle for conveying meaning. Clearly this also involves non-judgemental listening, clarifying, summarising and more often than not, compassion.

4. LIFE ON THE INSIDE

When organisations decide to approach an external consultant, this is usually preceded by a period of debate and negotiation within the organisation which is, in itself, part of the process of change. If only by virtue of the fact that external consultants cost money, key players will need to have been persuaded of the advantages of bringing someone in. Internal consultants miss out on this dynamic exchange and need to be aware of this when negotiating entry. Extra care will need to be taken to ensure that there is commitment from the senior team and it may be worth considering some system of internal charging to support the process of engagement.

If an external consultant is busy or does not feel that what is being requested is appropriate, then it is relatively easy to say no. This can be hard for the internal consultant who may be under some pressure hierarchically or indeed feel the need to be seen to be doing something. Internal consultants need to learn the skills of saying no, otherwise the quality of what they do will be undermined and their position eroded in the long run. Internal consultants probably have an advantage here, they can afford to take the long view and build a reputation for good quality work; some external consultants have to take a short term view in order to maintain their income.

Internal consultants need to be very disciplined about approaching data collection in the 'finding out' stage with an open mind. This is very hard to achieve when you know an organisation and some key players within it. Inevitably, working within a culture means that you become habituated to it to some extent, and the development of long-standing relationships within an organisation, both positive and negative, can skew perceptions and undermine trust. Good quality supervision and peer support from outside the organisation is critical to dealing with this, as is maintaining a work pace that incorporates regular reflective time.

Many organisations, such as the NHS, can be hierarchical and internal consultants may have to say some quite difficult things to people who, hierarchically, are more senior to them. This can be very tricky and will require excellent interpersonal and process skills. However, underpinning this is the internal consultant's need to give themselves permission to set the hierarchy aside and allow themselves to metaphorically move around inside the organisation without acknowledging these barriers. This means that the internal consultant will be able to explore the whole system, and not just the bit they are being directed to. If this looks like it may not be possible, then I have found the wisest move is not to take on the project.

Planning and involving others can sometimes be a little easier for the internal consultant than it is for an external consultant. It is likely that internals know the resources available within the organisation relatively well and can support the involvement of appropriate people. Some care needs to be taken at this stage to

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Dr Jan Hill-Tout has extensive
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practice she works with
organisations to help them
understand how internal process
issues can become a barrier to organisational health
and development. In particular she encourages
organisations to engage in systemic thinking, helping
senior teams to recognise the importance of
interdependence in organisational activity and the
pivotal role of leadership in making changes. In
addition to working as an independent consultant, Jan
has recently taken up a part-time post as an internal
organisational development consultant in a large UK
NHS Trust. Jan lives and works in Wales and is a
member of the UK-based Occupational Health
Psychology practitioner network.

ensure on-going involvement is appropriate, so that the internal consultant does not become the answer for everything. However, one advantage of being internal at this stage is that the on-going work can be monitored fairly closely so that difficulties that may arise can be dealt with sooner rather than later. Undertaken within prescribed boundaries, this can be extremely useful and offers a flexibility that it is difficult for external consultants to achieve. Indeed, some external consultancy projects never achieve their full potential because they are unable to deliver the 'little and often' on-going support that is so useful. Even in organisations that are ready and willing to change, new behaviours do not appear over night and need to be nurtured, reinforced and developed. Internal consultants have a great advantage in this area.

Saying goodbye is difficult but is an important process skill for any consultant. It gives organisations confidence and affirms that they are doing alright, but can seem a little unreal when you work in the next corridor, or the next building. Whatever the circumstances, very clear lines need to be drawn so that there is no confusion about where the consultant stands, and in particular that one project has a clear ending before another begins.

MY TOP TEN TIPS FOR INTERNAL CONSULTANTS
1. Take your time when negotiating the brief, you have most control at this stage.
2. Learn to say 'no' and mean it.
3. Identify a competent external supervisor and have regular supervision on the consultancy work.
4. Join a network of consultants doing similar work in other organisations.
5. Try not to be unreasonably constrained by hierarchies.
6. Publicise your successes as widely as the organisation allows – this enables you to access very senior staff.
7. Manage your time well and be reliable.
8. Don't take work on if you are too busy to do it, and be sure to build reflective time into your work routine.
9. Don't be too available.
10. STOP when the agreed work has been completed.

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Research Reviews

In this section we review and summarise a number of recent OHP research articles. Please contact the Editor (Email: P.Flaxman@gold.ac.uk) if you come across a research article that you think should be summarised in this section, or if you would like to see a review of one of your own recently published research studies.

Switching off mentally: Predictors and consequences of psychological detachment

The authors use the term psychological detachment to emphasize the psychological component of disengaging from work during off-job time as opposed to simply being physically absent from the workplace. Until now researchers have focused on psychological detachment during relatively long respite periods. Short-term psychological detachment needs to be investigated because if individuals do not recover sufficiently within shorter time intervals, strain reactions may accumulate and impair well-being. The basis for this research is an investigation into the relationship between work-situation variables (quantitative workload and psychological detachment) and whether psychological detachment from work during evening hours improves well-being after work.

Sonnentag and Bayer conducted research with 97 participants from ten different organisations. Individuals completed questionnaire measures consisting of chronic workload and control variables at the person level. In addition, daily survey measures had to be completed over three consecutive work days and they had to respond to items on two measurement occasions: (a) when returning home from work and (b) before going to bed. All items were in German.

In summary, the authors conclude that:

- When confronted with high workload, individuals are less successful at detaching themselves psychologically from work and the need for recovery increases. At the same time this high need for recovery is less likely to be satisfied.
- Psychological detachment from work is positively associated with positive mood and low fatigue at bedtime.
- It is not the amount of time pressure that one has faced that day that makes psychological detachment difficult but rather the anticipation that time pressure will continue during the working days to come.
- Short working hours do not attenuate the relationship between psychological detachment and fatigue.

These findings underscore the importance of psychological detachment for improving positive mood and reducing fatigue during evening hours. Individuals should be encouraged to switch off mentally from work when leaving their workplace. The most important intervention, however, is the reduction of workload. This will decrease an individual's need for recovery and positively impact on the recovery process by making a psychological detachment from work, contributing to an individual's work-life balance.

Sonnentag, S, and Bayer, U. (2005). Switching off mentally: Predictors and consequences of psychological detachment from work during off-job time. *Journal of Occupational Health Psychology, 10(4)*, 393-414.

Display rule 'regulators': The relationship between supervisors and worker emotional exhaustion

Display rules are interpersonal job demands in that they control the delivery of the interaction between the employee and the customer. When workers experience different emotions than those they are required to express, the effort involved in regulating these emotions lead to emotional exhaustion (Grandey, 2000). The conservation of resources (COR) model's basic tenet is that people strive to protect and build resources, such as energy, skills and social support. The potential or actual loss of these valued resources is threatening (Hobfoll & Freedy, 1993). Supervisors are likely to be important definers of display rules at the job level, given their direct influence on worker's beliefs about performance expectations.

The relationship among supervisor's importance on interpersonal job demands (display rules), worker resources and emotional exhaustion were tested in 429 participants in 215 different call centers. Using a survey design, measures of emotional exhaustion, supervisor variables and individual resource variables were collected.

The authors found that:

- The effect of supervisor emphasis on the importance of interpersonal job demands was significantly related to the degree of emotional exhaustion their subordinates experienced.

- Burnout is related to interpersonal job demands as enacted by the supervisor, when we controlled for workers' view of their supervisors as supportive. This suggests that's supervisors are not only a source of support for workers but also a source of stress.

In brief, organisations may be able to mitigate the negative effects of supervision by training supervisors to be more aware of how their actions and attitudes can influence the strain felt by their subordinates. Emotional exhaustion also resides at the individual level and organisations should promote career identity in workers through training and development.

Wilk, S.L. & Moynihan, L.M. (2005). Display rule 'regulators': The relationship between supervisors and worker emotional exhaustion. *Journal of Applied Psychology*, *90(5)*, 917-927.

Work stress and attentional difficulties: An initial study on burnout and cognitive failures
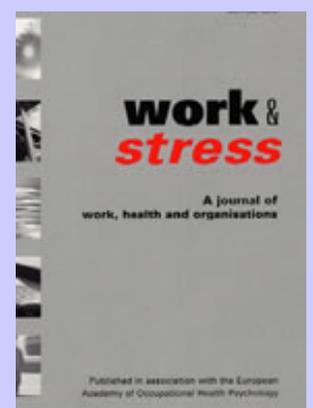
Burnout refers to a set of symptoms that an individual may develop during prolonged exposure to high levels of work stress and negatively affects perceived performance. There is little research on whether cognitive deficits are particularly present in clinical burnouts or can also be found in high (non-clinical) burnout employees. Burnout is accompanied with difficulties in the voluntary or executive control over attention. The authors examine whether burned-out individuals show difficulties in sustained attention and response inhibition. These two abilities are important aspects of executive control.

Objective measures of attentional deficits in controlled laboratory settings were carried out three groups (43 participants). The clinical group were participants who could no longer work and had sought professional help; the high (non-clinical) employees were working but had high burnout scores and the third was a no-burnout control group. Materials included burnout symptoms, self-reported cognitive failures in daily life, depressive

symptoms, Sustained Attention to Response Test (SART), The Bourdon-Wiersma (sustained attention) Test and self-reported performance measures.

- Severe burnout symptoms were associated with many self-reported cognitive failures.
- Participants with burnout symptoms did not adequately allocate attention to action.
- Cognitive deficits occur in employees who are still on the job but experience burnout symptoms. Thus the cognitive effects of burnout do not develop in discrete stages but rise in line with the severity of the main burnout symptoms.

Burnout is accompanied by objective changes in information processing. This finding provides insight into the potential difficulties that burned out individuals may experience. Treatment programmes for burnout might want to consider using methods that enhance executive control. Neuropsychological studies show several aids can support the high level control of attention and behavior.

Van der Linden, D., Keijsers, G.P.J., Eling, P. & Van Schaijk, R. (2005). Work stress and attentional difficulties: An initial study on burnout and cognitive failures. *Work & Stress, 19(1),* 23-36.

The Moderating role of Personality Characteristics on the relationship between Job Insecurity and Strain

Job insecurity involves the experiencing of a threat and implies a great deal of uncertainty regarding whether individuals get to keep their job in the future. It is associated with a number of detrimental consequences for both the individual and the organization. Little attention has been paid to the interaction between job insecurity and personality. The present study examines the moderating role of three personality characteristics (negative affectivity, positive affectivity and external locus of control) on the relation between job insecurity and outcomes (mental health outcomes, job dissatisfaction and job-induced tension).

Data was collected from nurses based in a hospital, which had recently undergone organizational change. There was a response rate of 71%. Most of the nurses were women (91%) and the mean age was 43 years. Questionnaire measures consisted of demographics, job insecurity, personality variables, negative affectivity, work locus of control, psychological strain, job dissatisfaction and job-induced tension.

The authors concluded that:

- There is a positive relationship between job insecurity and strain
- When controlling for personality disposition, the impact of job insecurity on mental health complaints was non-significant.
- Negative affectivity strongly predicts mental health complaints and job-induced tension.
- Those prone to external attributions tend to report higher levels of mental health complaints, job dissatisfaction and job induced tension.
- There was a significant interaction effect of job insecurity and external locus of control on mental health complaints.

These results show it is important to include personality in job insecurity research. This underscores the need for information on appraisal and coping with stress to be available to individuals in the workplace.

Naswall, K., Sverke, M. & Hellgren, J. (2005). The moderating role of personality characteristics on the relationship between job insecurity and strain. Work & Stress, 19(1), 37-4

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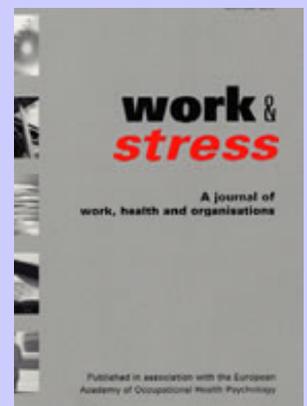
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A publication of the European Academy of Occupational Health Psychology

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Other articles

We welcome open letters to your fellow occupational health psychologists regarding any OHP-related topics, and summaries (in English) of OHP issues that have been reported by your national news media.

Please email your articles to
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