Perceived Stress, Mental Health Attitudes, Coping Strategies and the use of Employee Assistance Programmes in the Education Sector

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Abstract:

The quantative study considered possible effects of the presence of an EAP by comparing two groups in the Education Sector, with \((n=205)\) and without \((n=40)\) an EAP available to them.

A between groups survey design was used comprising the Perceived Stress Scale, Community Attitudes to Mental Illness and the Brief Cope. The research examined possible effects on levels of perceived stress and attitudes towards mental illness. The study also assessed gender differences in willingness to engage in the use of an EAP and the possible relationship between high levels of perceived stress and maladaptive coping style.

The study reported no significant differences existing with regard to willingness of use between genders. No significant differences were found in perceived stress levels and an ambiguous result was found in relation to attitudes to mental illness. Significant results were observed in the relationship between maladaptive coping styles and high perceived stress levels.
1. Introduction

In recent times, occupational stress has been reported to be on the increase (APA, 2011). Subsequently, there has been a rise in the Employee Assistance Programme (EAP) being offered by employers across Europe (Hopkins, 2005). There seems little empirical research available investigating the possible effects of the presence of social support in the form of the EAP on the employee.

With this in mind, the current study will investigate the effects of the presence of the Employee Assistance Programme (EAP) on a cohort of individuals working in the education sector. The study will compare a group which has access to an EAP (DIT) with a group which does not (NCIR). The aim of the study is to investigate whether the presence of the EAP will affect levels of perceived stress and attitudes to mental illness. A further aim includes investigating the relationship between coping strategies and perceived stress levels in the education sector and possible gender differences in willingness to use this form of social support.

1.1 Stress:

Stress can be described as ‘a negative emotional experience accompanied by predictable biochemical, physiological, cognitive and behavioural changes that are directed either toward altering the stressful event or accommodating its effects’ (Taylor, 2009, p.147). According to Dineen & McLeavey (1992) stress can be described as any change that one must adapt to, which might range from extreme physical danger to achieving long desired success.

There are many varying definitions of stress however, and stress as an experience, can be difficult to quantify, as it is different for each person. It is dependent to some extent, on
the individual’s perception of the stressor (Romano, 1992) among other things, making stress a highly subjective concept.

According to Lazarus & Folkman, (1984) stress can be considered in terms of an outcome of an individual’s appraisal processes. A person assesses whether they have the resources to meet the demands of their environment and if they feel that their resources are sufficient, they may deem the difficult event or situation as one that is not stressful. However, if the person believes that they do not possess the required resources, they may feel extremely strained by a situation.

Researchers Holmes & Rahe (1967) championed the stimulus approach of defining stress which suggests that external stressors, changes in life events or circumstances can cause stress in individuals. They suggested that when a person is faced with making a significant adjustment to the environment that the chances they will suffer stress as a result is high. Holmes and Rahe created an inventory of stressful life events called the Social Readjustment Rating Scale which reflects such stressful events, ranging from death of a spouse to events which are generally seen as positive in nature, such as Christmas or vacations. However, using a Stressful Life Events scale can cause difficulty. As Schroeder and Costa (1984) suggest individual differences are not considered. As Taylor (2009) points out, life events can mean entirely different things to different people, for example a divorce may be perceived as happiness and freedom to one person or an entirely negative experience to another.

Selye’s (1956, 1976) work is also of great importance when considering stress. Selye theorised that all stressors initiated the same physiological responses and conceived the concept of General Adaptation Syndrome. GAS consists of three phases; alarm, whereby the individual is instigated to meet the threat, resistance whereby the individual tries to deal with the threat and exhaustion, whereby the person has diminished resources as a result of failing
to overcome the threat. During times of stress, the brain induces physiological reactions which results in the activation of the hypothalamic-pituitary-adrenocortical (HPA) system (Amir et al, 2010). According to Selye (1956, 1976), during these times of stress, the hypothalamus releases corticotrophin releasing factor (CRF) which leads to the secretion of adrenocorticotropic hormone (ACTH) by the pituitary gland which as a result, activates the adrenal cortex to release corticoids including cortisol.

A major criticism of Selye’s theory is that it presumes that all people react to stress in a uniform way. There are many considerations when looking at variations in a person’s reactivity to stress and the resulting release of stress hormones. A recent study by Mirescu, C., Peters, J.D., Gould, E. (2004) found that maternal deprivation in rats produces abnormalities in the neuroendocrine functioning in the hippocampus. The hippocampus is a structure of the limbic system which plays a vital role in stress response, which contains high levels of glucocorticoid receptors and which is more vulnerable to long-term stress than most other brain areas (Joels, 2008). Mirescu et al (2004) found that adverse experiences in early life, diminishes the ability of the hippocampus to respond to stress in adulthood. Therefore, the individual response to stress may be as a result of past life events and not just as a result of current stressors. The biopsychosocial model must be adhered to when considering stress as a concept.

Regardless of the myriad of biological, psychological and social aspects which affect stress levels and reactivity to stress the fact remains that stress is highly subjective. As a result of this, it is generally accepted by many researchers that, in order to account for this fact, perceived stress is a more ideal way of measuring stress than instruments which measure the type of events that individuals have been exposed to. Cohen, Karamack and Mermelstein (1983) devised the Perceived Stress Scale. The questions used are general in nature and relatively free of content specific to any sub population group. This is a 14 item questionnaire
and refers to a subjective appraisal of events occurring within a one month time frame. The responses are rated using a Likert scale (0-4). The Perceived Stress scale will be used in this current study to investigate a possible relationship between perceived stress levels in the education sector and the presence of an Employee Assistance Programme.

1.2 Stress in the Workplace

According to Selye (1956), worker (or occupational) stress is no more than a simple reaction to stressful event in the work environment. Other researchers (French, Caplan, & Harrison, 1982) maintain that worker stress is a consequence of a lack of ‘fit’ between a person’s skills and abilities and the demands of the job.

The construct of occupational stress can be troublesome to define however. Clearly, occupational stress refers to stress that employees experience in the workplace, however it is the perception of stressful situations, the individual’s reactivity to stress and the level of predisposition to be stressed in each individual that causes problems in defining occupational stress (Greenberg, 1990).

Previous research conducted on occupational stress supports the notion that stressors can come from varying sources. Personal characteristics of the individual also play a part, such as anxiety levels, coping strategies, behaviour patterns such as whether or not they are Type A Personality (Greenberg, 1990). Other stressors refer to routine work stress, or those fundamental to the job, some to interpersonal stress and others refer to environmental stress of the work place (Steber, 1998).

Much research concludes that occupational stress has many undesirable outcomes such as psychological distress and negative health outcomes (Revicki & May, 1985; Repetti, 1993). High levels of stress are associated with chronic fatigue, anxiety and depression and may contribute to substance abuse in employees which in turn can lead to increased accident
rates (Wolf, 1986). Occupational stress is a major problem in western societies, where its relationship with various diseases is becoming increasingly obvious (Van der Hek & Plomp, 1997). These negative factors are not only psychological and health related outcomes but also financial. A recent study conducted by the Mental Health Commission in 2008 found that the cost of absenteeism in the workplace as a result of mental ill health, such as stress, in Ireland is 2% of GDP or €3 billion euro.

An even more recent study by the APA in 2011, found that as many as 36% of employees surveyed felt undervalued and stressed out at work. This study warned that occupational stress and a rise in mental health issues are emerging as principle social and occupational health concerns and could reach chronic levels in the coming years. According to the OECD (2011):

‘Increasing job insecurity and pressure in today’s workplaces could drive a rise in mental health problems in the years ahead. The share of workers exposed to work-related stress, or job strain, has increased in the past decade across the OECD. And in the current economic climate, more and more people are worried about their job security’ (pg.47).

Research suggests that rapidly changing conditions of work and employment, as employees have seen in recent years, have a negative effect on the psychological state of the workforce at large (Sauter et al, 1999).

There are many different occupations in the education sector, from administrative to technical to teaching, each one posing its own difficulties and stressors. Teaching is consistently identified as a particularly stressful job (Smith et al, 2000). Research shows that burnout is particularly high in the teaching profession (Burke, 1997). Aitken (2002) suggests that stress is a cause for many teaching staff leaving the profession altogether. These results
suggest that it is important to monitor stress levels and coping strategies of staff in the education sector. The current study will give an insight in to this.

Of course the on-going recession in Ireland has also undoubtedly caused an increase in stress levels for employees across most occupations, with layoffs causing increased role expectations and role uncertainty on those who remain in employment. A recent study conducted by Wirtz et al (2013) found that that occupational role stress, in terms of role uncertainty, acts as a background stressor that is associated with increased HPA-axis reactivity to acute stress, this in turn can lead to contribution to negative physical and mental health outcomes.

A recent study conducted in Northern Ireland which surveyed civil servants and published in the Journal of Occupational Medicine, revealed that work-related stress increased by 40 per cent during an economic downturn. It also suggested there was an increase of absenteeism due to stress to the tune of 25 per cent and total time off due to these types of psychological problems increased by more than a third during a slump (Houdmont, 2012).

1.3 Coping

In order to try to manage our stress, whether they are stressors in work or at home, we all adopt coping mechanisms. Samms, C. & Friedel, C.R., (2013) ask the question, do individuals attempt coping techniques in an effort to reduce stress? They suggest that individuals may adapt their behaviour through coping techniques and perform a style of coping outside of their norm. Riding & Sadler-Smith (1997) suggest that coping behaviours allow us to utilise our strengths and limitations in an optimal way.

Coping can be defined as ‘the thoughts and behaviours used to manage internal and external demands of situations that are appraised as stressful’ (Taylor, 2009, p.174). Coping
is a culmination of responses over time and is influenced by personality, genes and environmental factors.

What is it that determines a coping style in an individual? There are many determinants of coping strategies. Research suggests that, just as those who score highly on negative affectivity and neuroticism have more health issues, positive emotional styles have been correlated with lower cortisol levels, contribute to ability to cope, and fosters better mental and physical health overall. A study conducted by Brissette et al (2002) found that, having recorded measures of optimism, perceived stress, depression and social stress at both the beginning and the end of the first academic semester, those scoring high on optimism experienced less stress. Chang (1998) suggests that optimists view stressful situations in a less negative light and are more likely to make positive appraisals that they can deal with the stressor sufficiently.

Perceived control over a given situation is of great importance when considering the individual’s ability to cope. As Taylor (2009) states, it is ‘the belief that one can determine one’s own behaviour, influence one’s environment, and bring about desired outcomes’ (p.177). When people believe that they have a level of control of events that occur in their lives, they experience less stress and physical responses to stress are lowered. A study conducted by Friedman et al (1963) found that successful coping styles were associated with stable adrenocortical steroid excretion rates. Findings such as these can be related to employees, in that their ability to see stressors, such as increased work load, as events that are controllable, and could potentially affect their stress response both psychologically and physiologically.

Coping styles can also differ between Problem focused coping which involves the individual attempting to somehow change the stressful situation in a constructive manner and Emotion-focused coping which sees the individual trying to regulate the emotional effect of
the stressful situation. Emotion focused coping can lead to rumination which as Thomsen et al, (2004) suggests has negative effect on health outcomes. A far more constructive type of emotion focused coping is emotional approach coping whereby the person acknowledges and works through the emotions caused by the stressor. A study by Park & Adler (2003) found that individuals who used problem focused coping styles reported higher levels of wellbeing.

As well as general coping styles, research has also become more focused on more specific coping strategies. This type of analysis provides a more comprehensive view of how people manage the stressful situations which they encounter each day. Carver et al (1997) devised the Brief COPE to investigate the types of coping strategies different individuals use to deal with stressors in their lives. The Brief COPE scale, a condensed version of the COPE, is a 28 item self-reporting measure of both adaptive and maladaptive coping skills. The questionnaire is based on concepts of coping from Lazarus and Folkman (1984). Lazarus and Folkman (1984) posit that stress and subsequent appraisal of stress can change over time due to coping effectiveness, altered requirements, or changes in personal abilities. When an individual appraises a situation as threatening, the outcome is perceived as negative but the person will still try to master the circumstance. However, the individual is partly restricted in his or her coping capabilities, striving to restore his or her well-being. Lazarus and Folkman (1984) found that individual’s appraisals of stressful situations strongly predicted the type of coping strategies they would employ.

Adaptive strategies are active coping, planning, positive reframing, acceptance, humour, religion, using emotional support, and using instrumental support. Maladaptive coping includes self-distraction, denial, venting negative emotion, substance use, behavioural disengagement, and self-blame (Carver, 1997). Research conducted by Moore et al (2012) looked at family members of women substance abuser and their stress levels and coping mechanisms. They found a correlation between family member maladaptive coping style and
increased stress levels suggesting a possible link between the two. The current study will also investigate this link between coping styles and perceived stress levels.

The Brief Cope divides into 14 subscales; self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame. These 14 subscales are categorised into two groups, adaptive and maladaptive groups and is scored using a Likert scale (0-4).

As Carver (1997) suggests other more time-consuming measures have their pitfalls in that they create participant response burden, whereas the Brief Cope is condensed and less time-consuming and the participant is more likely to commit to involvement in the study. The current study will examine the relationship between the individuals perceived stress levels and type of coping strategies used in the education sector setting using the Brief Cope Scale. More specifically, the current study will investigate a possible correlation between maladaptive coping style and high levels of perceived stress.

1.4 Social Support and the Employee Assistance Programme

Social support is seen as one of the most relevant moderators in stress research (Bradley & Cartwright, 2002; Halbesleben, 2006). Studies show that social support is imperative in helping individuals cope with stressful events. The quality of support is also of importance as a study by Eisenberg et al (2007) found that those individuals with lower quality social support, as measured by the Multidimensional Scale of Perceived Social Support, were more likely to experience mental health problems, including a significant increase in depressive symptoms, compared with individuals who reported high quality social support.

When looking at the ways in which employee health may be affected by social support two models must be considered. These are the direct effects hypothesis of social support and the buffer model. The direct effects hypothesis posits that individuals who have
high levels of social support are generally in better health than those with low levels of social support, irrespective of stress levels (Cohen, 1985). Whereas the buffering model suggests that social support is protective and ‘buffers’ individuals from the stress of negative life events (Cohen, 1985). The buffer model prevails in work stress literature (Beehr, 1995; Bradley & Cartright, 2002).

There is a plethora of research looking at social support, in many forms and its effect on stress and coping ability in the workplace. A meta-analysis conducted by Viswesvaran et al in 1999 found that social support in the workplace has a positive effect on the strength of perceived threats, helps with coping with work related stress and lessens the strength of perceived stressors.

Recent research reveals that a more holistic view of employee wellbeing is emerging which includes an increased level of social support for the employee in the workplace. An example of such research could be seen in action during the Work, Stress and Health 2013: Protecting and Promoting Total Worker Health conference convened by the American Psychological Association in 2013, which focused on Total Worker Health. There is an acknowledgement that both work-based and non-work based issues have an impact on the individual’s wellbeing and that support systems, such as Employee Assistance Programmes, must be put in place to ensure the mental health of the workforce.

Employee Assistance Programmes (EAP) are becoming more popular in the workplace in recent years (Arthur, 2002). An EAP is a programme of counselling support and advice which provides assistance to employees when they are experiencing issues which are negatively affecting either work life or home life or both. The EAP is grounded in the humanistic model of Western organisational behaviour which emphasises the importance in providing tangible social support for staff members during times of stress, whether at home or in work (Bhagat et al, 2007). Arthur (2002) found that employees using EAPs were
experiencing significant mental health issues and that, employers providing such services were meeting a real need.

Despite the increased levels of stress in the work place, and the subsequent popularity of the EAP in western organisations, relatively little research exists regarding the effectiveness of EAPs (Weiss 1987). Counselling programmes pose many challenges in terms of evaluating effectiveness because it is difficult to evaluate which variables determine success (Mio & Goishi, 1988). The majority of research relating to the EAP looks at the cross-cultural context of implementation and maintenance of the EAP. The current research looks at whether or not, the mere presence of support such as an EAP in the workplace effects perceived stress levels and attitudes to mental health, as there is a lack of research in this area.

Another area of interest and one which the current study will address is participant willingness to use an EAP. Previous research suggests that women are more likely to receive more perceived social support than men (Cumsille and Epstein, 1994). Cumsille et al (1994) suggest that this may be because females are more willing to share their feelings than their male counterparts. Kendler, Myers and Prescott (2005) emphasized that the females have higher social support because they seek out emotional support as opposed to their males counterparts who only receive social support from their spouses. Another theory of gender differences in support-seeking behaviour suggests that the reasoning behind women seeking social support is as a result of evolution (Taylor et al, 2000). They suggest that the “fight-or-flight” response to a stressor is a more usual response of men than women, as perhaps they were more likely to encounter a predator. On the other hand women are more likely to “tend-and-befriend” when faced with threat. This suggests that the differences in genders and their propensity to seek out social support is biological in its basis.
Although many studies have considered demographics which include gender, among others (Blum & Roman, 1992; French et al, 1997) in terms of actual utilization of the EAP, there has been no such research which looks at gender as a predictor of willingness to use the EAP. As such, the current study will consider this question.

In this current study, employee attitudes towards the EAP will also be considered. Previous research suggests that concern that use of the EAP may have a negative effect on career and relationships with employers and colleagues is related to employee’s reluctance to use the service (Braun & Novak, 1986; Hall et al, 1991). The current study seeks to find if this still hold true and if employees are reluctant to use such a service, why this is so. This information could result in valuable data in terms of future application. Such information could be useful to employers in allaying any fears that the potential user may have in terms of confidentiality of the service.

Recent research suggests that the majority of EAP cases are employees suffering from psychological or emotional problems, and work-related problems (Macdonald et al., 2000; Mulligan, 2007). The current study will gather data in an attempt to assess if users of the EAP in the education sector setting are utilising the EAP for these reasons also.

1.5 Attitudes to Mental Illness

With mental health issues becoming more of an issue for both employees and employers, the question of attitudes to mental illness raises its head. Mental health issues are becoming more and more difficult to ignore in the workplace, and in society as a whole. Mental Health Ireland (2008) report that, one person in every three attending the family doctor has a mental health aspect to their medical problem and of those who live to sixty-five, one in nine will spend some time in mental health care. Mental illness touches the lives of most, either directly or indirectly.
As the prevalence of mental health issues continues to increase, have society’s attitudes become more favourable towards those suffering from mental illness or is stigma as present as ever? Stigma can be defined as

“a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental ill health. Stigma leads others to avoid living, socialising, or working with, renting to, or employing people with mental disorders -especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness’ (New Freedom Commission on Mental Health, 2003).

Research suggests that attitudes have improved over the years (Bhugra, 1989) however recent studies indicate that there is still very much a fear element and much misunderstanding around the topic of mental illness which continues to drive people’s negative perceptions.

In 2007 the Heath Services Executive (HSE) carried out a study called Mental Health in Ireland: Awareness and Attitudes, in an effort to gauge the public’s attitude to mental illness. This study found that 60% of adults would not want people knowing about it if they themselves were experiencing mental health problems and a large percentage also believe that people with mental health problems should not be employed in important positions such as healthcare. The study also found that fear of the unknown could be an influencing factor as one third of adults said that that they would find it difficult to talk to someone with mental health problems as they would not know what to expect.

The organisation See Change also conducted a study of 1,000 individuals in 2010 and found some startling results. Having asked about mental health in the workplace, they found that just 46 per cent felt that people who experience mental health problems should have the
same job rights as others. The workplace is considered a less accepting place for mental health problems with 48 per cent saying they would conceal their problem from colleagues and 57 per cent of full time workers believing that their mental health problem could have a negative effect on their job and career prospects. The current study builds on such research by considering if attitudes towards mental illness have changed in the workplace in recent years and also if the presence of an Employee Assistance Programme in the workplace has any bearing on these attitudes.

There are many options available when measuring attitudes to mental illness. One such measure is the Opinions about Mental Illness (OMI) questionnaire (Cohen & Struening 1962; Struening & Cohen 1963). This contains 51 items that measure attitude towards, and causes and treatment of, mental illness. There are 5 factors: (A) authoritarianism, (B) benevolence, (C) mental hygiene, (D) Social restrictiveness and (E) interpersonal etology. Each factor or dimension in the test is defined by a particular group of items. Responses to these items are rated from one (strongly agree) to six (strongly disagree) regardless of the direction (positive or negative) of the items.

The OMI has good construct validity and internal consistency and so Taylor and Dean (1981) built upon this to develop the “Community Attitudes to Mental Illness” (CAMI) scale. The scales represent dimensions including authoritarianism, benevolence, social restrictiveness, and community mental health ideology. The CAMI scale was tested by Taylor and Dear (1981) on a community in Toronto, Canada and the research establishes the consistency of the four scales and delivers strong evidence for the predictive validity of all four scales. The current study will employ the Community Attitudes towards Mental Illness (CAMI) scale to measure attitudes towards mental illness, in an education setting. The study will consider if the presence of an EAP in the workplace has an effect on these attitudes.
1.6 Research Objectives:

The first research objective hypothesis is to explore the differences in attitude towards mental illness between the two groups i.e. those with EAP available to them (Group A) and those without an EAP available to them (Group B).

H1: There will be a difference in attitudes to mental illness held among the two groups, with respect to the subscales of the Community Attitudes towards Mental Illness Scale (CAMI). It is predicted that Group A will demonstrate more favourable attitudes to mental illness than Group B.

The second research objective hypothesis is to explore the differences in perceived stress levels between Group A and B.

H2: There will be a difference in perceived stress levels between the two groups, with respect to the subscales of the Perceived Stress Scale (PSS). It is predicted that Group A will demonstrate lower levels of perceived stress than Group B.

The third research objective hypothesis is to explore the differences in willingness to use the EAP between genders.

H3: There will be a difference between gender groups and willingness to use the EAP. It is predicted that women will be more likely to engage in the possible use of EAP than men.

The fourth research objective hypothesis is to explore the relationship between perceived stress levels and coping strategies.

H4: There will be a significant relationship between levels of stress with respect to the subscales of the Perceived Stress Scale (PSS) and coping strategies with respect to the subscales of the Brief Cope Scale. It is predicted that those demonstrating higher stress levels will also demonstrate maladaptive coping strategies.
2. Methodology

2.1 Participants

A sample population was drawn from the education sector in Ireland and comprised of 245 employees. The participants consisted of employees of Dublin Institute of Technology (DIT) (n=205) and employees of National College of Ireland (NCIR) (n=40). The participants from DIT made up Group A i.e. those who did have an Employee Assistance Programme available to them and accounted for 83 per cent of the data collected and participants from NCI made up Group B i.e. those who did not have an Employee Assistance Programme available to them and accounted for 17 per cent of the data collected.

Both sample groups consisted of participants employed in various roles within the respective Institutes/Colleges within the education sector. Female participants accounted for 59 per cent (n=145) and male participants accounted for 41 per cent (n=100) of the sample. Participants were gained by a means of snowball sampling. Contacts in Human Resources Departments in various Education Sector Institutes, Colleges and Universities were approached by means of an explanatory e-mail. This email elicited information to ascertain if the Institute or college did or did not offer an EAP and if permission could be gained to survey staff members (Appendix 1). Permission was gained from both NCIR and DIT to conduct the survey. Recruitment of key contacts in these Institutes/Colleges led to further recruitment of colleagues of the contacts within the Institutes/Colleges.

2.2 Design

The design of this study is both quasi experimental and correlational. The groups participating are naturally occurring groups i.e. those who have an EAP available to them (DIT) and those who do not (NCIR). Comparisons relating to demographic information will
be made which also constitute naturally occurring groups. This study is a between groups survey design and it is a quantitative study.

The variables measured in this study are as follows:

**H1:** The independent variables are ‘group with EAP i.e. Group A’ and ‘group without EAP i.e. Group B’ (discrete). The participants are naturally occurring groups. The dependent variable is attitudes to mental illness.

**H2:** The independent variables are ‘group with EAP i.e. Group A’ and ‘group without EAP i.e. Group B’. The participants are naturally occurring groups. The dependent variable is levels of perceived stress.

**H3:** The independent variables are ‘male’ and ‘female’ i.e. gender class. The groups are naturally occurring. The dependent variable is willingness to use an EAP.

**H4:** The criterion variable is levels of perceived stress and the predictor variable is coping strategies. The design of the study relating to hypotheses one to three is quasi-experimental unlike hypothesis four which has a correlational design.

### 2.3 Materials

An online survey was devised using Google Docs and comprises of the following questionnaires:

1. **Perceived Stress Scale (Cohen et al, 1983).**

   The Perceived Stress Scale, devised by Cohen, Karamack and Mermelstein (1983) is a 14 item questionnaire which measures an individual’s perception of stress over a month time frame. For example, question one asks ‘how often have you been upset because of something that happened unexpectedly?’ The items refer to a subjective appraisal of events and whether or not the perception of the stress response may have an impact on health.
The following instructions were given to participants of the survey: *The following questions ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way*. The responses are rated using a Likert scale (0-4). In this case, the responses range from zero which corresponds to Never, to four which corresponds to Very Often. The scores for positively worded items are reversed (questions 4, 5, 7 & 8) when scoring and a total perceived stress level is calculated by totalling the scores for each question. The Perceived Stress scale was used in this current study to investigate a possible relationship between perceived stress levels in the education sector and the presence of an Employee Assistance Programme.

2. **The Brief Cope (Carver, 1997)**

Carver et al (1997) devised the Brief COPE to investigate the types of coping strategies different individuals use to deal with stressors in their lives. The Brief COPE Scale, a condensed version of the COPE Scale, is a 28 item self-reporting measure of both adaptive and maladaptive coping skills. For example items include such statements as ‘I’ve been turning to work or other activities to take my mind off things’. Participants of the survey were given the following instructions *These items deal with ways you've been coping with the stress in your life. Consider what you usually do when you're under a lot of stress*. The participant is then asked to rate on a Likert scale of between one and four, how much or how little they perform this behaviour. In this instance one on the scale coincides with ‘I haven’t been doing this at all’ and four coincides with ‘I’ve been doing this a lot’. There is no total score for this scale but the responses indicate how much a person uses a certain coping strategy. The questions correspond to 14 subscales; Self–distraction, Active coping, Denial, Substance Use, Use of emotional support, Use of instrumental support, Behavioural
disengagement, Venting, Positive Reframing, Planning, Humour, Acceptance, Religion and Self-blame. These 14 subscales are categorised in to two groups, adaptive and maladaptive groups. In order to shorten the length of the questionnaire the following subscales were omitted: Self-distraction, Venting, Humour and Religion.

3. Community Attitudes to Mental Illness (CAMI) (Taylor and Dean, 1981)

Taylor and Dean (1981) devised the “Community Attitudes to Mental Illness” (CAMI) scale in order to measure attitudes of people in the community towards the mentally ill. It is a 40 item questionnaire which includes items such as ‘The mentally ill should not be given any responsibility’. Participants are then asked to give an opinion on how they feel about the statement using a Likert scale of one (Strongly Disagree) to five (Strongly Agree). The participants of the survey were given the following instructions ‘The following questions relate to attitudes toward the mentally ill. Please indicate the answer which best represents your opinion’. The scale does not yield a total score but instead various dimensions of participants responses are represented such as Authoritarianism (questions 1 –10), Benevolence (questions 11 – 20), Social Restrictiveness (questions 21 – 30), and Community Mental Health Ideology (questions 31 – 40).

The current study will employ the Community Attitudes towards Mental Illness (CAMI) Scale to measure attitudes towards mental illness, in an education sector setting. The study will consider if the presence of an EAP in the workplace has an effect on these attitudes.

Further information was elicited from the participants using questions devised by the researcher. Participants were asked to confirm that they had given consent to take part in
the survey. Some demographic facts were requested such as gender and years employed in the College or Institute.

Further, more detailed information relating to the Employee Assistance Programme was requested also, such as the availability of an Employee Assistance Programme in the place of work. As well as a ‘Yes/No’ option, an option of ‘Unsure’ was included in order to ascertain if those who actually do have access to an EAP were aware of the fact. In order to investigate the levels of service use, a question to find out if participants who do have an EAP available to them, have used the service, was asked. For those who answered positively, further detail enquiring as to the reason was elicited. Five options were given as possible responses, including personal reasons, work related issues, managing money, retirement and keeping healthy.

In order to investigate the participants willingness to use the EAP, a question which asked if an EAP is offered, or was to be offered, by the employer would the participants make use of it if necessary, was included. For those who answered ‘No’ to this question, further information was required to investigate the reasoning for this. Three options were given as possible responses, which included ‘I would be concerned that my employer and colleagues would find out’/ ‘I do not think the service would be useful to me’/ ‘I can get the support I need from other sources’.

2.4 Procedure

The Human Resources Departments of 20 institutes/colleges in the education sector requesting information about whether or not they offered an EAP and if they would grant permission for employees to take part in the research. An introductory e-mail was sent (Appendix 1) outlining the research idea. Of those who responded, the majority did not give permission and those who did respond offered an EAP to their employees. Both NCIR and
DIT were among those contacted to see if permission to conduct the research could be granted. Written permission to forward the survey to prospective participants was received from both NCIR and DIT from the Human Resources Department contact. A link to the online survey, along with an informative email outlining the research (Appendix 2), informing participants of their right to withdraw from the study at any time and assuring them of complete confidentiality, was sent to my contacts in both colleges/institutes. The contacts subsequently forwarded an ‘all staff’ email to the employees of both colleges/institutes. The online link to the survey remained live for two weeks, after which time, the link was disabled and data received was assessed.
3. Results

The present investigation obtained a sample of 245 participants. Female participants accounted for 59% (n=145) and male participants accounted for 41% (n=100) of the sample. Participants from DIT accounted for 83% (n=205) of the sample and participants from NCIR accounted for 17% (n=40) of the sample. Table 1, below, represents demographic information and other related data elicited from participants of the study. The data illustrated below was gathered in an attempt to gain additional information, which may be of practical use to employer offering the EAP.

### Table 1: Demographic and related data

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender, %</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>100</td>
<td>41%</td>
</tr>
<tr>
<td>Female</td>
<td>145</td>
<td>59%</td>
</tr>
<tr>
<td><strong>Educational Institute/ College, %</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dublin Institute of Technology (DIT)</td>
<td>205</td>
<td>83%</td>
</tr>
<tr>
<td>National College of Ireland (NCIR)</td>
<td>40</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Years in employment with College/Institute, %</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2 years</td>
<td>26</td>
<td>11%</td>
</tr>
<tr>
<td>3-5 years</td>
<td>25</td>
<td>10%</td>
</tr>
<tr>
<td>6-10 years</td>
<td>62</td>
<td>25%</td>
</tr>
<tr>
<td>&gt;11 years</td>
<td>132</td>
<td>54%</td>
</tr>
<tr>
<td><strong>EAP offered in work place, %</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>152</td>
<td>62%</td>
</tr>
<tr>
<td>No</td>
<td>28</td>
<td>11%</td>
</tr>
<tr>
<td>Unsure</td>
<td>65</td>
<td>27%</td>
</tr>
<tr>
<td><strong>EAP service use, %</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>33</td>
<td>15%</td>
</tr>
<tr>
<td>No</td>
<td>192</td>
<td>85%</td>
</tr>
<tr>
<td><strong>If EAP service has been used, for what reason, %</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal issues</td>
<td>24</td>
<td>71%</td>
</tr>
<tr>
<td>Managing money</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Work related issues</td>
<td>9</td>
<td>26%</td>
</tr>
</tbody>
</table>
Retirement 1 3%
Staying healthy 0 0%

**Willingness to make use of service if offered, %**
Yes 154 65%
No 29 12%
Unsure 53 23%

**If no, reason for reluctance, %**
Fear of employer and colleagues finding out 33 60%
Does not think service would be useful to them 9 16%
Can get necessary support from elsewhere 13 24%

**Hypothesis One:**

The first research objective hypothesis was to explore the differences in attitude towards mental illness between the two groups i.e. those with EAP available to them (DIT), and those without an EAP available to them (NCIR).

Table 2: Differences in attitudes between employees of DIT and NCIR towards those suffering with mental illness as measured by the CAMI subscales

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Groups</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authoritarianism</td>
<td>DIT</td>
<td>21.57</td>
<td>5.15</td>
<td>1.75</td>
<td>220</td>
<td>0.12</td>
</tr>
<tr>
<td></td>
<td>NCIR</td>
<td>23.27</td>
<td>6.41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benevolence</td>
<td>DIT</td>
<td>17.98</td>
<td>5.48</td>
<td>1.63</td>
<td>213</td>
<td>0.13</td>
</tr>
<tr>
<td></td>
<td>NCIR</td>
<td>19.70</td>
<td>6.41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Restrictiveness</td>
<td>DIT</td>
<td>36.58</td>
<td>3.80</td>
<td>2.48</td>
<td>44.75</td>
<td>0.004</td>
</tr>
<tr>
<td></td>
<td>NCIR</td>
<td>34.28</td>
<td>5.44</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Mental Health Ideology</td>
<td>DIT</td>
<td>35.61</td>
<td>6.29</td>
<td>3.05</td>
<td>222</td>
<td>0.848</td>
</tr>
<tr>
<td></td>
<td>NCIR</td>
<td>32.02</td>
<td>6.83</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To investigate whether or not there was significant attitudinal differences between DIT participants and NCIR participants in relation to the Community Attitude toward Mental Illness scale (CAMI), an Independent t-test was used.

The results of the t-test analyses found that DIT employees and NCIR employees were not seen to have significantly differing attitudes with respect to the CAMI subscales of Authoritarianism ($t(220) = 1.75$, $p > .05$, 2-tailed) or Benevolence ($t(213) = 1.63$, $p > .05$, 2-tailed). An analysis of the means indicated that NCIR Authoritarianism score ($M = 23.27$, $SD = 6.41$) was higher than DIT Authoritarianism score ($M = 21.57$, $SD = 5.15$). These results suggest that NCIR employees hold the attitude that those with mental health issues need to be dealt with in a very strict manner, more so than DIT employees although the results were not significant. Mean NCI Benevolence score ($M = 19.70$, $SD = 6.41$) was higher than DIT Benevolence score ($M = 17.98$, $SD = 6.41$) indicating that NCIR employees have a more kind and understanding view of those with mental health issues, but again results were not significant in this regard. In terms of the subscales of Benevolence and Authoritarianism, we can reject the alternative hypothesis and we fail to reject the null hypothesis.

Significant differences between the groups were observed, however, for the Social Restrictiveness subscale ($t(44.75) = 2.47$, $p < .05$, 2-tailed), and the subscale of Community Health Ideology ($t(222) = 3.055$, $p < .05$, 2-tailed). Analysis of the mean scores show that DIT Social Restrictiveness score ($M = 36.58$, $SD = 3.80$) was higher than NCI Social Restrictiveness score ($M = 34.28$, $SD = 5.44$) suggesting that DIT employees reported higher levels of fear and mistrust of those with mental health issues. However, DIT Community Mental Health Ideology mean score ($M = 35.61$, $SD = 6.29$) was higher than NCI Community Mental Health Ideology score ($M = 32.02$, $SD = 6.83$) which indicates that DIT have a higher level of acceptance of the mentally ill in society. In terms of the subscales of
Community Mental Health Ideology and Social Restrictiveness subscales, as there was a statistically significant difference between the means (p<.05) we can reject the null hypothesis and accept the alternative hypothesis. Figure one below illustrates the significant results of this test.

Hypothesis Two:

The second research objective hypothesis is to explore the differences in perceived stress levels between participants from DIT and those from NCIR. It is hypothesised that there will be a difference in perceived stress levels between the two groups, with respect to the Perceived Stress Scale (PSS).
An Independent t-test was used to investigate whether or not there was a significant difference between the perceived stress levels of DIT participants and those of NCIR participants in relation to Perceived Stress Scale (PSS).

The results of the t-test analyses found that DIT employees and NCIR employees were not seen to have significantly differing levels of perceived stress ($t(209) = 0.43$, $p > 0.05$, 2-tailed). An analysis of the means indicated that DIT perceived stress levels ($M = 19.39$, $SD = 6.43$) were marginally higher than NCIR perceived stress levels ($M = 18.86$, $SD = 4.84$), (see figure 2), although the difference is not significant. Figure two above illustrates in the form of a bar chart, the mean difference between DIT and NCIR employees in the level of perceived stress as measured by the Perceived Stress Scale. As the results of the test were not statistically significant, ($p > .05$), we must reject the alternative hypothesis and fail to reject the null hypothesis.
Hypothesis Three:

The third research objective hypothesised is that there would be a difference in willingness or potential use of the EAP between different genders. Figure three below illustrates the differences between genders in willingness to use the EAP. A chi-square test for association was conducted between gender and willingness to use the EAP. All expected cell frequencies were greater than five. There was not, however, a statistically significant association between gender and willingness to use the EAP, $X^2(1) = 1.962$, $p = 0.375$. As the results of the test were not statistically significant, ($p > .05$), we must reject the alternative hypothesis and fail to reject the null hypothesis.

![Bar Chart illustrating differences between genders in willingness to use an EAP](image)

Hypothesis Four:

The fourth research objective hypothesis was to explore the relationship between perceived stress levels and coping strategies. It was hypothesised that there would be a significant relationship between levels of stress with respect to the subscales of the Perceived
Stress Scale (PSS) and coping strategies with respect to the subscales of Adaptive Coping and Maladaptive Coping of the Brief Cope Scale. It was predicted that those who reported higher perceived stress levels would also report a maladaptive coping mechanism.

Table 3: Correlation table displaying relationships between coping styles and perceived stress levels

<table>
<thead>
<tr>
<th>Variable</th>
<th>Adaptive Coping</th>
<th>Maladaptive Coping</th>
<th>Total Perceived Stress Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Coping</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maladaptive Coping</td>
<td>0.097</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Perceived Stress Level</td>
<td>0.059</td>
<td>0.588**</td>
<td></td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).

Preliminary analyses showed the relationship between maladaptive coping and stress levels to be linear. In order to explore the relationship between the above mentioned variables, a Pearson Correlation test was conducted. There was a strong positive correlation between maladaptive coping strategies and perceived stress levels in participants, $r = .588$ (see table three above). These results suggest that high levels of perceived stress levels can be paired with maladaptive coping styles. As there was a statistically significant relationship between perceived stress levels and maladaptive coping styles, we can reject the null hypothesis and accept the alternative hypothesis in this instance.
4. Discussion

4.1 Aim

The aim of the current study is to investigate the effects of the presence of the Employee Assistance Programme (EAP) on a cohort of individuals working in the education sector. The cohort consists of two groups within the education sector in Ireland. One group have access to an EAP through their place of work (DIT) and the other group do not (NCIR).

An objective of the current research is to assess whether or not, the mere presence of social support in the form of an EAP in the workplace, affects perceived stress levels and attitudes to mental health. Previous research suggests that social support is seen as one of the most relevant moderators in stress research (Bradley & Cartwright, 2002; Halbesleben, 2006). A meta-analysis conducted by Viswesvaran et al in 1999 found that social support in the workplace has a positive effect on the strength of perceived threats, helps with coping with work related stress and lessens the strength of perceived stressors. There is a distinct lack of recent research conducted to assess the possible effects of the existence of social support in the workplace, and none specific to social support in the form of the EAP. Therefore it is evident that more research needs to be done in this area.

Furthermore, leading on from research conducted by Eisenberg et al (2007) which posits that those individuals with lower quality social support, are more likely to experience mental health problems, compared with individuals who reported high quality social support it seems appropriate to consider the possible impact of high quality support in the form of the EAP, with this previous research in mind.

A further objective of the study includes investigating the relationship between coping strategies and perceived stress levels in the education sector. A study conducted by Friedman et al (1963) found that successful coping styles were associated with stable adrenocortical
steroid excretion rates and subsequently lower stress levels. More recent research (Carver, 1997) focused more on specific coping styles such as maladaptive and adaptive coping styles. As a result of research such as this, one of the aims of the current study is to examine a possible correlation between maladaptive coping styles and higher perceived stress levels in an Irish education sector setting.

Another aim of the study was to consider the willingness of participants to use the EAP in terms of gender. Previous research suggests that gender differences in support-seeking behaviour exist (Taylor et al., 2000). Leading on from this, the current study aims to identify if women are more willing to engage in social support in the form of the EAP.

Also, studies show that employers are dissatisfied with the level of uptake from staff in terms of EAP use, with the idea that using the EAP may affect career and work relationships negatively being the main concern of prospective users (Braun & Novak, 1986; Hall et al., 1991). The current study seeks to find if this concept of negative effect is still an issue for those who offer this form of support to their employees by investigating the possible reasons for the reluctance to use such a service.

A further aim of the study was to consider reasons for use of the EAP, as opposed to non-use and assess whether or not the reasons correlate with previous research findings.

4.2 Findings

Hypothesis One:

To investigate whether or not there was significant attitudinal differences between DIT participants and NCIR participants in terms of the Community Attitude toward Mental Illness scale (CAMI), an Independent t-test was used. It was hypothesised that DIT would demonstrate more favourable attitudes to mental illness than NCIR employees.
The findings suggested that DIT employees and NCIR employees were not seen to have significantly differing attitudes with respect to the CAMI subscales of Authoritarianism or Benevolence. Significant differences between the groups were observed, however, for the subscale of Social Restrictiveness and the subscale of Community Health Ideology. Analysis of the mean scores show that DIT Social Restrictiveness score was higher than NCI Social Restrictiveness score suggesting that DIT employees reported higher levels of fear and mistrust of those with mental health issues. However, DIT Community Mental Health Ideology mean score was higher than NCI Community Mental Health Ideology score which indicates that DIT show a higher level of acceptance of the mentally ill in society.

These findings only partially support the hypothesis that DIT participants will exhibit more favourable attitudes towards the mentally ill. These findings do not adhere to the idea that the presence of an EAP in the workplace, have an effect on attitudes to mental illness in any significant way. As there is no empirical research specific to this hypothesis, that the researcher could find, no interpretation with relation to previous research can be discussed.

**Hypothesis Two:**

In order to assess if there would be a difference in perceived stress levels between the two groups, with respect to the subscales of the Perceived Stress Scale (PSS) an Independent t-test was used. It was predicted that NCIR participants would demonstrate higher levels of perceived stress than DIT participants, as DIT participants have access to high level social support in the form of the EAP.

The findings of the study suggested that DIT employees and NCIR employees did not have significantly differing levels of perceived stress and an analysis of the means indicated that DIT perceived stress levels were only slightly higher than NCIR perceived stress levels. As a result, the hypothesis cannot be supported in this instance. The findings do not suggest
that the presence of an EAP have a significant bearing on the perceived level of stress in the workplace. These results are not consistent with a meta-analysis of previous research which suggests that social support in the workplace has a positive effect on levels of perceived stress (Viswesvaran et al, 1999).

**Hypothesis Three:**

The third research objective hypothesis was to explore the differences in willingness to use the EAP between different genders. It was hypothesised that there would be a difference between gender groups and willingness to use the EAP. More specifically, it was predicted that women would be more likely to engage in the use of EAP than men. A chi-square test for association was conducted to investigate this hypothesis. There was not, however, a statistically significant association between gender and willingness to use the EAP as predicted, therefore the hypothesis could not be supported.

These findings are not consistent with previous research which suggests that women are more likely to receive more perceived social support than men as posited by Cumsille and Epstein (1994). The findings are also not consistent with previously discussed research by Kendler et al (2005) and do not subscribe to research conducted by Taylor (2000) which posits gender difference in social support seeking behaviour.

**Hypothesis Four:**

The fourth research object was that there would be a significant relationship between levels of stress with respect to the subscales of the Perceived Stress Scale (PSS) and coping strategies with respect to the subscales of the Brief Cope Scale. Specifically, it was predicted that those demonstrating higher stress levels will also demonstrate maladaptive coping strategies.

In order to investigate the above mentioned hypothesis, a Pearson Correlation test was conducted. There was a strong positive correlation between maladaptive coping
strategies and perceived stress levels in participants, which suggests that high levels of perceived stress levels can be paired with maladaptive coping styles. In this instance the hypothesis was supported, as there a statistically significant relationship between perceived stress levels and maladaptive coping styles was found to exist. These findings are consistent with previous research, as conducted by Moore et al (2012) which found a correlation between family member maladaptive coping style and increased stress levels in families of women substance abusers.

Other Findings:

As mentioned above, previous studies show that there is a reluctance among many employees in using the EAP. Research suggests that negative effect on career and work relationships, is a main concern of employees (Braun & Novak, 1986; Hall et al, 1991). The current study is in keeping with these findings. The additional information requested by the researcher included a question which targeted those who were reluctant to use the EAP and elicited information as to why they felt this way. The options for response as to why they would not be willing to use the EAP included:

1. I would be concerned that my employer and colleagues would find out
2. I do not think it would be useful to me
3. I can get the support I need from other sources

The findings of the current study were that 60 per cent of those who answered were concerned about employee and colleague negative effect. These are interesting findings and have implications for practical use, which will be discussed later.

Further findings of the study were of interest and also in agreement with previous research conducted in the area. Recent research found that the main reasons for use of the EAP were emotional or personal problems and work related issues (Macdonald et al 2000;
Mulligan, 2007). The findings of the current study show similar results. The current study asked participants to state the reason for having used the EAP in the past. They were given the following options as potential answers:

1. Personal issues
2. Managing money
3. Work related issues
4. Retirement
5. Staying healthy

The current study found that 71 per cent of those who had used the EAP had used it for personal (i.e. emotional/psychological) reasons and 26 per cent had utilised the service for work related issues.

4.3 Limitations:

The extent of the inequality in comparison groups in the current study may be considered a limitation of the study. The current study gained 205 participants from DIT and only 40 participants from NCIR. This caused a large imbalance in comparison groups. Bearing in mind the difference in size of the two institute’s this is not surprising however. An issue which arose was time constraint, in terms of NCIR actually allowing the survey link to go live. If more time had been allowed, it is possible that the number of participants would have been greater.

Initially it had been hoped that permission to conduct the research would be granted by more than one education sector institute or college in order to increase the sample of those in the group who did not have access to an EAP. Unfortunately, all of the institutes or colleges who replied to the initial email (Appendix 2) either would not allow access to the participants or did offer an EAP. Future researchers should consider using more equally sized institutes in order to avoid this limitation.
A further limitation of the study was that not all demographic and related information elicited from the participants was used in the study. More consideration to the type of information requested should have made. In fact, requesting the age of the participant was not the demographic information rather than length of time in the job, would have been more appropriate. Previous research has looked at whether age is a factor in employee’s willingness to use the EAP and it would have been interesting to assess if the same was found in this study in an Irish education sector setting.

4.4 Future Research

Future researchers may consider looking at specific job roles in the education sector in terms of stress levels and possibly targeting the potential use of the EAP at specific groups. For example, as previously mentioned teaching is consistently identified as a particularly stressful job (Smith et al, 2000) and burnout is particularly high in the teaching profession (Burke, 1997). Aitken (2002) suggests that stress is a cause for many teaching staff leaving the profession altogether. It may be of interest to future researchers to see if there is indeed an increased level of stress in these particular jobs within the sector with a view to ensuring that individuals in these professions make full use of the social support on offer to them in their place of work, before as Aitken (2002) says, they leave the job.

Future researchers may also wish to consider additional variables where stress and coping are concerned, such as measuring well-being and/or self-efficacy in order to gain a more in-depth picture of the interactions between the variables which this study looks at. As the relationship between stress and coping is more complex than this study suggests.

In light of research carried out for this study, the area of attitudes to mental illness in the workplace is a topic which warrants further investigation. Although the current study does not delve in any in-depth level in to the area, mental illness stigma in the workplace has far
reaching affects and needs addressing. As results from the current study found, the main reason given for non-utilisation of the EAP was fear of colleagues and employers finding out that they were using the service, fear of negative affect.

Research in to this area conducted in 2007 by the Heath Services Executive (HSE) found that 60 per cent of adults would not want people knowing about it if they themselves were experiencing mental health problems and a large percentage also believe that people with mental health problems should not be employed in important positions such as healthcare.

It would be interesting to consider if the same attitudes to mental health are prevalent in the education sector. The CAMI, while useful for determining attitudes to mental illness in general, is not specific enough to gauge employee’s attitudes to colleagues with mental health issues. With this in mind, using similar questionnaires as the HSE study used to elicit this information may be a worthwhile endeavour.

4.5 Strengths and future applications:

A strength of this research is that it investigates the possible impact of social support in the workplace, specifically the EAP, and considers possible differences between groups who have this high level social support available to them and those who do not. There is little or no research conducted investigating the presence of the EAP on employees and certainly none specific to the education sector in Ireland. This research may ignite interest in further investigation in to the possible effects of the presence of social support in the work place.

The findings in relation to the possible reasons why potential users do not engage in the EAP is particularly interesting and has implications for employers who offer the EAP. The knowledge gained from the study which suggests that 60 per cent of those who are unwilling to use the service as a result of fear that colleagues and employers would find out, is vital. Employers can potentially use this information to ensure that their employees are
fully aware of the high level of confidentiality offered by the service. It is important that an attempt by employers to address such fears is made, if the EAP is to be made full use of by employees.

Also findings which suggest that the main reason for EAP use is personal issues are also relevant. Arthur (2002) found that employees using EAPs were experiencing significant mental health issues and that, employers providing such services were meeting a real need. That is why the results of the current study, which suggest that that a significant number of staff using the EAP are dealing with issues such as depression, anxiety and relationship issues every day in the workplace, are important. The need, however, is there to reach those who are dealing with these issues but are not using the service available to them. The practical application of these findings could be increased advertising promoting the use of the EAP in the workplace and open discussion initiated by management about its advantages.

Although significant results were not found in relation to attitudinal differences with regard to mental illness between the two groups, the topic itself is of importance, as mentioned above. Both groups were found to have quite high scores on the negative aspects of the CAMI, the subscales of Community Mental Health Ideology subscale and the Social Restrictiveness Subscale. The fact that the presence of an EAP has not significant bearing on attitudes towards mental illness is interesting. A possibility for this is the levels of stigma associated with mental illness.

As previously mentioned, See Change is an alliance of organisations working together through the National Stigma Reduction Partnership to challenge public attitudes and behaviour towards people with mental health problems. The organisation offers free facilitated seminars for staff in any organisation in an attempt to initiate conversation about mental health. They also promote initiatives such as Green Ribbon Day in the workplace to
do the same. A practical application of the findings of the current study regarding attitudes to mental health would be for employers to engage in such initiatives in an attempt to reduce stigma of mental illness and thereby possibly changing the views of those who report unwillingness to use the EAP.

4.6 Conclusion

In conclusion, this research proposed to examine the possible effects of the presence of an Employee Assistance Programme in the workplace. The study investigated the possible differences between two groups, those who have an EAP available to them (DIT) and those who do not (NCIR) in terms of attitude towards those suffering with mental illness. The study found no significant differences between the groups on the subscales of Benevolence and Authoritarianism, but a significant difference between the groups on the subscales of Social Restrictiveness and the subscale of Community Health Ideology. The findings were ambiguous as DIT showed more favourable attitudes on the Community Health Ideology subscale and less favourable attitudes on Social Restrictiveness.

The study found no significant differences between the groups in terms of perceived stress levels, however an analysis of the mean showed that DIT had higher perceived stress levels. This suggests that the presence of high level social support in the workplace, in the form of the EAP had no tangible positive effect in terms of perceived stress levels. The study also considered gender differences in relation to willingness to engage with the EAP, however, found no significant differences in this respect which is not in agreement with previous research.

Finally, the study found a significant result when investigating the possible relationship between maladaptive coping styles and elevated perceived stress levels, which is in agreement with previous research in the area.
It is hoped that this study raises some thought provoking questions in relation to the possible effects of EAPs in the workplace, as they are becoming more and more prevalent in the workplace.
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Appendix 1:

First e-mail sent to Institutes, Colleges and Universities in the Education Sector

Dear xxx,

I am a Dublin Institute of Technology Human Resources staff member and I’m also currently completing the final year of a BA in Psychology part time. For my final year project I will be making a comparison between Institutes/ Universities in the Education Sector that offer an Employee Assistance Programme with those who do not. An Employee Assistance Programme offers support to the employee, in the form of counselling, whose work performance and health and well-being is being adversely affected by personal or work-related issues. I will be looking at differences in employee attitudes towards mental health and perceived stress levels. I then hope to delve a little deeper in to the companies who do offer EAPs and look at coping styles and willingness to engage in EAPs.

Could you possibly let me know the following:

*Does the Institute/University by which you’re employed offer an Employee Assistance Programme or any type of counselling service or Occupational Health service for staff members?*

*If so, is it internally run or externally run?*

*If it’s externally run, by which company?*

*Would your organisation give me permission to send a survey to you, to be forwarded to staff members in order to ascertain attitudes to mental health, perceived stress and coping styles?*

Please bear in mind that the information collected in the survey will be treated in the strictest confidence, and will only be used to produce statistical tables, it will not be possible to identify the responses of any individual from the results produced. I would be hugely grateful if you could assist me with this, or point me in the right direction as to who may be able to.
Appendix 2:

*Introductory E-mail sent to participants with link to survey:*

Good afternoon,

I am a Dublin Institute of Technology Human Resources staff member and I’m also currently completing the final year of a BA in Psychology, part time. For my final year project I will be making a comparison between institutes/ colleges in the Education Sector that offer an Employee Assistance Programme with those who do not. An Employee Assistance Programme offers support to the employee, in the form of counselling, whose work performance and health and well-being is being adversely affected by personal or work-related issues. I will be looking at differences in employee attitudes towards mental health, perceived stress levels and coping strategies.

I would be very grateful if you would complete the survey, which can be accessed by clicking [https://docs.google.com/forms/d/1uJ-GbCZY_KQgdj3kxioAshXVGl3Qbl3dlV3MeaKgf6M/viewform](https://docs.google.com/forms/d/1uJ-GbCZY_KQgdj3kxioAshXVGl3Qbl3dlV3MeaKgf6M/viewform)

The survey should take in the region of 10 minutes to complete. You do not have to participate in this survey if you do not wish to, however please bear in mind that the information collected in this survey will be treated in the strictest confidence, and will only be used to produce statistical tables, it will not be possible to identify the responses of any individual from the results produced.

I would very much appreciate your cooperation with this survey. If you have any queries, or require any further information, please do not hesitate to contact me at the following e-mail address
Appendix 3:

Survey compiled using Google Docs and which includes the Perceived Stress Scale, the Brief Cope and the Community Attitudes to Mental Illness scale. The survey also includes additional demographic and related questions.

Section A.

Please answer the following questions by ticking the appropriate boxes.

1. Do you give your consent to participate in this questionnaire? *
   - Yes
   - No

2. Gender *
   - Male
   - Female

3. Which of the following Educational Institutes/Colleges are you employed by *
   - Dublin Institute of Technology
   - National College of Ireland

4. How many years are you in employment with the Institute/College
   - 0 - 2 years
   - 3 - 5 years
   - 6 - 10 years
   - > 11 years

5. Is an Employee Assistance Programme (EAP) offered to you in your place of work? *
   NOTE: An Employee Assistance Programme is a confidential counselling and information service run by an outside organisation such as VHI.
   - Yes
   - No
   - Unsure

6. If an EAP is available to you, have you ever used the service
   - Yes
   - No

7. If you answered yes to question 6, please indicate the reason for using the service
   Tick as many boxes as apply
Personal issues (e.g. dealing with stress, anxiety, relationship issues)
Managing money
Work related issues
Retirement
Staying healthy

8. If your employer offers, or was to offer an EAP, would you be willing to make use of the service if necessary?
☐ Yes
☐ No
☐ Unsure

9. If you answered no to question 8, which of the following would best describe your reluctance to use an EAP?
☐ I would be concerned that my employer and colleagues would find out
☐ I do not think it would be useful to me
☐ I can get the support I need from other sources

Section B.
The following questions ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. 0 = never; 1 = almost never; 2 = sometimes; 3 = fairly often; 4 = very often

1. In the last month, how often have you been upset because of something that happened unexpectedly?

2. In the last month, how often have you felt that you were unable to control the important things in your life?

3. In the last month, how often have you felt nervous and stressed?
4. In the last month, how often have you felt confident about your ability to handle your personal problems?

0 1 2 3 4

5. In the last month, how often have you felt that things were going your way?

0 1 2 3 4

6. In the last month, how often have you found that you could not cope with all the things you had to do?

0 1 2 3 4

7. In the last month, how often have you been able to control irritations in your life?

0 1 2 3 4

8. In the last month, how often have you felt that you were on top of things?

0 1 2 3 4

9. In the last month, how often have you been angered because of things that happened that were outside of your control?

0 1 2 3 4

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

0 1 2 3 4

Section C.

These items deal with ways you've been coping with the stress in your life. Consider what you usually do when you're under a lot of stress. 1 = I haven't been doing this at all; 2 = I've been doing this a little bit; 3 = I've been doing this a medium amount; 4 = I've been doing this a lot

1. I've been concentrating my efforts on doing something about the situation I'm in.

1 2 3 4
2. I've been saying to myself: "this isn't real."
   1  2  3  4

3. I've been using alcohol or other drugs to make myself feel better.
   1  2  3  4

4. I've been getting emotional support from others.
   1  2  3  4

5. I've been giving up trying to deal with it.
   1  2  3  4

6. I've been taking action to try to make the situation better.
   1  2  3  4

7. I've been refusing to believe that it has happened.
   1  2  3  4

8. I've been getting help and advice from other people.
   1  2  3  4

9. I've been using alcohol or other drugs to help me get through it
   1  2  3  4

10. I've been trying to see it in a different light, to make it seem more positive.
    1  2  3  4

11. I've been criticizing myself.
    1  2  3  4
12. I've been trying to come up with a strategy about what to do.
   1 2 3 4

13. I've been getting comfort and understanding from someone.
   1 2 3 4

14. I've been giving up the attempt to cope.
   1 2 3 4

15. I've been looking for something good in what is happening.
   1 2 3 4

16. I've been accepting the reality of the fact that it has happened
   1 2 3 4

17. I've been trying to get advice or help from other people about what to do.
   1 2 3 4

18. I've been learning to live with it.
   1 2 3 4

19. I've been thinking hard about what steps to take.
   1 2 3 4

20. I've been blaming myself for things that happened
   1 2 3 4

Section D.
The following questions relate to attitudes toward the mentally ill. 1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

1. The mentally ill should not be given any responsibility
   1 2 3 4 5
   - - - - -

2. The mentally ill should be isolated from the rest of the community
   1 2 3 4 5
   - - - - -

3. A woman would be foolish to marry a man who had suffered from a mental illness, even though he seems fully recovered.
   1 2 3 4 5
   - - - - -

4. I would not want to live next door to someone who had been mentally ill.
   1 2 3 4 5
   - - - - -

5. Anyone with a history of mental problems should be excluded from taking public office.
   1 2 3 4 5
   - - - - -

6. The mentally ill should be denied their rights
   1 2 3 4 5
   - - - - -

7. Mental patients should be encouraged to assume the responsibilities of normal life.
   1 2 3 4 5
   - - - - -

8. No one has the right to exclude the mentally ill from their neighbourhood.
   1 2 3 4 5
   - - - - -

9. The mentally ill are far less dangerous than most people suppose.
   1 2 3 4 5
   - - - - -

10. Most women who were once patients in a mental hospital can be trusted as babysitters.
11. One of the main causes of mental illness is a lack of self discipline and will power.

12. The best way to handle the mentally ill is to keep them behind locked doors.

13. There is something about the mentally ill that makes it easy to tell them apart from normal people.

14. As soon a a person shows signs of mental disturbances, he should be hospitalized

15. Mental patients need the same kind of control and discipline as a young child.

16. Mental illness is an illness like any other.

17. The mentally ill should not be treated as outcasts from society.

18. Less emphasis should be placed on protecting the public from the mentally ill.

19. Mental hospitals are an outdated means of treating the mentally ill.

20. Virtually anyone can become mentally ill.
21. The mentally ill for too long have been the subject of ridicule.

22. More tax money should be spent on the care and treatment of the mentally ill.

23. We need to adopt a far more tolerant attitude toward the mentally ill in our society.

24. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.

25. The mentally ill don't deserve our sympathy.

26. The mentally ill are a burden on society.

27. Increased spending on mental health services is a waste of tax money

28. There are sufficient existing services for the mentally ill.

29. It is best to avoid any one who had mental problems.

30. We have a responsibility to provide the best possible care for the mentally ill.
31. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.

32. The best therapy for many mental patients is to be part of a normal community.

33. As far as possible, mental health services should be provided through community based facilities.

34. Locating mental health services in residential neighbourhoods does not endanger local residents.

35. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.

36. Mental health facilities should be kept out of residential neighbourhoods.

37. Local residents have a good reason to resist the location of mental health services in their neighbourhood

38. Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great.
39. It is frightening to think of people with mental problems living in residential neighbourhoods.

   1  2  3  4  5
   ☐ ☐ ☐ ☐ ☐

40. Locating mental health facilities in a residential area downgrades the neighbourhood.

   1  2  3  4  5
   ☐ ☐ ☐ ☐ ☐

Thank you!

Thank you for taking the time to complete the questionnaire. It is very much appreciated. If any of the statements have had an effect on you and you wish to talk to somebody about it, here are the numbers of some organisations which may be able to help: Samaritans: 1850 60 90 90 Aware: Lo Call 1890 303 302 If you have any questions regarding this survey, please contact