



BULLETIN OF THE International Institute Of Organizational Psychological Medicine (IIOPM)



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**A Bulletin devoted to promoting positive mental health,
research and awareness in the field of Organizational
Psychological Medicine**

The Institute applies psychological medicine principles to the human elements in the
work place and combines the specialties of Psychological Medicine, Administration and
Management

The paradigm shift in Human Capital Management and Potential Enhancement

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THE IIOPM BULLETIN

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Editorial

Professor Srikanth Nimmagadda, The IOPM, United Kingdom
Dr Avinash De Sousa, The IOPM, India

The editors are extremely pleased to bring out the second edition of the bulletin of the International Institute of Organisational Psychological Medicine (IOPM). It is our intention, as the editors of this bulletin, to produce a globally contributed and globally relevant collection of articles, which comprehensively covers major themes comprising the field of organisational psychological medicine.

The IOPM was established in Australia and USA and has now expanded globally. The main objective of the IOPM is to enhance the potential of human capital in the organisations and intends to achieve this by preventing, identifying, and managing workplace related psychological pathologies in the human capital. The IOPM bulletin aims to promote and exchange ideas, theories and to develop the discipline of organisational psychological medicine in diverse organisations across the globe. The Institute's objective is also to raise the awareness of various aspects of the human capital management and productivity. It is our sincere hope that the field of organisational psychological medicine becomes the embracing and internationally recognised field as it develops into a global arena for science and practice over the next few decades.

Human capital is the most important resource of an organisation and it plays a pivotal role in the success of the organisation. It is the sum total of individual intelligence built on acquisitional skills, training and education, and experience for a lifetime. It is the application of this human knowledge to the workplace that creates real value and enhances productivity. Harnessing the human capital – the accumulated skills, experience, wisdom and capabilities of all the people employed in the organisation is fundamental to success and increasing the productivity of any organisation.

Bartlett and Ghoshal, in their book '*The Individual Corporation*' argue that the old corporate model orientated around strategy, structure and systems is now undergoing the process of rebirth as human capital replaces financial capital as the key strategy. The new model will be built around purpose, people and process. Human capital enhancement has become an issue of strategy importance for most of the organisations, leading more people to engage in high quality, lifelong learning is not just a nice option, it is now a business sustainability requirement. Investing in human capital produces better business returns. It provides cost savings and efficiencies, maximises the use of available resources and addresses specific performance productivity issues.

The psychological health of human capital in organisations can be impacted by the workplace and beyond. Poor psychological health results in poor outcomes in terms of the performance of both an organisation and its staff. Various studies of burn out and demoralisation of the human capital concluded that psychopathological sequelae resulted in the decreased efficiency and productivity of the workforce. Other studies have concluded that embitterment in the work place resulted in psychopathological embitterment post-traumatic stress disorder. This sets into motion a vicious cycle, i.e., workplace-related psychiatric pathology impacts on outcomes and also results in recruitment difficulties and poor retention of staff. These in turn negatively affect the need for good talent management for increased productivity in the organisations.

The Institute has established active academic links with various renowned universities and organisations across the globe and continues to expand in various parts of the world. The Institute has already a memorandum of understanding (MoU) with a range of academic institutions and Healthcare Universities in USA, India and Australia. The Institute also reached a memorandum of understanding (MoU) with Cheswold Park Hospital, a prestigious psychiatric hospital in Doncaster, UK.

The branch of Organisational Psychological Medicine's scope of practice expands from the diagnosis and management of work place-related psychological disorders to the added sphere of preventive psychological medicine, resilience and positive psychological medicine applied to the human capital within organisations. These include population health initiatives of developing programs that will enhance the outcomes of human capital of organisations. Thus, the discipline benefits the bottom line of both the individual and the organisation. It also broadens its horizons to encompass corporate social responsibility in this area and leadership along with the enhancement of human capital.

We are delighted to highlight some of the work and initiatives undertaken by the institute and the future plans in the next few paragraphs.

Over the past year, the institute has held human capital management meetings in Leicester (UK) and Kolkata (India) and has received a tremendous response and interest from various psychiatrists, senior managers, and doctors from other specialities. The IOPM faculty members were also invited to contribute in the symposium at the BIPA Conference, Leicester (UK) in June 2016. Professor De Souza talked about the paradigm shift in human capital management using a dynamic organisational psychological medicine approach. The other speakers talked about burn out and the essential role of emotional intelligence in enhancing productivity in organisations. The 3rd Seminar of The International Institute on Organisational Psychological Medicine Themed 'Work Place Psychological Medicine and Productivity' was held at the 17th Annual National Conference of the Indian Association of Private Psychiatry at Hotel ITC Sonar, Kolkata, West Bengal. The IOPM faculty members were also invited to contribute in the seminar. The scientific presentations essentially focussed on human capital management based on a psychological approach and were hugely successful. The events enabled the participants to gain insight and understanding into key issues related to the human capital management practices in organisations and learn ways to promote resilience and productivity of the workforce.

Professor De Souza and his team have successfully organised workshops in various organisations 'Valuing the Human Capital', a Workplace Health Promotion Programme using the principles of Organisational Psychological Medicine's human capital management. This approach offered a paradigm shift to deliver high performing individuals, high productivity, high retention, enhanced talent management with trust and loyalty. Professor Bellesini has successfully organised similar workshops in various educational institutes in Australia.

The IOPM has been rapidly growing over the last few years and given that the full curriculum is in place, psychiatrists, other doctors and professionals with administration and organisational experience would be eligible for the membership examination commencing in the next 2 years. This would enable them to obtain a qualification and use of post nominals, i.e., MIIOPM. The Institute honoured various senior psychiatrists and management professionals in health care organisations with a 'fellowship' after they met the requirements of rules and bye laws of the institute. The Convocation program held in Kolkata in September 2016 was a huge success. The Convocation address at the IOPM Convocation was delivered by Honourable Professor Dr Biswas the Vice Chancellor of the West Bengal University of Medical Sciences Kolkata. The Institute is honouring more senior colleagues and convocations of the will be taking place

globally, in Watford, United Kingdom, Orlando, United States of America and Jaipur, India over the next few months.

The Institute have signed an agreement with Oxford University Press and is working towards publishing the first text book on organisational psychological medicine. We are currently working with the contributing authors for relevant chapters and hoping that the book will be published in the next 6 to 9 months. The text book will provide an overview of this evolving and important discipline and will bring together the expanding research base covering the study of psychiatric and psychological pathology in the workplace and its prevention.

The editors are pleased with the quality and diversity of the contributions for the bulletin on varied range of topics including presenteeism, change management, mentoring, burn out, stress management, corporate responsibility, emotional intelligence in teams, suicide prevention at the workplace, organisational dynamics, human capital management by academics and clinicians from various organisations across the globe. Professor De Souza's and Professor McIntyre's article on *'Presenteeism, and Work Place Psychological Health Promotion'* has stressed that the most important issue for organisations is to design programs that should be designed, implemented, and evaluated to achieve the desired optimal, and implements programmers results to reduce risks of presenteeism and enhance productivity. Mr Mazeau's article on *'Wellbeing at Work: A Major Challenge for Socially Responsible Companies'* illustrates that despite the challenging economic conditions, corporate responsibility continues to move up the agenda for organisations. Although mostly large companies/organisations engage corporate responsibility, in many cases the approach adopted remains too generic. Therefore, a tailored approach to corporate responsibility, which bolsters and supports core business strategy, is much more likely to create real business and brand value.

Finally, the editors would like to express their sincere appreciation to Professor Russell D'Souza, Dean of the IOPM for his vision and relentless commitment to excellence in taking the institute to the next level.

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The Scope and Nature of Organisational Psychological Medicine

Dr Avinash De Sousa, The IOPM, India

The International Institute of Organisational Psychological Medicine (IOPM) was initiated in Australia and USA by psychiatrists working in this division of psychiatry, and working in collaboration with professionals involved with good organisational outcomes. These professionals include psychology, senior management and administrators. The scope and the education programs relate to the important need to achieving sustainable human capital for the organisation. These include early identification, diagnosing and managing psychopathological sequel resulting from the workplace and beyond, preventing psychopathologies resulting from workplace practices and standards. The added inclusion to the scope is the paradigm shift - the enhancing of human capital potential using holistic principals; resilience and positive psychological medicine. Thus, besides principals of positive psychological medicine the added coordinated use of neurosciences, dynamic psychological and management underpinnings, cognitive medicine and spiritual philosophy in programs will offer resilience and enhancement of the potential of human capital of an organisation.

The Scope of the IOPM

The scope includes:

- a) The scientific application of the principles of Psychological Medicine, Neurosciences and Management in optimising, and
- b) Synchronising the work place (Organisation) requirements with the psychological, biological and holistic needs of the human beings operating in the work place.

The Objectives of the IOPM

- ❖ Increase the sophistication in human capital management practices by using the underpinnings of Neuroscience and Psychological medicine.
- ❖ Supporting senior management and employee understanding of the need to develop the ability to map and nurture the inner needs of the individual along with the organisations objectives and goals.
- ❖ Educating senior management on identifying, resilience building and preventing psychopathological sequel resulting from work practice in the human capital, thus protecting the bottom line of the organisation and human capital's outcomes.
- ❖ Enhancing the health, psychological wellbeing and productivity of the human capital of organisations.
- ❖ Increase the return on investment (ROI) of the Human Capital in an organisation.
- ❖ Provide support using scientific principles for an Organisation's Corporate Social responsibility endeavours and programs.

Psychological medicine has been involved in the diagnosis, treatment, and prevention of mental illness and emotional problems. Due to their medical training, the psychiatrist understands the body's functions and the complex relationship between emotional illness and other medical illness. Thus, the psychiatrist is the mental health professional and physician best qualified to distinguish between physical and psychological causes of both psychological and physical distress.

The medical specialty of psychological medicine, utilizes research in the field of neurosciences, psychology, medicine, biology, biochemistry and pharmacology. It has hence been considered a middle ground between neurology and psychology. Unlike other physicians and neurologists, specialists in psychological medicine have added expertise, to varying extents in the use of psychotherapy and other therapeutic communication techniques.

Psychological health of Human Capital in organisations can be impacted by the work place and beyond. Poor psychological health results in poor outcomes to the bottom line of both the human capital and the organisation. The studies on demoralisation on human capital of organisations found it resulted in psychopathological sequelae. Similarly, studies in embitterment in the work-place have found it resulted in psychopathological Embitterment post-traumatic stress disorder.

Work-place related psychiatric pathology impacts on organisational outcomes, and among other issues also results in poor retention and attraction of human capital. These affect negatively the important management need of good talent management for increased production of goods and or services. This lead to the initiation of the defined branch of Organisational Psychological Medicine, which includes psychiatrists with added qualifications and experience in management and administration, who are interested and involved in researching, studying the work-place related psychological and psychiatric pathology.

This branch of psychological medicine's scope of practice expands from the diagnosis and management of work-place related psychological disorders to added forte of preventive psychological medicine and resilience and positive psychological medicine applied to the human capital of organisations. These include population health initiatives of developing programs that will enhance the outcomes of human capital of organisations. Thus, the discipline benefits the bottom line of both the individual and the organisation.

The discipline of Organisational Psychological Medicine offers neuro-scientific evidence based underpinnings and avenues for:

- ❖ Enhancing Human Potential of an organisation with the principles of positive psychiatry – Resilience and Psychological medicine.
- ❖ Preventing psychopathological sequel in the human capital of organisations resulting from the work- place - Preventive Psychological Medicine.
- ❖ Recognising and managing the psychopathological sequelae resulting from the work-place and beyond in the human capital of organisations.

Enhancing Human Capital's Potential of an organisation

- ❖ Developing and organising programs with neurosciences, positive psychiatry, dynamic psychological principles, management underpinnings, quantum physics and spiritual philosophy principles used in coordination for the dynamic outcomes:
- ❖ Maximising employee potential and output impacting on organisational creativity and entrepreneurship.
- ❖ Evidence based scientific programs to enhance the use of available discretionary effort and behaviour.
- ❖ Offering programs for Total Human Capital Management and enhancing organisational citizenship behaviour.
- ❖ Use of neuroscientific based programs to enhance human capital's sharpness in intellect, endurance and presence of mind, resulting in individual's skills of perception, observation and expression being optimised.

Preventing psychological pathologies in the Human Capital of an organisation

- ❖ Programs that identify and offer prevention of the psychopathological sequelae that ensues from the work place practice in an organisation such as demoralisation, embitterment, occupation fatigue and burnout:
- ❖ Preventing the psychopathological sequelae ensures the protection of the negative impact on the personal, physical, psychological and social outcome of human capital.
- ❖ This ensures the bottom line of the organisation and the individual are protected.
- ❖ Advisory and Advocacy to Organisations leadership on programs and education that will prevent psychopathological outcomes to the human capital in organisations.
- ❖ Creating and organising programs that fulfil the Corporate Social Responsibility of an organisation.

Managing the psychopathological sequelae

- ❖ Evidence based management Programs that identify, manage and resolve the psychopathology.
- ❖ Psychopathology education programs for management that result in early identification and minimisation of negative outcomes.
- ❖ Knowledge on the principles of rehabilitation programs – return to work place education and training programs.
- ❖ Relapse prevention and resilience programs for human capital of organisations.

Presenteeism, Organisational Psychological Medicine and Work Place Psychological Health Promotion

Professor Russell D'Souza, The IOPM, Australia
Professor Jack McIntyre, The IOPM, USA

As companies struggle to rein in health care costs, most overlook what may be a \$150 billion problem: the nearly invisible drain on worker productivity caused by psychological effects of early demoralisation, embitterment, burnout and compassion fatigue besides the somatic related ailments headaches, avolition and even heartburn.

Researchers say that *presenteeism* —the problem of workers' being on the job but, because of illness or psychological conditions, not fully functioning can cut individual productivity by one-third or more. In fact, presenteeism appears to be a much costlier problem than its productivity-reducing counterpart, absenteeism. And, unlike absenteeism, presenteeism isn't always apparent: You know when someone doesn't show up for work, but you often can't tell when or how much illness or a subsyndromal psychological condition is hindering someone's performance. "Outwardly you look fine," says Farler, "People don't see how you feel."

Presenteeism on the Rise

Presenteeism emerged as a business issue in the 1990s. It refers to the impact of an employee's physical and emotional health on decreases in on-the-job performance. The potential productivity losses include decreased quality of work and time not spent on job tasks. Although often hidden, the costs related to presenteeism are estimated to be higher than those related to absenteeism. And they are being driven up by an increasing number of people with chronic health conditions and an aging workforce.

Presenteeism, as defined by researchers, isn't about malingering or goofing off on the job (surfing the Internet, say, when you should be preparing that report). The term, which has gained currency despite some academics' uneasiness with its somewhat catchy feel, refers to productivity loss resulting from real health and psychological problems. Underlying the research on presenteeism is the assumption that employees do not take their jobs lightly, that most of them need and want to continue working if they can. "We're talking about people hanging in there when they get sick and or are dispirited, face lack of volition and trying to figure out ways to carry on despite their silent symptoms," says Debra Lerner, a professor at Tufts University School of Medicine in Boston, who notes that presenteeism may be more common in tough economic times, when people are afraid of losing their jobs. "If every employee stayed home each time a chronic condition of demoralisation, fatigue flared up, work would never get done." That some managers hold a less generous view of worker attitudes serves as a backdrop to researchers' continuing efforts to document their findings more conclusively.

Many of the medical and psychological related problems that result in presenteeism are, by their nature, relatively benign. (After all, more serious illnesses frequently force people to stay home from work, often for extended periods.). So, research on presenteeism focuses on such chronic subsyndromal depressive mood, amotivation, fatigue, demoralisation, embitterment and or resultant somatic episodic ailments as seasonal allergies, and other kinds of headaches, back pain, arthritis, and gastrointestinal disorder. Progressive conditions like heart disease or cancer, which require expensive treatments and tend to strike people later in life, generate direct health-related costs. But the illnesses people take with them to work, even though they incur far lower

direct costs, usually account for a greater loss in productivity because they are so prevalent, so often go untreated, and typically occur during peak working years. Those indirect costs have long been largely invisible to employers. Illness affects both the quantity of work (people might work more slowly than usual, for instance, or have to repeat tasks) and the quality (they might make more, or more serious, mistakes). Unknown, unrecognised and not taken into consideration these impede concentration. The discomfort of psychosomatic related gastrointestinal disorders, common but seldom-talked-about ailments such as irritable bowel syndrome and gastroesophageal reflux disease (also known as GERD, acid reflux disease, or, somewhat more prosaically, heartburn), is a persistent distraction. Depression causes, among other things, fatigue and irritability, which hinder people's ability to work together. Clearly, different conditions have different effects on different jobs. The result in either case: a significant sapping of worker productivity.

Costs That Can't Be Seen

Well-publicised studies in recent years have estimated the nationwide costs of several common ailments in the U.S workplace. Two articles in the *Journal of the American Medical Association* last year reported that depression set U.S. employers back some \$35 billion a year in reduced performance at work and that pain conditions such as arthritis, headaches, and back problems cost nearly \$47 billion. "Pain, no matter what the cause, will always translate into lost time at work," says the studies' lead author, Walter F. ("Buzz") Stewart, a director of the Centre for Health Research & Rural Advocacy at Geisinger Health System in Danville, Pennsylvania. Researchers have also tried to quantify the impact of disease in general on workplace productivity. Using the same methodology employed to gauge the costs of depression and pain, a yearlong telephone survey of 29,000 working adults, dubbed the American Productivity Audit, Stewart's research team calculated the total cost of presenteeism in the United States to be more than \$150 billion per year. Furthermore, most studies confirm that presenteeism is far more costly than illness related absenteeism or disability. The two *Journal of the American Medical Association* studies, for example, found that the on-the-job productivity loss, resulting from depression and pain was roughly three times greater than the absence-related productivity loss attributed to these conditions. That is, less time was actually lost from people staying home than from them showing up but not performing at the top of their game.

However, a handful of companies, including International Truck and Engine, Bank One (recently acquired by JPMorgan Chase), Lockheed Martin, and Comerica, are recognising the problem of presenteeism and trying to do something about it. That entails determining the prevalence of illnesses, medical and emotional/psychological problems that undermine job performance in the workforce, calculating the related productivity loss, and combating that loss in cost-effective ways. This is a new area of study, so questions remain around a host of issues, including the central one: the exact degree to which various illnesses reduce productivity. But researchers are discovering increasingly reliable ways to measure this and are concluding that presenteeism costs companies billions of dollars a year. Emerging evidence suggests that relatively small investments in potential enhancement resilience practice, screening, prevention, screening, managing and education can reap substantial productivity gains.

An Emerging Field

Productivity, always an elusive concept, is particularly difficult to measure in today's postmanul factoring, widget-sparse economy, in which so little of what we produce can be counted. So, researchers have turned to questionnaires that ask employees whether they suffer from a psychological or medical problem and, if so, how much it impairs their performance. At least a half-dozen assessment tools are currently in use, each looking at reduced productivity from a slightly different perspective. One, developed by Buzz Stewart and used in the American Productivity Audit, asks workers how much productive work time they think they've lost

because of a psychological and or medical problems. Another, developed by Ronald Kessler, a professor at Harvard Medical School, asks workers about their overall performance; it has been adopted by the World Health Organisation and will also be in two large regional studies sponsored by business organisations in the midwestern and south eastern United States. A third, developed by illness can hurt an employee's ability to function and how the combination will affect different jobs; it is used by a variety of academic researchers, pharmaceutical companies, and employers, including Lockheed, in the company's pilot study.

These and other research approaches have yielded quite different estimates of on-the-job productivity loss. According to a recent review of the research, such estimates range from less than 30% of a company's total health-related costs to more than 60%. Without a standard tool for measurement, "There are other soft spots in the research. For example, a relatively small decline in one person's performance may have a ripple effect on, say, an entire team that falls behind schedule because the ailing member has to skip a meeting and researchers continue to wrestle with such challenges as measuring the relative effects of individual ailments on productivity for workers who suffer from psychological and medical problem.

Organisational Psychological Medicine and Workplace Psychological Health Promotion

Little is known about the effectiveness of workplace health promotion programs on presenteeism. A review of areas that have worked with work place psychological health promotion with the principals of organisational psychological medicine was carried out. Studies involving supervisors and managers targeting organisational and/or environmental The identified avenues included, factors to influence behavior, using health-risk assessments or other methods to screen workers before they enter programs; improving supervisor/manager knowledge of mental health in the workplace, tailoring programs to the needs of individual workers, using behavioural change models to help reinforce desirable lifestyle behavior, providing workers with incentives, using participatory approaches that involve employees.

IOPM's Workplace Health Promotion Program 'Valuing the Human Capital'

For many the workplace has become a primary source of community. It is here a majority of time is spent and many friendships and relationships take place. It is the source of challenges, aspirations and the measure of a successful life for a large percentage of Human Capital. This where they contribute to their organisation and to society.

It is also here that loyalty might be the weakest and individuals perceived as inadequately challenged, and underutilised. It is here they might find it difficult to see connections between their immediate works and a contribution to society and it is here the impact of their diminished energy is felt. These contradictions in part contribute to the demoralisation, embitterment and burn out in human capital. The results are often encountered with the loss in productivity to the human capital and the organisation. There is an increased recognition now of the heart and mind component of the human capital management and the need of alignment of with organisational strategy for long term viability and organisational and personal success

This tested program in workplace health promotion, with the principles of Organisational Psychological Medicine's human capital management is a contemporary solution based on the principals of psychological medicine that optimises workforce potential and well-being. This dynamic program incorporating the coordinated use of neuroscience, analytical psychological underpinnings, organisational intellectual medicine, dynamic management and spiritual philosophy offer a paradigm shift to deliver high performing individuals, high productivity, high retention, enhanced talent management with trust and loyalty.

The use of evidence based techniques that creates a dynamic synchrony using a meaning based value system, synchronising the outer organisational mandates with the inner needs of its human capital offer guaranteed enhanced organisational citizenship. Expressed in discretionary behaviour that contributes positively to the organisational effectiveness. A positive attitude held by an employee towards the organisation and its values. Demonstrated support, and conscientiousness, toward the organization and the emergence of an organisational team spirit.

This scientific program designed and tested that for the first part will include focus on six avenues:

- i. **Identifying values** - This helps to identify human capital's own personal values and those values that have particular relevance for the profession they have chosen such as health care and or education. Central to this module is the notion that while your job depends crucially upon your training skills, attitudes and experience, well-being of everyone involved can be enhanced through an explicit framework of values that forms the basis for how we view ourselves and behave towards others.
- ii. **Optimizing Positivity at Work** - Here the first half is mainly about recognising the benefits of positive emotions, positive thinking, and about developing positive thoughts about oneself and other. The second half builds on these insights by applying the learning to work context and by introducing some more specific techniques for dealing with negative thoughts and cycles of thinking.
- iii. **Achieving successful cooperation** - This module focuses on experiencing and evaluating the qualities and skill of successful cooperation. To cooperate we have to want to understand and want to be understood. This connection is often helped by revealing something of ourselves allowing others to see beyond the behaviour, sharing our values or beliefs, our passions, our fears and our hopes. To do this however, you need to feel safe and to know that we are not being judged. Cooperation therefore involves the recognition of a shared responsibility for creating and maintaining a good and trusted relationship.
- iv. **Promoting Inner Peace** - Stress is a problem for modern workforce. Stress and worry can adversely affect one's health and their ability to function. There are methods or tools such as mediation and visualisation, which can reduce stress as well as improve one's sense of well-being. This program does not analyse the cause of stress but looks at how to promote inner peace. When one experience tranquillity they are likely to find they are better able to cope with problems. By practising peacefulness, one can develop the habit of peacefulness. By being peaceful the human capital has an increased ability to access other positive resources or qualities within themselves and develop their own well-being.
- v. **Enhancing valuing yourself** - Valuing one's self is a way of preventing burnout and its consequences. This program helps them to explore their own self-care but also their self-confidence and need for support, in order that they might introduce positive change and self-renewal in their life, respecting themselves and creating opportunity for self - discovery.
- vi. **Enhancing Well-being** - The well-being science offers an understanding of how one can enhance their well-being. Well-being can be defined as a person with mature character traits. These might include, wise, virtuous well-satisfied with life because they have frequent positive emotions such as happy, joyful, satisfied and optimistic and infrequent negative emotions seen as anxious, sad, angry, and pessimistic. Here the focuses are on the three-character traits associated with well-being with evidence based exercises to develop and enhance these character traits. The focus is on achieving living virtuously, with the categories of well-being traits. These include as high self-acceptance, personal growth, purpose in life, positive relations with others, environmental mastery and autonomy.

The exercises that will be explored, have been built on the underpinnings of neurosciences and the cognitive behavioural sciences. The use of the brain hemispheric specialization on one level and on another level, you will use the integration of cognitive and behavioural approaches from the cognitive behavioural sciences.

The Workshop

Experiencing the dynamic approach, guides participants to experience core values. Prompts an internal experience which can be identified and expressed. Creates a voyage of inner discovery, unique to each one and reveals a common understanding. Clarifies and enhances value based work force. The Dynamic approach includes applying the principle of learning self-care, emphasis on self-care and personal development to raise morale and restore a sense of purpose. Applying the second principal includes, understanding values through facilitated, experiential learning, rather than didactic instruction, time for silence, reflection and sharing in a supportive environment. The ability to reach that Direct 'Inner' Experience. Applying the third principal contains learning from experience. Learning experiences relevant to work, including team development and one's personal life. Emphasis on reflection, action planning, review, evaluation and commitment to ongoing Learning experiences relevant to work, including team development and one's personal life.

Conclusions

Workplace psychological health promotion represents one of the most significant strategies for enhancing the productivity of workers at a time when productivity is a factor that dominates organizational long-term success. Despite longstanding advocacy for comprehensive worksite programs, we need empirical evidence to link these strategies to improvements in psychological health and productivity. Organisational psychological medicine based workplace psychological health promotion program. Valuing the human capital, intervention has been run and studied in education and health care organisations. The preliminary evidence from studies are enhanced discretionary behaviour that contributes positively to the organisational effectiveness. A positive attitude held by an employee towards the organisation and its values. Demonstrated support, and conscientiousness, toward the organization and the emergence of an organisational team spirit. These have suggested resilience to and prevention of presenteeism.

Thus, in understanding presenteeism there is now, preliminary evidence of a positive effect for programs such as valuing the human capital, identified their components and some contributing risk factors for presenteeism. Interpreting these results will need to consider some factors as the heterogeneous response/participation rates, interventions, intervention delivery methods, presenteeism measurement tools, employee populations, geographical and workplace settings.

Currently it has been stated that the most important issue for organisations to address is not whether or not workplace psychological health promotion programs should be implemented to reduce risks of presenteeism and enhance productivity, but rather how such programs should be designed, implemented, and evaluated to achieve the desired optimal results.

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Wellbeing at Work: A Major Challenge for Socially Responsible Companies

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The international standard ISO 26000 states that the essential characteristic of corporate social responsibility (CSR) is the willingness of a company to incorporate social and environmental considerations in its decision making and to be accountable for the impacts of its decisions and activities on society and the environment. CSR encompasses a wide range of issues including environment, governance, human rights, consumer issues, fair operating practices, community involvement and development and labour practices (1).

One of the most important issue relating to labour practices is health and safety at work. For a responsible company, health and safety concerns the promotion and maintenance of the highest degree of physical, mental and social wellbeing of workers and prevention of harm caused by working conditions.

According to the International Labour Organisation (ILO), wellbeing at work covers all the aspects of working life, from the quality and safety of the physical environment, to how workers feel about their work, their working environment, the climate at work and work organization. Employees' well-being is a key factor in determining an organisation's long-term effectiveness. Many studies show a direct link between productivity levels and the general health and well-being of the workforce.

Although there is no consensus definition of wellbeing, it is clear that wellbeing is more than the merely absence of negative circumstances such as illness but it also includes positive features such as quality of job or happiness within one's life. Wellbeing at work is influenced by mental and physical health, job security, organisation of work, work engagement, work life benefits and wages. For the health component of wellbeing there is growing evidence of workplace intervention for occupational outcomes (e.g. musculoskeletal disorders, mental health) and personal factors (e.g. smoking, overweight) (2).

Although aspects of happiness and wellbeing at work have been studied for a long time including job satisfaction, job involvement, affective organisational commitment, work engagement, positive and negative emotions and moods at work and motivation, it is still not a priority for all companies.

However, wellbeing at work is becoming an issue of global significance. According to the World Health Organisation (WHO) the workplace represents a key channel for health promotion. Recognising that the economic and material basis of any society is dependent on the production capacity of its workforce, the WHO has repeatedly called for the development of national strategies to secure the physical, psychological and social health and wellbeing of workers worldwide.

Since an increasing number of governments are developing policies to embrace the wellbeing agenda, business has all to gain to anticipate and being proactive. In practice business has a strong influence on the life of their employees, on the communities where they operate or to which they are connected (e.g. through their supply chain) and on the life of the consumers that they reach through the goods and services they provide. This can be part of their CSR policy and

practices. That is why wellbeing can also be seen as a business concept (3). Companies need to develop a strategic approach to health and wellbeing and concentrate on building a sustainable workforce if they want to remain competitive. Wellbeing is an issue for employers that may have an impact on the bottom line.

Influence of CSR to wellbeing can also be discussed. Nowadays employees are more and more aware of the responsibilities of business towards society and it is a big challenge to recruit, retain and motivate employees applying socially responsible principles; the empirical evidence shows that companies undertaking CSR actions face more efficiently the pressures and social demands from the environment and their stakeholders. Employees feel more satisfied in the companies committing themselves in CSR programs; it helps to retain and motivate employees and increases their wellbeing and reinforces performance and sustainability. Wellbeing at work as a comprehensive concept, including well-balanced physical, psychical, emotional and social issues inside and outside of a workplace, contributes to the total personal benefit of each employee, as well to the company long-term effectiveness and competitiveness. (4)

Wellbeing at work is a growing challenge for companies. Because it becomes a condition of employees' commitment and professional development beyond health issues but also because it is a major factor of competitiveness that should be considered as a priority for companies that have to face a growing disengagement on the part of their employees. It has even been suggested to create a new job bridging human resources and CSR: A Chief Happiness Officer (CHO) to listen to the employees and make them happier and involved.

Employee wellbeing does not just affect the individual. If someone is feeling physically or mentally down, this can have wide-reaching consequences impacting on their colleagues, family and others; that is why companies should have holistic approaches including the promotion of a healthy life both at work and beyond.

Finally, companies are expected to contribute to the UN 2030 agenda "Transforming our world". Among the 17 Sustainable Development Goals, the SDG n°3 proposes the following goal: Ensure healthy lives and promote wellbeing for all at all ages. The UN Global Compact puts forward the benefits for companies investing in health and wellbeing of their employees: improved productivity, increases in employee satisfaction and reduction in staff turnover, protecting the older, experienced employees, increasing loyalty staff. Just another evidence that it is time to integrate wellbeing in CSR programs at a high level of awareness and concern.

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The Value of Emotional Intelligence in Team Working

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Introduction

This paper offers an overview of the principles of Emotional Intelligence (EQ) and its impact on team working in organisations. The article predominantly focuses on the Goleman's interpretation of EQ (Emotional Intelligence) and team working. There are wider areas of Emotional Intelligence that enable how successful a person is and how this further translates to good leadership, team working and productivity in organisations. This paper also highlights relevant literature that showed a linear link between EQ competencies on team working and productivity.

The role of Emotional Intelligence in Organisations

Goleman postulated emotional intelligence as the *'capacity for recognising our own feelings and those of others, for motivating ourselves, for managing emotions well in ourselves and in our relationships.'*

Goleman's research looked at 181 different management competence models that originated from 121 organisations across the world. The research stated that 67% of the abilities perceived as essential management competence were emotional competencies (Cameron & Green 2004). Goleman's (1998b) research challenged the traditional thinking and views about effective leadership models in various organisations. He argued that although technical skills and intelligence are important, they are not fully sufficient to develop truly effective leaders who are characterised by a high level of emotional intelligence. It is shown that emotional intelligence has real impact on the outcomes, sometimes doubling and even trebling productivity and efficiency in the organisations (Cherniss et al 2001).

The role of a Team

Individuals do not work in isolation, rather they are members of a group. The team leader considers the diversity of the group, such as age and ethnicity on group processes and work pressures. The pressures, in turn can have a great influence on the behaviours of group members, for example on what society expects from the members and also how they need to act in a particular way. Mullins (2013) highlighted that a *'team is a group of people working together to achieve common objectives leading to commit all their energies and necessity to ensuring that the objectives are achieved.'*

Fraser (1998) highlighted specific benefits from team work where the team can achieve goals more quickly and efficiently than individuals working alone. The teams also support each other to improve skills, become more confident and develop interpersonal skills, be more creative, more flexible and show commitment to the task and each other. The benefits of the team work also enable individuals to be self-motivated and enjoy the work by being with other people. Groups that have a diverse range of attributes appear to perform better because they can draw upon a wider range of resources when carrying out the task (Guzzo and Dickson, 1996). The leadership literature has demonstrated that the attributes of the group leader influences group productivity (Vogelaar and Kuipers, 1997).

The Value of Emotional Intelligence and Complex Team Working

It is important to highlight that individuals work and think in different ways in a team and as a result, this benefits overall progress of the task and can yield better outcomes. Belbin (2000) highlighted different roles taken on within a team structure and how each of these roles enhances or detracts from the effectiveness of the team. In a similar way, it can be argued that if a leader of a team knows about the best ways people work or take instruction, they can ensure that the team is effective in the way it works. Therefore, an emotionally intelligent leader can enhance the effectiveness of team working to achieve better outcomes.

A number of studies have found that the introduction of self-managed work teams does lead to improvements in productivity (for example Cohen & Ledford, 1994). A common assumption within the organisational psychology literature is that internal group processes (team work) at least partially mediates the relationship between the input and productivity (Cohen & Bailey, 1997).

A substantial body of research has examined the link between team work and productivity at the group level of analysis. A variety of team work factors have been found to predict object and subjective measures productivity, including: a) task related activities, such as communication, co-ordination, planning and leadership activities (Salas & Carson, 1994). b) boundary management activities, such as external presentation (Ancona & Caldwell, 1992) and c) maintenance activities such as social support (Pappas and Medsker, 1996).

Research has demonstrated that some personality traits such as conscientiousness, extraversion and emotional stability can influence group productivity (Barry and Stewart, 1997).

Shanta and Connolly (2013) have linked emotional intelligence in nursing practice to Kings interacting systems theory, which has a focus on dynamic interactions of humans through 3 interactive systems: Personal, Inter-personal and Social realms. With regard to the personal system, the individuals take in information processed through perception to allow understanding of self and others. Within the interpersonal system, the focus is on interactions, communications, transactions, role and stress. Within the remit of the social system is the interaction which occurs within and between groups for group interests and values. An intelligent leader knows how people work and think and this helps to enable to get the best out of them.

Spencer et al (1993) carried out a study of 300 top-level executives from fifteen global companies and concluded that that six emotional competencies distinguished stars from the average: influence, team leadership, organizational awareness, self-confidence, achievement drive, and leadership. It is also important that effective leaders are flexible in terms of achieving their overall objectives.

Kite and Kay (2012) highlighted that emotional intelligence leads to better outcomes by linking intellect and emotional awareness to manage one selves and relationships with others.

If we were to compare the styles of leadership alongside with emotional intelligence, we notice that transactional leaders tend to value one side communication, use emotional management and often delay gratification. In contrast, transformational leaders give more importance to empathy and two way communication. They tend to be friendly and use empathy to motivate the work force. Both approaches lead to effective team working and increased productivity. The leader with emotional should be able to use his knowledge to help members of the team to identify their

personal destiny. An engaged leader would be able to use his knowledge to help members of the team to identify and achieve their goals.

Conclusion

Emotional intelligent people continuously strive for personal development and they are unrelenting in terms of their commitment to support others interests. They also have clarity of thought and maintain their objectivity in sustaining positive outcomes to the organisation. They also have the ability to take the longer view and challenge the status quo. Importantly, they have the ability to nurture the team in terms of achieving better outcomes. Effective leadership underpin the efficient and safe running of any care organisation.

Emotional intelligence is widely known to be a key component of effective leadership. Emotional intelligence is the capacity to recognise and manage one's emotions and show empathy towards others and this is the foundation upon which organisational leadership is based. Keeping people motivated in an era of radical change is one of the most difficult challenges that leaders at all levels face in healthcare organisations. Leaders with emotional intelligence are good in managing their teams and resolving conflict which are vital to succeed as an effective leader. Leaders with emotional intelligence become less fearful, more courageous, and effective and will be more willing to take responsibility. Effective leaders in turn create an organisational climate that fosters superior performance.

Emotional Intelligence is increasingly relevant to team working and developing people, because it provides a new way to understand and assess people's behaviours, management styles, attitudes, interpersonal skills, and potential.

Emotional Intelligence can be developed by reflecting on experiences, learning about oneself and practicing the behaviours. An aspiration to develop emotional intelligence is all about personal transformation and doing so enables an individual to gain new skills, knowledge, expertise, deeper understanding about themselves, greater wisdom and more importantly, broader perspective.

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Suicide Prevention at the Workplace

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Mental health problems are commonplace at work. Many a times, they go undetected and no one seeks help for the same. It is very important that organisations are vigilant towards the early detection of mental health problems in their employees. One of the commonest problems noted at the workplace is depression and one of the commonest complications of depression is suicide. Suicide when occurring at the workplace leaves an indelible mark on the organisation, employees, head of the organisation and family of the individual involved. Human resource professionals and workplace counsellors must be vigilant to detect suicidal vulnerability in their employees at the earliest.

Suspecting that an employee is considering ending his or her life can be vexing. One may not know whether you should become involved in the problems of someone who is not a family member or close friend and just a work colleague. One may be unsure of what one can really do to help someone with emotional difficulties or feel uncertain whether that person is actually in serious trouble or whether one is just assuming the same. Being wrong about the mental health of another person could be embarrassing particularly at work. At the same time, being right could save a life. These issues are especially complicated if your workplace is small (<20 employees) which may not have a human resource backup or employee assistance or counselling programs.

Warning Signs of Suicide at the Workplace

Every year, many people take their own lives at the workplace. A large number of suicides and suicide attempts are related to treatable mental health conditions including depression and other mood disorders as well as alcohol and drug abuse. Some of the suicides may be due to workplace issues, marital problems and financial stresses that can be handled well if help is sought. Employees are reluctant to seek help at work as they fear being labelled and stigmatised by co-workers. They also feel that the workplace counsellor may breach confidentiality and inform higher management that may affect their promotions and future career. Most employees are unaware that there are now stringent laws all over the world that prevent discrimination and termination at work on the basis of mental health conditions. In fact, these laws mention that a supportive environment be provided for such employees at work.

People who are in danger of attempting suicide often display multiple warning signs. One may be in a good position to recognise such signs in employees even if they are trying to conceal their problems. One sees employees on a regular basis and thus able to gauge how they talk, act, behave, and even react to stress in the workplace. One can recognise changes in their behaviour, personality, or mood when it happens. Such changes may be the proverbial 'cry for help'.

Signs that a suicidal crisis is looming includes –

1. Talking about suicide or death off and on.
2. Making statements like 'I wish I were dead' and 'I wish it all ends'.
3. Mentioning in conversations about the aimlessness of life and that no one cares about them.
4. Remaining socially aloof and isolated at the workplace.
5. Expressing feelings that life is meaningless or hopeless and feeling worthless and helpless.

6. Giving away cherished possessions to others at work.
7. Feeling depressed and sad at work.
8. Neglect of appearance and hygiene.
9. Deterioration of work performance or productivity suddenly.
10. Found crying when alone in his room or in the washroom.
11. Family members mentioning some of the above symptoms.
12. Recent divorce or death of a child or spouse.
13. Failed interviews for promotion at the workplace.
14. Evidence that the employee is harassed at the workplace or bullied.

There is no way of telling that someone may be thinking of taking his or her life. Even psychological testing and professionals may not be able to predict suicide accurately but the above are warning signs and can also mean that a person has serious problems that affect his or her life, productivity, and the work environment. By recognising and acting on these signs, one can help an employee find professional help and improve his or her mental health status.

How organisations must respond to these warning signs

1. One should respond to warning signs that an employee may be thinking of suicide. If one is comfortable speaking with this person, one should ask the difficult questions that can help you understand that person's state-of-mind and intentions.
2. Do not be afraid to approach the issue directly and just ask the employee - 'Are you thinking of killing yourself?' or 'Do you feel sad, depressed or suicidal?'.
3. Ask them if they have been feeling depressed for a while now and whether any attempts at suicide have happened in the past.
4. If their response gives you an indication that they have been considering suicide or having suicidal thoughts, ask them to find help immediately.
5. Offer to accompany them to your company's counselor or human resource team and make an appointment with a counselor. One may seek help outside the company if the individual is reluctant to seek help at work but help must be sought.
6. Help them find a mental health counselor and the organisation may help pay for the treatment if finances are an issue.
7. There are a number of online counseling portals and suicide helplines that may be sought to seek help but face to face counseling is the best approach in these cases.
8. Some of your employees may be personal friends. You may maintain a more professional relationship with others or even not get along with some of the employees at work. If the relationship with an employee who may be thinking about suicide is such that you do not feel he or she will talk to you about these issues, please ask someone close to that employee to take the lead to speak to him or her.
9. But as an owner or manager, you cannot delegate or assign responsibility to employees to help one another with emotional issues. It is on the team leader to take care of his employees.
10. If you think a person is in immediate danger, do not leave him or her alone until you have found help. This may require taking the help other employees or the person's friends or family. One may contact them and call them over to the workplace to discuss the issue.
11. Do not hesitate to make a call to someone's family or to emergency psychiatric services if you suspect someone may be on the verge of harming him or herself. One may end up saving a life.

Seeking help from a mental health professional

The emotional problems associated with suicide include depression, bipolar disorder, alcohol other drug use along with marital issues and job issues. These are all difficult and complex

conditions requiring professional intervention. One of the most important things one can do for an employee who may be considering suicide is help him or her find professional help immediately.

This may require overcoming his or her reluctance to go to a mental health professional. Larger companies which have access to a human resources department or a workplace counsellor have an advantage in locating such help. One needs to also have some control over the work environment. If an employee tells you that conditions in the workplace perhaps stress or conflicts with other employees are contributing to their depression or suicidal feelings, one must take action to fix this problem or relieve this stress without violating the employees' right of confidentiality regarding his or her mental condition. Change of environment at work and confidence that the organisation care for their employees is one of the most protective factors in suicide prevention.

Occupations with high risk of suicide

People in occupations where some of the following factors are present generally have higher suicide rates –

1. Easy access to lethal means like (e.g. guns, pesticides industry).
2. Exposure to chemicals (e.g. pesticides) that can cause mood or behavior changes.
3. High workplace stress (e.g. trauma, dangerous working conditions, mines, police, army).
4. Job insecurity (e.g. contract work).
5. Low wages.
6. Gender imbalance (women working in traditionally male-dominated industries).
7. Inconsistent work schedule (e.g. shift work) which can cause a disruption of family routine, inconsistent sleep patterns and other challenges.

Suicide Postvention – What organisations must know

Postvention is psychological first aid, crisis intervention, and other support offered after a suicide to affected individuals or the workplace as a whole to alleviate possible negative effects of the event.

A suicide death of an employee is only one type of suicide that could affect the workplace. The suicide death of clients, vendors, or a family member of an employee can also have a profound impact.

The organisation must prepare for postvention in the following manner:

Immediate or Acute Measures

1. Coordinate: Contain the crisis.
2. Notify: Protect and respect the privacy rights of the deceased employee and their loved ones during death notification.
3. Communicate: Reduce the potential for contagion.
4. Support: Offer practical assistance to family.

Short Term Measures

5. Link: Identify and link impacted employees to additional support resources and refer those most affected to professional mental health services.

6. Comfort: Support, comfort, and promote healthy grieving of the employees who have been impacted by the loss.
7. Restore: Restore equilibrium and optimal functioning in the workplace.
8. Lead: Build and sustain trust and confidence in organisational leadership. Demonstrating leadership in times of crisis is always an opportunity to build trust, confidence, and workplace cohesiveness.

Long Term Measures

9. Honor: Prepare for anniversary reactions and other milestone dates.
10. Sustain: Transition postvention to suicide prevention.

Recommended Reading

1. <http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Managers-Guidebook-To-Suicide-Postvention-Web.pdf>
2. http://www.iasp.info/resources/Suicide_and_the_Workplace/
3. <https://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-postvention-toolkit>

Resistance to Change: A Foe or an Ally of Organisational Change Efforts?

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Introduction

Change is a constant variable in the business environment (McShane and Travaglione, 2003). Organisational change is motivated by companies' desire to strategically juxtaposition their resources to maintain their competitive edge in the corporate world (Hoag, Ritschard and Cooper, 2002). It can therefore be argued that the success with which change is managed is a critical force that can determine a company's future viability. One of the major impediments to change is the reluctance to embrace its implementation, which can be encountered at all levels of the organisation (King and Anderson, 1995). This phenomenon has been conceptualised in the organisational change literature as 'resistance to change'. Hence Waddell and Sohal (1998) argue that "resistance to change has long been recognised as a critically important factor that can influence the success or otherwise of an organisational change effort" (p.543). Studies support the proposition that resistance is one of the major contributors to organisational failure in implementing change (Maurer, 1996 in Waddell and Sohal, 1998; Trader-Leigh, 2001). Consequently, managerial theorists have come to see it as the enemy of corporate governance to be overcome at all costs.

The author questions the validity of the negative connotations embedded in such a construct and proposes to argue that, in many contexts, 'resistance to change' can play a positive and powerful role in implementing meaningful change. In order to achieve this, however, there needs to be a conceptual shift in the construction of the framework used to analyse effective change, from an individual pathology orientation to a systemic constraints perspective that give rise to it. People do not 'resist' change for its own sake (Waddell and Sohal, 1998). There are operant conditions that immobilise individual capacity for change that are located in the external environment (Hoag, Ritschard and Cooper, 2002). Such discourse has the promise of creating a non-blaming disposition to the causality of resistance, thereby joining the management and employees in a collaborative endeavour to addressing its genesis. Reasons are invariably connected to inadequate planning, inadequate explanation of the process and the vision for change, and lack of willingness to accept responsibility in addressing the preceding factors (Hoag, Ritschard and Cooper, 2002; Mabin, Forgeson and Green, 2001). Responsibility in this context is about organisational leaders exercising self-awareness by developing change strategies that fit the emerging forces against change.

Hence, the purpose of this essay is to challenge the conventional construct and offer a paradoxical view of resistance. Rather than being the enemy to be overcome per se, it is a force containing untapped source of organisational communication necessary for effective change. Thus, resistance as a concept is posited as a powerful dichotomous analytical tool: it can assist both in the diagnoses of, and offer solutions to; the wider organisational problems that undermine change efforts (Waddell and Sohal, 1998). The author proposes to address this proposition by firstly expanding on the reasons for depathologising the 'resistors of change'. In doing this, the paper will, paradoxically, explicate the utility of resistance. Further, the author will identify cogent issues, which provoke resistive behaviour, and reframing these behaviours as a communication modality in an organisation undergoing change. The writer will particularly focus on organisational fairness, as it relates to change management. It is argued that it is one of the most pervasive causes of resistance in employees when they believe to have been unfairly

treated at procedural, distributive and interactional levels (Folger and Skarlicki, 1999). This is further compounded by management's failure to adequately tap into the expertise of its staff in designing a fit between the organisational resources, structure, and culture and the change efforts (McShane and Travaglione, 2003). It must be stressed, however, that a thorough exposition of these factors is beyond the scope of this essay, given their complexity and the space limitations. Before going any further, however, one must offer a definitional examination of what is meant by 'resistance'?

Resistance to Change

For the purposes of this paper, resistance will be defined as a set of behavioural responses to efforts by management to introduce practices that alter the status quo (Ford, Ford and McNamara, 2002). Lewin's 'field theory', also known as the force field analysis, explicates resistance as factors that work against the organizational drivers' for organisational change (King and Anderson, 1995). He postulates that the role of the change manager is to increase the strength of the drivers while reducing the influence of resisting forces, which in this instance would be employee attitudes and the subsequent actions that are perceived as undermining change. The writer joins Goldberg and Dent (1998) in introducing a new dimension to these conventional definitions by adding that resistance is also as much about behavioural expression of disenchantment with a process or an outcome as it is about non-verbal diagnostic communication about the source of the problem thwarting change efforts. It thus has the inherent capacity to inform and guide the change process to the desired organisational outcome. How does one fully capture the utility of the communication contained in resistance to change? As was stated earlier, by depathologising the concept. Depathologising can lead to better emotional relationship between the organisation and its employees, which can promote greater psychological ownership of the change process which is seen as a necessary precursor to effective change (Dirks, Cummings and Pierce, 1996).

The Importance of Depathologising Resistance to Change Effort

The Australian Oxford Dictionary defines pathology as the "study of the diseases of the body". The disease is located in the body, so it follows that the unit of study is the host body. The same perspective transplanted to a change context would see resistance as the disease and the employee as the body being investigated. Unless the disease, resistance, is extricated from the body, employees, then the system would collapse, the organisation. Application of this model to the understanding of resistance is to disregard context and thereby create a psychological divide between employees and employers (Waddell and Sohal, 1998; Goldberg and Dent, 1999; Hoag Ritschard and Cooper, 2002). Such reductionist view oversimplifies the complexity inherent in factors influencing 'resistive behaviour'. It creates an unsophisticated appraisal of the inherent dynamics at play by promoting an 'us' and 'them' dichotomy between the organizational leaders and the rest of the staff. Successful change comes about, in part, from the enlightened leadership that is enshrined in their fundamental belief that people are fair want what is best for themselves and the organisation, as the two are inexorably linked. Such belief would impel a collaborative view by addressing factors that may be constraining individuals from cooperating with the change effort. As Goldberg and Dent (1998) argue, "When organisations attempt a major change, the employees often understand the new vision and want to make it happen, but there are obstacles that prevent execution" (p.26).

These 'obstacles' are mainly located in the choice of emphasis on targeted changes, rather than employee unwillingness to change (Bovey and Hede, 2001a; Goldberg and Dent, 1999).

There is, for example, a desire for organisations to plan and implement the technical dimensions of change first, such as updating old equipment, the overall cost effectiveness of the process and the strategies to actualise them (Bovey and Hede, 2001b). Studies show that these approaches

seldom succeed and often provoke resistance on the part of staff who are vital to the outcome (Bovey and Hede, 2001a). Change efforts become fruitful when employee trust is gained in the process and a match is achieved between the technical change and the ability of the workforce to adapt to the new demands by management instituting appropriate up-skilling (McLain and Hackman, 1999). Hence, organisational change begins with the dissemination of appropriate knowledge and attitudinal shift (Dent and Goldberg, 1999). Bovey and Hede (2001b) argue that in order to achieve a high order cognitive shift, adequate information must be given so that individuals can reference their thinking to the new rationale for change based on logic, and governed by principles of organisational fairness (Folger and Skarlicki, 1999). Addressing the issue of resistance thorough such critical factors, which are not exhaustive by any means, provide the potential basis for long-term alliance between all the stakeholders, rather than the short-term gains to be made by 'merely overcoming' the 'resistors' (Piderit, 2000, p.783).

Organisational Fairness

Folger and Skarlicki (1999) contend that one of the critical factors determining resistance to change, among others, is the treatment employees receive during the change process. They argue that the interplay between procedural, distributive and interactional justice provide the setting for much of the negative employee behaviour toward change. This so called negative behaviour, such as passivity, sabotage etc., when viewed from the 'depathology' perspective underscored in much of systemic thinking, becomes a form of communication that informs the change managers about the faultiness of the process.

Procedural, Distributive and Interactional Justice

One of the characteristic responses to planned change has been the feeling of loss (Piderit, 2000; Bovey and Hede, 2001b). This may be at an individual level, such as loss of status or potential or actual loss of pay, or at a group level, loss of autonomy in self-managed teams. One of the commonly instituted changes has been in the area of performance and reward management systems to procure the desired change in behaviour to affect the overall company strategy (Gabris and Ihrke, 2001). However, lack of emphasis on procedural and distributive justice is paradoxically leading to increased dissatisfaction and lowered employee investment in the change process. (Mani, 2002; O'Donnell and O'Brien, 2000;).

Procedural justice, or fairness, is the extent to which a person believes the method by which an employee's performance is assessed to be fair in its process of application (Gabris and Ihrke, 2001). Distributive justice, on the other hand, relates to equitable distribution of rewards based on the outcome of such an assessment (Gabris and Ihrke, 2001). When individuals engage in both overt and covert behaviours of protest, such as absenteeism, lack of ownership, they are, in effect, what Dent and Goldberg (1999) term as staff simply communicating the flaw in the process. If the reward and performance practices are not aligned with the overall organisational strategy, the outcome will be less than optimum (Heneman and Dickson, 2001). For example, many organisations want to cash in on the productivity improvements to be had in implementing self-managing teams as they are seen to be more responsive to service demands (Castka, Bamber, Sharp and Belohoubek, 2001). Tension emerges when the performance appraisal system is geared toward measuring individual outcomes and a reward management system that compensate individual productivity over team-based performance and output (Castka et al, 2001; Heneman and Dickson, 2001). The self-aware organisations will recognise in the decrease in productivity, in part based on employees decreased motivation which can potentiate resistive behaviour (Bovey and Hede, 2001b), the communicated intent: that the strategy for higher productivity gain is flawed in its execution.

Interactional justice, on the other hand, refers to the treatment employees receive during the enactment of the procedural changes imposed. "It includes various actions displaying social

sensitivity, such as when supervisors treat employees with respect and dignity” Folger and Skarlicki, 1999, p.38). When employees are not informed about the change process and adequate reasons are given for their imposition, the ultimate message conveyed becomes one of disrespect, as they are not worthy recipients of such information (Folger and Skarlicki, 1999). Hence, it rests on the premise that it matters more to the employees as to ‘how’ the change is implemented rather than ‘what’ it is. People are more vulnerable to perceiving interactional injustice when there is loss of power in an imposed change and the threat this can cause to the established relationships, particularly in groups such as self-managing teams. This can be perceived also as violation of the psychological contract that exists between the employer and the employee (De Cieri and Kramer, 2003; Folger and Skarlicki, 1999).

Psychological Contract

Psychological contract is a concept denoting a state of reciprocity of obligations that exist between employee and employer (Dirks, Cummings and Pierce, 1996). An illustration of this point is contained in the example that there is an informal understanding about the mutuality of benefits to be gained from certain forms of employee and employer loyalty in organisations (De Cieri and Kramer, 2003). Such loyalty may be rewarded by implied promise of career advancement. If the resultant outcome of an organisational change is undermining of this implicit arrangement then “resisting organisational change (maybe) one response to a psychological contract violation” (Folger and Skarlicki, 1999, p. 40). In appraising this ‘resistive behaviour’ from a systemic viewpoint, the organisation will accept it as a form of communication conveying the company’s transgression of trust. A consequence of lack of organisational redress may be the loss of broad-based trust, the absence of which would make any future prospects for organisational change bleak at best (McLain and Hackman, 1999). Analysed from the vantage point offered by Lewin’s (in King and Anderson, 1995) theory of change, the greater the intensity of the opposition which in this instance is a loss of broad-based support from staff due to loss of trust, would decrease the potency of the driving forces for change. Although Bovey and Hede (2001) see resistance to change as inevitable and argue that, “resistance is a natural part of the change process and is to be expected” (p.534), the question becomes, which has been the theme observed throughout this paper, how does one harness its potential as a signpost communicating the dangers ahead for the organisational change efforts.

Resistance as an Adjunct to Organisational Change Analysis

Several authors have combined to challenge the conventional theories of change management by crediting resistance as a positive force (Dent and Goldberg, 1999; Waddell and Sohal, 1998; Hoag, Ritschard and Cooper, 2002; Folger and Skarlicki, 1999; Trader-Leigh, 2002). The intersecting point for most of these arguments has been the resolve that underlying resistive behaviour is an intention of communication by those on whom the change is enacted that the process of implementation is flawed. For example, a middle manager that perceives loss of power as a result of the implementation of self-managed teams may promote ongoing dependence rather than the independence required in such teams. Using resistance to change construct as a model of analysis, and as a form of communication (Dent and Goldberg, 1999; Piderit, 2000), can identify the source of the failure not so much in the individual manager but in systems failure to adequately address the underlying issue of job insecurity felt by the manager. Hence, the assertion that resistance, once accepted as a mode of organisational communication, in assisting with the identification of the problem, it also allows to brainstorm solutions.

Resistance to Solution

Change theorists argue that the most effective way to neutralise the insecurity observed in the above hypothetical scenario is to heighten employee ownership in the process. (Dent and Goldberg, 1999; King and Anderson, 1995). The most commonly used strategies, among others

are to encourage information sharing, participation, institution of mechanisms to improve technical capacity to match changed expectations and psychological ownership which aims to establish a cross-over between employee and employer interests (Pardo del Val and Fuentes, 2003; Savery and Luks, 2000; Waddell and Sohal, 1998; King and Anderson, 1996). Hence, one can argue that the naming of the problem is intrinsically linked to a desire to seek solutions, or as Piderit (2000), suggests having an ambivalence to the proposed changes so that the information conveyed through resistance can be easily incorporated into change strategy. It is proposed that the mere discovery of a problem is the beginning of the solution process, and therein lies the essence of the positive role resistance can play in the change process.

Conclusion

The ongoing argument is predicated on a theme of non-blaming reconstruction of the concept of 'resistance to change'. Attribution of failures in organisational change efforts to individual pathology is an analysis of a problem at the symptom level and, one the author believes ultimately, to be an unhelpful conceptual construct that promotes division when unity of purpose is required. The writer contended that far from being an inherently negative behavioural response to organisational change, resistance, or specifically, resistance to change, is a form of communication between the affected stakeholders during a change process. It has the capacity both to offer some insights into the factors underlying the failures in organisational change process and to aid in the discovery of solutions. Submerging from the surface analysis to a depth of causal analysis would require the weight found in the reframing of resistance as a form of communication of the endemic problems of inadequately planned and resourced change processes. Failure to acknowledge this would be akin to resisting change.

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Stress, Satisfaction and Burnout among Medical Specialists

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Stress-related illnesses, such as burnout, among physicians are receiving increased attention.^{1,2,3,4,5} The negative consequences of stress pose a serious problem, not only for physicians' well-being⁵ but also for the quality of patient care.^{3,5,6,7}

Personal, interpersonal and organisational factors have been reported to relate to stress and burnout.⁸ For instance, burnout seems to be less prevalent among older people and among married people.⁸ Perfectionism, in contrast, increases vulnerability.⁸ Stress induced by emotion-laden patient contacts is often considered a cause of burnout.⁹ In the well-known model of Karasek,¹⁰ social support¹¹ is emphasised as being a moderator between high work load, low work control and stress. In the work of Ramirez and colleagues^{1,12} workload and a lack of adequate resources emerged as important stressors for medical specialists.

Recent changes in society may be relevant to the growing incidence of stress-related diseases among medical specialists. Patients have evolved from being fully dependent to being partners in medical decision-making. They are better informed, more critical and better protected by law.¹³ In addition, in many countries job security has diminished owing to changes in health care organisations.^{14,15} In recent years the balance between work and family has been liable to change as well. Family life increasingly demands time and devotion from both partners.¹⁶ These changes may influence physicians' experience of their work.

Ramirez and colleagues¹ found that job satisfaction among British medical specialists protected against the physical and psychological effects of long-term stress. Therefore, to design effective methods of intervention, research into both stress and satisfaction is needed.

The current findings suggest the protective effect of job satisfaction against the negative consequences of work stress and the importance of organisational rather than personal factors in managing both job stress and job satisfaction. Despite relatively high levels of stress, medical specialists are generally satisfied with their work. This, however, does not imply that medical specialists never run the risk of experiencing burnout. When stress was high and satisfaction low, the risk for emotional exhaustion — the central aspect of burnout — increased considerably. This protective effect of satisfaction on the relation between job stress and emotional exhaustion was also found among British medical consultants.¹

Current evidence suggests a minimal relation between personal characteristics and levels of stress and satisfaction. More surprisingly, job characteristics are found to contribute to stress and satisfaction. The specialists' levels of stress and satisfaction are best understood by their perception of working conditions. Negative consequences of time pressure were important factors. Both the extent to which work intrudes into private life and the extent to which workload makes one feel unable to work according to one's standards contributed to the stressfulness of the job. Changes in society affect job stress as well. The restriction of professional autonomy, job insecurity owing to mergers and the fear of lawsuits were factors that have been discussed.

The specialist physicians job satisfaction has been found to depend on feeling well managed and well resourced. If specialists do not feel supported by colleagues and by the organisation, their satisfaction level falls, a finding also reported by Freeborn²⁶ in a study among physicians

employed by health maintenance organisations. The promotion of personal growth and security in finance and employment influenced satisfaction levels positively, a conclusion also drawn in a US study on job satisfaction.²⁷

Organisational psychological medicine based resilience promotion, workplace psychological health promotion programs have shown to address presenteeism and on the job performance.³⁰

Data available do not support the general assumption that stress among health care professionals is induced by emotion-laden patient contacts.⁹ Although this was the most frequently encountered “stressor,” it did not contribute substantially to overall stress and satisfaction. This finding underscores the relevance of the current shift to organisational stressors in burnout research.²⁸

Studies show that explanations for stress, satisfaction and burnout are primarily found in how specialists experience their working conditions. The profession of medical specialist is inherently stressful and requires a high level of dedication. Owing to societal changes, traditional benefits, such as financial security, status and autonomy, can no longer be taken for granted.

From an organisational psychological medicine workplace psychological health promotion approach, a focused approach to specialists' stress and satisfaction on both an organizational and a health policy level can be a way in mitigating stress and enhancing satisfaction. The principals of wisdom competency has a place in enhancing work satisfaction, impacting positively with perceived stress. For example, other types of rewards and support, such as recognising extra effort by allowing a conference visit, could be provided. Better administrative support and availability of resources and services could help as well. If time is freed up for more crucial and rewarding tasks, particularly patient care, the negative consequences on perceived quality of work may decrease.

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The Role of Mindlessness in Organisational dynamics

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This is an important and evolving phenomenon, the understanding of which leads to enhanced productivity through Infrastructure management. In the corporate world, it is always important to emphasize a top-down approach. Water, used as an analogy, the symbol of nurturance, always flows downward. Therefore, if change occurs at the top of the management chain then this would result in profound changes at the bottom.

If the work atmosphere is seen as supportive ("My workplace is my nurturance") there is better acceptance of work related demands. When we talk about productivity we are often referring to tangible criteria. The human machine does not answer to standard computation as it is managed by an immeasurable entity, the Mind, which may more aptly be assigned the role of the INTRASTRUCTURE. That is to say, Manage the Mind and you manage your manpower. It may more aptly be stated that open-door policies will not work if the internal door is closed i.e. biased. The experiential awareness in the workplace, whether it be subjugative, nutritive or oppressive, results in experiential pathology congruent with the developmental experience and associated transference phenomena. Enhancing, nurturing environments result in positive interdependency leading to peer support and teamwork. Belittling, demoralising experiences lead to negative interdependency, peer conflict and team failure. Human capital management therefore requires awareness and reflectivity of one's behaviour and longitudinal follow through with special attention to pervasive positive change. This applies to the leader and each member of the team.

The CEO's, the department heads and the team managers who are often considered to be the Business Alpha must practice emotional incentiveness vs subjugation by domination. The latter is a manifestation of corporate racism which is defined as an irrational bias toward members of a workgroup who are considered to be of lower hierarchy. The negative outcome of such a bias results in Compathic implosion, Empathic Anhedonia and justification of subordinates "Entitlement to misery".

The cognitive conglomerate which is the result of the sum of the productive and counterproductive dynamic templates influencing the "fluid" state of the mind needs to be positively enhanced by improving ethical acceptability, knowledge of the self and awareness of thinking and behaviour which does not create cognitive dissonance (mind discomfort). The improved ability in identifying, modifying and preventing bias; the ability to manage the cognitive conflict of interest and acquiring dynamic synchronicity results in remodelling of the infrastructure via self-reflection.

Mindlessness, defined as the path towards infrastructure betterment, is a state of being where one is oblivious to that which has been experienced in the past or will be experienced in the future, with a heightened sense of being in the here and now. Achieving mindlessness results in a state of static psychodynamics and enhances productivity in the workplace through the development of mindless dedication.

Valuing the Human Capital in Education Spirituality, and its Contribution to Organisational Transformation

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Issues regarding workplace spirituality have been receiving increased attention in the organisational sciences (Giacalone & Jurkiewicz, 2003a; Mitroff & Denton, 1999), and the implications of workplace spirituality for leadership theory, research, and practice make this a fast-growing area of new research and inquiry by scholars (Giacalone, Jurkiewicz, and Fry, 2005). Moreover, there is emerging evidence that workplace spirituality programs not only lead to beneficial personal outcomes such as increased positive human health and psychological wellbeing but that they also deliver improved employee commitment, productivity and reduced absenteeism and turnover (Giacalone & Jurkiewicz, 2003b; Fry, Vitucci, & Cedillo, 2005; Malone & Fry, 2003). Evidence suggests that there is a positive nexus between spirituality and achieving transformation of organisations.

In a study Malone and Fry (2003) from Tarleton State University undertook a quantitative field experiment in their local central Texas school district to *“determine if there was a relationship between the qualities of spiritual leadership and teacher organisational commitment and productivity”*

Their intention was to engage with two schools in the difficult task of organisational transformation in which significant changes would be made to the workplace “environment, vision, goals, strategies, structure, processes and organisational culture”

Underpinning their method were Senge’s (1990) five disciplines of learning organisations and Fry’s (2003) theoretical work on spiritual leadership as a causal model for organisational transformation.

This model was linked to intrinsic motivation theory and incorporated a number of concepts including “vision, hope/faith, and altruistic love, theories of workplace spirituality, and spiritual survival”. Malone and Fry (2003) explain the practical meaning of some of these concepts.

Creating a vision where in leaders and followers experience a sense of calling in that their life has meaning and makes a difference; establishing a social /organisational culture based on the values of altruistic love whereby leaders and followers have a sense of membership, feel understood and appreciated, and have genuine care, concern, and appreciation for both self and others.

This research was based on the belief that spiritual leadership could positively contribute to the needs of school personnel. They believed the practice of spiritual leadership could develop in people a sense of calling and membership leading to greater congruence in terms of their shared vision and values, as well as improved individual, team and organisational empowerment.

In summarising their research design and results, Malone and Fry (2003) say, “Our field experiment initially examined 229 employees from three elementary and one middle school to test and validate a general casual model for spiritual leadership, employee spiritual survival, and organisational commitment and productivity”.

A one-year longitudinal field experiment was then conducted with two of the original schools with an OT [organisational transformation] visioning/stakeholder analysis intervention, performed in one school with the other as a control. Initial results show strong support for the model and the intervention.

A closer examination of their results shows the school which reported high levels of vision and altruistic love also indicated high levels of commitment, motivation and retention of staff.

The other control school, which lacked vision and love, experienced a noticeable deterioration in its organisational culture. This school was marked as “*a very intimidating, conflict ridden environment*”. In a subsequent report, the principal of the first school said, “*Everything we did as a campus was a result of the campus mission and values which was a direct result of our work with the spiritual leadership theory*” (Malone & Fry, 2003). However, in their conclusion, the researchers concede, “The conceptual distinction between spiritual leadership theory variables and other leadership theories and constructs must be refined”.

Secondly, they point out that there was evidence validating value-based leader behaviour having positive effects on “follower motivation and work unit performance” more research is needed in terms of linking spiritual leadership to such effects.

Key Take Home points:

1. Which practical aspects of educational leadership described in this first example of research by Malone and Fry (2003) do you identify with in your own teaching practice?
2. How do you promote a sense of calling, membership and shared values within your School/organisation?
3. What might ‘altruistic love’ look like and sound like in the context of your leadership?
4. What effect do you perceive your spirituality informed leadership values are having on your school organisation’s transformation and effectiveness?
5. How do you know and how might you find out?

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Infusing Education with Values – Spiritual Values

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Education is humanising as it empowers students to become fully alive, to care for their own and the common good, to relish life and accept its challenges, to exercise their rights and honour their responsibilities, to champion justice and compassion. It fosters students who are confident in their own identity but open to other cultures and perspectives, and who have a knowledge of and appreciation for the sciences, humanities, and arts.

Holistic education engages the whole person - teaching students to think critically and creatively for themselves. Such visionary education requires solid grounding in reading, writing, arithmetic, and rhetoric but adds two more - respect and responsibility.

And that brings us to the crux of the crisis. The most likely sources from which to draw a humanising and holistic education are more spiritual than philosophical. Such education addresses the "deep heart's core," as poet Yeats said. At its best, education is a spiritual affair.

Any mention of soul and spirituality triggers concern about separation of church and state. But the ban on an "established religion" shouldn't mean excluding common spiritual values from our educational system. Proselytising on behalf of a particular religion is very different than allowing spiritual values to permeate our approach to education.

Meanwhile, we are complacent about the philosophy that presently undergirds the education and schooling - a narrow pragmatism concerned primarily, as philosopher William James said, with "the cash value." Such a philosophy isn't neutral: it's as value-laden as any spirituality, imparting an outlook that canonizes whatever "works."

There are spiritual values around which many of the great world religions and spiritualities reach consensus. For educators to allow such spiritual convictions to permeate their teaching and the ethos of schools would be transforming:

- **The equal dignity, rights, and responsibilities of everyone.** This would encourage a liberating, integrated education instead of a functional, fragmented one.
- **Life is a gift charged with purpose and meaning.** This could encourage students to find hope and joy in living in contrast to nihilism and escapism.
- **An emphasis on community.** An understanding that we need and must care for each other. This could offset the reigning "me" attitudes.
- **Spirituality emphasises the quest for wisdom of life.** This could lend a noble vision to study, with every discipline of knowledge fostering an ethic for life.
- **All great spiritual movements teach justice for all and compassion for the needy.** This suggests education in critical consciousness and commitment to social service and transformation.

- **At their best, most faiths are universal in outlook.** Emphasising open hearts and minds and cherishing truth.
- **All spiritualities also are convinced that the human person is essentially spiritual.** That the human vocation is to live in "right relationship" with Almighty - however named - and with oneself, others, and creation.

Infusing values in education goes further to assert that values education for the purposes of influencing character formation, sees every point of interaction within the school, and indeed, the school itself as a possible pathway for the promotion of Morals and Values Education and is capable of being developed to carry effective messages concerning ethics, morality and positive values.

The Value of Mentoring in the Retention of Staff

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Within this chapter clinical supervision and mentorship will be explored and how this can affect the retention of staff in the working environment as well as how mentorship programmes can be beneficial to both individuals and larger organisations. It will briefly look at some recent research carried out by the author. The author is a qualified mental health nurse who has 14 years' experience, post qualification, and 10 of those years have been in a management role within secure services, some low secure and some medium secure.

What is clinical supervision?

Clinical supervision has been part of psychiatric nursing since 1943 and in 1982 the Registered Nurses syllabus included clinical supervision within it however it first became part of NHS Policy in 1993 via the document 'Vision for Future' (Royal College of Nursing, 1999). Clinical Supervision was introduced as a way of sharing good practise, sharing ideas, an opportunity to discuss patient care, enhance the support to the nurses and thus improving patient care. Clinical supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practise and enhance consumer protection and safety of care in complex clinical situations (Chief Nursing Officer, 1993).

Clinical supervision is defined as a supportive relationship between two equals that provides and promotes professional development (Times, 2005). This article, which is about improving practice through clinical supervision, explains that there are several positive outcomes to having effective clinical supervision, to not only the individual but the organisation as well. Identified benefits of allowing staff to have clinical supervision are well documented and is highlighted in this document as the following:

- improved quality of care
- professional development and growth
- reduced stress
- lower sickness rates
- improved recruitment and retention
- improved morale
- better work culture
- reduced emotional exhaustion
- improved relationships with peers and management

The Royal College of Nursing (Nursing, 2002) identifies that not only does supervision improve service delivery and enhance learning opportunities for nurses but it also assists in improving staff recruitment and retention.

What is Mentorship?

Mentorship can be identified as several different things such as coaching, supporting, advising, listening, encouraging, observing and nurturing individuals to be the best they can.

When considering mentorship, Gopee (2008) identifies that mentoring has become a significant dimension of professional life. He goes on to explain that the role of the mentor has been identified by various different titles in the past such as clinical educator and practise supervisor by different healthcare professionals.

‘A mentor affects the professional life of a protégé by fostering insight, identifying needed knowledge, and expanding growth opportunities. This assistance supplements the coaching an individual already receives from his or her supervisor. Traditionally, the mentoring relationship consists of an experienced executive providing guidance and advice to an associate with less experience. The associate is looking to move up the career ladder, usually by learning from someone who is successful and well respected’ (Hollister, 2001).

Hollister in 2001 recognised that mentorship was extremely valuable to those that are skilled to deliver effective mentorship and that it is to do with guidance, fostering and nurturing talent and enabling the individual to grow and develop.

Rey (2016) explains, organisations need to understand the power of effective mentoring and need to get established programs to help younger professionals identify and gain support from more experienced professionals.

According to the Nurse Mentoring Toolkit (MidAmerica, 2009) a mentor is someone that is a coach, advisor, friend, councillors and their role is to support, encourage and guide a nurse so they will continue to grow, both personally and professionally. Some people find this same support through clinical supervision.

In summary, mentorship and clinical supervision are exceptionally similar and have very similar focuses, i.e. supporting and encouraging staff to be the best they can be whilst reflecting and learning from others experiences as well as their own. Having effective mentorship programmes in place will benefit the organisation massively, especially where recruitment and retention is considered.

Identified benefits from having a quality mentorship programme within the workplace have been identified by management mentors (Mentors, 2015) and these have been categorised into 3 separate areas; benefits to the mentor and mentee but also benefits to the company that has mentorship programmes. The benefits to the organisation are listed below:

- shows the outside world that employees are valued
- conveys message to employees that they are important to the company
- creates a more positive work environment
- fosters leadership skills
- fosters more loyal employees – improves retention
- promotes a sense of cooperation and harmony within the company

Block et al (Linda Merre Block, 2005) recognised in 2005 that hospitals were facing nurse retention challenges in the new millennium. They reported that nurses were abandoning the bedside due to job dissatisfaction and that mentorship programmes might help this problem.

They go on to say that if a mentorship programme should be developed, this might well lead to more job satisfaction and thus improve the retention problems that have been identified, and then ultimately, improve patient experiences and outcomes.

In 2008 the Chartered Institute of Personal Development (CIPD) published a model of Engaging Leadership, based on a 3 years’ investigation involving 6000 staff from both the NHS and the

private and public sectors in healthcare environments. Within this model, it is stressed that being a good leader should not be extraordinary, and it is about that individual being open, accessible and transparent. It highlights teamwork, collaboration and removing barriers to enhance communication and original thinking and this provokes engagement from people. Adopting this model in the workplace could help with retention in the workplace as it encourages staff to be innovative, they are encouraged with support to have and embrace new ideas, they would feel valued and listened to. This would develop a culture of development and learning, where the leader is the role model for learning, some would compare this to the role of a mentor.

Retention

When thinking about retention in the workplace Garber (Garber, 2008) explains that the challenge for employers is not only the keep their employees from leaving the organisation, but to keep them interested and focussed on their jobs. He explains that the working environment for new employees needs to be both nurturing and challenging if the organisation wants them to feel like there is a future there for them. Employees need to feel valued and respected but also feel that there is a meaningful career within the organisation. Within the World Health Report (World Health Organisation, 2006) it explores about enhancing the workforce. It recognises that there needs to be strategies identified to improve existing workforce needs and that this needs to be done with immediate effect. The World Health Organisation explains that this can be done by exploring various methods however supervision does make a big difference. It states that supervision is one of the most effective instruments available to improve the competence of individual health care workers.

If people aren't managed and nurtured then subsequently they won't feel valued and potentially look for alternative employment, this is where mentorship programmes could help, they should be allocated and encouraged to aid the morale as well as nurturing and sharing expertise and advise within the workforce.

When looking into retention, leadership plays such an important role within the health care sector as the public are having more expectations and the patient care needs to be of the highest of quality. Within good leadership comes engagement, and mentorship comes under this umbrella as the staff have to engage in the clinical supervision process and if staff do not have confidence in their leader/manager then this might be a challenge. A business case for leadership and engagement is convincing, the organisations with engaged staff deliver better patient experience, experience fewer errors and incidents, have lower infection rates, stronger financial management, higher staff morale and motivation and less absenteeism and less stress, according to a report commissioned by the Kings Fund in 2012 called Leadership and Engagement for Improvement in the NHS (The Kings Fund, Leadership and Engagement for Improvement in the NHS, 2012). Within this report, it recognises that organisations need to be supporting the idea of leadership and engagement in delivering its objectives. There are ideas identified of how to carry this out within organisations and appraisals, clear job design and a well-structured team environment are all mentioned, which are all linked to good mentorship.

Organisations with more engaged clinicians and staff achieve better outcomes and a better experience for the patients' these staff look after (The Kings Fund, Leadership and Engagement for Improvement in the NHS, 2012). If staff feel respected, listened too, empowered and are able to influence and improve care then they are more likely to engage with the organisation for whom they are working for as it will give them a sense of belonging.

The stress that is connected to health care professionals could lead to other problems such as emotional difficulties and attachment problems, which without the right support can lead to certain individuals leaving or experiencing 'burn out'. Burn out is a widely used term within healthcare, especially in secure environments, however, does need to be taken seriously if staff

are showing the signs of burn out as this is a contributing factor to staff leaving. Leiter and Maslach (1997) explain that the joy of success and the thrill of achievement are more and more difficult to attain and this is a major contributing factor for people feeling dissatisfied in the workplace (Leiter, 1997). They identify that burnout is always more likely to occur if there is a mismatch between the job and the person that is employed to carry out said job. Workload is perhaps the most obvious indication of a mismatch within an organisation, people feel that they have to do too much in too little time with too few resources.

When considering engagement of staff within an organisation West and Dawson (2012) suggest that managers needs to give the staff autonomy, enable them to use a wide range of skills, ensure that he job is satisfying and give staff support, recognition and encouragement (Dawson, 2012). Again, this approach has similarities to mentorship.

When thinking about the employee retention it refers to policies and practises that organisations use to prevent valuable members if staff from leaving their jobs. Vasantham and Swarnalatha identify that businesses often find that they spend a considerable amount of time, effort and money to train and develop the new staff into valuable members of the team but this is often for them to leave the company (Vasantham, 2016).

The author of this chapter carried out some research that studied data collected from 2013 through to 2017, and the subjects researched were that of mentorship, clinical supervision and retention within a secure environment based particularly around nursing staff with the nursing shortage in mind. This research project was conducted within a secure mental health hospital that has both low and medium secure wards for male patients over the age of 18 years, that have a diagnosis (or require an assessment for) a mental illness, personality disorder, learning disability and/or autism. It has both acute and rehabilitation services and therefore requires a staff team that are flexible and adaptable to suit the ever-changing needs and challenges of the patient that require our care.

Within this piece of research, it was found that staff that had not left the organisation but had thought about leaving, did not leave due to the support they received. It was highlighted during this piece of research that when staff did have effective mentorship they found this to be of a supportive nature and that this increased their loyalty to the organisation they worked for as well as their job satisfaction.

Employee retention is beneficial for the organisation and retention strategies need to be prioritised, mentorship can help with the retention of staff due to improving morale, the feeling of being valued and supported in the workplace.

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LGBT Terminology – What Organisations Must Know

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People from the LGBT community are now present in every workplace. Not every organisation is aware of the problems that they undergo, and not many organisations have a basic understanding of what various terms used to describe members of this community mean. The members of the LGBT community may face various problems at the workplace which include:

1. Lack of acceptance in groups.
2. Coming out into the open about their LGBT status at work.
3. Employee rejection.
4. Workplace bullying and harassment.
5. Use of slang demeaning terms to describe them.
6. Being the target of fun and ridicule.

The following list of terms aims to describe scientifically the various terminology used in conjunction with the LGBT community and how they must be used when referring to this population with respect and dignity. If possible, organisations must circulate the same amongst their employees so that no misunderstandings and misgivings happen.

Some of the commonly used terms include –

- **Ace:** A sexual orientation label referencing asexuality. It is sometimes called the “Ace Umbrella” to represent the wide spectrum of asexual identities and experiences.
- **Agender (Also Non-gender):** not identifying with any gender, the feeling of having no gender.
- **All-Gender:** Descriptive phrase denoting inclusiveness of all gender expressions and identities.
- **Ally:** Someone who confronts heterosexism, homophobia, biphobia, transphobia, heterosexual and cisgender privilege in themselves and others; 2) A concern for the wellbeing of lesbian, gay, bisexual, trans*, and intersex people; 3) A person who believes that heterosexism, homophobia, biphobia and transphobia are social justice issues; A person who identifies with the privileged group.
- **Asexual:** 1) A sexual orientation where a person does not experience sexual attraction or desire to partner for the purposes of sexual stimulation; 2) a spectrum of sexual orientations where a person may be disinclined towards sexual behaviour or sexual partnering. See also: Ace.
- **Assigned Sex (Assigned Sex at Birth):** The process of sex designation. See also: Designated Sex.
- **Atypical Gender Role.** A person who exhibits a gender role at odds with the norm for their assigned gender and social position.
- **Bigender:** To identify as both genders and/or to have a tendency to move between masculine and feminine gender-typed behaviour depending on context; 2) Expressing a distinctly male persona and a distinctly female persona; 3) Two separate genders in one body.
- **Bisexual:** A person emotionally, physically, and/or sexually attracted to males/men and females/women. This attraction does not have to be equally split between genders, and there may be a preference for one gender over others.

- **Bi-phobia:** The fear, hatred, or intolerance of people who identify or are perceived as bisexual.
- **Cisgender:** A person whose gender identity is aligned to what they were designated at birth, based on their physical sex; 2) A non-trans* person.
- **Closeted (In the Closet):** Refers to a homosexual, bisexual, queer, trans* person, or intersex person who does not or cannot disclose their identity or identities to others.
- **Coming Out:** The process by which one accepts one's own sexuality, gender identity, or intersex status (to come out to oneself); 2) The process by which one shares one's sexuality, gender identity, or intersex status with others (to come out to friends, etc.). This can be a continual, life-long process for homosexual, bisexual, trans*, and intersex people.
- **Crossdresser (CD):** A person who wears clothes, makeup, etc. that is considered to be appropriate for another gender but not one's own (preferred term rather than "transvestite"). Considered part of the greater transgender umbrella community, cross-dressing may be considered "full time" or "part-time."
- **Designated Sex (Designated Sex at Birth):** The sex one is labelled at birth, generally by a medical or birthing professional, based on a cursory examination of external and/or physical sex characteristics such as genitalia and cultural concepts of male and female sexed bodies. Sex designation is used to label one's gender identity prior to self-identification. See also: Assigned Sex.
- **Designated Female at Birth (DFAB):** A phrase describing a person who was deemed to be the female sex at birth via the subjective viewing and labelling of the body's characteristics; 2) having been labelled female at birth because the body possessed traits culturally recognized as female sex; 3) representing the wide spectrum of identities and bodies that were labelled as female when born; 4) In the cases of those who are within the intersex spectrum, the word "assigned" is more frequently used to recognize the subjective labelling of non-binary sexed bodies which may then be surgically altered to reflect culturally constructed female sexed bodily traits (to be written Female Assigned at Birth).
- **Designated Male at Birth (DMAB):** A phrase describing a person who was deemed to be the male sex at birth via the subjective viewing and labelling of the body's characteristics; 2) Having been labelled male at birth because the body possessed traits culturally recognized as male sex; 3) Representing the wide spectrum of identities and bodies that were labelled as male when born; 4) In the cases of those who are within the intersex spectrum, the word "assigned" is more frequently used to recognize the subjective labelling of non-binary sexed bodies which may then be surgically altered to reflect culturally constructed male sexed bodily traits (to be written Male Assigned at Birth).
- **Disorders of Sex Development (DSDs):** A medical classification for intersex people within both the medical community and some intersex communities. See also: Intersex.
- **Drag or In Drag:** Wearing clothes considered appropriate for someone of a different gender. Most often used in performance contexts but also commonly used as an identity label, especially within gender variant communities of colour.
- **Drag King:** A person who identifies as a woman or female who dresses in masculine or gender-marked clothing, makeup, and mannerisms for the purpose of performance. Many drag kings perform by singing, dancing or lip-synching; 2) A person who feels connection to a male or masculine identity while wearing masculine clothing, either in a performance space or in everyday life; 3) A person of any gender identity that identifies with masculine drag "king" performance communities.
- **Drag Queen:** A person who identifies as a man or male who dresses in feminine or gender-marked clothing, makeup, and mannerisms for the purpose of theatre or performance. Many drag queens perform by singing, dancing or lip-synching; 2) A person who feels connection to a female or feminine identity while wearing feminine

clothing, either in a performance space or in everyday life; 3) A person of any gender identity that identifies with feminine drag “queen” performance communities.

- **Fluid:** A gender identity where a person identifies as 1) neither or both female and male; 2) Experiences a range of femaleness and maleness, with a denoted movement or flow between genders; 3) Consistently experiences their gender identity outside of the gender binary. See also: Genderqueer.
- **FTM or F2M (Female-to-Male):** Term used to identify a person who was designated a female sex at birth and currently identifies as male, lives as a man, or identifies predominantly as masculine. This includes a broad range of experiences, from those who identify as men or male to those who identify as transsexual, transgender men, transmen, female men, new men, or FTM. Some reject this terminology, arguing that they have always been male internally and are now making that identity visible, where others feel that such language reinforces an either/or gender system. Some individuals prefer the term MTM (male-to-male) to underscore the fact that although they were assigned female at birth, they never had a female gender identity.
- **Gay:** Term used to refer to homosexual / same gender loving communities as a whole, or as an individual identity label for anyone who does not identify as heterosexual; 2) Term used in some cultural settings to specifically represent male identified people who are attracted to other male identified people in a romantic, erotic, and/or emotional sense.
- **Gender:** A social combination of identity, expression, and social elements related to masculinity and femininity. Includes gender identity (self-identification), gender expression (self-expression), social gender (social expectations), gender roles (socialized actions), and gender attribution (social perception).
- **Gender Affirming Surgery:** Surgical procedures that alter or change physical sex characteristics in order to better express a person’s inner gender identity. May include removal of the breasts, augmentation of the chest, or alteration or reconstruction of genitals. Also called Gender Confirming Surgery or Sex Reassignment Surgery (SRS). Preferred term to “sex change surgery.”
- **Gender Bender:** An individual who bends, changes, mixes, or combines society’s gender conventions by expressing elements of masculinity and femininity together (Also see Gender Fuck).
- **Gender Binary:** 1) The cultural insistence of two diametrically opposed, traditionally recognized genders – male and female; 2) The idea that there are only two genders: male and female. May include a sensed requirement that a person must be strictly gendered as either/or.
- **Gender Cues:** Socially agreed upon traits used to identify the gender or sex of another person. i.e. hairstyle, clothing, gait, vocal inflection, body shape, facial hair, etc. Cues vary by culture.
- **Gender Dysphoria:** Description of emotional or mental dissonance between one’s desired concept of their body and what their body actually is, especially in reference to body parts/features that do not align or promote to one’s gender identity; 2) A term used in psychiatry to refer to the incongruence between an individual’s designated birth sex and their gender identity, with marked dissociation from one’s physical body. See also: Trans* Pathologization.
- **Gender Expression:** How one chooses to express one’s gender identity to others through behaviour, clothing, hairstyle, voice, body characteristics, etc. Gender expression may change over time and from day to day, and may or may not conform to an individual’s gender identity.
- **Gender Identity:** An individual’s internal sense of being male, female, both, neither, or something else. Since gender identity is internal, one’s gender identity is not necessarily visible to others.

- **Gender Identity and Expression:** The most common phrase used in law and policy addressing gender-based needs, often in reference to violence and/or discrimination; encompasses both the inner sense (gender identity) and outer appearance (gender expression).
- **Gender Identity Disorder (GID):** Series of three diagnosis published in the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), originally called "transsexualism" (1980), referring to gender non-conforming identities such as transgender identities. Includes: Gender Identity Disorders in Adolescents and Adults, Gender Identity Disorders in Children, and Transvestic Fetishism (TF). In 2013, the diagnosis will be renamed Gender Dysphoria, Andro/Anthrogynophilia. See also: Trans* Pathologization.
- **Gender Non-Conforming:** Gender expression or identity that is outside or beyond a specific culture or society's gender expectations; 2) A term used to refer to individuals or communities who may not identify as transgender, but who do not conform to traditional gender norms. May be used in tandem with other identities. See also Gender Variant.
- **Gender Neutral:** Used to denote a unisex or all-gender inclusive space, language, etc. Ex: A gender neutral bathroom is a bathroom open to people of any gender identity and expression.
- **Gender Role:** The behaviours, attitudes, values, beliefs etc. that a cultural group considers appropriate for males and females on the basis of their biological sex.
- **Gender queer:** An umbrella term for people whose gender identity is outside of, not included within, or beyond the binary of female and male; 2) Gender non-conformity through expression, behaviour, social roles, and/or identity; See also Fluid, Non-Binary.
- **Gender Variant:** People whose gender identity and/or expressions are different from the societal norms; Broad term used to describe or denote people who are outside or beyond culturally expected or required identities or expressions.
- **Heterosexual:** A person emotionally, physically, and/or sexually attracted to people of different sex or gender.
- **Homosexual:** A person emotionally, physically, and/or sexually attracted to the people of their same sex or gender.
- **Intersex:** One who is born with sex chromosomes, external genitalia, and/or an internal reproductive system that is not considered "standard" or normative for either the male or female sex. Preferred term to hermaphrodite.
- **Intergender:** A person whose gender identity is between genders or a combination of genders.
- **LGBTQPIA:** Acronym representing Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Pansexual, Intersex, Asexual, Ally. Often seen as LGBT or LGBTQ.
- **Lesbian:** Term used to describe female identified people attracted romantically, erotically, and/or emotionally to other female identified people.
- **Metrosexual:** A heterosexual male or masculine person who has a strong aesthetic sense or interest in personal fashion and appearance. First used in 1994 by journalist Mark Simpson.
- **MTF or M2F (Male-to-Female):** Term used to identify a person who was designated a male sex at birth and currently identifies as female, lives as a woman, or identifies as feminine. This includes a broad range of experiences, from those who identify as women or female to those who identify as transsexual, transgender women, transwomen, male women, new women, or as MTF as their gender identity. Some reject this terminology, arguing that they have always been female where others feel that such language reinforces an either/or gender system. Some individuals prefer the term FTF (female-to-female) to underscore the fact that though they were assigned male at birth, they never had a masculine gender identity.

- **Outing (To Be Outed):** The process where someone discloses a person's sexual orientation, gender identity, or intersex status without the concerned person's permission. Directly associated with personal safety and consent.
- **Pangender:** A person whose gender identity is comprised of many gender identities and/or expressions.
- **Pansexual:** A sexual orientation where a person desires sexual partners based on personalised attraction to specific physical traits, bodies, identities, and/or personality features which may or may not be aligned to the gender and sex binary; 2) A sexual orientation signifying a person who has potential emotional, physical, and/or sexual attraction to any sex, gender identity or gender expression; 3) Sexual orientation associated with desiring/loving a person's personality primarily, and specific bodily features secondarily.
- **Passing:** The ability to present oneself as their chosen gender identity rather than one's assigned gender; 2) Being normatively accepted as one's promoted identity, as part of specific cultural expectations; 3) An individual's desire or ability to be perceived as a member of a particular gender, race, or cultural group. See also: Read/Being Read.
- **Queer:** An umbrella term representative of the vast matrix of identities outside of the gender normative and heterosexual or monogamous majority. Reclaimed after a history of pejorative use, starting in the 1980s; 2) An umbrella term denoting a lack of normalcy in terms of one's sexuality, gender, or political ideologies in direct relation to sex, sexuality, and gender.
- **Questioning:** A person is in the process of questioning or analysing their sexual orientation, gender identity, or gender expression.
- **Read (Getting/Being Read):** How a person's gender is perceived by a casual observer, based on gender cues or expression; 2) A trans* person being perceived as transgender, another gender than what they wish to be perceived, or as their designated sex. Also used in reference to how one's race is perceived based on cues or expression.
- **Real Life Test:** A tactic used by healthcare providers where trans* people are required to prove or demonstrate their chosen gender identity by living as their true gender for a year before being allowed to access medical transition resources such as hormones or gender affirming surgeries. Considered a controversial practice, it was changed from a requirement to a recommendation in the Standards of Care in 2011. See also: Standards of Care, Trans* Pathologization.
- **Sex Identity (Sex):** The physical, biological, chromosomal, genetic, and anatomical make up of a body, classified as male, female, intersex, or (in some schools of thought) transsexual; 2) The categorization of a person's physiological status based on physical characteristics; 3) Label of bodies based on a socio-cultural concepts of physiology (e.g. what is a male vs. what is female).
- **Sexual Orientation:** An individual's physical and/or emotional attraction to and desire to sexually or emotionally partner with specific genders and/or sexes. e.g., homosexual, heterosexual, bisexual, pansexual, asexual.
- **Sexual Orientation Identity:** How a person self-identifies in regard to their sexual orientation. (I.e. identifying as Straight, Queer, Lesbian, Gay, Dyke (Dike), Homo, Hetero). Just like Sexual Orientation, Sexual Orientation Identity is not necessarily aligned to the sex or gender a person is attracted to or to whom they are partnered.
- **Single Gender:** Descriptive of a person whose gender consists of one identity, usually either male or female.
- **Social Gender:** The construction of masculinity and femininity in a specific culture, denoted by norms and expectations on behaviour and appearance. See also: Gender.
- **SOFFA:** Acronym for Significant Others, Friends, Family and Allies. Used to indicate those persons' supportive relationship to a queer, trans*, and/or gender non-conforming person.

- **Spivakian Pronouns:** Gender-neutral pronouns: ey/em/eir/eirs/emself (as in ey laughs/I hugged em/eir heart warmed/that is eirs/ey loves emself).
- **Stealth:** Describes the process of a trans* person interacting with others without disclosing their trans* identity or status; 2) Purposefully not disclosing trans* identity or status in order to aid in identity empowerment, promote privacy, or to increase personal safety.
- **Stud:** A female identified or gender fluid person who identifies themselves as masculine physically, mentally or emotionally. Most frequently seen within lesbian communities of colour, most specifically black and African American lesbian communities.
- **Third-Gender:** A gender identity where a person is neither male nor female, nor androgynous; 2) Term used in cultures where it is recognized that there is another gender in addition to male and female; 3) Term used to denote people who are not considered men or women for the purpose of social categorization or documentation; generally used for transgender and/or intersex people.
- **Trans*:** Umbrella term, originated from Transgender (see below). Used to denote the increasingly wide spectrum of identities within the gender variant spectrum. The asterisk is representative of the widest notation of possible trans* identities. Aimed at promoting unification among gender variant communities by placing focus on gender transgression over specific identity labels, genders, or bodies.
- **Transgender (TG):** An umbrella term describing a diverse community of people whose gender identity differs from that which they were designated at birth; 2) Expressions and identities that challenge the binary male/female gender system in a given culture; 3) Anyone who transcends the conventional definitions of man and woman and whose self-identification or expression challenges traditional notions of male and female.
- **Transgender Man (Transman):** A transgender individual who identifies as a man (see also FTM).
- **Transgender Woman (Transwoman):** A transgender individual who identifies as a woman (see also MTF).
- **Transition:** The coming out process of a trans* person; may be continual or deemed to be a set period of time or series of events; 2) To physically change one's appearance, body, self-describing language, and/or behaviours in accordance with their gender identity. May be broken down in parts; social transition (language, clothing, behaviour, legal documents) and physical transition (medical care such as hormones, and/or surgery).
- **Transmasculine:** A spectrum of identities where male identity or masculinity is prominent; 2) descriptive term representative of DFAB, trans male, and/or FTM people; 3) A gender-variant gender expression that has a prominent masculine component.
- **Transphobia:** The fear, hatred, or intolerance of people who identify or are perceived as transgender; 2) Fear and hatred of all those individuals who transgress, violate or blur the dominant gender categories in a given society.
- **Transsexual (also Transsexual)(TS):** A person whose gender identity is different from their designated sex at birth and has taken steps of physical transition so that their body is congruent to both their gender identity and the conventional concept of sexually male and female bodies.
- **Transvestic Fetishism (Previously Transvestism):** A diagnosis in the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) used to describe sexual arousal in connection to gendered clothing, specifically for heterosexual cisgender (non-transgender) men. In 2013, to be renamed and expanded upon in the DMS-V. See also: Trans* Pathologization.

References:

1. Adapted with permission from JAC Stringer of The Trans and Queer Wellness Initiative (2013) JAC (at)
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