

The Impact of Online Resilience Training for Sales Managers on Wellbeing and Work Performance

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Abstract

In a randomised controlled trial, the internet-based *ResilienceOnline* (ROL) program was evaluated among sales managers from an Australian industrial organisation. This program is designed to enhance resilience by teaching seven skills to help improve ability to cope with challenges and setbacks and maximise potential achievements. Sales managers were allocated to complete the ROL program ($n = 26$) or to be in a waitlist-control condition ($n = 27$) and were compared on pre- and post-intervention measures of happiness, quality of life, depression, anxiety, stress and work performance. Sales managers found the resilience training very enjoyable and believed it would improve their work performance and life skills. However, a high proportion of sales managers did not complete the ROL program and it was not found to significantly reduce distress or improve quality of life or work performance.

Keywords: *Resilience; Wellbeing; Workplace; Internet; Online program*

Introduction

While online programs have been found to be effective for treating clinical mental health problems (where a person is experiencing difficulty undertaking daily activities and/or significant distress; Spek et al., 2007), online programs for enhancing mental health (optimising wellbeing) are only just emerging. The internet has been found to be an effective medium to deliver stress management training (Zetterqvist, Maanmies, Stöm, & Andersson, 2003), to promote the development of psychological resources (hope, efficacy, optimism and resilience; Luthans, Avey, & Patera, 2008) and for increasing happiness (Seligman, Steen, Park, & Peterson, 2005) and cognitive wellbeing (Mitchell, Stanimirovic, Klein, & Vella-Brodrick, 2009).

One emerging area for online health promotion is for enhancing resilience in the workplace; a person's ability to persevere in the face of challenges, setbacks and conflicts (Reivich & Shatte, 2002). Research supports the effectiveness of providing resilience training in educational settings (e.g., Gillham, Hamilton, Freres, Patton, & Gallop, 2006) but comparatively little research exists concerning the effectiveness of resilience training in the workplace (Youssef & Luthans, 2007; Martin, 2005).

Most individuals routinely encounter challenges and setbacks in the workplace and hence workplace resilience training has the potential to improve employees' mental health and work performance (Martin, 2005; Youssef & Luthans, 2007). A higher level of resilience in employees has been associated with greater job satisfaction, work happiness and organisational commitment (Youssef & Luthans, 2007). Face-to-face resilience training within government organisations has been found to improve employee's self-esteem, sense of control over life events, sense of purpose in life and interpersonal relations (Waite, 2004).

Given widespread access to the internet in the workplace and time and resource constraints, internet-based training has the potential to be a more accessible, flexible, and cost-effective way to deliver resilience training. However, to our knowledge, published research on online resilience training in the workplace has been limited to one study (Luthans et al., 2008). A two session internet-delivered program was found to enhance levels of hope, efficacy, optimism and resilience in employees, compared to a control program. Only one of these sessions focussed on boosting resilience.

There is a need for research that evaluates the effectiveness of providing comprehensive resilience

training via the internet. *ResilienceOnline* (www.reflectivelearning.com/RO_info.htm) is an internet-based program developed from research at the University of Pennsylvania, designed to enhance resilience by teaching seven core skills. The aim of this study was to evaluate whether online resilience training, through the ResilienceOnline (ROL) program, would improve the psychological health, wellbeing and work performance of sales managers from an Australian industrial organisation.

Method

Participants

Sales managers from an Australian industrial organisation were randomly allocated to the ROL program ($n = 26$) or to a waitlist-control condition ($n = 27$). The group of sales managers are an isolated group, largely based in home-offices in rural and urban Australia. They have very clear work-performance measures in a business that is highly competitive.

Design

ROL was evaluated using a randomised controlled trial design. Online questionnaires were obtained on three occasions; at pre-intervention (prior to starting the program or waiting period), post-intervention (after the end of the program or waiting period) and at follow-up (10-weeks after the end of the program or waiting period). This paper reports on the data collected at the pre- and post-intervention phases.

Measures

The questionnaires used included the Authentic Happiness Inventory (AHI; Christopher Peterson, University of Michigan, unpublished measure), which measures happiness; The World Health Organization Quality of Life – BREF (WHOQOL-BREF; The WHOQOL Group, 1998), which measures four domains of quality of life (psychological health, physical health, social relationships and environment) and the Depression Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995), which measures depressive, anxiety, and stress symptoms.

The AHI is an updated measure of the Steen Happiness Index, which was reported as having good validity, when compared to other happiness measures (Seligman et al., 2005). Researchers who have used the AHI in university student samples have reported internal consistency values for the measure ranging from .92 to .95 (Schiffirin & Nelson, 2008; Silberman, 2007).

The reliability of the DASS-21 and the WHOQOL-BREF is excellent, with the internal consistency of the DASS depression, anxiety and stress scales being $\alpha = 0.84$, $\alpha = .91$, and $\alpha = .90$, respectively (Lovibond & Lovibond, 1995). The internal consistency of the

WHOQOL-BREF scales of physical health, psychological health, social relationships and the environment have been reported to range from .66 to .84 (The WHOQOL Group, 1998).

Statistics for individual work performance (i.e., margin of product sold, and volume of product sold) were obtained from the organisation for the months of June 2008 and October 2008, which coincided with the periods in which participants completed the pre- and post-intervention questionnaires respectively. For both sets of statistics, sales managers had a target level of product gross margin (profit) and volume of product sold to reach. Statistics collected referred to the proportion of that target which was reached.

Additionally, a self-developed “ROL Satisfaction Questionnaire” was administered to the participants after completing the ROL program.

Intervention

ResilienceOnline. The ROL program is designed to enhance seven components of resilience: emotion regulation, impulse control, optimism, causal analysis, empathy, self-efficacy and reaching out (see Table 1).

Table 1: Components of resilience targeted in ROL.

Resilience component	Definition
Emotion regulation	Staying calm under pressure.
Impulse control	Controlling impulses and delaying gratification.
Optimism	Believing that things can change for the better.
Causal analysis	Accurately identifying the causes of problems.
Empathy	Ability to read other people's cues as to their psychological and emotional states.
Self-efficacy	Believing we are effective in the world.
Reaching out	Enhancing positive aspects of life, such as intimacy and taking on new challenges.

ROL enhances resilience by teaching users seven core skills of resilience, based on cognitive therapy. The user is guided through the skills by a video of a psychologist and accompanying slides. The program enables users to interact at any time during the program with several Virtual Partners that help users understand the key learning components from multiple perspectives.

The user is first introduced to the concept of resilience and is able to measure his/her resilience with the Resilience Factor Inventory (measures the seven components of resilience shown in Table 1) and graphical feedback is provided on resilience strengths and areas for improvement, along with a table indicating which resilience skill will help improve each area of resilience.

The core part of the program is learning seven skills of resilience. The first skill "Learning your ABCs" involves understanding the influence of thoughts on feelings and behaviours. In "Avoiding thinking traps" the user identifies habitual automatic thoughts and learns how to challenge them. The third skill "Detecting icebergs" involves identifying underlying beliefs and the fourth skill "Challenging beliefs" involves challenging them. In "Putting it in perspective", the user examines the influence of catastrophic thinking and in "Calming and focusing" the user learns ways to become calm and focused when under stress. Finally, "Real-time resilience" examines quick ways to replace counterproductive thoughts with more resilient ones. The user then makes an action plan by identifies how he/she can apply some of the skills to everyday life.

Waitlist control. Participants allocated to the waitlist control group were informed that they would be contacted in 10-weeks time with details of how they could undertake the ROL program.

Procedures

This study received ethics approval from the Swinburne University Human Research Ethics Committee.

Sales Managers received an email from the organisation's medical advisor inviting them to take part in the Building Life Performance study evaluating the ROL program. Interested sales managers were directed to a website where they read a study information statement and completed an online registration form. Registrants subsequently received an automated email containing their log-in details and a link to a second website, where they were asked to complete three online questionnaires (AHI, DASS-21, and WHOQOL-BREF).

Participants who completed the questionnaires were randomly allocated by a staff member of Reflective Learning (the owners of ROL) to the ROL intervention or waitlist control group sequentially (i.e., AB, AB) using a block design.

Participants were then contacted by email by the Project Manager (located at Swinburne University) to inform them of which group they had been allocated to, and for the details of how they could access the ROL program.

Participants in the ROL group were offered an individual telephone call from a staff member of Reflective Learning in the second week ($n = 18$ received a call) and in the tenth week ($n = 0$ requested a call), to

answer questions about accessing the program or applying the skills to one's life. Midway through the intervention, participants in the ROL group were invited to take part in a group conference call ($n = 4$ took part) with two staff members of Reflective Learning. The purpose of the group conference call was to provide a forum whereby participants could share their experiences, ask questions and talk to staff with specialised knowledge about the program.

Participants also received emails from the Project Manager, encouraging them to complete the program and questionnaires.

On average ($n = 53$), the number of emails sent to the participant by the Project Manager was $M = 5.04$ ($SD = 1.6$) and the number of emails sent by participants was $M = 1.53$ ($SD = 1.9$).

At the end of the 10-week intervention period, participants were asked to complete post-intervention questionnaires (AHI, DASS-21, WHOQOL-BREF, and ROL Satisfaction Questionnaire) those in the waitlist group were invited to do the ROL program.

Standard work performance statistics were obtained from the organisation.

Results

Statistical analyses and procedures

Results were analysed in SPSS Version 16 using intention-to-treat analyses. Dependent variables that were non-normally distributed were transformed (i.e., all 3 scales on the DASS at pre- and post-intervention required a square root transformation). Means and standard deviations for each dependent variable at each assessment phase are shown in Table 2. At pre-intervention there were no significant differences between the groups in terms of the gender, age or educational level of participants (see Table 3). There were no differences between the groups on any of the pre-intervention measures.

Two repeated measures MANOVAs (DASS-21 subscales, WHOQOL-BREF domains) and three repeated measures ANOVAs (AHI, gross margin, volume of product) were conducted, using intention-to-treat analyses.

Response rate

At post-intervention questionnaire response rates were 46% (12/26) for the ROL group and 70% (19/27) for the waitlist control group. The remaining participants did not complete any of the questionnaires at post-intervention.

Table 2: Intervention and waitlist control outcome measures.

Variable	Intervention (<i>N</i> = 26)		Waitlist control (<i>N</i> = 27)	
	<i>M</i> (<i>SD</i>)		<i>M</i> (<i>SD</i>)	
DASS (depression)				
Pre-intervention	5.31 (5.09)		3.78 (5.39)	
Post-intervention	4.69 (4.93)		3.70 (5.28)	
DASS (anxiety)				
Pre-intervention	2.31 (2.24)		2.07 (2.80)	
Post-intervention	2.31 (2.24)		1.56 (2.38)	
DASS (stress)				
Pre-intervention	10.77 (7.44)		7.63 (6.89)	
Post-intervention	9.69 (5.95)		6.30 (4.89)	
QOL (physical)				
Pre-intervention	57.83 (7.42)		58.20 (8.45)	
Post-intervention	58.24 (8.74)		59.51 (9.06)	
QOL (psychological)				
Pre-intervention	69.55(11.17)		71.45 (14.05)	
Post-intervention	70.51 (10.60)		73.46 (14.59)	
QOL (social)				
Pre-intervention	67.95 (19.25)		74.07 (20.19)	
Post-intervention	68.59 (22.15)		75.01 (18.36)	
QOL (environment)				
Pre-intervention	77.16 (10.71)		75.46 (12.73)	
Post-intervention	78.00 (10.73)		76.29 (12.10)	
Authentic Happiness Inventory				
Pre-intervention	3.36 (.48)		3.35 (.47)	
Post-intervention	3.44 (.48)		3.46 (.49)	
Gross margin (% of target met)				
Pre-intervention	93.85 (30.34)		91.96 (28.26)	
Post-intervention	97.10 (23.50)		107.26 (21.87)	
Volume of product sold (% of target met)				
Pre-intervention	87.10 (21.65)		82.52 (23.85)	
Post-intervention	89.20 (27.47)		87.78 (24.40)	

Table 3. Demographic characteristics of intervention and control groups.

Variable	Intervention (<i>N</i> = 26)		Waitlist control (<i>N</i> = 27)	
	<i>M</i> (<i>SD</i>)	%	<i>M</i> (<i>SD</i>)	%
Proportion male	-	84.6	-	88.9
Age	40.50 (9.45)	-	46.00 (9.99)	-
Education level				
- Some high school or less	-	19.2	-	7.4
- High school	-	23.1	-	33.3
- Some university	-	15.4	-	18.5
- Associates degree	-	3.8	-	14.8
- Bachelors degree	-	26.9	-	18.5
- Post-graduate degree	-	11.5	-	7.4

Attrition

Of those participants in the ROL group, four did not start the program, eight only looked at some of the introductory material and four people completed the first resilience skill. Three people completed either the

second, third or fourth skills and seven completed the whole program.

Distress and quality of life

Repeated measures MANOVAS on the DASS-21 and WHOQOL-BREF revealed no significant main effects or interactions. That is, after the 10-week intervention or waiting period there were no significant differences between groups on depression, anxiety, stress or quality of life measures (see Table 4).

Happiness

A repeated measures ANOVA on the AHI revealed a significant time main effect (see Table 4). Both groups reported being happier after the 10 week intervention or waiting period than at baseline, but there were no differences between the groups in happiness (see Table 4).

Work performance

Work performance statistics were available for the pre- and post-intervention periods for 43/53 (81.1%) of the sales managers. For the proportion of sales managers' target gross margin met, a repeated measures ANOVA indicated there was a significant time main effect (Table 4). Both groups met more of their target gross margin after the intervention than at baseline, but there were no differences in work performance between groups. For the proportion of sales managers' target volume of product sold there were no significant main effects or interactions.

Satisfaction with the ROL program

The 12 people (12/26; 46%) who completed questionnaires after undertaking part or all of the ROL program were very positive about the program and how useful it was for them (Figure 1).

The aspects of the program that the participants liked the most included: the personal relevance of the program; the applicability to real life situations; the presentation format; having a talking head (video of a presenter explaining the concepts); and thinking about how other people view a situation; not just from their individual perspective.

Participants also reported on aspects of the program that they liked the least. These included: not finding enough time to work on the program; some of the terminology/jargon used; difficulty recalling what they had covered in the last session; the talking head moving/speaking too quickly, and the video of people who talked about their personal experiences.

Discussion

The aim of the current study was to test the effectiveness of an online resilience training program for improving sales managers' wellbeing and work performance. Participants who completed the ROL

Table 4. Results of MANOVAs and ANOVAs.

Variable	Time effect				Group effect				Time x Group			
	<i>F</i> (<i>df</i>)	<i>p</i>	Partial η^2	Power	<i>F</i> (<i>df</i>)	<i>p</i>	Partial η^2	Power	<i>F</i> (<i>df</i>)	<i>p</i>	Partial η^2	Power
DASS	.76 (3, 49)	.52	.05	.20	1.55 (3, 49)	.21	.09	.38	.33 (3, 49)	.81	.02	.11
AHI	10.50 (1, 51)	.00	.17	.89	.00 (1, 51)	.97	.00	.05	.26 (1, 51)	.61	.01	.08
WHOQOL	.75 (4, 48)	.57	.06	.22	1.23 (4, 48)	.31	.09	.36	.13 (4, 48)	.97	.01	.07
Gross margin	4.85 (1, 41)	.03	.11	.57	.37 (1, 41)	.55	.01	.09	2.04 (1, 41)	.16	.05	.29
Volume of product sold	.52 (1, 41)	.47	.01	.11	.30 (1, 41)	.59	.01	.08	.10 (1, 41)	.76	.00	.06

program reported that they enjoyed the program, found it easy to use and thought that it would be of benefit to their work performance and life-skills. However, there was a high attrition rate and the program was not found to improve happiness, wellbeing or work performance in comparison to the control condition. Nevertheless, it is important to examine the reasons why participants drop out of internet-based programs to inform current knowledge about how best to promote adherence and motivation for wellbeing enhancement programs.

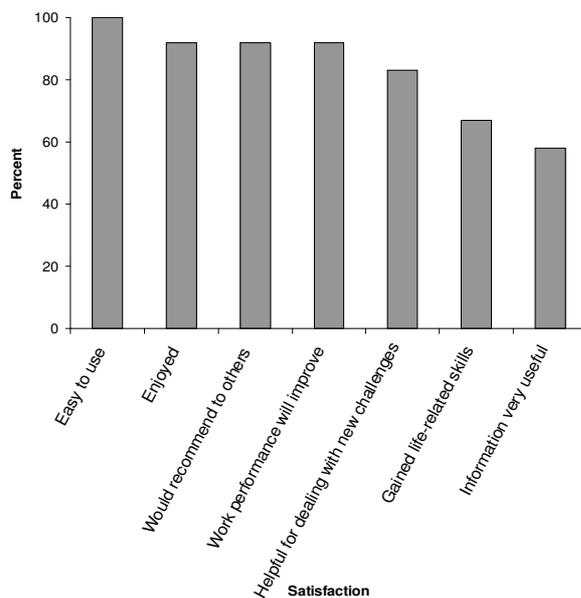


Figure 1: Satisfaction with ROL program

Interestingly, both the ROL and waitlist control groups were happier after the intervention period than before. A similar finding of increased happiness immediately after intervention in both intervention and control conditions was reported by Seligman and colleagues (2005). However, there is some evidence

that the broader effects of wellbeing interventions may not be apparent immediately after intervention, although may be evident at follow-up (Lindquist & Cooper; Seligman et al., 2005). Follow-up data currently being collected for the present study may thus clarify this finding.

Therefore, the absence of significant improvements in distress and quality of life immediately following the program may be due to the insufficient amount of time elapsing for significant change to occur. Alternatively, it may be a reflection of the insensitivity of questionnaires available in this field that are capable of measuring any immediate post-intervention changes in wellbeing. Additionally, changes are likely to be smaller than those seen in people who score in the clinical range. Mean scores for the DASS-21 indicated that participants were not experiencing depression, anxiety or stress prior to intervention (in the "normal" range for the scale). Prior to intervention, participants, on average, reported a lower quality of life in terms of their physical health ($M = 57.83$) compared to the mean score ($M = 80$) from Australian population norms (World Health Organization, 2000) but the other quality of life domains scores were comparable to the norms.

No differences between intervention and control groups were found in sales managers' work performance measures. During the study period, a number of factors were reported by sales managers as affecting the company's ability to meet work performance measures, including floods, drought, price rises, and a 30% decrease in the Australian dollar. Any positive effects of the program may not have been strong enough to overcome these external factors, especially as many people did not complete all of the program. As with the questionnaire measures any changes in work performance may also take time to show and not be evidenced immediately after the intervention.

It is also possible that the absence of significant findings was because the program was not effective for reducing distress or improving happiness, quality of life or work performance. Participants who completed

questionnaires after undertaking ROL ($n = 12$) reported that they found the program enjoyable, easy to use and of benefit to their work performance and life-skills. This suggests that the program did benefit participants but requires replication using more sensitive measures capable of detecting immediate changes in wellbeing.

The absence of significant findings may also be due to the small sample size and high attrition rate. The attrition rate itself raises questions as to why people did not complete the entire program. Three participants reported that they found it hard to make time to do the program. This may be one of the key reasons for the low rate of program completion. Another study with participants working in industry also found participants dropped out of an internet-based program (for tinnitus distress) in part due to lack of time (Abbott et al., in press)

Although participants in the current study were informed by their employer that they could engage in the ROL program activities during work hours, participants were reasonably well and not experiencing distress. They may not have prioritised the program as something that could benefit them over other commitments and interests. Further research is needed to determine ways to motivate people to want to undertake and complete online health promotion programs, such as brief training in time management, prioritisation, and examining values as a precursor to starting the program. Qualitative data via telephone interviews is currently being collected to further determine the impact of ROL on sales managers' wellbeing and work performance, as well as methods of promoting adherence and motivation.

The limitations of the study include a small sample size and a high attrition rate and possible confounding issues (i.e., it is possible that participants in the control group heard about the program content from colleagues who were undertaking ROL), yet this is unlikely as the sales managers are spread all across Australia and work remotely. Nevertheless, this study has helped fulfil a need for evaluation of comprehensive online resilience programs for employees.

In conclusion, sales managers who completed online resilience training found it very enjoyable and reported that it would improve their work performance and life skills. However, a high proportion of sales managers did not complete the ROL program and it was not found to significantly reduce distress or improve quality of life or work performance, in comparison to a control condition. Follow-up questionnaire data and qualitative interview data will provide further insight into the effectiveness of online resilience training for promoting sales managers' wellbeing and work performance.

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Conflict of interest

The Swinburne University eTherapy Unit was contracted by the organisation, from which participants were recruited from, to conduct the evaluation of ResilienceOnline. Mr Andrew Rosenthal is Vice President: Business Development and Marketing for Reflective Learning, the company that owns ResilienceOnline. Andrew was involved with designing the evaluation but the data analyses were carried out by the Swinburne researchers.

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to assist in program implementation and develops partnerships to expand distribution of positive psychology products. Prior implementation includes work with the military, educational institutions, and Global-500 corporations. Andrew has co-founded happier.com, a site that builds happiness and resilience tools for consumers, developed based on research from the University of Pennsylvania and other institutions.

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Research Profile

Dr Jo Abbott is a registered psychologist and Research Fellow in the Faculty of Life and Social Sciences at Swinburne University. Jo has worked on a number of internet-based research studies concerning enhancing resilience and wellbeing, treating posttraumatic stress disorder and treating tinnitus distress.

Associate Professor Britt Klein Britt is a clinical psychologist and the Co-Director of the National eTherapy Centre and the eTherapy Unit in the Faculty of Life and Social Sciences at Swinburne University. Britt's research involves developing and evaluating internet-based clinical assessment systems and singular and transdiagnostic treatment programs for anxiety, mood, and addictive/eating disorders; as well as physical and mental health preventative and wellbeing programs.

Dr Catherine Hamilton is an occupational health physician and has extensive industry experience. Catherine has collaborated with the Swinburne University researchers on a number of projects evaluating online mental and physical health programs.

Mr. Andrew Rosenthal is Vice President: Business Development and Marketing for Reflective Learning. Andrew works with corporate and institutional partners