

Keeping the Faith

When our behavior results in desirable consequences we are likely to do that behavior again. And, when our behavior enables us to escape an undesirable consequence we continue that behavior. Thus, when we see the results of our action -- the fruits of our labor -- we are naturally motivated to keep performing. But often we're asked to perform behaviors that do not result in immediate motivating consequences. And sometimes we never experience a supportive consequence for our actions, yet we continue to perform, often with the presumption that our behavior will prevent an undesirable consequence. In other words, for a variety of proactive behaviors, consequences are not available to naturally motivate us. We perform these behaviors because we have faith they are good for us.

Rule-Governed Behavior

Many people take vitamin pills religiously everyday even though they experience no beneficial consequence. They have developed a belief, perhaps from physicians or research reports, that certain vitamins are good for us. The only supportive consequence received from the behavior of taking a vitamin pill is the internal consequence or "inner speech" that the right behavior was performed. Behavioral scientists call this "rule-governed behavior," meaning we follow a rule because we believe it is good or appropriate, even though we don't experience an immediate external consequence to support our proactive behavior. Often we have faith that a beneficial consequence will occur in the future, but sometimes we don't even think of a consequence. We just take the pill, do the exercise, or buckle the safety belt because someone or something convinced us such performance was good for us. Much of what we do for safety and health can be classified as this sort of rule-governed behavior.

Delayed and Uncertain Gratification

Last October (1996), my article in ISHN introduced the concept of “emotional intelligence” as it relates to safety and health. I discussed the need to control our own emotions, as well as understand and benefit the emotions of other people. For example, safety requires impulse control and rule-governed behavior under difficult circumstances. To be safe, we are asked to do various things which are inconvenient or uncomfortable in order to prevent a negative consequence that seems remote and improbable.

In that article, I described the “marshmallow test” devised by Walter Mischel to measure the impulse control of children. Four-year-olds were given a marshmallow and told they could eat it now or wait until later and receive two marshmallows. Some children went for immediate gratification, whereas others waited for the experimenter to return with a second marshmallow. These children were presumed to have greater emotional intelligence because they could delay immediate gratification for a later, bigger reward.

Waiting for a delayed reward is relatively easy if we really believe the reward will come. In the marshmallow study, it was easy to believe a bigger reward was possible. The children saw one marshmallow right there in front of them, and if there was one marshmallow, there could be two. So getting an extra reward for waiting was credible. When it comes to safety, however, the consequences for impulse control or delaying immediate rewards are usually uncertain and actually improbable.

When we ask people to actively care for health and safety, we’re asking them to give up a powerful immediate reward -- the ease, speed, or comfort they get from at-risk behavior. In return for extra effort, we promise a bigger reward -- they will prevent personal injury or perhaps reduce the possibility a coworker will be injured. Unfortunately, this delayed reward might not

seem credible. People have learned they can get away with at-risk behavior, and many people have not made the connection between their own behavior and the reduction of injuries among others.

Safety requires more emotional intelligence than that shown by the children who waited for two marshmallows. Believing in the availability of an extra marshmallow was easy, compared to believing participation in a safety process will have a beneficial consequence. Even though we'll likely never see a direct connection between a particular safety practice or process and a reduction in our plant's safety record, we maintain our faith that certain work practices and interpersonal communications need to continue. How do we gain faith that certain behaviors will actually reduce our injury record?

Putting Our Faith in Consultants

Safety consultants can provide valuable information and service relevant for injury reduction. But which consultants should we listen to and what kind of service should we request? How can we determine which safety program or consultant service to implement? Where should we put our faith?

Well, how should you decide which vitamin pill to take, which exercise program to follow, or which diet plan to comply with? Do we rely on slick advertisements for direction? Do we count on advice from friends or acquaintances who have selected a particular action plan? Are product promotions and opinions from friends sufficient to give us enough faith to maintain a practice that offers only delayed and remote benefits, at best? I don't think so. Only rigorous unbiased research can give us the assurance that a certain product should be used or a practice followed in the absence of direct observable benefits. Shouldn't we use the same logic when selecting a safety process or consulting service?

Faith in a particular safety process should be directly proportional to the amount of scientific research supporting the theory, principles, or procedures directly related to the process in question. And, don't put much faith in case studies, marketing presentations, or benchmarking visits to another company that used the product or service. This is tantamount to selecting medication or a nutrition program on the basis of a promotional flyer (illustrating remarkable results for certain individuals) or a testimony from a friend or acquaintance.

Too many safety efforts are based solely on benchmarking experiences, slick marketing campaigns, or personal opinion (referred to as "common sense"). Non-scientific and subjective evidence does not warrant long-term commitment to a proactive effort. Such evidence is not enough to sustain the kind of faith necessary to keep our proactive behavior going in lieu of external supportive consequences. Instead, our faith needs a foundation of systematic, objective, and reliable research. So safety professionals need to look beyond a sales pitch to the relevant scientific literature.

Holding Consultants Accountable

Given the need to base our faith on evidence from rigorous research, the key question we should ask the safety consultant is, "What scientific investigation supports the approach you are advocating?" It's not necessary, of course, for consultants to have conducted the empirical investigation themselves, but they should be able to offer substantial scientific justification for their claims. Unfortunately, so many safety presentations in books, magazines, and at professional conferences come across as personal opinion rather than science-supported conclusions. Such presentations will not cultivate sufficient faith for long-term rule-governed behavior, nor should it.

My point here is that safety consultants need to be held accountable for understanding the scientific literature related to the proactive information they teach and the prevention strategies they help to implement. Appropriate research evidence will enable the development of a belief system (or a supportive mental script) sufficient to maintain continuous prevention behaviors. Thus, we need to hold safety consultants accountable for convincing us the prevention approach they advocate is scientifically valid.

Given they have a safety promotion approach founded on scientific research, consultants should be held accountable for helping their clients implement this particular prevention approach. If this includes education and training, an assessment device should be used to determine whether the appropriate knowledge and skills are transferred to the relevant participants. I have found it rare, however, for training consultants to include such an assessment tool with their education or training process. This is partly because participants don't like to be tested. It makes training too much like school. But, how can a client have faith the right stuff is learned without systematic assessment of participants' gain in relevant knowledge and skills?

At seminars and workshops, including my own, presenters are often evaluated more on whether their information sounds good and supports our common sense than on whether the information is founded on valid principles and research-supported procedures. And, evaluation procedures reflect more concern about the ability of the instructor to give an interesting and engaging presentation rather than how much the participants' learn (as potentially assessed by a knowledge or skills test). Unfortunately, assessing gains in knowledge or ability is not easy because high scores on a test of material presented could indicate the information was too elementary or redundant with participants' prior knowledge or skill level.

When consultation includes actual implementation of a particular prevention process, it's possible to maintain a continuous check of the intervention components initiated and completed. The ultimate accountability check occurs when the intervention activities implemented are compared with those found to be scientifically valid in the research literature.

It's possible the recommended intervention process was customized for the particular work culture. And, it's likely the industrial personnel did not implement the preventive process exactly as suggested in the scientific literature. In other words, the real-world setting might be quite different than the one in which the intervention process had been tested and verified. Thus, it would be unfair to hold consultants accountable for final outcomes (such as injury reduction). What's critical is they helped a client implement intervention strategies shown to be effective in systematic scientific research.

Consultants also help their clients customize valid intervention procedures for their culture, and are evaluated on their ability to make that happen. But many things outside the consultant's control (including personnel changes, lay-offs, management policy, etc.) impact the ultimate success of a large-scale intervention. So hold consultants accountable for process variables they can control, not outcomes influenced by factors outside their domain of influence. Then consultants will focus on implementing valid processes rather than promising outcomes beyond their immediate influence.

In Conclusion

This article started with a rationale for cultivating a strong belief in the effectiveness of proactive intervention. Since our efforts to prevent industrial injuries will only rarely be followed by natural supportive consequences, we need to develop an internal script (or belief system) to keep us going. Such faith should be founded on rigorous scientific research, and not

the selected case studies of consultants' marketing presentations or the selective perceptions derived from benchmarking experiences. Only valid scientific research published in peer-reviewed journals warrants the kind of faith needed to fuel a long-term process designed to prevent occupational injuries.

While it's unfair to hold consultants accountable for actual injury outcomes, it is fair and advisable to hold consultants accountable for promoting, teaching, and implementing intervention procedures which have been empirically verified through scientific investigation. Thus it seems we need more presentations of scientific evidence, and less marketing talks, benchmarking visits, and common-sense appeals. This won't happen, of course, if safety professionals use less than scientific evidence to select an intervention approach and cultivate their faith in a process.

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