EAP Study Guide

1996

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Compiled by the UAW and
Produced in collaboration with
The George Meany Center for Labor Studies
Substance Abuse Institute
& Educational Design Unit

Domains I, II, III

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EAPA CODE OF ETHICS

MISSION STATEMENT

The purpose of the EAPA Ethics Committee is to foster the highest practice among Employee Assistance Professionals and the Employee Assistance Professionals Association ("EAPA") members by providing Education and training with regard to the EAPA Code of Ethics and standards for the profession and its members.

PREAMBLE

The EAPA Board of Directors ("Board"), at the call of the Membership, has developed and adopts this Code of Ethics ("Code"). The Code is based on key activities, behavioral standards and most importantly, fundamental goals and values self evident through the examination of our diverse and rich history. This Code has been established to encourage Employee Assistance Professionals to adhere to high standards of ethical behavior for the benefit of their clients. This Code shall apply to activities and relationships between employees, employers, unions, colleagues, professionals from other disciplines, the local community, and society as a whole.

The Board and Membership hold each other, as well as each individual member, responsible for conducting their professional and personal activities consistent with the intent of this Code. This Code serves as a set of guidelines by which Employee Assistance Professionals shall conduct their professional behavior

This document does not supersede nor replace the guidelines on ethics in the *EAPA Standards* or the *EACC Code of Professional Conduct.*

PROFESSIONAL COMPETENCY

Employee Assistance Program (EAP) practitioners shall be professionally competent and proficiently knowledgeable about the employer organization, human resources management, EAP policy and administration, and EAP direct services.

Decisions shall be made according to the client's best interest in treatment modality and continuity of care.

Members who are EAP practitioners shall recognize their boundaries of competence and shall provide services only for which the EAP practitioner is qualified as a result of his/her training and experience. EAP practitioners shall be competent in addressing chemical dependency addictions and emotional disorders.

EAP practitioners shall continue to participate in education and training programs to maintain and enhance proficiency and competency.

Members who are EAP practitioners shall exercise due diligence to recognize the effects of personal impairment on both their personal and colleague's professional performance and quality of services to their clients and, thus, members shall be willing to regularly participate in self care education, and to utilize colleague assistance programs and/or seek appropriate treatment for themselves or for a colleague in such an event.

Members shall recognize the effects of personal impairment on their professional performance and quality of services to their clients and, thus, members shall be willing to seek treatment for themselves or for colleagues in such an event.

PROFESSIONAL CONDUCT

All members shall perform their professional conduct in an ethical and legal manner

A Member shall be considered in violation of this Code if within the two-year period prior to joining EAPA or any time during his/her membership he/she:

a) is convicted of a misdemeanor related to his/her professional functions;
b) is convicted of a felony;
c) is expelled from or disciplined by other professional organizations;
d) has his/her license or certification suspended or revoked, or is otherwise disciplined by regulatory bodies;
e) is no longer competent to practice because he/she is impaired due to physical or mental causes, or the abuse of alcohol or other substances;
f) is determined to have operated outside the recognized boundaries of his/her professional competencies.

CONFIDENTIALITY

Members shall treat all client related information as confidential unless released in compliance with a proper court order or subpoena, or with the written permission and consent of the client.

Members shall adequately inform their clients their rights regarding the scope of limitations of confidential communications during the assessment, referral, treatment, and follow-up process.

Members shall not disclose information without their client's written consent except when failure to disclose would likely result in imminent threat of serious bodily harm to the client or others, and as may be required by law.

The term "client" shall include individual employees as well as the employer company or organization. Members shall also regard their organizational consulting activities as confidential unless given written permission to do otherwise by the company or organization.

CONFLICT OF INTEREST

EAPA members shall not allow any personal consideration, either financial or otherwise, or any other matter which may cause a conflict of interest to affect, in any way, the best interests of the EAP's client.

CONSUMER PROTECTION

EAPA members shall not discriminate because of a client's race, religion, national origin, political affiliation, disability, gender, or sexual orientation. Members shall not engage in professional conduct that results in conflict of interest

When conducting research, members shall respect and safeguard the welfare of research participants.

Individual members shall make full disclosure to their clients and employer organizations regarding the functions and purposes of the Employee Assistance Program as well as any affiliation with a proposed personal provider or organization.

Members shall not provide or receive any financial consideration or gain of any other considerations for referring clients to particular therapists or treatment programs.

Members shall not engage in sexual conduct with clients seeking assistance, referral, treatment, or follow-up services for assessment during the existence of any professional-client relationship, which relationship shall be deemed to exist five years beyond the last date on which the member and the client met professionally. A member shall not act in any manner that compromises the professional relationship with the client.

BUSINESS PRACTICES

Members shall conduct their businesses and professions in an ethical manner. Typical EAP business issues may include sales, competition, advertising, and general business operations, such as record keeping and hiring.

Members shall not discriminate against employing persons based on race, gender, color, religion, national origin, political affiliation, disability, or sexual orientation. All policies and procedures pertaining to employment should ensure compliance with this policy and other applicable employment policies and laws.

All records shall conform to written Standards as maintained by EAPA.

Members shall conduct themselves in such a manner that their business concerns shall not harm or interfere with the positions of their professional responsibilities to clients and employer organizations, as well as to the community at large.

EAP professionals shall conduct supplier/vendor relationships so that there are no personal obligations, actual or implied, which might affect decisions in awarding business.

Members shall conduct themselves fairly and provide all services as agreed to by the member and the client.

Members shall contribute to the betterment of others and the field. Members shall protect the anonymity and confidentiality of clients.

PUBLIC RESPONSIBILITY

EAPA members are encouraged to maintain and promote the highest standards in their profession and to promote employee assistance programs to the public.

EAPA members should commit to educate and foster professional development throughout the field.

Cooperation within a professional community precludes denigrating other professionals to promote one's own interests. An Employee Assistance Professional shall not, in any manner engage in misleading advertising practices, and his/her professional qualifications shall be presented to the public in an accurate and truthful manner.

Research shall be conducted in accordance with ethical standards as maintained by EAPA Standards.

What is an employee assistance program (EAP)?

An employee assistance program (EAP) is a worksite-based program designed to assist (1) work organizations in addressing productivity issues and (2) "employee clients" in identifying and resolving personal concerns, including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance.

"Employee Assistance is the work organization's resource that utilizes specific core technologies to enhance employee and workplace effectiveness through prevention, identification and resolution of personal and productivity issues."
Approved by EAPA Board of Directors, July 2003

EAP Core Technology

The employee assistance program Core Technology (EAP Core Technology) represents the essential components of the employee assistance profession. These components combine to create a unique approach to addressing work organization productivity issues and "employee client" personal concerns affecting job performance and ability to perform on the job. The EAP Core Technology consists of the following:

(1) Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance, and outreach to and education of employees and their family members about availability of EAP services;

(2) Confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance;

(3) Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance;

(4) Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services;

(5) Consultation to work organizations in establishing and maintaining effective relations with treatment and other service providers and in managing provider contracts;

(6) Consultation to work organizations to encourage availability of, and employee access to, health benefits covering medical and behavioral problems, including but not limited to alcoholism, drug abuse, and mental and emotional disorders; and

(7) Identification of the effects of EAP services on the work organization and individual job performance.

Standards and Guidelines for EAPs

Following is an abridged version of the *EAPA Standards and Professional Guidelines for Employee Assistance Programs*. The complete text of the *Standards and Professional Guidelines* provides more detailed information on the essential and recommended components of an EAP, including the intended effect and outcome of implementing each standard. To order the complete text, visit the Resource Center section of this Web site or contact the EAPA Resource Center by calling (703) 387-1000 ext. 307 or sending an e-mail to rescen@eap-association.org.

I. Program Design

A. Needs Assessment

Program design shall be based on an assessment of organization and employee needs.

B. Advisory Function

An advisory process within the organization shall be created and shall provide for the involvement of representatives of all key segments of the workforce.

C. Service Delivery Systems

Employee assistance program services shall be provided through a distinct, identifiable delivery system.

D. Additional Services

The employee assistance program shall remain alert for emerging needs and may add new services when they are consistent with, and complementary to, the EAP Core Technology.

E. Organizational EAP Policy Statement

The organization shall adopt a written policy that defines the employee assistance program's relationship to the organization, describes the program as a confidential resource, and states the scope and limitations of the program's services.

F. Implementation Plan

An implementation plan shall outline the actions needed to establish a fully functional employee assistance program and set forth a timeline for the completion of such actions.

II. Management and Administration

A. EAP Administrative and Operating Procedures

Written procedures for employee assistance program administration and operation shall be developed based on organization needs, program objectives, and the organization's employee assistance program policy statement.

B. Staffing Levels

An adequate number of employee assistance professionals shall be available to achieve the stated goals and objectives of the employee assistance program.

C. Staff and Affiliate Criteria
The employee assistance program shall retain professionals qualified to perform their duties.

D. Affiliate Management
The employee assistance program shall ensure that all affiliates understand and accept the policies, procedures, and responsibilities associated with their role in the employee assistance program.

E. EAP Consultation and Case Supervision
Every employee assistance professional who provides client services shall receive consultation and/or case supervision.

F. Professional Development
The employee assistance program shall support employee assistance professionals' efforts to maintain and upgrade their knowledge.

G. Record Keeping
The employee assistance program shall create and maintain client records that are consistent with the employee assistance program's service delivery system, the organization's policies, program procedures, and applicable legal requirements.

H. Risk Management
The employee assistance program shall take all reasonable precautions to limit its risk for exposure and liability.

I. Ethics
The employee assistance program shall require that all employee assistance personnel adhere to the EAPA Code of Ethics.

III. Confidentiality and Regulatory Impact on Protective Rights

The employee assistance program shall prepare and implement a written policy of confidentiality that reflects professional standards and ethics and clearly elucidates all limits of confidentiality.

IV. Employee Assistance Program Direct Services

A. Problem Identification/Assessment and Referral
The employee assistance program shall identify and/or assess problems of the client, develop an appropriate plan of action, and, when necessary, recommend or refer the client to an appropriate resource for problem resolution.

B. Crisis Intervention
The employee assistance program shall offer responsive crisis intervention services to employees, eligible family members, and the organization.

C. Short-Term Problem Resolution
The employee assistance program shall establish procedures to determine when to provide short-term problem resolution services and when to make a referral to professional and/or community resources.

Roman (1974) further indicated that such jobs provide a setting for "successful deviant drinking" among middle- and upper-middle-level employees (p. 18).

One contributing factor to job defeatedness that may lead to alcohol and drug dependency among lower-status workers lies in the absence of work-role features. Roman and Trice (I 976) have found this absence of work-role features to be similar precursors for possible alcohol abuse in high-status jobs. However, Roman and Trice (1976) provided suggestions on how tasks; considered highly structured, menial, and repetitive; of many blue-collar workers might encourage alcohol abuse.

Job Stress

Work stress often results when an individual is faced with a situation where action is required but an immediate solution is not available (Blake and Mouton, 1982). Increasingly, job stress will become more of a problem for American corporations. Cooper and Marshall (1978) observed, "...Life in complex industrial organizations can be great source of stress: the mental and physical health effects of job stress are not only disruptive influences on the individual ... but also a 'real' cost to the organization on whom many individuals depend on. Cost which is rarely or ever seriously considered in either human or financial terms by the organizations, but one which they incur in their day to day operation (p. 8 1)."

Studies have shown that if a company is experiencing high levels of absenteeism or turnover it may be due to the mismanagement of stress. A distressed employee walking off the job or a middle-manager dying of a heart attack may be signs of mismanaged stress. When the quality and quantity of work decreases in a particular segment of the workforce, this decrease may be a result of the effects of stress on productivity.

Stress is a naturally occurring experience that can have either positive or negative results. Stress is essential to performance, development, and growth at work; and the worker's personal life. At the same time, destructive consequences of stressful experiences are not inevitable. Improper management of stress can have negative effects, for both the individual and the organization.

Milboum (1984) identified two sources of organizational stress: (a) organizational frustration and (b) job stress. Organizational frustration results when people feel they are blocked from achieving their goals. The normal response to being blocked is an attempt to "overcome" the barrier through some form of aggression. Three propositions about the frustration-aggression relationship have been developed by Milboum (1984):

1. The greater the frustration, the greater the instinct to aggression.

2. The stronger the motive being frustrated, the greater the frustration and the impulse to aggression.

3. Aggression as a response to frustration increases with the number of frustrations up to a point, then it decreases (p.2).

Job stress takes two forms: job ambiguity and job conflict. Job ambiguity leads to the lack of clarity surrounding a person's job authority, responsibility, task demands, and work methods. If a job is ambiguous, the worker has unclear work goals, procedures, and responsibilities, and may be uncertain about his or her authority. The person suffering from job ambiguity simply does not know what is expected in terms of job performance.

Job conflict refers to the degree of incompatibility of expectations felt by a person on the job. A worker experiences job conflict when he or she must choose to do nothing over another alternative such as leaving his or her job. This conflict causes the workers to feel uneasy and frustrated.

While job conflict and ambiguity are the most common sources of job stress, there are several other factors that can influence the level of stress. These factors include underutilization of skills, work overload, resource inadequacy, insecurity, and non-participation.

Job stress, from these types of situations, was found to be significantly related to the manifestations of poor mental health including: escapist thinking, depression, low self-esteem, low life and job satisfaction, low motivation to work, intentions to quit job, and absenteeism (Milboum, 1984).

Q Stress research indications that on-the-job stress is caused by all of the following except:

a. Trying to juggle work and home responsibilities

b. Underwork more often than overwork

c. Confusion over job responsibilities

d. Too much responsibility without resources

The answer is "a," trying to juggle work and home responsibilities is not an on-the-job stressor.

EAP Components

The model for employee assistance programming has three major components. The first component is the EAP itself. The second component is not necessarily an entity, as is the EA program, but rather it is a function to be performed. The function is primarily diagnosis, evaluation and referral for employees who are clients of the various EA programs. Because the function may be performed at one location for a number of EA programs, in the model it is labeled as Central Diagnosis and Referral (CDR). The third component is the treatment provider or the various treatment agencies which serve the employee clients.

Function of EAP

The functions of the EA program are generally carried out by either a program coordinator or a steering committee. As the name implies, the responsibilities are coordinative in nature. In the early phases of a program the steering committee has developmental responsibilities; throughout the life of the program, the committee administers and operates the program. The responsibilities of the EAP coordinator or steering committee are summarized below.

Early Phase of Program - Development

Policy Development. A policy which defines the EA program objectives is developed by the steering committee. The policy usually covers the rights of both management and labor, issues such as confidentiality and employee rights, and safeguards to job security and promotional opportunities if the program is utilized. Ideally the policy developed by the steering committee is endorsed by both management and the union(s) where represented.

Procedures Development. Procedures for operating the program are developed by the steering committee. Internal procedures cover; a) the in-plant referral system used by supervisors and union representatives when employees have job performance problems, b) follow-up and feedback procedures when job performance referrals are made to the steering committee, c) program records and confidentiality safeguards, and d) provision for education and training of supervisors and union representatives and program awareness activities (brochures, posters, etc.) for employees.

In addition to developing procedures which are utilized within the employment setting, the steering committee must determine procedures to be utilized in referring clients for diagnosis and treatment in the community. This generally requires familiarity with and, ideally, site visits to available treatment providers and agencies who can perform the CDR function. Procedures for referring employees to the CDR and obtaining feedback from the CDR are developed and agreed upon by both parties.

Second Phase of Program - Operational and Administrative

The EA program operationally deals with two types of clients: those who are referred by supervisors on the basis of job performance deterioration and those who are self-referred. If supervisors have an employee whose performance is deteriorating and who has not been responding to the usual corrective action, the employee may be referred to the EA program. The EA program's specific responsibilities for such a job performance referral would be to:

- Evaluate the individual and the situation to determine how the EA program could be of assistance
- Motivate the worker to respond to the job problem
- Refer the worker to the CDR for assistance

- Monitor the referral by following up to insure it was both effective and appropriate
- Obtain written release of information from the worker to obtain feedback from CDR which would assist the EAP coordinator to help the employee's supervisor in handling any possible disciplinary procedure. Information feedback would also be needed for a union representative if the worker was involved in a disciplinary or grievance process. This feedback generally is done to assure for appointments and follow through with recommendations.

When the EAP coordinator sees an employee who has been self-referred, the same steps are followed as in the job performance referral except that no information would be fed back to the employee's supervisor or union representative unless the employee requested this step.

Education, training, and community outreach are closely associated activities which are provided by the EA program. Employees, supervisors, union representatives and steering committees all require education and training, as well as familiarity with the functions of the CDR and the services of the various treatment resources.

Outreach efforts, through use of posters and other media in the work setting, may also generate a service population for which intervention occurs at an earlier time and with more success than other client populations.

Functions of Central Diagnosis and Referral

The underlying thesis for EA programming activity is that the resolution of personal problems will, for many individuals, result in the resolution of job problems. The CDR activity is developed in order to provide the link between these two areas. This link is designed to insure that people do not "slip through the cracks" and to insure that safeguards are incorporated which protect the individual's confidentiality with regard to any possible personal problem.

The primary functions of the CDR activity can be delineated in the following substantive areas: diagnostic, motivational, referral, interim maintenance, coordinative, and communicative.

In general the functions of the CDR include:

- Diagnosing the nature of the personal problems affecting work performance problems.
- Motivating the worker to accept assistance for these personal problems.
- Referral of the worker to appropriate treatment resource in the community.

Functions of the Treatment Agencies

The responsibilities of the third component of the model, the treatment agencies, are generally well understood. The provision of treatment to individuals referred from the CDR is the primary function. As is necessary in each component, motivational assistance may be required as part of the general treatment process, especially with regard to job performance referrals.

The treatment agencies included in the network may be as broad as the community has to offer. Where available the inclusion of various treatment environments (inpatient, outpatient, residential, and half-way) may be offered. Similarly, the range of services may cover alcohol and drug detoxification, substance abuse treatment, mental health services, family, marital, financial, and legal counseling.

Q Core EAP functions include which of the following?

a. Collaboration with providing wellness programs

b. Early warning system for employee relation problems

c. Assessment and referral of problem employees

d. Management consultation for organizations dysfunction

The answer is "c," assessment and referral of problem employees.

Steps to Developing an Employee Assistance Program

1. Information and Education

The initial step in developing an employee assistance program is to become informed and learn about the different programs models, costs, and resources that are available in the community. Education is one means that can help to shape the worker's behaviors and attitudes toward better personal health care, work performance, and productivity. Providing workers with information on substance abuse and health maintenance is another means of prevention.

2. Assessing Available Resources

Assessing the need and determining the resources, e.g., staffing, budget, commitment in human resources, medical security, safety, and health benefits available are critical elements in the development of an EA program.

Another area is to identify existing employee assistance programs, substance abuse and mental health treatment resources in the community.

3. Commitment and Support

A successful employee assistance program must have the commitment and support of the company's top executives, managers, supervisors, workers and union's top officials, representatives, stewards, and board.

4. Assessing the Need

To determine the type of employee assistance program that best fits the company, set up a labor/management committee or steering committee made up of managers, supervisors, union officials, representatives, stewards, and life staff to: a) study the risk factors within the organization that may cause worker stress, absenteeism, turnover, low morale, etc.; b) identify the company's strengths and weaknesses; and c) develop a set of recommendations for correcting weaknesses. and d) develop a joint EAP policy.

5. Joint Labor/Management Policy

The union and company must reflect workers as the key success factor and investment in future growth. It must integrate employee needs and business objectives into its organizational goals.

6. Designing the Program

In designing the employee assistance program, keep in mind that it should assist the workers in changing behaviors and attitudes that affect their work performance and productivity. It should also include the active participation and input of the workers in the development and decision-making process of the program.

7. Developing the Plan

Once the assessment has been completed, set up a committee consisting of members from all levels of your organization and union to develop a plan to address the labor/management or steering committee's recommendations. Be sure to include input from all of the workers in the development of this plan.

8. Buying into the Plan

Present your employee assistance program plan to the workers, at your general staff meeting, labor/management meeting, council meeting, or at a company retreat. The success of the plan depends on the acceptance and commitment of the employees to the plan.

9. Evaluation

The plan should be evaluated every 3 to 6 months to ensure that the company is on the right track. This will help the company determine if the plan is effective or not without wasting a lot valuable time and resources on a plan that is not effective.

10. Feedback

On-going feedback is vital to the success of the employee assistance program efforts. Feedback can be achieved through memos, newsletters, staff meetings, and praise.

11. Training

The EA program should also provide on-going joint training for union and management EAP leadership on early identification, EAP referral process, and constructive confrontation.

Q The first step in developing an employee assistance program is:

a. Hiring a qualified EAP counselor

b. Developing a formal policy

c. Investigating program types, costs, and advantages.

d. Training of managers and supervisor.

The answer is "c," investigating program types, costs, and advantages.

Q Which of the following steps occurs last in developing an employee assistance program?

a. Hiring a qualified EAP counselor

b. Developing a formal policy statement

c. Investigation program types, costs, and advantages

d. Training of managers and supervisors

The answer is "d," training of managers and supervisors.

Questions

1. If an employee assistance professional receives a phone call from a friend of an employee explaining the employees apparent drinking problem, which of the following should the professional do?

   a. Contact the employee's family

   b. Call the employee in for an assessment

   c. Inform the employee's supervisor of the call

   (d.) Provide guidance to the friend in addressing the concern.

2. A recent trend for employee assistance services is:

   a. Cost effectiveness

   b. Assessment of problem employees

   (c.) Managed care

   d. All of the above

3. EAPs can assist in maintaining organizational health by all of the following except:

   a. Identifying groups needing team building

   b. Conducting stress management workshops

   c. Developing health and wellness programs

   (d.) Advising management of problem employees

4. A client who has met with the EAP counselor, but has not followed through on the referral given, may be considered:

   (a.) An active case

   b. A follow-up case

   c. An incomplete case

   d. A closed case

5. A "paper program" is a term used to describe an EAP that:

   a. Is written, but not implemented

   b. Receives low priority in the organization

   c. Is poorly designed

   (d.) All of the above

6. The differences between EAPs and treatment facilities include:

   a. In an EAP, the client is sometimes the company

   b. The length of contact time differs

   c. Treatment is always client centered

   d. A & C only

7. Companies that chose to implement EAPs have which of the following characteristics in common?

   a. Pragmatic interest in productivity

   b. Sense of social responsibility

   c. Concern for employee relations

   (d.) All of the above

8. In your first session with the Jones family, Mr. Jones told you that he is dating a friend of his wife. In a second session, Mrs. Jones admitted to having a substance abuse program that has created marital problems. In a third session to determine a plan of action, Mrs. Jones cries out that she believes her husband is cheating on her. He tells her in a most sincere way that he is not and never would. You, as the EAP counselor, should:

   a. Confront him with the lie.

   b. Not confront the lie, but instead focus the session on why neither of them trusts the other.

   c. Ask the husband if he thinks his wife is cheating, to show her that suspicion can cause from either side.

   (d.) Not confront the lie, but refer them to a substance abuse program that does excellent family work.

9. Which of the following are not core skills of the EAP counselor?

   a. Constructive confrontation skills

   b. Consultative skills to supervisors

   c. Workplace problem identification skills

   (d.) Benefit consultation skills

10. In the past 3 months, six different employees within a 100 person department have come to you with job stress. All report behaviors of a particular supervisor that do not sound appropriate and may be sexually harassing in nature. No company policy exists regarding the EAPs role in reporting sexual harassment complaints. How would you handle this?

   a. Report your knowledge to the Personnel Manager without using the names of the employees who gave you the information.

   (b.) Encourage each to document the specific behaviors and report the incident(s) to the supervisor's boss.

   c. Ask the employees to write you memos concerning this supervisor so you can talk to him or her.

   d. Give the employees each others names so they can start a petition to get rid of the supervisor.

11. Given the following options, where would be the best place to physically locate an in-house EAP office for all employees?

    a. Medical department/health clinic

    b. On site union office

    c. Human Resource/Personnel Department

    d. Nearby office building

12. A union employee has been strongly urged to see you by management for an assessment due to continued job performance problems. The employee is currently in the disciplinary process, with the referral to the EAP documented. Assuming the union contract makes no specific mention of this type of situation, which of the following is true.

    a. The employee may have his or her steward present if he or she desires, without a consent form being signed.

    b. The employee must have his or her steward present for an EAP session with any mandatory referral.

    c. An employee must provide written consent to have his or her steward present during an initial assessment.

    d. Under no circumstances should the steward be present during an assessment.

13. A supervisor has referred a 60 year old employee to you for missing time from work, memory lapses, and inability to get along with co-workers at times. All of these are occasional occurrences (less than 3x/month). In your interview with the employee, she indicates that she drinks 2 beers per evening and lives alone. What would be your next step?

    a. Refer her to a psychiatrist for mental status exam.

    b. Refer her to a medical doctor for a complete physical

    c. Obtain consents and contact significant others for additional information, including her family doctor.

    d. Refer to a treatment facility for alcoholism.

4. Which of the following is not a component of re-entry interview?

    a. Starting job performance expectations

    b. Restating problems which prompted the referral

    c. Arranging of times to do random drug screens

    d. Arranging times for follow-up sessions with the EAP

15. Determination of Fitness for Duty is the responsibility of.

    a. The supervisor

    b. The Medical Review Officer

    c. The EAP counselor

d. The employee

16. Which of the following would not be a component of the constructive confrontation process?

a. Present employee with evidence of poor job performance

b. Urge him to see an EAP counselor

c. Coach the employee on ways to improve his work

d. Threaten to fire if the employee doesn't stop drinking

17. Which of the following is the first step a supervisor should take in addressing an employee problem?

a. Call the EAP counselor

b. Confront the employee

c. Document job performance

d. Recognize that a problem exists

18. Qualifications of EAP counseling staff should include all of the following except:

a. Skills in interviewing and motivating employees

b. Appropriate managerial and administrative experience

c. A masters or doctorate degree in psychology

d. Knowledge of substance abuse in the workplace

19. A client who has voluntarily met with the EAP counselor, but has not followed through on the referral after several weeks may be considered:

a. An active case

b. A follow-up case

c. An incomplete case

d. A closed case

20. For statistical purposes, which of the following situations would best be described as a "contact"?

a. The EAP counselor is stopped in the hall and asked for the name of a good marital therapist.

b. The EAP counselor is called by the husband of an employee about his wife's drinking. The counselor spends over 1/2 hour trying to encourage the man to come in for an assessment.

c. An employee comes for an assessment and agrees to follow the recommendations made.

d. A supervisor calls and asks to review the procedure for confronting a problem employee.

21. Which of the following is not an advantage of an internal EAP
    a. Greater likelihood of confidentiality
    b. Direct access to employees
    c. Knowledge of the organizational system
    d. Strong communication linkages

22. The most significant factor in choosing an external over an internal EAP is likely to be:
    a. Accessibility by employees
    b. Perceptions regarding confidentiality
    c. Knowledge of the company politics
    d. Utilization by upper management

23. The primary difference between EAPs and psychiatric/chemical dependency treatment facilities is:
    a. In an EAP, the client is always the company
    b. EAPs handle all types of client problems
    c. Treatment is always focused on psyche or substance abuse only
    d. In treatment, the client is always the patient

24. "Paper programs" may occur as the result of:
    a. Company intent to help employees with personal problems
    b. High priority given in the organization to the EAP
    c. Poor or flawed design components
    d. Support from union and management

25. Cost effectiveness of EAP services can be measured in which of the following ways?
    a. Pre & Post treatment co-worker satisfaction
    b. Pre & Post treatment health care costs
    c. Pre & Post treatment tardiness and absenteeism rates
    d. Pre & Post treatment supervisory costs

26. A proactive EAP program would provide all of the following except:
    a. Long term counseling of employees
    b. Management & union training
    c. Early identification of problem employees
    d. Employee awareness activities

27. Utilizers of EAP services have which of the following characteristics in common?

a. They are always referred by supervisors

b. They are in middle/upper management

c. They are open to change and trust the EAP

d. They are women and recognize they have a problem

28. In determining whether a malpractice charge has merit, three of the four following criteria are primary considerations. Which one would indicate that malpractice did not occur?

a. There are resultant damages, either physical or emotional, to the client or his or her family

b. There is a cause-effect relationship between the counselor's actions/ inactions and the event, known as "proximate cause"

c. The counselor was negligent and did not adhere to the standards of her profession in performing her duties

d. Neither the EAP or anyone else could have predicted or prevented the event from occurring

29. You are an EAP counselor employed by a company with over 5000 employees. At a non work related event you meet and find yourself attracted to an individual whom you later learn works for the same company. What is the best response in this situation?

a. Check the company policy on fraternization among employees

b. Enjoy yourself since the co-worker isn't a client of yours

c. Ask the co-worker how he or she feels about dating the EAP counselor

d. Explain that ethically you can't continue the relationship

30. What is the first step to stress with supervisors in handling problem employees?

a. Prepare

b. Observe

c. Confront

d. Document

31. Which of the following would not indicate a possible personal problem?

a. Increased absenteeism

b. Decreased productivity

c. Complaining about job reassignment

d. Changes in personal habits

32. Identification of declining job performance in the impaired executive would include all of the following except:

a. Job shrinkage, both quality and quantity

b. Coverage by secretary

c. Decreased trust and credibility

d. Absenteeism and tardiness

33. The following assumptions must be kept in mind for effective constructive confrontation with executives or professionals except:

a. Job performance is documented

b. Executives/professionals are motivated to progress in their work

c. Career is not a major element

d. Peers may be reluctant to confront him or her

34. A union steward contacts the EAP regarding an employee with multiple grievance filings. Part of the core technology of the EAP would be to:

a. Advise the steward on how to handle the grievance hearing

b. Advise the steward on how to use constructive confrontation skills

c. Teach the steward how to detach

d. Teach the steward how to gather information about the employee's family situation.

35. Employee education about EAPs must include which of the following to be effective?

a. Alcohol and drug awareness

b. Stress management awareness

c. Awareness about EAP policies and programs

d. Family of origin programs

36. All of the following are reasons why an internal EAP program might be viewed as a conflict of interest. Which has the greatest significance for the EAP?

a. Both the EAP counselor and workers are employed by the same company and could have the same boss/supervisor

b. The EAP counselor may not be able to juggle the conflicting needs of the employee and employer

c. The EAP may compromise on employee needs to protect company interests

d. Confidentiality could be compromised since the employee records are actually owned by the company

37. One difference between constructive confrontation and counseling is that:

a. Counseling's focus is on job performance

b. Counseling's origins are in theories of psychotherapy

c. Constructive confrontation's focus is on job performance

d. Constructive confrontation's origins are in humanitarian concerns

38. Factors which influence the ability of problem drinkers being able to accept help from the supervisor include all of the following except:

a. Constructive information regarding services available

b. Having the EAP counselor present during the meeting

c. Meeting alone with the immediate supervisor

d. Telling the employee to quit drinking or he'll be fired

39. Factors related to improved performance following a constructive confrontation with a problem drinker include:

a. Receiving a written warning

b. Being suspended without pay

c. If the worker is older

d. Having the EAP counselor present

40. The main factor which facilitates voluntary utilization of the EAP services is:

a. Sense of confidentiality

b. Recognizing a need for help

c. Supervisory support of the program

d. Job consequences not yet evident

41. An EAP program that provides for early identification, employee education, and management training is said to be:

a. Reactive

b. Selective

c. Proactive

d. Dedicated

42. At least what percentage of all hospital admissions are due to complications of alcoholism?

a. 30%

b. 50%

c. 70%

d. 90%

43. Each of the following topics would not be appropriate for an EAP specific curriculum?

a. Labor history and history of collective bargaining

b. Organizational and management theories

c. Alcohol and other drug assessment techniques

d. Diagnosis of psychiatric illness

44. In preparing for a formal intervention, which of the following would not be appropriate?

a. Having one or tow treatment options available

b. Respecting the employee's confidentiality

c. Having as many people present as possible

d. Coaching the participants as to their roles

45. To avoid the possibility of a lawsuit for negligence, the EAP counselor should do which of the following?

a. Conduct a thorough assessment and referral based on client needs

b. Utilize a limited number of referral resources

c. Insure continuing communication with the supervisor

d. Obtain appropriate liability insurance

46. A borderline personality disorder client responds best to what type of supervisor in the workplace?

a. An easy going, non demanding supervisor

b. Consistent, empathic supervision

c. Multiple and changing supervisors

d. Punitive, demanding or paternalistic supervisors

47. Industrial alcoholism programs prior to the 1970's differed from today's EAPs in which of the following ways?

a. Older programs encouraged self referrals

b. Older programs were proactive in nature

c. Older programs focused on alcohol problems only

d. In treatment, the client is always the patient

48. Each of the following would best meet the description of a "troubled employee"?

a. An employee who is upset because his vacation has been canceled by his supervisor

b. An employee who was accidentally injured on the job

c. An employee whose absenteeism and tardiness are increasing due to a recent divorce.

d. An employee who is nearing retirement and can't decide whether to move to Florida.

49. Broadbrush EAPs are designed to:

a. Promote employee wellness

b. Reduce stress in the workplace

c. Focus solely on chemical dependency in the workplace

d. Address personal problems affecting employee work performance

50. Who/What was the "Thundering Hundred?"

a. Ralph Nader's watchdogs for public policy

b. Two federal agents/state to enforce the Hughes Act

c. Federal agents who monitored Prohibition laws in each state

d. NIAAA's funding of two occupational Program Consultants per state

51. Approximately what percent of on-the job accidents are due solely to personal problems?

a. 0 - 10%

b. 15 - 20%

c. 45 - 50%

d. 60 - 65%

52. Which of the following would best meet the description of a "troubled employee"?

a. An employee who is upset because his vacation has been canceled by his supervisor

b. An employee who was accidentally injured on the job

c. An employee whose absenteeism and tardiness are increasing due to a recent divorce

d. An employee who is nearing retirement and can't decide whether to move to Florida

53. Advantages of internally based EAP programs include all of the following except greater:

a. Likelihood of confidentiality

b. Convenience of employees

c. Knowledge of the organization

d. Communication linkages

54. An internal EAP is one in which the:

a. The EAP counselor is employed directly by the organization/ company

b. The EAP counselor is not an employee but his or her office is on site

c. EAP services are provided by an outside service contract/vendor

d. EAP services are provided by the union for several companies

55. An externally based EAP is one in which:

a. The location of the EAP counselor is within the organization/facility.

b. The EAP counselor is an employee, but his or her office is off the premises.

c. The EAP services are provided by an outside service contract.

d. The EAP services are provided by the union only.

56. Advantages of externally based EAPs include all of the following except greater:

a. Likelihood of confidentiality

b. Accessibility to employees

c. Autonomy in operations

d. Utilization by top management

57. Advantages of internally based EAP programs include all of the following except greater:

a. Likelihood of confidentiality

b. Convenience to employees

c. Knowledge of the organization

d. Communication linkages

58. The key factors in selecting a site for an internal EAP office would be:

a. Easy physical accessibility for all employees

b. Warm inviting atmosphere

c. A location that protects confidentiality

d. Close proximity to the medical department

59. EAP training for supervisors and union representatives would MOST appropriately include:

a. Counseling a troubled employee

b. Documentation of work performance problems

c. Advocacy for the troubled employee with upper management

d. Identification of an alcoholic employee in need of an EAP

60. Constructive confrontation refers to the supervisor confronting the:

a. Employee about his drinking problem

b. Employee concerning his attitude

c. Union steward about his employee

(d.) Employee concerning his job performance

61. For constructive confrontation to be effective, it should include all of the following except:

a. Giving specific behaviors as examples of poor job performance

b. Defining what is acceptable job performance

c. Reminding the employee that the EAP is available to him or her

(d.) Confronting the employee about his drug use off the job

62. What is the FIRST step that the supervisor should take before confronting a troubled employee?

a. Refer the employee to the medical unit for evaluation.

(b.) Document evidence of the employee's work performance.

c. Talk to the employee's family about the suspected problem.

d. Discuss the employee's problem with other supervisors to get their opinions.

63. Which of the following is not a part of the core technology of EAPs?

a. Identification of problem employees through job performance

b. Identification of the alcoholic/substance abuser

c. Provision of linkages with treatment resources

(d.) Short term counseling of families

64. Each of the following is not a part of the core technology of EAPs?

a. Assisting supervisors to problem employees through job performance indicators

b. Assessment and referral of the alcoholic/substance abuser

(c.) Provision of Managed Mental Health care

d. Training supervisors regarding appropriate use of constructive confrontation

65. An EAP program that provides for early identification, employee education, and management training is said to be:

a. Reactive

b. Selective

(c.) Proactive

d. None of the above

66. An employee who contacts the EAP counselor to discuss a problem with a co-worker:

a. Is a voluntary referral
b. Is a supervisory referral
c. Is not using the program appropriately
d. Should be referred to his supervisor

67. The main factor which contributes to non-utilization of the EAP services is:

a. Questionable confidentiality
b. Denial of need for services
c. Lack of supervisory support
d. Fear of job jeopardy

68. The least likely factor contributing to utilization of EAP services is:

a. Recognizing a need for help
b. Trust in the services
c. Supervisory support of the program
d. Peer referral

69. Cost effectiveness of EAP services can be measured in which of the following ways?

a. Pre- & post treatment absenteeism
b. Pre- & post treatment cooperation with co-workers
c. Pre- & post treatment supervisory costs
d. None of the above

70. When an employee relapses, the employer should:

a. Contact the EAP counselor
b. Stay focused on job performance
c. Fire the employee
d. None of the above

71. Signs in the workplace of a chemically dependent employee's potential of relapse includes:

a. Increased efficiency
b. Increase in compulsive behaviors at work
c. Insisting on only working 40 hours so they can attend AA meetings
d. Admitting that they are having difficulty at work

72. Core EAP functions include which of the following?

a. Collaboration with providing wellness programs

b. Early warning system for employee relations problems

c. Assessment and referral of problem employees

d. Management consultation for organizations dysfunction

73. The first step in developing an employee assistance program is:

a. Hiring a qualified EAP counselor

b. Developing a formal policy

c. Investigating program types, costs, and advantages

d. Training of managers and supervisor

74. Which of the following steps occurs last in developing an employee assistance program?

a. Hiring a qualified EAP counselor

b. Developing a formal policy statement

c. Investigating program types, costs, and advantages

d. Training of managers and supervisors

75. Which of the following services needed by employees when a lay off or downsizing occurs would be best supplied by the EAP?

a. Extended medical benefits

b. Help with resume writing and job search skills

c. Assessment of need for supportive counseling

d. Assistance with values clarification workshops

76. Stress research indications that on-the-job stress is caused by all of the following except:

a. Trying to juggle work and home responsibilities

b. Underwork more often than overwork

c. Confusion over job responsibilities

d. Too much responsibility without resources

77. Broadbrush EAPs are designed to:

a. Promote employee wellness

b. Reduce stress in the workplace

c. Focus solely on chemical dependency in the workplace

d. Address personal problems affecting employee work performance

78. If an employee assistance professional receives a phone call from a friend of an employee explaining the employee's apparent drinking problem, which of the following should the professional do?

a. Contact the employee's family
b. Call the employee in for an assessment
c. Inform the employee's supervisor of the call
d. Provide guidance to the friend in addressing the concern

79. An employee performing unsatisfactorily should be initially approached by the:

a. Supervisor
b. Company physician
c. Human resources professional

80. A self referral to the EAP would be:

a. A family member who contacts the EAP about his son
b. A supervisor who contacts the EAP about his employee
c. An employee who contacts the EAP about his boss
d. All of the above

81. Conflict of interest may occur in which of the following situations?

a. If a personnel manager tells the EAP where to send clients for treatment
b. An EAP counselor refers employees to therapists he has personally met
c. An external EAP program sends all of its chemically dependent employees to the hospital/facility that owns the EAP
d. An EAP refers all clients with financial problems to Consumer Credit

82. Which of the following have been found to be true regarding differences between men and women using EAP services?

a. Men tend to be more supervisory referred
b. Women are usually extrinsically motivated
c. Job loss poses a more serious threat to women
d. Men are more concerned about relationship problems

Answers

1–d
2–c
3–d
4–a
5–d
6–d
7–d
8–d
9–d
10–b
11–d
12–a
13–c
14–c
15–a
16–d
17–d
18–c
19–d
20–c
21–a
22–b
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73–c
74–d
75–c
76–a
77–d
78–d
79–a
80–d
81–c
82–a

CHAPTER 2 EAP POLICY DEVELOPMENT

I. Policy Development

The very substance of an Employee Assistance Program (EAP) is provided through a written policy which, in effect, states the organization's position on substance (alcohol and other drugs) use/abuse. The program's acceptance and credibility depend upon how well this policy provides clear-cut answers to questions which are uppermost in the minds of the affected employees (George C. Dimas, 1977). Questions to be addressed by the policy include:

1. Does the organization really accept alcoholism and drug addiction as a disease?

2. Will it be handled the same as any other disease?

3. How is alcoholism and drug dependency defined for program purposes?

4. Will request for, or acceptance of treatment affect job security or promotional opportunities?

5. Will records of the program be kept in strict confidence?

6. Will group health insurance benefits cover treatment of alcoholism and drug addiction, mental health?

7. What are the consequences of refusing or failing to respond to treatment?

8. Will there be opportunity for self-referral on a confidential basis?

9. Is the primary purpose to encourage employees to seek diagnosis and treatment in order to arrest the disease/addiction as early as possible?

These crucial questions must be answered jointly by union and company.

In addition, any policy that is formulated, careful consideration should be given to:

A. Clarifying something about which there has been confusion or ambiguity;

B. Altering a previous policy, written or unwritten, which is obsolete, inadequate or in error; or

C. Changing an existing course of action that has been found to be detrimental to the overall objectives of the organization.

Regardless of the personal or health problems to be included in an Employee Assistance Program, the language of general policy will focus upon establishing uniformity of action regarding the following matters:

Affirming the principle that the illnesses listed in the policy will henceforth be handled in a manner consistent with the handling of other recognized illnesses.

Assuring that nothing in this new policy, except as specifically stated, will be construed to alter standard personnel policies, and the responsibilities or right of individuals, unions or management will not be changed.

Explaining that the same degree of confidentiality will be accorded to the handling of behavioral-health problems (including alcoholism and drug dependency) as would be appropriate in the case of other illnesses.

II. Policy and Procedure

A. Policy Statement

An organization shall adopt a written policy statement on alcoholism and other problems covered by the Employee Assistance Program. This will be signed by the Chief Executive and union head where appropriate, and will reflect management and labor attitudes and agreements as to the Program's objectives. The policy should state that alcoholism is a disease responsive to treatment and rehabilitation and specifying the responsibilities of management, union representatives, and employees as they relate to the Program. The EAP need not in any way alter management's responsibility or authority or union prerogatives. Participating in the EAP will not affect future employment or career advancement, nor will participation protect the employee from disciplinary action for continued substandard job performance or rule infractions.

B. Confidentiality

Written rules will be established specifying how records are to be maintained, for what length of time, who will have access to them, what information will be released to whom, and under what conditions, and what use, if any, can be made of records for purposes of research, evaluation, and reports. Client records maintained by an EAP should never become part of an employee's personnel file. Adherence to Federal regulations on confidentiality of alcohol and drug abuse records (42 CFR Part 2) is required of a Program even indirectly receiving Federal funds.

A policy statement developed within the workplace for EAPs should include:

a. Endorsement by both labor and management

b. A statement about confidentiality

c. A statement about family usage of the program

d. A & B only

The answer is "d," a policy statement should be developed by joint labor/ management and include a statement about confidentiality.

C. Procedures for individuals referred by management and/or union representatives

Each EAP will prepare written procedures for action initiated by management and/or union representatives. This will provide an assessment by EAP staff, evaluation by professionals, referral for treatment, feedback to and from the referral source and follow-up. For alcoholism or drug addiction cases there should be a follow-up at least monthly for a minimum of one year.

D. Procedures for voluntary use of the program by employees/family members

Procedures for individuals who refer themselves will provide for assessment by EAP staff, evaluation by professionals, referrals for treatment and follow-up. The Program will initiate no contact with management/union concerning individuals who refer themselves, consistent with confidentiality regulations.

III. Administrative Functions

A. Organizational position of the EAP

Operation of or responsibility for the EAP should be a position at an organizational level high enough to insure the involvement of senior management and/or union leadership in sustaining the Program.

B. Physical location of the EAP.

The physical location of the EAP should facilitate easy access while insuring confidentiality.

C. Record-keeping system.

Each EAP will have a record-keeping system carefully designed to protect the identity of the client, while facilitating case management and follow-up and providing ready access to statistical information.

D. Relation of the EAP to the medical and disability benefit plans.

There should be a review of medical and disability benefits to insure that plans adequately cover appropriate diagnosis and treatment for alcohol, drug, and mental health problems. Where feasible, coverage should include outpatient and day treatment care. The EAP staff should be familiar with provisions of the medical and disability benefit plans so they can advise clients clearly as to the extent, nature and cost of the recommended treatment and reimbursement available.

E. Malpractice/liability insurance.

The organization should conduct a legal review of all aspects of the EAP program. The purpose is to insure that there should be adequate protection for all EAP staff and the organization against possible malpractice/liability claims.

F. Qualifications of EAP staff.

The EAP staff should combine two primary qualifications:

Appropriate managerial and administrative experience.

Skills in identifying problems, interviewing, motivating, referring clients, and, where appropriate, in counseling or related fields. Experience and expertise in dealing with alcohol related problems are essential.

IV. Education and Training

A. Communicating EAP services to employees and their families

It is important that employees and their families are informed about the organization's EAP and the services it offers and are continually updated by various educational techniques on its existence and availability. Information about the EAP should be made available to all new employees and their families.

B. Employee education

An organization should have a major commitment to ongoing education about alcohol and drug use and abuse. Additional efforts should be made to educate employees about prevention and other recognized problem areas.

C. Orientation of management and union representatives

Management and union representatives should be thoroughly informed about their key role in utilizing the EAP services. Orientation for management and union representatives should be updated regularly.

V. Resources

A. Resource file of providers of assistance

Each EAP should maintain current information about substance abuse, mental health and other resources. These include Alcoholics Anonymous, Al-Anon, Alateen, and other self-help groups, appropriate health care, community services and other professionals.

B. Program review and evaluation

There should be a periodic review of the EAP program to provide an objective evaluation of operation and performance.

C. Staff performance evaluation

There should be an annual evaluation review of EAP staff performance.

Components of a Policy

I. Indication of Labor/Management Cooperation

A. Rationale

1. To insure cooperation by emphasizing joint effort and concern.
2. To let workers know that the program is supported by both labor and management.

B. Example

The XYZ Company and Local 123 have agreed to work cooperatively in the development and implementation of this program. It is understood that this cooperation will be within the framework of the existing contractual agreement. A committee having equal representation from labor and management will be formed to coordinate the program functions.

II. Recognition That Alcoholism and Other Drug Addictions are Illnesses

A. Rationale

1. To dispel the stigma that alcoholism and drug addiction stem from a poor moral character.
2. To emphasize that alcohol and other drug addictions can be successfully treated.
3. To increase awareness that the illnesses do exist both in society and the company.

B. Example

The XYZ Company and Local 123 recognize that alcoholism and other drug addictions are illnesses that can be successfully treated; and that treatment is in the best interest of the worker, union and company.

III. Recognition That Other Personal Problems Exist

A. Rationale:

1. To combat a stigma that personal problems are caused by a weak moral character.
2. To stress that all personal problems can be successfully treated.
3. To increase awareness that personal problems of many kinds do exist in society and in the company.

B. Example

The XYZ Company and Local 123 recognize that among the total number of cases referred for professional diagnosis on the basis of deteriorating job performance, there will be problems other than alcoholism and other drug addiction; e.g., family, marital, financial, or mental health, or others.

IV. Statement of Program Purpose and Objectives

A. Rationale

1. To clarify the purpose of the program.
2. To specify who the program is for.

B. Example

The primary objective of this program is to provide effective assistance and treatment to those individuals in need and to help labor/management

deal more effectively with workers with personal problems which cause deteriorating job performance.

V. Statement of Workers' Rights

A. Rationale

To assure workers that neither job security nor promotional opportunities will be jeopardized by their involvement in the program.

B. Example

XYZ Company and Local 123 assure any worker that involvement in this program will not jeopardize his/her job security and/or promotional opportunities. THIS PROGRAM IS TO HELP, NOT HARM. IT IS DESIGNED FOR REHABILITATION, NOT ELIMINATION OF THE WORKER.

VI. Statement of Labor/Management Rights

A. Rationale

To assure compliance with labor/management contractual agreement.

B. Example

Nothing in this statement of policy is to be interpreted as constituting a waiver of management's right to take disciplinary measures or labor's right to the grievance procedure within the framework of the contractual agreement.

VII. Statement Concerning Confidentiality of the Program

A. Rationale

1. To ensure worker's anonymity.
2. To generate worker's trust in the program.
3. To assure worker's legal rights.

B. Example

All problems and records handled through this program will be treated in a strictly confidential manner.

VIII. Statement of Worker's Responsibility

A. Rationale

1. To differentiate between worker's responsibility and labor/ management responsibility.
2. To clarify rights of worker regarding use of the program.

B. Example

To make the decision to accept involvement in the program is the personal responsibility of the worker. Persons participating in the program will be expected to meet existing job performance standards and established work rules within the framework of existing labor/management agreements. Any exceptions to this requirement will be by mutual agreement between labor/management.

IX. Statement of Labor/Management Responsibility

A. Rationale

To assure that all levels of labor/management will implement the policy and follow established procedures.

B. Example

It will be the responsibility of all management supervisors and labor representatives to implement this policy and follow the established procedures.

Q A policy statement developed within the workplace for EAPs does not need to include:

a. Endorsement by both labor and management

b. A statement about confidentiality

c. A statement about family usage of the program

d. A statement about employee use of the program

The answer is "c," a policy statement does not have to include information about family usage of EA program.

Questions

1. A policy statement developed within the workplace for EAPs should include:

   a. Endorsement by both labor and management

   b. A statement about confidentiality

   c. A statement about family usage of the program

   d. A & B only

2. A policy statement developed within the workplace for EAPs does not need to include:

   a. Endorsement by both labor and management

   b. A statement about confidentiality

   c. A statement about family usage of the program

   d. A statement about employee use of the program

Answers

1–d

2–c

CHAPTER 3 CONFIDENTIALITY

The privacy of persons receiving alcohol and drug abuse prevention and treatment services is protected by federal laws. The legal citation for these laws is 42 U.S.C. ss290dd-3 and 33-3. The regulations directing the implementation of these statutes were issued in 1975 and revised in 1987. They are found in the Code of Federal Regulations: 42 C.F.R. Part 2.

Many states also have confidentiality laws that apply to substance abuse treatment. These may afford individuals even greater privacy than the federal law. However, state laws may not be less stringent than federal laws. If they are, the federal law (or the more rigorous one prevails).

The federal confidentiality law applies to all programs providing alcohol or drug abuse diagnosis, treatment, or referral for treatment that are federally assisted. Included are the following:

- Programs receiving any type of federal funding
- Programs receiving tax exemption status through the Internal Revenue Service
- Programs authorized to conduct business by the federal government, such as those licensed to provide methadone or those certified as Medicare providers
- Programs conducted directly by the federal government or state or local governments that receive federal funds

The primary intent of the confidentiality law is to prevent disclosure of information - both written and verbal - that would identify a person as a patient receiving alcohol or drug treatment. This protection is even extended to those who have applied, but were not admitted to the program for treatment, and to former patients and deceased patients. Not only are programs prohibited from disclosing information, except under certain conditions to be discussed later, but they also are not allowed to verify information that is already known by the person making an inquiry.

As an EAP specialist, you have two major responsibilities:

- Protection of written information
- Protection of verbal information

Patients are entitled to notifications of the federal confidentiality laws and regulations. Programs should provide a written summary of these provisions upon admission. The written summary should include:

- Information about the circumstances in which disclosure can be made without the client's consent

- A statement that violations of the regulations may be reported as a crime
- A warning that committing or threatening a crime on the program's premises or against program staff can result in release of information
- Notification that the program must report suspected child abuse or neglect
- Reference to the federal law and regulations

Programs must keep client records in a secure room, a locked file cabinet or other similarly protected places. There should be written procedures concerning who has access to client records. A single staff member should be designated to handle inquiries and requests for information about clients.

Protection of Information from Oral Disclosure

This area of responsibility may be a bit more difficult to fulfill. You are responsible for the protection of information from illegal and/or unethical oral disclosure. Conversations about clients with friends or union or supervisors may seem harmless or insignificant. However, to engage in such conversations is an illegal disclosure of confidential information, even though this may not be your intention.

Exception to the General Confidentiality Conditions

Under certain conditions, programs may disclose information about persons receiving or applying for treatment. These are described in the following sections.

■ Patient Consent

Clients may sign a consent form allowing for the release of information. However, consent forms must contain specific information, including the following:

- Program name
- Person or individual to receive the information
- Client name
- Purpose or need for the disclosure
- The specific amount and kind of information to be released
- A statement that the client may revoke the consent at any time
- Date, event, or condition upon which the consent will expire
- Date upon which the consent is signed

Only information that is necessary to accomplish the purpose stated in the form may be released. Even if a properly signed consent form is in effect, programs are allowed discretion about disclosing information, unless the form is accompanied by a subpoena or court order. It is usually necessary for clients to sign separate consent forms for each type of disclosure and

for each person or organization to whom information is to be released. However, if similar information will be released to the same person/ organization during the period the consent form is valid, signing a form for each release is not required. This might occur with funding sources requiring verification of treatment provided over the course of a person's enrollment in a treatment program. On the other hand, if a different type of information is requested by the same person/organization, a new consent form would be required.

Client's may revoke their consent at any time, either verbally or in writing. This does not require the program to retrieve information disclosed when the consent form was valid. If a client revokes a consent form permitting disclosure of information to a third-party payer, the program still may bill the payer for any services provided during the time the consent form was valid. However, after revocation of consent, the program may not release information to third-party payment sources. If services continue to be provided, the program risks not receiving reimbursement.

The expiration date of consent forms should be at a time that is reasonably necessary to achieve the purpose for which they are signed. Rather than a specific date, consent forms may expire when a certain event or condition occurs.

Q To release information on troubled employees, the employee assistance professional needs the consent of the:

a. Employee or client

b. Corporate counsel

c. Immediate supervisor

d. Director of human resources

The answer is "a", employee or client.

General Confidentiality Rules

Confidentiality rules are strict and they apply to any and all information that relates to the client. Such information includes the client's:

- Identity
- Attendance
- Diagnosis
- Status and involvement in the program
- Treatment plans
- Physical whereabouts

The best policy is simply to refuse to involve yourself in any discussion about a client unless proper written authorization is obtained on a formal written consent form.

■ Internal Communications

Information about a client may be shared among staff within a program only if there is a legitimate need for them to know. When there is a need for internal communications, information that is shared always should be specifically related to the provision of services being delivered. However, any information that is not necessary to the provision of services should not be disclosed.

■ Disclosures Without Identification of Clients

Programs may release information that does not identify an individual as a substance abuser or verify someone else's identification of a client. Reports of aggregate data about a program's participants may be provided. Individual information may be communicated in a manner that does not disclose that the person has a substance abuse problem. For example, the program may disclose that a person is a client in a larger organization (e.g., general hospital, school) without acknowledging that she/he has a substance abuse problem. Information may be disclosed anonymously without identifying either the individual's status as a client or the name of the program. Finally, an individual's case history may be reported anonymously, provided information about the client and the agency are disguised sufficiently so that the person's identity cannot be determined by a reader.

■ Medical Emergencies

In a situation that poses an immediate threat to the health of the client or any other individual, and requires immediate medical intervention, such as a dangerous drug overdose or an attempted suicide, necessary information may be disclosed to medical personnel. Such a disclosure must be documented in the client's records, including the name and affiliation of the person receiving the information, the name of the person making the disclosure, the date and time of the disclosure, and the nature of the emergency. Programs should ask participants in advance to indicate a person to be notified in the event of an emergency, and the client should be asked to sign a consent form allowing the program to notify the named person if an emergency should arise. Even without client consent, information may be disclosed to the federal Food and Drug Administration if an error has been made in packaging or manufacturing a drug used in treatment or this may endanger the health of clients.

■ Court Orders

State and federal courts may issue orders authorizing programs to release information that otherwise would be unlawful. However, certain procedures are required when such court orders are issued. A subpoena, search warrant, or arrest warrant alone is not sufficient to permit a program to make a disclosure. First, a client whose records are sought must be

given notice that an application for the court order has been made. The program and the individual must have an opportunity to make an oral or written statement to the court about the application. If the purpose of the court order is to investigate or prosecute a client, it is only necessary to notify the program.

Before an order is issued, there must be a finding of "good cause" for the disclosure. If the public interest and need for disclosure outweigh possible adverse effects to the individual, the doctor-client relationship, and the program's services, the order may be issued. Information that is essential for the purpose of the court order is all that may be released. Only persons who need the information may receive it. A court order may require disclosure of confidential communications if one of the following conditions exist:

- Disclosure is necessary to protect against a threat to life or of serious bodily injury
- Disclosure is required to investigate or prosecute an extremely serious crime
- Disclosure is necessary in a proceeding in which the client has already provided evidence about confidential communications

Before a court order can be issued to release information for a criminal investigation or prosecution, five criteria must be met. They are:

1. The crime is extremely serious (e.g., threatening to cause death or serious injury)
2. The records sought will probably contain information that is significant to the investigation or prosecution of the crime
3. There is no other feasible way to acquire the information
4. The public interest in disclosure outweighs any harm to the client, doctor-patient relationships, and the agency's ability to provide services
5. The program has an opportunity to be represented by independent counsel when law enforcement personnel seek the order

Subpoenas may require a person to appear to give testimony or to bring documents to a hearing. Although they may be signed by a judge or other legal officials, subpoenas are not the type of court order required by the confidentiality regulations. Thus, federal confidentiality laws and regulations prohibit treatment programs from responding to subpoenas by disclosing information concerning current or former clients. However, if the person about whom the information is requested signs a proper consent form authorizing the release, the program may do so. If a court order is issued after giving the program and the client an opportunity to be heard, and after making a good cause determination, treatment programs may respond to subpoenas.

If a subpoena is served upon an EAP professional, they may have no alternative but to provide the information to the court and the attorneys requesting the information. A subpoena duces tecum (a subpoena for materials) will compel an individual to appear in court and bring with him or her certain documents or notes which are specifically listed in the subpoena. No EAP professionals should provide any information, documentation, or notes to any person without a court order. A subpoena duces tecum in and of itself is not sufficient (Camazine, 1987).

Q An EAP counselor receives a court order and a subpoena duces tecum to produce all of his or her counseling records regarding a certain client. The counselor does not want to disclose the records. He or she should:

a. Write a letter to the judge explaining why she refuses to comply

b. Destroy the records so he or she can honestly claim no records exist

c. Sent only objective data such as dates seen, durations, of sessions, and fees paid

d. Comply with the court order

The answer is "d," comply with the court order.

Search warrants, similarly, may not be used to allow law enforcement officers to enter the program's facilities. However, arrest warrants do permit law enforcement personnel to search for a particular patient who has committed or threatened a crime on the premises of the program or against program personnel. Unless the arrest warrant is accompanied by a court order, the program may not cooperate with a search for a patient who committed a crime elsewhere.

■ Research and Audits

Researchers may obtain client-identifying information if certain precautions are applied. The research protocol must ensure that information will be securely stored and not redisclosed except as allowable under the federal regulations. Confidentiality safeguards must be approved by an independent body of three or more persons. Researchers are strictly prohibited from redisclosing client information. Reports of the research must not identify a client, directly or indirectly.

Government agencies, third party payers and peer review organizations may need to review program records without client consent to conduct an audit or evaluation. Those persons involved in such activities must agree in writing that they will not redisclose client identifying information unless it is pursuant to a court order to investigate or prosecute the program (not a patient). A government agency that is overseeing a Medicare or Medicaid audit or evaluation also may receive client information.

■ Child Abuse Reports

The State statues differ in that some statues mandate reporting by any individual who has information relating to the abuse of a child while other state statues specifically list certain individuals who must disclose information. If the state statues does not explicitly mention the EAP professional, they may be required to report abuse if the EAP professional has the credentials of one of the individuals listed. For example, if the EAP professional is a social worker they may be required to disclose information about the possible abuse of a child regardless of whether or not they have permission from their client to do the same.

Q Written consent to release information must be obtained in all of the following situations except when it is necessary to:

a. Communicate with the employee's supervisor

b. Communicate with the employee's union steward

c. Report evidence of child abuse

d. Talk with family members about the employee's problem

The answer is "c," report evidence of child abuse.

Q Release of confidential information without the client's consent may occur in all of the following situations except:

a. Immediate threat to self and others

b. Suicidal ideation without a concrete plan

c. A court order and subpoena

d. Suspicion of child abuse

The answer is "b," suicidal ideation without a concrete plan.

Confidentiality and Specific Diseases

Doctor-patient privilege is an accepted practice in medical treatment. In some cases, medical personnel are ethically bound not to divulge information about their patients' medical conditions. However, confidentiality requirements for most medical situations are not nearly as stringent as those that apply to substance abuse treatment programs. For example, generally, physicians are not restricted from acknowledging that an individual is a patient, as is the case with substance abuse treatment.

For substance abuse treatment programs, there are some special considerations when clients have a specific disease. The medical emergency exceptions to confidentiality does not apply to reporting the results of venereal disease tests to public health officials, as this does not present an

immediate medical danger. Thus, these disease are not reportable by substance abuse treatment programs (Legal Action Center, 1991).

There are some special considerations related to HIV disease, which is also a highly stigmatized illness requiring strict patient confidentiality. All states mandate that cases of AIDS be reported to public health authorities who subsequently report them to the federal Centers for Disease Control and Prevention. Some states also require that positive tests for HIV be reported. Sometimes information is used for tracing and contacting persons who might have been exposed to HIV by the client, constituting a "duty to warn." This may pose conflicting legal obligations for programs to report such information and maintain client confidentiality. In some cases, anonymous reports can be made using codes rather than client names. It also may be possible to get client consent to make mandated reports. Some programs enter into qualified service organizations agreements, and the necessary information is reported by a laboratory or medical care provider without identifying the individual as a recipient of substance abuse treatment. In the event that substance abuse treatment records must be released with client consent or by a court order, programs may need to take precautions not to reveal HIV status inadvertently. Such release of information about HIV status to insurers, employers, and others could have serious ramifications for the infected individual. Ways to avoid unnecessary release of HIV information include maintaining a separate medical file which is not released, releasing the file without the HIV-related information, or having the individual sign a consent form authorizing the release of HIV-related information (Legal Action Center, 1991).

Duty to Warn

If a client poses a threat to somebody's life, the therapist must warn the intended victim. This duty first developed in the case of Tarasoff v. Regents of the State of California, 529 p.2d, 553 (kCA, 1974). In this case, a graduate student at the University of California met a woman who was also a student. He courted her but she did not return his affections. During a counseling session at the university sponsored counseling service, the student confided to a psychologist his intentions to kill this woman. The psychologist considered the treats to be serious enough and therefore called the campus police. The student was detained by the campus police but released when he later appeared "rational." The psychologist reported his concerns to the director of the counseling service, a psychiatrist, who determined that no further action be taken in the case. No one warned the woman, who was overseas for the summer, nor did anyone warn her family of the threat. Upon the woman's return from overseas, she was murdered. A lawsuit was filed by the woman's parents against the university, the psychologist, the psychiatrist and the police. The Supreme Court of California held as follows:

When a therapist determined, or pursuant to the standards of his profession should determine that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the

intended victim against such danger. The discharge of this duty may require the therapist to take one or more various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police or to take whatever steps are reasonably necessary under the circumstances. (Camazine, 1987).

Q A landmark case for "Duty to Warn" that has implications for the EAP counselor is:

a. Tarasoff v. Regents of University of California

b. Jablonski v. United States Government

c. Hedlund v. Superior Court of Orange County

d. Division of Corrections, et.al. v. Neakok

The answer is "a," Tarasoff v. Regents of University of California.

Access to Medical Records

In the past, clients had almost no right to see or copy their medical records, which were considered doctors' property. Today, about twenty-seven states have laws granting patients access to their medical records. To find out about your state's laws, contact the medical society in your state. You can get its address and telephone number from the American Medical Association's Washington, D.C. office (202) 789-7400.

State laws place conditions on the availability of records. Despite the variations among states, one way to find out is to check with the treatment facility on the procedures for obtaining a copy of medical records.

Q With regard to EAP counseling records, the law is likely to take the view that:

a. The client has a right to access his or her records

b. Counselors are the owners of the records they create

c. Client records are the property of the court

d. Client records are privileged and thus inadmissible in court

The answer is "a," the client has a right to access his or her records.

Penalty for Violations of Confidentiality Regulations

Any individual who violates federal confidentiality rules has committed a criminal offense. This offense is considered a misdemeanor. The penalty for the first offense is a fine not less than $500, and it is not more than $5,000 for each and every offense after that. A jail sentence cannot be

given for the first or second offense. However, the client has the right to sue for damages in a civil suit against the counselor who violates his or her confidentiality.

Questions

1. To release information on troubled employees, the employee assistance professional needs the consent of the:

a. Employee
b. Corporate counsel
c. Immediate supervisor
d. Director of human resources

2. Which of the following would not be a factor in determining counselor negligence in exercising his or her "duty to warn"?

a. The event was foreseeable
b. A proximate cause can be identified
c. Consent was obtained
d. A detailed history was obtained

3. An EAP counselor receives a court order and a subpoena to produce all of his or her counseling records regarding a certain client. The counselor does not want to disclose the records. He or she should:

a. Write a letter to the judge explaining why she refuses to comply
b. Destroy the records so he or she can honestly claim no records exist
c. Sent only objective data such as dates seen, durations, of sessions, and fees paid
d. Comply with the court order

4. Written consent to release information must be obtained in all of the following situations except when it is necessary to:

a. Communicate with the employee's supervisor
b. Communicate with the employee's union steward
c. Report evidence of child abuse
d. Talk with family members about the employee's problem

5. Release of confidential information without the client's consent may occur in all of the following situations except:

a. Immediate threat to self and others
b. Suicidal ideation without a concrete plan
c. A court order and subpoena
d. Suspicion of child abuse

6. A landmark case for "Duty to Warn" that has implications for the EAP counselor is:

a. Tarasoff v. Regents of University of California

b. Jablonski v. United States Government

c. Hedlund v. Superior Court of Orange County

d. Division of Corrections. et.al. v. Neakok

7. With regard to EAP counseling records, the law is likely to take the view that:

a. The client has a right to access his or her records

b. Counselors are the owners of the records they create

c. Client records are the property of the court

d. Client records are privileged and this inadmissible in court

8. In determining whether a malpractice charge has merit, three of the four following criteria are primary considerations. Which one would indicate that malpractice did not occur?

a. There are resultant damages, either physical or emotional, to the client or his or her family

b. There is a cause-effect relationship between the counselor's actions/ inactions and the event, known as "proximate cause."

c. The counselor was negligent and did not adhere to the standards of her profession in performing her duties.

d. Neither the EAP or anyone else could have predicted or prevented the event from occurring.

9. An employee comes into your office and requests a copy of his file. The most appropriate way to handle this would be to:

a. Call your attorney and the company's attorney's first

b. Agree to send a copy to his therapist

c. Tell him it is against company policy

d. Offer to review the contents of the file with him

10. Which of the following situations would permit a EAP counselor to break confidentiality?

a. The wife of an employee tells you her spouse beats her when he gets drunk.

b. An employee admits to feeling suicidal after freebasing cocaine.

c. An employee says she has a gun in her locker and would really like to kill her boss after work today.

d. An employee tells you he has thought about suicide more frequently over the past two months but has no plan.

Answers

1–a

2–c

3–d

4–c

5–b

6–a

7–a

8–d

9–d

10–c

CHAPTER 4 WORK ORGANIZATIONS

An organization is a social system deliberately established to carry out some definite purpose. It consists of a number of people in a pattern of relationships. The pattern is not entirely dependent on the particular persons who belong to the organization at a given time. The organization assigns a position to each of its members, and the incumbent of a position has a set part to play in the organization's collective program. Every organization has a program - a set of planned activities that can go well or poorly.

Organizational Changes

The changes that corporate America will face in the year 2000 may include: 1) new types of employees; 2) different jobs; 3) new culture; and 4) new companies and structures. According to Kanter (1989) managerial work is undergoing such rapid change that they had to reinvent their profession as they go. In working with a new structure and workforce, corporations will need to reevaluate their management of workers, and decide if they should continue their traditional style of autocratic systems or adopt a new management style model.

The flattened "management hierarchies,"(i.e., management structures with few supervisory levels), are now becoming the norm (Kranetz, 1988, p.75). One of the reasons for the change in structure (from tall to short or flattened) is due to changes in the nature of jobs. Jobs are changing from blue collar to white collar; and service occupations that are more generalists oriented now require more skills than jobs of the past. They also involve more shared responsibilities and team work than before. What these new jobs have in common is that they require less supervision. The workers will be expected to have more technical skills and be capable of handling most activities on their own.

Other changes in structure include horizontal ties between peers, replacing vertical channels of activity and communication (Kanter, 1989). The organizations of the 1990s and beyond will be leaner, less bureaucratic and more entrepreneurial. Career paths are no longer straight forward and predictable but have become idiosyncratic and confusing (Kanter, 1989).

Q

Which of the following characteristics describe the changing management style of future organizations?

a. The organization will flatten its authority

b. Individuals will learn from each other

c. Support and direction will come form various directions

d. All of the above

The answer is "d", all of the above.

Demographic Changes

Like any significant change, increased diversity within the workforce is difficult to acknowledge, particularly among those who consider themselves to be part of the cultural mainstream. The magnitude of this change is already demanding new responses from each of us, though, we may prefer to deny its importance in an attempt to maintain our own levels of comfort and to reinforce the status quo. Despite this tendency to deny the existence and impact of change, it is difficult to argue with the current demographics.

Here are some predictions about the ways in which the American workforce will change:

- Throughout the 1990's, people of color, white women, and immigrants will account for 85 percent of the net growth in our nation's labor force (Johnston & Packer, 1987).
- In 1980, women made up 43 percent of the total workforce. By the year 2000, they will account for more than 47 percent of the total workforce, and 61 percent of all American women will be employed (Handbook of Labor Statistics, 1989).
- In 1980, African Americans made up 10 percent of the total workforce and Hispanics accounted for 6 percent. By the end of the 1990's, African Americans will make up 12 percent of the total labor force. Hispanics will account for 10 percent and Asian another 4 percent (Kiplinger & Kiplinger, 1989).
- In this same decade, the American workforce will continue to mature, with those in the 35-54 age group increasing by more than 25 million - from 38 percent of the workforce in 1985 to 51 percent by the year 2000 (Johnston & Packer, 1987). At the same time, those in the 16-24 age group will decline by almost 2 million, or 8 percent (Handbook of Labor Statistics, 1989).

Throughout U.S. society, there is evidence of increasing ethnic and cultural diversity in almost every community and geographic locale. Consider these statistics:

- During the 1980's, immigrant populations accounted for one third of the total population growth in America (Statistical Yearbook, 1989).
- Currently, white men are a declining share of the U.S. population - accounting for just 37 percent of the total (The Numbers News, 1989).
- Among the top 25 urban markets throughout the United States, people of color now make up the majority population in 16 of them (D. & B. Donnelly Demographics, 1988).
- Over the next 20 years, the U.S. population is expected to grow by 42 million. Hispanics will account for 47 percent of this growth. African Americans will account for 22 percent. Asians and other people of color will make up 18 percent of this increase, while whites will account for only 13 percent (Randle, 1990).

Organizational Structure

Organizational structure can be broadly defined as those patterns of work and hierarchical arrangements that serve to control or distinguish an organization's component parts. Structure is generally conceptualized in terms of the division and specialization of work (differentiation and integration) and the ways in which it is coordinated and controlled.

One of the key concepts underlying organizational structure is division of labor. This refers to the specialization of the tasks and roles undertaken by organizational members. Whereas, differentiation is concerned with the amount of work segmentation of an organizational system into component parts. Organizations may be differentiated in a number of ways.

- **Horizontal differentiation**, where work is divided up on a particular level of an organizational hierarchy.
- **Vertical differentiation**, where work is divided up by levels of the organizational hierarchy; the distinction between tall and flat organization refers to whether it has many or few levels of hierarchy.
- **Personal differentiation**, where work is divided according to personal specialty (e.g., a law firm may have trial lawyers, probate lawyers, patent lawyers, admiralty or marine lawyers, and corporate lawyers).
- **Spatial differentiation**, where work is divided according to geographical location (such as one company's automobile assembly plants scattered throughout the country).

Q

Differentiation in an organization refers to:

a. The way the work is divided up within it

b. Geographic segmentation of an industry

c. Division of work by specialty areas

d. All of the above

The answer is "d," all of the above.

Types of Organizational Structures

The functional organization is the most basic organizational structure. In it, each group of related activities is collected under one functional head. Thus, in figure 1-1, a meat supervisor may have under her all the meat cutters, trimmers, and packers; the stockroom supervisor all the receivers, inspectors, and pricing clerks; and so forth. The functional approach to organizing yields the simplest structure. It also provides the basic framework from which other types of structures are built. It is, essentially, a line organization.

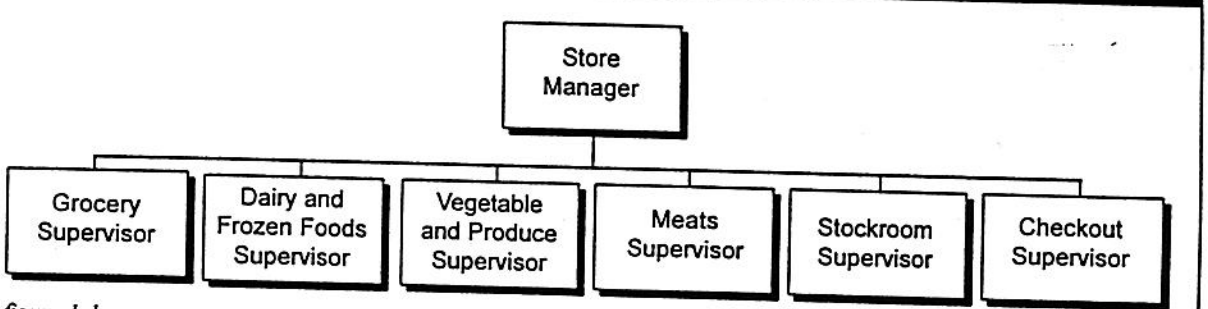

figure 1-1

Q

An organization in which a single manager exercises authority over a group of workers is called a:

a. Line and staff organization

b. Functional organization

c. Line organization

d. None of the above

The answer is "c," line organization.

A line-and-staff organization adds to the basic features of a functional (or line) organization staff group that either gives advice to, or performs services for the line functions. A line-and-staff organization is illustrated in figure 1-2.

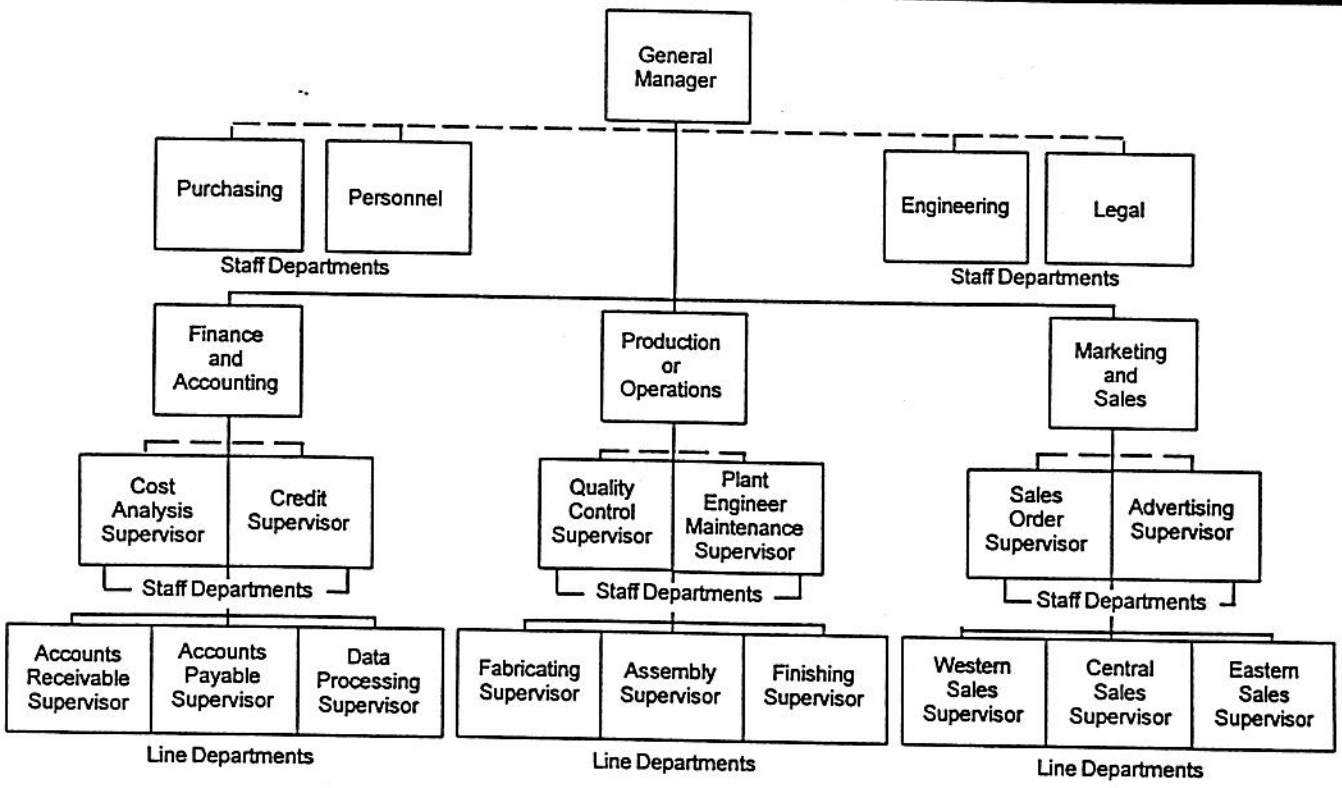

figure 1-2

Difference Between Line and Staff Groups

An organization works best when it gets many related jobs done effectively with the minimum friction. This requires coordination and determination of what to do and who is to do it. Those managers and supervisors whose main job it is to see that products and services are produced are usually considered members of the line organization. Other management people who help them to decide what to do and how to do it, assist in coordinating the efforts of all, or provide service or special expertise, are usually called staff people.

In manufacturing plants, line activities are most commonly performed by production departments, sales departments, and, occasionally, purchasing departments. The production supervisor or first-line supervisor is likely to be a member of the line organization.

Departments that help line departments control quality and maintain adequate records are typically staff departments. Industrial engineering, maintenance, research, and personnel relations are some examples of typical staff activities.

Other Ways in Which Organizations Are Structured

Divisional or product. All functions needed to make a particular product are gathered under one highly placed manager. If a firm manufactures tractors for farmers, road graders for construction contractors, and lawn mowers for home use, it might "divisionalize" in order to make and sell each major product in its product line. Note that under each division head this organization is essentially a functional one; as a consequence, labels such as "functional" and "divisional" can be misleading.

Spatially Differentiated (Geographic). A firm may divide some of its activities, such as sales, or all of its activities according to the geographic region where these take place.

Customer. A company may also choose to organize some or all of its activities according to the customers it serves, such as farmers, contractors, and homeowners. This kind of organization is closely related to the product organization.

Q Which of the following best describes a spatially differentiated organization?

a. Work is divided according to geographical location.

b. Work is divided by levels of organizational hierarchy.

c. Work is divided according to personal specialty.

d. Work is divided on a particular level or organizational hierarchy.

The answer is "a," work is divided according to geographical location.

Matrix Organization

Matrix organization is a nontraditional format, especially suited for projects, task-force work, or the one-of-a kind enterprise. It is commonly used in research and development organizations and engineering firms for one-of-a-kind projects or contracts.

Centralized and Decentralized Organization

A centralized organization tends to have many levels of management, to concentrate its facilities in one location, to perform certain functions (such as engineering, labor negotiations, computer operations, and purchasing) from a single source, and to gather together its power and authority at headquarters.

Centralization refers to the location of decision-making authority in an organization. A centralized organization is one in which decisions are concentrated at one or a few points; a decentralized structure disperses authority (low concentration) for making decisions throughout a number of positions in the organization. In terms of management concepts, authority for making decisions can be centralized or decentralized, and the chain of

command delineates the path of decentralization (extent of participation and input from lower level individuals, units, etc.).

A decentralized organization tends to have the opposite characteristics, especially when a company is divided into distinctly separate units with varying degrees of independence. These units may be set up along product lines, according to geography, or according to methods of marketing and distribution.

Q The extent to which organizational decisions are concentrated at one or a few points is called:

a. Formalization

b. Complexity

c. Integration

d. Centralization

The answer is "d," centralization.

Formalization is the extent to which expectations concerning job activities are standardized and explicit. The clearer and more detailed these specifications are for a particular role or task, the greater the degree of formalization. This dimension of organizational structure, thus reflects the amount of discretion that is built into particular roles and positions. Professional positions, for example, tend to have a greater amount of freedom of activity than less skilled, more routine work (e.g., assembly line jobs that require relatively simple and repetitive behavior).

Formalization can vary depending on organizational function. For instance, people in accounting or production departments have much more standardization in their activities (standard procedures and methods of work accomplishment) than members of marketing, human resource, or research and development departments (with less stable and less repetitive activities).

Q The extent to which job activities are standardized and explicit is called:

a. Formalization

b. Complexity

c. Integration

d. Centralization

The answer is "a," formalization.

Different Organizational Structure

Structure reflects the organization's situation – for example, its size, type of production system, and the event to which its environment is complex and dynamic. For example larger organizations need more formalized structures - more rules, more planning, tighter job descriptions; so do those in stable environments and those in mass production. Organizations in more complex environments need higher degrees of decentralization; those diversified in many markets need divisionalized instead of functional structures.

The different structures are labeled Simple Structure, Machine Bureaucracy, Professional Bureaucracy, Divisionalized Form, and Adhocracy.

To understand the five configurations, we must first understand each of their elements.

The Elements of the Five Configurations

Organizational structure becomes a problem when more than one person must coordinate different tasks to get a single job done. That coordination can be divided into five basic forms:

1. Direct supervisor. One person gives direct orders to others and so coordinates their work, as when an entrepreneur tells different machine operators to make specific parts of an assembly.

2. Standardization of work processes. One person designs the general work procedures of others to ensure that these are all coordinated, as when a methods engineer specifies how an assembler should bolt a fender onto an automobile.

3. Standardization of outputs. One person specifies the general outputs of the work of another, as when headquarters tells a division manager to generate sales growth of 10% in a given quarter so that the firm can meet its overall growth goal.

4. Standardization of skills. A person is trained in a certain way so that he or she coordinates automatically with others, as when a surgeon and an anesthesiologist perform together in the operating room without having to utter a single word.

5. Mutual adjustment. Two or more people communicate informally among themselves to coordinate their work, as when a team of experts meet together in a space agency to design a new rocket component.

Different parts of the organization play different roles in the accomplishment of work and of these forms of coordination. The five basic parts of the organization:

1. The **operating core** is where the basic work of producing the organization's products and services gets done, where the workers assemble automobiles and the surgeons remove appendixes.

2. The **strategy apex** is the home of top management, where the organization is managed from a general perspective.

3. The **middle line** comprises all those managers who stand in a direct line relationship between the strategic apex and the operating core; among other tasks, the managers of the middle line (as well as those of the strategic apex) carry out direct supervision.

4. The **technostructure** includes the staff analysts who design the systems by which work processes and outputs are standardized in the organization.

5. The **support staff** comprises all those specialists who provide support to the organization outside of its operating workflow – in the typical manufacturing firm, everything from the cafeteria staff and the mailroom to the public relations department and legal counsel.

The division of the labor of the organization into different tasks and the achievement of the various kinds of coordination among these tasks are accomplished through the use of a set of "design parameters," such as job specialization, behavior formalization, training and indoctrination, unit grouping, unit size, planning and control systems, liaison devices, vertical decentralization.

Five Basic Parts of the Organization

figure 1-3

Source: Henry Mintzbert. The Structure of Organizations (Englewood Cliffs, NJ, 1979)

The Simple Structure

The Simple Structure is characterized as having little or no technostructure, few support staffers, a loose division of labor, minimal differentiation among its units, and a small middle line hierarchy. Little of its behavior is formalized, and it makes minimal use of planning, training, or the liaison devices. Decision making is informal, with the centralization of power allowing for rapid response.

The environment of the Simple Structure tends to be at the same time simple and dynamic. A simple environment can be comprehended by a single individual, and so allows decision making to be controlled by that individual. A dynamic environment requires organic structure. Young organizations and small organizations tend to use the Simple Structure, because they have not yet had the time, or yet reached the scale of operations, required for bureaucratization. Finally, extreme hostility in their environments forces most organizations to use the Simple Structure, no matter how they are normally organized. To deal with crises, organizations tend to centralize at the top temporarily, and to suspend their standard operating procedures.

The classic case of the Simple Structure is the entrepreneurial firm. The firm is aggressive and often innovative, continually searching for risky environments where the bureaucracies hesitate to operate.

The Simple Structure

figure 1-4

Source: Mintzberg, The Structuring of Organizations

The Machine Bureaucracy

The Machine Bureaucracy is highly specialized and has routine operating tasks, very formalized procedures and large-sized units in the operating core. It relies on the functional basis for grouping tasks throughout the structure, little use is made of training and of the liaison devices. Power for decision making it relatively centralized with some use of action planning systems, and an elaborate administrative structure with a sharp distinction between line and staff. This is the structure Woodward (1965) found in the mass-production firms. Burns and Stalker (1961) in the textile industry, Crozier (1964) in the tobacco monopoly. Lawrence and Lorsch (1967) found it in the container firm; it is the structure the Aston group (Pugh et.al., 1969) referred to as "workflow bureaucracy."

The Machine Bureaucracy is often associated with external control. The greater the external control of an organization, the more its structure tends to be centralized and formalized, the two prime design parameters of the Machine Bureaucracy.

Typical examples of organizations drawn to Machine Bureaucracy configuration are mass-production firms; service firms with simple, repetitive work, such as insurance and telephone companies; government agencies with similar work, such as post offices and tax collection departments; and organizations that have special needs for safety, such as airlines and fire departments.

The Machine Bureaucracy

figure 1-5

Source: Mintzberg, The Structuring of Organizations

Q An organization in which senior administrators have more knowledge of problems facing the organization than those at lower levels and where standardized policies and procedures are in place to govern organizational decision making is most likely to be considered a(n):

a. Organization with a union shop

b. Organic or adhocratic organization

c. A line and staff organization

d. A bureaucratic or mechanistic organization

The answer is "d," a bureaucratic or mechanistic organization.

The Professional Bureaucracy

Organizations can be bureaucratic without being centralized; that is, their behavior can be standardized by a coordinating mechanism that allows for decentralization. The coordinating mechanism is the standardization of skills. A reliance on skills gives rise to the configuration called Professional Bureaucracy, found typically in school systems, social-work agencies, accounting firms, and craft manufacturing firms. The organization hires highly trained specialists- called professionals - in its operating core, and then gives them considerable autonomy in their work. In other words, professionals work relatively free not only of the administrative hierarchy but also of their own colleagues. Much of the necessary coordination is achieved by design - by the standard skills that predetermine behavior. This autonomy in the operating core means that the operating units are typically very large, as shown in Figure 1-6, and that the structure is decentralized in both the vertical and horizontal dimensions. In other words, much of the formal and informal power of the Professional Bureaucracy rests in its operating core, clearly its key part. Not only do the professionals control their own work, but they also tend to maintain collective control of the administrative apparatus of the organization. Managers of the middle line, in order to have power in the Professional Bureaucracy, must be

professionals themselves, and must maintain the support of the professional operators. Moreover, they typically share the administrative tasks with the operating professionals. At the administrative level, however, in contrast with the operating level, tasks require a good deal of mutual adjustment, achieved in large part through standing committees, task forces, and other liaison devices.

The Professional Bureaucracy appears in conjunction with an environment that is both complex and stable. Complexity demands the use of skills and knowledge that can be learned only in extensive training programs, and stability ensures that these skills settle down to become the standard operating procedures of the organization.

The Professional Bureaucracy

figure 1-6

Source: Mintzberg, The Structuring of Organizations

The Divisionalized Form

The Divisionalized Form is not so much a complete structure as the superimposition of one structure on others. This structure can be described as market-based, with a central headquarters overseeing a set of divisions, each charged with serving its own markets. In this way there need be little interdependence between the divisions (beyond that which Thompson (1967) refers to as the "pooled" type), and little in the way of close coordination. Each division is thus given a good deal of autonomy. The result is the limited, parallel form of vertical decentralization, with the middle line emerging as the key part of the organization. Moreover, without the need of close coordination, a large number of divisions can report to the one central headquarters. The main concern of that headquarters then becomes to find a mechanism to coordinate the goals of the divisions with its own, without sacrificing divisional autonomy. It does that by standardizing the outputs of the divisions - specifically, by relying on performance control systems to impose performance standards on the divisions and then monitor their results. Hence, figure 1-7 shows a small headquarters technostructure, which is charged with designing and operating the performance control system. Also shown is a small headquarters support staff. Included here are those units that serve all the divisions (such as legal counsel), with other support units dispersed to the divisions to serve their particular needs (such as industrial relations).

One factor above all encourages the use of the Divisionalized Form - market diversity; specifically, that of products and services. (Diversity only in

region or client leads, as Shannon (1976) has shown, to an incomplete form of divisionalization, with certain "critical" functions concentrated at headquarters, as in the case of purchasing in a regionally diversified retailing chain). But by the same token, it has also been found that divisionalization encourages further diversification.

The Divisionalized Form is very fashionable in industry. It is found in pure or partial form among the vast majority of America's largest corporations, the notable exceptions being those with giant economies of scale in their traditional business (Wrigley, 1970; Remelt, 1974). It is also found outside the sphere of business (in the form of conglomerate unions and government itself), but often in impure form owing to the difficulty of developing relevant performance measures.

The Divisionalized Form

figure 1-7

Source: Mintzberg, The Structuring of Organizations

The Adhocracy

Sophisticated innovation requires a fifth and very different structural configuration, one that is able to fuse experts drawn from different specialties into smoothly functioning project teams. Adhocracy is such a configuration, consisting of organic structure with little formalization of behavior; extensive horizontal job specialization based on formal training; a tendency to group the professional specialist in functional units for housekeeping purposes but to deploy them in small, market-based teams to do their project work. It relies on the liaison devices to encourage mutual adjustment - the key coordinating mechanism - within and between these teams, and decentralizes power selectively to these teams, which are located at various places in the organization, and involve various mixtures of lien manger and staff and operating experts. Of all the configurations, Adhocracy shows the least reverence for the classical principles of management. It gives quasi-formal authority to staff personnel, thereby blurring the line-staff distinction, and it relies extensively on matrix structure, combining functional and market bases for grouping concurrently and thereby dispensing with the principle of unit of command.

Adhocracies may be divided into two main types. In the Operating Adhocracy, innovation is carried out directly on behalf of the clients, as the case of consulting firms, advertising agencies, and film companies. In

the Operating Adhocracy, the administrative and operating work tend to blend into a single effort. In other words, adhoc project work does not allow a sharp differentiation of the planning and design of the work from its actual execution.

In the Administrative Adhocracy, the project work services the organization itself, as in the case of chemical firms and space agencies. The administrative and operating components are sharply differentiated; in fact, the operating core is typically truncated from the rest of the organization - set up as a separate structure, contracted out, or automated - so that the administrative component is free to function as an Adhocracy.

Figure 1-8 shows both types of Adhocracies, with the blurring of the line-staff distinction in both cases and the truncation of the operating core (indicated by dotted lines), or else, in the case of the Operating Adhocracy, its inclusion in the mass of activities in the administrative center.

Adhocracy is very much in vogue today - emphasis on expertise, organic and matrix structure, teams and task forces, decentralization without power concentration, sophisticated and automated technical systems, youth, and complex, dynamic environments. Adhocracy seems clearly to be the structure of future organizations.

The Adhocracy

figure 1-8

Source: Mintzberg, The Structuring of Organizations

Q An organization that is designed to cope flexibly with rapidly changing environments is called :

a. Adhocracy

b. Mechanistic organization

c. Bureaucracy

d. Differentiated organization

The answer is "a," adhocracy.

Leadership and Motivation

Leadership relies on providing direction that satisfies the motivation needs of others, and the direction chosen reflects a leader's assumption about these needs.

Motivation is a power that arises within an individual to satisfy a need. A person can have motivation without another person's leadership. Leadership, however, cannot succeed without motivation on the follower's part.

Theory X and Theory Y

To understand your members and workers, we must first understand the principle of management. Douglas McGregor, in his work The Human Side of Enterprise, outlined much of today's management thinking. The world has changed, and new thinking is needed for top efficiency today. That's the core of this unique philosophy of pitting Theory X against Theory Y.

Theory X, the traditional framework for management thinking, is based on the following set of assumptions about human nature and human behavior:

- The average human being has an inherent dislike of work and will avoid it if possible.
- Because of this human characteristic of dislike of work, most people must be coerced, controlled, directed, or threatened with punishment to get them to put forth adequate effort toward the achievement of organizational objectives.
- The average human being prefers to be directed, wishes to avoid responsibility, has relatively little ambition, and wants security above all.

Do these assumptions make up a straw person for purposes of scientific demolition? Unfortunately, they do not. Although they are rarely stated so directly, the principles that constitute the bulk of traditional management action could have been derived only from assumptions such as those of Theory X.

Theory X of management is considered to be on the paternalistic side, while Theory Y utilizes more worker participation (team building, management circles, etc.).

In the "X-Y" theory of management, theory X includes all of the following except:

a. A paternalistic view of management

b. Emphasis on worker assignments

c. More worker participation

d. A top-down management style

Answer is "c," theory X does not include emphasis on worker participation.

Theory Y finds its roots in recently accumulated knowledge about human behavior. It is based on the following set of assumptions.

- The expenditure of physical and mental effort in work is as natural as play or rest.
- External control and the threat of punishment are not the only means for bringing about effort in the service of objectives to which they are committed.
- Commitment to objectives depends on the rewards associated with their achievement. The most important rewards are those that satisfy needs for self-respect and personal improvement.
- The average human being learns, under proper conditions, not only to accept but also to seek responsibility.
- The capacity to exercise a relatively high degree of imagination, ingenuity, and creativity in the solution of organizational problems is widely, not narrowly, distributed in the population among both men and women.
- Under the conditions of modern industrial life, the intellectual potentialities of the average human being are only partially realized.

Under the assumptions of Theory Y, the work of the supervisor is to integrate the needs of employees with the needs of the department. According to McGregor (cited in Newstrom, 1990, p.271):

(Supervisors) are dealing with adults who are only partially dependent. They can-and will- exercise remarkable ingenuity in defeating the purpose of external controls that they resent. However, they can-and do- learn to exercise self-direction and self-control under appropriate conditions... (The supervisor's) task is to help them discover objectives consistent both with organizational requirements and with their own personal goals.

Q In the "X-Y" theory of management. Theory Y includes all of the following except:

a. More worker participation

b. A paternalistic view of management

c. Team building activities

d. A participative management style

The answer is "b," a paternalistic view of management.

What Do People Want From Life and Their Work?

People tend to have a variety of concurrent needs, but one among them is always stronger than the others. That need is the one that largely determines an individual's motivation and therefore his level of performance. Maslow defined a set of needs, as shown below, that tend to lie in a hierarchy: when a lower need is satisfied, one higher is likely to take over.

Maslow's Hierarchy of Needs

1. Physiological Needs. These needs consist of things that money can buy, like food, clothing, and other basic necessities of life. Fear is hitched to such needs: one fears the possible deprivation of food, clothing, and so on.

2. Security/Safety Needs. These come from a desire to protect one's self from slipping back to a state of being deprived of the basic necessities. Safety and security needs are fulfilled, for example, when medical insurance provides employees protection against the fear of going bankrupt trying to pay doctor and hospital fees. The existence of benefits is rarely a dominant source of employee motivation, but if benefits were absent and employees had to worry about such concerns, performance would no doubt be badly affected.

3. Social/Affiliation Needs. The social needs stem from the inherent desire of human beings to belong to some group or other. But people don't want to belong to just any group; they need to belong to one whose members possess something in common with themselves. For example, when people are excited, confident, or happy, they want to be around people who are also excited, confident, or happy. Conversely, misery loves not just any company, but the company of other miserable people. Nobody who is miserable wants to be around someone happy.

As one's environment or condition in life changes, one's desire to satisfy a particular set of needs is replaced by a desire to satisfy another set. The physiological, safety/security, and social needs all can motivate us to show up for work, but other needs – esteem and self-actualization - make us perform once we are there.

4. Esteem/Recognition Needs. The need for esteem or recognition is readily apparent in the cliche "keeping up with the Joneses." Such striving is commonly frowned upon, if an athlete's "Jones" is last year's Olympic gold medalist, or if an actor's "Jones" is Lawrence Olivier, the need to keep up with or emulate someone is a powerful source of positive motivation. The person or group whose recognition you desire may mean nothing to someone else – esteem exists in the eyes of the beholder.

All of the sources of motivation discussed so far are self-limiting. That is, when a need is gratified, it can no longer motivate a person. Once a predetermined goal or level of achievement is reached, the need to go any further loses urgency.

5. Self-Actualization Needs. For Maslow, self-actualization stems from a personal realization that "What I can be, I must be." Self-actualization

means: the need to achieve one's utter personal best in a chosen field of endeavor. Once someone's source of motivation is self-actualization, his or her drive to perform has no limit. Thus, its most important characteristic is that unlike other sources of motivation, which extinguish themselves after the needs are fulfilled, self-actualization continues to motivate people to ever higher levels of performance.

Two inner forces can drive a person to use all of his or her capabilities. He or she can be competence-driven or achievement-driven. The competence-driven concerns itself with job or task mastery. The achievement-driven are moved by an abstract need to achieve in all that they do.

Researchers classified the three types of behavior. The first group, termed gamblers, took high risks but exerted no influence on the outcome of events. The second group, termed conservatives, were people who took very little risk. The third group, termed achievers, had to test the limits of what they could do, and with no prompting demonstrated the point of the experiment: namely, that some people simply must test themselves. By challenging themselves these people were likely to miss a peg several times, but when they began to ring the peg consistently, they gained satisfaction and a sense of achievement. The point is that both competence-and-achievement-oriented people spontaneously try to test the outer limits of their abilities.

Questions

1. Which of the following characteristics describe the changing management style of future organizations?

   a. The organization will flatten its authority

   b. Individuals will learn from each other

   c. Support and direction will come form various directions

   d. All of the above

2. Differentiation in an organization refers to:

   a. The way the work is divided up within it

   b. Geographic segmentation of an industry

   c. Division of work by specialty areas

   d. All of the above

3. An organization in which a single manger exercises authority over a group of workers is called a:

   a. Line and staff organization

   b. Functional organization

   c. Line organization

   d. None of the above

4. Which of the following best describes a spatially differentiated organization?

a. Work is divided according to geographical location
b. Work is divided by levels of organizational hierarchy
c. Work is divided according to personal specialty
d. Work is divided on a particular level or organizational hierarchy

5. The extent to which organizational decisions are concentrated at one or a few points is called:

a. Formalization
b. Complexity
c. Integration
d. Centralization

6. The extent to which job activities are standardized and explicit is called:

a. Formalization
b. Complexity
c. Integration
d. Centralization

7. An organization in which senior administrators have more knowledge of problems facing the organization than those at lower levels and where standardized policies and procedures are in place to govern organizational decision making is most likely to be considered a(n):

a. Organization with a union shop
b. Organic or adhocratic organization
c. A line and staff organization
d. A bureaucratic or mechanistic organization

8. An organization that is designed to cope flexibly with rapidly changing environments is called an:

a. Adhocracy
b. Mechanistic organization
c. Bureaucracy
d. Differentiated organization

9. In the "X-Y" theory of management, theory X includes all of the following except:

a. A paternalistic view of management
b. Emphasis on worker assignments
c. More worker participation
d. A top-down management style

10. In the X-Y theory of management. Theory Y includes all of the following except:

a. More worker participation

b. A paternalistic view of management

c. Team building activities

d. A participative management style

11. Which of the following is a current strategy used by business to increase profit margins:

a. Diversifying products and services

b. Enriching employees benefit plans

c. Increasing the size of the workforce

d. Intensifying short term planning services

Answers

1–d

2–d

3–c

4–a

5–d

6–a

7–d

8–a

9–c

10–b

11–a

CHAPTER 5 LABOR/MANAGEMENT

Role of Shop Steward/Committeeperson

With the increased number of employee assistance programs, there is a need to show how union representatives and supervisors can, by performing their duties, assist in the implementation of the EA programs. The role of a shop steward or committeeperson as a union representative includes grievance handlers, negotiators, counselors, educators, communicators, spokespersons, leaders, and friends. The basic objective of an employee assistance program is to help the worker who has a personal problem, i.e., alcohol, drug, marital, financial, mental, etc. There are two situations in which union representatives will become involved with the employee assistance process within the performance of their duties.

1. When a problem is interfering with job performance and/or attendance of the worker.
2. When a problem is interfering with the worker's life outside of the work setting.

Deteriorating Job Performance Related to Employee Personal Problem

It is known that if an individual is experiencing a deterioration in job performance, or an increase in absenteeism over a period of time, there is a good chance that a personal problem is causing the deterioration. The union representative, by utilizing the normal grievance procedure along with the procedures of the employee assistance program, is in a position to not only assist the worker with a disciplinary problem, but also help guide the worker to help for the personal problem.

Grievance Procedure

In the United States of America, our legal system provides for due process of the accused, the right to be heard, and a presumption of innocence until proven guilty.

Union agreements provide for a due process system known as the grievance procedure. A worker who feels unjustly treated may file a grievance through the union. If the issue is not resolved, the grievance can be heard by an impartial third party known as an arbitrator or mediator. The union may also file a grievance on behalf of its members, challenging the intent of the agreement, or when the employer is not living up to the agreement.

The grievance procedure insures that what the parties have agreed to remains intact. The procedure may be enforced through the courts, unlike a complaint procedure or open-door policy.

A grievance is a worker's legitimate complaint that the company has violated one of his or her rights. It is usually caused by a violation of a specific part of the contract or supplementary agreements. Other grieveable areas where violations occur are state and federal labor laws, health and safety regulations, national labor relations board rulings, arbitration or umpire decisions, past practice and policies or the employer's own regulations, and conditions which unfairly impose a financial, mental, or physical hardship on the worker. An arbitrator is a person who hears both sides of an unresolved labor/management dispute.

There are three basic kinds of grievances in any local union grievance situation; 1) the individual, 2) group, or 3) policy grievances. The employee assistance program zeroes in on the most basic type of grievance which involves a "single individual" in the complaint or grievance procedure.

Under the law, a union has a duty to accept a grievance from a member, unless the grievance is, on its face, worthless and improper. While the union has no duty to "fight every case", it does have certain duties which may make it legally responsible. Those duties are to be honest, to act in good faith, to be nondiscriminatory, to be informed, and to have a rational basis for making a decision. In other words, the union owes a duty of "fair representation" to all those in units which it represents.

Q The individual who hears both sides of an unresolved union-management dispute is called a(n):

a. Union steward

b. Impartial arbitrator

c. Claims adjudicator

d. Attorney

The answer is "b," impartial arbitrator.

Constructive Action

The steward/committeeperson should not give up on an individual because the grievance procedure is helpless. The worker may have a personal problem that he or she needs help with that is causing the disciplinary situation. The steward should offer the services of the employee assistance program.

Q A union steward contacts the EAP regarding an employee with multiple grievance filings. Part of the core technology of the EAP would be to:

a. Advise the steward on how to handle the grievance hearing

b. Advise the steward on how to use constructive confrontation

c. Teach the steward how to detach

d. Teach the steward how to gather information about the employee's family situation

The answer is "b," advise the steward on how to use constructive confrontation.

Role of the Supervisor

The supervisor or manager has the right to expect good performance from an employee. This does not give the manager the right to tell an employee what to do or not to do on his or her own time, but it does give the manager the right to inform the employee of the effect of such behaviors on his or her ability to perform his or her job.

The supervisor or manager's responsibilities:

a. Developing a safe, healthy and productive work environment. If an employee is influenced by drugs, alcohol, anxiety, depression, or other personal problems, he or she jeopardizes the health and safety of others and harms the work environment.

b. Getting the job done. If an employee's performance is slipping and the job is not getting done, the supervisor/manager has a responsibility to intervene with the employee and to do whatever is necessary to increase performance.

c. Delivering a quality product to the consumer. Poor performance does not always mean a reduction in *quantity* of work; it may result in the reduced *quality* of work.

Disciplinary Procedure

Management in the private sector has traditionally had the right to take disciplinary action based on common law understanding that "an employee has the right to quit a job at any time," and the employer, in the absence of a violation of a statute, has the right to discharge at any time. The discipline should be "corrective action necessary to maintain efficiency and insure the survival of the enterprise" (Chruden and Sherman, 1984). In the public sector, however, where a constitutional right exists, an employee may not be deprived of property, i.e., a job, without procedural due process" (Repos, 1984).

In a unionized setting, this management right to discipline at will is controlled by the union/management collective bargaining agreement. Two processes are generally imposed on management's rights: just cause and due process.

Just Cause: This means that corrective action must be for clear, compelling, and justifiable reasons (Chruden and Sherman, 1984). Seven principles have been developed by arbitrators to determine whether discipline was given for "just cause."

1. Management must inform the worker which conduct could result in a possible or probable disciplinary action.
2. The work rule must be reasonably related to the orderly, efficient, and safe operation of the employer's activity.
3. Management must investigate whether a violation occurred before it takes disciplinary action.
4. Management's investigation must be conducted fairly and objectively.
5. Evidence obtained in the investigation showing that the worker was guilty as charged must be substantial.
6. Management must apply its rules, orders, and penalties on a nondiscriminatory basis.
7. The degree of discipline must be reasonably related to both the seriousness of the proven offense and the service record of the employee (Repos, 1984).

Due Process: Implies that procedural requirements must be followed for the protection of the individual.

1. Formal charges must be filed in a timely manner.
2. The worker must be informed of all charges, and additional ones cannot be introduced after suspension or discharge.
3. The union must be given a chance to protest management's action and the union must receive an opportunity to prepare a defense.
4. Management has the burden of proof to show the misconduct occurred (Repos, 1984).

Progressive Discipline And The Grievance Procedure

Progressive discipline is the process most used by management with union contracts. It is discipline given in a progressive manner. The complexity and sophistication of progressive discipline differs from organization to organization, but the process is the same virtually everywhere.

Before discipline begins, a supervisor must be certain that the employee has had the proper training on the job and been completely briefed on company policies. If an individual is not properly trained or informed, he or she cannot be held responsible for his or her actions. The supervisor must then evaluate and document the employee's non-acceptable

performance or rule violation. If there is a violation, the supervisor must confront the employee. The formal discipline begins. Keep in mind the only legitimate reason for the use of the disciplinary procedure is to correct behavior. The goal is not to punish the worker.

Labor-Management Consideration

If an organization has union representation, planning for an employee assistance program should be done jointly. Decisions will need to be made about which functions are to be performed jointly, and which should properly be handled unilaterally by the union, or by management.

The usual pattern within sizable organizations is to establish a joint labor-management committee of six people, three union representatives and three management. Co-chairpersons should jointly moderate meetings. In smaller work populations, a committee of four members would be more appropriate through a consortium, or an outside service agency, union input, sponsorship or committee involvement might be accomplished through a central labor body.

Q In a company where a union is present, an employee assistance program should be developed:

a. By the top management of the company

b. By joint union-management efforts

c. By the union for its members

d. By the Human Resources Department

The answer is "b," by joint union-management efforts.

Joint Labor-Management Committee Functions

The following functions have been found to be appropriate for such joint committees:

- A committee should be responsible, with the consultation of an experienced staff person, for the development of a policy statement regarding behavior-health problems among employees. Following such formulation, members of the committee would be responsible for presenting the proposed document to their constituencies for changes, approval, and signing by the respective parties. (This would not constitute a labor-management contract, but would be an agreement about the general purposes and policies under which operations would be conducted.)
- The committee would be responsible for the general overseeing of the operations: for providing advice to the coordinator, for suggesting and recommending ways in which the services could be improved, and for monitoring program operations to see that they

were conducted in accordance with the policy, so that the rights of labor, management, and employees were in no way jeopardized.

3. The committee would be responsible to see that appropriate confidentiality of personal information was preserved, and that proper evaluation of the program was conducted on a continuing basis.
4. The committee should not get involved in personal, confidential interviews with employees referred for help, but rather should act as though its functions were similar to the Board of Directors of a mental health or treatment agency.

Labor-Management Law

Labor-Management relations are governed by a large body of law. The most basic is the National Labor Relations Act, which is administered by the National Labor Relations Board.

Wagner Act

The Wagner Act (correctly called the National Labor Relations Act) describes the conditions under which workers can bargain collectively through their authorized representatives. The act did not create any new rights. It was intended to safeguard and enforce existing rights.

The Wagner Act does not set up any specific working conditions (as so many people erroneously believe) that employers must give to their employees. It does not concern itself with the terms of the union agreement. All it does is guarantee that employees may act in a group together - rather than as individuals - if they so desire, in bargaining for their wages.

Taft-Hartley Act

The labor law of the land is the National Labor Relations Act (the Wagner Act) as amended by the Taft-Hartley Act (Labor-Management Relations Act) in 1947.

With organized labor gaining increased strength throughout the country, the political tide turned against unions in 1947, with the passage of the Taft-Hartley Act. This law weakened the effectiveness of unions by outlawing the "closed shop," forbidding political contributions and making unions legally liable for breach of contracts and any subsequent damages. The Taft-Hartley Act greatly reduced the original intent of the Wagner Act and made it harder for unions to organize and bargain.

Under the law, unions and their agents are forbidden to:

- Attempt to force an employer to discharge or discriminate against former members of the union who have been expelled for reasons other than nonpayment of regular union dues or initiation fees.

- Attempt to force an employer to pay or deliver any money or other things of value for services that are not performed. This outlaws featherbedding and other make-work practices.
- Restrain or coerce other employees into joining or not joining a union.
- Require excessive or discriminatory fees of employees who wish to become union members.

In addition, individual employees are protected in their desire to bargain or not to bargain collectively:

- They may take up a grievance directly with management - provided that the settlement is in line with the union contract and a union representative is given an opportunity to be present.
- If they are professional employees, they have a right to vote with a company's other professional employees on whether they want a collective bargaining unit of their own.

Other significant changes enacted by the Taft-Hartley Act are:

1. The 60-day notice of contract termination. If either the company or the union wants to end the contract, it must give the other party 60 days' notice- even though the contract has a definite termination date. During the 60-day period no employee can strike or slow down; management cannot alter, in a manner contrary to the contract requirements, the employment status or working conditions of any employee.
2. The 80-day injunction. Should a labor dispute, in the opinion of the President of the United States, imperil the health and safety of the nation, procedures are set up so that after proper investigation the President may petition the federal district court for an injunction to stop the strike or lockout. During this 80-day cooling-off period, certain other procedures must be followed. Toward the end of the cooling-off period, if the dispute remains unsettled, the National Labor Relations Board (NLRB) must take a secret ballot of employees to ascertain whether they wish to accept the terms of the employer's last offer. If still unsettled after 80 days, the strike or lockout may resume.
3. Right to sue for damages. Both companies and unions may sue in federal court for damages caused by breach of contract. Employers may also sue for damages arising out of illegal strikes and boycotts.
4. Plant guards' units. Plant guards are permitted to form their own bargaining group but may not bargain collectively through a union associated with other employees.
5. Freedom of speech. Employers and unions are given equal rights to speak their minds freely about each other - except when they actually utter a "threat of reprisal, or force, or promise of benefit." (Note that "promise of benefit" is not considered to restrict a union

from describing the potential benefits to be derived from union membership.)

Union Shop – Closed Shop

The closed shop was outlawed by the Taft-Hartley Act. In a closed shop, a man or woman had to belong to the bargaining union before he or she could be hired. The union shop is somewhat similar. The difference lies in the fact that a person need not be a union member at the time of hiring. But an employee must become a member of the union within 30 to 60 days of employment.

Q A company which requires all of its qualified members to join the union as a condition of employment is called a(n):

a. Collective bargaining unit

b. Union Shop

c. Pro-Union Company

d. Open shop.

The answer is "b," Union Shop.

Right-to-Work Law

When the Taft-Hartley Act outlawed the closed shop, it also permitted the individual states to pass laws making the union shop illegal. Such laws, enacted in 21 states, are called right-to-work laws. In these states, the laws permit workers to escape their responsibility of union membership even when they reap the benefits of union contracts. In an agency shop, where workers are not required to become union members; it is possible for 51 percent of a company's employees to be union members and 49 percent to be nonmembers.

Walsh-Healey Public Contracts Act

Walsh-Healey sets the rules for any company that works on a government contract in excess of $10,000. The act forbids hiring boys under 16 and girls under 18. It limits the basic hours of work to 8 a day and 40 a week. The employer must pay time and a half for overtime. The act sets up strict standards for safety, health, and working conditions and also may establish a minimum wage for a particular industry.

Fair Labor Standards Act

Also known as the Wages and Hours Law, this act regulates methods of wage payment and hours of work for any industry engaged in commerce between two or more states. The law restricts the employment of children over 14 and under 16 to non-manufacturing and non-mining positions and prohibits the employment of children between 16 and 18 in hazardous jobs, including driving or helping a driver of a motor vehicle. The law sets the

minimum wage and prescribes that time and a half must be paid for all hours worked over 40 in a week. It also establishes what is "work" and what is not - such as waiting in line to receive paychecks, changing clothes, washing up or bathing, and checking in or out. (All this may be considered work in a union agreement if the parties so agree.)

If an employee's salary is over $250 (as in the case of a highly paid staff specialist) there are fewer restrictions on what he or she can do and still be exempt from overtime.

Non-exempt employees are bound by collective bargaining and include all wage-roll and clerical people; overtime provisions of the law apply to them. Professional employees who require advanced knowledge, customarily acquired through prolonged instruction and study of a specialized field, are usually considered exempt. However, apprenticeship, a college degree, and routine training will not necessarily qualify an employee as a professional.

Q A "non-exempt" employee is:

a. A union member only

b. A salaried employee

c. Exempt from the collective bargaining agreement

d. Bound by the collective bargaining agreement

The answer is "d," a non-exempt employee is bound by the collective bargaining agreement.

Disclosure Act of 1959

In 1959, the Landrum-Griffin Act was passed with the intent to clean up corrupt unions. This law established strict financial reporting procedures.

Officially designated as the Labor Management Reporting and Disclosure Act of 1959, Public Law 86-257 (also known as the Landrum-Griffin Act) compels employers to report:

- Payments to labor union officials, agents, or shop stewards (for purposes other than pay for work)
- Payments to employees (other than regular wage payments) or to groups or committees of employees for purposes of persuading other employees regarding choice of a union or other union matters
- Payments to a consultant on labor union matters

Payments that must be reported also include reimbursed expenses. More important, the law also compels a labor union to make a more complete disclosure regarding the sources and disbursement of its funds.

The law is aimed primarily at (1) preventing unethical collusion between a company and a union or other interference with the due process of collective bargaining, (2) preventing the misuse of a union's funds by its leaders, and (3) otherwise minimizing the possibility of labor "racketeering."

National Labor Relations Board (NLRB)

The National Labor Relations Board (NLRB) is a government agency made up of five members appointed by the President of the United States. Its duty is to:

- Administer the National Labor Relations Act and, in so doing, determine proper collective bargaining units.
- Direct and supervise recognition elections.
- Prevent employers, employees, and unions from violating the act through unfair labor practices, as defined in the statutes.

The NLRB is not a federal court with power to settle disputes, but it makes the major decisions about how the National Labor Relations Act should be interpreted. Since it is not a court, the company or a union must petition a federal district court or the United States Supreme Court to set aside a ruling made by the NLRB. The federal court or the Supreme Court, in such a case, would have the final say - not the NLRB.

Collective Bargaining

Right to Bargain

Within certain limits, labor unions have the legal right to organize a company's employees to allow the union to represent them in the employee's dealing with management. Management also has the right to try to persuade its employees that they might be better off without union representation. When 30 percent of the employees show interest, the union is entitled to ask for a representation election among the company's employees. This election is supervised by the NLRB. If the union wins the election, management must then bargain collectively with employees through the union. If the union does not win a majority in the election, the union has no further say in labor relations matters at that company. It may, however, petition for another election after one year.

Collective Bargaining

Collective bargaining takes place only after a labor union has won a representation election. When authorized representatives of the employer and authorized representatives of the employees bargain together to establish wages, hours, and working conditions, this process is called collective bargaining. Various labor laws have determined what are fit matters for collective bargaining and what are not. Generally speaking, the term "working conditions" is so broad that almost anything that affects employees at work or the manner in which they carry out their jobs can be included.

The union can bargain for its position, and management has to bargain in good faith over the issue. But the company does not have to accept the union's position. Several considerations will determine the issues final disposition: the reasonableness of the union demand; the desirability of the demand to employees, management, and stockholders; the ability of the company to pay for its cost; the judgment of management as to its worth; and, finally, the bargaining strength or weakness of the union or the company.

Collective bargaining usually starts with the negotiation of the union agreement and the signing of the labor contract. But it does not end there. Supervisors, managers, employees, and union stewards must live with the agreement for the next 365 days or longer. Applying the contract and interpreting its meanings from day to day are what make collective bargaining effective. The contract, like any other contract, is rarely changed during its life. But there are dozens, sometimes hundreds, of occurrences between supervisor and employee that require astute judgment on how the situation should be handled to best carry out the meaning of the contract. It is such interpretation and differences of opinion between management and unions that make labor relations a key responsibility.

Q Collective bargaining is best described as:

a. Being represented by a union at the worksite

b. Application of democratic processes to employer-employee relations

c. Forcing a company to recognize a union

d. Preventing unfair labor practices by organizing a union

The answer is "b," application of democratic processes to employer-employee relations.

Unions

What is a union?

The United States of America is a union. It is each state coming together for common laws, principles and the good of all citizens, yet maintaining their individuality. Many groups belong to organizations in order to promote common economic and political interests such as doctors in the American Medical Association, attorneys in the American Bar Association, small businesses and large corporations in the Chamber of Commerce.

What is a labor union?

A labor union is the coming together of workers with similar needs. They may be workers of a single employer, multiple employers, or of a single craft, and they come together to achieve certain goals.

What do unions do?

Unions give us democracy in the workplace, a voice in decisions, a measure of control and a system of fairness. Without a union, we are left to the will and whims of management, and our only recourse for any injustice may be legal action which is costly and many times unsuccessful.

Unions work for legislation and education that benefits all workers such as workers' compensation laws, Occupational Safety and Health Act (OSHA), and unemployment insurance laws and programs. Unions work for tuition and grant programs to colleges, universities, vocational schools and continuing education programs, both in collective bargaining and political action efforts. Unions also work for a clean and safe community environment and a fair tax structure for all Americans.

How does the union work?

A union is a democratic organization of a majority of the employees in a facility. The basic idea of a union is that by joining together with fellow employees to form a union, workers have a greater ability to improve conditions at the worksite. In other words, "In unity there is strength."

The workers control this organization, elect its own officers and make its own rules. This organization (called a Local Union) is federated with hundreds of other Local Unions in a national organization.

The primary purpose of the union is to negotiate a contract that improves wages, benefits and working conditions, and protects workers from unfair treatment. The Local Union elects a negotiating committee to negotiate a contract with management. This committee is assisted by national union representatives. Before negotiations, the negotiating committee develops proposals in consultation with the workers for the first union contract.

After the contract is negotiated, it can only take effect if it is voted on and ratified (approved) by the workers.

After a contract goes into effect, workers elect their own shop stewards and officers. It is the stewards' job to protect their fellow workers' rights and to enforce the contract.

Stewards are sent to training classes where they learn how to enforce a contract and represent their fellow workers.

Whenever a worker in a union shop has a complaint, the worker first has the opportunity of complaining to his or her supervisor, just like before. Under a union contract, however, the supervisor, or plant manager no longer has the final say — they are no longer the judge and jury.

If the worker is not satisfied with the response of the supervisor, the complaint may become a grievance and the steward can accompany the employee to discuss it with the supervisor. If they cannot get satisfaction, the steward and the employee discuss the issue with the manager. If they still are not satisfied, a full-time representative of the union (called a staff representative) attempts to resolve the case with the manager. If the

complaint is still not taken care of, then the issue is placed before an outside neutral judge (called an arbitrator).

Of course, this long process is rarely necessary because workers and their stewards can usually solve a problem at the very first step. Even the most well-intentioned supervisors behave much better when they know that an appeal to higher authority is possible and they do not have the final say. This is what a union really is – a democratic organization through which workers can have some control over the decisions which affect their work life.

Why do workers join labor unions?

Workers join labor unions for at least three reasons:

1. The union offers services and security in collective activity that many individuals cannot or do not wish to provide by acting alone. That's the underlying purpose of labor (or trade) unions: to promote, protect, and improve -through joint action - the job related economic interests of their members.
2. Membership is often compulsory. In three-quarters of the labor agreements an individual must join or at least pay dues if she or he wants to keep a job. The idea behind compulsory membership is that everyone should pay his or her fair share of the cost of the benefits derived from unionism and that no one should get a free ride.
3. Membership provides a sense of independence from management's power to hire, promote, or fire at will. No matter how fair-minded management may try to be, many individuals feel "pushed about" or helpless in today's increasingly large and complex organizations. For many such individuals, union membership provides a feeling of strength that is otherwise lacking.

Won't it cost the company a lot of money if the union gets in?

In the short run it's true the unions cost companies more in better wages and benefits. But in the long run, that doesn't necessarily hurt companies. Many unions are good for the companies as well as for their employees.

The reason for this is simple – better wages and benefits make for more satisfied employees. Satisfied employees are more productive and less likely to quit – and this eliminates one of the highest costs the company has...the cost of constantly training new employees.

Usually employee turnover decreases dramatically once employees realize the benefits of having a union.

What can the unions do about unsafe conditions in the workplace?

Most union contracts have a clause which says: "The company agrees to maintain safe and sanitary conditions in the workplace." And a simple clause like that can make a big difference.

Without a union, if something is unsafe, all you can do is try to find a government agency to make a complaint to.

With a health and safety clause in the contract, you don't have to wait for the government to act. The union can take up the health and safety complaints through the grievance procedure. If the complaint is not corrected immediately, we can have a judge (arbitrator) order that the conditions be corrected. Also, union contracts have safety committees to monitor unsafe conditions.

What about favoritism?

Fairness is the most important part of a union contract – the same rules apply to everyone. The rules are in black and white in a legally binding contract. If any worker feels he or she is being discriminated against in any way, the grievance procedure can correct it.

Can the company take away benefits that workers currently have if the union gets in?

The law prohibits the company from threatening to take away any benefits if the union wins the election. If they do so, they could face charges before the National Labor Relations Board.

When the union does win the election, the company cannot change any existing benefit unless your local union agrees; and the only change is one that would improve benefits at the company.

Under Federal law, no worker's hours, or any other "term or condition of employment," can be changed without the Union's consent, once the Union represents a majority of workers. Without a legally binding contract the company can change whatever it wants, whenever it wants. But more important than the law, common sense tells us that benefits, wages, and working conditions will improve when you organize a union because you will have more bargaining power. Every union contract improves what existed before there was a union.

If the union is so good, why is management against it?

The answer is that most management oppose unions initially to some extent, simply because they would rather not pay the higher wages and benefits which unionization brings. More importantly, they do not want the employees of this company to have a voice over their working conditions. Besides, if the union cannot do anything to improve things, then why is the company fighting the union so hard? Because it knows that unions are good for workers – that's why management wants you to vote against the union.

Who runs the union?

The workers run their own union. They elect their own negotiating committee and prepare their own list of improvements for a union contract. They elect their own officers. The Union staff, including staff representatives, attorneys, and technicians, will be available to the workers when they request it.

The union is a democracy. Each local sends delegates to the international conventions. These delegates are workers like yourself from worksites across the country, and they make union policies by a majority vote.

The union is not an "outsider." It is you, the workers. The strength and activity of the union lie at the local level, because the union is only as strong as its members.

What can we hope to obtain by forming our own local union?

a. A written and legally binding contract with the company
b. The right to bargain as equals with management for improvements in wages, benefits and working conditions at the company
c. The assistance of an experienced union staff, including trained representatives, lawyers, and technicians

Is the union contract legally binding?

Yes. The contract, unlike an employee handbook, is bargained for and signed by both employee representatives and company representatives. It is legally enforceable. For example, in the past, management has cut rates merely to lower employees' wages. A written union contract would prevent this. Without a legally binding contract, the company can continue to cut rates and/or lower pay ceilings as they have done in the past, or reduce benefits.

What role does the first-line supervisor play in labor matters?

In the eyes of the law, supervisors are the responsible agents of their companies. Your employers are held responsible for any action you take in dealing with employees or with labor unions, just as if they had taken the action themselves. For this reason, if for no other, it is essential that a supervisor be familiar with labor law on two particular points: (1) the way in which the supervisor's actions affect labor unions in their attempts to gain or retain bargaining rights for employees and (2) the labor contract that the company may have signed with a union and the impact this has on policies, practices, and procedures that make for amicable labor relations.

Glossary

Union Label or Bug. A stamp or tag on a product or card in a store or shop to show that the work is done by union labor. The "bug" is the printer's symbol.

Union Local. Group of organized employees holding a charter from a national or international labor organization. A local may be confined to union members in one company or one specified locality, or it may cover multiple contracts with various employers.

Union Shop. Form of union security provided in the collective bargaining agreement which requires employees to belong to or pay dues to the union as a condition of employment.

Volunteer Organizing Committee (V.O.C.). Term sometimes used to describe union members who volunteer for the union during organizing campaigns. Volunteers may donate their time and/or be compensated for lost wages while they assist the campaign by visiting workers at their homes, leafleting, and attending meetings.

Questions

1. The individual who hears both sides of an unresolved union-management dispute is called a(n):

   a. Union steward
   b. Impartial arbitrator
   c. Claims adjudicator
   d. Attorney

2. A union steward contacts the EAP regarding an employee with multiple grievance filings. Part of the core technology of the EAP would be to:

   a. Advise the steward on how to handle the grievance hearing
   b. Advise the steward on how to use constructive confrontation
   c. Teach the steward how to detach
   d. Teach the steward how to gather information about the employee's family situation

3. An employee performing unsatisfactorily should be initially approached by the:

   a. Supervisor
   b. Company physician
   c. Human resources professional
   d. Employee assistance professional

4. EAP training for supervisors and union representatives would MOST appropriately include:

   a. Counseling a troubled employee
   b. Documentation of work performance problems
   c. Advocacy for the troubled employee with upper management
   d. Identification of an alcoholic employee

5. What is the FIRST step that the supervisor should take before confronting a troubled employee?

   a. Refer the employee to the medical unit for evaluation
   b. Document evidence of the employee's work performance
   c. Talk to the employee's family about the suspected problem

d. Discuss the employee's problem with other supervisors to get their opinions

6. Which of the following is the first step a supervisor should take in addressing an employee problem?

a. Call the EAP counselor
b. Confront the employee
c. Document job performance
d. Recognize that a problem exists

7. An employee who contacts the EAP representative to discuss a problem with a co-worker:

a. Is a voluntary referral
b. Is a supervisory referral
c. Is not using the program appropriately
d. Should be referred to his supervisor

8. A self referral to the EAP would be:

a. A family member who contracts the EAP about his son
b. A supervisor who contacts the EAP about his employee
c. An employee who contacts the EAP about his boss
d. All of the above

9. In a company where a union is present, an employee assistance program should be developed:

a. By the top management of the company
b. By joint union-management efforts
c. By the union for its members
d. By the Human Resources Department

10. A company which requires all of its qualified members to join the union as a condition of employment is called a(n):

a. Collective bargaining unit
b. Union Shop
c. Pro-Union Company
d. Open shop

11. A "non-exempt" employee is:

a. A union member only
b. A salaried employee
c. Exempt from the collective bargaining agreement

d. Bound by the collective bargaining agreement

12. Collective bargaining is best described as:

a. Being represented by a union at the worksite

b. Application of democratic processes to employer-employee relations

c. Forcing a company to recognize a union

d. Preventing unfair labor practices by organizing a union

Answers

1–b

2–b

3–a

4–b

5–b

6–d

7–a

8–d

9–b

10–b

11–d

12–b

CHAPTER 6 INSURANCE

Excerpts from The Health Insurance Answer Book, 1986 & 1989 Update

By Charles E. Vadkin II & Zelda Lipton

Joseph G. Kozlowski

Group insurance is an economical way to insure a group of individuals under a single contract, or policy, from financial loss resulting from illness, injury, or death. The contract is between the insurer and the entity representing the group – the policyholder. The group must be associated with the policyholder for some purpose other than the purchase of insurance. One set of premium rates for the entire group is determined by averaging the demographic characteristics such as age and sex for all individuals in the group.

Third-Party Administrator (TPA)

TPAs are persons or organizations that are hired to provide certain administrative services to group benefits plans. Their functions may include premium accounting, claims review and payment, records, and negotiations with insurers that provide stop-loss protection for large claims. Sometimes a TPA also fills the role of the consultant - broker, in which case the TPA would help design the benefits plan and recommend the appropriate purchase and funding vehicles. However, TPAs are most commonly employed by association groups, trusts, and employers that self-fund. At the start of their business arrangement, the employer and TPA sign an agreement that outlines the services and authority of the TPA. If the employers plan is only partially self-insured, most insurance companies reserve the right to approve the employers appointment.

Large companies with more than 500 employees often self-fund all or part of their group health insurance plans. The employer's objectives would be to improve cash flow, save premium taxes, eliminate the insurer's risk charge, and benefit from better than expected claims experience.

Q Companies which completely underwrite its risk of benefits and hires a claims processing service or uses its own staff to process claims is called a (n):

a. Self-funded plan

b. Indemnity plan

c. Insurance plan

d. Captivated plan

The answer is "A" self-funded plan.

Mandated Benefit

A mandated benefit is a specific coverage that an insurer is required to include in its contract. For example, most states require that coverage for substance abuse treatment be provided. Other kinds of coverage that are mandated in some states include coverage for newborn children, mental and nervous disorders, and hospice care.

Most states differ in the way they require the insurer to provide the mandated benefits. Some states require that benefits be provided on the same basis as for any other illness; others require that an insurer provide an annual maximum dollar amount or number of visits for each individual for claims relating to certain mandated benefits.

Federal Laws

There are two general types of federal law that have a material impact on group health insurance plans. The first type involves those laws enacted primarily to protect employees from discrimination in employment. Although these laws do not specifically address growing health insurance premiums, they do contain relevant regulations. The most important of these laws are the Age Discrimination in Employment Act of 1967, as amended in 1978 (ADEA); the Employee Retirement Income Security Act of 1974 (ERISA); and Title VII of the Civil Rights Act of 1964, as amended.

The second type of federal law addresses specific health insurance issues. The most important of these include the 1965 amendment to the Old Age, Survivors' and Disability Insurance Act (OASDI), which established Medicare, effective July 1966; and the HMO Act of 1973. Two more recent laws, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Deficit Reduction Act of 1984 (DEFRA), also affect the design of group insurance plans.

ADEA

ADEA prohibits discrimination in employment against individuals age 40 to 70 (until 1983, the maximum age was 65). While the main intent of this

law is to prohibit mandatory retirement before age 70 (with certain exceptions), related provisions of the law apply to health insurance. ADEA, as amended by TEFRA in 1982, requires employers with 200 or more employees to offer older active employees under age 70 who are eligible for Medicare (and their spouses if they are also under age 70) the same health insurance coverage that is provided to younger employees.

TEFRA

For employers of 20 or more employees, TEFRA amended the Social Security Act to make Medicare secondary to employer group health plans for active employees and their spouses, aged 65 through 69. TEFRA also amended ADEA to require employers to offer employees aged 65 through 69 and their dependents the same coverage available to younger employees. Employers do have the right to reduce or terminate medical coverage for employees who are age 70 or older. DEFRA further extended the law to require that group health plans be offered to dependents in the 65-69 age bracket, even if the employee is not in that age bracket.

Employees have the right to reject their employer's plan and elect only Medicare coverage. Employees can also choose to participate only in their employer's plan, even though they are eligible for Medicare. Or they can choose to have their Medicare benefits supplemented with benefits from their employer's group health insurance plan. In this case, the employer's plan would have to be coordinated with Medicare benefits. If the employer does provide coverage as a supplement to Medicare, the plan design may be written in one of three ways:

1. Benefits payable under the employer's plan are reduced by the benefits payable under Medicare. Generally, the employer's plan covers the same benefits as Medicare but is reduced by the Medicare payments. This is commonly referred to as "carve out."
2. Benefits payable under the employer's plan are specially designed to pay for expenses that Medicare does not cover.
3. Benefits payable under the employer's plan are combined with Medicare benefits using a coordination of benefits provision, which allows the insured to be reimbursed for up to 100% of expenses allowable under either plan

Medicare

Medicare coverage consists of a hospital benefits plan (Part A) and supplementary medical insurance (Part B). Part A covers individuals for expenses incurred at hospitals, extended care facilities, home health care agencies, and hospices. Part A is automatic at no fee to eligible individuals. "Eligible" refers to individuals who are under age 65 and are eligible for Social Security because they receive Social Security disability income or receive treatment for end-stage kidney disease. Individuals over age 65 but not eligible for Social Security benefits may enroll in Part A by paying a premium.

Part B helps pay for physicians' services and other medical services not paid for under Part A. Participation in Part B is voluntary and requires premium contribution by the individual to Medicare.

ERISA

ERISA was enacted primarily to effect pension equality, but it also protects the interests of group insurance plan participants and beneficiaries. Under ERISA, group health insurance plans must be established pursuant to a written instrument that describes the benefits provided under the plan, names the persons responsible for the operation of the plan, and spells out the arrangements for funding and amending the plan.

ERISA established the reporting procedure that requires that a summary plan description (SPD) be filed with the Department of Labor, and an annual financial report be filed with the Internal Revenue Service. However, most plans with fewer than 100 participants are not required to file these reports because Congress considered the reporting requirements too burdensome for small employers. Plan participants must be given copies of the SPD and the summary annual report (if the plan is subject to annual financial reporting).

Q Which of the following best describes ERISA?

a. Protects children of pensioned employees

b. Regulates workers' compensation plans

c. Prohibits discrimination in pension contribution

d. Prohibits discrimination in hiring disabled workers

The answer is "c," it prohibits discrimination in pension contributions.

HMO ACT OF 1973
(Health Maintenance Organization Act)

The provisions of the HMO Act that has the most significant effect on group health insurance plans is the "dual choice option." This provision requires that employers with 25 or more employees in a health maintenance organization (HMO) service area include HMO coverage as an alternative to the employer's regular health plan. This law requires that at least one group practice and one individual practice HMO be offered to employees if the employer receives a request for inclusion by each type. HMOs are responsible for requesting inclusion by employers as alternative health plans, and are subject to certain federal requirements in order for employers to be required to recognize them. Employers must make the same contribution on behalf of their employees to an HMO as they do for their other health care plans.

HMO

An HMO is an organization that provides comprehensive health care to a voluntarily enrolled population at a predetermined price. Members pay fixed, periodic (usually monthly) fees directly to the HMO and in return receive health care service as often as needed. This payment structure is known as a "capitative" payment structure.

HMO revenues increase only when enrollment increases, not when services increase. If monthly payments from members exceed the funds the HMO expends on care, the HMO profits. If revenues are less than the cost of care, the HMO loses.

HMOs are organized on a physician basis. There are four basic organizations of HMO physicians. Interstudy, the leading HMO analysis organization, provides the following definitions:

Group model. An HMO that contracts with one independent group practice to provide health services. Care is usually billed to the HMO on a fee-for-service basis.

Staff model. An HMO that delivers health services through a physician group that is controlled by the HMO unit. The physicians, in effect, are employed and paid by the HMO.

Network model. An HMO that contracts with two or more independent group practices (no solo practices) to provide health services.

IPA model. An HMO that contracts with physicians from various settings (a mixture of solo and group practices) to provide health services.

Q Effective efforts to work with HMOs may include all of the following except:

a. Educating employees regarding the nature of coverage before selection

b. Advocacy with the HMO physician on behalf of the employee

c. Complaining to management about the HMO

d. Learning about the operating policies of each HMO involved in the company's benefit plans

The answer is "c," complaining to management about the HMO.

Q An insurance plan that pays none of a client's non-emergency health care costs if a physician outside the accepted group is used is called a(n):

a. PPO plan

b. HMO plan

c. UCR plan

d. Indemnity plan

The answer is "b," HMO plan

PPA/PPO (Preferred Provider Arrangement/Preferred Provider Organization)

A PPA is a Preferred Provider Arrangement. It refers to an agreement between health care providers and another entity or group of entities (insurance companies, employers, TPAs) to provide medical care services at negotiated fees to certain groups in return for prompt payment and increased patient volume. A PPO typically indicates an actual organization of providers, while a PPA suggests simply that a contractual agreement has been made, but there is no other legal entity formed as a result of the agreement. The providers enter into a contract directly with the insurer, employer, or TPA. The term PPA can be used to describe a PPO arrangement itself, and is sometimes used interchangeably with the term PPO.

DRG (Diagnosis-Related Group)

In 1975, Yale University introduced a system of Diagnosis-Related Groups (DRGs) for 467 diagnoses. Initially, these DRGs were meant to be used as a management and planning tool for the health care system. Because of the need for cost management, the federal government decided to apply them to reimbursement definitions. Payment schedules for all DRGs were developed. Patients' conditions are translated to a DRG, and the allowable charge is determined based on the payment schedule.

Currently, only hospital care is paid on a DRG basis. There are, however, some hospitalizations that are given special consideration under the DRG system of reimbursement. These fall into two groups. First, certain kinds of hospitals are not required to subscribe to DRG rules to date. These include some teaching and psychiatric hospitals where the model for the determination of payment by diagnosis has not yet been developed, and because of different services involved and the complex issue of allowable costs of education involved at teaching hospitals. The other kinds of hospitalizations that are given special consideration are known as "outliers." Individuals whose illnesses are unique may not be classifiable under one of the DRGs. They may require care that is necessary but outside the realm

of the established reimbursement norms. These cases are handled individually for Medicare reimbursement.

DRGs have forced some hospitals to "cost shift" the revenue they lose from DRGs to other insurers. Many insurers – private companies, as well as state Medicaid administrations – are championing the introduction of "all payer" systems, under which all insurers would pay on the same basis, although not necessarily on a DRG basis.

Q Diagnostic related groups (DRGs) refer to which of the following?

a. A classification or rating system in which diagnoses and procedures are rated.

b. Utilize a limited number of referral resources.

c. Insure continuing communication with the insurance company.

d. Obtain appropriate liability insurance.

The answer is "a," a classification or rating system in which diagnoses and procedures are rated according to the cost and intensity of services.

Managing Health Insurance Costs

There are two broad interrelated factors that have resulted in rising health insurance costs: the rising cost of health care services and an increase in the frequency of claims. The proliferation of new medical technologies, inappropriate use of medical services and over supply of medical professionals and facilities, high malpractice insurance rates, overall inflation, a payment system that insulates individuals from the true cost of care, and programs such as Medicare and Medicaid that require the private sector to pick up more than its true share of the cost of health care (known as "cost shifting") have all contributed to rising health care costs and increased utilization. Thus, the problem is widespread, and each party involved in the delivery of, consumption of, and payment for health care has contributed significantly to unbridled cost increases.

Utilization Review (UR)

A process called Utilization Review (UR) has been implemented by some insurers and employers in recent years. It evaluates the appropriateness, necessity, and quality of health care provided at various states in its delivery. Although this feature is technically a part of health insurance plan design, it is different in that it analyzes whether the care prescribed and delivered is justifiable and appropriate. Other cost-management plans encourage cost-effective use of care, rather than try to manage care on an individual basis.

Utilization review offers some control over providers' decisions on what care to provide, and allows for retrospective review of care provided to uncover aberrant practice patterns among physicians. For years insurance companies have retrospectively reviewed claims in order to catch charges or services that were inappropriate. UR is peer review – doctors analyzing other doctors' care, and some of it is done before or during delivery of care.

Employers can obtain UR services directly from a UR company, through a broker or TPA, or through the insurer. Numerous review companies are available to choose from, but their services are similar. The services usually focus on hospital review, but some UR agencies provide review of outpatient surgery, treatment of mental illness, and long-term care. The hospital review services usually consist of:

1. Pre-admission certification
2. Concurrent review with discharge planning
3. Retrospective review

Q The means by which an insurance company or outside vendor determines appropriate use of an insurance plan, positively or negatively is called:

a. Utilization review

b. Concurrent review

c. Cost containment

d. Self insurance

The answer is "a," utilization review.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The COBRA Act of 1985 (COBRA) is a federal budget measure that included a requirement for mandatory continuation of health benefits coverage for employees and their dependents who would otherwise lose their group health plan eligibility. Briefly, COBRA requires employers to make health care plans available to former employees and qualifying family members. These plans are to be made available for periods ranging from 18 to 36 months. The legislation specifies rates, coverage, qualifying events, eligible individuals, notification requirements, and payment terms.

COBRA continuation coverage. Group health plan coverage that must be offered to an employee or dependent of that employee in the event of a qualifying event, such as termination of employment, divorce, and so forth.

Qualified Beneficiary. Any individual who is covered by a group health plan on the day before a qualifying event takes place. This person must also be the spouse or dependent child of the employee. If the qualifying

event is the termination of the covered employee (or a reduction in his or her working hours), the covered employee is also a qualified beneficiary.

Qualifying Event. An event that triggers protection under the provisions of COBRA. These events include death of the employee, termination of employment, reduction of work hours, Medicare eligibility, divorce, legal separation, or a dependent child ceasing to meet dependency requirements.

Q Which of the following is false about COBRA?

a. An employee has 60 days after leaving employment to sign up.

b. The employer must continue to pay the premiums.

c. COBRA can be available for up to 36 months in certain cases.

d. The law was enacted to allow employees to access continued health care benefits after leaving employment.

The answer is "b," the employer does not have to continue to pay the premiums.

Q COBRA is a federal law affecting companies with 20 or more employees and addresses:

a. Worker's compensation compliance requirements

b. Mandatory offering of health care benefits following a "qualified event"

c. Social Security benefit administration

d. Pension plan administration

The answer is "b," mandatory offering of health care benefits following a "qualified event."

Managed Care

Managed care arose as a response to the economic imperatives of spiraling unmanaged mental health and substance abuse costs. In light of escalating costs, payers were essentially faced with two alternatives - cut benefits (which many have done) or manage them so as to control costs and ensure quality (Feldman and Goldman, 1993). In addition to concerns about costs, purchasers identified several quality-related problems:

Overuse of hospitalization

- Purchase of services without indication of clinical effectiveness – making it difficult to identify good care and good providers
- Incentives in traditional benefit plans using hospitalization rather than outpatient alternatives

- Fragmented service delivery and lack of coverage for case management service in traditional indemnity plans (England & Vacarro, 1991).

Utilization review and second options, which have been in place for over a decade for medical-surgical insured health benefits, will probably be used in the managed care system. Their general purposes are to insure payers that consumers receive the level of care needed and that excessive, inappropriate or unnecessary care is not delivered or reimbursed. These practices arose to regulate the functioning of the fee-for-service system, where financial incentives tend to encourage the delivery of more health services and more expensive procedures.

In general the managed care organization has gone through three major phases since the mid-1980's:

- The first generation of managed care organizations (MCOs) managed access to healthcare, with a primary focus on utilization review (UR). Access was controlled by limiting benefits and requiring significant co-payments to contain costs. MCO's also introduced administrative barriers such as pre-admission certification.
- The second generation of managed care focused on managing benefits. MCOs added fee-for-service provider networks, selective contracting and treatment planning to the UR function.
- The current generation of MCOs focuses on managing care, performing utilization management instead of utilization review - with a greater emphasis on treatment planning, delivery of the most appropriate care in the most appropriate setting, and moving patients through a continuum of services.

Managed care organizations expect development of a fourth generation product in which they manage outcomes as a part of an integrated services system, moving both public and private patients through a full continuum of treatment services (Waxman, 1994).

The selection criteria of MCOs cover several areas:

Access to care and a provider's response time: i.e. the availability of inpatient and residential beds as needed, and access to outpatient services based on:

- Emergencies: immediately
- Urgent services: 1-2 days
- Routine services: 4-6 days

Minimal delays for patients transferring from one service to another, particularly within a single provider.

Administrative and clinical responsiveness.

HIPAA Primer

WHAT IS HIPAA?

"HIPAA" is an acronym for the Health Insurance Portability & Accountability Act of 1996 (August 21), Public Law 104-191, which amended the Internal Revenue Service Code of 1986. Also known as the Kennedy-Kassebaum Act, the Act includes a section, Title II, entitled Administrative Simplification, requiring:

1. Improved efficiency in healthcare delivery by standardizing electronic data interchange, and
2. Protection of confidentiality and security of health data through setting and enforcing standards.

More specifically, HIPAA called upon the Department of Health and Human Services (HHS) to publish new rules that will ensure:

1. Standardization of electronic patient health, administrative and financial data
2. Unique health identifiers for individuals, employers, health plans and health care providers
3. Security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

- The bottom line: sweeping changes in most healthcare transaction and administrative information systems.

Who is affected?

Virtually all healthcare organizations – including all health care providers, health plans, public health authorities, healthcare clearinghouses, and self-ensured employers – as well as life insurers, information systems vendors, various service organizations, and universities.

Are there penalties?

HIPAA calls for severe civil and criminal penalties for noncompliance, including:

– fines up to $25K for multiple violations of the same standard in a calendar year

– fines up to $250K and/or imprisonment up to 10 years for knowing misuse of individually identifiable health information

Compliance deadlines?

Most entities have 24 months from the effective date of the final rules to achieve compliance. Normally, the effective date is 60 days after a rule is published. The Transactions Rule was published on August 17, 2000; the compliance date for that rule is October 16, 2003. The Privacy Rule was published on December 28, 2000, but due to a minor glitch didn't become effective until April 14, 2001. Compliance with the Privacy Rule was required as of April 14, 2003. The final Security Rule was published April 21, 2003, with compliance required as of April 21, 2005. The final Standard Unique Employer Identifier was published on May 31, 2002. Compliance is required by July 30, 2004. Final standards for Provider and Health Plan Identifiers have not yet been published.

How are healthcare organizations affected?

Broadly and deeply. Required compliance responses aren't standard, because organizations aren't. For example, an organization with a computer network will be required to implement one or more security authentication access mechanisms – "user-based," "role-based," and/or "context-based" access – depending on its network environment.

Effective compliance requires organization-wide implementation.

Compliance requirements include:

- Building initial organizational awareness of HIPAA
- Comprehensive assessment of the organization's privacy practices, information security systems and procedures, and use of electronic transactions
- Developing an action plan for compliance with each rule
- Developing a technical and management infrastructure to implement the plans
- Implementing a comprehensive implementation action plan, including
    - Developing new policies, processes, and procedures to ensure privacy, security and patients' rights
    - Building business associate agreements with business partners to support HIPAA objectives
    - Developing a secure technical and physical information infrastructure
    - Updating information systems to safeguard protected health information (PHI) and enable use of standard claims and related transactions
    - Training of all workforce members
    - Developing and maintaining an internal privacy and security management and enforcement infrastructure, including providing a Privacy Officer and a Security Officer

The Rules Under HIPAA

HIPAA's **"Administrative Simplification"** provision is composed of four parts, each of which have generated a variety of "rules" promulgated by the Department of Health and Human Services. The four parts of Administrative Simplification are:

1. Standards for Electronic Transactions
2. Unique Identifiers Standards
3. Security Rule
4. Privacy Rule

1. STANDARDS FOR ELECTRONIC TRANSACTIONS

The term **"Electronic Health Transactions"** includes health claims, health plan eligibility, enrollment and disenrollment, payments for care and health plan premiums, claim status, first injury reports, coordination of benefits, and related transactions.

In the past, health providers and plans have used many different electronic formats to transact medical claims and related business. Implementing a national standard is intended to result in the use of one format, thereby "simplifying" and improving transactions efficiency nationwide.

Virtually all health plans must adopt these standards. Providers using non-electronic transactions are not required to adopt the standards for use with commercial healthcare payers. However, electronic transactions are required by Medicare, and all Medicare providers must adopt the standards for these transactions. If they don't, they will have to contract with a clearinghouse to provide translation services.

Health organizations also must adopt standard code sets to be used in all health transactions. For example, coding systems that describe diseases, injuries, and other health problems, as well as their causes, symptoms and actions taken must become uniform. All parties to any transaction will have to use and accept the same coding, for the purpose of reducing errors and duplication of effort. Fortunately, the code sets proposed as HIPAA standards are already used by many health plans, clearinghouses and providers, which should ease transition to them.

2. Unique Identifiers for Providers, Employers, and Health Plans

In the past, healthcare organizations have used multiple identification formats when conducting business with each other – a confusing, error-prone and costly approach. It is expected that standard identifiers will reduce these problems. The Employer Identifer Standard, published in 2002, adopts an employer's tax ID number or employer identification number (EIN) as the standard for electronic transactions. Final standards for Provider and Health Plan identifiers have not yet been published.

3. Security Rule

The final Security Rule was published on February 20, 2003 and provides for a uniform level of protection of all health information that is housed or transmitted electronically and that pertains to an individual. The Security Rule requires covered entities to ensure the confidentiality, integrity, and availability of all electronic protected health information (ePHI) the covered entity creates, receives, maintains, or transmits. It also requires entities to protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI, protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required by the Privacy Rule, and ensure compliance by their workforce. Required safeguards include application of appropriate policies and procedures, safeguarding physical access to ePHI, and ensuring that technical security measures are in place to protect networks, computers and other electronic devices.

The Security Standard is intended to be scalable; in other words, it does not require specific technologies to be used. Covered entities may elect solutions that are appropriate to their operations, as long as the selected solutions are supported by a thorough security assessment and risk analysis.

4. PRIVACY RULE

The Privacy Rule is intended to protect the privacy of all individually identifiable health information in the hands of covered entities, regardless of whether the information is or has been in electronic form. The rule establishes the first "set of basic national privacy standards and fair
information practices that provides all Americans with a basic level of protection and peace of mind that is essential to their full participation in their care". 65 Fed. Reg. at 82464The Privacy standards:

- Give patients new rights to access their medical records, restrict access by others, request changes, and to learn how they have been accessed
- Restrict most disclosures of protected health information to the minimum needed for healthcare treatment and business operations
- Provide that all patients are formally notified of covered entities' privacy practices,
- Enable patients to decide if they will authorize disclosure of their protected health information (PHI) for uses other than treatment or healthcare business operations
- Establish new criminal and civil sanctions for improper use or disclosure of PHI
- Establish new requirements for access to records by researchers and others
- Establish business associate agreements with business parteners that safeguard their use and disclosure of PHI.

- Implement a comprehensive compliance program, including
  - Conducting an impact assessment to determine gaps between existing information practices and policies and HIPAA requirements
  - Reviewing functions and activities of the organization's business partners to determine where Business Associate Agreements are required
  - Developing and implementing enterprise-wise privacy policies and procedures to implement the Rule
  - Assigning a Privacy officer who will administer the organizational privacy program and enforce compliance
  - Training all members of the workforce on HIPAA and organizational privacy policies
  - Updating systems to ensure they provide adequate protection of patient data

Use of brief problem-centered clinical approaches rather than long-term rehabilitative approaches.

Positive practice profiles: i.e. providers that are pragmatic, innovative, team oriented, consumer oriented, case management oriented, and outcome oriented.

Cultural competence.

Willingness to arrange.for related social services as needed, e.g., housing or job placements.

Questions

1. Companies which completely underwrite its risk of benefits and hires a claims processing service or uses its own staff to process claims is called a(n):

   a. Self-funded plan
   b. Indemnity plan
   c. Insurance plan
   d. Captivated plan

2. Which of the following best describes ERISA?

   a. Protects children of pensioned employees
   b. Regulates workers compensation plans
   c. Prohibits discrimination in pension contribution
   d. Prohibits discrimination in hiring disabled workers

3. Effective efforts to work with HMOs may include all of the following except:

   a. Educating employees regarding the nature of coverage before selection.
   b. Advocacy with the HMO physician on behalf of the employee.
   c. Complaining to management about the HMO
   d. Learning about the operating policies of each HMO involved in the company's benefit plans.

4. An insurance plan that pays none of a client's non-emergency health care costs if a physician outside the accepted group is used is called a(n):

   a. PPO plan
   b. HMO plan
   c. UCR plan
   d. Indemnity plan

5. Diagnostic related groups (DRGs) refer to which of the following?
   a. A classification or rating system in which diagnoses and procedures are rated
   b. Utilize a limited number of referral resources
   c. Insure continuing communication with the supervisor
   d. Obtain appropriate liability insurance

6. The means by which an insurance company or outside vendor determines appropriate use of an insurance plan, positively or negatively is called:
   a. Utilization review
   b. Concurrent review
   c. Cost containment
   d. Self insurance

7. Which of the following is false about COBRA?
   a. An employee has 60 days after leaving employment to sign up
   b. The employer must continue to pay the premiums
   c. COBRA can be available for up to 36 months in certain cases
   d. The law was enacted to allow employees to access continued health care benefits after leaving employment

8. COBRA is a federal law affecting companies with 20 or more employees and addresses:
   a. Worker's compensation compliance requirements
   b. Mandatory offering of health care benefits following a "qualified event"
   c. Social Security benefit administration
   d. Pension plan administration

Answers

1–a

2–c

3–c

4–b

5–a

6–a

7–b

8–b

CHAPTER 7 HEALTH AND SAFETY

The federal government establishes and monitors through the Occupational Safety and Health Administration (OSHA) strict standards for protection of safety and health at work.

In 1971 the passage of the Williams-Steiger Occupational Safety and Health Act of 1970 and the creation of the Occupational Safety and Health Administration (OSHA) have put the federal government and the Department of Health, Education, and Welfare (HEW) squarely into the safety act in every significant plant and office in the United States. The purpose of OSHA is to establish safety and health standards with which every employer and every employee must comply. And to make sure that there is compliance, OSHA makes over 35,000 inspections annually.

The General Duty clause of the Act states that each employer:

1. Must furnish to each employee employment and a place of employment that are free from recognized hazards causing or likely to cause death or serious harm to employees.
2. Must comply with occupational safety and health standards publicly decreed by the act.

The poster that OSHA requires each employer to display in the area adds this:

"The act further requires that employers comply with specific safety and health standards issued by the Department of Labor."

The standards (called National Consensus Standards) are derived form the American National Standards Institute (ANSI) and the National Fire Protection Association (NFPA) and are supplemented by the Established Federal Standards, which were derived from previous acts.

Q Which of the following requires employers to assure healthy working conditions for employees?

a. EEOA

b. OSHA

c. ERA

d. CRA

The answer is "b," OSHA.

Workers' Compensation

There are five key points to workers' compensation:

- It is a no-fault system. To be compensated, you do not have to show that your employer caused your injury or was to blame in any way. The company's negligence is irrelevant. All that is needed is that the injury was sustained on the job.
- Injured workers cannot sue their employer (with few extremely limited exceptions). Even if the worker was hurt because of the gross negligence of the employer, the worker is not permitted to sue.
- Every state has its own workers' compensation law. Although there are many common features, each law is somewhat different.
- Workers' compensation pays medical bills, death benefits, and a portion of lost wages to disabled workers.
- Workers' compensation is your right.

Workers' compensation is a child of the Industrial Revolution. As workers moved from the farm to the factory, industrial accidents took an increasing toll. Workers had little chance of being compensated for their injuries. They could sue, but because the law favored employers, they were almost sure to lose.

The theory behind the workers' compensation system is simple, both employees and employers trade risk for certainty. Employees exchange the risk of going to court, which could result in a financial bonanza but is more likely to result in nothing, for the certainty of receiving limited compensation for injuries. Companies agree to pay job-related injury claims, whether or not it was their fault, and in return are assured that they will not be sued. The cost of workers' compensation is passed on to the consumer in the form of higher prices.

Q Workers' Compensations is regulated by the:

a. Individual states

b. Federal government

c. Employer

d. Union

The answer is "a," individual states.

Q Which of the following is least likely to be considered a compensable injury under the workers' compensation system, regardless of state?

a. A salesman who was drinking with a client and who is injured in a one car auto accident on his way back to the office

b. An employee who has his hand injured in a punch press accident

c. An employee who claims her alcoholism was caused by the stress she experienced at work each day

d. An employee who develops a severe depression following an injury on the job that caused him to be unable to perform the job he had done for ten years

The answer is "c," an employee who claims her alcoholism was caused by the stress she experienced at work each day.

Glossary

Accident. An unplanned or uncontrolled event in which action or reaction of an object, material, or person results in personal injury.

Hazard. A potentially dangerous object, material, condition, or practice that is present in the workplace, to which employees must be alert and from which they must be protected.

Occupational Safety and Health Act (OSHA). Comprehensive legislation that establishes standards and calls for the inspection of safety and health conditions and the investigation of all serious accidents and alleged safety or health hazards.

Worker's compensation. Financial separations or awards granted by an employer (often in accord with rate tables prescribed by a state's legislature) to an employee who has suffered an on-the-job injury or illness that is judged to have permanently restricted the employee's earning capacity.

Questions

1. Which of the following requires employers to assure healthy working conditions for employees?

   a. EEOA

   b. OSHA

   c. ERA

   d. CRA

2. Workers' Compensations is regulated by the:

   a. Individual states

   b. Federal government

   c. Employer

   d. Union

3. Which of the following is least likely to be considered a compensable injury under the workers' compensation system, regardless of state?

   a. A salesman who was drinking with a client and who is injured in a one car auto accident on his way back to the office

   b. An employee who has his hand injured in a punch press accident

   c. An employee who claims her alcoholism was caused by the stress she experienced at work each day

   d. An employee who develops a severe depression following an injury on the job that caused him to be unable to perform the job he had done for ten years

Answers

1–b

2–a

3–c

CHAPTER 8 EMPLOYMENT ACTS

Law	Provision
Equal Pay Act (1963)	Amended the long-standing Fair Labor Standards Act of 1938 to require the same pay for men and women doing the same work.
Titles VI and VII, Civil Rights Act of 1964 as amended by Equal Employment Act of 1972	Prohibits job discrimination in all employment practices on the basis of race, color, sex, religion, or national origin. This includes recruiting, selecting, compensating, classifying, assigning, promoting, disciplining, and terminating, as well as eligibility for union membership. The EEOC administers these laws and monitors related affirmative action programs.
Executive Order 11246 of 1965 as amended by Executive Order 11375 of 1967	Prohibits discrimination in employment in organizations having contracts of $10,000 or more with the federal government. The orders require that these organizations institute affirmative action programs and recruit and promote women and minorities where necessary.
Age Discrimination in Employment Act (1967) as amended in 1975	Prohibits discrimination in hiring and employing workers over 40 years of age unless bona fide occupational qualification (BFOQ) can be established.
Rehabilitation Act of 1973 and Executive Order 11914 of 1974	Prohibits discrimination of physically and mentally handicapped applicants and employees by federal contractors.
Vietnam Era Veteran's Readjustment Assistance Act of 1974	Prohibits discrimination – by federal contractors – in employment of disabled veterans and veterans of the Vietnam War; also specifies certain affirmative actions in the employment of veterans.

Question

The Rehabilitation Act of 1973:

a. Applies only to Federal contractors with contracts under $2500
b. Requires an employer to take steps to accommodate a handicapped worker
c. Specifies the number of handicapped individuals who must be hired
d. Requires that employers must pay for rehabilitation of injured workers

Answer

1–b

CHAPTER 9 DRUG TESTING

There are several reasons why employers may decide to implement a drug testing program. The decision presents significant challenges and therefore employers should carefully examine their reasons for doing so, explore various options for accomplishing the desired results and make sure they involve representatives of the employees in the process. Random drug testing is often used to deter current employees from using drugs since employees have no notice of when they may be required to submit to a test. Random testing is not connected to performance, but rather determined by some method of random selection. Pre-employment testing is used to discourage drug-users from applying for jobs at drug-free workplaces.

Drug testing is one mechanism that can be used to identify drug users. Although employees may self-report substance abuse problems in order to access treatment, addicted individuals are not usually inclined to do so. While supervisors can be trained to recognize signs of workplace substance abuse, it is ill-advised that supervisors make that judgement without some method of verification. Rather, supervisors should concentrate on identifying poor job performance, not drug use or addiction. Testing following accidents (post-accident), other specified critical incidents, or based on reasonable, articulated suspicion of drug use is used to confirm (or deny) drug use and provide objective evidence of policy violation on which disciplinary action or referral to treatment can be based.

Drug testing may also be implemented because of specific Federal or State regulatory requirements. For example, safety-sensitive employees in the transportation industry (e.g., operators in aviation, trucking, railroads, urban mass transit, maritime, and pipeline industries) are subject to the Department of Transportation (DOT) drug testing rules and requirements. These requirements include testing for marijuana, cocaine, opiates, amphetamines, PCP, and alcohol. Conditions which require testing include post-accident, reasonable suspicion, return to duty, and random selection. DOT regulations also require some education and training for supervisors on the dangers of drug use and alcohol abuse and how to make testing determinations. Similarly, those who have contracts with the Department of Defense (DOD) are also required to implement drug testing as part of their program for preventing, detecting, and treating drug abuse which must also include an EAP, supervisory training, and opportunities for self-referral. Employees whose duties involve access to sensitive information or whose positions involve national security, health, safety, or a high degree of trust must submit to testing. Those who test positive must be removed from their sensitive positions until a determination of fitness is made. The

Department of Energy (DOE) and the Nuclear Regulatory Commission (NRC) also have drug testing rules.

Q All of the following are purposes of drug screening in companies except:

a. Deter employee drug use

b. Identify drug abusers

c. Make an example of drug users

d. Comply with regulatory requirements

The answer is "c," it is not a purpose of drug testing to make an example of drug users.

The Drug-Free Workplace Act of 1988

This act requires employers who have at least one contract with the Federal Government for $25,000 or more and/or employers who receive a grant from the Federal Government to have specific written policies against substance abuse. They must inform their employees about those policies in writing. The Act does not require drug testing or the establishment of an employee assistance program, but does require a drug awareness education program. The Act also requires that employers let employees know about the availability of assistance. Employees and employers must report convictions for drug offenses in the workplace.

Q The Drug-Free Workplace Act of 1988 requires all of the following elements, with the exception of:

a. A continued effort to maintain a drug-free workplace

b. Drug testing

c. Educational awareness program to inform employers about the dangers of workplace drug use

The answer is "b," drug testing.

Drug Testing Situations

Companies have different policies or practices regarding the situations for which testing is required and the consequences of positive drug test results. Consequences can range from firing the employee to referring the employee for treatment. The most common situations where testing is required include pre-employment, critical incident/post accident, reasonable suspicion, periodic, rehabilitation, and random as described below:

Pre-employment – Screening job applicants for the presence of drugs before they are hired as employees. Applicants are notified in advance that they will not be hired if they fail to produce a negative test. Pre-employment

screening is more legally defensible than other types of testing because the applicants are notified in advance that it is a condition of employment and give their consent to be tested. It is also not complicated by issues of job performance and benefits coverage.

Critical incident – The screening of an employee who has been involved in an on-the-job accident (post-accident) or other specifically defined incident. Screening is used to confirm or deny drug use as a factor contributing to the incident.

Reasonable suspicion – Testing required based on identifiable performance problems or behavioral signs observed by supervisors. It is extremely important to have specific, clear, consistent definitions of what behavior would justify drug testing and careful training of supervisors who make referrals. Erratic application of reasonable suspicion testing may be viewed by employees as discriminatory and unfair and expose employers to justifiable lawsuits.

Periodic – Scheduled in advance and uniformly administered, periodic testing is usually part of a routine physical. Such tests are generally more acceptable to employees than unannounced tests, but are less effective as a deterrent since users can plan to abstain prior to the test. Periodic testing is common in jobs where employees are subject to other fitness requirements.

Rehabilitation – Screening for drug use in conjunction with drug rehabilitation treatment. This type usually occurs at a chemical dependency treatment facility as a way of ensuring abstinence and supporting recovery. Some employers may require this as a condition of returning to work after treatment.

Random – The selection of employees on a random basis for no special reason or cause and without advance notice. This type of testing is usually intended to be a deterrent to drug use since employees cannot anticipate it and refrain from using for a limited time. In order to assure a negative test, employees cannot afford to continue drug use. However, because testing is not connected to any evidence of use and no notice is given, there are constitutional concerns that this violates the Fourth Amendment which restricts government from unreasonable search and seizure. (See "Constitutional Concerns," page 135)

Which of the following types of drug screening is least likely to be challenged in court?

a. Requiring a candidate for employment to undergo drug testing before being hired.

b. Requiring that any employee who has an accident at work have a drug test done immediately afterwards.

c. Requiring that employees be part of a random pool for drug testing, regardless of the type of work they do.

d. Requiring that employees in security sensitive positions have random drug tests done.

The answer is "a," pre-employment screening is announced as a condition of employment and conducted with the applicant's consent.

The Flaws of Drug Testing

If the employer's goal is to make sure that none of his or her employees are under the influence of drugs on the job, drug testing is an expensive and flawed tool for the purpose.

All a drug test can tell you is that the person was exposed to drugs at some point in the recent past. It can't tell you whether the person is currently impaired.

Many chemicals such as so-called "designer drugs, " are undetectable by current commercial drug screens. An employee can be under the influence of a chemical compound like "ice," "ecstasy," "crank" and "crystal meth" and come up negative on a drug screen while the next person tested, who smoked marijuana nearly a week ago, will come up positive.

Many employers who institute drug testing decide within a few years that the results aren't worth the effort and expense. According to a recent survey conducted by the Bureau of Labor Statistics, one-third of employers who reported having drug testing programs in 1988 had abandoned them by 1990.

Q All of the following are true about drug screening in the workplace except:

a. It may generate false positives or negatives

b. It can be invalidated by an experienced user

c. It will usually detect newer drugs on the street

d. It may identify non-drug users

The answer is "c," it may not detect newer drugs from the street.

Your Rights

Drug testing is a mandatory subject of bargaining. That means the employer must notify you prior to implementing testing and you have the right to request bargaining on the program.

When you negotiate a testing program, here are some things to keep in mind:

Testing only with reasonable suspicion.

Testing should be based on "reasonable suspicion" of drug or alcohol abuse. Reasonable suspicion means direct, firsthand observation by at least two employer representatives regarding the appearance, behavior, speech or breath odor of the employee. The observations should be documented in writing with a copy provided to the union representative.

Establishment of an Employee Assistance Program (EAP).

An employee assistance program should be in place and operating before testing is implemented so that workers have access to treatment and aftercare programs.

However, drug testing should not be done as part of the employee assistance program. That would seriously erode the atmosphere of trust and confidentiality the program needs to succeed.

No one is exempt.

All employees, including supervisory and management personnel, should be subject to testing on the same basis as the rest of the workforce.

Employers who are serious about the issue don't use a double standard – punishing hourly workers for reporting to work impaired, but looking the other way when an executive is impaired.

Affected employees and applicants should be informed in advance about the company's policy concerning screening. They should be made aware of their right to refuse such screening and of the consequences of such refusal to their employment.

Establishment of procedural safeguards.

The accuracy of the test results is crucial. Every precaution must be taken to ensure against contamination of the sample and the possibility of a false reading.

Protecting privacy and dignity.

The drug testing procedure should also protect workers' rights to privacy and dignity.

Written consent for screening and for communication of results to the employer should be obtained from each individual prior to screening.

Constitutional Concerns.

The U.S. Constitution, which restricts government but not private sectors from arbitrarily interfering with individual rights, prohibits the government from unreasonably infringing on workers' rights relating to privacy and job security. With respect to workplace privacy, the Fourth Amendment prohibits unreasonable "searches." In 1989, the Supreme Court, considering that a public employer's taking of a blood, urine, or breath specimen for the purpose of alcohol and other drug testing (or Government) constitutes a "search" under the Fourth Amendment because it implicates significant privacy concerns. The Court further held that the determination of whether

such testing is "reasonable," and therefore constitutionally valid, requires a balancing of the degree of intrusion on the individual's privacy interest against the promotion of the employer's legitimate interests.

Q Legal issues concerning the constitutionality of drug testing usually center on violation of the employee's rights under the:

a. Second Amendment

b. Third Amendment

c. Thirteenth Amendment

d. Fourth Amendment

The answer is "d," the Fourth Amendment prohibits government from unreasonably infringing on workers rights to privacy and job security.

Types of Drug Tests

A. Screening Test

Drug screening in the workplace is not an EAP function. The accuracy of drug tests is by no means guaranteed. The initial screening is usually done with an immunoassay test in which an antibody is mixed with the urine sample to produce a reaction which indicates the presence of certain drugs.

Common brands of immunoassay tests are Emit and Abuscreen. These tests, in which computers evaluate hundreds of samples in an hour, are the least expensive and the most likely to be inaccurate. Some research has shown false positives as high as 30%.

Knowledge of the following terms will assist in the evaluation and selection of which laboratories to use:

Accuracy: A test's ability to correctly measure the presence or absence of drugs.

Reliability: A test's ability to obtain the same test results from the same sample, in repeated tests.

Retention Time: The length of time a particular drug remains active in the urine. Retention time differs for each class of drugs and varies according to variability of urine specimens, drug metabolism, and half-life. It also varies according to a person's physical condition, fluid intake, method and frequency of drug use, quantity of drug use, and interaction with and/or use of other drugs.

EMIT Screening (Enzyme Multiplied Immunoassay Technique): An EMIT test utilizes both a urine specimen and a calibrated laboratory sample. It is a way of comparing the amount of a drug in the calibrated laboratory sample with the urine specimen that contains an unknown quantity of the drug. If the specimen response during the test registers less than the laboratory sample, it is classified as negative for the drug. If the specimen

response is higher than the laboratory sample, it is considered positive for the drug.

Mass Spectrometry (MS): A complicated method by which the presence of specific drugs is confirmed. It is a confirmation method, not a screening method. Since each drug has its own fingerprint, MS matches the composition of the drug being tested with the standardized drug fingerprint. Both gas chromatography and MS can be used as screening methods. However, the use of these tests for screening is not recommended due to the expense of these methods, the need for extremely sophisticated equipment, and the need for highly trained technicians.

Gas Chromatography (GC): A complicated method for confirming the presence of specific drugs. This method can be used alone, but is most effective when used in conjunction with MS.

There are three major methods of drug screening: thin layer chromatography, enzyme immunoassay, and radio-immunoassay.

Thin-Layer Chromatography (TLC): A method of drug screening. It is the least expensive method of drug urinalysis, and it must be performed in a laboratory. It is not as sensitive as the immunoassay tests.

Enzyme Immunoassay (EIA): A method of drug screening. It is slightly more expensive than TLC. It is designed to detect the eight major classes of drugs and can be used outside the laboratory setting (e.g., at the worksite).

Radioimmunoassay (RIA): A method of drug screening. It is slightly more expensive than TLC. It also tests for the presence of the eight major classes of drugs, but cannot be used outside the laboratory. All positive screening results should be confirmed by one of the confirmation methods previously discussed.

B. Confirmatory Test

If an initial drug screen comes back positive, a confirmatory test should be run using one of the more accurate and more expensive technologies such as thin layer chromatography, in which a technician measures the movement of a few sample drops across a specially treated paper, or gas chromatography/mass spectrometry in which the sample is converted to a gas and its progress through a glass tube is measured.

Gas chromatography coupled with mass spectrometry (GC/MS) has evolved as the preferred method for confirmation of a positive urine screening test, primarily because it provides the greatest level of specificity and therefore the greatest margin of certainty and legal defensibility. Additionally, it is the only method which provides a documented data record suitable for review and interpretation by an outside expert. This method of confirmation is required of laboratories which are certified for urine drug testing for Federal employee programs.

The Drug Testing Procedure

1. Explaining the procedure

Before being required to produce samples, the employee should have the entire procedure explained by the person responsible for receiving, preparing and shipping the specimen. The explanation should include the conditions under which the specimen is to be produced, chain of possession procedures and how the test results will be reported.

2. Ensuring against tampering

The employee then selects one sample collection kit at random from a supply of at least ten kits. As an added precaution, these kits should be shrink-wrapped or the specimen bottles individually sealed as a safeguard against prior contamination.

3. Collecting a sample

In this urine collection procedure, urine shall be obtained directly in the two tamper-resistant urine bottles contained in the specimen collection kit. At the employee's option, the urine specimen may be collected in a wide mouthed "clinic" specimen container which shall remain in full view of the employee until the urine is transferred to the two tamper-resistant urine bottles in the kit sealed and initialed.

4. Extra precautions

The urine containers should be sealed and labeled, then initialed by the employee without the containers leaving the employee's presence. The specimens must be immediately placed in a transportation container, which should be sealed and again initialed by the employee and sent via air courier or other fastest available means to the designated testing laboratory.

5. The Chain of Custody procedures

All handling and transportation of the urine specimen should be through chain of custody procedures as specified in the Mandatory Guidelines for Federal Workplace Drug Testing Program, published by the U.S. Department of Health and Human Services (H.H.S.).

6. Choosing a laboratory

The laboratory to which the sample is sent for analysis should be selected by the union and employer from among those laboratories certified by the U.S. Department of Health and Human Services.

7. Analyzing the results

A Medical Review Officer is a licensed physician who will analyze positive test results to determine whether there may be another explanation, medical or nonmedical for the result. The Medical Review Officer (MRO) may, if necessary, conduct a confidential interview with the employee to find out about health or medical conditions that may have affected the tests.

8. Reporting the results

- **Positive Test Results:** Test findings indicating the presence of specific drugs in sufficient quantity to be detected.
- **Negative Test Results:** Test findings indicating that no drugs are present in the test sample or that the level of drugs present was too low to be detected by the test method used.

The laboratory shall be instructed to report the results to the Medical Review Officer, according to the test methods, cutoff levels and procedures prescribed in the H.H.S. Guidelines, with the following provision for the split sample procedure:

A. The "Split Sample" procedure

When a urine test kit is received by a laboratory, one sealed urine specimen bottle shall be removed immediately for testing. The shipping container with the remaining sealed bottle shall be immediately placed in secure refrigerated storage.

B. The right to second tests

If the first urine specimen is reported by the Medical Review Officer as positive, the employee may, within 24 hours of being notified of the positive report, request that the second urine specimen be forwarded to a different testing laboratory of his or her choice for Gas Chromatography/Mass Spectrometry testing. This laboratory shall be agreed upon in advance by the union and the employer, and must be certified by the U.S. Department of Health and Human Services.

The Boundaries of Drug Testing

A. What can employers test for?

Urine and blood samples can be used to test for a number of things which are not privileged information to the employer – for example, pregnancy or AIDS. The drug testing policy which is negotiated should specifically state the drugs for which tests can be run and limit any testing to only those drugs. For example, guidelines for testing of Federal employees specify testing only for marijuana, cocaine, opiates, amphetamines and phencyclidine (PCP).

B. What about prescription drugs?

Some employers may require workers to disclose prescription drugs they're currently taking. Again, this falls under unprivileged information. If workers have medical conditions which they prefer to keep private, they should be able to do so as long as those conditions don't affect their work. The best agreement would be one in which employees don't have to disclose prescription drugs they're taking, or, if absolutely necessary, would only disclose those which carry a warning label that might affect their ability to do their jobs.

If a prescription drug creates a false positive on a drug test, that's a matter to be cleared up in a confidential discussion between the employee and the Medical Review Officer.

Last Chance Agreements

If an employee is about to be discharged for using drugs or alcohol on the job, the employer may offer what's known as a "last chance" agreement.

The employee promises to go through a rehabilitation program and agrees to random testing for a specific length of time. If the employee doesn't complete the program or any of the tests come up positive, he or she is discharged immediately.

Before signing a last chance agreement, consider the following:

- Given the nature of alcoholism and chemical dependency, a relapse or "slip" is highly likely even when treatment is going well. "Last chance" agreements disregard what we know to be a fundamental characteristic of the illness.
- The "last chance" agreement is not part of the contract which means the employee won't be able to grieve any disputes about how the agreement is being enforced.

Did You Know? You Could Test Positive For...

Marijuana, if you're using:
Advil®, Nuprin®, Mediprin®, Motrin®, Rufen®, or if you have a bladder or kidney infection or liver disorder.

Amphetamines, if you're using:
NyQuil®, Vick's® Inhaler, Contac®, Sudafed®, diet pills, health and asthma medications, or a nasal spray.

Cocaine, if you're using:
Amoxicillian (antibiotic), tonic water, herbal tea.

Methadone, if you're using:
Elavil®, Benadryl®, Soma®, Norflex®, Pernergan®.

Barbiturates, if you're using:
Dilantin®, Phenobarbital®.

Heroin, if you're using:
Pernergan, Vick's® Formula 44, tonic water, poppy seeds.

Alcohol, if you're using:
Contac®, Dristan®, NyQuil®, Hall's® Mentholated Cough Drops, Terpinhydrate®, many cough medicines.

From "Drug Testing on the Job: Know Your Rights", Food and Allied Service Trades Dept., AFL-CIO.

Performance Testing – An Alternative to Drug Testing

A new system designed to provide an alternative to drug testing has already moved into several union workplaces. "Performance Testing" is being sold as a more accurate, less invasive and less expensive way of determining worker impairment.

The most common version requires the employee to use a video game job stick to keep a pointer centered in a target area. The game measures the employee's hand/eye coordination and response time and compares it to a baseline which he or she has previously established.

Possible Drawbacks of Performance Testing

Although the non-invasiveness of the procedure is a positive step, there are potential drawbacks to be considered: Who's being tested? Will there be mass testing of the workforce? Is hand/eye coordination really a crucial part of the job and an accurate measure of impairment? Does a low motor-response time realistically mean that the worker is incapable of performing his or her job? Or, is something like decision-making ability actually more important than response time?

Resources on Drug Testing

Mandatory Guidelines for Federal Workplace Drug Testing Programs published by the U.S. Department of Health and Human Services. For a copy, call the National Institute on Drug Abuse (NIDA) at 1-800-843-4971.

The AFL-CIO Guide-Drug & Alcohol Testing on the Job, available from the Publications and Materials Office of the AFL-CIO, can provide you with more detailed information.

Glossary

Cutoff (also referred to as "detection limit"): The lowest amount of a drug that can be reliably detected by the specific test method used by a particular laboratory. It is usually expressed in nanograms (ng) and varies from one laboratory to another based on the laboratory's capabilities and the methods it is capable of using. There are no nationally established cutoff limits for testing various drugs.

Passive Inhalation: The body's ability to take in a substance through the ordinary breathing process by being exposed to it in unventilated areas. Passive inhalation usually refers to exposure to marijuana smoke and is the opposite of an active, deliberate attempt to inhale marijuana. It is possible, but highly unlikely, to obtain a positive drug test via normal passive inhalation.

Confirmation: The ability to substantiate test results. All positive screening tests should be confirmed to eliminate error. Screening by one test method should be confirmed by a different and more sensitive test method.

False Positive: An error in testing or in reporting that shows the presence of drugs in a urine sample when in fact no drugs are present.

False Negative: An error in testing or in reporting that shows the absence of drugs in a urine sample when in fact drugs are present.

Chain of Custody (COC): A documented procedure which ensures that a urine sample was handled properly. The procedure should result in an audit trail which can be used to verify that specified procedures were followed. The COC process should ensure that samples and test results do not get mixed up. The process begins at the point the urine is voided and ends when the written report and/or confirmation is received at the point of origin.

Negligent Testing: A legal concept that refers to a test which is performed by a laboratory or a technician that is not well qualified, does not follow acceptable standards, or does not follow the test manufacturer's recommendation, especially as it relates to confirming positive results.

Questions

1. Which of the following types of drug screening is least likely to be challenged in court?

a. Requiring a candidate for employment to undergo a complete physical including drug testing.

b. Requiring that any employee who has an accident at work have a drug test done immediately afterwards.

c. Requiring that employees be part of a random pool for drug testing, regardless of the type of work they do.

d. Requiring that employees in security sensitive positions have random drug tests done.

2. All of the following are purposes of drug screening in companies except:

a. Deter employee drug use

b. Identify drug abusers

c. Make an example of drug users

d. Comply with regulatory requirements

3. All of the following are true about drug screening in the workplace except:

a. It may generate false positives or negatives

b. It can be invalidated by an experienced user

c. It will usually detect newer drugs on the street

d. It may identify non-drug users

4. Legal issues concerning the constitutionality of drug testing usually center on violation of the employee's rights under the:

   a. Second Amendment
   b. Third Amendment
   c. Thirteenth Amendment
   d. Fourth Amendment

5. The Drug-free Workplace Act of 1988 requires all of the following elements, with the exception of:

   a. A continued effort to maintain a drug-free workplace
   b. Drug testing
   c. Educational awareness program to inform employers about the dangers of workplace drug use
   d. Written policy prohibiting workplace drug use

6. In drug testing a false negative result is:

   a. An error in reporting the presence of drugs in urine when no drugs are present.
   b. A test which is performed by a laboratory or technician not well qualified.
   c. An error reporting the absence of drugs in urine when in fact drugs are present.
   d. The lowest amount of a drug in a urine sample before it becomes positive.

Answers

1–a

2–c

3–c

4–d

5–b

6–c

CHAPTER 10 VIOLENCE IN THE WORKPLACE

The National Panel on the Understanding and Control of Violent Behavior give a narrow definition of violence: "...behaviors by individuals that intentionally threaten, attempt, or inflict physical harm on others."

Advocates of Human Rights define violence as abuse involving "cruel, inhuman or degrading treatment or punishment." We violate others whenever we deliberately attack them physically, but we also violate them when we attack their honor, their dignity, or some essential component of their identity.

Violence in the Workplace

Violence in the workplace has become more and more common. It is one of the fastest growing types of homicide in the United States. From 1980 to 1989, according to the Centers for Disease Control, homicide was the cause of death for an average of 750 workers annually, making it the third leading cause of death in the workplace during the decade. In 1992, an average of three people were murdered on the job every working day, making homicide the second-leading cause of workplace deaths (Washington Post, 1994). Also, it is estimated that 111,000 incidents of workplace violence occurred in 1992, ranging from sexual harassment and assault to homicide (Hanson, 1994). What's more, it is estimated the total cost to employers for such incidents is approximately $4.2 billion.

According to Scott (cited in Johnson, 1994), who researches aggression, the three essential controls that protect a society against homicide are:

- An economic system that provides full or nearly full employment
- A law enforcement and legal system that emphasizes prevention and apprehends and punishes criminals without delay
- A cultural system that maintains a norm of good behavior

These controls are what we may strive to achieve as a society as a whole. However, the key to preventing incidents of workplace violence is developing an approach of positive management of workplace violence. This approach includes training labor and management to recognize and respond to issues that can compromise health, safety, and organizational effectiveness.

Causes of Violence

According to EAP Digest (1994) American workers believe workplace violence is caused by the following factors (multiple responses allowed):

Factor:	% of Workers Responding :
Alcohol and drug abuse	56%
Layoffs/firings	53%
Poverty	52%
Availability of guns	46%
Violence on TV or in movies	36%
Pressure/too much work	34%
Overly controlling management	32%
Conflicts with co-workers	28%

Source: Northwestern National Life Insurance Company

Potential for Violence

You need to understand your client's potential for violence as it may place severe limitations on referrals and treatment. An individual may be violent in one of two ways.

- He or she may exhibit the impulsive violence that occurs when a person gets angry or frustrated. (This type of anger is most unpredictable and can be disruptive to your program.) Assessment of this form of violence is part of the assessment of impulse control.
- Your client may be violent but have good impulse control. (Such individuals can plan criminal acts such as armed robbery or murder and successfully carry them out.)

Some individuals may become violent only when they become drunk or high. In general, the client exhibiting this type of violence is easier to treat than the person who is impulsively violent while not under the influence of drugs or alcohol. You should consider your client's response to questions such as those that follow in order to assess your client with regard to violence.

- Violence potential
  a. Have you ever harmed anyone? If yes, who was it? What were the circumstances?
  b. Was it when you were drinking or using drugs?
  c. Was it when you were not under the influence of alcohol or drugs?
- Motivation
  a. Was it survival or self-defense?
  b. Was it revenge? NOTE: Take into consideration data from arrest record if appropriate.

Behavioral Emergencies

Workplace Behavioral Emergencies are those situations that involve violent or potentially violent behaviors. Three major types of behavioral emergencies are:

- Unusual behavior which suggests a break with reality and loss of control
- Threats of violence
- Acts of violence

Unusual Behavior

This category includes any behavior or actions which suggest:

- A break with reality
- Loss of control
- Escalating emotional rage

Potential risk of such behavior include: irrational outbursts, unpredictable behavior, unreliable inhibitors, or potential danger to self/others.

Threats of Violence

This category includes threats of violence against another person which may be characterized by one or more of the following elements of behavior:

- Serious intent
- Specific type of violence
- Identified target
- Plan of action (when, where, how)
- Stalking

Potential risks of such behavior include: clear indication of violent intent, unpredictable erratic behavior, or potential for acts of violence.

Acts of Violence

This category includes violent acts against a person, operations, or property already committed or in progress, such as the following:

- Murder
- Assault
- Hostage-taking
- Rape
- Terrorism
- Destruction
- Sabotage

Potential risks of such behavior include: violence in progress, unpredictable erratic behavior, or potential for further violence.

Prevention Strategies

In too many cases of workplace violence, early warning signs are clearly present- usually long before the incident actually happens. Unfortunately

these signs are overlooked with the hopes that whatever the problem is, it will eventually go away.

Personal Warning Signs

The following are generally listed as personal warning signs of potential violence and should receive serious consideration:

- History of violent outbursts
- History of mental disorders
  - Psychosis
  - Paranoia
  - Personality disorders
  - Romantic obsession
- Chronic substance abuse

Work-related Warning Signs

In addition to these personal warning signs, supervisors and union representatives should also be alert to the work-related warning signs of unresolved personal problems:

- Attendance problems
- Excessive or unrealistic demands
- Decreased productivity
- Inconsistent work patterns
- Poor interpersonal relations
- Concentration difficulties
- Poor safety practices
- Significant change in behavior and attitude
- Alibis and blaming others

Timely response in the early stages of a personal problem is the most direct and effective way to prevent workplace violence.

Q Which of the following may indicate that a client is about to become violent?

a. History of past violence

b. Inability to maintain eye contact

c. Recent increase in assaultive behavior

d. Increase in physical movement

The answer is "d," increase in physical movement.

Action Strategies

Workplace Behavioral Emergencies require immediate response. Each company needs to develop procedures to address the following:

- Initial risk assessment

- Efforts to calm a hostile or enraged individual
- Physical intervention
- Protective custody
- Transportation
- Psychiatric evaluation and treatment
- Medical treatment of victims

Questions

1. Which of the following may indicate that a client is about to become violent?

   a. History of past violence

   b. Inability to maintain eye contact

   c. Recent increase in assaultive behavior

   d. Increase in physical movement

2. Violence at work include all of the following cases except:

   a. Two co-workers who get into a fight off duty over a woman

   b. A teacher who is hit by a student

   c. A secretary threatened with job loss if sexual favors are not given

   d. A laborer whose co-worker threatens him or her with a gun at work

Answers

1–d

2–a

CHAPTER 11 SUICIDE PREVENTION

Assessment of your client's suicide potential is the most important assessment you may make. This is because large numbers of persons who have sought treatments have attempted or successfully completed suicide. Employee Assistance Programs are, therefore, in an important position to intervene in suicide.

There is a relationship between the use of alcohol and suicide. About 20 percent of the people who kill themselves are alcoholic and another 20 percent are heavy or problem drinkers. It is not clear if alcohol clouds people's thinking so that they are not aware that they are about to kill themselves, or if alcohol releases inhibitions against suicide. However, even people who do not normally drink tend to take a drink shortly before killing themselves.

There is also a relationship between the use of non-alcoholic drugs and suicide. Approximately 30 percent of the women and 10 percent of the men who enter treatment for drug abuse report having attempted suicide one or more times.

Most suicidal people do not want to die. They are generally seeking relief from an intolerable situation in which they are experiencing more stress than they can stand. Suicidal persons usually want to be helped. But they have difficulty asking for help, aren't sure to whom they should address their plea, and don't know specifically what it is that they want done for them.

If you are dealing with someone who has an extremely strong desire to die, you will not be able to stop him or her, even if you institutionalize the person. However, most suicidal people are ambivalent about dying and actually wish to be rescued. Therefore, about 75 percent of them will give notice of their intentions in the form of clues. By doing so, they are trying to find out if anyone around them really cares if they live or die. For you as a counselor, it is important that the clues be recognized and treated as serious indications of a problem. However, don't panic simply because you've observed any one clue in isolation. Instead, look for a clustering of clues in the proper context. One clue by itself means nothing, but a constellation of clues in a negative context may be an important danger signal.

There are four basic types of clues. The first two types are subtle and therefore, not often associated with suicidal intentions. The second two types may be very blatant.

- Situational Clues – The situation itself is conducive to suicidal thoughts and feelings.

- A person who has been involved in his or her work role is suddenly fired from a job that he or she has held for many years
- A very happy marriage is ended abruptly by the unexpected death of a spouse

❷ Depressive Symptoms – The person is displaying several symptoms that are associated with the syndrome of depression. Such as:

- Insomnia
- Inability to concentrate
- Apathy
- Feelings of worthlessness
- Loss of self-esteem
- No desire to socialize
- Poor personal hygiene
- Preoccupation with death

❸ Verbal Clues – Something that the person says that indicates that he or she is thinking about harming him or herself. Some verbal clues are so blatant that they are vital pronouncements of a wish to die.

- "I wish I were dead."
- "My family would be better off without me."
- "I just can't go on any longer."
- "You're going to regret how you've treated me."
- "If (such and such) happens, I'll kill myself."
- "Here, take this (valued possession). I won't be needing it anymore."

You should always treat the discussion of suicide seriously, even if your client mentions it jokingly. Assume the threat is genuine, don't put your client in a place where he or she has to carry out what he or she has said.

❹ Behavioral Clues – Something that the person does that indicates that self-destructive feelings may be present.

- A previous suicide attempt.
- Putting personal and business affairs in order as though preparing to take a long journey.
- A sudden, unexplained recovery from a severe depression. Such people may be expressing great relief because they have "resolved" all of their problems by deciding to kill themselves.
- Suddenly resigning from organizations such as clubs or church groups.
- Buying a gun (especially when the person never wanted guns in the home).

Q Four basic types of clues in recognizing suicidal clients are:

a. Situational, depressive, verbal and sarcastic

b. Situational, verbal, anger and behavioral

c. Situational, depressive, verbal and behavioral

d. Depressive, frustration, verbal, cognitive

The answer is "c," these clues help you to detect a potential suicide victim.

Once you suspect that someone is a potential suicide victim, the best possible approach is to confront the person directly in a warm, accepting, non-judgmental manner and ask something on the order of, "Have your problems been getting you down so much lately that you've been thinking about harming yourself?" Usually, if the client admits that he or she has been contemplating suicide, you should do the following:

You should always ask the client: "How would you harm yourself?" The answer to that vital question will enable you to determine if the person has a plan of attack and if he or she really poses a serious suicide threat.

If the person does have a plan in mind you should assess the degree of risk inherent in such situations. How specific are the details of the plan? Is the implement or method available to carry out the threat? How quickly would it cause death?

In responding to a suicidal person, reinforce the person for confiding in or calling you and try to sound confident and concerned. It is important that you assure a person that you are definitely going to render the necessary assistance. If the client is at the program, you should make every effort to keep the client with you and never leave the client alone. Telephone a crisis program specialist who is most highly qualified to handle a suicide situation. You should explain the situation to him or her and request that they come immediately to help your client. You should also explain to the client that you are seeking special help. You should give the client information about the crisis counselor which will help the client transfer trust and confidence to this person. When the person arrives you should encourage your client to work with this crisis counselor. As the crisis counselor takes over the situation, he or she will give you cues as to what you should do next. You may be requested to stay and help the crisis counselor, leave the office to provide the client and the crisis counselor privacy or seek the immediate assistance of the police, paramedics or others.

If the client is telephoning you, you should first find out where the person is. If possible you should get a professional on the telephone line and hold a three way conversation. Follow the procedures described above for transferring the client's trust to the other counselor and assuring the client that you will seek help. The decision as to the next step may be sending someone to the client's home or to obtain the assistance of the police, paramedics or others. Regardless, the client should be encouraged to remain on the telephone until help arrives.

Q Once you suspect that someone is a potential suicide victim:

a. Contact the police

b. Tell the person to stop talking about suicide

c. Stay with the person until qualified help arrives

d. Always take notes

The correct answer is "c," you or somebody you assign should always stay with a suicidal client until proper action may be taken.

Who is at Greatest Risk?

Take a few minutes to answer the following questions about your client.

1. How old is the client?
2. What gender is the client?
3. Has the client suffered the recent loss of a close friend or relative due to death, divorce, separation, or a move?
4. Does the client have a chronic or painful physical illness?
5. Is the client socially isolated?
6. Does the client feel unliked?
7. Is the client having problems at work, e.g., production problem, time and attendance?
8. Does the client have a relationship problem, .e.g., conflict with management, co-workers, family members?
9. Is the client angry or aggressive?
10. Is the client impulsive?
11. Is the client uncommunicative?
12. Is the client perfectionistic?
13. Does the client hear voices or have other psychotic symptoms?
14. Does the client use drugs or alcohol?
15. Does the client have a friend or relative who has committed suicide?
16. Has the client ever attempted suicide?

Age

Older children attempt and complete suicide much more often than younger children. One theory suggests that the hormonal surge at puberty for both boys and girls contributes to an increased incidence of depression in this

age group. Older children, especially older adolescents, can more easily plan a method of suicide and then carry it out.

Gender

Three times more girls than boys attempt suicide, but three times more boys die. The male hormones that make boys more prone to aggressiveness may affect their choice of more violent and therefore more fatal means of suicide.

Loss

When a person loses physical health, competence, vigor, or something to live for, he or she must be considered at higher risk for depression and suicide. For children the loss of a parent frequently precedes suicide. A catastrophic loss might produce an immediate depression, called "anaclitic." Untreated, anaclitic depression can be fatal.

Chronic illness or disability, major surgery, or deprivation of any important physical function.

Physical Illness function can leave a person feeling defective, discouraged, and scared.

Social Isolation

Suicidal individuals frequently describe a sense of being emotionally cut off from other family members.

Rejection

Depressed individuals are particularly vulnerable to rejection, even a minor slight can precipitate a suicide attempt.

Work Problems

Some highly intelligent, competitive, perfectionistic individuals cannot tolerate any failure. Their self-hatred after seemingly small career disappointments may be deadly.

Conflicts

Suicide attempts frequently follow violent arguments among family members, close friends, co-workers, supervisors.

Anger and Aggression

Though a history of violence increases an individual's risk for suicide, the suicidal person is usually not the only angry person. Researchers have observed that significant others may direct hostility toward the suicidal member.

Impulsivity

When an individual tends to act quickly, without considering the consequences, the stage is set for a dangerous physical expression of depressed feelings and self-hatred. Impulsivity correlates closely with suicide attempts. Suicide attempts may be a spur-of-the moment reaction to a temporary problem that might resolve itself given time and patience.

Transient changes in relationships, disappointments, fights – all can trigger suicidal behavior.

Psychosis

Psychotic symptoms include hearing voices or seeing visions that aren't real (hallucinations) and believing irrational ideas such as that one's thoughts are being broadcast aloud to the world (delusions). The more severe the mental disorder, the greater the risk of suicide.

Drugs and Alcohol

Abuse of drugs or alcohol increases a person's risk of committing suicide. These substances impair judgment, remove inhibitions to behavior, and promote reckless or self-destructive acts.

Means

Having a convenient means, such as a revolver in a dresser drawer, increases an individual's risk.

Suicide Threats and Prior Attempts

Contrary to popular myth, previous attempts and talk about suicide do not mean an individual will not actually commit suicide. Individuals who attempt suicide almost always give some warning. And most completed suicides have been preceded by at least one attempt. Never ignore, contradict, or belittle a suicide threat. Immediate intervention is very important.

Not every suicide attempt advertises itself with warning signals such as gestures, threats, or notes. Occasionally, an individual who kills him or herself has never given the slightest hint that he or she is depressed. But due to stress, a lack of personal support, inadequate coping skills, and the availability of means, these individuals find an answer in suicide.

The 12 Warning Signs of Suicide:

1. Personality change: a gregarious individual becomes withdrawn or from shy to extremely outgoing.
2. Disregard for appearance.
3. Social withdrawal.
4. Giving away treasured possessions and putting affairs in order.
5. Preoccupation with death or morbid themes.
6. Overt or veiled suicide threats: "I won't be around much longer." "They'd be better off without me." "I wish I were dead."
7. Prior suicide attempts.
8. Acquisitions of a means (ropes, guns, hoses).
9. Substance abuse.
10. Work performance problems.
11. Sudden elevation of mood.

12. Increased accidents or multiple physical complaints with no medical basis.

Suicidal Thoughts

What to Do

The task for the EAP practitioner in managing a suicidal crisis is to reduce the crisis state back to the client's usual state.

- *Remain calm.* Don't show panic. Remember the client is overwhelmed and confused as well as ambivalent.
- *Get vital statistics,* including the client's name, address, home phone number and a close relative's phone number.
- *Develop a quick trusting relationship.* Assure the client that he or she has done the right thing by making contact with you.
- *Permit the client to talk.* Listen! Reflect back what you hear the client saying. Clarify that the client is planning a trip (suicide). How does the client plan to take the trip, how long has he or she been planning and thinking about the trip? What events motivated the client to take this trip?
- *Monitor the client's behavior periodically.*

What Not to Do

- *Don't ignore your suspicions or intuitions.*
- *Don't minimize the client's threat.* Take it seriously.
- *Don't worry about silences.* The client needs time to think.
- *Don't lose patience with the client.*
- *Don't promise confidentiality.* Promise help. Promise privacy.
- *Don't argue with the client* about whether suicide is right or wrong.

Suicide in Progress

What to Do Promptly

- Get the client's name, address and phone number.
- Stay with the client. Assure him or her that emergency help is coming.
- Mobilize another professional to inform an administrator.
- Call 911.
- Note when the incident occurred, and what the client said and did. Stick with the facts.
- Secure any weapon, pills or suicidal notes. Record the time the drug was taken. Provide this information to the emergency medical staff or police.

- Have the administrator or designee contact a close relative. Advise the relative the client is hurt and that you will call back immediately to direct the relative to the hospital to meet the client. Tell the relative to keep the telephone line clear.

What Not to Do

- Don't moralize.
- Don't leave the client alone.
- Don't send the client to the restroom if he or she is distraught.
- Don't discuss the client's situation with colleagues.
- Do take care of yourself after the event.

Managing the Crisis

You should know the clues and causes of suicide. You need to:

- Believe it.
- Talk freely.
- Get help.

It may be helpful to keep in mind that in any crisis situation, the stress process has three parts:

1. Precipitating stress – rejection, loss, hurt.
2. Negative feeling – depression, anger, hurt, hopelessness.
3. Action – constructive coping or destructive response.

Show concern and ask questions in a straightforward and calm manner. Your goal is to show that you are willing to discuss suicide and that you aren't appalled or disgusted by it. Secondly, you are willing to open lines of communication and are prepared to evaluate the seriousness of the problem to get care for the client. (Crisis Intervention Handbook, Detroit Public Schools).

Impulse Control

Impulse control is your client's ability to avoid acting on strong thoughts or feelings. Your assessment of impulse control is of great importance in determining your client's ability to avoid chemical abuse and stay in treatment. It will also help you determine ways to help your client lead a drug free life. Consideration of your client's responses to the following questions may help you assess your client's ability for impulse control:

General impulse control

a. Can you wait for something, or do you have to have it now?

b. Do you often act on the spur of the moment without thinking about the consequences? Give examples.

Anger

a. Do you get angry easily?

b. What kinds of things make you angry?

c. How do you handle anger?

d. How would I know if you were angry with me?

Driving record

a. Do you drive?

b. How often do you drive?

c. What do you do when other drivers make you angry?

Food

a. Have you ever been on a diet?

b. Were you able to stick to it?

Smoking

a. Do (did) you smoke?

b. How much do (did) you smoke?

c. Have you ever tried to quit?

d. What were your reactions?

Q Impulse control is the client's:

a. Sense of anger

b. Ability to avoid acting on strong thoughts or feelings

c. Inability to control severe elevations in mood

d. Focus on thoughts of suicide

The correct answer is "b," impulse control is the ability to control one's action when having intense feelings.

Questions

1. In assessing a person's suicidal potential, which of the following is least critical:

a. Age and sex of the person

b. Lethality of the plan

c. Prior suicidal behavior

d. Immediateness of the plan

2. Most individuals who actually commit suicide:
   a. Are either women or adolescents
   b. Have been alcoholics a long time
   c. Have been planning to commit suicide for a long time
   d. Are males from broken homes

3. An employee comes to you and states that her teenage son has been keeping to himself a lot, has been having insomnia, and most recently gave away his favorite tapes and pictures. What is the most likely explanation for this?
   a. He is using cocaine
   b. He is going through a normal phase of adolescence
   c. He's depressed and possibly suicidal
   d. His mother is overreacting

4. When a client who telephones you causes you to believe that the client wishes to kill him or herself, you should:
   a. Never ask the client how he or she would go about killing him or herself
   b. Keep the client on the phone until you can get help for him or her
   c Ask the client to dispose of anything that he or she needs or has in his or her possession which could be used to kill him or herself.
   d. Never ask the individual about prior suicide plans or attempts

5. If you suspect your client may be suicidal, you should:
   a. Not discuss this with him or her as it may put an idea into his head
   b. Ask him if he's ever thought of hurting himself
   c. Call his spouse and tell her to keep an eye on them
   d. Take the client to the nearest hospital

6. Most suicidal people:
   a. Are adolescent or elderly
   b. Have been addicts a long time
   c. Do not want to die
   d. All of the above

7. Most suicidal people:
   a. Hide their desire for suicide
   b. Are seeking relief from an intolerable stress situation
   c. Do not want you to talk about suicide
   d. All of the above

8. A client has a sudden, unexplained recovery from a severe depression. He shows signs of relief and takes problems more lightly. But he has a history of attempting suicide. What might explain this sudden recovery from depression?

   a. He became interested in religion
   b. He inherited money
   c. He plans to attempt suicide again
   d. None of the above

9. Once you suspect that someone is a potential suicide:

   a. Contact the police
   b. Tell the person to stop talking about suicide
   c. Do not leave the room until qualified help arrives
   d . Always take notes

10. Impulse control is the client's:

   a. Sense of anger
   b. Ability to avoid acting on strong thoughts or feelings
   c . An inability to control mood swings
   d. Focus on thought of suicide

11. When you believe that a client who is telephoning you wishes to kill him or herself you should:

   a. Ask the client how he or she would go about killing him or herself
   b. Keep the client on the phone until you can get help for him or her
   c. Ask the client if he or she knows what he or she needs for killing him or herself
   d. All of the above

12. In assessing a suicidal employee, the most critical concern is whether or not the employee has:

   a. A specific suicide plan
   b. A strong support system
   c. Been under a therapist's care
   d. Considered suicide previously

13. Four basic types of clues in recognizing suicidal clients are:

   a. Situational, depressive, verbal and sarcastic
   b. Situational, verbal, anger and behavioral
   c. Situational, depressive, verbal and behavioral
   d. Depressive, frustration, verbal, cognitive

Answers

1–a
2–c
3–c
4–b
5–b
6–c
7–b
8–c
9–c
10–b
11–d
12–a
13–c

CHAPTER 12 POST-TRAUMATIC STRESS DISORDER

People suffering from post-traumatic stress disorder (PTSD) are survivors. They have lived through a terrifying, overwhelming trauma or a critical incident, in which events or people's behavior conflicted with closely held values and assumptions about life. And they survived.

For years, the condition was known as "shell shock" and considered to be a condition that affected only war veterans.

When significant numbers of veterans returned from Vietnam, mental health professionals realized that this condition – called post-traumatic stress disorder (PTSD) today – was a psychiatric disorder that could be identified by specific symptoms. Moreover, researchers learned that anyone who had endured severe crisis, agony or torment could develop the disorder.

Among the people who may develop PTSD are those who are victims or witnesses of a violent crime. Murder, rape, robbery, kidnapping or sexual assault is just some of the criminal acts that are to blame in many cases of this illness. Others have survived or witnessed a disaster, either through natural causes such as a fire or flood, or man-made causes such as car or airplane crashes, riots or bombings.

PTSD has been expanded to include employees exposed to the potentially stressful situation. This includes victims of violence in the workplace and those who felt threatened or those who witnessed the violence. However, perceived stress is subjective and, therefore, will not affect all employees to the same extent.

Critical incident is an abnormal, traumatic event, such as violence, suicide, homicidal or accidental death, and serious injuries which occur in a person's life and are experienced by normal people.

Critical Incident Stress or Post Traumatic Stress is the normal reaction of normal people to the trauma of the critical incident. The natural stress reaction to the incident overloads and overwhelms the individual's coping abilities and results in physical, thought, emotional, and behavioral symptoms.

Post-Traumatic Stress Debriefing (PTSD) or Critical Incident Stress Debriefing (CISD) is a planned and structured intervention designed to minimize the impact of the incident. PTSD or CISD is a group process in which symptoms are shared, understood, and accepted by members of the group with the result that recovery is more rapid and more thorough.

Key Characteristics

Critical incidents are usually:

- Sudden
- Unexpected
- Short in duration

They typically involve sights, sounds, and odors beyond the normal range of day-to-day experiences.

Who is Affected by PTSD?

The traumatic experiences these people have survived include:

- Terror, helplessness or extreme fear for their lives or the lives and safety of loved ones.
- The destruction of their homes or communities.
- Witnessing someone being severely injured or killed.
- Being subjected to individual violence such as rape or group violence such as military combat.
- Team member death or injury.
- Death of a child – particularly when abuse is involved.
- Familiarity with the victim.
- Working under, or believing you are working under, threatening conditions.

For some, the symptoms of PTSD are short-lived and quickly resolved. But others will suffer for months or years, improving only with treatment.

Symptoms of PTSD

People who have PTSD re-experience their trauma in some way. Most often, they develop intrusive and recurrent recollections or extremely distressful and repeated nightmares about the experience. Psychiatrists report that, among a few people, the illness results in what is called dissociative states. During these stages, the person seems to lapse into a trance and may re-enact the traumatic event.

People suffering from PTSD develop immediate emotional distress when they are exposed to situations or conditions that resemble or symbolize their trauma in some way, such as an anniversary or commemoration. A woman who was raped in a snowstorm may become depressed every time it snows; a veteran may get angry and aggressive each year on Memorial Day.

People with PTSD also avoid anything associated with the event. Some suppress any emotions or thoughts that occurred during the trauma, or that remind them of the event. A sexual abuse victim may find it difficult to have normal, trusting relationships. In some people, this avoidance is

so severe that they actually respond less to their environment. The condition – called psychic numbing or emotional anesthesia – may prompt people to complain of feeling detached from others. They may no longer enjoy the activities they once loved, or be able to feel their normal range of emotions anymore.

Finally, people with PTSD experience persistent symptoms of increased anxiety, watchfulness or vigilance about what is happening in their surroundings. Many have an exaggerated, startled response. For example, a survivor of a school yard shooting spree may "hit the dirt" and cover his or her head when he or she hears a car backfire.

Other people with PTSD have difficulty falling or staying asleep. Some have trouble concentrating. Many experience survivor's guilt because they lived through an event that caused physical injury or death to others.

Still others report increased feelings of irritability or aggression that they must constantly control. Some fear they will lose control. Many may burst into unpredictable explosions of hostility or anger or, conversely, be absolutely unable to express any emotions at all.

Question

1. Which of the following symptoms differentiate PTSD (Post traumatic stress disorder) from other psychiatric classifications?

   a. Feelings of helplessness and hopelessness
   b. History of experiencing events outside the normal realm of experiences
   c. Flashbacks and nightmares
   d. Phobic like symptoms

Answer

1–b

CHAPTER 13 GRIEF

Losses come in all shapes and sizes. Loss of a parent, spouse, child, job, or of dignity or independence, all create emotional pain and require growth work. Loss sets in motion a train of feelings called grief. Grief is a healthy, natural and necessary reaction to a significant change or loss in life.

When we think of grief, we often think only of death, but any loss or change can also cause stress and can include a period of sadness. By being aware of the typical stages of grief, you can help your client pass through the stages with minimum harm – either physical or emotional.

During the grieving period, what is normal goes contrary to what we usually think of as a good adjustment; namely, a rational approach to problem-solving. Most people go through a process of disorganization, reorganization, and resolution – that is, letting go of the loss and rebuilding life without it. Normal grief, despite the appearance of behavioral changes, is healthy. Grief should, under favorable environmental conditions, lead not only to recovery, but also to growth and healthy changes. The stages of grief, which may not occur in this order, are:

Shock

This is the first response. It might take the form of withdrawal, numbness or physical pain. We don't believe that we really lost the person, we hope for a miracle. We don't act, because we do not accept our loss.

Denial

This process takes the form of behaving as if the loved one were still present and no loss had occurred, even to the point of behaving as if the person is present.

Emotional Release

We need to give vent to our feelings of anger, sadness, frustration, jealousy, etc. Holding in feelings may lead to physical symptoms or may delay in moving on to action.

Depression and Physical Distress

The survivor experiences the pain, despair and emptiness of loss. It may or may not be accompanied by an emotional release such as crying, but if a person could cry, it would help release stress. We feel lost and helpless. We doubt our abilities. We may feel hopeless. We show physical signs of stress like sleeplessness, loss of appetite or back and stomach problems.

Panic and Guilt

Panic reactions occur, as the survivor realizes the changes that will take place, the loneliness looming ahead, and the increased responsibility.

Also, the person often blames him or herself for not having expressed more love while the deceased was living, or perhaps believes the cause of death was his or her fault. We have trouble thinking and cannot plan effectively. We feel responsible for the loss, even though we had no control over it. We keep thinking, "if only." We try to do everything at once, and nothing efficiently.

Anger and Hostility

There is aggression toward those who might have prevented the loss, such as doctors or family members. There is also aggression toward the deceased. Acknowledgment of anger toward the deceased is difficult to express, but is necessary to move along the grief process. This is an important part of the recovery process. Anger can be positive, but we sometimes feel angry at those around us. We need to learn to use these strong feelings to give us the energy to make plans.

Re-integration

During this stage, the deceased has been relinquished and laid to rest, and emotional reactions are extinguished. The survivor is capable of starting a new way of life, and seeks new relationships. Some relapses usually occur, particularly on birthdays or anniversaries. (Crisis Intervention Handbook, Detroit Public Schools, 1994).

Resolution

We let go of our anger and false hopes. We feel in control of our lives again. The loss is still part of us but does not dictate or control our actions.

Helping Clients Deal With Loss

There are certain basic psychological issues for an individual facing a loss, whether it is a job, a family member, spouse, co-worker, friend, or a relationship. These psychological issues are directly related to the experience of loss. If the issues aren't addressed, they can become barriers that prevent people from getting the services they are entitled to and need.

These psychological needs are normal and predictable responses to the situations people face – not signs of failure or something that's wrong with an individual.

Bereaved clients are particularly sensitive to verbal and non-verbal signs from co-workers to stifle their grief and confusion. Clients need to know that they can think about and talk about their loss. The following are suggestions for EAP professionals to help clients deal with loss.

1. Talking with the client.
2. Listening with a neutral perspective to what he or she is saying and how he or she says it. This helps the client to clarify feelings.

3. Reassuring him or her; helping the client to feel safe and secure.
4. Allowing the client to grieve and to mourn. Giving the client the opportunity to express feelings is important to good emotional growth.

Recovery takes time. People often need the most help after the initial shock of a loss. Continue to provide support for as long as it's needed.

Questions

1. When a family member has died, it is not uncommon for manifestations of grief to appear in the workplace. An employee comes to you and says, "If only I had been nicer to him before he died." This is an example of which stage of the grieving process?

a. Denial
b. Bargaining
c. Anger
d. Acceptance

2. An employee comes to see you following the death of a family member. As he or she talks, you realize that he or she has moved through his or her denial of the events and is in the anger phase of the grieving process. Which of the following statements would support this assessment?

a. "I just can't believe it!"
b. "God wouldn't do this to me!"
c. "I hate God for taking her/him away from me!
d. "Where is the justice of it all?"

Answers

1–b

2–c

CHAPTER 14 SEXUAL HARASSMENT

Sexual harassment in the workplace is nothing new. Sexual harassment is usually, any unwanted action or remark based on sex or gender that causes a negative reaction in most people, or that puts the person receiving it at a disadvantage.

The Equal Employment Opportunity (EEO) says that, for something to be sexual harassment:

- The harasser's conduct must be unwelcome.
- The harasser may be the victim's supervisor, a supervisor in another area, a co-worker, a client or a non-employee.
- The victim does not have to be the person harassed, but anyone affected by the offensive conduct.
- Unlawful sexual harassment can occur without economic injury to the victim.
- The harassment can be physical (touching, kissing), verbal (lewd jokes, sexual comments), and visual (pornographic materials).
- The conduct must be sexual in nature.

Types of Harassment

Sexual harassment falls into two categories: "Hostile Environment" and "Quid-Pro-Quo."

Hostile Environment

Sexual harassment occurs when offensive conduct unreasonably interferes with an employee's work or creates an intimidating, hostile, or offensive work environment. This can include verbal vulgarity, graffiti, pinups, and statements or actions with double meanings. The events generally repeated are harmful to the employee's emotional well-being.

Quid-Pro-Quo

This Latin phrase means "something in exchange for something else." Harassment occurs when an employer or supervisor offers an employee a job, promotion, or benefit in exchange for sexual favors.

Extortion is also part of this kind of harassment. In extortion, a supervisor threatens to fire or demote a worker if he or she does NOT comply. Employers are often held responsible for the actions of the offending supervisor whether or not upper management knew of the harassment.

Also, when employment opportunities are given based on a person's giving in to sexual advances, the employer may be held liable for discriminating against other qualified employees who did not receive the opportunity or promotion.

What is Not Sexual Harassment

In defining sexual harassment, it is not a casual compliment (nor is it conduct that is strictly outside the workplace and does not involve co-workers). Also, a social invitation is not sexual harassment. If a person keeps pornography at home, for example, or has an affair with someone other than a co-worker, you may not like the behavior, but as long as it does not influence job performance, it is not sexual harassment.

Why Sexual Harassment is Often Unreported

Psychologists who work with those who have been harassed say there are several reasons why sexual harassment is not reported.

1. Fear of losing a job. Those who report sexual harassment do not always receive the response from management they deserve. Fear of being labeled a troublemaker or of being fired keeps many people silent.

2. Feeling out of control. Sexual harassment often has a complex affect on the person who is harassed. He or she does not feel in control of the situation, so it is very difficult for them to confront the harasser or to report him or her to authorities. Those who are harassed often keep silent, hoping things will change.

3. Feelings of guilt. Even though people who have been harassed are NOT responsible for the behavior of the offender, they ask themselves if they could have done or said anything to cause the behavior. This keeps them from reporting the offense.

4. Lack of knowledge. Those who are harassed may simply not know what to do. If they report the problem to the department manager and are met with a lack of caring or with disbelief, they may not know what else to do.

Questions

Which of the following is a myth about sexual harassment?

a. Victims of sexual harassment usually do not complain about offensive behavior out of embarrassment or fear

b. Sexual harassment includes any behavior or act that focuses on gender rather than work role

c. Sexual harassment can happen to both men and women

d. Sexual harassment is often caused by the way a person dresses or acts

Correct Answer

1–d

CHAPTER 15 OLDER ADULTS

There is no set age at which a person becomes classified as an older adult. Definitions commonly in use vary anywhere from ages 50 to 65. For example, a person is eligible to belong to the American Association of Retired Persons at age 50; in most cases, full Social Security benefits begin at age 65; the Federal Older Americans Act of 1965 defined older adult at age 60. Most specialized older adult substance abuse treatment and prevention programs use age 55 and older.

Population

There is a wave of population which peaked with persons born in the late 1940's, 1950's and 1960's Each year a larger percentage of the American population is older adults. Demographers agree that this trend will continue at a dramatic pace for the next two decades before a gradual decline occurs.

This population growth was recognized in the late 1950's and 1960's when the construction of school buildings reached an all-time high. The crest of this population bulge known as the "baby boomers" is of people living longer It is reported by the National Institute of Aging that 35,808 Americans celebrated their 100th birthday in 1992 (Vobejda, 1992).

In 1900, only 4% of the United States population was over the age of 65. By 1980, the figure was 11%. It is estimated by the year 2000, 13% of our population will be over age 65 (Mosher, 1990). Projections indicate that the over 65 group will grow from the current 12% of the U.S. population to 22% by the year 2050. The population shift is clearly noted by the projection that there will be five million fewer 18- to 24- year-olds in 1995 than there were in 1990 (Dychtwald, 1990).

Q What percentage of Americans are estimated to be over 65 by the year 2000?

a. 4%

b. 13%

c. 25%

d. 30%

The answer is "b," 13%.

Aging Process

Many people perceive aging as a disease rather than a natural process. As the body ages, a number of changes take place which significantly influence the pharmacological effects of alcohol and other drugs. Organ systems function less efficiently, causing drugs to be absorbed, distributed, broken down and excreted at slower rates than in the younger body. Disease of a specific organ or organ system can further alter these processes. The body's fat-to-water ratio increases with advancing age, heightening the potential for toxic levels of drugs to build up in fatty tissue. In general, an older person needs less of a particular drug to achieve the desired therapeutic effects than does a younger person. Very few manufacturers have dosage criteria specifically tailored to the needs of older adults like they have for children (MOSA, 1988).

The aging process creates new physical, social and psychological stresses that increase the risk level of alcohol and drug use and misuse for older adults. The physical aging process may promote a dependence on alcohol and other drug use. Efforts in reducing the symptoms of alcohol and other drug use may lead to abuse. Physical changes from aging intensify the effect of alcohol, and the aging body is not as efficient at detoxification. Because the aging body clears toxins more slowly, older clients may require several weeks, even months, to recover from the physical effects of alcohol.

Chronic health problems may be inappropriately linked to normal aging or late-onset chronic illnesses. The symptoms of alcohol abuse may include falls, accidents, gaps in memory, trembling, weight loss, fatigue, insomnia, incontinence, aggression, depression, cognitive impairment, general debility, malnutrition, self-neglect and increased problems with certain diseases. These health problems may be caused or exacerbated by alcohol abuse.

As people age, chronic health problems are more frequent. Chronic problems may require regular contact with physicians who prescribe drugs. These physicians may be less concerned with the prevention of illness and more concerned with medicating symptoms, and so stop investigating the possibilities of a cure of the health problem in the older adult (Lawson, 1990).

Referral Sources

Older adults typically view substance abuse as a moral problem and find it difficult to seek help. They are generally not as comfortable sharing personal issues. Older adults often fail to accept their alcohol and drug abuse because of their sense of independence. For someone to suggest they need assistance with their substance abuse can make them feel guilty and inadequate (Schiff, 1988). Older adults typically are not motivated to seek treatment because of their denial or feelings of hopelessness about their condition (Bridgham & Green, 1991).

Alcoholism is a family disease and it would seem that families would be encouraged to become involved in treatment. However, many older patients feel their lives are run by their adult children. Those who live with their

children feel themselves to be a burden to them and resent any intervention by their families (Schiff, 1988).

The term "family" should be considered in the broader sense and include all those persons such as friends and caregivers who are a part of the older adult's social circle. For older adults, there are often people in their communities who are closer to them than their sons and daughters. To help prevent relapse it is essential that these close acquaintances be involved in the treatment process. When this valuable support group is involved in the treatment process, true recovery can happen.

Family members, friends and others often may act as enablers of the older adult drinker. Guilt feelings may prevent a spouse from facilitating recognition and treatment of the alcoholic. An employer may wish to carry along an aging, dysfunctional employee as a reward for past service and in recognition of impending retirement. Health professionals are often reluctant to separate an older person form his or her "one remaining source of pleasure" (Bienenfeld, 1987).

Treatment Barriers and Approaches

Older adults also need services similar to those of other population groups such as detoxification units, residential and outpatient care, alcohol education, as well as individual and group counseling. However, the emphasis in treatment may differ for older adults.

Specialized treatment programs assist older adults in dealing with the following treatment barriers: 1) older adult drinkers labeled as a poor risk are often turned down for treatment in favor of younger clients at some programs; 2) age-based prejudice is a common attitude in many hospital treatment programs; 3) the older alcoholic is often regarded as less productive to society; 4) the preference is to use shrinking financial resources on a younger population; 5) little or no training or formal education of medical professionals related to geriatric alcoholism is required; and 6) problems of older adults often get labeled as a function of their age and psychological stress and therefore not appropriate for treatment. People are too quick to assume that the signs and symptoms of chemical dependency are signs of normal aging (Johnson, 1988).

Comprehensive specialized treatment programs for older adults need to take into account those problems associated with later life: adjustments to the losses of income, loved ones and social support systems; physiological changes connected with aging, lower tolerance and the increase in toxic effects. Special concerns that relate to older adults might include the interaction of prescribed drugs with alcohol. This often leads to additional problems such as sensory deficits and short-term memory loss, depression, decreased metabolism, sedation and reversible drug dementia.

Many older adults have sensory deficits that are barriers to successful treatment. For example, older adults often suffer some vision loss. Whenever printed information is presented, it should be in large, bold-face type. Hearing impairments also can be barriers to effective treatment. In

order to be heard, it is often necessary to speak in lower tones and more clearly and slowly. Many times an older adult should wear a hearing aid but fails to do so due to cost, embarrassment, or because hearing aids amplify all sounds which makes it difficult to adjust to the noise clutter (MDPH, 1990).

Transportation to and from treatment services is a significant problem for many older adults. In urban areas, older adults may be afraid to use public transportation, and in rural areas, public transportation designed for older adults and persons with disabilities might not be available. Physical mobility may also be a factor. Even though all treatment facilities must be barrier free, many older adults may not be able to use wheel chairs or walking aids and therefore will be confined to their homes. Home visits are helpful but often older adults must travel great distances to receive proper services.

According to the Center for Substance Abuse Services, older adults have the highest rate of treatment success of any age group. They are more likely to complete treatment and have a higher one-year sobriety rate than other population groups. Prognosis for recovery of the older adult substance abuser is excellent once the problem is identified and treatment is started. There is evidence that older alcoholics respond to treatment better than younger alcoholics. This is especially true with late-onset alcoholics (MDPH, 1990). Older adult clients also tend to be more reliable, rarely missing appointments because this is often their only social interaction.

Because of the chronic health problems of older adults, they are more likely to need detoxification services in a medical facility. Confusion and unsteadiness appear long after standard detoxification is completed. The signs and symptoms typical of alcoholism – depression, incompetence, incontinence and confusion – are also stereotypical symptoms of aging. In younger alcoholics, these symptoms would stimulate concern and action, whereas they are frequently dismissed as senility in the older adult (Bridgham & Green, 1991).

In addition, there is a greater chance for organic brain syndrome in older adults which results in impaired short term memory. Because organic brain syndrome can result in the inability to retain recent learning, repetition is often necessary. Often long term memory is still intact; as a result, reminiscence can be a productive tool in treating older adults.

The disease concept of alcoholism was accepted by the American Medical Association in 1956, but few older adults consider alcoholism a disease. When they were growing up, alcoholics were "skid-row bums – immoral, weak people." Individual counseling, therefore, is essential for the older adult. Most older adults have strong feelings and believe that they should keep these feelings to themselves. They have very strong stigmas associated with their drinking and may need more counseling sessions than their younger counterparts (Williams, 1993). The need for a slower paced approach with repetition and less confrontation may result in the need for a longer length of stay in treatment. A flexible treatment plan and counselor

sensitivity to certain age-related concerns are important to keep older adults in treatment and to help them maintain sobriety in aftercare (MDPH, 1990).

The special characteristics of the therapist are a vital factor:

The therapist needs to have more than a liking for older adults. They must have a genuine respect and deep sense of caring for the older adults; a history of positive experiences with the older adults; an ability and desire to learn from them; a conviction that the last years of life can be challenging and fruitful; knowledge of the biological, psychological and social needs of the older adults; a healthy attitude regarding their own eventual old age; an understanding of the development tasks of each period of life; an ability to deal with extreme feelings of depression, hopelessness, grief, hostility, and despair; personal characteristics such as humor, patience, enthusiasm, courage, endurance, hopefulness, tolerance, nondefensiveness, freedom from limiting prejudices, and a willingness to learn; and the ability to be both supportive and challenging and the sensitivity to know when each is needed (Corey & Corey, 1982).

Many older adults have not learned to express their feelings. This only increases their sense of loss and isolation. They are passive and fearful of what is on their minds (Schiff, 1988). Group psychotherapy has proven effective for both early-onset and late-onset alcoholics. While the traditional confrontation that is used with the younger alcoholic does not usually work with the older patient, the group can address the denial in a non-threatening manner (Kofoed, 1987).

Special EAP Consideration

An emphasis is needed on case management techniques that will enable older adult clients to access health facilities and human service agencies. Older adults often present a variety of problems (mental, physical and financial) in addition to their substance abuse problem. EAP specialists can advocate for older adults and link them to the needed services. This coordination is essential to the successful recovery of older adults.

Problems Encountered by Retirees

The value of planning and preparedness is key to a successful retirement. Persons retiring today have 20% or more of their life ahead of them on the average. These are years free from the routines of an occupation, when satisfactions and self-fulfillment, rather than promotions and increases in pay, become goals. Retirement from a job can become a retiring to a new and exciting life. There are new choices such as where to live, what life-style is preferred, what to do with leisure time, and how to live most comfortably.

Since 80% of men and 40% of women are married at the time of retirement (Weinstein, 1979), there may be a need to become reacquainted with one's spouse. This realignment at home may create some marital difficulties.

Financial resources shape most of the choices and decisions retirees make. Ideally the retiree took stock of financial resources in the middle years, gaining financial elbow room, a surplus of earning over expenses, in order to build net worth and future income for retirement years. Workers who assume that their pension plans and social security benefits will provide all of their retirement income that they will need may be bitterly disappointed. Many retirees discover belatedly that their pension income is far less than they had anticipated. In some cases, expected pensions do not materialize at all for a variety of reasons.

For most retired adults, there will be about 50 extra hours of free time per week in retirement. It is a mistake to assume that most retirees will suddenly be able to invent fulfilling, satisfying things to do the day they retire. He or she may miss co-workers and their job, and may not have anyone or anything to replace them. Poor health might be a problem - physical or psychological. Weinstein (1979) identifies four phases in retirement. They are:

1. Honeymoon phase – retirement is great and everything is wonderful
2. Disenchantment – boredom sets in. There is either not enough to do, or there is too much meaningless, "busy" activity
3. Reorientation – a second try at a new organization of one's life
4. Contentment

Q EAP counseling to retirees would be especially beneficial during which phase of retirement adjustment?

a. Disenchantment phase

b. Honeymoon phase

c. Contentment phase

d. Reorientation phase

The answer is "a," disenchantment phase.

Retirement Planning Needs

There are some basic issues to consider in retirement planning. First, one must plan ahead in order to avoid two traps:

1. One must not allow himself or herself to be pressured into activities selected by others.

2. One must not pick activities at random, activities that lack meaning and just fill up time.

By assessing their needs and talents and exploring new activities and pursuits, retirees hope to ensure that their free time now and in retirement is filled with meaning and purpose. Many people feel either a psychological or a financial need to work for pay, at least part time, after they retire.

What adults think about leisure says something about the way they think about themselves. The ancient Greeks interpreted leisure as contemplation in search of cultural enlightenment and knowledge of self. Such contemplation was a vital part of the Greek ideal way of life. Leisure was not thought of as something to be enjoyed for its own sake, separately from work, but as a concept that permeated all of man's activities in order to achieve the perfect balance of accomplishments that represented the ideal. Our work ethic dictates that more people get greater satisfaction from work than from leisure. This can be crushing for new retirees. As EAP practitioners, we should encourage retirees to:

- Engage in a variety of activities. Few people can endure even the most absorbing activity all day, every day.
- Plan some activities that they can do alone and some to do with other people.
- Commit to an activity. Invest in it. Share it with others.
- Make sure some of the activities are demanding enough for the retiree so that they are not too easily mastered and provide the challenge of increasing levels of difficulty.
- Consider activities that offer the retiree the sense of contribution to others, for it is vital for them to have a feeling of self-worth.
- Don't overextend. Consider quality rather than quantity as their main criterion for choosing activities.
- Considering the reality of some physical slowdown in later years, undertake a variety of activities some physical, some creative, some intellectual.
- Upon retiring, put some structure in their life, to replace the structure of work. Have a routine, however, (make sure it is) loosely followed and flexible.
- Fitness, optimum physical and mental health, has many facets: exercise, adequate rest, sound nutrition, calorie counting, wise use of drugs, and control over unhealthful habits. Total fitness is not a "sometime" thing. Encourage the retiree to practice wise health habits, which in turn will help to slow down aging's degenerative effects. With life expectancy steadily rising, there is a good chance many adults will remain healthy and active into their ninth decade. Most of the factors that contribute to longevity are within a person's control.

Questions

1. One area that remains significantly underserved by most EAPs is:
   a. Single parent workers
   b. Dual career couples
   c. Older workers
   d. Parent of teenagers

2. EAP counseling to retirees would be especially beneficial during which phase of retirement adjustment?
   a. Disenchantment phase
   b. Honeymoon phase
   c. Contentment phase
   d. Reorientation phase

3. What percentage of Americans are estimated to be over 65 by the year 2000?
   a. 4%
   b. 13%
   c. 25%
   d. 30%

4. Which of the following would not be included in a retirement planning program?
   a. Nutrition and exercise information
   b. Financial planning information
   c. Psychological adjustment
   d. Coping with grandchildren

Answers

1–c

2–a

3–b

4–d

CHAPTER 16 AIDS

During the 1980's, AIDS emerged as a major health threat, particularly to Americans under age 65. Over this century, infectious diseases have given way to chronic conditions as major causes of morbidity and mortality. Infection from the human immunodeficiency virus (HIV) now affects an estimated 1 million Americans. HIV infection leads to the development of AIDS, including severe opportunistic infections, Kaposi's sarcoma and multiple-system medical complications.

AIDS was recognized as a medical condition during the early 1980's Acquired Immune Deficiency Syndrome (AIDS) is a disease complex characterized by a collapse of the body's natural immunity against disease. Because of this failure of the immune system, patients with AIDS are vulnerable to one or more unusual infections or cancers that do not pose a threat to persons whose immune system is working normally.

In 1993, the Centers of Disease Control and Prevention revised the definition of AIDS to add pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer to the list of diseases that indicate AIDS has fully developed in HIV-infected persons. The expanded case definition indicate that AIDS has fully developed in HIV-infected persons. The expanded case definition led to an increase in cases reported in 1993, because HIV infected persons who did not meet the previous case definition now did and were reported.

Trends in AIDS Case Rates

In 1980, the age-adjusted mortality rates for Blacks were substantially higher than Whites for disease of the heart, cancer, cerebrovascular disease, pneumonia and influenza, diabetes, and chronic liver disease. The current data indicate that the leading causes of death within the Black community continue to be heart disease, cancer, and homicide. For all three causes, the 1990-1992 rates are higher than in the 1980's

Heart disease continues to account for the largest number of excess deaths among African Americans. Hypertension, obesity, lack of physical activity, smoking, and poor access to early detention and treatment services all contribute to the elevated mortality rates from coronary disease for African Americans. Diabetes ranked fourth in excess deaths, averaging 190 annually for 1990-92.

AIDS was the fifth leading cause of years of potential life lost in 1992 in the United States, up from ninth and sixth respectively in 1991. Years of potential life lost is a mortality measure that sums the number of years of life lost prematurely to death for individuals under the age of sixty-five.

This measure helps quantify social and economic loss owing to premature deaths and it emphasizes specific causes of death affecting younger age groups.

Nationally, HIV infection was the third leading cause of death in 1991 for the White population aged 25-44 years, and the leading cause for the African American population in this age group. HIV/AIDS accounted for 15 percent of all deaths for persons in this age group, 18 percent for males and six percent for females. The death rate for HIV/AIDS for African American men aged 25-44 was three times the rate for White males in this age group. An analysis of declines in Black life expectancy from 1984 through 1989 identified HIV infection as one of the two causes contributing most to the decrease in life expectancy for both males and females (MDPH, 1995).

Prevention/Treatment

Investigators have discovered a virus that is believed to cause AIDS. Different groups of researches have given different names to the virus: Human Immunodeficiency Virus (HIV); Human T-lymphotropic Virus, Type III (HTLV-III); Lymphadenopathy Associate Virus (LAV); or AIDS-related Virus (ARV).

No treatment is yet available to prevent death from AIDS, although early detection of HIV infection offers the opportunity for antiviral treatment and prophylaxis against opportunistic infections. In addition, treatment of HIV-positive women with the drug zidovudine during pregnancy can cut perinatal transmission of the infection to newborns (MDPH, 1995).

Efforts to limit the further spread of the AIDS epidemic have focused on educational and other interventions to change behaviors that put persons at risk of acquiring HIV. Condom use is effective in preventing sexually transmitted HIV, but national survey data show low levels of use among high risk groups, e.g. adolescents, and sexual partners of injection drug users. Needle exchange programs, under both public and private auspices, have sought to limit the spread of HIV through contaminated needles. In many cases, these programs have met with political opposition. The rise in case rates among women is of concern, especially with respect to perinatal transmission of HIV.

Transmission Modes

There are only four ways that the AIDs virus can be transmitted:

1. **Sexually.** Sexual contact, particularly with many partners, is highly risky. Homosexual transmission accounts for over 60 percent of AIDs cases, a proportion that has decreased as the gay community has adopted "safe sex" practices of abstinence and condom use. Although AIDS is often perceived as a disease afflicting homosexuals, it can also be transmitted from men to women.

   About one in every ten AIDs victims is a woman, largely as a result of contact with bisexual men or intravenous drug use. The

percentage is rising rapidly – in 1990 the number of women with AIDs grew by 29 percent, compared with an 18 percent in men (Isaacs & Swartz, 1992).

2. **Through sharing infected needles.** Needle sharing among intravenous drug users accounts for 25 percent of the reported cases of AIDS. As AIDS among the gay population decreases, it is becoming increasingly a disease of poor, drug-abusing minority men and women.
3. **Through infected blood.** Although tests in use since 1985 have made today's blood supply almost completely safe, there is still a small possibility – estimated at one in 250,000 – of getting the AIDS virus from a blood transfusion.
4. **Through pregnant women or lactating mothers.** The chances of a woman with AIDS virus transmitting it to her baby, during pregnancy or through infected breast milk, are thought to be between 25 and 30 percent (Isaacs & Swartz, 1992).

Q Who is at the least risk to develop AIDS?

a. Hemophiliac child

b. IV drug abuser

c. Sexually active female

d. Homosexual male

The answer is "c," the sexually active female has the least risk of AIDS.

Causes of AIDS

Infection with this virus does not always lead to AIDS, and researchers are investigating whether other co-factors may be necessary to trigger the disease. Preliminary studies show that many HIV infected persons remain in good health; others may develop the illness varying in severity from mild to extremely serious. Currently 20-30% of those infected with HIV have ultimately developed AIDS.

Employment

Questions about AIDS in the workplace usually fall into two camps: employer and co-worker. Both are motivated by fear. An employer, who is worried about the cost of health insurance or losing customers, may try to bar people with AIDS or fire them once their condition is discovered. Frightened co-workers may refuse to work with an HIV-positive fellow employee, afraid they will catch the deadly virus. The rights and legality of such issues are still being defined through state laws and two federal laws which are the 1973 Rehabilitation Act and the 1990 Americans with Disabilities Act. Although the law of AIDS in the workplace is still

emerging, the following are guiding principles which will help people to understand the rights of people with the virus, their fellow workers, and their employers:

- People with AIDS and those who are HIV positive are legally considered handicapped or disabled under federal laws. The federal laws, and the laws of just about every state and many large cities, protect people with the AIDS virus against discrimination.
- The AIDS virus is extremely hard to transmit and cannot be spread by the casual contact associated with a normal workplace.

The Americans with Disabilities Act of 1990 bans discrimination against disabled employees or job applicants, including those who have AIDS, are HIV-positive, or are perceived as being in one of these categories. The act, applies to employers of fifteen or more employees. (Smaller companies will continue to be bound by state and local laws.) Even if an employee is disabled, he or she must, as the law states, be "qualified," that is, able to perform the essential tasks of the job. New York Law School professor Arthur Leonard, an AIDs expert, identified two tests to determine whether a person is so qualified:

- Does the person have the mental and physical ability to do the job? In the case of an HIV-positive person showing no signs of AIDS, this is easy to resolve in favor of the individual. If a person does have some of the symptoms of AIDS – for example, excessive fatigue – the opinion of one or more doctors will probably be needed. If he or she cannot do the job, the employee can be let go or placed on disability.
- Does this HIV-positive individual pose an unacceptably high danger to others? With the possible exception of some health care workers, the answer is very likely to be no. Because the AIDS virus is extremely difficult to transmit, few people who carry it present a threat to the health of others.

Q An employee with AIDS is transferred from one department to another. The employee comes to you and asks whether to tell anyone in this new department about his illness. At this time, no one in the company is aware of his diagnosis. Which of the following is the best guideline to follow?

a. The EAP counselor should assist the employee to tell his co-workers and supervisor about his illness in a group session.

b. The EAP counselor should assess whether there is any "need to know" within the department and proceed accordingly.

c. The EAP counselor should obtain consent from the employee to contact his physician and determine if the employee is restricted from any duty where the supervisor would have a need to know and proceed accordingly.

d. The EAP counselor should provide a general AIDS Education week prior to the employee returning to the workplace.

The answer is "c," the EAP counselor should obtain consent from the employee to contact his physician and determine if the employee is restricted from any duty where the supervisor would have a need to know and proceed accordingly.

Confidentiality

Since AIDS does not pose a risk to the general public there is no need for neighbors, shopkeepers, co-workers or others who may have casual contact with a person with AIDS to know.

Questions

1. Who is at the least risk to develop AIDS?
   a. Hemophiliac child
   b. IV drug abuser
   c. Sexually active female
   d. Homosexual male

2. An employee with AIDS is transferred from one department to another. The employee comes to you and asks whether to tell anyone in this new department about his illness. At this time, no one in the company is aware of his diagnosis. Which of the following is the best guideline to follow?
   a. The EAP counselor should assist the employee to tell his co-workers and supervisor about his illness in a group session.
   b. The EAP counselor should assess whether there is any "need to know" within the department and proceed accordingly.
   c. The EAP counselor should obtain consent from the employee to contact his physician and determine if the employee is restricted from any duty where the supervisor would have a need to know and proceed accordingly.
   d. The EAP counselor should provide a general AIDS Education week prior to the employee returning to the workplace.

Answers

1–c

2–c

CHAPTER 17 ADULT CHILDREN OF ALCOHOLICS (ACOA)

An addict is a person who is powerless over a substance or a process in his or her life to the point that progressive immersion in the addiction will lead to death. All addictions are fatal, although addictions are also the only disease for which recovery is possible if the person addicted begins a program of recovery.

There is not one typical typology for all Adult Children of Alcoholics. An adult child of an alcoholic (ACOA or ACA) is a person who grew up in a family in which one or more parents was an alcoholic, or in a family that repeats alcoholic or addictive patterns. Adult children may not be addicts themselves as adults, although they can be. However, ACOAs carry a unique set of emotional problems and specific personality disorders that affect their lives. Identification of the personality characteristics is relatively recent, and the first National Organization of Adult Children of Alcoholics (National Association of Children of Alcoholics) is only a few years old.

Q Which of the following is true about typical typologies of Adult Children of Alcoholics

a. They are extremely immature in dealing with co-workers

b. They are passive-aggressive individuals

c. There is not one typicality for all Adult Children of Alcoholics

d. They are trusting, open, communicative, and feeling individuals

The answer is "c," there is not one typicality for all Adult Children of Alcoholics.

A co-dependent is anyone who had an alcoholic parent or grandparent, is in a marriage or love relationship with an alcoholic or other addict, or who came from an emotionally repressive family. Estimates on the number of co-dependents in the United States range up to 9 percent of the population. Whereas, ACOAs are estimated to be 15 percent of the U.S. population (Schaef & Fassel, 1988).

From these definitions, it can be presumed that every ACOA is by definition also a co-dependent. Every co-dependent is not necessarily an adult child of alcoholics. Addicts can be ACOAs and co-dependents although they may not be.

Adult Children of Alcoholics at Work

Adult children of alcoholics have special difficulties in the workplace. Goldberg (cited in Schaef & Fassel, 1988) identified the following issues that ACOAs must face at some point in their career:

Perfectionism/Self-Criticism

ACOAs feel they must do each job perfectly. Their self-criticism is so extreme that they disregard praise, feeling it could not possibly be true. They tend to put in inordinate amounts of overtime, in order to ensure that projects are just right.

Workaholism

The addiction of choice for many ACOAs is overwork. Some do it to make up for feelings of insecurity or inferiority, thereby constantly going the extra mile. Others are unable to say no to the demands of co-workers and bosses. ACOAs are workaholics because they prefer to stick with what they know best, and ACOAs are better at work than they are at personal relationships, which they find difficult and anxiety producing.

Rigidity in Thinking

ACOAs lack flexibility; their thinking tends to be dualistic. They think in terms of black and white, and right and wrong. Their rigidity, combined with their perfectionism, leads to their belief that there is one and only one correct solution for everything. They are rarely open to options. Their motto is "I'll do it my way."

Crisis Handling

ACOAs tend to be superb during a crisis. In fact, they are coolest when things are falling apart. This is probably because they spent their childhood in addictive families that were fraught with unpredictability, where crisis was usual.

The ability to stay calm during crisis is an admirable quality in the workplace. Unfortunately, the crisis orientation becomes a way of life for ACOAs. They have trouble with calm.

Teamwork

The ACOAs are having difficulty adjusting to new changes in the American Corporation. Especially as it change from the autocratic system of managing to the team approach. ACOAs would rather be left alone; they are not team players. Many ACOAs never learn the rudimentary lessons of cooperation in the family unit. In fact, participation in the family was a source of pain and fear. Being alone was safe. Consequently, many ACOAs come to the workplace with very poor skills and little or no experience in working together.

Goldberg identifies three major reasons why ACOAs are poor team members: 1) they have difficulty listening and communicating; 2) they have difficulty giving and receiving criticism; and 3) they have a strong need for control (cited in Schaelf & Fassel, 1988).

As supervisors, ACOAs can be tough bosses, difficult to work for and driving taskmasters. Because of their high need for control, they do not delegate easily.

As employees, ACOAs typically have trouble with authority. Managers and supervisors are seen as surrogate parents, and ACOAs can unconsciously seek from them things they never received from a parent.

Co-Dependents at Work

In organizations, the co-dependent relates to an addict in the same fashion that an enabler spouse relates to the addict in the family. Co-dependents tend to protect the addict and will cover for him or her when performance is questioned or appointments missed. Co-dependents, like ACOAs, are anxious, rough authority figures, but co-dependents tend to be compliant and try to please, whereas ACOAs become resistant or defiant. Co-dependents avoid conflict at all costs.

Co-dependents have an unusually high tolerance for confusion and crisis. They view confusion as normal in their families and expect the same in the organization.

Question

1. Which of the following is true about typicalities of Adult Children of Alcoholics

   a. They are extremely immature in dealing with co-workers
   b. They are passive-aggressive individuals
   c. There is not one typicality for all Adult Children of Alcoholics
   d. They are trusting, open, communicative, and feeling individuals

Answer

1–c

CHAPTER 18 SELF-HELP PROGRAMS

Self-help or Twelve-Step organizations involve mutual help among peers experiencing similar problems. With the development of the first Alcoholics Anonymous group (A.A.) in 1935 in Akron, Ohio, a long tradition of the use of self-help groups for substance abusers was launched. Self-help groups often meet in churches, community facilities, prisons, and other locations, but they generally claim no political or religious affiliations.

Alcoholics Anonymous

Alcoholics Anonymous (A.A.) describes itself as a voluntary, self-run fellowship. Its membership is multi-racial and there are no age, educational, or other requirements for members. It is non-professional and has no dues or outside funding sources. An important characteristic for many persons is its promise of anonymity, protecting the right to privacy of its members (Doweiko, 1990; Nace, 1992).

Members of A.A. believe that addiction is a disease that can never be cured. However, they maintain that progression of the disease can be arrested, and those in remission are recovering alcoholics (Doweiko, 1990). Groups function to reinforce social and cognitive behaviors that are incompatible with addictive behaviors. The Twelve Steps provide a concrete, tangible course of action (Galanter, Castaneda & Franco, 1991; Nace, 1992).

In A.A., the words sober and dry denote quite different states. A dry person is simply not drinking at the moment. Sobriety means a more basic, all-pervasive change in the person. Sobriety does not come as quickly as dryness and requires a desire for, and work towards, a contented, productive life without reliance on mood-altering chemicals. The Twelve Steps provide a framework for achieving this latter state.

The primary goals of A.A. and similar self-help groups are to (Galanter, Castaneda & Franco, 1991):

- Achieve total abstinence from alcohol or other drugs.
- Effect changes in personal values and interpersonal behavior.
- Continue participation in the fellowship to both give and receive help from others with similar problems.

Self-help groups often are used in tandem with other treatment modalities, such as residential or outpatient treatment programs.

The Twelve Steps

The Twelve Steps function as the therapeutic framework of A.A. These steps consist of a series of cognitive, behavioral, and spiritual tasks including:

Step 1: We admitted we were powerless over alcohol – that our lives had become unmanageable. (An admission of powerlessness.)

Step 2: Came to believe that a Power greater than ourselves could restore us to sanity.

Allows for the gradual reliance on some agent outside (God, the A.A. group, the therapist, or a combination) to aid an about-face, recognizes the craziness of the drinking behavior.

Step 3: Made a decision to turn our will and our lives over to the care of God as we understood Him.

Enables the alcoholic to let go of the previous life preserver, the bottle and accept an outside influence to provide direction. It has now become clear that as a life preserver, the bottle was a dud, but free floating cannot go on forever, either. The search outside the self for direction has now begun.

Step 4: Made a searching and fearless moral inventory of ourselves.

Allows a close look at the basic errors of thinking and acting that were part of the drinking debacle. It also gives space for the positive attributes that can be enhanced in the sober state.

Step 5: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

Provides a method of cleaning the slate, admitting just how awful it all was, and getting the guilt-provoking behavior out in the open instead of destructively bottled up.

Step 6: Makes the alcoholic aware of the tendency to cling to old behaviors, even unhealthy ones. Were entirely ready to have God remove all these defects of character.

Step 7: Took care of the fear of repeated errors, again instilling hope that personality change is possible. (At this stage in the process, the alcoholic is likely to be very short on self-esteem.) Humbly asked Him to remove our shortcomings.

Step 8: Made a list of all persons we had harmed and became willing to make amends to them all.

Step 9: Made direct amends to such people wherever possible; except when to do so would injure them or others.

Steps 8 and 9 are a clear guide to sorting out actual injury done to others and deciding how best to deal with such situations.

They serve other purposes, too. First, they get the alcoholic out of the "bag" of blaming others for life's difficulties. They also provide a mechanism for dealing with presently strained

relationships and for alleviating some of the overwhelming guilt the now-sober alcoholic feels.

Q In a follow up session with a recovering employee, the employee tells you that he has made a list of all the people he has harmed, but is having difficulty determining how to make amends to those he has harmed. Given your knowledge of A.A., what is the next step he is working on?

a. Ninth

b. Eighth

c. Seventh

d. Sixth

The answer is "a," ninth step.

Step 10: Continued to take personal inventory and when we were wrong promptly admitted it.

Ensures that the alcoholic need not slip back from the hard-won gains. Diligence in focusing on one's own behavior and not excusing it keeps the record straight.

Step 11: Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of His will for us and the power to carry that out.

Fosters continued spiritual development.

Step 12: Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Steps 10 through 12 are considered the continuing-maintenance steps.

Points the way to sharing the process with others. This is one of the vital keys to maintaining sobriety. It implies that a continued practice of the new principles is vital to the sober life.

"Two Steppers" is a phrase used to describe a few individuals in A.A. who come in, admit they are alcoholics, dry out, and set out to rescue other alcoholics. However, it is often said in A.A. that "you can't give what you don't have." This refers to a quality of sobriety that comes after some long and serious effort applying the entire Twelve Steps.

A.A. groups are autonomous and traditionally are open to all members. Some groups may be directed to special-interest groups, such as women, minority groups, gays, or physicians (Galanter, Castaneda, & Franco, 1991; Nace, 1992). There are several types of meetings (Nace, 1992).

- Closed meetings are for A.A. members or prospective members only.

- Open meetings are for non-alcoholics as well.
- Speaker meetings involve A.A. members who describe their experiences with alcohol and their recovery.
- Discussion meetings are those in which an A.A. member describes personal experiences and leads a discussion on a topic related to recovery.
- Step meetings (usually closed) consist of discussion of one of the Twelve Steps.

Narcotics Anonymous

The self-help approach was first applied to drug addiction in the U.S. Public Health Service Hospital in Lexington, Kentucky, in 1947. Narcotics Anonymous (NA) is modeled on the Alcoholics Anonymous concept, and although the two programs are not affiliated, they use the same Twelve-Step program. NA is a different organization with diverse jargon, style, substance, and social traditions. It is concerned with the problem of addiction, and members may have had experience with any or all of the entire range of abusable psychoactive substances (Doweiko, 1990; Galanter, Castaneda & Franco, 1991; Gifford, 1989).

The two self-help groups are quite different from each other. Alcoholics Anonymous focuses on alcohol dependence and behaviors, while Narcotics Anonymous focuses on drug addictions and uses drug-specific language and approaches.

Self-help or Twelve-Step programs may be useful adjuncts to treatment for alcohol and other drug abuse. Persons who attend A.A. and other treatment programs have a more favorable outcome in regard to drinking. Those who attend more than one meeting per week, have a sponsor and/or sponsor others, lead meetings, and work Steps 6 through 12 tend to have even more favorable outcomes (Geller, 1992; Nace, 1992).

Glossary

Alcoholics Anonymous (A.A.) provides information and support to recovering alcoholics through local chapters in communities nationwide. 212/686-1100

Narcotics Anonymous (NA) provides information and support to recovering drug addicts through local chapters in communities nationwide. 818/780-3951

Al-Anon provides information on alcoholism and alcohol abuse and refers callers to local Al-Anon support groups established to help friends and families of alcoholics. 1-800-356-9996

Nar-Anon provides information on drug abuse and refers callers to local Nar-Anon support groups established for friends and families of drug users. 213/547-5900

Questions

1. An individual in A.A. speaks out on television stating; "I'm a member of A.A. and I think everyone with a drinking problem needs to go to Alcoholics Anonymous." Which is a likely response of the A.A. community?

   a. He or she may be turned to Intergroup for disciplinary action.

   b. He or she may be given a verbal reprimand for violating the third tradition

   c. No action will occur since the Traditions are an honor code rather than formal rules.

   d. Any member may say what he or she wants as long as he or she does not speak for the group or A.A. as a whole.

2. What is the difference between A.A. and NA?

   a. Members of NA admit their powerlessness over narcotics only

   b. A.A. is primarily for individuals who desire to quit drinking

   c. NA is only for individuals who want to get off cocaine or crack

   d. To be a member of A.A., you need to have really hit bottom

3. In a follow up session with a recovering employee, the employee tells you that he has made a list of all the people he has harmed, but is having difficulty determining how to make amends to those he has harmed. Given your knowledge of A.A., what is the next step he is working on?

   a. Ninth

   b. Eighth

   c. Seventh

   d. Sixth

Answer

1–d

2–b

3–a

The Twelve Traditions

(The Long Form)

Our A.A. experience has taught us that:

One - Each member of Alcoholics Anonymous is but a small part of a great whole. A.A. must continue to live or most of us will surely die. Hence our common welfare comes first. But individual welfare follows close afterward.

Two - For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience.

Three - Our membership ought to include all who suffer from alcoholism. Hence we may refuse none who wish to recover. Nor ought A.A. membership ever depend upon money or conformity. Any two or three alcoholics gathered together for sobriety may call themselves an A.A. group, provided that, as a group, they have no other affiliation.

Four - With respect to its own affairs, each A.A. group should be responsible to no other authority than its own conscience. But when its plans concern the welfare of neighboring groups also, those groups ought to be consulted. And no group, regional committee, or individual should ever take any action that might greatly affect A.A. as a whole without conferring with the trustees of the General Service Board. On such issues our common welfare is paramount.

Five - Each Alcoholics Anonymous group ought to be a spiritual entity having but one primary purpose—that of carrying its message to the alcoholic who still suffers.

Six - Problems of money, property, and authority may easily divert us from our primary spiritual aim. We think, therefore, that any considerable property of genuine use to A.A. should be separately incorporated and managed, thus dividing the material from the spiritual. An A.A. group, as such, should never go into business. Secondary aids to A.A., such as clubs or hospitals which require much property or administration, ought to be incorporated and so set apart that, if necessary, they can be freely discarded by the groups. Hence such facilities ought not to use the A.A. name. Their management should be the sole responsibility of those people who financially support them. For clubs, A.A. managers are usually preferred. But hospitals, as well as other places of recuperation, ought to be well outside A.A. — and medically supervised. While an A.A. group may cooperate with anyone, such cooperation ought never to go so far as affiliation or endorsement, actual or implied. An A.A. group can bind itself to no one.

Seven - The A.A. groups themselves ought to be fully supported by the voluntary contributions of their own members. We think that each group should soon achieve this ideal; that any public solicitation of funds using the name of Alcoholics Anonymous is highly dangerous, whether by groups, clubs, hospitals, or other outside agencies; that acceptance of large gifts from any source, or of contributions carrying any obligation whatever, is unwise. Then, too, we view with much concern those A.A. treasuries which continue, beyond prudent reserves, to accumulate funds for no stated A.A. purpose. Experience has often warned us that nothing can so surely destroy our spiritual heritage as futile disputes over property, money, and authority.

Eight - Alcoholics Anonymous should remain forever non-professional. We define professionalism as the occupation of counseling alcoholics for fees or hire. But we may employ alcoholics where they are going to perform

those services for which we might otherwise have to engage nonalcoholics. Such special services may be well recompensed. But our usual A.A. Twelfth Step work is never to be paid for.

Nine - Each A.A. group needs the least possible organization. Rotating leadership is the best. The small group may elect its secretary, the large group its rotating committee, and the groups of a large metropolitan area their central or intergroup committee, which often employs a full-time secretary. The trustees of the General Service Board are, in effect, our A.A. General Service Committee. They are the custodians of our A.A. Tradition and the receivers of voluntary A.A. contributions by which we maintain our A.A. General Service Office in New York. They are authorized by the groups to handle our overall public relations and they guarantee the integrity of our principal newspaper, the A.A. Grapevine. All such representatives are to be guided in the spirit of service, for true leaders in A.A. are but trusted and experienced servants of the whole. They derive no real authority from their tides; they do not govern. Universal respect is the key to their usefulness.

Ten - No A.A. group or member should ever, in such a way as to implicate A.A., express any opinion on outside controversial issues—particularly those of politics, alcohol reform, or sectarian religion. The Alcoholics Anonymous groups oppose no one. Concerning such matters they can express no view whatever.

Eleven - Our relations with the general public should be characterized by personal anonymity. We think A.A. ought to avoid sensational advertising Our names and pictures as A.A. members ought not be broadcast, filmed, or publicly printed. Our public relations should be guided by the principle of attraction rather than promotion. There is never need to praise ourselves. We feel it better to let our friends recommend us.

Twelve - And finally, we of Alcoholics Anonymous believe that the principle of anonymity has an immense spiritual significance. It reminds us that we are to place principles before personalities; that we are actually to practice a genuine humility. This to the end that our great blessings may never spoil us; that we shall forever live in thankful contemplation of Him who presides over us all.

CHAPTER 19 RELAPSE PREVENTION

Looking at the relationship between the worker and the organization is also important in the context of employment. Porter, Lawler and Hickman (1975) indicated that the relationship between the individual and the organization is thought of as an exchange. The organization has goals and objectives, as well as tasks and activities, that present demand on the individual. The individual applies these demands to his or her knowledge, ability, and potential to grow and develop. Therefore, a person who cannot function organizationally is handicapped (Schaelf & Fassel, 1988).

One problem that EAP practitioners often encounter is client relapse after treatment. This problem arises when a client has successfully completed treatment and is returned to the same system that perpetuated the addictive behavior. As a result, there is a greater chance for relapse. According to Schaef and Fassel (1988), in order "...to understand organizations and to work creatively with them, there needs to be a mechanism for opening the ways the organizations themselves are the same as the addictive society. Individuals function the same way as the organization they inhibit, and the system is made up of the individuals in the organizations.

Consequently, the focus should be on both the workers as the addict or problem and the system that perpetuates organizations to create environments that attract and contribute to troubled employees (Schaelf & Fassel, 1988). Troubled organizations often spend thousands or millions of dollars on consultants and packages designed to "fix up" problems within the organization or corporation. Yet, according to Schaef and Fassel (1988) these quick fixes only correct the problem on the surface but do not change the system to remedy the problem. Those same problems often re-emerge with even greater force and tenacity within the organization.

Addiction

Addiction is a chronic relapsing disorder, thereby making the prevention of relapse one of the critical elements of effective treatment for alcohol and other drug abuse. Studies have shown that 54 percent of all alcohol and other drug abuse patients can be expected to relapse, and that 61 percent of that number will have multiple periods of relapse. It is not unusual for addicts to relapse within one month following treatment, nor is it unusual for addicts to relapse 12 months after treatment; 47 percent will relapse within the first year after treatment (Simpson, Joe &

Lehman, 1986). Although relapse is a symptom of addiction, it is preventable. A key factor in preventing relapse is improved social adjustment (Joe, Chastain, Marsh & Simpson, 1985a).

Relapse prone individuals are those who recognize and accept that they are chemically dependent, and have tried to overcome their dependence through a treatment setting combined with AA (Alcoholics Anonymous) meetings (Gorski cited in Bell, 1989). Such individuals have been unable to maintain sobriety even though they have made a conscious effort in a recovery program (Bell, 1989).

Relapse does not occur within a vacuum. There are many contributing factors, as well as identifiable evidence and warning signs which indicate that a client may be in danger of returning to substance abuse. Relapse can be understood as not only the actual return to the pattern of substance abuse, but also as the process during which indicators appear prior to the patient's resumption of substance use (Daley, 1987). Relapse, however, is not an automatic sentence to a lifetime of substance abuse for an individual. Studies of lifelong patterns of recovery and relapse indicate that approximately one-third of clients achieve permanent abstinence through their first serious attempt at recovery. Another third has brief relapse episodes which eventually result in long-term abstinence. An additional one-third has chronic relapse which result in eventual recovery from chemical addiction (Gorski, Kelley & Havens, 1993).

Several situations may lead to relapse, such as social and peer pressure or anxiety and depression. Studies have indicated that the highest proportion of high-risk situations for alcoholics involves interpersonal negative emotional states, while the highest proportion of high-risk situations reported by heroin addicts involves social pressure (Marlatt & Gordon, 1985).

Contributing Factors

An understanding of some of the personal factors which may contribute to substance abuse relapse is useful in relapse prevention. These may include (Peters, 1993):

- Inadequate skills to deal with social pressure to use substances
- Frequent exposure to "high-risk situations" that have led to drug or alcohol use in the past
- Physical or psychological reminders of past drug or alcohol use (e.g., drug paraphernalia, drug-using friends, money)
- Inadequate skills to deal with interpersonal conflict or negative emotions
- Desires to test personal control over drug or alcohol use
- Recurrent thoughts or physical desires to use drugs or alcohol

Relapse occurs when attitudes and behaviors revert to ones similar to

those exhibited when the person was actively using drugs or alcohol. Although relapse can occur at any time, it is more likely earlier in the recovery process. At this stage, habits and attitudes needed for continued sobriety, skills required to replace substance use, and identity with positive peers are not firmly entrenched (Nowinski, 1990).

Categories of Clients

According to Gorski and Miller (1986), chemically addicted individuals can be categorized according to their recovery and relapse history. Clients are: prone to relapse; or chronically prone to relapse. Individuals who are relapse prone can be further divided into three subgroups:

1. **Transition clients.** Transition clients do not accept or recognize that they are suffering from chemical addiction, even though their substance abuse may have created obvious adverse consequences. This usually results from the client's inability to accurately perceive reality, due to chemical interference.
2. **Unstabilized relapse prone clients.** Unstabilized clients have not been taught skills to identify their addiction. In such cases, treatment fails to provide these clients with the necessary skills to interrupt the process and disease of addiction. As a result, they are unable to adhere to a recovery program requiring abstinence, treatment, and lifestyle change.
3. **Stabilized relapse prone clients.** Stabilized clients recognize and are aware of their chemical addiction, that abstinence is necessary for recovery, and that an ongoing recovery program may be required to maintain sobriety. Despite their efforts, however, these individuals develop dysfunctional symptoms which ultimately lead them back to alcohol or other drug abuse.

It has been estimated that 40 to 60 percent of persons who are recovering from chemical dependence relapse at least once following their first serious attempt at treatment.

Relapse Prevention

In order for relapse prevention to be successfully effective, systems coordination is necessary. The EAP practitioner can assist in the process of relapse prevention by developing a program that includes:

- Development of a personal relapse prevention plan
- Identification of on-the-job warning signs
- Development of a return-to-work plan
- Formalization of an employment agreement
- Development of a follow-up plan (Bell, 1989)

The personal relapse prevention plan should be developed prior to the employee's discharge from treatment. This involves the counselor, the employee's family, best friend, and AA or Narcotics Anonymous (NA) sponsor. The plan charts the individual's relapse pattern, including his or her personal relapse warning signs.

The second step is to identify relapse warning signs that may be observable in the workplace. This step is accomplished at the treatment center with the employee, primary counselor, and the EAP counselor. One of the earliest warning signs is when an employee pushes too hard. He or she feels gratitude toward the employer and overcompensates by becoming "super employee." This excessive behavior often alienates the supervisor and co-workers. In turn, the alienation causes the employee to become stressed; and the more stress he or she experiences, the more symptoms manifest. If these symptoms are not recognized as indicators of relapse, the employee remains at high risk for returning to chemical use.

In step three, the EAP professional meets with the employee and the supervisor to work out a return-to-work plan. The supervisor must clearly describe job performance expectations. In turn, the supervisor is advised of the employee's particular on-the-job warning signs.
The next step is utilized only when there are performance or behavior problems and the employee is involved in disciplinary procedures at work. A meeting is held to review the ongoing aftercare plan by the persons involved in step three. The inclusion of the union representative is necessary because of the employee's involvement in the disciplinary process. The idea is to involve all those people who interact with the employee in various capacities. In that way, everyone involved is informed at all stages and is aware of his or her responsibilities. Conditions of continued employment are reviewed.

The final step is the follow-up. It is important for susceptible individuals. The purpose of the follow-up meeting is to ensure that the employee is living up to job performance expectations and, in order to protect the employee's job, to ensure that the supervisor is satisfied with those performance expectations.

If, in spite of all the prevention measures, the employee relapses, the supervisor should continue to document and confront the employee on his or her job performance. The EAP professional needs to find a treatment facility that will focus on helping the client identify his or her own relapse patterns and recognize the relapse warning signs.

Questions

1. When an employee relapses, the employer should:
   a. Contact the EAP counselor
   b. Stay focused on job performance
   c. Fire the employee
   d. None of the above

Answer

1–b

CHAPTER 20 CAUSES OF ALCOHOL & DRUG ADDICTION

Many assumptions and beliefs about the causes of substance abuse have been espoused. As the amount of knowledge gained through research expands, some of these explanations have been discounted or proved false. For example, the moral model attributes the cause of drug and alcohol problems to moral weaknesses in the character of individuals. Supporters of this model believe change is possible only through personal motivation and efforts. While there is currently little support for the moral model within the drug treatment community (Singer, 1992), it is, unfortunately, supported in significant segments of the general population.

Substance abuse, like other physical or mental disorders is multifaceted and complex. Many viewpoints have been developed that appear to have validity in advancing an understanding of alcohol and other drug addictions. There is a general consensus among researchers, that there are no miracle cures for substance abuse that can help an addicted person achieve sobriety without the structure, discipline, and personal resolve needed to help him or her remain drug-free. When matching client and treatment considerations should include: the characteristics of treatment programs and the personality, background, mental conditions, and substance abuse patterns of individuals to realize the best fit and the greatest chance of successful treatment (Office of National Drug control Policy, 1990).

Concepts about the causes of addiction often are grouped in various categories because of their similarities and differences. Four categories will be discussed in this section.

1. Biophyschosocial
2. Medical
3. Clinical
4. Social

Biopsychosocial Model

The biopsychosocial model provides a broader, more holistic view of substance abuse and its treatment. It is the model that is most widely endorsed by treatment researchers because it can most adequately explain the intricate nature of addiction. This model incorporates elements of the other three more narrowly focused models.

Biological causes of substance abuse include a possible hereditary predisposition, especially for alcoholism. As research progresses, there also is evidence that use of chemical substances may actually alter brain

chemistry. With habitual substance abuse, natural chemicals may no longer be produced in the brain, resulting in dependency on alcohol or other drugs to avoid discomfort. Substance abuse also may be initiated and continued because individuals experience emotional and psychological problems. Initially, chemicals can produce positive sensations that help counteract painful events and underlying problems. Alcohol and other drug use often begins in social situations. It is through social interactions that substance use often is learned and reinforced. Addiction also is often correlated with various social problems such as unemployment, poverty, racism, and family dysfunction.

Variables affecting substance use often interact with each other and cut across multiple levels. When assessing and intervening with an individual troubled by problems related to chemical dependency, the individual's uniqueness, level of functioning, and attraction toward and susceptibility to addictive behavior must be considered. Multiple measures of biological, psychological, and social functioning must be collected, integrated, and interpreted. Addiction, then, is impacted by physiological, social and behavioral, and environmental factors (Donovan & Marlatt, 1988).

The most important implication of the biopsychosocial model for treatment is the realization that a single treatment approach is unlikely to be sufficient. Rather, as biological, psychological, and social needs are assessed, an integrated, comprehensive treatment response must be implemented to meet the entire range of needs of the individual. The first stage of this response requires a comprehensive assessment to determine the entire range of strengths, needs and problems presented by the individual.

A biopsychosocial approach necessitates comprehensive services and appropriate client – treatment matching. For individual clients, this often requires multidisciplinary teams of treatment professionals to provide the array of treatment and case management services needed. A continuum of treatment and supportive services is needed for adequately meeting the extent of needs presented by addicted persons.

Medical and Biological Causes of Substance Abuse

Alcohol or drug addiction is considered a chronic, progressive, relapsing, and potentially fatal disease. Although persons may choose whether or not to initiate the use of psychoactive substances, alcohol or drug dependence is an involuntary result. Common characteristics include impaired control over drinking or taking drugs, preoccupation with a substance of abuse, continued use despite adverse consequences, and distortions in thinking (Morse & Flavin, 1992). The following medical/ biological causes of substance abuse have evolved and are supported by some research findings.

Genetic Causes

Research into the biological causes of addiction has resulted in convincing evidence that there is a hereditary vulnerability to alcoholism. Alcohol-related disorders have been found in multiple generations of families and

have been studied over time. It is believed that many people with genetic predisposition to alcoholism will progress to dependency if they begin using alcohol. Although a similar assumption is often made about other drugs of abuse, research evidence is much more difficult to obtain. Mood-altering drugs produce various pharmacological effects. The use of drugs over time is often influenced by fads and availability. Thus, different generations of families may be exposed to different types of drugs, whereas use of alcohol has been consistent over several generations. This makes the multigenerational study of drug abuse more difficult than similar studies of alcoholism (Anthenelli & Schuckit, 1992).

Brand Reward Mechanisms

Certain areas of the brain, when stimulated, produce pleasurable feelings. Psychoactive substances are capable of acting on these brain mechanisms to produce these sensations. These pleasurable feelings become reinforcers that drive the continued use of the substances (Gardner, 1992).

Altered Brain Chemistry

Because of long-term use of alcohol or other drugs, the normal release of various types of natural chemicals in the brain that produce pleasurable sensations may be disrupted. Habitual substance use can alter brain chemistry, requiring continued use of psychoactive substances to avoid discomfort created by brain chemistry imbalance (Hollandsworth, 1990; ONDCP, 1990, Serban, 1984).

Self-Medication

Some individuals who have psychiatric conditions, such as anxiety or depression, use psychoactive substances to alleviate the symptoms they experience. If their emotional discomfort is relieved by alcohol or other drugs, they may persist in using chemicals to continue achieving such results (Jaffe, 1992; Schinke, Botvin & Orlandi, 1991).

Concepts of the medical/biological causes of substance abuse influence treatment in two important ways. First, according to these concepts, abstinence is viewed as the only feasible way to avoid the negative consequences of substance abuse. If alcohol- or drug-dependent persons are unable to control their use of chemical substances (whether because of genetic factors, metabolic imbalance, or altered brain chemistry), they must refrain from any use of psychoactive substances. It is impossible for them to use any alcohol or other drugs without experiencing physical, social, and emotional effects.

Second, pharmacotherapeutic interventions have been developed or are being sought to meet the following needs (National Institute on Drug Abuse (NIDA), 1991):

- Substitute for abused drugs and provide a more controllable form of addiction
- Block the effects of abused drugs

- Reduce cravings for drugs
- Alleviate drug withdrawal symptoms and block the toxic effects of drugs

Use of pharmacological modalities is regulated by the United States Food and Drug Administration (FDA). Programs providing this type of treatment must have medical staff who administer medications and supervise the program and clients.

Clinical Causes of Substance Abuse

Clinical or psychological causes of addiction focus on personal needs or personality traits of those abusing substances. They can be divided into two categories: 1) those emphasizing the rewards derived from the use of mood-altering drugs that tend to perpetuate their use, and 2) those stressing that substance abusers have different personalities from those who abstain (Goode, 1972).

Reinforcement Processes

People tend to seek rewards and minimize negative consequences through their behaviors. If past behaviors have brought a response that is perceived as reinforcing, persons tend to repeat those behaviors to obtain similar rewards. Drug use may be rewarded in several ways, as described in the following list.

Positive reinforcement. Persons abusing drugs and alcohol have found their use rewarded and therefore, continue use (Goode, 1972; Jaffe, 1992). Without a positive reward, substance abuse would not likely continue, according to this perspective. There are many types of positive rewards that may accrue to someone using psychoactive substances, including their pharmacological effects (e.g., euphoria), social rewards, peer acceptance and esteem (Jaffe, 1992; Shaffer, 1992).

Avoidance of pain. Behaviors also may be motivated by a need to seek relief or avoid pain. If using alcohol or other drugs helps someone who is suffering (physically or emotionally), he or she is likely to use the substance again when experiencing the same distress, and a strategy for coping with pain or stress develops that is dependent on the use of alcohol and other drugs. Some drugs produce painful withdrawal symptoms when use of them is discontinued. Persons dependent upon a drug may find that taking a dose will diminish their pain (Goode, 1972; Jaffe, 1992). Substance abuse also may be motivated by a desire for relief from pain, anger, anxiety or depression, and alleviation of boredom (Jaffe, 1992; Shaffer, 1992).

Drug cues. Another aspect of reinforcement pertains to the anticipation of rewards. Certain stimuli can be associated with a drug and its rewards. These stimuli may act as triggers for drug seeking and use. Physiological responses, sometimes called cravings, may result from the introduction of a cue or stimulus. Cues vary from one individual to another, but may include being with specific people, engaging in particular activities, or going

to certain places (Childress, Ehrman, Rohsenow, Robbins & O'Brien, 1992; Jaffe, 1992).

Personality Traits

The use of drugs is linked with emotional problems and personal inadequacies according to this school of thought. Substance abuse may provide the individual with an escape from the problems of life through euphoria and drug-induced indifference. Although such drug use may mask certain difficulties temporarily, the underlying problems are not solved, and addiction generates new, and often more serious, problems (Goode, 1972).

As a response to psychological suffering, substance abuse is sometimes viewed as an adaptive effort for survival. Associations have been found between drug use and psychological characteristics such as low self-esteem, low self-confidence, low self-satisfaction, need for social approval, high anxiety, low assertiveness, greater rebelliousness, and self-regulatory deficiencies. The causes of these characteristics have been attributed variously to factors such as peer rejection, parental neglect, high achievement expectations, school failure, social and physical stigma, and poor coping ability, among others. Deviant activities, such as substance abuse, may be chosen by some as a way of achieving group acceptance, status, and membership or escaping the realities of rejection (Brehm & Khantzian, 1992; Goode, 1972; Schinke, Botvin & Orlandi, 1991). Some research indicates that Antisocial Personality Disorder and Borderline Personality Disorder may place persons at increased risk of substance abuse (Mirin & Weiss, 1991).

Based on the concept of reinforcement, behavioral treatment approaches often try to help individuals find significantly greater rewards from legitimate activities. Involvement in a variety of activities, depending on individual interests and abilities, may help some persons achieve greater peer acceptance and self-esteem. Substituting other activities to achieve feelings of happiness and well-being also are recommended. For example, some persons claim to get a "high" from running or other physical activities. Virtually all of the prevailing psychosocial treatment approaches emphasize helping chemically dependent persons learn new ways to structure their time and social relationships through drug-free activities.

Relapse prevention, a critical component of treatment, is closely tied to drug cues. Approaches are recommend for helping individuals control or change their reactions to drug cues. Avoiding people, places, and activities formerly associated with substance abuse is one example. Relapse prevention is a critical element of any treatment approach.

Adversive conditioning is a technique that involves pairing a negative stimulus with drug cues. Some methods that have been tried include chemically or hypnotically induced nausea or electric shocks paired with the sight, taste, smell, or other reminders of specific substances. Another approach, sometimes called extinction or cue exposure, consists of presenting the drug cue repeatedly. However, in controlled settings ,where

this cue cannot be followed by alcohol or drug use, reaction to the stimulus is gradually reduced. Substance abusers also may receive skills training and cognitive behavioral tools to avoid relapsing to alcohol or other drug use (Childress et.al, 1992; Siegel, 1988).

A variety of therapeutic interventions may be implemented in addressing the personal and emotional problems thought to underline substance abuse. Traditional mental health approaches may include building self-esteem, lowering anxiety, and resolving other distressful problems through individual, group, and family counseling.

Behavioral or psychosocial treatment approaches often are linked to a clinical understanding of addiction. These methods include self-help and individual group, and family counseling. All rely heavily on changing the individual's self-concept and dealing with distressing situations and relationships thought to underline substance abuse.

Social Causes of Substance Abuse

These perspectives focus on situations, social relations, or social structures related to substance abuse. Virtually any factor outside the individual, such as peers, family, or the media, could be associated with social causes of addiction.

Social Learning. In group settings, individuals are exposed to persons who model certain behaviors, and they receive rewards or punishments for their own behaviors from group members. When one associates with groups that define drug use as desirable and whose members model drug-related behavior, drug use by the individual is learned and rewarded (Goode, 1972).

Subculture Perspectives. This viewpoint indicates that drug use is expected and encouraged in certain social circles, while it is discouraged, and even punished, in others. There is not a single drug subculture; rather, there are several of them. For example, there might be a drug subculture of white, high school youth, or young adult black males, and some drug subcultures are formed according to the drug of choice (e.g., groups for alcohol, marijuana, cocaine, or heroin users). Members of a subculture teach new members how to use a particular drug, supply the drug initially, and provide role models (Goode, 1972).

Socialization. According to this perspective, potential drug users are attracted to other drug-involved individuals and drug subculture groups because their own values and activities are compatible with those of persons who use drugs. The four main agents of socialization for adolescents are parents, peers, school, and the media. The greater the youth's affinity for drug use, the more likely he or she is to choose to participate with others having similar values and norms. Alienation from parents and friendship with drug-using peers are especially strong factors in the socialization of youth into drug use (Goode, 1972).

Social Control. This approach claims that absence of the social control requiring conformity leads to drug abuse. Those more attached to

conventional society are less likely to engage in behavior that violates societal values and norms. Socially detached persons will not feel the constraint of these norms and values (Goode, 1972).

Social Economic, and Political Factors. Elements of unemployment, poverty, racism, sexism, family dissolution, and feelings of powerlessness and alienation are associated with the problem of substance abuse. Although not universal by any means, some persons consistently subjected to these conditions are drawn into drug activity to escape their painful life circumstances (Haddock & Beto, 1988; Lowinger, 1992).

One approach to treating substance abuse from the social perspective involves changing the substance abuser's environment and peer association. The behavioral treatment approaches emphasize positive peer associations and pro-social life-styles and activities. For example, therapeutic communities are based on group support and confrontation to help members learn new attitudes and behaviors toward drugs and other persons (NIDA, 1991). Self-help strategies similarly encourage drug-free activities and association with others in recovery.

Working to strengthen social values and norms that preclude drug dependency also is important. Our society generally is committed to eliminating pain, suffering, and discomfort (Servban, 1984). Millions of dollars are spent on advertising products such as patent medicines, alcohol, and tobacco as "quick cures" for physical and emotional distress. Promoting and glamorizing the use of such substances contributes to an attitude that drinking and other drug use is acceptable and even desirable. Instant gratification is an underlying theme throughout most of American society.

Treatment strategies must consider more than just the individual affected by substance abuse. Considerations of economic, political, and social changes are also important concerns of treatment professionals and decisions makers.

CHAPTER 21 TREATMENT MODALITIES

There is no magic cure for effectively treating persons with substance abuse problems. Different people respond to various approaches in diverse ways. The effects of various substances of abuse produce different symptoms and needs among users. There are diverse ways in which the causes and progression of drug and alcohol addiction may be understood. This makes it critically important that individuals be matched appropriately with the treatment program or modality that is most likely to attack the problems resulting in their particular needs; the most successful treatment is individualized. Many factors must be considered, including personality, background, mental condition, and drug use experience (ONDCP, 1990).

There are several ways to categorize treatment programs and modalities. In general, they are grouped into two broad categories:

1. Those that are biologically based, including:
   - Pharmacotherapeutic treatment
   - Acupuncture
2. Those that are behaviorally or psychosocially based, including:
   - Residential or inpatient treatment programs such as:
     - Inpatient hospitalization
     - Therapeutic communities
     - Outpatient nonmethadone treatment

Various treatment components and approaches are used in these treatment programs and modalities, including:

- Self-help program
- Individual counseling
- Group counseling/treatment
- Behavior modification

Pharmacotherapeutic Modalities

Substance abuse, by definition, is a chronic disease in which the use of psychoactive substances may result in both physical and psychological addiction. Thus, one treatment approach that has shown favorable outcomes is pharmacotherapy – the use of approved medications with medical supervision. The goals of pharmacotherapy include (Lowinson, Marion, Joseph & Dole, 1992):

- Reduction in the use of illicit drugs and alcohol
- Reduction in criminal behavior
- Improvement of social behavior and psychological well being.

A further goal is the urgent imperative to control and prevent the spread of substance abuse-related infectious disease, such as HIV/AIDS and tuberculosis. For those already infected, treatment for alcohol and other drug addiction may stabilize their physical condition, boost the immune system, and delay or prevent the onset of serious illness.

More research has been conducted on drug therapies for opiate drugs and alcohol than on other categories of abused substances. There are four categories of pharmacological treatment for substance abuse.

Agonist

These drugs can be substituted for the drug of abuse to provide a more controllable form of addiction. The properties and actions of these drugs are similar to those of particular abused drugs. Using them alleviates many of the withdrawal symptoms often experience by persons addicted to various psychoactive substances. Examples of drugs in this category include methadone, clonidine and LAAM.

Methadone, a synthetic narcotic analgesic compound, is the most commonly used form of pharmacotherapy for opiate drugs. It is medically safe and has few side effects. It produces a stable drug level and is not behaviorally or subjectively intoxicating. It blocks the cravings for opiate drugs and does not produce euphoria, as heroin and other drugs do. The characteristics of methadone clients have changed considerably over the past decade because of increased rates of HIV infection among intravenous drug abusers, concomitant use of cocaine and crack, and homelessness. These changes have resulted in methadone programs' needs of enlarged and more sophisticated physical facilities, better trained staff, and more funding (Lowinson, Marion, Joseph & Dole, 1992).

Among the various pharmacotherapies, methadone maintenance has been studied most thoroughly. Methadone maintenance is generally successful in meeting treatment goals. When appropriate doses of methadone are administered, heroin use decreases markedly. However, in some cases other drugs, such as cocaine and alcohol, continue to be used. A substantial reduction in criminal behavior has been documented by several studies, and this reduction increases with length of time in methadone treatment. Socially productive behavior, such as employment, education, or homemaking, has also been shown to improve with the length of time in treatment (Lowinson, Marion, Joseph & Dole, 1992).

Clonidine can partially suppress many withdrawal symptoms of opiates, alcohol, and tobacco. It is most effective for persons who are motivated and involved in their treatment program. It is not as useful in maintaining abstinence after withdrawal from opiate drugs has been achieved (Greenstein, Fudala & O'Brien, 1992; Thomason & Dilts, 1991).

LAAM (Levo-alpha-acetyl methadol) is an experimental synthetic opiate that produces morphine-like effects. It is longer acting than methadone, allowing for doses to be administered only three times per week. It has not yet been approved in the United States for treatment of opiate dependence (Greenstein, Fudala & Dilts, 1991).

Antagonists

These drugs occupy the same receptor sites in the brain as specific drugs of abuse. However, they do not produce the same effects as the abused drugs, and they are nonaddicting. Thus, when they are present, the effects of the abused drug are blocked because they cannot act on the brain in the usual way. Therefore, they do not produce the expected mood-altering experiences. Antagonists may be used for persons who do not want to be maintained on drug substitutes (i.e., agonist, like methadone); they also are used, at times, for persons leaving other drug-free treatment programs and reentering the community, to diminish their risk of relapse (Greenstein, Fudala & O'Brien, 1992).

Naltrexone is an opiate antagonist, but experimental use with alcohol addiction has also been initiated. It does not result in euphoria as do opiate drugs (Alterman, O'Brien & McLellan, 1991; Greenstein, Fudala & O'Brien, 1992; Wesson & Ling, 1991).

Buprenorphine is a mixed agonist-antagonist agent. It is long-acting and blocks the effects of other opiate drugs. It produces less physical dependence than methadone, but some withdrawal symptoms do occur with its use (Greenstein, Fudala & O'Brien, 1992; Thomason & Dilts, 1991).

Antidipsotropics

These drugs create adverse physical reactions when the person consumes the substance of abuse. These drugs are used to develop an aversion to the abused drug (Alterman, O'Brien & McLellan, 1991).

Antabuse (Disulfiram) interferes with the metabolism of alcohol, causing unpleasant side effects when alcohol is ingested. Facial flushing, heart palpitations and a rapid heart rate, difficulty in breathing, nausea, vomiting, and possibly a serious drop in blood pressure is the major effects produced by the combination of alcohol and Antabuse. Paired with other treatment approaches, Antabuse has been successful in preventing relapse (Alterman, O'Brien & McLellan, 1991; Doweiko, 1990).

Psychotropic Medications

These control various symptoms associated with drug use and withdrawal. Antianxiety drugs, antipsychotics, antidepressants (for major depressions), and lithium have been tested. However, further research is needed on the effectiveness of these agents. Current research has produced conflicting results in some cases or has been inconclusive (Alterman, O'Brien & McLellan, 1991).

Wesson and Ling (1991) conceptualize two categories of therapeutic medications. Those that help clients stop abusing drugs include medications that reduce acute drug withdrawal symptoms, medically maintain clients, decrease drug craving, and block the drugs' reinforcing effects. Methadone, clonidine, buprenorphine, LAAM, desipramine, bromocriptine, and Naltrexone are included in this category. Medications that help prevent relapses are able to reduce prolonged withdrawal syndromes, decrease drug craving, alter the drug's reinforcing effects, treat underlying psychopathology, and treat drug-induced psychopathology. Included in this category are antidepressants, desipramine, bromocriptine, naltroxone, and disulfiram.

Acupuncture and Transcutaneous Electrical Nerve Stimulation

Acupuncture applies a treatment method developed in China and other Far Eastern countries to the problem of alcohol and drug addiction. Addiction represents an adaptation of the central nervous system's activity in response to chronic drug administration, resulting in withdrawal symptoms when drug use is discontinued. Acupuncture or transcutaneous electrical nerve stimulation can modulate central nervous system activity in those regions of the brain affected by substances of abuse (Katims, Ng & Lowinson, 1992). Therefore, acupuncture may serve as a useful adjunct to comprehensive treatment for addiction.

Residential or Inpatient Treatment Programs

Programs in which the individual lives in the facility while participating in treatment can be defined as inpatient or residential programs. Some detoxification programs as well as therapeutic communities, and hospital-based programs are in this category. These programs are most appropriate for individuals who have not been successful in outpatient settings, those who have a very serious substance abuse problem, those needing concomitant medical or psychiatric care or observation, and those without a stable social support system in the community. Inpatient programs are the most restrictive, structured, and protective types of programs (Doweiko, 1990).

Inpatient Hospital Treatment

Inpatient treatment programs may be located in hospitals or in specialized chemical dependency centers. Chemical dependency treatment, Minnesota Model, 28-day programs, or Hazelden-type treatment are terms that may be used to denote this type of treatment approach.

A variety of treatment techniques and strategies are usually employed in these programs, including the Twelve-Step model (the basis of Alcoholics Anonymous and other self-help programs – see Chapter 18), individual, group and family counseling, drug education and medical management. Long-term aftercare and transitional services, especially for opiate addicts, are an important part of treatment, but many programs do not devote

significant resources to them (Doweiko, 1990; Institute of Medicine, 1990). These programs may be especially appropriate for persons with concomitant psychiatric disorders, persons assessed to be suicidal, those addicted to more than one chemical, or persons with serious medical complications. Inpatient treatment provides comprehensive treatment services, constant support during the early stages of sobriety, and close supervision to prevent relapse and respond to medical emergencies. Most inpatient programs have a multidisciplinary staff team, representing a range of training and experience and are capable of offering a variety of services (Doweiko, 1990).

Therapeutic Communities

Therapeutic communities are self-contained residential programs that emphasize self-help and rely heavily on ex-addicts as peer counselors, administrators, and role models. They provide a highly structured milieu, with program stages through which members must progress; this advancement is noted with special tasks and ceremonies. The stages progressively demand more responsibility and provide more freedom. Group encounter sessions often are confrontational, focusing on openness and honesty. Social and vocational skills also are taught.

The goals of therapeutic communities include (Institute of Medicine, 1990):

- Habitation or rehabilitation of the total individual
- Changing negative patterns of behavior, thinking, and feelings that predispose drug use
- Development of a drug-free life-style

The length of stay in traditional therapeutic communities ranges from 5 to 24 months (ONDCP, 1990). There are several adaptations of the therapeutic community model (Singer, 1992). These include:

- Modified therapeutic communities, where stays last an average of six to nine months
- Short-term therapeutic communities, where residents remain an average of three to six months
- Adolescent therapeutic communities for juveniles
- Therapeutic communities in correctional facilities to begin the treatment process in jails and prisons

Outpatient Nonmethadone Treatment

Outpatient nonmethadone treatment programs involve trained professionals working with addicted persons to achieve and maintain abstinence while living in the community. Community mental health centers, private clinics, and professional therapists in private practice are examples of settings in which outpatient treatment is offered. Outpatient treatment programs offer a range of services and treatment modalities, including

pharmacotherapy, and individual, group, and family counseling. They often incorporate a Twelve-Step philosophy (Doweiki, 1990).

Outpatient treatment allows individuals to live at home, continue working, and be involved in family activities while receiving treatment. Outpatient treatment is usually less expensive than residential treatment alternatives. It also allows for longer-term support of the individual than is possible with inpatient programs (Doweiko, 1990).

Considerations for referring individuals to outpatient treatment programs include their motivation for treatment, ability to discontinue use of drugs or alcohol, social support system, employment situation, medical condition, psychiatric status, and past treatment history (Doweiko, 1990). Those who remain in outpatient (nonmethadone) treatment longer tend to have better outcomes than shorter-term clients. However, dropout rates are high (Institute of Medicine, 1990).

Combined Settings

Some treatment programs have been developed to attempt to capitalize on the advantages of both inpatient and outpatient treatment approaches. They provide elements from each type of setting, attempting to maximize benefits while reducing costs.

Two by Four Programs are two-phase approaches. The individual is hospitalized first for a short time (usually two weeks). This ensures complete detoxification. This is followed by outpatient treatment. However, there is the option to return to inpatient care if he or she is unable to function in the less restrictive outpatient program (Doweiko, 1990).

Day or partial hospitalization involves treatment in the program during normal working hours, but the person returns home during the evening hours. The individual lives at home and has to assume more responsibility than would be the case in inpatient treatment. A prerequisite for this type of treatment is a supportive, stable family (Doweiko, 1990).

Halfway houses provide an intermediate step between inpatient treatment and independent living. It is a good alternative for persons who do not have a stable social support system. Halfway house programs generally have a small patient population, emphasize Twelve-Step programs, and have a minimum of rules and few professional staff members. Usually residents must find employment or work within the house (Doweiko, 1990).

Mental Health - Disorders

A. Schizophrenia

1. At least 2 of the following:
    a. delusions
    b. hallucinations
    c. incoherence or marked loosening of associations
    d. catatonic behavior
    e. flat or grossly inappropriate affect

2. bizzare delusions

3. prominent hallucinations

B. Delusional (Paranoid) Disorders

1. non-bizzare delusions
2. auditory or visual hallucinations
3. types
    a. erotomanic - prominent theme is that person, usually higher status, is in love with the subject
    b. grandiose - inflated worth, power, knowledge, identity or a special relationship to a diety or famous person
    c. jealous - one's sexual partner is unfaithful
    d. persecutory - being malevolently treated in some way - complaint usually taken to legal authorities
    e. somatic - some physical defect, disorder or disease
    f. unspecified - delusion of reference without malevolence

C. Psychotic Disorders

1. Brief reactive psychosis
    a. break with reality after some event or trauma

2. Induced psychotic disorder
    a. shared delusion with second person, usually a close relationship

D. Mood Disorders

1. Manic episode
    a. distinct period of abnormally and persistently elevated, expansive or irritable mood
    b. During period of mood disturbance at least 3 of following:
        1. inflated self-esteem or grandiosity
        2. decreased need for sleep
        3. more talkative than usual or pressure to keep talking
        4. flight of ideas or subjective experience of racing thoughts
        5. distractibility
        6. increased psychomotor agitation or goal-directed activity
        7. excessive engagement in pleasurable activities with high potential for painful consequences
    c. disturbance sufficiently sever to cause impairment in functioning
    d. no delusions or hallucinations
    e. no organic cause

2. Depressive Disorder
    a. 5 of the following
        1. depressed mood, most of the day, nearly every day
        2. diminished interest or pleasure in all or most activities
        3. significant weight loss or gain - more than 5% in month
        4. insomnia or hypersomnia
        5. psychomotor agitation or retardation
        6. fatigue
        7. feelings of worthlessness or excessive or inappropriate guilt
        8. diminished ability to think or concentrate
        9. recurrent thoughts of death, suicidal ideation without plan, suicide attempt or specific plan for suicide
    b. no delusions or hallucinations

3. Bipolar Disorder
    a. fluctuation between manic and depressive episodes

E. Anxiety Disorders

1. Panic Disorder
    a. 4 of the following
        1. shortness of breath
        2. dizziness
        3. palipitations or accelerated heart rate
        4. trembling or shaking
        5. sweating
        6. choking
        7. nausea or abdominal distress
        8. depersonalization or derealization
        9. numbness or tingling
        10. flushes
        11. chest pain or discomfort
        12. fear of dying
        13. fear of going crazy or doing something uncontrolled

2. Social Phobia
    a. persistent fear of social situations

3. Agoraphobia
    a. fear of being in a place from which escape might be difficult

4. Simple Phobia
    a. persistent fear of specific stimulus

5. Obsessive Compulsive Disorder

6. PTSD

CHAPTER 22 DEPRESSION

Depression is a very common emotional illness. In varying degrees of severity, it affects about 6 percent of all U.S. adults, more than nine million people in any given six month period, according to the American Psychiatric Association. At least one in five Americans will experience a major depressive episode during their lifetime, with women twice as likely to develop depression than men. According to Webster's Ninth New Collegiate Dictionary, depression is defined as, "A state of feeling sad...marked especially by sadness, inactivity, difficulty in thinking or concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness, and sometimes suicidal tendencies; a lowering of vitality or functional activity."

People who are depressed usually suffer silently with the ache that they feel deep inside, unaware of just why they're feeling moody or having such a bad day. In reality, feelings are too fluid, dynamic, and objective in their meaning and experience to be classified as depression. McGrath (1992) used the terms "Healthy" and "Unhealthy" Depression to describe the feeling between "good" and "bad." According to McGrath (1992, p.22), "Healthy Depression is defined as realistic feelings of pain, sadness, and disappointment accompanied at times by guilt, anger, discriminating unfair treatment, and unresolved past damage. An individual, experiencing Healthy Depression can still function, although usually not as well as they would otherwise.

Unhealthy Depression is defined as an inability to function in one or more basic life areas (such as work, relationships, body functions, etc.) due to the depth of bad feelings. These bad feelings can be caused by changes in body chemistry, genetic vulnerability, and/or too many painful psychological experiences that we are unable to resolve.

The diagnosis and treatment of depression is an evolving specialty area. As an EAP professional, it is quite valuable to have a basic understanding of the various kinds of Unhealthy Depression and the treatment options available. The more you know and understand, the more you can help in the EAP referral process.

There are five major kinds of Unhealthy Depression: dysthymic depression, atypical depression, major depression, bipolar disorder (also called manic depression), and seasonal affective disorder.

1. Dysthymic Depression

Dysthymic depression used to be called "neurotic depression." It's the kind of Unhealthy Depression most women suffer, and it's more than twice

as common in women than in men. Dysthymic depression is often experienced as a sense of helplessness about getting what one needs, feeling deprived and sometimes hopeless about the past, present, and future, and feeling sadness and/or anger over real or imagined loss and disappointment. Dysthymic depression can also result from the dysfunctional ways we've learned to interact with other people and think about ourselves. It can also stem from living in an unhealthy culture and constantly blaming ourselves for our culturally defined inadequacies.

With dysthymic depression, bad feelings fluctuate. After weeks of sleeping soundly, a person may find they are unable to sleep for days at a time. They may also find they are eating too little or too much for more than a few days. Although basically able to function, an individual feels consistently bad either about him/herself or those around him/her. Of all the Unhealthy Depression, it is easiest to move from Healthy Depression into dysthymic depression.

Healthy Depression fundamentally differs from dysthymic depression, however, because Healthy Depression is based on realistic losses and pain that would make anyone feel depressed. Dysthymic depression is based on a subjective misinterpretation of pain and loss either by exaggerating or denying it, reacting as if losses from the past are still happening now, feeling more hopeless, helpless, and pessimistic than is necessary or appropriate, and having our feelings interfere with our functioning more than necessary.

2. Atypical Depression

Atypical depression is often disguised as dysfunctional behaviors or other disorders, such as bulimia, anorexia nervosa, compulsive overeating, oversleeping, irritability, impulsivity, and addictions. Some of these symptoms can also occur for major depressions, but with atypical depression the symptoms don't last as long and aren't as strong. A person with atypical depression may report having physical symptoms, phobias, and hysterical reactions that are more disturbing than his/her depressed feelings. Yet, it's their unacknowledged depression that is actually causing or magnifying those symptoms.

No one is certain why many of the symptoms of atypical depression are often opposite to the symptoms typically associated with depression, nor are we sure why atypical depression is more common among women than men. What we do know is that if a woman suddenly finds herself craving too much sleep (hypersomnia), experiencing greatly increased appetite (hyperphagia) or increased sexual drive over a period of two weeks or more, or is developing an addiction, she may have an atypical depression that is likely to worsen without professional help.

3. Major Depression

Major depression is diagnosed when a person experiences an inability to function in one or more major areas of his or her life for more than two weeks. It is often signaled by a person feeling suicidal. Major depression is also more common among women than men, although here the gender

differences are not nearly as significant, probably because this is the depression most related to biological and genetic causes.

If a woman is consistently sleeping and/or eating too little or too much for weeks at a time, is having difficulty maintaining or coping with relationships, or finds herself unable to get or keep a job, she is a prime candidate for the diagnosis of major depression.

The major difference between dysthymic depression and major depression is that major depression can be so intense and severe that a person is incapacitated and unable to function. With dysthymic depression, the person can continue to function, although not as well as if he/she was healthy. What makes major depression so difficult to identify and treat is the fact that it's a recurrent, progressive illness. Like spontaneous remission in cancer, it can resolve itself – but without treatment, it usually comes back more quickly and with more intensity the next time.

A woman who has close relatives who were depressed is more likely to have a genetic vulnerability to major depression. Biochemical changes in the brain cause this depression and/or occur as a result of it. That's why people with major depression usually need medication to help balance their brain chemistry so they can fully utilize therapy to heal.

4. Bipolar Disorder (Also Called Manic Depression)

Manic depression is a disorder in which periods of deep depression alternate with periods of elation and hyperactivity. In the manic phase, those affected feel grandiose and invincible, as though they can conquer the world. They thrive with very little sleep, concoct unrealistic plans for their future, spend money they don't have, convince others to join them in wild business ventures, sometimes become promiscuous, and eat and drink to an excess that most of us can only imagine (and perhaps envy). The adrenaline rush of a manic phase leaves those who experience it feeling that life is terrific, people are wonderful, and no challenge is too great.

But after days or even weeks of feeling on top of the world comes the crash: a debilitating depression that leaves them feeling fatigued, defeated, and doomed. The intense high energy they enjoyed is now eclipsed by a total lack of desire. Their vivid, bright world is suddenly black and bleak.

The rates of manic depression are about the same in women and men. Some evidence suggests creative women and those in leadership positions may have a higher incidence of manic depression than the general female population (Goodwin & Jamison, 1990). Mania may actually help blast through the sexist barriers and fear of success that impede so many women. It may also help generate more creativity and productivity. As long as the mania doesn't become extreme or prolonged, many of these women report that they enjoy being somewhat hyperactive because they get so much done.

Manic depression, like major depression, seems to be the result of a biochemical imbalance in the brain and often requires a combined treatment of medication and therapy. While it's important to recognize one's biological

predisposition to manic depression or major depression, it's also vital to understand there are other factors and contributors that trigger its appearance. Just because someone has a genetic or biological vulnerability doesn't automatically mean that depression must follow. In many cases, excessive stress triggers the biological vulnerability.

In bipolar disorder, periods of normal mood usually occur between the periods of extreme highs and lows. The lengths of each episode vary from person to person and can change over time. If you or someone you know has experienced cycles of the following behaviors, professional help should be considered:

Manic Stage Behaviors:

- Increased energy
- Inappropriate elation
- Decreased need for sleep; may go days with little or no sleep
- Increased sexual activity
- Uncharacteristic participation in high-risk activities that are likely to lead to painful results, such as spending sprees, foolish investments, over-scheduling, or gambling.
- Loud, fast or incoherent speech
- Disconnected, racing thoughts
- Easily distracted
- Suddenly irritable
- Conviction that he or she is all-powerful
- Sudden paranoia or rage
- Denial that anything is wrong
- Alcohol or drug abuse
- Delusions and hallucinations; in later stages, may become convinced that he or she is in touch with creatures from outer space, knows celebrities or God, or has superhuman knowledge or powers

Depressive Stage Behaviors:

- Changes in sleeping patterns; sleeping too much or too little
- Changes in eating patterns; eating too much or too little
- Pains and digestive problems with no medical basis
- Excessive crying
- Thoughts of death or suicide
- Loss of interest in normally pleasurable activities
- Inability to concentrate or function at work

- Loss of sex drive
- Overwhelming feelings of despair, hopelessness, and helplessness
- Slowed thinking

Treatment

Seventy percent or more of those clients with bipolar disorder respond well to medication that helps reduce the frequency and intensity of manic episodes. Lithium carbonate is the medication used most often to treat bipolar disorder. A combination of medication and professional counseling helps most patients return to productive and fulfilling lives.

Q What type of medication is most likely to be used in the treatment of bipolar disorder?

a. Lithium

b. Prozac

c. Antidepressants

d. None of the above

The answer is "a," Lithium.

5. Seasonal Affective Disorder (SAD)

A person who feels gloomy and sluggish in the winter may have seasonal affective disorder (SAD). SAD is a cyclical depression. The symptoms usually peak during the fall and winter and usually disappear in the spring and summer, though for a small percentage the opposite pattern can be true. Many people experience a lesser degree of SAD as a case of the "winter blahs," but for those who suffer from the more severe forms, it's far more intense and potentially debilitating.

SAD is one of the most easily treated depressions when diagnosed properly. The problem with seasonal affective disorder is that its symptoms are often misdiagnosed. As a result, the client often ends up in therapy and on medication, when all that's needed is light. Any person who believes he or she may be susceptible needs to see a SAD specialist, not a general psychotherapist or psychiatrist, to receive proper diagnosis and treatment. For further information on SAD and how to locate a SAD specialist, write to Seasonal Studies, National Institutes of Health, Building 10/45-239, 9000 Rockville Pike, Bethesda, MD 20892.

Q What element of treatment has been found to be effective in treating a client with seasonal /situational affective disorder (SAD)?

1. Cognitive/Behavioral Therapy
2. Interpersonal Therapy
3. Light

4. None of the above

The answer is "3," light that is similar to sunlight.

Treatment for Unhealthy Depression

Clinical depression is one of the most common illnesses affecting working adults. Each year, 17.6 million adults (almost one in ten) experiences clinical depression. More than the normal feelings of sadness or grief that accompany the challenges of daily living, clinical depression is a serious, costly , and often disabling illness that may result in suicide.

Unhealthy Depression, whether physical, psychological, or a combination of both, is frightening and debilitating, not only for the depressed person but for those around them. Fortunately, however, treatment technologies have evolved so much in recent years that the great majority of Unhealthy Depressions can be successfully treated. These treatment approaches are more effective, less costly, and require less time to produce results than ever before.

Depression Among Women and Men

Depression affects different people in different ways. One of the clearest associations in the depression literature relates to gender. Women are twice as likely as men to suffer from major depression, seek treatment for depression, or attempt suicide. The gender difference in depression applies across racial groups and national boundaries and even persists when income level, education and occupation are controlled (McGrath et al., 1990). However, men and women suffer from bipolar disorder in roughly equal numbers, and men are more likely to successfully commit suicide. There is no precise explanation for the significant gender difference in rates of depression. However, in search of an explanation, researchers (McGrath et al., 1990) have explored various factors affecting women, including:

- Reproductive-related events and depression
- The relation of personality traits and other psychological factors to depression in women
- Women's roles and status in relation to depression
- Victimization and poverty as factors affecting depression in women
- Diagnostic bias and its effect on diagnosing depression in women (In Good Company, April 1995, p.14).

Interpersonal Therapy

According to theories in the psychology of woman, a woman's sense of self is primarily developed through connection rather than autonomy. Her self-esteem is often heightened or diminished by the quality of her relationships, and depression feeds on relationship failure. Therefore, interpersonal therapy (IPT), which focuses on development and application

of relationship skills, would seem a natural treatment choice for many depressed women.

IPT is based on the health partnership model. The person seeking help is typically called a "client" instead of a "patient" because she is not regarded as sick or in a dependent position, in need of an "expert" and a "cure." An essential component of IPT is that the therapist helps the client to understand how critical positive relationships are to her well-being, and to assess the quality and quantity of the relationships she currently has. The first several sessions are spent exploring and defining current relationship problems and arriving at goals for treatment.

The client then focuses on developing relationship skills, practicing how she can be more effective in her relationships and developing new ones if that's what she needs. The quality of the relationship with the therapist is critical in this kind of therapy because an important part of the healing occurs as a result of the warmth, support, and validation the client feels from the therapist.

In IPT, the emphasis is on empowering the client in her relationships at home and at work so she can become increasingly independent and able to internalize these skills. The focus is on the "here and now," on the present rather than therapy. Homework assignments are mutually developed in a spirit of cooperation between the therapist and client. Outcomes are discussed and strategies are modified until the techniques are effective in helping the client achieve her goals.

There are some problems with IPT. It doesn't work for everyone. It is a short-term behavioral approach. Until now, it has been used primarily as a research tool so it is difficult to find people teaching and practicing it. When interpersonal therapy is appropriate — and it often is — it works very well, especially at various stages of therapy.

Cognitive/Behavioral Therapy

Cognitive therapy is based on the assumption that the way people feel is the direct result of the way they think. In other words, if they think negatively, they are going to feel negatively. This therapy defines depression as a distortion in thinking. Many women develop a negative pattern of thinking that automatically causes depressed feelings, and they do not even realize what they are doing to themselves. Negativity becomes a comfortable habit and causes chronic depressed feelings and less effective functioning. One of the best descriptions of this self-destructive process is found in a book called Learned Optimism (Segilman, 1991) by noted psychologist Dr. Martin Seligman.

Cognitive therapy helps women and men understand why they think the way they do and how to substitute positive for negative thinking. Negative thinking, or cognitive distortion, falls into clear categories or patterns.

Among the more typical distortions cognitive therapists describe are: "personalization," in which one sees himself or herself as the cause of an

event they weren't responsible for; "magnification or minimization," in which a person exaggerates the importance of some things and inappropriately diminishes the value of others; and the ever-popular "all-or-nothing thinking," a favorite among women because with this kind of either/or thinking we feel like total failures if we're not totally perfect.

Cognitive therapy trains clients to label and understand these typical self-sabotaging distortions and to recognize when they're using them. It is primarily an intellectual rather than an emotional approach. It stresses quality of thinking more than expression of feelings and may appeal more to men on that basis. It's important to understand, however, that despite several shortcomings, cognitive therapy provides vital tools for depressed people. A combination of cognitive therapy and IPT can be a successful recovery strategy for both Healthy and Unhealthy Depression.

Behavioral therapy is similar to cognitive therapy and focuses on changing clients' behavior in addition to changing their thinking patterns. It is based on the idea that the depressed client is receiving enough positive reinforcement in his or her life and needs to create more sources of rewards. Therefore, an assessment of the structure of their life and the effectiveness of their functioning skills is conducted. Suggestions and homework in the form of behavioral assignments are then given so that the client can begin to exercise more control over his or her environment and develop management skills to receive more positive reinforcement. Behavioral therapy is particularly successful in enabling clients to gain control over fears and phobias, as well as for gaining life skills that substantially improve their quality of life.

Interpersonal therapy, behavioral therapy, and cognitive therapy are especially valuable treatments for women with Unhealthy Depression because they emphasize action instead of talk. All encourage the development, through homework and feedback, of practical skills that enable women to function with greater competence and mastery in their relationships and work lives. The client will inevitably feel better about herself because she is more effective and more aware that people are responding more positively to her. She has also learned a new, more positive way of thinking so that she now focuses on what she has and what she can do, rather than on what she's lost and what she can't do.

Feminist Therapy

Feminist therapy isn't about politics or rhetoric. It's based on the fundamental belief and acknowledgment that women and men can't fully understand their sources of depression until they appreciate how our society and culture directly contribute to that depression. Each woman has a lifetime of subjective experiences that has helped create or contribute to her depressed feelings. But women also have a collective vulnerability to depression, which results simply from living in a culture in which sexism, discrimination, and violence against women are allowed and sometimes even encouraged.

Feminist approaches in therapy don't encourage blame—which just feeds Victimization Depression—but rather emphasize recognition and acknowledgment of cultural influences on individual experience. Some of women's vulnerabilities to various kinds of Healthy Depressions, such as Depletion Depression and Victimization Depression, clearly comes from being cast as a second-class member of a society that devalues women. Without understanding this, it's very easy for a woman to assume full responsibility for her depression when other contributing factors need to be acknowledged.

The other key component of feminist therapy is that the client develops a relationship with the therapist in which empowerment and equalities are nurtured as much as possible. Rather than promote dependence, feminist therapy encourages women to utilize their own power, to value who they are, and to become as active as possible in the therapy process. Both feminist and interpersonal therapy strengthen the woman with the feeling that she is not alone in the growth process because the therapist is with her for support and serves as a guide when requested.

Group Psychotherapy and Self-Help Groups

Groups can be highly effective for both Healthy and Unhealthy Depression. In fact, with Unhealthy Depression there comes a point where group therapy can become a critical component of the healing process, assuming the therapist running the group is experienced and knowledgeable in depression treatment.

Group therapy has been found to be effective for most kinds of depression because many of the special needs of depressed clients can be met in a group setting. Clients with Unhealthy Depressing vitally need to feel a sense of connection, because the depression has often drained their energy and isolated them from others. Groups make it easier for clients to explore the sources of their depressed feelings by identifying cultural punishers and the impact of our Traditional Core on our feelings and behavior. Clients can formulate and support more effective action strategies together. They can also practice building and maintaining healthy relationships and benefit enormously from the instant relationship feedback available in a group.

In many ways, a good group becomes an intense social laboratory for relationships. It's a safe haven where clients can risk new behaviors they may not be ready to try in the outside world. They are encouraged to explore and discover new strengths while challenging old ways of thinking. Groups provide an opportunity to discuss the health and potential of current relationships, learn how to share and effectively help others, and to develop and nurture communication skills that are valuable in every facet of life.

Self-help groups, such as Alcoholics Anonymous, Overeaters Anonymous, Adult Children of Alcoholics, and Gamblers Anonymous, are not designed to do therapy but can provide valuable support for depressed women. In the past ten years, the popularity and availability of such groups have

increased, as more people begin to appreciate the value of sharing their pain and feelings with others who understand what they are going through.

Self-help groups based on twelve-step programs can be very helpful to those with Unhealthy Depression because many clients are depressed in part because of unresolved addictions. If their addictions are getting in the way of their recovery from depression, a self-help group enables them to go into "recovery" and begin resolving it. Twelve-step approaches can also be more effective in working directly with the addictions than many forms of psychotherapy. They provide an immediate opportunity to connect with others and create healthier relationships.

Self-help groups can be an excellent introduction to the group process, especially for those who are resistant to any kind of therapy. They teach participants that they are not responsible for their disease but are responsible for corrective behaviors. This can be very helpful in empowering depressed women. The groups are more supportive because women have found this experience to be less intrusive or demanding. The fact that these groups are free is also important, because many women who need support are economically distressed.

As with group therapy, self-help groups do have their limitations. While they provide an excellent opportunity to express and share feelings, they rarely if ever provide feedback about what to do with the feelings and how to work through the problem. Many clients need more individualized information and the structure and support of individual and/or group therapy to guide them toward new levels of growth. Regardless of how effective a self-help group may be in working with addictions or other problems, it alone can't provide the support and techniques needed to resolve depression. Clients suffering from Unhealthy Depression need a professional evaluation, individual therapy possibly followed by group therapy, and perhaps medication.

Medications for Unhealthy Depression

There are more than thirty different kinds of antidepressant drugs prescribed in this country today. At lease 150 others are in development (McGrath, 1990, p.67). Americans spend a staggering $700 million a year on antidepressant medication; the use of mind-altering prescription drugs such as Prozac and Xanax is increasing at an alarming rate. According to market analyses conducted by Shearson, Lehman, and Hutton, by 1995 the use of antidepressants in America will nearly triple, making the companies that produce them some of the strongest growth stocks in the pharmaceutical industry (Smith, Adkins & Walton, 1988).

These medications can be very helpful as part of the treatment for Unhealthy Depression. The bad part of that is the pressure to prescribe and use these drugs in order to justify their existence and contribute to corporate coffers, will continue to intensify for depressed clients. Women are – and will continue to be – the group most vulnerable to economic exploitation and

physical risk as a result of over prescribed or inaccurately prescribed antidepressants.

Women are currently given far more prescriptions for antidepressants than men. In 1984, 64 percent of the 131 million prescriptions for antidepressants and 72 percent of the prescriptions for tranquilizers were given to women (McGrath, 1990). In addition 70 percent of these prescriptions are written by physicians with no specific training in the diagnosis or treatment of depression. Also 30 percent to 50 percent of depressions are misdiagnosed (McGrath, 1990). This underscores the very real possibility that perhaps up to half the time, a woman may receive the wrong medication for a misdiagnosed disorder if she works with a professional who isn't a specialist in the diagnosis and treatment of depression.

The biggest problem with most mind-altering medications is that many times they're prescribed without psychotherapy and without proper monitoring for side effects. If medication is to be used in the treatment of depression, it must be done in conjunction with therapy in order to have optimal results. Without therapy, the clients likely to use the medication improperly or to stop using it, which ultimately makes him or her more vulnerable to feelings of despair and hopelessness.

Another reason a depression specialist is so important is that women need health professionals who are aware of and sensitive to gender differences in depression diagnosis and treatment.

While antidepressants are not always the answer to feeling bad, they're essential for those who are suicidal or significantly impaired either psychologically or organically by depression. Antidepressants or other prescription drugs are sometimes the only answer to the biochemical imbalance of certain disorders. They are needed to replenish the chemicals depleted by the depression so that a person can function and begin using therapy to work through the issues that plunged him or her into the depression in the first place.

Prozac (fluoxtine), for example, has proven to be a generally helpful drug and has become the current antidepressant of choice because it has the fewest side effects. But Prozac has also proven to be a major problem for a small minority of clients, escalating aggressive, agitated, or suicidal feelings to dangerous levels (McGrath, 1990).

Prozac is a prime example of the promise and problems with all such medications. They all have side effects. Most of them are manageable, but for a few the side effects can be dangerous or even deadly. For nearly one-third of depressed people, these medications don't even work (Gold, 1986).

Questions

1. What type of medication is most likely to be used in the treatment of bipolar disorder?

   a. Lithium

b. Prozac

c. Antidepressants

d. None of the above

2. What element of treatment has been found to be effective in treating a client with situational/seasonal affective disorder (SAD)?

a. Cognitive/Behavioral Therapy

b. Interpersonal Therapy

c. Light

d. None of the above

Answers

1–a

2–c

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CHAPTER 23 EATING DISORDERS

Dieting or, at the very least, watching what we eat, has become a way of life for many of us. However, the model often portrayed in American advertisement is one that is thin and young looking. Therefore, many tend to strive to look like the ideal portrayed in American society. Losing weight is a part of an obsession. Yet the majority of dieters are not actually overweight, they simply do not believe they are "thin enough."

For some, what originally appear to be "normal" concerns about weight and staying in shape evolve into severe and even deadly preoccupation with food, weight, and body image. The result is sometimes an eating disorder.

Anorexia Nervosa

Anorexia nervosa is primarily a disorder of young women. The cardinal feature is a relentless pursuit of thinness, often leading to life-threatening weight loss. This pursuit of thinness becomes associated with intense fears about eating, gaining weight, and fear of loss of control over food intake. Typically, the disorder begins innocently: a young girl goes on a simple diet, but before long the diet is out of control.

Several methods are used to lose weight. First, high-calorie foods are eliminated from the diet; then other food items remain in the diet. The girl may begin binge-eating and thereby validate her fear of loss of control over food intake, creating tremendous anxiety. She may immediately try to rid herself of this food by self-induced vomiting, by taking large doses of laxatives, or by exercising excessively. Often she learns all these behaviors. Before long she begins to look emaciated. Whereas at first she may have received praise for her weight loss, friends and family soon criticize her looks and try to get her to eat. The anorectic shuns advice — usually thinking others are trying to make her fat — and becomes more determined in her desire to lose weight. She is usually unaware of her extreme thinness; even if she recognizes it, however, her intense fears about getting fat prevent her from changing the anorectic behavior that has become dominant in her life.

Anorexia nervosa is characterized by a refusal to eat which leads to extreme weight loss, often to the point of emaciation. Anorexics are so afraid of gaining weight that they will stop at nothing in order to stay slim. Unfortunately, an anorexic never reaches her "ideal" weight. She always has just a few more pounds to lose. Regardless of how thin an anorexic becomes, she still perceives herself as fat.

Common Clinical Features

The failure of some patients to acknowledge their anorectic illness – their denial of illness – can be a stumbling block during the diagnosis and assessment of patients. They may fail to acknowledge their thinness, hunger, and fatigue and to recognize their nutritional needs. Because they don't perceive themselves as abnormal, they refuse help. This denial, which is considered a typical characteristic with diagnostic significance (Crisp, 1967), is included in the Feighner diagnostic criteria for anorexia nervosa. Failure to acknowledge illness is considered by some to be an early sign of the disorder (Crisp, 1967, Brush, 1973).

There is evidence that denial may be associated with greater severity of illness. For example, more denial of illness was associated with less weight gain during a 35-day treatment study of hospital anorectics (Goldberg, Halmi, Eckert, Casper, Davis, Roper, 1980). In the same study, denial was associated with body size overestimation (Casper, Halmi, Goldberg, Eckert, & Davis, 1982) and depression (Eckert, Goldberg, Halmi, Casper, & Davis, 1982).

Failure to acknowledge illness sometimes extends beyond the strictly anorectic issues to include psychological changes. Anorectic "deniers" rated themselves in a recent study as having significantly less neurotic and somatic complaints, being more self-defensive and socially extroverted, and being less psychologically disturbed when compared with anorectics who admitted their anorectic illness (Vandereycken & Vanderlinden, 1983).

Many questions about the characteristics of anorexia nervosa remain unanswered, and clear diagnostic criteria are not yet agreed upon. Anorexia nervosa has yet to be differentiated from other eating disorders, particularly the bulimic syndrome and atypical eating disorders. Some of the common clinical features — denial or failure to acknowledge illness, hyperactivity, and body distortion — remain perplexing phenomena. The identification of subgroups within anorexia nervosa shows promise.

The true incidence and prevalence of anorexia nervosa are still unknown, but there is evidence that the disorder is increasing in frequency. The etiology of the disorder is probably a combination of predisposing, precipitating, and perpetuating factors. Of the associated psychiatric problems, the relationship between affective disorder and anorexia nervosa has received the most attention, although it needs further classification.

Q A person with anorexia nervosa tends to:

a. Have intense fear of becoming obese.

b. Have no known medical illness that could account for weight loss.

c. Have denial of illness with failure to recognize nutritional needs.

d. All of the above.

The answer is "d," all of the above.

Bulimia

Bulimia is an eating disorder characterized by a pattern of episodic binge-eating. Patients with this disorder are aware that their eating pattern is abnormal, but they feel unable to stop eating voluntarily. Their binge-eating is a solitary behavior frequently followed by depression and remorse. They are chronically concerned about their weight, often inducing vomiting or abusing laxatives to prevent weight gain or to promote weight loss (Johnson, Lewis, Love, Stockey, & Lewis, 1983).

Like anorexics, bulimics are obsessed with food and weight. However, as opposed to not eating, bulimics often binge eat and then purge themselves to avoid gaining weight. During the binge, bulimics eat large amounts of food, very rapidly, and with little self-control. Purging may involve vomiting, using laxatives, or excessive exercise. Despite this cycle, bulimics are usually average weight, or slightly overweight.

Q A person with bulimia may:

a. Have recurrent episodes of binge-eating

b. Consume high-caloric, easily ingested food

c. Repeat attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics

d. All of the above

The answer is "d," all of the above.

Identification of Patients with Bulimia

Bulimia is not a rare disorder, but patients with this problem frequently hide it from their doctors. Health professionals who work with young females should routinely inquire about abnormal eating patterns because these problems are common and serious enough to be major health concerns.

When asking about eating behaviors, health professionals can use certain general topics of questioning to identify the patients who have profound problems with eating. As when discussing other topics that are uncomfortable for some patients, a direct nonjudgmental approach is usually best in order to elicit the necessary data. One can ask whether the patient has binge-eating episodes and what the usual pattern is. Inquiry about the use of laxatives and self-induced vomiting should be routine. A history concerning any significant weight change will also prove useful.

When the examining professional has evidence suggesting an underlying eating disorder, more detailed questioning is indicated. Areas to be covered should include the following:

A. History of eating patterns

1. Was the patient ever underweight or overweight?

2. What were the highest and lowest adult weights and when did they occur?
3. What was the eating patterns like before the onset of the eating problems?
4. What circumstances surrounded the onset of the eating problems?
5. What has the eating pattern been like since the onset of the eating problems?
6. Does the patient binge eat? What are the amounts and types of food ingested during an eating binge? Where does the patient binge eat? What factors seem to precipitate binge eating episodes? Does the patient engage in any diets or fasts?

B. History of associated characteristics

1. Vomiting – What is the frequency and how does the patient induce the vomiting?
2. Laxative usage (frequency, type, dosage)?
3. Use of diuretics (frequency, type, dosage)?
4. Use of amphetamines or over-the-counter stimulant drugs (frequency, type, dosage)?
5. Exercise pattern – Is there evidence of hyperactivity?
6. Body weight distortion – Does the patient feel fat when thin?
7. Menstrual history – are amenorrhea or irregular menses present?
8. Preoccupation with food?
9. Mood changes – particularly as related to depression?
10. Sleep pattern – Any evidence of insomnia? Night binge eating?
11. Stealing behavior?
12. Alcohol or drug abuse?

C. History of associated social complications

1. Problems at work, school?
2. Problems in relationships? (Mitchell, 1985, p. 42-43)

One may also ask about the presence of effective disorders, eating problems, and drug abuse in relatives because of the suggested familial relationships among these disorders.

Who Develops an Eating Disorder, and Why?

Both anorexia nervosa and bulimia nervosa commonly begin during early adolescence, coinciding with the onset of puberty. However, an eating disorder may strike as early as age eight or as late as middle age. Although many reports suggest that eating disorders are more common in individuals raised in middle to upper class homes, eating disorders are not restricted to

any specific class or culture. Eating disorders are up to 20 times more common in women than in men. Five to 10 percent of adolescent girls and young women in today's society have eating disorders of anorexia nervosa and bulimia nervosa.

It is often difficult for others to understand what would provoke a woman to starve herself or to purposely vomit after eating. Theories developed to explain the emergence of eating disorders usually regard these illnesses as the result of a combination of biological, psychological and social factors.

Biological: It appears the genetics may predispose a person to an eating disorder. But once an eating disorder develops, there are several biological changes that might result in the intensification of the illness. For instance, the self-starvation of anorexics may lead to chemical changes that dull a person's feelings of hunger or result in feelings of depression or sadness. In addition, it is believed that vomiting can chemically induce feelings of euphoria or light-headedness that some bulimics may seek out to mask feelings of anxiety or depression.

Psychological: A variety of psychological factors are likely to influence the development of an eating disorder. These may include:

Perfectionism: People with eating disorders often place high expectations on themselves in every area of life.

Self-esteem: Many anorexics and bulimics report feeling worthless.

Rigid thinking: Individuals with an eating disorder frequently report dealing with life in the extreme. Everything is black or white; there is no gray area.

Control Issues: Many people with eating disorders report feeling they have no control over their lives or environments.

Identity: Anorexics and bulimics are frequently in the midst of a painful struggle of identity, with unanswered questions like: Who am I? What Do I Like? What do I feel?

Sexuality: A significant number of anorexics and bulimics have had traumatic sexual experiences, frequently sexual abuse or rape.

Other Psychiatric Disorders: Eating disorders frequently coexist with other psychiatric illnesses such as depression, substance abuse or anxiety.

Social: A variety of social factors play a role in the development of eating disorders. The excessive value that is placed on thinness in our society can lead women to believe that their self-worth depends on their body size or appearance. Thinness becomes equated with achievement, intelligence, popularity, and success. This may lead to a persistent struggle to create the "perfect body."(National Medical Enterprises)

It has also been suggested that an individual's family life may affect a child's risk of developing an eating disorder.

Questions

1. A person with anorexia nervosa tends to:
   a. Have intense fear of becoming obese
   b. Have no known medical illness that could account for weight loss
   c. Have denial of illness with failure to recognize nutritional needs
   d. All of the above
2. A person with bulimia may:
   a. Have recurrent episodes of binge-eating
   b. Consume high-caloric, easily ingested food
   c. Repeat attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics, or diuretics
   d. All of the above
3. The similarities between bulimia and anorexia nervosa are:
   a. Both are diagnosed as eating disorders
   b. Both are treated with nutritional diets
   c. Both present a high incidence of childhood sexual abuse
   d. All of the above

Answers

1–d

2–d

3–d

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