To The Graduate Council:

I am submitting herewith a dissertation written by Olney Ricky Toomey entitled "Impact of Patient Variables on Successful Intervention in an Industrial Counseling Program." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Education, with a major in Educational Psychology.

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We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Vice Provost
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IMPACT OF PATIENT VARIABLES ON SUCCESSFUL INTERVENTION IN AN INDUSTRIAL COUNSELING PROGRAM

A Dissertation

Presented for the

Doctor of Education

Degree

The University of Tennessee, Knoxville

Olney Ricky Toomey

May 1989

DEDICATION

This dissertation is dedicated to my wife, Susie, my daughter, Kelly, and my son, Chris. They have supported my pursuit of graduate education through their patience with me during my moments of frustration, their acceptance of my absence when they would have preferred my presence and their encouragement of me to complete my graduate program. They contributed greatly to a good environment for learning and I've learned much from them.

ACKNOWLEDGEMENTS

I wish to thank my committee members. First, I want to thank Dr. Siegfried Dietz without whose patience and guidance this dissertation could not have been completed. Secondly, my thanks to Dr. Lawrence DeRidder who has been a friend and encourager for me and many doctoral students; thirdly, to Dr. Kenneth Newton who was the professor for my first graduate course and was a motivating force in my decision to pursue a graduate degree; and, fourthly, Dr. Gary Klukken for his teaching and modeling of counseling skills with warmth and great competency. In addition, I would like to thank Dr. Schuyler Huck and Dr. Mark Hector for contributions they made during the brief periods they served on my committee.

Additionally, my appreciation is expressed to Renee' Sharp for typing my dissertation and other assistance along the way.

I owe special thanks to my employer for allowing me to conduct my research in the field of my work and to certain colleagues for their assistance. First, my gratitude is expressed to my supervisor, Mr. Charles Gibson, for his support; secondly, to Ms. Kathy White, my secretary, for a variety of assistance; and, thirdly, to Mr. Bob Brown and Ms. Eileen Johnson for their help with statistical analysis.

Finally, my gratitude is expressed to my wife, Susie, for her help with preliminary typing and critique of my work.

ABSTRACT

The primary purpose of this study was to evaluate potential predictors of counseling outcome utilizing a brief cognitive-behavioral counseling approach within an industrial Employee Assistance Program (EAP). These relationships were investigated in a study of 115 counselees who received brief counseling for a variety of personal problems. The measures of treatment outcome were counselee evaluation of outcome utilizing the Malan rating scale and level of counselee absenteeism on the job. The predictor variables evaluated were career competence, social competence, job performance, occupational/income level, educational level, marital status, age, referral source, problem severity and counselor empathy.

The results showed that six predictor variables were correlated with outcome as measured by counselee evaluation at an alpha = .01 level. High counselor empathy, as measured by counselee evaluation, was the strongest predictor of successful counseling outcome. Counselees with more severe problems showed the next strongest association with successful outcome. Lower levels of career competence, social competence, job performance and occupational/income level also showed significant associations with successful outcome.

The level of employee absenteeism was not a good measure of counseling outcome but reduced absenteeism showed potential as a behavioral measure of counseling outcome. However, none of the predictor variables were correlated with counseling outcome as measured by reduced absenteeism.

Results did indicate that counseling interventions through an industrial Employee Assistance Program do reduce employee absenteeism.

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CHAPTER I

INTRODUCTION

Introduction

Since Employee Assistance Programs (EAPs) began evolving in the 1960's over one-half of the Fortune 500 companies have implemented such programs (Wrich, 1980). These short-term counseling, assessment and referral programs grew out of industrial alcohol rehabilitation programs. Services offered by EAPs may include any or all of the following: assessment of personal problems, referral to treatment resources, short-term counseling, follow-up and aftercare services, management consultation and educational and prevention programs.

The significance of EAPs in the mental health field must be taken seriously since annual utilization of these programs by employees is usually in the 2 to 5 percent range of the employee population. This means that a significant number of people are either receiving mental health services directly from EAPs or accessing such services in the community through EAPs.

The justification for EAPs in business and industry is basically two-fold. First, it is offered as a benefit,

usually at no cost to employees, as an expression of concern by companies for employees and their family members. Secondly, companies provide these services under the assumption that employees troubled by personal problems cost the company money. These costs include: high absenteeism, poorer quality and reduced quantity of work, worker's compensation claims, accidents, costs associated with waste due to poor performance and higher health care costs (Rountree & Brand, 1975).

Companies implementing EAPs are addressing these costs by making assistance for personal problems readily available to employees. The intent is that, by encouraging employees to utilize these programs, employees will resolve their personal problems and become more effective in the workplace. Although there have not been any documented controlled studies of the cost savings associated with Employee Assistance Programs, many companies have reported such savings.

A common element of all EAPs is assessment and determination of what treatment is utilized. As a result, it is important to choose treatment which will have a high probability of success. Since many EAPs provide short-term counseling, it is also important to determine ways to predict when the outcome of this therapy approach is likely to be successful.

Statement of the Problem

Employees who utilize an EAP seek counseling for a variety of personal problems including: marriage and family problems, depression, anxiety, psychotic disorders, financial difficulties, chemical dependency and job related problems. This study will evaluate career competence and social competence measures, other client variables and a counselor variable to determine if any of the variables predict the outcome of brief counseling. The client characteristics that will be evaluated are: job performance level, occupational/income level, educational level, career competence, social competence, age, marital status, severity of problem and referral source. The counselor variable which will be evaluated is counselor empathy.

Hypotheses

The following hypotheses were tested in this study:

H:1 Employees who seek counseling for personal problems experience higher absenteeism than other employees.

H:2 Successful EAP counseling intervention will result in lower employee absenteeism.

H:3 Individuals who are successful in career preparation and performance activities are more successful in resolving personal problems.

Purpose of the Study

A wealth of research has been conducted through the years in an effort to identify variables which might predict the outcome of various therapeutic interventions. Most of this research is performed with a single presenting problem. The vast majority of the research has been carried out with depressed or schizophrenic clients. Since EAPs deal with a much wider variety of personal problems, present research does not provide predictors for some of the problems presented to EAP counselors.

Particular attention was paid to certain career-related variables. The career-related variables of job performance, occupational/income level and educational level were not only evaluated individually but were combined into a career competence measure. This career competence measure, which has not been defined prior to this study, was evaluated separately to determine whether career competence predicts whether an individual is more successful in resolving personal problems. The review of literature did not indicate that this type of career measure has been used as a predictor of outcome in therapy. Zigler and Phillips (1961) developed a social competence measure which combined I.Q., age, marital status, educational level, occupational level and employment history. Employment history does not discriminate in the

workplace since every subject is regularly employed. The I.Q. variable is not normally available, and, as a result, testing would be necessary to obtain this variable. These two variables, identified by Zigler and Phillips, were eliminated from the social competence variable and job performance was added. This revised social competence measure was evaluated as a predictor of outcome and compared to the career competence measure. The career competence measure included only those variables which are more directly related to the workplace where EAPs function.

Significance of Study

In order to provide the most effective assistance to employees seeking assistance through an EAP, it is important to determine what course of treatment would have the highest probability of success. Determining patient variables which predict success would help in properly referring patients to appropriate treatment resources. This determination could also be used to identify other interventions which might enhance the treatment process.

Listed below are contributions this study will make to EAPs and counseling in general.

1. The study will help to validate whether lower absenteeism is a valid measure of successful counseling intervention.

2. The study will add to the body of empirical research on patient variables which predict outcome of counseling. It will fill a particular void in the area of predictors for problems in living as opposed to more severe emotional disturbances.

3. The study will determine effectiveness of EAPs in saving money for companies through reduction in absenteeism.

4. The study will help determine whether competency in dealing with career and work-related decisions and tasks predict success in resolving personal problems.

5. This study will add to the body of empirical research on the effectiveness of brief therapy in treatment of emotional disturbances.

6. This study will help to illustrate the fertile field that exists in business and industry for research in the mental health area.

Rationale for Study

In a study by Weissman, Klerman, Prugoff, Sholomskas and Padian (1981), results showed that psychotherapy was more effective than antidepressant medication in the treatment of problems involving social functioning symptoms, such as a mood, apathy, suicidal ideation and work functioning. This ability to determine treatment based on diagnosis is critical in EAPs since a major function of an EAP is assessment and

referral. Since many EAPs provide brief therapy, it is also important to determine what clients would be good candidates for brief therapy. Certainly diagnosis is one variable which must be considered, but another client characteristic which predicted outcome was developmental level of self-concept (Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984).

A significant amount of research discussed in the review of literature identified measures of personal effectiveness which were effective predictors of outcome in brief therapy. These measures of personal effectiveness included social competence, occupational level, work performance, marital status, educational level and self-concept. If these variables can help identify those clients who would benefit most from brief therapy, then EAPs could improve their treatment effectiveness by providing counseling to clients who fit a particular profile.

However, this discriminatory approach to treatment raises the question, what treatment is then provided for the clients who are not good candidates for brief therapy. Pilkonis, Imber, Lewis and Rubinsky (1984) suggested enhancement treatment approaches for high risk clients that might improve their ability to respond in a more positive manner to therapy. This raises an exciting possibility within the workplace. Most companies are actively involved

in enhancing the personal effectiveness of their employees through various training activities. These training programs help employees improve interpersonal functioning, decision-making skills, communication skills, time-management and various other areas of personal effectiveness. Thus, EAPs, which are strategically located in the workplace, could refer high risk clients to various training courses in the area of personal effectiveness prior to or as a part of their treatment. Through improved self-sufficiency, the client might be more successful in resolving personal problems.

This study sought to establish what client variables predict outcome in a brief counseling intervention. Particular attention will be given to identifying client variables which could be enhanced through some type of training activity which might improve a client's chance of resolving their personal problem.

Limitations of Study

The major potential limitation of this study was the truthfulness of the responses on the self-report questionnaire (Appendix 1). This questionnaire was used to collect client evaluation of the relative success of the counseling intervention, severity of presenting problem, helpfulness of EAP and the empathy of the Employee

Assistance Counselor. Whether clients responded in a socially acceptable manner was difficult to determine. The fact that this questionnaire was done four to six years after the counseling intervention was likely to affect the reliability of the survey responses due to potential difficulty of recall.

In order to control for the treatment variable, only data for clients receiving counseling from a single Employee Assistance Counselor were used. If clients received counseling from any other source for the two years following EAP intervention, they were eliminated from the study. This means that the treatment, with the exception of the number of counseling sessions, was held constant. This prevented the necessity of evaluating various treatment options.

The criteria used to determine the outcome of the counseling intervention was client evaluation and lower absenteeism. The client evaluation is subjective in nature. However, research on brief psychotherapy frequently uses client, therapist or clinician observer evaluations of success (Koss, Butcher, & Strupp, 1986). Although these evaluations differ, depending on who is doing the rating, evaluations of this type are reliable predictors of certain measures of treatment outcome such as symptom relief (Horowitz, Marmar, Daniel, Weiss, Kaltreider, & Wilner, 1986). Absenteeism has not been used as a measure of success

in previous research. Certainly many factors, such as medical treatment which is not symptomatic of an emotional disturbance, impact the absenteeism measure. However, it was used in this study since reduction of absenteeism is one economic justification for EAPs.

Definition of Terms

1. Absenteeism: days absent from work during a year due to illness or other personal absences other than vacation, holidays or approved leaves of absence.

2. Career Competence: measure of individual effectiveness in dealing with career-related situations and problems. This measure is a composite score which combines the following factors: occupational/income level, job performance and educational level.

3. Clients: individuals seeking counseling assistance.

4. Employee Assistance Counselor: counselor within an Employee Assistance Program who has completed all coursework, including fifteen hours of supervised doctoral level counseling practicum, for an Ed.D. in educational and counseling psychology.

5. Employee Assistance Program (EAP): counseling program offered by employers to their employees and family members. Counseling is provided for the following personal

problems: marriage and family problems, anxiety, depression, severe emotional problems, chemical dependency, financial difficulties and job-related problems.

6. Occupational/Income Level: level of work within an organization as determined by job evaluation categories. These categories determine general income level since the categories determine ranges of income based on job level.

7. Performance Appraisal: formal system of evaluating on-the-job performance of employees.

8. Predictor: client variables which might predict whether a counseling intervention is successful or unsuccessful.

9. Self-efficacy: personal effectiveness in exercising some control over events that affect our lives.

10. Social Competence: a measure of individual effectiveness in dealing with social situations and problems. This measure is a composite score which combines the following factors: age, marital status, occupational/income level, job performance and educational level.

11. Multicollinearity: a situation where the regressor variables are not independent and, as a result, display redundant information.

12. Job evaluation: a system of determining the relative earning potential of jobs by evaluating

the following job factors: job knowledge, physical effort and responsibility.

Methodology of Study

Client variables and counselor empathy were used to predict the outcome of an EAP counseling intervention, as determined by client evaluation of outcome and absenteeism. The client variables were: age, marital status, educational level, job performance, occupational/income level, severity of problem, referral source, social competence and career competence.

The measures of outcome, client evaluation and absenteeism, were also compared to see if they correlate as measures of treatment outcome.

Sampling and Data Collection

Subjects for this study had to meet the following criteria:

1. Employees who received counseling from an Employee Assistance Counselor and no other professional for the two years following the initiation of counseling with EAP.

2. Counselees who were still employed by the organization offering EAP services.

3. Counselees who chose to participate in the study by completing a questionnaire.

All counselees who met the first two criteria were called by the Employee Assistance Counselor from whom they received counseling and were asked if they would participate in the study by completing a questionnaire. If they chose to participate, a questionnaire was sent to the participants which they were asked to return.

The data concerning client variables and evaluation of treatment collected by the questionnaire were then combined with biographical data from personnel records to complete data collection. This data included all the predictor variables which were to be evaluated and the two measures of counseling outcome.

Analysis of Data

Since ten predictor variables were evaluated concerning their effectiveness in predicting treatment outcome as measured by two dependent variables, multiple linear regression was used to evaluate which predictor variables were associated with successful counseling intervention.

The multiple linear regression model made it possible to identify which single variables were effective predictors of outcome. Correlations were also calculated to determine which variables might be related to each other. The composite career competence variable was also evaluated. In addition, stepwise regression was used to build the best

single model for predicting outcome of counseling. A partial F-test was used to add and maintain variables in the model which contributed to prediction of success. Preselected F-in and F-out values were used to add and eliminate variables. This helped to minimize the effect of multicollinearity.

CHAPTER II

REVIEW OF LITERATURE

Introduction

This chapter reviews several areas of pertinent literature as a background for this study. Areas of literature reviewed cover the following topics: Employee Assistance Programs (EAPs), brief psychotherapy, interaction of client variables, diagnosis and treatment, treatment goals, career competency and measures of outcome in treatment. Empirical literature is abundant for all the aforementioned areas except EAPs and career competence. These two research voids will be addressed in this study.

Employee Assistance Programs

The growth of EAPs in industry has been a significant development in the 1970's and 1980's. In Wrich's highly regarded book on EAPs, he has chronicled their rapid growth (Wrich, 1980). By 1972, approximately 300 employers had some type of Employee Assistance or Occupational Alcoholism Program. By 1980, over 5000 companies had such programs. Among Fortune 500 companies, the percentage of companies having EAPs increased from 27% in 1972 to 57% in 1979. More recently, Hellan (1986) reported that 60% to 70% of all employers with 3000 or more employees have EAPs.

The alcohol rehabilitation movement which began in industry in the 1940s evolved into the EAP movement of the 1960s. Wrich (1980) indicates that, although EAPs grew out of Occupational Alcoholism Programs, the focus is not on a single problem like alcoholism, and two reasons are cited to justify a broader focus. First, all personal problems have an impact on the effectiveness of employees in the workplace. Secondly, by dealing with all personal problems, which are frequently secondary issues with alcoholism, EAPs have been more successful than the Occupational Alcoholism Programs in identifying and helping the alcoholic employee.

EAPs provide employers with the unique opportunity to combine humanistic concern for employees with the cost savings associated with identifying and treating troubled employees (Rowntree & Brand, 1975). Certainly, a major purpose of EAPs is "to help employees who either have job performance problems or are likely to as a result of personal problems" (Wrich, 1980, p. 16).

Although it is difficult to document cost savings associated with EAPs, most employers who have such programs believe EAPs in fact are cost-effective through the retention and performance improvement of employees who receive assistance (Sullivan, 1987). The Health Insurance Association of America reported that several major companies reported cost savings between $68,000 and $2,000,000 as a result of having an EAP (1981). Success rates of helping

employees in these companies were reported as being between 70% and 85%. Although the number of controlled studies on cost savings associated with EAPs are few, a study by Hoffman and Harrison (1986) showed consistent evidence that treatment of chemically dependent employees reduced absenteeism, improved work performance, reduced utilization of medical care and resulted in less emotional distress that might adversely affect on-the-job effectiveness and relationships with others. Certainly, these results will both save dollars for employers and increase effectiveness.

The EAP in which this study was conducted is very similar to most other EAPs. Functions include: problem assessment, short-term counseling, referral, follow-up care, management consultation and training about personal problems and preventive educational programs. Meyers (1984) proposes standards by which EAPs should be measured and the EAP in this study meets those standards. These guidelines cover the following areas: program policy statement, rules for program records and program referral procedures.

A significant amount of mental health services are now being delivered by or accessed through EAPs. Brayfield (1971), through his research, has acknowledged that industry provides a fertile field for research in the area of human behavior. EAPs provide a tremendous opportunity for research with a significant cross-section of our adult population.

Most of the research in the area of counseling, psychotherapy and the treatment of emotional or personal problems has been conducted on college campuses, in psychiatric hospitals or in mental health settings. Research in these settings is limited, oftentimes, to certain age groups, more serious psychiatric problems or studies with small populations. EAPs provide access to a significant number and wide variety of subjects with a full-range of personal problems. Hopefully, this and other empirical studies will open the door for future research in this area.

Brief Therapy

Most EAPs are limited to problem assessment, referral and short-term counseling. The focus of this study is on predictors of outcome in short-term counseling interventions. Therefore, it is important to establish a firm support for the effectiveness of brief therapy or short-term counseling.

The following are reasons for the emphasis on brief treatment methods today: "clients are looking for problem resolution and not personality overhaul, and brief treatments seem to be as successful as longer term treatment" (Koss et al., 1986, p. 60). Brief treatment is a much more active approach to therapy.

According to Koss et al., (1986), "being active means talking more, keeping the therapy focused, making interpretations, offering support and guidance, formulating plans of action for the client to follow, assigning homework, involving significant others, teaching problem solving, using adjunctive aids to therapy such as self-help organizations and encouraging a constructive life philosophy" (p. 61). They also listed the following technical characteristics of brief psychotherapies:

1. Limited time
2. Limited goals
3. Maintenance of focus
4. High therapist activity
5. Prompt intervention

Due to the nature of short-term counseling, it is essential to have clearly defined goals. Armstrong, Yasuna and Hartly (1981) state that the aim of brief psychotherapy should be to accomplish one objective in a highly structured approach. However, findings from one study suggested that brief psychotherapeutic treatment was insufficient to stabilize the functioning of individuals with severe character disorders who had recently experienced the death of a parent (Horowitz et al., 1986). Presence of the character disorders compounded by the death of a parent

evidently provided therapeutic demands that were too great for a brief therapeutic approach. Heiberg (1976/1977) used criteria developed to determine appropriateness of short-term anxiety-provoking psychotherapy and found that only 10% of inpatients should be offered short-term treatment. If Heiberg's criteria are reasonable, it appears that singleness of purpose is important in brief psychotherapy. Complex emotional problems seem to require more extensive treatment. Rosen (1979) used brief psychotherapy with situations involving the impairment of interpersonal relationships or problems in role functioning. Treatment was limited to a maximum of ten, forty-five minute sessions. With a singular focus for treatment, Rosen found brief psychotherapy to be effective except with patients who were evaluated as having limited capacity to change. This indicates that certain patient characteristics might impact the effectiveness of brief psychotherapy. Research by Horowitz et al., (1984) supported this conclusion. Although they found that demographic variables were not generally good predictors of outcome, they discovered that certain patient variables were good predictors of outcome. Patients who had high ratings on developmental level of self-concept or had a history of good interpersonal relationships were more successful in time-limited dynamic psychotherapy. From

this research, it seems that brief psychotherapy is more successful with patients who are effective in some areas of their lives.

The effectiveness of brief psychotherapy has been documented by numerous other studies and a few will be cited here to illustrate the breadth of problems for which this treatment approach is appropriate. Patterson, Levene and Breger (1984) evaluated both brief behavior modification and brief psychoanalytic approaches with a variety of emotional problems presented at an outpatient psychiatric clinic. The authors found both approaches to be successful according to client evaluation at a one-year follow-up. Woodward, Santa-Barbara, Levin and Epstein (1978) found that 64% of the clients who were treated with brief family therapy were satisfied with the services they received. Despite some discrepancies, there was a direct relationship between client satisfaction and other outcome measures that were obtained at a six-month follow-up. The outcome measures included: closure status, change in treatment, therapist's prognosis, feeling regarding original problems, recidivism and goal attainment. Fisher (1984) provided support for the effectiveness of brief treatment in producing more than temporary improvement in a child clinic sample. In this research, some of the clients were treated with explicit time limits (e.g., maximum of six sessions) and he concluded

that explicit time limits did not contribute to increased therapeutic effectiveness. However, he did point out that time limited therapy can shorten the length of therapy, apparently without diminishing effectiveness. Bierenbaum, Nichols and Schwartz (1976) used brief emotive psychotherapy to treat a group of patients with the following diagnoses: neurotic, personality disorder and transient situational. They found that positive outcomes resulted after 4 to 10 hours of emotional catharsis. Even though Greenwald (1979) found that more positive outcomes were realized with therapy of longer length, it appears that brief therapy is sufficient in many cases.

Leibovich (1983) proposed the use of short-term integrative psychotherapy with borderline patients which is not an easy population with which to work. In his paper, Leibovich stresses that a clear rationale must be used in determining when to use a short-term approach. In making this decision, aspects of the specific brief therapeutic procedure and patient symptomatology and characterological manifestations should be considered. With accurate diagnosis, short-term integrative psychotherapy characterized by a structured, stable, consistent, empathetic and focus-oriented therapist-patient relationship can be effective in helping borderlines deal more realistically with their world. Horowitz et al., (1984)

found brief psychotherapy to be effective in helping patients who were going through the bereavement process.

The research on brief psychotherapy indicates that it is effective in helping individuals deal with a variety of personal problems with the exception of severe emotional disturbances. However, the research also indicates that treatment must have a clear focus and care should be taken in selection of candidates for brief therapy. In selection of candidates, the better candidates are those with a good self-concept, good interpersonal functioning and competence in some area of their lives.

Interaction of Diagnosis and Treatment

The interaction of problem diagnosis and type of treatment seems to have an impact on the success of treatment. In other words, one type of treatment might be more efficacious for a specific type of problem. The difficulty, of course, is making an accurate diagnosis and knowing which treatment is most appropriate for the problem. In this section, a few studies will be cited to illustrate how the interaction between diagnosis and treatment must be addressed in any consideration of treatment outcome.

Weismann, Prugoff, DiMascio, Neu, Goklaneym and Klerman (1979) studied the relative efficacy of antidepressant treatment and psychotherapy in the treatment of depression.

They found that each form of treatment was equally effective. Both were more effective than a control group of non-scheduled treatment. The question raised by their research is: would patients who did not respond well to one of the two active treatments possibly respond to the other? Prugoff, Weismann and Klerman (1980) addressed this issue in a study with patients who were diagnosed as suffering from situational or endogenous depression. Patients with each diagnosis were assigned to one of three treatment groups. The treatment groups included psychotherapy, antidepressant medication and a combination of both. The authors found that patients with both diagnoses responded to the combined treatment. Patients who were diagnosed as situationally depressed, responded positively to both psychotherapy and medication. Patients with the diagnosis of endogenous depression, responded only to antidepressant medication. These results indicate that, when endogenous depression is present, antidepressants should be included in treatment. This will not insure success, but it will enhance the probability of success. This study indicates that success in treatment is affected by the appropriateness of treatment. McLean and Hakstian (1979) confirmed this by citing conclusions from other studies that verbal and problem-solving type therapies are more effective in helping depressed patients with personal

and social adjustment problems. Antidepressant medication was more effective with patients experiencing a lot of symptomatology.

In the research by Nigl and Weiss (1976), the interaction of diagnosis and treatment with a group of subjects presenting a wider range of problems was studied. Presenting problems included: anxiety, depression, interpersonal difficulties and academic problems. Brief psychotherapy was used with all presenting problems and was effective with all presenting problems. This would indicate that brief psychotherapy is effective with a wide variety of less severe emotional disturbances.

Rounsaville, Dolinsky, Babor and Meyer (1987) identified an interesting phenomenon in the interaction of diagnosis and treatment. In the treatment of primary alcoholism, the authors found that males with a history of depression or other disorders experienced poorer outcomes than males with no disorder other than alcoholism. Ironically, just the reverse was true with females. Females treated for alcoholism suffered worse outcomes when they had not experienced depression or any other disorder. With males, it seems that complexity of diagnosis impacts success in treatment. However, since the reverse was true with females, patient variables such as sex evidently affects the success of treatment. These patient variables which might

predict success of treatment will be addressed in the next section.

Diagnosis in terms of problem severity also seems to have an effect on the outcome of treatment. Horowitz et al., (1986) found that brief psychotherapeutic treatment was insufficient to raise or stabilize the functioning of patients suffering from pathological grief where severe character disorders also were present. Hovne (1984) found that patients experiencing lower levels of distress at the initiation of treatment were more likely to experience a successful outcome. McLean and Hakstian (1979) also found that psychotherapy was less successful with more serious cases of depression.

Utilizing diagnosis in the determination of which treatment has the highest probability of success appears to have a good deal of merit. However, this approach is not without its problems. Spitzer, Endicott and Rolins (1978) used different professionals to diagnose subjects using research diagnostic criteria. The study indicated some difficulty in clearly distinguishing between endogenous versus situational depressive disorder. Of the subjects who had primary depressive disorder, 64% also met the criteria for endogenous depression and 51% met criteria for situational depression. Therefore, enthusiasm for basing treatment simply on diagnosis must be tempered by the

complexity of making an accurate diagnosis. Other factors which must be considered are the individual characteristics of the patient. This will be reviewed in the next section.

Predictors of Treatment Outcome

Numerous patient variables have been evaluated as predictors of outcome in various types of psychotherapeutic interventions with a variety of emotional disturbances. The focus of this section will be on a review of literature related to the predictor variables that will be evaluated in this research. It is impossible to evaluate every patient variable impacting the outcome of psychotherapy. However, this research will evaluate a significant number of variables in comparison to most studies which were reviewed.

Through the years, sociodemographic variables (e.g., age, sex, race, social class and marital status) have been proposed as good predictors of psychotherapeutic outcome. However, the research does not consistently support this position. In fact, DiMascio, Weismann, Prugoff, Neu, Zwilling and Klerman (1979) concluded that sociodemographic factors are not predictors of outcome in treatment.

Since this study will evaluate several sociodemographic variables, literature related to those variables will be reviewed. In a study by Rosen, Klein and Gittleman-Klein (1971), age of first psychiatric treatment for schizophrenia

was related to rehospitalization for additional treatment. Younger patients were more likely to be rehospitalized than older patients. Therefore, treatment was more successful for older patients. Harrow, Tucker and Bromet (1969) also found that age was related to the length of hospitalization of schizophrenic patients, with younger patients staying in the hospital longer. Gonzales, Lewinsohn and Clarke (1985) studied predictors of relapse in the treatment of adults suffering from unipolar depression. After being treated with twenty-four hours of cognitive-behavioral psychotherapy, patients were evaluated again in approximately two years. The authors found that early age at entry into treatment predicted relapse. In a conflicting study, McLean and Hakstian (1978) found that age was not a predictor of successful treatment with clinically depressed patients. The research on age as a predictor appears to be non-conclusive.

The research by Harrow et al., (1969) indicated that sex of the patients was not related to length of hospitalization for psychiatric treatment of schizophrenic patients. Glick and Zigler (1986) confirmed these findings in a study with patients diagnosed as affective disorder, neurotic and personality disorder. Sex had no relationship to length of hospitalization. In a study with patients treated for alcoholism, Siegel, Alexander and Lin (1984)

found that sex had no impact on readmission to the hospital. The evidence seems to indicate that the sex of a patient does not impact the outcome of treatment. In spite of the conflicting findings by Rounsaville et al., (1987) that were previously cited, the conclusion of most research is that the sex of the subject does not affect outcome.

Social class is a difficult sociodemographic variable to evaluate because of the subjective nature of the variable and the variety of ways it is defined. The following studies indicated social class was not a good predictor of treatment outcome: Harrow et al., (1969); Siegel et al., (1984); and, Gonzales et al., (1985). However, Pilkonis et al., (1984) found patients from a lower class experienced poorer outcomes with psychotherapy. Research by Turner and Gartrell (1978) found that social class affected outcome of treatment as measured by length of hospitalization. However, they concluded by controlling social competence and social class that competence had stronger independent predictive value. This raises the question of whether social class might be reflective of some other predictor variable. Research by Lorion (1973) raised an important question concerning why social class might be predictive. Lorion found that socioeconomic status was a predictor of acceptance for and duration of individual psychotherapy. This would indicate that people from higher social classes

may only be more successful in treatment because they receive better treatment. Social class presents several problems when used as a predictor. These problems include contamination by other factors, difficulty in measuring and its effect on treatment received.

As with other sociodemographic variables, differing results are reported concerning the predictive power of marital status. In spite of some conflicting results, marital status has the strongest support of the sociodemographic variables as a predictor of treatment outcome. Gonzales et al., (1985) concluded that marital status did not predict relapse of patients treated for unipolar depression. The research by Turner and Gartrell (1978) also indicated that marital status did not relate to the time of treatment for schizophrenic patients. They concluded that the correlation of marital status to treatment outcome occurs because varying marital status is reflective of important differences in social competence which is a significant predictor of outcome. Social competence will be discussed more thoroughly later. Studies supporting marital status as a predictor of treatment outcome include: Free, Green, Grace, Chernus and Whitman (1985); Rosen, Klein and Gittleman-Klein (1971); and, Harrow et al., (1969). Two other studies supported the predictive power of marital status in psychotherapy and also made some

interesting observations concerning why marital status is a good predictor. Gittleman-Klein and Klein (1968) concluded from their review of literature that marital status is the best sociodemographic predictor of outcome among patients suffering from schizophrenia. Theories cited to explain this indicate that people who are married are less likely to have premorbid asocial schizoid personality, and married patients have more external support from family for their reintegration into the community. These authors conclude that the prognostic value of marital status in this study is a practical one. They believe that the real prognostic value of marital status is a epiphenomenon of premorbid social functioning. Sherman, Moseley, Ging and Bookbinder (1964) indicated that marital status had prognostic value as a result of its relationship to most other predictors such as: presence of spouse in community offering support for recovery, socioeconomic pressure and selection process which ascribes a higher level of ego functioning to the married patient.

Research indicates that the relationship between education and treatment outcome is negligible at best. Turner and Zabo (1968) found a slight but insignificant correlation between the educational level of patients and several outcome measures. Harrow et al., (1969) confirmed this finding when they discovered that neither educational

level nor intelligence predicted outcome as measured by length of inpatient psychiatric treatment.

Occupational level has not been studied to a significant degree as a predictor of treatment outcome. Turner and Gartrell (1978) found occupational level to have no predictive power independent of its combination with other variables to form a social competence factor. Turner and Zabo (1968) identified a weak relationship between occupational level and treatment outcome as measured by length of hospitalization. Occupational level was slightly weaker than work performance and marital status but much stronger than educational level. The relationship between work performance and outcome was confirmed by Turner and Gartrell. Patients who received inpatient treatment were more likely to be readmitted to the hospital if their work performance was poor.

In relation to income level, Turner and Gartrell (1978) found this variable to be ineffective as a predictor of outcome. However, other researchers have found a strong relationship. Greenwald (1979) found that reported outcome of treatment was positive with patients who had higher income levels. Judd (1980) found income to be a significant predictor in the successful treatment of alcoholism. In interpreting the value of income level as a predictor, the research by Lorion (1973) must be considered. Lorion found

income level to be a predictor of successful outcome. However, successful outcome seems to have less to do with the patient variable of income level than the type and effectiveness of treatment higher income patients receive due to their socioeconomic status.

Quality of social relationships has some support as a good predictor of treatment outcome. In the research by McLean and Hakstians (1978) on the relative efficacy of four types of therapy in the treatment of clinical depression, they found the quality of social relationships to be a good predictor of outcome. Rosen et al., (1971) found that patients with good premorbid social adjustment were less likely to be hospitalized after inpatient psychiatric treatment. The premorbid social adjustment measure included the following variables: extent of patient's withdrawal, adequacy of peer relationships and range of interests. Gittleman-Klein and Klein (1968), in their study of the prognostic value of marital status, concluded that much of the predictive power of marital status in psychiatric treatment is derived from the high incidence of asocial traits in the personalities of single adults. Thus, the strength of marital status as a predictor of outcome might be a function of premorbid social functioning. This lends further support for the impact of social functioning on successful treatment. Haley (1985) found that psychiatric patients had fewer social

skills than a control group of non-psychiatric patients. This indicates that deficits in social skills may predispose individuals to a broad variety of psychopathologies.

The ability of the therapist to respond with empathy is stressed in a therapeutic setting. Strupp (1980) pointed out that the therapist's ability to create an empathetic environment contributes significantly to a positive outcome. Free et al., (1985) found that patient ratings of empathy were significantly correlated to the two outcome measures of hostility and interpersonal relationships. These researchers also found that therapeutic empathy was rated in the following manner: highest by patients, second highest by the therapists and lowest by the supervisors. Their data also indicated that the ratings of the supervisors were heavily influenced by the therapist's interaction with the supervisors. This research supports the position that the best person to rate therapists' empathy is the patient, to whom the empathy matters most.

Very little research has been done concerning who refers patients for psychotherapy and the impact that the referral source might have on treatment outcome. Beaumont and Allsop (1984) found patients treated through an industrial alcoholism program had more successful treatment outcomes when they were referred by supervision. The authors proposed

several reasons for these results. First, the average age of successes was forty-seven and the average age of failures was thirty-seven. The self-referrals were typically younger employees with lesser company service. They also concluded that potential coercion associated with a supervisory referral might motivate patients in certain settings such as an industrial environment.

A patient variable which would seem to have inherent significance for treatment is self-concept or self-efficacy. These terms will be used interchangeably as the literature is reviewed. The basic concept captured by these terms is the perception that individuals have of their personal effectiveness in various areas of their lives. Self-concept seems to be a powerful predictor of treatment outcome. Horowitz et al., (1984) found that bereaved patients who had a higher rating on the developmental level of self-concept showed a more favorable outcome on two measures of success. The authors also concluded that patients with a history of good interpersonal relationships are better candidates for time-limited psychotherapy. Coelho (1984) found rating of self-efficacy to be a good predictor of short-term success in the treatment of individuals for smoking cessation. Bandura, Adams, Hardy and Howell (1980) found that an individual's perception of self-efficacy predicted whether the subject was more likely to change to a more effective

coping behavior in dealing with agoraphobia (fear of snakes). Locke, Frederick, Lee and Bobko (1984) looked at self-efficacy in a non-therapeutic setting but their findings have relevance to the treatment process. Treatment involved goal setting and task performance and this research examined how self-efficacy affected these factors. The authors found that higher self-efficacy of subjects predicted more effective goal setting and task performance. Bandura (1982) points out that persons with strong perception of self-efficacy are better able to focus their attention and effort on a given situation without being distracted by obstacles. Betz and Hackett (1987) found that perceived efficacy determined subjects' ability to respond effectively to situations that promote career advancement. Lack of competence and perceived self-efficacy reduced the likelihood of effective behavior. In a study by Neimeyer and Metzler (1987), subjects with a high level of self-efficacy in the area of career decision-making were involved in vocational systems that were highly integrated and differentiated. This research, from both the psychotherapeutic and educational perspective, indicates that self-concept and self-efficacy are highly related to how individuals deal with a variety of situations. A high level of self-efficacy predicts success in resolving problems, performing tasks and making good decisions.

Social Competence

Research for a prognostic tool to assist in predicting outcome in psychotherapy is probably as old as psychotherapy itself. Much of this research is conducted in a "hit or miss" fashion in the hope of identifying a variable that will assist the therapist in providing successful treatment to an individual client. Much of this research is conducted without a sound theoretical framework. Simply examining random biographical variables without a conceptual foundation lacks direction and is not likely to yield meaningful results.

Zigler and Phillips (1961) developed a very sound theoretical approach to predicting treatment outcome. They suggested a developmental approach which dealt with the issue of personal and social maturity. They believed that "the individual progresses through successive stages of maturity and that individuals differ in the final level of maturation attained" (p. 265). Individual differences in maturation depend on how the individual handles the complex series of tasks that society presents to them. If the individual follows a normal pattern of adaptation, they approach personal and social maturity. However, if they resolve the tasks inappropriately, then one possible result might be various forms of psychopathology.

Zigler and Phillips (1961) recognized the difficulty in constructing a comprehensive index of maturity. However, they did develop a very practical measure that they believed captured factors which were important elements of personal and social maturity. This measure, which they called social competence, combined the variables of age, intelligence, education, occupational level, employment history and marital status. They combined these variables into a composite score for social competence as shown in Table 1. Having defined social competence, Zigler and Phillips (1961) hypothesized that "a more mature person as defined by social competence can more adequately utilize the opportunities to change afforded by a psychotherapeutic relationship" (p. 268).

In testing the above hypothesis, they found that patients who were hospitalized for some type of psychiatric treatment were more likely to be rehospitalized and have longer periods of hospitalization when they were low in social competence. They concluded that there was a positive relationship between premorbid social competence and prognosis and incidence of mental disorders. This confirmed their hypothesis and gave credibility to the social competence measure.

Table 1. Scoring for Variables Contribution to Social Competence.

	Point Values Per Various Level		
Characteristic	0	1	2
Age	24 and below	25-44	45 and above
Intelligence (I.Q.)	84 or less	85-115	116 and above
Education	Through grade school	Grade school through high school	Some college
Occupation	Unskilled/ semi-skilled	Skilled and service	Clerical/ sales, professional or managerial
Employment History	Unemployed	Seasonal, Fluctuating, part-time employment	Regularly employed
Marital Status	Single	Separated, divorced, remarried or widowed	Single marriage

Several studies will be cited that support Zigler and Phillip's theory and research. Glick and Zigler (1986) studied patients diagnosed as affective disorder, neurotic and personality disorder and found that patients with high social competence had shorter initial hospitalizations. Harrow et al., (1969) studied the relationship of social competence and the outcome of treatment for schizophrenic patients. They found that patients who were more socially competent did not require as much treatment in terms of length of hospitalization. In very similar studies, Turner and Zabo (1968) and Turner and Gartrell (1978) confirmed the results just cited.

Other research on social competence indicates that it has relevance to pathology and treatment beyond its usefulness as a predictor of treatment outcome. Beckfield (1985) found that subjects believed to be at high risk for psychosis rated lower on the social competence factor. This indicates that individuals who are less socially competent are at higher risks for developing a psychopathology. Marziali (1984) found that social adjustment influenced the patient's involvement in the treatment relationships which would certainly impact the effectiveness of treatment.

Turner and Gartrell (1978) concluded that the individual components of social competence have significance only because they reflect important differences in the social competence of the individual. This raises the question of whether social competence is a result of social selection or social causation. Social selection says that people with less maturity and lower competence make bad decisions which are reflected in poorer results in the factors contributing to social competence. Social causation says that the different statuses on each of the components of social competence result due to the individual being associated with social systems that either enhance or lower the social competence of the individual. Understanding whether the development of social competence is a result of selection or causation is important from a developmental perspective. However, from a psychotherapeutic perspective social competence is important because it "plays a major role in determining: whether a person might ever become or be defined as mentally ill, the type of symptoms that are likely to be expressed and, thus, the character of the disorder and the probability of recovery or improvement" (Turner and Zabo, 1968, p. 42).

Since social competence impacts pathology, symptoms and outcome of treatment, improvement of social competence would

seem to be a desirable treatment goal. Pilkonis et al., (1984) suggested developing enhancement treatment approaches for social competence with "high-risk" groups. In Turner and Gartrell's (1978) significant study on social competence, they reached a similar conclusion. They believed their findings supported the enhancement of competence as an important and legitimate therapeutic goal. They indicated that, from the perspective of desired outcome, enhancing social competence is as important as addressing the dynamics underlying symptom expression. Botvin, Baker, Botvin, Filazzola and Millman (1984) found that enhancing the social competence of junior high students reduced alcohol misuse. Social competence was increased by teaching the following psychosocial skills: decision-making, techniques for coping with anxiety, social skills including assertiveness and self-improvement. More research is needed to determine how enhancement of social competence through treatment would impact the outcome of treatment. Since premorbid social competence is such a strong predictor of treatment outcome, addressing social competence in treatment seems to have merit.

Another measure will be developed and evaluated in this research. The measure will be defined as career competence and will include the following factors: job performance, educational level and occupational/income level. Each of

these variables are measures of competency in career preparation and performance. Career competency has not been evaluated previously as a predictor of treatment outcome. However, with the evolution of EAPs, this measure could have particular significance in the workplace in relation to diagnosis and treatment. Erfurt and Foote (1986) noted that the workplace is an ideal setting to establish proactive delivery systems for mental health care. EAPs in the workplace could utilize career competency to determine what individuals would benefit from treatment if career competency predicts outcome. For those deficient in career competency, enhancement programs could be offered to improve the individual's ability to respond positively to treatment.

Social Competence as Treatment Goal

Radin (1979) indicated that effectiveness of treatment cannot be evaluated unless goals have been established. Ryle (1980) indicated the major goals of therapy for the patient are to change ineffective behavior, develop better ways of thinking and eliminate problem symptoms. In approaching treatment from the standpoint of enhancing social competence or self-efficacy, Williams, Dooseman and Kleinfield (1984) proposed that the therapist has an important role in structuring mastery experiences in ways that will have a major impact on self-efficacy

Bandura has been the leader in the field of self-efficacy. In a summary of some of his findings on self-efficacy, Bandura (1982) pointed out the following conclusions:

1. "Those who judge themselves inefficacious in coping with environmental demands dwell on their personal deficiencies and imagine potential difficulties as more formidable than they really are" (p. 123).

2. "Persons who have a strong sense of efficacy deploy their attention and effort to the demands of the situation and are spurred to greater effort by obstacles" (p. 123).

3. "Perceived efficacy gives rise to progressively higher performance accomplishments" (p. 124).

4. "Self-percepts of efficacy often surpass final performance as predictors of future performance" (p. 125).

5. "Experiences that increase coping efficacy diminishes fear arousal and increase ability to perform dreaded activities" (p. 136).

The issue addressed in this section is whether this powerful factor of self-efficacy or social competence can be enhanced through treatment, and if so, what impact does an increase in self-efficacy have on treatment outcome. Bandura (1986) theorized that self-efficacy enables the individual to organize cognitive, social and behavioral subskills into integrated action that accomplishes a variety of purposes.

He even believed that the perception of self-efficacy by the individual was a significant determinant of performance which operates independent of whether the underlying skills are present. If these beliefs are true, enhancement of self-efficacy should certainly improve the probability of achieving other therapeutic goals.

Nezu (1986) used development of problem-solving skills in the treatment of depression. He found that individuals receiving this treatment experienced a substantial reduction in depression which was maintained over a six-month follow-up period. The increase in problem-solving skills also changed the locus of control from external to internal. Individuals with a strong sense of self-efficacy are more likely to have an internal locus of control (Bandura, 1986).

Williams et al., (1984) evaluated two approaches in the treatment of phobias. One approach was exposure where the subjects were exposed to increasing levels of fear producing stimuli. The second approach was to develop mastery skills in responding to the fear producing stimuli. The mastery oriented approach, which basically developed self-efficacy in responding to a fear producing situation, was more effective in reducing severe and intractable phobias.

Bandura et al., (1980) treated subjects suffering from agoraphobia (fear of snakes) by attempting to improve their self-efficacy. The treatment involved enactive and vicarious

modeling, changing cognitive interpretation of the fear producing situation and developing coping behaviors for the emotional response. The treatment increased subjects' self-percepts of efficacy which brought about positive changes in coping behavior.

Rude (1986) used assertiveness training and cognitive treatment to modify the thinking and interpersonal skills of depressed patients. This social skills training provided the depressed person with a range of more effective response options which helped them eliminate negative outcomes and produce more constructive events. Depression, as measured by the Beck inventory, was reduced among the patients receiving this treatment.

In the study by Botvin et al., (1984) which was previously cited, improving psychosocial skills like decision-making, techniques for coping with anxiety, social skills, assertiveness and self-improvement strategies reduced alcohol misuse among junior high students.

Hawkins, Catalano and Wells (1986) used a social skills, interpersonal problem-solving and social network development intervention to treat chemical dependency. This approach brought about an improvement in patients' performance in role-play situations involving avoidance of drug use, coping with relapse, social interaction, solving interpersonal problems and managing stress. No follow-up

was done to see if these more effective behaviors actually prevented relapse.

The research cited seems to indicate that self-efficacy and social competence can be enhanced in treatment and when those variables are enhanced, treatment appears to be more successful. These findings have favorable implications for diagnosis, determination of treatment and preventive programs that might help individuals avoid the development of more serious personal problems.

If the enhancement of social competence is a treatment goal, then it is important to identify knowledge, skills and behaviors that contribute to a person being socially competent. The research cited defined certain personal characteristics that probably contribute to self-efficacy and social competence but no systematic effort has been made to identify competence factors and test those in treatment.

Career Development

If career competence proves to be as effective as social competence in predicting treatment outcome, then career development takes on added significance. Career development activities might be helpful to individuals in addressing the personal problems in their lives. By focusing attention on competency in their career, individuals will likely develop traits that are helpful in the treatment setting.

Otte and Groepper (1984) described the similarities that exist between EAP and the career development function. Both functions overlap in ways and are likely to refer individuals to the other. Secondly, they both should have significant input into the formulation of human resources policy. These similarities create a sound basis for an EAP to help in assessing career competence and using that for treatment purposes as well as career enhancement purposes.

The purpose of career development programs in private organizations is "to match the individual's needs and interests with organizational opportunities and requirements so that both can prosper" (Gerstein and Amos, 1986, p. 211). In addition to this primary purpose, these authors indicate that career development should also enhance the self-worth and self-esteem of employees while increasing their opportunities for job advancement within or outside that organization. Some resulting benefits for the organization are improved employee productivity, lower job turnover and a better image of the organization by employees. These objectives and benefits are very similar to those of an EAP. Therefore, a linking of these two functions certainly makes sense.

This interaction of self-efficacy and career development was confirmed in the research by Neimeyer and Metzler (1987). They found that individuals functioning in

highly integrated and differentiated vocational systems had higher self-efficacy. So self-efficacy does appear to be enhanced for people who have gone through significant career development activities.

Measures of Treatment Outcome

Client evaluation of outcome and employee absenteeism will be used to measure the outcome of the brief psychotherapy used in this study. Client evaluation is frequently used while level of absenteeism is seldom used.

Koss et al., (1986) note that many studies supporting the effectiveness of brief psychotherapy use client and therapist ratings as the only outcome criteria. The research by Horowitz et al., (1986) indicated that the outcome of brief psychotherapy is viewed differently by the patient, the therapist, clinical judges and significant others. However, all four evaluators judged the outcome to be successful from the standpoint of symptom relief. They point out that the primary objective of the patient is symptom relief. Therefore, from the standpoint of patient's goal for treatment, the evaluations of all the evaluators were the same. Clinicians and therapists differed from the patients in evaluating adaptive functioning which is rather subjective in nature. Free et al., (1985) points out that adaptive functioning is related to the resolution of

intrapsychic conflict which is probably more of a therapist's goal. In rating the process variable of therapist empathy in counseling versus an outcome variable, they found that clients rated therapist empathy highest with the therapists' rating of themselves being the next highest and the lowest rating being given by the supervisors. However, when they correlated the empathy ratings with two measures of outcome, they found that the patients' ratings had the most significant correlation. This would indicate that client ratings of outcome are probably as, if not more, effective as the ratings of the therapist or clinical observer.

Malan (1976) has been one of the leading researchers in the field of validating and evaluating the effectiveness of brief psychotherapy. He developed a very simple but effective approach to evaluating the outcome of treatment. He used a single question concerning outcome with a five point scale to measure the evaluator's response. He and others have utilized this five point scale for subject, therapist and observers evaluation of outcome (Marziali, 1984). The scale, as shown in Table 2, has proven to be both a reliable and valid measure of outcome.

Table 2. Rating Scale for Treatment Outcome

Points	Treatment Outcome
0	Essentially unchanged
1	Slightly to moderately improved
2	Improved
3	Much improved
4	Recovered

As previously indicated, one of the major business reasons for companies implementing EAPs is to reduce employee absenteeism. Therefore, reduction in absenteeism is a measure of EAP effectiveness used by companies. Even though absenteeism has not been used extensively as a measure of successful counseling interventions, other related research provides some findings that can be used as justification for its use.

Since the major cause of absenteeism is illness, it is important to establish a link between emotional disturbances and physical illness. Sifneos (1984) indicated that 50% of all patients who see a family physician for some type of physical problem were diagnosed as having a psychological disturbance for which the physical problem was a symptom. In his research, he found that patients who have better psychotherapeutic outcomes experienced a reduction in their

physical symptoms. The research by Keefe, Wilkins, Cooke, Crisson and Muhlbaier (1986) also established this link between physical symptomatology and emotional disturbance. They found that a significant proportion of each measure of physical pain was predicted by severity of depression.

Due to the relationship between emotional disturbances and physical problems, it makes sense that reduction of physical problems is an appropriate treatment goal. Ryle (1980) cited elimination of physical symptoms as one of the aims of therapy. In using this as one of the treatment goals for this study, patients experienced a reduction in physical symptoms. This study plus the work by Sifneos (1984) support reduction of physical problems as a treatment goal and a measure of treatment outcome.

With this relationship between emotional disturbances and physical problems, it seems reasonable to use absenteeism as a measure of successful EAP counseling outcome since the major cause of absenteeism is illness. A study by Brayfield (1971) found frequency of employee absenteeism to be a reliable criterion of outcome. Although amount of absenteeism was not found to be reliable in Brayfield's research, it will be used in this study due to its significance as a measure of EAP success. The fact that little research has been done in evaluating this measure is another reason for using it. By correlating patient

evaluation and amount of absenteeism, additional data will be generated to evaluate the effectiveness of absenteeism as a measure.

The review of literature has established the roles of EAPs as deliverers of short-term counseling in the workplace. The effectiveness of short-term counseling in helping individuals resolve personal problems has been established through a review of literature on short-term psychotherapy. The interaction of diagnosis, treatment and outcome was established, and its importance in providing short-term counseling was described. A review of numerous predictors of treatment outcome was conducted to determine variables that help in diagnosis and determination of treatment. Many of these variables will be tested to determine their usefulness as a diagnostic tool within an EAP.

CHAPTER III

RESEARCH METHODS AND PROCEDURES

Introduction

This chapter presents (1) the procedure for selection of subjects, (2) the description of treatment, (3) the research procedures for data collection, (4) the design of the study, (5) the statistical procedures and (6) the sources of bias.

Procedure for Selection of Subjects

The subjects used in this study were employees who sought counseling assistance from a company's EAP. The following criteria and rationale were used to identify subjects to be included in the study:

1. The subjects were counselees who were employees and were employed by the subject company at the time of this study. This insured that the attendance data used as a measure of counseling outcome was available on each subject. This also facilitated the collection of certain data from the subjects through the use of a questionnaire (Appendix 1).

2. The subjects were counselees who were employees and who received counseling from the author of this study and no other treatment resource for the two years following initial EAP counseling. By limiting the subject population in this manner, it was possible to control for treatment, since treatment was provided by the same counselor using the same brief psychotherapeutic approach.
3. Counselees who met the first two criteria were asked to complete a questionnaire which included questions about client characteristics, the counseling process and counseling outcome. Only counselees who returned the questionnaire and gave a negative response to question number six were included in the study. The questionnaire was used to gather certain information about client and counselor characteristics which were evaluated as predictors of counseling outcome. It also collected counselees' evaluation of counseling which was utilized as a measure of outcome for counseling.

Description of Treatment

The treatment provided for the subjects in this study was a short-term counseling intervention. The number of

sessions ranged from one to twenty-five. Sessions were approximately fifty minutes in length.

A cognitive-behavioral approach was used for the counseling conducted in this study. From a theoretical standpoint, this approach is grounded in the link between thoughts, feelings and actions. Psychological disorders or personal problems are thought to result from maladaptive cognitive processes and behavior. In order to treat emotional disturbances and daily problems in living, the focus of counseling was on the modification of fundamental irrational assumptions and/or maladaptive behaviors. The initial assessment in the counseling process determined whether the presenting problem was caused by irrational beliefs, maladaptive behaviors or both.

The counselees in this study were those who were determined to have a problem appropriate for a brief counseling approach. Counselees who required long-term psychotherapy, medication or inpatient treatment were referred to community treatment professionals and were not included in this study. The initial part of the counseling for subjects in this study involved an appropriate expression of feelings and then an assessment of what irrational beliefs and/or maladaptive behaviors might be contributing to their emotional disturbance or problem.

If the counselee had dysfunctional or distorted cognitive functioning, the counseling involved teaching counselees to challenge and change negative automatic thoughts and to replace them with more rational and functional responses. Another type of cognitive dysfunctioning might be poor approaches to solving problems. In this case, the counselor helped the client develop better problem-solving or decision-making skills.

In treating counselees whose problem was associated with a maladaptive behavior, a number of approaches to modifying behavior were utilized. Some of these approaches included: assertiveness training, role-playing problem situations, relaxation training, developing a support system and experimenting with new, more adaptive behaviors.

Treatment involved a high level of counselor involvement in helping the counselee identify more functional beliefs and more adaptive behaviors and the utilization of self-teach courses, audio-tapes, books, self-help groups and various homework assignments. Appendices 3 and 4 have excerpts from counseling notes that describe counseling interventions used to help counselees develop more effective beliefs and behaviors.

Counseling was terminated either at the counselee's discretion or when the counselor and counselee agreed that the counselee had a grasp of the new beliefs and behaviors

which would reduce the emotional distress or resolve the counselee's problem.

Research Procedures for Data Collection

The collection of data for this study involved two procedures. Some of the data were collected through the company's personnel records. Access to these records is granted on a need to know basis, and EAP personnel are approved to utilize this data. Use of this personnel data for this research was approved by the company's Director of Industrial Relations. Additional data were collected through the use of a questionnaire (Appendix 1) designed for this study.

Personnel Records

Information collected for this research from personnel records included: job performance, sex, occupational/income level and attendance data. With the exception of attendance information these data were used in the study to help identify counselee characteristics that might predict the outcome of counseling. The attendance information was used as one of the measures of counseling outcome.

When each subject was contacted about participating in the study, they were told that the data from their questionnaires would be combined with personnel information

such as job level and job performance to determine what factors might be associated with counseling outcome.

The job performance variable used in this study represented a subjective evaluation of an employee's performance on the job by the supervisor of that employee. This evaluation was reviewed by several levels of management and was compared to the evaluations of other employees to determine its validity. This comparison took place among large groups of employees (approximately 400 or more). This comparison of one employee to others enabled management to insure that a given employee was evaluated fairly relative to other employees.

Supervisors who evaluated the job performance of employees received extensive training, coaching and assistance in this performance evaluation process. Each first line supervisor experienced approximately forty hours of supervisory training in which evaluation of job performance was an important component. In addition, supervisors received four to eight hours of additional training which focused specifically on the company's performance evaluation system. Each supervisor was also provided with a performance appraisal manual which describes: purpose and use of performance evaluations, performance expectations for various performance levels and mechanics of the evaluation process. Each supervisor can

refer to this manual while completing the performance evaluation. Finally, each division within the company has a personnel representative who is thoroughly trained and experienced in the performance evaluation process. This personnel representative also helped in reviewing the evaluations for consistency within the division. Since the categories determined by performance evaluations help determine rate of pay and job advancement, great effort was invested in making a necessarily subjective system as objective as possible. The definition of the system, training in the system and staff support for the system helped to insure a reasonable level of reliability.

The individual evaluation of an employee's job performance is one part of the company's overall performance appraisal process. The other part of the performance appraisal process is the appraisal interview where each employee has their performance reviewed by their supervisor including a discussion and planning of opportunities for development related to the performance appraisal interview. As can be seen, the performance evaluation is the basis for giving employees feedback about their performance and helping employees plan for their personal and career development.

There are two systems within the subject company for evaluating the job performance of employees. One system is

used to evaluate hourly roll employees working in certain operating, maintenance and laboratory jobs which are typical "blue collar" jobs. The second system is used for special roll and salaried employees who are in clerical, technician, professional and supervisory positions which are more traditional "white collar" jobs. The performance categories used in the two systems are defined in Table 3.

Table 3. Determination of Job Performance Level

Job Classification	Performance Categories Per Level			
	Level 1	Level 2	Level 3	Level 4
Hourly	US & NI	ME	OS	EX
Special & Salary	US & NI	ME & ME+	OS	EX

Note: The performance categories are defined as follows:

Unsatisfactory (US) - did not meet important requirements and expectations

Needs Improvement (NI) - must be improved to clearly meet job requirements and expectations

Meets Expectations (ME) - met all requirements and expectations

Meets Expectations Plus (ME+) - often exceeded expectations and may have sometimes been outstanding

Outstanding (OS) - consistently exceeded requirements and expectations

Exceptional (EX) - far exceeded requirements and expectations

The largest portion of employees should be evaluated as meeting expectations. Although percentages are not specified for the different performance levels, the evaluation instructions for special roll and salaried employees suggests that approximately two-thirds of all employees should be rated as either "ME" or "ME+".

For this research, performance levels three and four defined in Table 3 were combined. This resulted in the following three performance levels: not meeting expectations, meeting expectations and exceeding expectations. By limiting performance levels to these three categories, it was believed that distinctions between categories would be more reliable. Although any individual performance evaluation is given serious consideration, movement from one of these three categories to another receives an even more thorough review.

The second variable gathered from personnel records which requires elaboration here was occupational/income level. Occupational and income level were combined into one variable in this research primarily because, within the subject company, these two variables are directly related to each other. In other words, the major determinant of an employee's income is occupational level. There were two other reasons for combining occupational and income level into one factor. First, income information in the subject company is confidential and not available to the researcher.

Second, although specific income is confidential, income levels were accessible and reflect ranges of income which were sufficient for this research. The range of income within which each employee falls is determined by the nature of the work they perform. Each job within the company is assigned a job classification which is determined by the knowledge, skills and physical effort required to perform the job in addition to the importance of the job in terms of contribution and responsibility. These job classifications reflect the occupational level of each employee. The job classification also determines the earning potential of each employee by placing them in a salary range. Determination of a specific income for an employee depends on job classification, length of service with the company and the employee's performance.

The research by Zigler and Phillips (1961) defined the following three occupational levels: unskilled or semi-skilled; skilled, service and clerical; and, sales, professional and managerial.

These categories do not differentiate sufficiently at the upper end of the continuum and do not always relate to income differences. In this study, three categories were differentiated and are described in Table 4.

Table 4. Definition of Occupational/Income Levels

Occupational/ Income Level	Occupational Descriptions	Salary Range*
1	Manufacturing, crafts, laboratory and clerical jobs	$27,000 & below
2	First level supervisory and professional jobs	$27,001 - 38,000
3	Senior level professional and managerial jobs	$38,001 & above

*These salary rates are shown to illustrate relative differences and do not necessarily reflect actual company experience.

The occupational/income levels described in Table 4 provide three levels that are very distinct in terms of occupational levels and represent significantly different income levels. This type of differentiation helped in testing this variable for its impact on counseling outcome.

The final information collected from the personnel records was the attendance record for each subject in the study. Number of days absent was collected for the two years prior to receiving counseling, the year counseling was initiated, and the two years following the initiation of counseling. The use of this absenteeism data as a measure of counseling outcome will be described later in this chapter.

Survey of Subjects

Each subject in this study completed a questionnaire (Appendix 1) which included biographical questions about each subject and questions concerning the process and outcome of counseling.

To protect confidentiality, all subjects, each a former counselee of the author, were contacted by the author to determine if they would consider participating in the survey. They were told that the survey had the following two purposes: to assist in the ongoing process of evaluating the effectiveness of the company's EAP and to provide information for the author's doctoral research on factors contributing to successful counseling intervention. If the subject expressed a desire to participate in the study, they were sent a questionnaire (Appendix 1) along with a brief explanation of the survey (Appendix 2). These two documents were mailed to the place they specified, which was either their home or work station. The 132 subjects in this study represent those who completed and returned the questionnaire.

The questionnaire was used to collect the following biographical data on each subject: marital status, educational level, referral source, age and type and severity of the problem. These data were used or combined

with other data to define variables which might predict counseling outcome.

Question six on the questionnaire was, "did you pursue counseling with a professional therapist outside the company for the two years after you first came to EAP?" This question was included to insure that the effects of counseling through EAP was not contaminated by receiving other professional assistance subsequent to EAP counseling. Anyone receiving such assistance was excluded from the study.

Question seven was, "how would you evaluate the effectiveness of your counselor in understanding your thoughts, feelings and the problem and responding with appropriate concern while remaining objective during the counseling process?" This question was used to collect data on the counselor empathy variable. This question included the key elements of empathy identified in the Barrett-Lennard Relationship Inventory (Free et al., 1985). This inventory is composed of 16 statements about the counselor which are used to evaluate the counselor on a six-point scale. The important elements of counselor empathy addressed in this inventory are ability to understand thoughts, feelings and experiences of the counselee, ability to understand the meaning of counselee's experiences, ability to see things through the eyes of the

counselee, ability to remain detached and objective while expressing appropriate concern for counselee and ability to avoid imposing personal views on the counselee.

Question eight on the questionnaire was, "how helpful was EAP in helping you deal with your personal problem?" This question was included to determine the contribution of counseling in helping the subject with their personal problem. This question was used to assist the company to evaluate the impact of the EAP on any positive treatment outcome.

Item nine on the questionnaire was, "check the phrase that best describes the outcome of the problem for which you sought counseling." Responses to this item provided subject feedback on the outcome of therapy. This question allowed the subject to evaluate the outcome of counseling on a five-point scale developed by Malan (1976). This scale has high inter-rater reliability (Malan) when used by clinical observers. In Malan's research, subject evaluation was a valid measure when compared to specific clinical observations of treatment outcome. Marziali (1984) used this rating scale and found counselor rating of outcome to be associated with other outcome measures. Malan considered counseling to be successful if the subjects were evaluated or evaluated themselves to be improved, much improved or recovered. These evaluations resulted in a score of two,

three or four on a five-point scale. If subjects were evaluated as essentially unchanged (zero points) or slightly to moderately improved (one point), counseling was considered to be unsuccessful. Description of the scoring for this rating scale is shown in Table 2.

Each subject in the study was assigned an observation number in order to match data gathered from personnel records and the questionnaire. All subjects were informed about the observation number on the questionnaires when they were asked by phone to participate in the study. There was also a reference to the observation number in the explanation of the study (Appendix 2) that accompanied the questionnaire.

Design of the Study

This study primarily involved the evaluation of several independent variables, which were nominal, to determine their association with the two dependent variables, which were continuous. The independent variables evaluated were: age, marital status, educational level, occupational/income level, job performance level, referral source, severity of problem, counselor empathy, social competence and career competence. Each of these independent variables with the exception of career and social competence have been defined on three levels as indicated in Table 5.

Table 5. Point Values Assigned to Different Levels of the Independent Variables

Independent Variable	Points Per Level		
	0	1	2
Age	29 & below	30 - 44	45 & above
Marital Status	single	separated, divorced or widowed	single continuous marriage
Educational Level	less than high school	completed high school	college ed. or above
Occupational/ Income Level*	semi-skilled, skilled, manufacturing & laboratory, ($27,000 & below)	first level supervisory & professional ($27,001 - $38,000)	senior level professional & managerial ($38,001 & above)
Performance Level	does not meet expectations	meets expectations	exceeds expectations
Referral Source	supervisory referral	referral by family or peer	self-referral
Counselor Empathy	poor	good	very good
Problem Severity	little	somewhat	significant

*These salary rates are shown to illustrate relative differences and do not necessarily reflect actual company experience.

As previously cited, social competence has strong support as a predictor of treatment outcome. Career competence as a concept has never been evaluated. A prime purpose of this study was to evaluate through calculation of a correlation coefficient the effectiveness of career competence as a predictor of outcome and to compare it to social competence. Calculation of a point value for career competence was determined by adding the point values for educational level, occupational/income level and performance level as indicated in Table 5. Social competence was determined by adding the point values for age and marital status from Table 5 to the point value for career competence. In order to better differentiate between different levels of career and social competence, these point values were not sub-grouped as they were in the research previously cited on social competence.

Age, marital status, occupational/income level and job performance were chosen as independent variables because the review of literature revealed inconclusive results concerning their predictive value. Education was included because it is a component of both career and social competence. Counselor empathy and problem severity were included in the evaluation because each have been proven to be predictors of outcome. By including them it was possible to control for any influence they might have.

The dependent variables used to measure individual counseling outcome were absenteeism and the subject's evaluation of the counseling outcome. The absenteeism variable was utilized as an indicator of individual outcome by averaging the annual absences for the two years following counseling. One purpose in implementing an EAP is to reduce absenteeism or maintain it at a reasonable level. If subjects receiving counseling from EAP maintained their absenteeism at a low level subsequent to counseling, then the company judged counseling intervention to be successful. If absenteeism is elevated subsequent to counseling, the outcome was judged to be unsuccessful. The outcome of treatment was also measured according to the subject's evaluation based on their response to the five-point rating scale. The higher scores indicated greater success in counseling.

Another issue addressed in this study was a determination of the outcome of the counseling intervention. Two measures were used to determine the individual outcome of counseling. First, subject absenteeism was used to evaluate the outcome by determining whether counseling helped maintain absenteeism at a lower level than the plant average. If so, counseling was judged to be successful according to the absenteeism measure. The second measure of outcome was subject evaluation. Counseling was judged to be

successful according to this measure if a significant percentage of the subjects judged it to be so according to their responses to question nine on the questionnaire.

Statistical Procedure

The evaluation of overall counseling outcome as measured by absenteeism and subject rating was performed by using the binomial distribution. The binomial distribution is appropriate to use in investigations that meet the following criteria: known number of independent trials, outcome of each trial with one of two mutually exclusive events and the probability of success is constant for all independent trials (Cox, 1987). This investigation met these criteria.

Outcome was considered to be successful according to the absenteeism measure if the subjects average annual absenteeism was lower than the plant average subsequent to counseling. Outcome was considered to be successful according to the subject's evaluation of outcome if the subject's rating was greater than or equal to two on the rating scale. It was assumed that, if treatment did not affect outcome, outcome as measured by the dependent variables would be half successful and half unsuccessful. Therefore, if successful ratings per absenteeism and subject evaluation were significant at the alpha = .05 level, then

counseling outcome was considered to be successful (Willemsen, 1974).

In order to evaluate the relation of the two dependent variables, a coefficient of correlation was calculated (Williams, 1968). This correlation helped determine the relationship of these two measures of treatment outcome and whether absenteeism is a valid measure of outcome.

A Pearson multiple regression analysis was used to determine the effect of the ten independent variables on each of the two measures of treatment outcome. The coefficient of multiple correlation and its square, the coefficient of multiple determination, were calculated and an F test was used to test the significance of the relationship between the two dependent variables and regression of the ten independent variables.

The coefficient of multiple correlation made it possible to establish any association that the independent variables had with the two dependent variables. The coefficient of multiple determination was used to measure the variation in the dependent variables which is explained by variations in the independent variables (Schraeder, Sjoquist & Stephan, 1986). An analysis of the partial correlations helped to evaluate the association of each independent variable with the dependent variables while controlling the other independent variables.

Possible Sources of Bias

The major source of bias in this study was subject evaluation of counseling outcome. Subjects may tend to respond in a socially acceptable manner. This is a potential problem whenever subjective evaluations like these are used.

In order to help limit this potential source of bias, the author did not see individual responses but only worked with summary data. The author's secretary worked with the individual data and this was done by an identification number and not by name. This anonymity hopefully minimized socially acceptable responses.

One other possible source of bias was within the absenteeism measure. An underlying assumption in the use of this outcome measure was that unresolved personal problems increased absenteeism and resolution of personal problems will reduce absenteeism. However, there are certainly many health problems which are not related to personal problems, and absences associated with these health problems were included in the absenteeism measure. It was assumed that absences due to these other health problems occurred randomly within the sample, and differences were attributed to personal problems.

CHAPTER IV

RESULTS AND DISCUSSION

This chapter will report and discuss the results of the study. The results center on the statistical analysis of the data collected from personnel records and the questionnaire sent to the subjects of the study. A report of the response to the subject survey will precede the description of results from the statistical analysis.

Survey Results

Telephone calls were made to 154 counselees who were thought to meet the criteria for subjects as defined on pages 54 and 55. Two counselees did not choose to participate in the study.

Questionnaires were then sent to the 152 counselees who chose to participate and 132 of the counselees returned their questionnaires. This represents an 86.9% return rate of questionnaires. Sommer and Sommer (1980) indicated that a return rate of over 50% is very good when a specific connection is established between the respondent and the survey. This connection was certainly made in this survey through the telephone call to each counselee and the description of the research (Appendix 2) included with each

questionnaire. Other factors contributing to this high return rate were: brevity of the questionnaire, familiarity of the employee population with surveys, indication by the subjects of their willingness to participate when contacted by phone and convenience associated with returning the questionnaires through the plant mail or self-addressed stamped envelope. The normal return rate for employee surveys within this organization is 55%, which is consistent with the data reported by Sommer and Sommer.

Of the 132 counselees who returned questionnaires, seventeen indicated they had received counseling from a professional counselor during the two years subsequent to initiating counseling with EAP. They were eliminated from the study in order to hold the treatment constant. As a result, each subject in this study received counseling from the same counselor utilizing a cognitive-behavioral approach as described in appendices three and four.

As will be pointed out later, the counselees' evaluation of counseling outcome was very positive. This raises the question of whether the subjects responded in a socially acceptable manner. Although it is probably impossible to eliminate this potential source of bias in any survey, two factors contribute to an argument for the credibility of the results of this survey. One factor is the confidentiality associated with the survey.

Secondly, the counselees in this survey are part of an employee population that participate in regular employee surveys concerning various issues related to the workplace. These employee surveys use a five-point rating scale similar to the one used in this study. To illustrate the range of responses in these surveys, some data related to the employee satisfaction index, which is generated from the employee survey, will be described. Eleven questions are combined to form the employee satisfaction index and this index has been in the 71%-75% positive range during each quarter for 1987 and 1988. However, the individual responses on the eleven questions range from 54% to 91% positive. This seems to indicate that employees feel free to express dissatisfaction. This company has an excellent record in the area of employee satisfaction and the fact that the majority of the responses are positive support this record. Another indication of this good employee satisfaction record is that of the six questions for which there are national norms, the subject company rated 10% to 30% higher on four of the questions concerning employee satisfaction. On the other two questions, the responses of the employees from the subject company were only 3% below the national norm.

As will be seen later, the evaluation of counseling outcome by counselees was much more positive than the overall employee satisfaction index.

Evaluation of Outcome Measures

The results of the evaluation of counseling outcome by the counselees utilizing Malan's rating scale (Malan, 1976) is shown below in Table 6.

Table 6. Counselees' Response to Evaluation of Treatment Outcome

Points	Treatment Outcome	Number of Responses
0	Essentially unchanged	7
1	Slightly to Moderately Improved	8
2	Improved	27
3	Much Improved	36
4	Recovered	37

Previous research using this scale evaluates the outcome as successful when the point value for the response is greater than or equal to two. Using this criteria for successful outcome, the success rate for the brief counseling approach used in this study was 87.0%. This success rate of 87.0% falls within the confidence belt (Dixon & Massey, 1957) using a confidence level of 0.99 for the binominal distribution. The limits of the confidence belt for X = 100 and N = 115 or a 87.0% success rate are 77% and 93%. The inference that can be drawn from this is that the true success rate will fall within the stated limits 99

times out of 100 for the indicated sample size. In the majority of cases, the brief counseling was successful in contributing to improvement in the counselee's personal or emotional problem as measured by counselee evaluation.

Even though all the questionnaires were not returned, there is no reason to assume that the success rate for non-responders would be significantly different from those who responded. Those who did not return their questionnaires indicated a willingness to participate when contacted by telephone. Therefore, it is most likely that they simply failed to return their questionnaire for reasons independent of their evaluation of treatment outcome. However, in order to establish the relative success of outcome, a confidence level was determined under the assumption that all of the non-responders evaluated treatment as unsuccessful. In this case where X = 100 and N = 135 the success rate was 74.1%. For this success rate and using a confidence coefficient of 0.99, the confidence limits are 0.62 and 0.83. Since the 74.1% success rate, assuming all non-responders evaluated counseling as unsuccessful, is still within the confidence belt at a 0.99 level, the counseling was predominantly successful as measured by counselee evaluation.

One of the purposes of this research was to determine whether low absenteeism subsequent to counseling could be

used as a measure of treatment outcome. Most evaluations of treatment outcome use subjective measures such as evaluations by the client, clinician or clinician observer or self-report assessments by the client. These methods of evaluating outcome seem to be reliable and valid measures. However, they are more perceptual as opposed to behavioral measures. If absenteeism proves to be a good measure of treatment outcome, then a behavioral measure will be added as an evaluation tool.

The first hypothesis addressed was:

H:1 Employees who seek counseling for personal problems experience higher absenteeism than other employees.

Table 7 shows that the employees who sought counseling through EAP during 1982 and 1983 experienced approximately twice the absenteeism of the average employee prior to and during the year they sought counseling. This supports the hypothesis that employees who seek counseling for personal problems experience higher absenteeism than other employees. Data were available for all 429 counselees counseled during 1982 and 1983. The 115 counselees included in this study is a subgroup of this population of counselees. Data for the subjects in this study also support the hypothesis.

Table 7. Annual Absenteeism Data for Counselees and General Employee Population

Employee Group	Average Days Absent Per Year					
	1980	1981	1982	1983	1984	1985
All employees (11,000)	7.3	6.3	5.8	5.5	4.9	4.5
All 1982 EAP Counselees (152)	12.9	13.1	18.5	12.9	8.4	
All 1983 EAP Counselees (277)		9.0	9.4	10.0	7.9	7.8
1982 Counselees Who Maintained or Lowered Absenteeism (122 or 80%)	15.2	14.0	15.7	6.1	4.0	
1983 Counselees Who Maintained or Lowered Absenteeism (218 or 75%)		8.2	10.5	10.5	3.4	3.7

The average absenteeism for this group of counselees for the two years prior to counseling was 9.7 days per year. The general employee population average for those same years was 6.4. This evidence clearly indicates that employees who seek counseling for personal problems experience higher absenteeism than the average employee and, thus, the first hypothesis is accepted.

The second hypothesis to be addressed is:

H:2 Successful EAP counseling intervention will result in lower absenteeism.

The method used to evaluate this hypothesis was an analysis of the percentage of counselees whose average absenteeism for the two years subsequent to counseling was below the mean for all employees. This percentage was evaluated utilizing the binominal distribution to determine if a significant percentage of counselees had absenteeism below the plant average after the counselees received counseling. The success rate for counselees utilizing this absenteeism measure was 60.9%. Utilizing a confidence coefficient of 0.95, this success rate of 60.5% falls within the confidence belt. The limits of the confidence belt for $X = 70$ and $N = 115$ are 51% and 71%. This would appear to indicate that counseling outcome was successful when measured by low absenteeism. However, an examination of the

mean and median for counselee absenteeism raised some questions about this conclusion. The mean for absenteeism subsequent to counseling was 7.4 days per year while the median was 3.4. This indicated that half the counselees had absenteeism below 3.4 even though the mean was 7.4. These data along with a scatter plot of absenteeism indicated that the distribution for absenteeism was skewd to the lower end of the scale. The plant mean for those same years was 4.9 and so it appears the very high absenteeism of some employees in the subject population elevates the mean. As a result, post-counseling absenteeism was below its mean for more than 50% of the counselees. Since this would inflate the success rate, employee absenteeism prior to counseling was also examined and the same percentage (60.9%) of counselees had pre-counseling absenteeism below the mean for all employees. Evidently, this approach of utilizing below average absenteeism as a measure of outcome has no real merit since any population of employees at any time will likely have a significant percentage of those employees below the mean.

Rather than rejecting the validity of absenteeism as a measure of outcome, additional absenteeism data were analyzed. The means for absenteeism before and after counseling was examined to determine if there was a significant reduction. The mean for annual absenteeism for

the two years prior to counseling was 9.7 days and the mean for the two years subsequent to counseling was 7.4 days. This represents a 23.7% reduction. This is certainly not significant when compared with a 22.9% reduction which took place with the entire employee population. The counselees' absenteeism was only reduced at a rate similar to the rate for all employees. However, it should be pointed out that employees with personal problems do not seem to be affected by general employee population trends in absenteeism. In Table 7, the plant average for absenteeism is going down each year while the average absenteeism of counselees, seen during 1982 and 1983, increased for the years prior to and during the initiation of counseling. This may indicate that the 23.7% reduction in annual absenteeism among the counselees in this study may be related to counseling.

In order to further evaluate reduction in absenteeism, the absenteeism rate for each subject was analyzed to determine how many counselees either maintained or lowered their absenteeism subsequent to counseling. Maintenance or reduction in annual absenteeism was achieved by 64.9% of the counselees. Utilizing a confidence coefficient of 0.99 this success rate of 64.9% falls within the confidence belt. The limits of the confidence belt for X = 74 and N = 115 is 51% to 70%, signifying that a maintenance or reduction in absenteeism of this magnitude would not likely happen by

chance. This also indicated that maintenance or reduction in absenteeism might be a valid measure of treatment outcome. Additional evidence for this conclusion is seen in Table 7. When all the counselees seen by EAP in 1982 and 1983 are considered, 77.8% of the counselees either maintained or reduced their level of absenteeism. These counselees include the subjects in this study plus the counselees who saw another EAP counselor or a counseling resource outside the company. Many of these counselees had more severe emotional or chemical dependency problems which required either inpatient or long-term outpatient treatment. Absenteeism is assumed to be a greater problem with these more serious personal problems. The mean annual absenteeism for all counselees seen during 1982 and 1983 was 10.5 versus the 9.7 for the counselees included in this study. Employees with more severe personal problems have higher absenteeism.

An examination of the means for annual absenteeism of the successful and unsuccessful groups of counselees with success being defined as maintenance or reduction in individual absenteeism provided some interesting data. Table 8 shows how the absenteeism for the successful groups declines significantly. Since a significant percentage of the counselees do maintain or reduce absenteeism, counseling intervention does seem to reduce absenteeism and, as a result, the second hypothesis should be accepted.

Table 8. Absenteeism Means for Successful and Unsuccessful Counselee Groups*

Counselee Group	Mean for Annual Absenteeism In Days: Before Counseling	After Counseling
All Successful Counselees for 1982 and 1983 (77%)	10.9	4.1
All Unsuccessful Counselees for 1982 and 1983 (23%)	8.9	25.9
Successful Counselees in This Study (64%)	11.8	3.0
Unsuccessful Counselees in This Study (36%)	5.9	15.7

*Success is defined as counselees who maintained or reduced their level of absenteeism subsequent to counseling

The outcome of the counseling provided for subjects in this study was successful when measured by both counselee evaluation and reduction in absenteeism. As indicated earlier, counselee evaluation is a commonly used measure of treatment outcome while employee absenteeism has not been used as a measure of treatment outcome. Absenteeism may have some merit as a measure in evaluating treatment outcome. Since each measure of outcome indicated that counseling was successful, an evaluation of the association of these two measures was of interest. The coefficient of correlation for the two measures of outcome, or dependent

variables, is -.02, which means there is practically no association between these two measures. This seems unusual since both measures of outcome indicated counseling was successful. A potential explanation is that each measure is evaluating a different aspect of counseling outcome. Counselees evaluation measures the perception of the counselee about how successful they were in resolving the personal problem for which they sought help. Reduction in absenteeism is a behavioral measure of the physical problems which are frequently associated with personal problems. Counselee perception of success and reduced absenteeism are both important to counseling outcome, but, evidently, it is not uncommon for one of these measures to indicate success while the other indicates failure.

Evaluation of Predictor Variables

In this section, the results of the multiple regression analysis will be reported. Particular attention will be focused on the association of the independent variables with the two dependent variables which were measures of counseling outcome. All coefficients of correlation will be reported where the alpha value was 0.10 or less. This value denotes that the probability of this coefficient of correlation occurring by chance is 10% or less.

There are some interesting associations between the

independent variables. The first independent variable that will be examined is the composite career competence variable. Since career competence combines the scores for job performance, occupational/income level and educational level, it would be expected that career competence would be associated with these variables. Career competence and social competence should be associated with each other since social competence includes the three components of career competence plus age and marital status. However, several other associations of interest appeared. Table 9 shows the coefficients of correlation for these associations and their statistical significance.

Table 9. Associations of Independent Variables with Career Competence

Independent Variable	Coefficient of Correlation	alpha Value
Social Competence	0.87	0.0001
Job Performance	0.58	0.0001
Occupational/Income Level	0.68	0.0001
Educational Level	0.69	0.0001
Referral Source	0.28	0.0024
Marital Status	0.20	0.0364
Age	0.23	0.0151

The strength and statistical significance of the association of career competence with social competence and the three individual components of career competence was expected. The other associations are not strong but they are statistically significant. The association of career competence and referral source implies that employees who are more career competent are more likely to be self-referred. Employees who are less career competent are more likely to be referred by supervision or someone else within the company. This indicates that employees who have more career competence are more likely to make the decision to seek help on their own as opposed to waiting until the problem is evident to others resulting in a referral. The association of career competence with marital status and age implies that the more career competent employees are more likely to be married and older. The association with age is not unexpected since employees usually advance in their careers as a function of time. The association with marital status implies that career competence has some relationship to an individual being married.

Table 10 shows the coefficients of correlation and the statistical significance for the associations between social competence and other independent variables.

Table 10. Associations of Independent Variables with Social Competence

Independent Variable	Coefficient of Correlation	alpha Value
Career Competence	0.87	0.0001
Job Performance	0.37	0.0001
Occupational/Income Level	0.54	0.0001
Educational Level	0.56	0.0001
Marital Status	0.36	0.0001
Age	0.38	0.0001
Referral Source	0.27	0.0042

The strength and statistical significance of the association of social competence with career competence and the five variables which are combined to determine social competence was expected. Due to the strength of the association between career and social competence, it is not surprising that social competence is related to referral source in the same way career competence was. It appears that the more socially competent employees are also more likely to seek assistance on their own while less socially competent employees are more likely to be referred by their supervisor or someone else within the company.

In addition to being associated with the composite career and social competence variables, the referral source variable was associated in some way with three individual variables. The coefficients of correlation and statistical significance of those correlations are shown in Table 11.

Table 11. Associations of Independent Variables with Referral Source

Independent Variable	Coefficient of Correlation	alpha Value
Occupational/Income Level	0.16	0.0971
Educational Level	0.16	0.0946
Counselor Empathy	-0.17	0.0692

Since referral source is related to occupational/income level and educational level and not the other components of career and social competence, it appears that the association of referral source with career and social competence is due to the influence of occupational/income and educational level. This implies that employees with a higher occupational/income and educational level are more likely to be self-referred. Most employees in the higher occupational/ income and educational categories are professional or senior level/managerial personnel. One possible explanation is that these employees are more aware of the assistance available through EAP. Although promotion of EAP is conducted on a plant-wide basis, all the supervisory personnel do receive training on how to identify and refer troubled employees. This training and the familiarity with EAP it provides could result in more self-referrals among this employee group. Another potential

explanation is that the more educated and successful employees are more comfortable seeking professional assistance for personal problems. A final explanation is that less educated lower level employees might be more skeptical about the confidentiality associated with a company provided counseling program. The significant percentage of employees utilizing EAP and the good cross section of employees voluntarily utilizing EAP regardless of the referral source would raise questions about this last explanation. The negative association between referral source and counselor empathy is interesting. This is not a very strong association and any conclusions drawn should be tentative. Nonetheless, this association indicates that employees who are referred by supervision or some other company source are more likely to perceive the counselor as empathic. This might have a lot to do with expectation. Self-referred counselees might expect the counselor to be empathic, and thus their ratings of counselor empathy might not be as high. On the other hand, counselees who are not self-referred might enter counseling with lower expectations of counselor empathy and rate counselor empathy higher as a result of lower initial expectations.

Table 12 shows the coefficients of correlation and their statistical significance for the associations between occupational/income level and the other independent variables which have not been previously discussed.

Table 12. Associations of Independent Variables with Occupational/Income Level

Independent Variable	Coefficient of Correlation	alpha Value
Educational Level	0.44	0.0001
Marital Status	0.25	0.0074
Age	0.31	0.0009

The strong association with educational level was expected since most of the higher level positions within this organization require college or post-graduate education. The association with age was also expected because career advancement is in some ways a function of time. However, the association with marital status, especially since marital status and age are not associated, seems to imply that employees who advance in the careers have some competence that assists in maintaining a marriage relationship.

The only association with educational level which has not been previously discussed is age. One conclusion that can be drawn from this association is that younger employees with higher education are less likely to seek assistance than older employees with less education. In managing an EAP, it might be worthwhile to give special attention to

promoting EAP services to these populations who are less likely to use EAP.

Another association between independent variables which has not been discussed is the association that exists between counselor empathy and severity of problem. The coefficient of correlation between these two variables is 0.47 with alpha = 0.0001. This fairly strong association implies that counselees who perceive the severity of their problem as more significant also perceive the counselor as more empathic. Whether the counselor was more empathic toward counselees with more severe problems, or whether the severity of the problem made the perception of counselor empathy by the counselee stronger is impossible to determine. However, counselees experiencing more severe problems would probably be more aware and appreciative of counselor empathy.

Now that the associations between independent variables have been explored, attention will be focused upon the association between the independent variables and the two dependent variables. Table 13 shows the coefficients of correlation and their statistical significance for the associations between counselee evaluation of treatment outcome and the independent variables.

Table 13. Associations of Independent Variables with Counselee Evaluation

Independent Variable	Coefficient of Correlation	alpha Value
Career Competence	-0.28	0.0022
Social Competence	-0.26	0.0060
Job Performance	-0.24	0.0101
Occupational/Income Level	-0.24	0.0100
Counselor Empathy	0.38	0.0001
Problem Severity	0.33	0.0003

The strongest association with outcome as measured by counselee evaluation is with counselor empathy. This indicates that counselees who perceived the counselor as more empathic also perceived the outcome of treatment as more successful. This supports the research which indicates that counselor empathy is a strong predictor of treatment outcome. However, in this study, counselor empathy had no association with treatment outcome as measured by low absenteeism. This perceptual predictor variable does not relate to a behavioral measure of outcome in the way it does to a perceptual measure. Of course, absenteeism does not have the credibility that counselee evaluation does as a measure of treatment outcome.

The positive association between problem severity and success as measured by counselee evaluation indicates that counselees with more serious problems perceived counseling outcome to be more successful. This conflicts with research

previously cited which indicated that success in counseling was more likely to occur with less severe problems. However, the research cited was conducted with schizophrenia, severe depression and other more serious emotional problems. Certainly the probability of success would be expected to be greater when these more serious emotional problems are less severe. The subjects in this research were experiencing less serious emotional disturbances which might more appropriately be described as problems in living. The association that exists between problem severity and outcome as measured by counselee evaluation indicates that counselees who are experiencing less severe problems are less likely to perceive the outcome of counseling as successful. This might be due to the fact that counselees experiencing more severe problems are more likely to observe a difference in their personal problem subsequent to counseling since the adverse impact on their lives prior to counseling was greater.

One of the major purposes of this study was to test the following hypothesis:

H:3 Individuals who are successful in career preparation and performance activities are more successful in resolving personal problems.

The career competence measure is similar to the social competence measure which was also evaluated in this research. The difference in these two measures is that career competence only includes educational level, occupational/income level and job performance which are the variables related to career competence. In the review of literature, research was cited which established social competence as a good predictor of treatment outcome with more serious emotional disturbances requiring inpatient or long-term outpatient treatment. In this research, with subjects receiving brief counseling intervention for less serious personal problems, there was an association of career competence with outcome but the association was not in the expected direction. The more career competent counselees according to the career competence measure were less likely to evaluate the outcome of counseling as successful. Therefore, the third hypothesis must be rejected.

The association between social competence and counselee evaluation was very similar and slightly less statistically significant. It appears that the two non-career components of social competence, age and marital status, do not add to and may detract slightly from the power of career competence as a predictor of treatment outcome. In the review of literature, it was noted that age had no support as a

predictor of outcome. However, marital status appeared to be the best sociodemographic variable in predicting outcome. Marital status was not a good predictor of outcome as measured by counselee evaluation in this study. Two components of career competence were almost as effective as both composite variables in predicting outcome. Job performance and occupational/income level both had a significant negative correlation with subject evaluation of outcome. The third component of career competence, educational level, was not associated with outcome. Ability to perform well and advance in one's job and higher scores on the composite variables of career and social competence increased the probability that counseling outcome will not be perceived as successful by the counselee.

In interpreting these results several possible reasons will be offered to explain these surprising associations. One possible reason is that the brief counseling intervention was not adequate to provide the assistance needed by the more career and socially competent counselees. The cognitive-behavioral counseling approach focuses on developing more adaptive behaviors and belief systems. These interventions might have been inadequate for the more career and socially competent counselees.

A second possible reason for these results might be counselee expectations of treatment outcome. Counselees who

are accustomed to investing a lot in their career might expect more extensive treatment than what they received from the brief counseling intervention used in this study. These more competent counselees might also have higher expectations of outcome and as a result rate outcome lower than counselees who are less career competent.

The association between less career and socially competent counselees and success as measured by counselee evaluation can be viewed as in support of the thesis that helping counselees improve personal competency will assist them in resolving personal or emotional problems. Research by Bandura et. al. (1980), Nezu (1986), Rude (1986) and others indicated that helping counselees adapt more effective cognitive and behavioral approaches to dealing with their emotional and personal problems resulted in a successful treatment outcome. The cognitive-behavioral counseling approach used in this study focused on developing more effective responses to problems. This counseling approach may have helped these less competent counselees improve personal effectiveness in a manner that resulted in a higher probability of success than the counselees who entered counseling with a higher level of competency. It appears that improvement of self-efficacy is a desirable treatment goal, especially with counselees who are less career and socially competent.

Table 14 shows the coefficients of correlation and their statistical significance for the associations between low counselee absenteeism and the independent variables.

Table 14. Associations of Independent Variables with Low Counselee Absenteeism

Independent Variable	Coefficient of Correlation	alpha Value
Career Competence	-0.22	0.0166
Social Competence	-0.20	0.0317
Job Performance	-0.20	0.0285
Occupational/Income Level	-0.20	0.0326

The negative correlation between career and social competence and outcome as measured by low absenteeism would seem to lend support to the more competent counselees experiencing lower absenteeism subsequent to counseling, since high absenteeism represents failure. However, as indicated earlier the more competent counselees also experienced lower absenteeism prior to counseling. This conveys that career and social competence are probably not predictors of counseling outcome as measured by low absenteeism but, rather, a predictor of low absenteeism. Lower absenteeism would be expected of the more career and socially competent individuals because these individuals are

more effective in the workplace and one measure of that effectiveness is low absenteeism. Reinforcement for this conclusion was the similar association that exists between the two specific workplace variables, job performance and occupational/income level. In other words counselees who are better performers on the job and have advanced in their careers have lower absenteeism.

A stepwise regression was used to build the best single model for predicting outcome of counseling. The best single model for predicting outcome as measured by subject evaluation included career competence, social competence, counselor empathy and problem severity. With these variables in the model, the value for R^2 was 0.4147, which indicates that approximately 41% of the variation in outcome can be explained by this model. This model was also the best single model for predicting outcome as measured by low absenteeism. However, the R^2 value for this model was only 0.2051 which implies that only 21% of the variation in absenteeism can be explained by the model.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

Significant conclusions and their implications will be discussed in this chapter along with recommendations for future research.

Research in Business and Industry

Most research in the area of mental health problems has typically been conducted in college or institutional mental health settings. This type of research tends to be limited to certain age groups or to more severe mental health problems. Unfortunately, a large cross section of the adult population with less severe personal and emotional problems are often excluded from research efforts. Business and industry offers a fertile field for research in this neglected area of mental health if the research community conducts research that has tangible benefits to the business community. These types of partnerships have been successful in the business and technical fields and there is no reason they cannot work in the area of mental health.

Employee Absenteeism as Measure

The absenteeism data for the subjects in this study confirms that employees experiencing personal problems have a much higher rate of absenteeism than the average employee.

A basic tenet of EAP's is therefore supported, that emotionally disturbed individuals can frequently be identified by a high absenteeism record. Consequently, referral of employees with high absenteeism to EAP or some other resource for counseling is warranted.

The data compiled for this research provided support for the hypothesis that counseling intervention will, in many cases, reduce absenteeism. However, a significant reduction in absenteeism was more observable with more severe emotional and chemical dependency problems. This supports the existing data which indicated that there were significant cost savings for companies from reduced absenteeism where their employees have access to an EAP (Hoffman and Harrison, 1986). Reduction of absenteeism seems to have potential as a good measure of counseling outcome, even though it was the weaker of the two measures used in this study and did not correlate with the more widely accepted counselee evaluation of outcome as measured by the Malan rating scale (Malan, 1976).

Effectiveness of Brief Counseling

The brief cognitive-behavioral counseling approach used in this research proved to be effective as measured by counselee evaluation and reduced absenteeism with the broad range of chemical dependency, emotional and personal problems typically presented to a company-based EAP. Most

research with brief therapy reviewed in the literature was focused on the treatment of depression and anxiety. The scope of this study involved counselees with marriage and family problems, job-related problems and chemical dependency, in addition to more typical emotional disturbances.

Since most EAP's are primarily short-term counseling, assessment and referral services, this type of active brief counseling approach is particularly effective. A brief counseling intervention enables EAP's to invest a small amount of counseling time to treat with equal effectiveness and lower costs disturbed employees who were previously accessing longer term, more expensive forms of treatment. Distinguishing where assessment stops and treatment begins is difficult because treatment actually begins to occur as the counselee shares information and feelings which are used by the counselor in making an assessment. A bonding also begins to take place in that initial counseling session that is primarily focused on assessment. For these reasons, completion of the counseling process with the EAP counselor when the problem is such that brief counseling is sufficient is more effective and easier for the counselee.

Evaluation of Outcome Measures

Since both of the outcome measures used in this study indicated that the outcome of counseling was successful, an

association between the two measures would be expected. The fact that no association was found between outcome as measured by counselee evaluation and reduced absenteeism could indicate that each of these variables is measuring a different component of outcome. Since counselee evaluation has good support in the literature as a valid measure of treatment outcome and reduced absenteeism does not, it could also be assumed that the findings in this study related to reduced absenteeism as a measure of outcome are invalid. Certainly, additional research of this measure is warranted.

The subjective nature of counseling outcome makes measurement in an objective, scientific manner a difficult process. Due to this difficulty, subjective measures like evaluations by clients, therapists or observers are frequently used. Sometimes psychological assessment instruments are used to measure a client's emotional state prior to and subsequent to counseling. These measures are more objective but they rely on counselees' perception and measure subjective concepts like depression.

Since there is no direct scientific way at this time to measure treatment outcome, the use of two or more diverse measures has merit. Use of both a perceptual measure, like counselee evaluation, and a behavioral measure, like reduced absenteeism, may provide a more thorough analysis of all components of outcome. This study illustrates the advantages of this approach to evaluation.

Predictors of Counseling Outcome

In discussing predictors of treatment outcome, only the association between the predictor variables and outcome as measured by counselee evaluation will be discussed. As pointed out previously, level of employee absenteeism subsequent to counseling was not a good measure of outcome and reduced absenteeism did not show any significant associations with any of the predictor variables.

This study supported previous research which indicated that counselor empathy is an effective predictor of treatment outcome (Strupp, 1980 and Free et al., 1985). The ability of the counselor to communicate understanding of the counselee's thoughts, feelings and problems and respond with appropriate concern while remaining objective appears to be an essential part of the counseling process. Counselor empathy clearly had the strongest positive association with outcome as measured by counselee evaluation.

The fairly strong negative association of problem severity and outcome as measured by counselee evaluation seems to contradict previous research (Hovne, 1984 and McLean & Hakstian, 1979). However, most of that research was conducted with people experiencing much more severe and complex emotional and personal problems than the people included in this study. These previous findings would seem to indicate that the more severe problems are difficult to resolve because of their complexity and the possibility that

the counselees have been overwhelmed by the severity of the problem. This study indicates that if the problem is not severe enough, it is not as likely to be successfully resolved. The highest probability of successful outcome seems to occur in that mid-range of problem severity where the problem is not overwhelming but sufficient enough in terms of impact to cause the counselee to invest in making the changes required to successfully resolve the problem.

Another unexpected finding in this study related to the ability of social competence and career competence to be positively associated with and thus a predictor of outcome in counseling. In previous research, the composite measure of social competence seemed to have real promise as a predictor of treatment outcome (Glick & Zigler, 1986, Harrow et al., 1969, Turner & Zabo, 1968 and Turner & Gartrell, 1978). However, previous research was conducted with clients suffering from more severe emotional disturbances requiring inpatient treatment or long-term therapy. The negative association between social and career competence and counseling outcome in this research indicated that this relationship of the more socially competent clients being more successful in treatment does not apply with less severe emotional disturbances and personal problems. In fact, the opposite is true. The less socially competent counselees were more likely to experience a positive outcome. Lower

initial expectations of counseling by less competent counselees or their responsiveness to the cognitive-behavioral counseling approach used in this study may be the cause. This counseling approach focuses on increasing cognitive and behavioral competency which might be of greater benefit to the less competent clients than those clients who are more competent when they begin the counseling process. More competent clients may need a more insight-oriented and intensive treatment to bring positive results.

The career competence measure had a stronger association with outcome than the social competence measure. The two non-career components of social competence, age and marital status, added little to the strength of the career variables in predicting outcome. In fact, two components of career competence, occupational/income level and job performance, were almost as good a predictor as the composite social competence measure. The impact of these two variables on treatment outcome merit additional study. The career competence measure seems to have a stronger negative association with outcome and is at least as effective as social competence in predicting outcome.

Recommendations

This study illustrated the potential for workplace factors like absenteeism to be used as measures of

counseling outcome. These measures are more objective and behavioral than many that are used. Additional research to evaluate the effectiveness of absenteeism as an outcome measure is warranted. The proliferation of EAP's in industry provides great opportunities for research of this type.

Additional research is warranted in the area of career and social competence as predictors of counseling outcome, especially since this research contradicted previous findings. The focus of future research should be the impact of these competing measures on counseling outcome with less severe personal and emotional problems. The interaction of this type of treatment and competency also merits attention. The major issue in evaluating this interaction is examining whether competency oriented counseling approaches such as cognitive-behavioral interventions are more successful with counselees who have competency deficits.

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APPENDICES

APPENDIX 1

QUESTIONNAIRE ON EMPLOYEE ASSISTANCE PROGRAM (EAP)

Please check the appropriate box under each question:

1. What was your marital status when you first used EAP?

   Never Married . ☐ Divorced . ☐ Widowed . ☐
   Separated . . . ☐ Remarried . ☐ Married . ☐

2. Please check the highest level of formal education that you have completed.

   Grade School . ☐ College . ☐ Doctorate . ☐
   High School . ☐ Masters . ☐

3. Who referred you to EAP for assistance?

   No One (Came on my own) . ☐ Supervision . ☐ Medical . ☐
   Family Member ☐ Friend ☐ Personnel . . ☐ Other _____

4. What was the primary problem for which you first sought help from EAP:

   Marital . . . . ☐ Grief. . . . ☐ Alcohol . . ☐
   Family. . . . . ☐ Anxiety. . . ☐ Drug. . . . ☐
   Parenting . . . ☐ Depression . ☐ Financial . ☐
   Relationships . ☐ Job. . . . . ☐ Other _____

5. To what extent was your health, job, emotional and mental well-being being adversely affected by the problem for which you sought help?

   Little . ☐ Somewhat . ☐ Significantly . ☐

6. Did you pursue counseling with a professional therapist outside the company during the two years after you first came to EAP?

   Yes . ☐ No . ☐

7. How would you evaluate the effectiveness of your counselor in understanding your thoughts, feelings, and problem and responding with appropriate concern while remaining objective during the counseling process?

   Poor. . . . . ☐ Good. . . . . ☐ Very Good. . . . . ☐

8. How helpful was EAP in helping you deal with your personal problem?

   Not Helpful . ☐ Somewhat Helpful . ☐ Very Helpful . ☐

9. Check the phrase that best describes the outcome of the problem for which you sought counseling.

   Essentially Unchanged . . . . . ☐
   Slightly to Moderately Improved . ☐
   Improved . . . . . ☐
   Much Improved . . . . . ☐
   Recovered . . . . . ☐

10. Date of Birth: Month ____ Day ____ Year ____

APPENDIX 2

TO: EAP COUNSELEES

As a part of our Quality Management process, I am surveying a number of EAP counselees in an ongoing effort to evaluate the effectiveness of our Employee Assistance Program. In addition, I am currently doing some research as a part of my doctoral work in educational and counseling psychology. My research involves an evaluation of the effectiveness of our EAP and what factors affect successful counseling.

Your assistance with this evaluation and research is requested. You can help by completing and returning the attached questionnaire. Simply address it to Kathy White, Building 215.

Your survey form has been assigned an EAP number which will be used in analyzing the data to protect confidentiality. My secretary, Kathy White, will be the only person to work with the individual data and the data will only be reviewed in relation to the EAP numbers and not names of counselees. I will only review and report the data in a summary fashion that will further protect identification of a given individual.

Participation in this evaluation and research is voluntary and you should not feel any obligation to participate. Your honest feedback will help us evaluate and improve the quality of our services. Your responses will not be reviewed individually, so please be candid.

Your consideration of participating is appreciated. If you have any questions, please call me at Extension 6608.

Hope things are going well with you at this time.

Sincerely,

Rick Toomey

APPENDIX 3

Description of Counseling for a Cognitive Problem

Presenting Problem: Counselee came to counseling for help with the anxiety and depression she was experiencing related to problems she was having with some significant relationships in her life. She felt she could not meet expectations of her supervision and her parents. She became very upset when supervision was not pleased with some aspect of her work. She would also get very disturbed by the interference of her parents in her life. She lived by herself in a house close to her parents and she felt they were overly involved in her life.

Treatment: Treatment for this counselee involved the following steps:

1. Ventilation by the counselee of the frustration and hurt she was experiencing as a result of not being able to please the significant people in her life.

2. Identification of the irrational beliefs she was using to interpret situations involving significant others. She believed that if she did not do what others wanted her to do and in a manner that pleased them, they would reject her and not value or care for her.

3. Disputation of irrational belief that she must always please people through Ellis' cognitive therapy approach.

4. Reading material was used to reinforce the development of more rational and functional beliefs.

5. After the counselee began to incorporate these new beliefs into her belief system, she began to deal with ways she could be more assertive with the significant people in her life. This was accomplished through discussions about ways to respond assertively reinforced by readings on assertiveness.

Outcome: Counselee became much less anxious about not meeting others expectations. She did not feel devalued if her supervision pointed out mistakes and did not feel unloved if her parents expressed displeasure with her decisions or behavior. She also became more assertive in stating her wishes even if significant others did not agree. The depression gradually subsided and she felt much better about herself.

Length of Treatment: Nine 50-Minute Sessions

APPENDIX 4

DESCRIPTION OF COUNSELING FOR A BEHAVIOR PROBLEM

Presenting Problem: A personnel report had been prepared and discussed with the counselee concerning some problem behavior on the job. The client responded to the personnel report in a very defensive manner and accused his supervision of unfair treatment. The discussion of the personnel report ended with no common understanding about the nature of the problem behavior and what the counselee needed to do to correct the problem. The outcome of this discussion was very distressing to the counselee and he came to counseling for help in reconciling the situation with his supervision.

Treatment: Treatment for this counselee involved the following steps:

1. Ventilation by the counselee of the anger he felt toward his supervision for the personnel report which he perceived to be filled with false accusations.

2. Identification of points in the personnel report with which the counselee disagreed.

3. Evaluation of counselee's effectiveness in bringing these points to supervision's attention. The counselee recognized that he had attacked his supervision and had not effectively expressed his concern about the inaccuracy of some of the problem behaviors described in the personnel report.

4. Discussion of assertive communication and its effectiveness in resolving conflict situations. The counselee was given reading material on assertiveness and in a subsequent session role-played with the counselor a discussion of his concerns with supervision.

Outcome: The counselee discussed his concerns with supervision in an assertive manner and they understood and addressed each of his concerns. The personnel report was reviewed and both the counselee and supervision accepted some responsibility for the

problems and agreed on a course of action to correct the problems. The counselee was very pleased with the outcome and recognized how assertive communication could help in improving the quality of his relationships in all areas of his life.

Length of Treatment: Three 50-Minute Sessions

VITA

Olney Ricky Toomey was born in Athens, Tennessee on January 10, 1947. He attended public schools in Athens and graduated from McMinn County High School in 1965. He went on to receive a Bachelor of Science degree with a major in Industrial Management from the University of Tennessee in 1970.

After working in private industry for three years, he began graduate work at Southern Baptist Theological Seminary and received a Masters of Religious Education in 1974. After serving in several ministerial positions for five years, he began his doctoral program in 1979. He presently is a Coordinator for an Employee Assistance Program in private industry.

He is married to the former Susie Kelly of Knoxville, Tennessee and currently resides in Blountville, Tennessee. Mr. Toomey and his wife have a son and a daughter.