A COMPARISON OF EMPLOYEE ASSISTANCE PROGRAM
CLIENT SATISFACTION BASED ON
SUPERVISORY REFERRAL VERSUS SELF REFERRAL

BY

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Abstract of Dissertation Presented to the Graduate School of the University of Florida in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

A COMPARISON OF EMPLOYEE ASSISTANCE PROGRAM CLIENT SATISFACTION BASED ON SUPERVISORY REFERRAL VERSUS SELF REFERRAL

By

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Major Department: Counselor Education

Work organizations have offered some form of an employee benefit similar to current employee assistance programs since the 1800s. This study explored whether there is a significant mean level difference in employee satisfaction based on referral source (i.e., supervisor or self). Employees of seventeen companies located throughout the southeastern region of the United States who had used their employee assistance program during a six month period in 1996, were surveyed using the Client Satisfaction Questionnaire-8. Chi-square analysis supported the hypothesis that there was a statistically significant greater number of self-referrals to the employee assistance program compared to those that came in under supervisory referral conditions. Chi-square analysis failed to support
any significant difference in referral source by gender. Factorial three-way analysis of variance (two by two by two design), main effects model, supported the hypothesis of a higher mean level of satisfaction for self-referrals as compared to supervisory referrals. The hypothesis that there would be no mean level difference in satisfaction by gender was supported. The hypothesis that the mean level of satisfaction would be lower for those presenting with drug problems, as compared to other problems, was not supported. Due to limitations of sample size, within-group comparisons were not possible to determine if mean level of satisfaction differences were affected by those who responded without follow-up. This study appears to support cognitive dissonance theory in that those who freely seek help will tend to be more satisfied.
CHAPTER 1
INTRODUCTION

Problem and Its Context

Employee assistance programs are "worksite-based programs designed to help identify and facilitate the resolution of behavioral, health, and productivity problems that may adversely affect employees' well-being or job performance" (Blum & Roman, 1995, p. 1). The purpose of an Employee Assistance Program (i.e., EAP) is "to provide timely, professional aid for employees whose personal problems might otherwise lead to work impairment, absenteeism, accidents, conflicts in the work setting, or even job termination" (Lewis & Lewis, 1986, p. 4).

EAP Development

The origin of employee assistance programs informally dates back to the "welfare capitalism" of the early 1800s (Smith, 1987) when companies, fearful of unionization occurring among newly-arrived immigrant employees, set out to provide various types of social services. These services, available both to the employee and their family members, were to provide practical assistance to individuals as well as help in the acculturation process. It was not
until the early 1940s, however, that one finds what came to be recognized as the formal beginnings of the employee assistance program. "Two major complex and intertwined historical threads, occupational social welfare and occupational alcohol programs, have led to the development of EAPs" (Midanik, 1991, p. 69). Since that time, throughout the historical development of employee assistance programs, changes have occurred in terms of focus, location, and type of providers.

In the early 1940s, company-sponsored programs were called occupational alcohol programs (i.e., OAPs) and dealt exclusively with the issue of alcohol abuse (Dubreuil and Krause, 1983, p. 85-86). These programs were normally internal (i.e., services were utilized by going through the company) and were "staffed primarily by indigenous nonprofessional or recovering counselors" (Cunningham, 1994, p. 3). These individuals typically had no formal training and were usually in recovery themselves. As the provision of company-sponsored services addressing alcohol problems of their employees gained credibility, expansion into the availability of other services occurred. Programs underwent a process of change in focus from alcohol only to what is today termed broad-brush employee assistance programs (Brody, 1988). Blum, Roman, & Harwood (1995) state that the term, "broadbrush" describes a program that is designed "to assist workplace personnel in identifying and resolving
problems involving alcohol or drug abuse, and family, stress, emotional, marital, financial, legal, and other personal concerns" (pp. 126-127). As mentioned above, in the days of occupational alcohol programs, programs were usually internal.

Internal programs refer to the fact that the providers of occupational alcohol program services were usually company employees. While corporate-based, in-house employee assistance programs still exist in some of the largest U.S. companies, "most of the recent growth in EAPs and employment has occurred as a result of the development of contracting groups and external providers who supply fee-based services to employers" (Cunningham, 1994, p. 19). Providers are now most often clinicians in their own specialty area (e.g., addiction specialists, professional counselors, social workers and psychologists) who seek and obtain employment in employee assistance programs (Emener, 1988). Many have met both knowledge and experience requirements to become credentialed as Certified Employee Assistance Professionals (i.e., CEAP). Smith, Salts, and Smith (1989) in their paper, "Preparing Marriage and Family Therapy Students to Become Employee Assistance Professionals," for example, addressed some of the specific qualifications needed by the contemporary employee assistance program professional; and, suggested ways to accomplish the acquisition of the necessary skills within the context of an academically-based
training program. In addition, these authors presented a list of citations related to how other contemporary professionals such as social workers, rehabilitation counselors, psychologists, and psychiatrists fit within the employee assistance program framework.

By the 1990s, there had been a significant growth of employee assistance programs to the point that more than seventy-five percent of Fortune 500 companies offered some form of a personal counseling service (Feldman, 1991). Blum and Roman (1992) reported that a 1991 United States national data sample revealed that 45 percent of full-time employees who were not self-employed had access to an employer-provided employee assistance program. While the number of free visits may differ, and while a small number of programs are still essentially an occupational alcoholism program, it appears that American work organizations have incorporated the concepts of the employee assistance program.

Utilization of EAP Services

Employee assistance programs are designed to be accessed by employees at any level within a company. Most programs also are designed to incorporate access by eligible family members. In some cases, the program may also be available to employees who are retired. Not only have the number of available employee assistance programs increased, so has the rate of utilization. It is estimated that,
"approximately five percent of employees working in an organization offering an EAP used the EAP in a twelve-month period" (Blum & Roman, 1995, p. 127). Miller, Jones, and Miller (1992), stated that an increase in self-referrals has become evident in the 1990s and appears to be directly related to on-the-job stresses. Blum and Roman (1995) reported on a survey carried out with full-time employees from the end of 1993 through the beginning of 1994. One of their findings was that the use of employee assistance programs among both employees and dependents had increased (p. 2). While the majority of individuals who utilize the employee assistance program are the result of self-referral, another significant referral source is supervisory in nature. In fact, an essential function of an effective employee assistance program, is training supervisors to recognize (but not diagnose) the problem behaviors of troubled employees in order to make an appropriate referral to the employee assistance program. A study carried out by Gerstein, Eichenhofer, Bayer, Valutis, and Jankowski (1989) supported the idea "that constructive confrontation training enhances supervisors' recognition of impaired employees" (p. 15).

Human Capital Theory

According to Jerrell and Rightmyer (1988), it is Schramm's "human capital" model (which analyzes the costs
and benefits of employee assistance programs) that provides a theoretical model for understanding the development of employee assistance programs and the tools to evaluate such a program (p. 269). Human capital theory, which was developed by Carl J. Schramm (1980), established a basis for service delivery and offered a rationale based on economy that would justify to an employer the expenses involved in offering employees and family members access to an employee assistance program. Schramm's theory posits that just as employers are interested in investing in capitalizing a physical plant or equipment, making improvements through technology, or providing a safe working environment, they should be interested in investing in their employees' well-being. When employers make a commitment to invest capital (e.g., money, time etc.) in their human commodity, they typically anticipate a return on the investment in terms of increased productivity, better attendance, and improved morale and interpersonal interactions. This, in turn, is anticipated to result in increased income to the company. Employers are, therefore, willing to spend money to provide employees with training, continuing education, maintenance of a safe working environment, and in many cases through the provision of an employee assistance program.

While a company's decision to provide an employee assistance program might appear altruistic at first glance, the long term expectation is that the employer's investment
will yield increased returns on behalf of the employer. Studies have demonstrated, for example, that companies having employee assistance programs demonstrate a marked diminishment in lost productivity, tardiness, and absenteeism while demonstrating an increase in employee retention. One significant study (De Fuentes, 1986) addressed a number of these areas. Findings from this study indicated that following an employee's participation in the employee assistance program, an average reduction rate occurred in (a) absences (68%), (b) disciplinary actions (59%), (c) hospitalizations for problems identified through employee assistance program participation (71.5%), and (d) informal sick time (19.5%). An increase in performance review ratings (15%) also was noted. This study, consisting of a combination of interviews and record reviews of the total number of employees (n=739) seen over a three-year period (i.e., 1980-1983), also noted a significant high rate in the area of employee retention. As was the case with "welfare capitalism" in the 1800s, human capital theory allows the employer, as well as the employee, to benefit.

As employee assistance programs developed, attention was given to improving performance, attendance, and conduct on the part of the employee. Supervisors received training, usually from representatives of their employee assistance program, in order to learn to identify problem areas and make appropriate referrals.
Systems Theory

Another theory that provides support for the development of employee assistance programs is systems theory. Cunningham (1994) states that "systems theory offers a helpful overall framework in understanding both the complex structures in which people carry out their work lives and the interactional patterns that exist in work groups" (p. 43). Employee assistance professionals long have recognized that workers bring personal concerns into the work arena and vice versa. Roman (1989), for example, provided a case of how an employee with a drug problem had multiple and inter-related problems that affected both family and work.

Ford and Ford (1986) in their article, "A Systems Theory Analysis of Employee Assistance Programs," viewed every employee assistance program as a complex system. The researchers listed the following ten macrosystems (a) employee assistance program administrator and case manager and the external or internal group they represent, (b) upper level management of the employing organization, (c) middle level and supervisory management, (d) line and staff employees, (e) employees' families, (f) labor union(s), (g) health care and social service networks, (h) private and government subsidizers, insurers, and health care payors, (i) related employers such as suppliers, distributors etc.,
and (j) the general public (p. 37). The authors went on to state that "no person, no action, no problem stands alone in the network of systems to which each EAP belongs. Each referral signifies potential disruption, whether overt or unrecognized, within or between all the interfacing systems which cannot be ignored" (p. 38). This is particularly true in the case of supervisory referrals.

A core technology and set of functions derived from a body of research by Blum and Roman (1989) emphasizes the importance of employee assistance program interaction with managers and supervisors. According to Blum and Roman (1992, p. 121) there are two core technologies of employee assistance programs consisting of EAP liaison with supervisory management, and EAP liaison with benefits management. In addressing the employee assistance program liaison with supervisory management, there are three subtechnologies: (a) the identification of employee problems using documentation of impaired job performance, (b) consultation with supervisors, managers, and/or union stewards regarding troubled employees, and (c) effective use of constructive confrontation. Employee assistance program liaison with benefits management likewise consists of the following three subtechnologies: (a) micro-linkages of employees with appropriate services, (b) macro-linkages of employees with treatment providers, and (c) addressing alcohol-problem benefits on a parity with other health care
provisions. One might view this core technology as the philosophical underpinning of the employee assistance program.

Blum and Roman (1992) have an extensive body of research that has not only resulted in the development of the core technology of the employee assistance program, but which has also resulted in identifying two significant core functions: (a) management-related strategies, and (b) benefits-related strategies (p. 121). Each of these core functions has three components. Management-strategies include the retaining of valued employees, providing assistance to troubled supervisors, and providing due process to those employees whose personal problems have possibly affected their job performance. The employee assistance program function components, as related to benefits strategies, include controlling the cost of health care utilization, acting as a channeling function for the employees' and dependents' use of services for substance abuse, psychiatric and family problems, and acting as an employee benefit and morale booster.

It is from this philosophical base that utilization of employee assistance programs through the process of supervisory and management referral is supported. It is the ability to identify employees' behavioral problems which frequently results in "coaching" or "mandated" referrals to the employee assistance program.
Bystander-Equity Model

A third model that has been used in studies concerned with supervisory and management involvement in making referrals to the employee assistance program is the bystander-equity model. According to Gerstein, Eichenhofer, Bayer, Valutis and Jankowski (1989), "this model predicts that the supervisor-troubled worker recognition process varies as a function of the clarity and severity of the worker's dilemma, the costs connected with helping, the extent of inequity supervisors experience in their relationships with their subordinates, and supervisors' attitudes about their EAP. This model also suggests that the identification process is affected by supervisors' degree of arousal linked with helping" (p. 18).

To appreciate this model, it is important to understand the social and systemic context out of which helping behavior originates. One of the areas addressed by the field of social psychology is that of prosocial or helping behavior (i.e., altruism). An excellent summary of the background for the bystander-equity model, is presented in the chapter, "Prosocial and Antisocial Behavior: The Psychology of Altruism and Aggression," in a text by Worchel, Cooper, and Goethals (1988, p. 387-422).

A major study by Latane and Darley (1970), cited in this chapter, posits that any helping behavior consists of a
series of steps in what they term a decision tree. At each step in the decision process, an individual who witnesses an emergency situation is called upon to make an appropriate judgment if an intervention is to take place. At each step, however, the individual is faced with other options that could lead to the possibility that the individual will ignore the need for intervention. This decision tree, described by Latane and Darley (1970), consists of the following basic steps: (a) to notice or not notice a situation requiring intervention, (b) to interpret or not interpret a given situation as an emergency, (c) to decide whether the individual is or is not responsible for considering an intervention (i.e., based on whether there is an authority figure present and/or how many people are present to witness a given event), and to (d) decide on an appropriate level of assistance (i.e., direct or indirect). According to this model, if the individual has made the appropriate decisions consistent with moving toward helping behavior at each point in the decision tree, the final step is to implement a decision to help.

In deciding whether the individual is or is not responsible for considering an intervention, two major studies are available that address contributing factors involved in a decision to help. One finding, as a result of Latane and Darley's research, is that as the number of individuals (i.e., bystanders) present in an emergency
increase, the less likely it becomes that anyone will step forward to intervene.

A second study, also cited in this chapter, by Schwartz and Gottlieb (1980) reports on subjects who observed an emergency situation under two different conditions: (a) alone or (b) with another bystander. The results indicated that eighty percent of those who witnessed a situation and were alone felt it was their responsibility to act. Only seventeen percent of those present with another felt they needed to help. Thus, the presence of another party appears to significantly diminish an individual's decision to become involved.

What other issues appear to contribute to helping behavior? Worchel, Cooper, and Goethals (1988) presented the following contributing factors to helping versus non-helping bystander behaviors. First, situational context and how it is interpreted may result in an individual defining a situation in such a way as to whether they will or will not help (pp. 400-402). Second, an analysis is made in terms of the cost of intervention to the bystander and to the victim if the bystander fails to intervene. "Direct intervention is expected to occur when the bystander does not accrue high costs for trying to help and the victim will suffer great harm if the bystander fails to act" (p. 403).

A third study also cited within this chapter (Piliavin, Dovidio, Gaertner, & Clark, 1982) suggests three additional
factors that appear to contribute to whether a bystander will or will not intervene: (a) factors that may affect the degree of empathy between bystander and victim, (b) any psychological arousal that is interpreted by the bystander as being brought about by the victim's distress, and (c) an actual decision to help as a function of the bystander's perception of the costs involved (p. 408). Clearly, there appears to be an investment on the part of the individual who makes a decision to intervene.

The factors mentioned above are clearly applicable to the workplace. Throughout the historical development of the employee assistance program, it has been the role of supervisors to make a referral to the employee assistance program when they perceive deficits in an employee's performance, attendance, or conduct at work that are of sufficient magnitude and concern to the work organization.

The classic studies mentioned above have contributed not only to our general understanding of why people help but have provided a solid basis for the research that was to be connected specifically to the supervisor. The insights gained from this body of research are clearly connected to what makes one supervisor intervene in a troubled employee's situation while another will choose to ignore it. Studies that specifically address the bystander-equity model as it applies to helping behavior on the part of supervisors by Bayer and Gerstein (1990), Gerstein and Bayer (1991), and
Gerstein, Moore, Duffey, and Dainas (1993) will be reviewed in further detail in Chapter 2 of this study.

Evaluating EAP Services

As employee assistance programs have increased, evaluation of services is acknowledged to be an important aspect of program management. Lubin, Shanklin and Sailors (1992), in their survey of employee assistance program publication trends indicate that 1982 was the first year that more than five articles pertinent to employee assistance program research were published (p. 47). In Lubin, Shanklin IV, and Polk's (1996) review of the employee assistance program literature consisting of "journal, book and book chapter literature from 1991 through the first half of 1995," it is reported that "the annual publication rate for journal articles during the first half of the 1990s ranges between 35 and 75" (p. 59). By 1996, just utilizing the key words "employee assistance program evaluation" in a computer search resulted in 140 entries over the last thirteen years.

In order to grasp the specific problems in conducting research related to employee assistance programs, Jerrell and Rightmeyer (1988) stated that "understanding the basic objectives, program components, and procedures of employee assistance programs (EAP) is necessary" (p. 252). In their review of employee assistance program studies, they
determined most studies have been directed toward either specific components of employee assistance programs or monitoring employee assistance program implementation and/or outcome components such as cost-effectiveness. Some examples follow, having been gleaned from a review of the literature.

Battle (1988), for example, studied issues to be considered by a researcher in planning employee assistance program evaluations. Frost (1990) found employee awareness to be a first step in the process of utilizing an employee assistance program and Ahn and Karris (1989) explored the cost benefits of employee assistance programs. While entire issues of journals have been devoted to research related to employee assistance programs, and while it is important to understand the theory behind and need for such work, outcome measurement is also a critical element.

**Definition of Outcome**

Docherty and Streeter (1995) state that "although 'outcome' is often used in a simple and global fashion, it is actually a complex construct composed of several independent dimensions" (p. 11). This construct includes symptomatology (psychiatric and substance abuse), social or interpersonal functioning, work functioning, satisfaction, treatment utilization, health status or global well being, and (g) health related quality of life--value weighted (p.
12). They state that outcome data can be used to "achieve four main objectives: management of clinical and administrative operations, regulatory compliance, marketing, and research" (p. 9).

**Consumer Satisfaction**

Outcome data, in the form of consumer satisfaction, is used in this study in keeping with its objective of research. Assessment of consumer satisfaction with mental health services was unusual until the late 1970s. Attkisson and Greenfield (1995) state that now, however, "consumer satisfaction has achieved the status of an important measurement domain in health and human service outcome assessment" (p. 120). According to Lebow (1982) changes resulted from the following contributing factors: (a) more frequent use of evaluative approaches to mental health programs, (b) movement to a more consumer-oriented society, (c) increased financing of treatment by government and third party payors, (d) a more complex clientele, and (e) the simplicity and ease of administration of measures of consumer satisfaction (p. 244). Lebow (1982) stated that "measures of consumer satisfaction assess the extent to which treatment gratifies the wants, wishes, and desires of clients for service" (p. 244). Three reasons why "few solid conclusions can be drawn from consumer satisfaction literature" at the time are cited by Lebow (1982, p. 249)
and include the relatively short history of such research, the primitive status of most methodology, and concentration having been placed on assessing satisfaction for entire facilities without proper attention being given to specificity. In addition to publication of Lebow's (1982) review, "research on patient satisfaction has grown rapidly and served as the subject of several reviews published from the mid-1970s to 1980" (Pascoe, 1983, p. 185). Then, by the 1990s, since consumer satisfaction had achieved the status of an important measurement domain in health and human service outcome assessment, it would seem to be an important consideration in the employee assistance program field.

The literature indicates that consumer assessment of, or satisfaction with, care has demonstrated consequences for health outcomes. LeVois, Nguyen, and Attkisson (1981, p. 139) tell us that "in the private sector, dissatisfied health service clients can often seek services elsewhere as an expression of dissatisfaction." Kaplan and Ware (1989, p. 40) state that consumers who are dissatisfied with care, for example, may "engage in activities that disrupt their medical care and could compromise their health outcomes." It could be hypothesized that dissatisfaction with services offered by employee assistance programs could have similar results. It would be important to determine, for example, if an individual would return to the employee assistance program for future assistance if needed regardless of how
the employee came to the EAP (i.e., through supervisory versus self-referral). This particular question is addressed in the instrument used in this study (i.e., CSQ-8).

This study addressed the question of whether consumer satisfaction would be impacted by the source of referral (e.g., supervisory versus self). According to Eisen, Grob, and Dill (1991), "emphasizing the patient's perspective has unique advantages to evaluators" (p. 213). Two of their three suggestions to tapping this perspective were included in this study: (a) recruiting clients as evaluators of their own progress through self-report, and (b) assessing satisfaction with various aspects of treatment --what is termed the consumer model (p. 214).

In this study, consumer satisfaction was measured by the Client Satisfaction Questionnaire-8 (i.e., CSQ-8) as a mailed survey to selected employees. The CSQ-8 utilized a self-report format to "measure satisfaction with services received by individuals and families" (Attkisson & Greenfield, 1995, p. 120). It was designed to be used in studies across a variety of settings including employee assistance programs.

Self Report

According to Attkisson and Greenfield (1995), "consumer satisfaction has achieved the status of an important
measurement domain in health and human service outcome assessment” (p.120). Lebow (1982) indicates that “survey methods are the most widely used means of gathering data” (p. 244). According to Kaplan and Ware (1989), “no other data source currently part of the traditional quality assessment machinery incorporates patients’ values or preferences in the same way as directly as surveys of patients’ opinions” (p. 26). While surveys may offer the advantage of direct involvement in the assessment of one’s own care, it is important to recognize that there are methodological questions to be raised in relation to self-report. These questions will be addressed in detail in Chapter 2.

Docherty and Streeter (1995), for example, discuss what they term the “Rashomon” effect whereby responses to specific treatment will vary according to the perspective of the reporting participant (p. 12). This means that each perspective should be rated independently. In addition, even when looking at a single person, one needs to consider issues such as response bias. An excellent presentation of methodological issues to be considered when dealing with self-reported data can be found in Borg and Gall (1983).

Alexander (1990), in her review of self-report, indicates that “the use of self-report has a venerable history, from introspection through the advent of behaviorism to the cognitive-behaviorism of today” (p. 2).
She goes on to state that "self-report is one of the best ways of illuminating the experience of an individual" (p. 2). Any study that uses a self-report measure must take care, however, to address issues in methodology that may lead to questionable results. These methodological concerns will be further addressed in Chapter 2.

**Purpose of Study**

**Statement of the Problem**

The purpose of this study was to determine if the source of referral to employee assistance program services (i.e., supervisory versus self) would have an impact on the level of consumer satisfaction. Companies that were selected for this study consisted of those which had a broadbrush employee assistance program in place for at least one year. These particular study requirements allowed for the supervisors and managers to have gained familiarity formally (e.g., through training) and informally (e.g., through experience) with the employee assistance program philosophy, practices and providers. Seventeen companies that met these criteria were collapsed for purposes of data analysis and to further ensure the confidentiality of the participants. In addition, this study was ex post facto in order to allow for "psychological distance" from the actual reception of services to occur. This concept is discussed by Docherty and Streeter (1995, p. 13).
Need for the Study

As mentioned earlier, Kaplan and Ware (1989), believe that dissatisfaction leads to significant problems that could potentially result in compromising an individual's care. It can be argued that having knowledge about whether an individual is satisfied with care would be of particular importance to an employee assistance program. Satisfaction has been measured from the perspective of supervisors and clients (DeFuentes, 1986), as determined by whether the service was received via face-to-face or telephone contact (Champion, 1988), or whether service was specific to an HMO (Pearson & Maier, 1995). To date there has been no published study using the Client Satisfaction Questionnaire-8 (i.e., CSQ-8), a standardized instrument, to explore whether there would be a difference in an employee's satisfaction with employee assistance program services based on the source of referral (i.e., supervisor or self). This is particularly important since a percentage of the employee population will utilize employee assistance program services only when they are referred by their supervisors.

Research Questions

This study investigated and compared differences in satisfaction based on the referral source bringing the employee to the EAP (i.e, supervisory versus self). In
addition, this study investigated possible between group differences in satisfaction based on gender, and drug or alcohol being the presenting problem as compared to other concerns. The following five hypotheses, formulated on the basis of previous research, were tested:

**Hypothesis 1.** There will be a significantly greater percentage of self referrals to the employee assistance program as compared to employees who come in under supervisory referrals. A body of research from diverse settings has emphasized the prominence of self-referrals to employee assistance programs. Backer and O'Hara (1991), for example, support the view that the majority of employees who seek help do so through self-referral.

**Hypothesis 2.** Women will be significantly more likely than men to self-refer to the employee assistance program. Brodzinski and Goyer (1987), in their study on employee assistance program utilization and gender, determined that women were more likely to self-refer than men. Hall, Vacc, and Kissling (1991) also found that women were more likely to self-refer. Blum and Roman (1992), in a study cited earlier explored client utilization of employee assistance program services and found that women were less likely than men to be referred by supervisors.

**Hypothesis 3.** There will be a higher mean level of satisfaction from self-referral as compared to supervisory referral. Keaton (1990), studied the effect of voluntarism
on treatment attitude in relationship to previous counseling experience in an employee assistance program. Results, consistent with cognitive dissonance theory, showed a significant relationship between voluntarism and viewing the counseling in a positive light. While the goal of one's participation in the employee assistance program is problem resolution, the fact that a person is told to participate may set up a situation of cognitive dissonance leading to less satisfaction with the help received by the employee. Keaton's (1990) results "confirmed the hypothesis that voluntary participants have a more positive attitude regarding the treatment situation than involuntary participants" (p. 64). Pearson and Maier (1995) also found that self-reported improvement was negatively related to being referred by a supervisor.

**Hypothesis 4.** There will be no difference in mean level of satisfaction as determined by gender. Lebow (1982) stated that research up to the time of his study had consistently demonstrated that demographic characteristics were not good predictors of satisfaction. While it appeared that satisfaction was unrelated to gender, Lebow did encourage more research to examine the relationship of client variables to satisfaction. Over ten years later, Attkisson and Greenfield (1995) reiterated that future research should control for variables they viewed as functioning as covariates of satisfaction. They stated that
gender effects are perhaps the most important candidates as covariates that may contribute variance to satisfaction ratings.

**Hypothesis 5.** Mean level of satisfaction will be lower for those who present with drug problems as compared to those who present with other problems. Lebow (1982), for example, cites several studies and states that "satisfaction has variously been found to be lower for drug abusers" (p. 251).

**Definitions**

This study investigated differences in satisfaction level based on the referral source for participants in their employee assistance program in terms of number and general level of satisfaction. In addition, between group differences based on gender and whether the presenting problem was drugs/alcohol or some other concern was addressed.

In order to provide a conceptual framework for evaluating previous research, a brief overview of definitions will precede the literature review. In this study, the following definitions were applicable:

**Employee Assistance Program (EAP)** - A worksite-sponsored program for employees that is broadbrush in nature and which covers a wide range of emotional and human service needs. For this study, only employee assistance programs
that have had a minimum of a full year of operation were considered.

"Welfare capitalism" - A sociological phenomena described by Brandes (1976) whereby companies, in order to avoid unionization of employees and assist in the process of acculturation for new immigrants, began to offer company-sponsored social services in the 1800s.

Occupational Alcoholism Program - The more formal beginnings of the movement toward employee assistance programs. Occupational alcoholism programs were sponsored by companies to initially address alcohol problems being experienced by employees that the company viewed as resulting in an impact on the employees' work performance, attendance, and conduct.

Broadbrush - A term that refers to the expansion of services offered by employee assistance programs to include areas other than drugs or alcohol. Such additional services typically include emotional, financial, relationship, legal and other services.

Self-referral - A visit to the employee assistance program that is initiated by the employee after having been exposed to information garnered from brochures, company sponsored orientations, posters, co-worker recommendations, family member(s) or the like. In this case the employee makes a voluntary choice to participate in employee assistance program services.
Supervisory-referral - A visit to the employee assistance program that is initiated by a supervisor or manager due to on-the-job concerns related to an employee's productivity, attendance or conduct decline or reasonable suspicion of substance use. In this study, due to available sample size, no distinction was made between referrals made by a direct supervisor, a manager, or a member of Human Resources.

Constructive confrontation - The process by which a supervisor, who has noted a decline on the part of the employee in work performance, attendance, and conduct, or who has reasonable suspicion of an alcohol or other drug problem, takes appropriate steps to confront the employee. The supervisor focuses on the following issues within the context of a confrontation with the employee: (a) deficits observed by the supervisor regarding work-related issues, (b) documentation of both verbal and written interventions regarding the deficits, and (c) specific steps taken by the supervisor as part of coaching or disciplinary procedures in order to remediate the concerns. It is at this point that the supervisor develops a behavioral plan with the employee and makes a referral to the employee assistance program.

Satisfaction - The direct evaluation by the consumer of services received from the employee assistance program through the utilization of a standardized instrument, the Client Satisfaction Questionnaire-8.
CSQ-8 - The Client Satisfaction Questionnaire-8, developed by Attkisson and Greenfield (1995), is a standardized self-report questionnaire designed to measure satisfaction with services received. This instrument required only one administration. The CSQ-8 is suggested for evaluating services received from a variety of settings including an employee assistance program.

Outcome - As related to mental health care, it comprises seven dimensions including: (a) symptomatology (psychiatric and substance abuse), (b) social and interpersonal functions, (c) work functioning, (d) satisfaction, (e) treatment utilization, (f) health status and global well being, and (g) health-related quality of life—value weighted (Docherty & Streeter, 1995, p. 12).

Organization of Study

This study was organized into five chapters. Chapter 1 provides an introduction and rationale for the purpose of this study. A review of the problem being studied is presented leading to the development of the research questions and hypotheses under consideration. Chapter 2 presents a review of the literature covering the following areas: (a) historical development of employee assistance programs, (b) key elements of an employee assistance program, (c) employee assistance program research strategies, (d) outcome studies, (e) satisfaction studies,
(f) issues related to self-report, (g) supervisory referral, and (h) self-referral studies. Chapter 3 describes the methodology of the study which includes: (a) participants, (b) variables (independent and dependent), (c) instruments, (d) demographic information, and (e) procedures. Chapter 4 discusses the results of the study. Chapter 5 presents a discussion to include information regarding limitations of the study and future research.
CHAPTER 2
REVIEW OF THE LITERATURE

Historical Development

Employee assistance programs (i.e., EAPs) cannot be described in terms of a single entity that, in their essential elements, have remained unchanged throughout history. Employee assistance programs span a period of development from the informal to the formal. Practitioners today would not recognize the initial efforts as being a precursor to what was eventually to become the employee assistance program (i.e., a continually-evolving service that strives to address more and more of the issues critical to a productive, healthy workforce). From the welfare capitalism of the 1800s and occupational alcoholism and social welfare programs of the late thirties and forties, through the broadbrush programs of today, it is change that predominates.

In a general sense, the basis for what was to eventually develop into employee assistance programs (i.e., EAPs) as we know them today, began with a social movement of the late 1880s referred to as welfare capitalism. Following this period, Midanik (1991) states, however, that "two major complex and intertwined historical threads, occupational
social welfare and occupational alcohol programs, have led to the development of EAPs" (p. 69). In order to get a clear grasp of the concept and purpose of employee assistance programs, it is important to develop an understanding of these historical trends.

**Occupational Social Welfare**

Brandes (1976) in *American Welfare Capitalism*, indicates that it was the influx of immigrants into the United States that created a need for industry to both defend corporate interests and assist immigrants and their families with the process of acculturation in the United States. In order for industry to defend its own self interest, it needed to prevent the organization and development of unions. As a result, companies began to provide multiple services that we would today term "social services". Kotschessa (1994) states that "the concept of welfare capitalism refers to the voluntary provision of benefits and services by employers in order to retain, control, and socialize the rapidly growing workforce at a time when workers were desperately needed" (p. 65). While these company-sponsored services appeared to be efforts directed to help the newly-arrived immigrants and their families adapt to a new culture, and in fact were helpful in that regard, it was also a self-serving effort on the part of industry. According to Kotschessa (1994), specialists
known either as "social secretary" or "welfare secretary" were hired by companies to "attend to the physical, cultural, personal, and economic welfare" of employees and family members (p. 65). The provision of these company-sponsored services lasted until approximately the Depression of 1929. Following the Depression, government-sponsored programs began to develop. It is probably this trend that has led to our understanding of a broadbrush employee assistance program.

A second trend in the formal movement toward what we would today call an employee assistance program occurred with the development of occupational alcoholism programs (i.e., OAPs). Although this programmatic trend is historically and widely reputed to coincide with the beginnings of Alcoholics Anonymous, there are reports of more informal efforts on the part of industry occurring prior to that time. One of the earliest is reported by Dubreuil and Krause (1983, p. 86). The example cited is a Litchfield, Connecticut corporation that in 1789 issued a pledge to discontinue supplying distilled spirits to its employees.

**Alcoholics Anonymous**

With the exception of some isolated efforts, such as that cited above, formal movement on the part of industry toward the development of employee assistance programs is
usually reported to coincide with the beginnings of Alcoholics Anonymous (i.e., AA) which started in 1935. The teaching and structure of Alcoholics Anonymous quickly spread throughout the United States (Dickman & Challenger, 1988). This growing support movement eventually began to exert its influence by making a major impact on industry's view of and approach to dealing with employees who experienced problems with alcohol. Trice and Schonbrunn (1981), in their review tracing the history of job-based alcoholism programs from 1900-1955, describe the predecessor of employee assistance programs as evolving from workers having problems with alcohol informally sharing with others who had similar problems.

**Occupational Alcoholism Program**

A program, then called occupational alcoholism program (i.e., OAP), developed to deal exclusively with employees experiencing alcohol problems. Trice and Schonbrunn (1981) discuss three factors they believe to have been influential in the development of occupational alcoholism programs at that time: (a) the emergence and development of alcoholics anonymous (AA), (b) concerns of physicians working within industrial settings, and (c) an increased need for workers during a period of war involvement in this country. This latter factor demonstrates the interplay of socio-cultural factors on business and industry that became further evident
around the time of World War II. It was during wartime that the availability of employees for non-military activities was limited so that workers with alcohol problems resulting in decreased productivity or who developed attendance or conduct problems became more noticeable.

Evolution from OAPs to EAPs

Although there are reported informal, or "quasi-private", attempts during or after World War II to assist employees with alcohol problems, researchers typically consider E. I. DuPont de Nemours and Company and Eastman Kodak Corporation, Allis Chalmers, and Consolidated Edison to be the pioneers of more formal approaches toward the development of work-sponsored programs in the 1940s (Archer, 1977; Trice & Schonbrunn, 1981). There are several good historical reviews available which address the development and growth of occupational alcoholism programs.

A classic article by Presnell (1967), discusses the early expansion of occupational alcoholism programs. Archer (1977) provides a description of the historical development of occupational alcohol programs from the early 1940s to the early 1970s. She says that "the major thrust of arguments to persuade companies to adopt programs was that alcoholism was a health problem that primarily afflicted individuals who were in their middle service years, and hence persons in whom the company had a large investment" (p. 4). Archer
(1977) indicates that, "since the early programs, the supervisor's role has been restricted to that of documenting absenteeism and decreased work performance instead of attempting to distinguish the signs and symptoms of alcoholism" (p. 5). She goes on to state that "when confronting the employee with his declining work performance, the supervisor informs the worker that help will be made available if he cannot himself deal with the source of his problem" (p. 5). In addition, Archer analyzes the expansion of occupational alcohol programs toward what later became known as "broadbrush programs".

Limitations of Occupational Alcoholism Programs. It should be noted that services provided to employees by occupational alcoholism programs were limited. Some of these limitations as listed by Nye (1990) include the following: (a) the difficulty experienced by the workplace in recognizing early-stage alcoholism, (b) employees with chronic alcohol problems who were viewed as untreatable, (c) programs that relied almost exclusively on supervisors to recognize symptoms resulting in supervisors making more referrals of rank-and-file members, (d) failure to identify the alcohol problems of executives and managers, and (e) employees with alcohol problems who tended to hide their problems so that they only became noticeable at later stages of development (pp. 2-3). As these limits came to light, awareness developed that changes were necessary.
Kemper Group. In 1962, the Kemper Group developed a program that not only addressed the problem of alcoholism but expanded their program to address other life problems as well. According to Dickman and Challenger (1988), this initiative considerably changed occupational alcoholism programs and resulted in an evolutionary leap toward our modern employee assistance programs (p. 49). This occurred well before NIAAA's rather strong endorsement of the need to develop "broadbrush" programs in the early 1970s.

The Hughes Act and NIAAA. In 1969, Senator Harold Hughes of Idaho became concerned about the failure of both federal and state government to be concerned regarding the problem and treatment of alcoholism. In 1970, Congress passed a Federal Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act (Public Law 91-616). An outcome of this Act was the creation of the National Institute of Alcoholism and Alcohol Abuse (i.e., NIAAA). According to Dubreuil and Krause (1983), cited earlier, the NIAAA was created to develop leadership and handle monies aimed at alcohol prevention and treatment. According to Archer (1977), "before the creation of NIAAA, occupational alcoholism policies and programs, with few exceptions, were designed to provide assistance solely to the problem-drinking employee" (p. 8). Archer continues to state that, on the basis of its survey of existing programs and of knowledge in the field, NIAAA wound up endorsing the
"broadbrush" approach "as the ideal strategy for occupational alcoholism programs" (p. 8). Another goal of NIAAAA was to recognize that alcoholism was a disease and not a moral or legal issue. According to Archer (1977), the disease model of alcoholism was pioneered by E. M. Jellinek and officially accepted by the American Medical Association in 1956. By 1971, most states had followed the lead of the federal government and enacted legislation resulting in the recognition of alcoholism as a disease. It should be noted, however, that the disease concept so readily embraced by practitioners and occupational alcoholism specialists, was not without its critics. Archer (1977) presented numerous studies that considered the disease concept as demeaning. Archer states that "by contrast, the approach now recommended by NIAAA's Occupational Programs Branch relies more heavily on the sociocultural model" (p. 12).

Steele (1989), another historical reviewer, discussed the history of job-based alcoholism programs from 1955 through 1972. In a second study, Steele and Trice (1995) traced the history of job-based alcoholism programs from 1972 through 1980 and discussed the influences of professional organizations such as Alcoholics Anonymous and the National Council on Alcoholism. By reading these three articles, one would wind up with a fairly good understanding of both the development and contributing influences on occupational alcoholism programs.
Prior to the development of the NIAAA, two general practices were acceptable in occupational alcoholism programs. First, alcoholism could best be identified if supervisors were trained and monitored employee work performance. Second, if reasonable steps to improve performance proved to be ineffective, an offer of professional assistance should accompany constructive confrontation (Roman, 1988, p. 58). NIAAA adopted and encouraged the practice of these provisions as efforts were expanded to include a “broadbrush” approach (Roman, 1988, p. 59).

According to Roman (1988), it was NIAAA that coined the phrase “occupational alcoholism” to describe programs that developed with this as their focus (p. 57). The use of this term was intended to de-emphasize the public’s stereotypical perception of alcoholism as pertaining only to individuals drinking out of brown bags under bridges and living on the streets.

Project 95. Under the sponsorship of NIAAA, “Project 95” became a major enterprise. Project 95 had as its specific purpose the identification of and assistance toward an estimated 95 percent of alcoholics not found on skid row. In other words, NIAAA attempted to draw attention to the larger percentage of individuals who were employed but who also experienced problems with alcohol. Other efforts of the NIAAA included sponsoring research and providing grant
monies to states to hire and train specialists in the area of alcoholism. The establishment of employee assistance programs, although not required at that time, was encouraged.

**ALMACA.** In 1971, the Association of Labor and Management Administrators and Consultants on Alcoholism (i.e., ALMACA) was established. This group is today called EAPA (i.e., Employee Assistance Professional Association) and has local chapters both within the United States and abroad. Today, "EAPA, an organization with a membership of over 6,000, has adopted standards for EAPs that specify a comprehensive set of services" (Blum & Roman, 1995, p. 1). The Employee Assistance Professional Association provides dissemination of educational and training materials and provides seminars and workshops to aide in the professional development of individuals providing employee assistance services. In the 1980s, EAPA became a driving force behind the development, testing, and monitoring of the CEAP (i.e., Certified Employee Assistance Professional) test and credential. As can be noted by the name change, this group recognized the development of services within corporate America that reflected the ever-expanding role of professionals and companies from offering alcohol only to broadbrush employee assistance programs.

**1980s.** In the 1980s, employee assistance programs continued to develop both in terms of the number available
and of their becoming more comprehensive in nature. During this period, major changes occurred in both employee assistance program development and services offered. As mentioned above, plans began to develop to certify and credential EAP practitioners. This required clarification regarding role descriptions and functions of employee assistance program professionals. Also, unions began to become more involved with and more accepting of employee assistance programs. It was also becoming evident that some companies offered employee assistance programs that basically existed only on paper. Researchers began to address the question of what made an employee assistance program effective.

By 1987, the Bureau of National Affairs considered the development and expansion of employee assistance programs to be important enough to merit national attention. The Bureau published a seminal document addressing a wide variety of EAP-related issues. A key point discussed is that in almost all instances an employee assistance program is maintained after it is established. Studies undertaken since then appear to confirm this point. Seid (1991) states that "the permanence of an EAP may be attributed to reasons other than proven efficiency, effectiveness, and high levels of satisfaction" (p. 3723). Another recent study by Oher (1993) measured employee assistance program consumer satisfaction by surveying 55 Human Resource managers. In
discussing implications for employee assistance programs, Oher (1993) states that "as the results from this corporate survey indicate, many aspects of EAP service that reflect firmly held beliefs may not be present in programs that are, none the less, perceived as worthwhile" (p. 74).

**Drug-Free Work Place Act.** A further contributor to the development and growth of employee assistance programs occurred in 1988 with the enactment of the Drug-Free Work Place Act (Nye, 1990). This Act required that employers who receive federal grants and/or contracts over $25,000.00 must maintain a drug-free workplace environment. According to Nye (1990) a company must take a number of steps in establishing a drug-free workplace and in coming into compliance with the Drug-Free Work Place Act: (a) publish a statement notifying employees of what is prohibited and the action to be taken regarding any violations, (b) establish an awareness/educational program for employees, (c) give every employee a copy of the drug-free statement, (d) indicate that employees must abide by the policy as a condition of employment, (e) require satisfactory completion of any needed abuse assistance or rehabilitation program by anyone needing such help, and (f) continue to implement the requirements as indicated by the Drug-Free Workplace Act (pp. 223-224). A key element that is strongly recommended, although not required, is the availability of employee assistance program services (Cunningham, 1994, p. 12).
In the early 1980s, major attention was being directed employee assistance programs in terms of research. While many earlier studies were not experimental in design and possessed numerous methodological flaws, as shall be discussed later in this section, it should be noted that researchers were beginning to realize that employee assistance programs offered a fertile field for study. Researchers became interested in addressing the key components of an employee assistance program, determining whether EAPs rendered effective services, whether certain components were more effective than others, and in clearly defining EAP technology and functions.

Core Technology of Employee Assistance Programs

Core Elements

This early research eventually led to the development in the early 1980s of the beginnings of what was later to be called the core technology of employee assistance programs. Roman (1989) and Blum and Roman (1989) have since identified six core elements that they refer to as the "core technology of employee assistance programs". These core elements include (a) employees' behavioral problems being identified as a result of impaired job performance issues, (b) the provision of expert consultation to supervisors, managers, and union stewards (where applicable) on when and how to apply and use employee assistance program policies,
(c) appropriate use of constructive confrontation, (d) micro- and (e) macro-linkages of the home organization with counseling, treatment, and other community resources, and (f) mainstreaming alcohol-problem benefits on a parity with other health care in a milieu supportive of alcohol prevention and intervention. Blum and Roman (1992) believe that these core elements for employee assistance programs can be “addressed only by providing comprehensive services” (p. 120).

Core Functions

In addition to the core technology mentioned above, Blum and Roman (1992) also developed what are termed employee assistance program functions. These functions are divided into two main categories to include strategies specifically related to management and strategies that are related to benefits. The management-related strategies include the retention of valued employees, provision of assistance to troubled supervisors, and the provision of due process for employees whose personal problems may be having an impact on their job performance. The benefits-related strategies include controlling the costs involved with health care utilization, serving as a channeling function for employees’ and dependents’ utilization of services under the umbrella of employee assistance, and serving as an additional employee benefit and morale booster (p. 121).
Key Elements of an Employee Assistance Program

In order to understand how an employee assistance program functions from a systemic perspective, it is essential to review what are considered to be the key elements that any effective employee assistance program must possess. Dickman and Emener (1988), following their review of the literature, have determined that there are ten attributes considered critical in any successful employee assistance program. These elements exemplify the importance of reaching all parts of an organization in terms of "backing" or support, union involvement (if applicable) and training. Each of the following critical elements, as presented by Dickman and Emener (1988), reach across the broad spectrum of an organization: (a) backing of management at the highest level, (b) support of labor, (c) confidentiality, (d) ease of access, (e) availability of supervisory training, (f) labor steward training, (g) involvement of insurance plan, (h) availability of a broadbrush program, (i) professional leadership on the part of the employee assistance program, and (j) follow-up and evaluation to measure program effectiveness (pp. 279-280).

These key elements have been determined to be present in the companies that were selected for this study. Each of the seventeen companies, from which the employee samples have been drawn, have had a minimum of one year receiving
services from the employee assistance program providers. Companies selected for this study have demonstrated backing of leadership at the highest levels and active involvement of the employee assistance program professionals. Each company has ensured that their Human Resource Department, managers at all levels, and supervisors have received appropriate training regarding proper utilization of the employee assistance services within the context of a broadbrush program. Individual employees have had ease of access and confidentiality has been stressed in their orientation programs. These factors are reiterated in the promotional materials distributed to employees. In addition, confidentiality is emphasized on client information forms and in the initial assessment session.

This study, designed as an ex post facto survey, hoped to achieve two goals. First, given the still developing state of employee assistance program research, it hoped to contribute to the existing literature on EAP effectiveness. Second, it has helped to determine if any differences in satisfaction exist based on source of referral.

EAP Research Strategies

Seid (1991) states that "progressive companies are currently providing a variety of health care services to combat employees' personal problems that affect productivity ... however, most of the anecdotal, cost-benefit, and survey
data presented can be challenged on methodological grounds" (p. 3723). Harris and Heft (1992) confirm that although utilization of employee assistance programs has grown dramatically since their inception, "there has been little rigorous research on this topic" (p. 253). The researchers state that this has been a major source of criticism directed at studies of employee assistance programs. They claim that no rigorous, systematic study exists and that most of the available research contains significant design flaws (p. 255).

A majority of the studies assessing employee assistance programs consist of case studies or anecdotal reports which are typically descriptive in nature (e.g., they describe the organization in terms of number of employees, type of industry, development of the employee assistance program etc.). DeFuentes (1986), in her study evaluating an aerospace employee assistance program, for example, used a combination of record review and interviews to determine the degree of employee assistance program implementation. Berman, Sulsky, Pargament, and Balzer (1991) in, "The Role of Needs Assessment in the Design of Employee Assistance Programs: A Case Study," used a multi-method needs assessment of 250 employees. Data was gathered for this case study from a review of employee records, interviews with key leaders and employees, and an employee survey. McKibbon (1993), in his review of employee assistance
programs in Canada, found that over 80 percent of studies in the prior five years used anecdotal evidence as a way of providing a description of employee assistance programs. Finally, Csiernik (1995), in his review of the literature focusing on employee assistance program delivery options, found that 24 out of 48 studies reviewed consisted of a case study approach. Few of the studies used cost-benefit analysis, process evaluations or needs assessments. Studies have ranged from the specific components of employee assistance services (e.g., smoking cessation programs, worksite health promotion, effects of company-sponsored relocation counseling) to determining who is more likely to utilize services. In terms of evaluating cost outcomes, a methodology based on standard economic theory is available. French, Zarkin, and Bray (1995) discuss the four components of this methodology and indicate that researchers should try to incorporate each of them. These four components include (a) a process description of employee assistance program structure, environment, and goals, (b) an analysis of employee assistance program costs, (c) an analysis of employee assistance outcome in terms of work-related performance and productivity, and (d) an economic evaluation of cost-effectiveness ratios, cash benefits, and net benefits. A significant amount of research has been directed to the cost-effectiveness of employee assistance programs. Other methodologies need to be developed.
Docherty and Streeter (1995) posit that "a sophisticated, comprehensive outcomes measurement system will not only allow us to effectively respond to ... external forces, but such information will also provide the necessary tools to systematically improve the quality of mental health care" (p. 8). According to the same authors, outcome "is actually a complex construct composed of several independent dimensions" (p. 11).

**Outcome Studies**

**Definition of Outcome**

According to Eisen (1996), "the field of mental health outcomes research has produced an enormous body of literature encompassing many professional disciplines, employing a wide range of methodologies, and incorporating many definitions of 'outcomes'" (p. 71). As mentioned above, Docherty and Streeter (1995) define outcome as "a complex construct composed of several independent dimensions" (p. 11). They present seven dimensions of outcome that include symptomatology (psychiatric and substance abuse), social and interpersonal functioning, work functioning, satisfaction, treatment utilization, health status and global well being, and health-related quality of life--value weighted (p. 12).

According to Eisen, Grob and Dill (1991), "treatment outcome and satisfaction are not strongly correlated" (p.
"Low but statistically significant correlations between improvement and satisfaction suggest that although there is some tendency for those who are doing well to be more satisfied with the care received, satisfaction cannot be predicted very accurately from knowledge of a patient's improvement or level of functioning" (p. 230).

EAP outcome indicators. According to Jerrell and Rightmyer (1988), there are four categories of outcome indicators in employee assistance program evaluation: (a) accidents, sick leave, medical-surgical costs and insurance premiums, (b) absenteeism, tardiness, and job inefficiency, (c) rehabilitation rates, and (d) job performance ratings, grievances, disciplinary actions and labor arbitration incidents (p. 260). What is missing in these categories, is the place of the consumer. According to major researchers in the area of consumer satisfaction, "emphasizing the patient's perspective has unique advantages to evaluators" (Eisen, Grob & Dill, 1991, p. 213).

Consumer perspective. Eisen, Grob and Dill (1991) posit that a client's perspective can be emphasized and explored in three ways. First, by designing outcome measures around treatment goals defined by the clients. Second, by recruiting clients as evaluators of their own progress through utilizing self-reports. And, third, by assessing client satisfaction with varying aspects of their treatment—what is described as the consumer model (p. 214).
Kaplan and Ware (1989) state that "one of the thornier issues currently facing practitioners, medical educators and health policy makers is the definition of a reasonable and appropriate role for patients in the medical care process" (p. 25). In reviewing the research and practical issues related to client role, Kaplan and Ware (1989) address two client roles that they view as being distinct: (a) "as evaluators of care, both directly and indirectly, supplying information used by others in evaluating care", and (b) "as active participants in care, shaping the nature of the care they receive" (p. 25).

This review reinforces involving client’s in their care for the following reasons. First, clients are a practical source of information. Second, client satisfaction or assessment of care has been demonstrated to affect both the therapeutic relationship and the client’s health status. According to Kaplan and Ware (1989), clients who are dissatisfied may physician-shop, change health plans, sue, not follow treatment recommendations, and avoid further visits. Third, research has shown a link between clinical and client-reported measures of health outcomes. Fourth, clients appear to desire an expanded role in their own care. Fifth, clients who are dissatisfied with or not permitted to participate in their care may turn to self-care. Sixth, there are underway a number of large-scale data collection efforts to gather clients’ assessment of their care.
While this review addresses patients' medical care, it does consider five behavioral health concepts which include: (a) physical health, (b) mental health, (c) social functioning, (d) role functioning, and (e) general well-being (pp. 26-27) each of which are relevant to employee assistance program services and satisfaction. It is important to remember that employee assistance programs are not limited exclusively to mental health concerns even though a fairly large proportion of presenting problems fall within that category.

Other subcategories listed by Kaplan and Ware (1989) are also of concern to employee assistance programs. These include anxiety and depression, psychological well-being, behavioral and emotional control, cognitive functioning, social and interpersonal contacts, social resources, and role functioning (pp. 43-47).

**Issues in Outcome Research**

There are major issues to be considered when measuring outcome. In their paper, Docherty and Streeter (1995) emphasize three of them.

**Rashomon Effect**

Docherty and Streeter state that the source of outcome data is important and affects results. They discuss the "Rashomon effect"—that is, outcome will vary according to
the perspective of the person doing the reporting. For example, a client will most probably “rate outcome according to the experienced change in subjective state” (p. 12). A therapist or employer who is asked to evaluate the same outcome might look at something completely different. Conte, Ratto, Clutz and Karasu (1995), for example, explored 138 outpatients’ level of satisfaction with their therapists. Patient satisfaction was related to measures of psychotherapy outcome as derived from patients themselves, therapists, and an independent rater. Several specific therapist characteristics and an overall rating of satisfaction appeared to be significantly correlated with the patients’ ratings of self improvement, help received, and therapist ratings of outcome.

**Timing**

A second factor in outcome assessment is timing. This is particularly important in the area of measuring consumer satisfaction. If a researcher assesses too closely to the time clinical services are provided, one might find a “positively biased response because of patient concerns regarding retaliation, anonymity, or other demand characteristics of the immediate social context” (Docherty & Streeter, 1995, p. 13). While having a client fill out a satisfaction questionnaire immediately following reception of EAP services might increase survey return rates, research
indicates that allowing adequate psychological distance is an important issue to consider for the reasons cited above.

Population

A third issue involves the population under study. Demographic information can "greatly enhance the value of the data and expand the analyses that can be conducted" (Docherty & Streeter, 1995, p. 13). This study presents multiple areas of demographic information which is taken from the Client Information Form (see Appendix B) filled out just prior to reception of employee assistance program services.

Objectives

Docherty and Streeter (1995) indicate that clinical outcome data can be used to reach four main objectives. First, outcome data can affect change in the management of clinical and administration operations. Second, data can assist in identifying areas for change in order to maintain regulatory compliance. Third, data can provide support for marketing claims and information. Last, and perhaps most important, in terms of this study is the contribution to research in terms of what works and what does not (p. 9).

Theories

Kiesler (1983) states that methodological and conceptual issues have arisen because prior research on
client satisfaction has not been driven by theory. Kiesler proposes that there be a more informed use of attitude change and attitude measurement technology in this area. According to Jerrell and Rightmyer (1988), "except for Schramm's (1980) 'human-capital model of analyzing the costs and benefits of an EAP, there is little theoretical guidance for developing or evaluating these programs" (p. 269). In addition to human capital theory, however, two other theories also contribute to one's understanding of employee assistance programs; namely, systems theory and the bystander-equity model.

**Human Capital Theory.** This theory developed by Carl J. Schramm places a company's provision of employee assistance program services within the same context with other capital improvements. According to this theory, an employer invests in procurement of land, equipment, and other material elements in order to build the business and increase revenues. According to Schramm (1980), companies now view employees as being as precious a commodity as some material acquisition. If an employee is happy, healthy, and free of unnecessary degrees of stress, it is anticipated that the employee will be more productive. There is documented evidence to indicate that companies that invest in an employee assistance program find employees who utilize services have fewer absences, experience lower hospitalization rates for problems identified by the
employee assistance program, require less informal sick time, and require fewer disciplinary actions (thus freeing up supervisor’s time and perhaps lowering their stress levels). In the study cited earlier, De Fuentes (1986) supports the position that an employee who addresses personal and work-related problems through participation in an employee assistance program often winds up, at the very least, being available more often at work. The employer does not have to spend additional monies hiring and training substitutes.

In some instances, referral of a troubled employee to the employee assistance program results in retention of what had been a valued employee prior to the onset of personal or work-related concerns. In this case, the employer is saved having to replace the employee entirely which would have led to a significant amount of unproductive time while an employee search and retraining occurred. According to this model, therefore, whatever an employer can do to help retain and maintain a productive employee represents a positive outcome for their investment.

**Systems Theory.** Clearly, one familiar with systems theory can see the interaction of various micro- and macro-components of organizational and family systems in the employee assistance field that drives the core technology and functions, as presented by Roman and Blum (1989) earlier in this study. An employee assistance professional is
accustomed to interacting on a variety of levels with a complex network of individuals. These range from the employee alone to possibly involving a supervisor, a manager, a union steward, or a member of the Human Resource Department. While an employee may come in through self-referral, according to systems theory, others are still involved in the network of the person's experience. This is even more evident when an employee is referred by their work organization. Clearly, in the latter instance, there is concern related to performance, attendance, or conduct problems that have a rippling effect on others within the environmental sphere of the troubled employee.

According to Ford and Ford (1986), "the essential principles of systems theory can provide a conceptual and practical guide for the EAP administrator and case manager" (p. 37). "The systems principles of nonsummativity, nonlinear causality, feedback, dynamic equilibration, equifinality, and permeable boundaries provide a conceptual backdrop for practical guidelines" (p. 47) in helping in the development of an action plan for an employee to establish a better balance in all relevant life areas.

Bystander-Equity Theory. This model, derived from social psychology, is important particularly in a study such as this. In the first chapter of this study, background information was provided that established a basis for understanding what leads to helping behavior on the part of
a bystander. Classic studies such as those of Latane and Darley (1970) along with Schwartz and Gottlieb (1980) were discussed in order to provide the reader with information regarding the decision tree leading to helping behavior and to understand how the presence of an authority figure or someone else who could help tends to inhibit the helping response. Since this study compared supervisory and self-referral to the employee assistance program, it was important to have an understanding of what factors contribute to a supervisor making the decision to refer a given employee. As is discussed in the section on supervisory referrals later in this chapter, a number of studies have identified variables that appear to impact a supervisory referral.

Supervisory involvement is a critical employee assistance program core element in the appropriate referral of troubled employees. This study addressed whether the involvement of others in one's participation in the employee assistance program does, in fact, have any effect on the level of satisfaction.

**Consumer Satisfaction**

According to Docherty and Streeter (1995), "research has suggested that patient satisfaction is often independent of clinical outcome" (p. 12). As discussed earlier in this study, these authors state that "within the scientific
literature for mental health care, the seven main dimensions of outcome are symptomatology (psychiatric and substance abuse), social and interpersonal functioning, work functioning, satisfaction, treatment utilization, health status/global well being, and health-related quality of life—value weighted" (p. 12).

**Definition of Satisfaction**

Lebow (1982) states that "measures of consumer satisfaction assess the extent to which treatment gratifies the wants, wishes, and desires of clients for services" (p. 244). Kalman (1983) defines satisfaction as a composite of many variables. Williams (1994) states that there are a number of implicit assumptions about the nature and meaning of the term satisfaction.

Pascoe (1983) who presents various models for the conceptualization of satisfaction and states that "patient satisfaction has not been explicitly guided by a well-supported definition or psychological model of satisfaction" (p. 185). According to Pascoe, "the major exception to a lack of psychological theory-building in patient satisfaction research is the model recently proposed by Linder-Pelz" who "characterizes patient satisfaction as a positive attitude" (p. 185). The attributes of the Linder-Pelz model "are distinct dimensions of health care, such as access, efficacy, cost, and convenience" (p. 186).
Pascoe (1983) also discusses discrepancy theory and fulfillment theory. According to Pascoe, "fulfillment theories define satisfaction as a function of the amount received from a situation regardless of how much one feels they should and/or want to receive" (p. 186). The second model, discrepancy theory "includes the subject's perception of what is expected or valued as the baseline for comparing actual outcomes. Thus discrepancy theories define satisfaction as the difference between actual outcome and some other ideal outcome" (p. 186).

In his review of the literature, Williams suggests that clients may hold a complex set of important, relevant beliefs that cannot be embodied in the general term satisfaction. This leads to the question of whether satisfaction is multi- or uni-dimensional in nature.

Lebow (1982) reviews four factor analytic studies that are multi-dimensional and point to the possibility that consumers are capable of differentiating between aspects of satisfaction (p. 252). Other studies suggest that satisfaction is uni-dimensional. At the time of his writing, Lebow also had to admit that "a coherent literature on the subject has yet to develop" (p. 244). The question to be addressed is whether the situation has changed?

From both a practical and research-driven perspective, Smith (1996) asks why patients, clinicians and purchasers are increasingly uncomfortable with current methods of
procuring health care (p. 43). Smith responds "because the patient has been left out of the equation. Nowhere in the current purchasing scheme is the patient or patient's health care part of the consideration in a literal or substantial way" (p. 43). While consumer satisfaction might be a part of some decisions, it "is rarely assessed in a scientifically valid manner, and no one is sure what the measurements indicate about the quality of care or how well a patient is doing" (p. 43).

Eisen (1996), who has researched client satisfaction, recently wrote an article asking "Client Satisfaction and Clinical Outcomes - Do We Need to Measure Both?". She responded that "prior research on the relationship between satisfaction and outcome has produced varied results" (p. 72). She then argued for the conceptual differences between clinical outcomes and satisfaction stating that satisfaction cannot be accurately predicted from knowledge of a client's improvement or functional status.

May (1991), reviewed 13 studies examining the effect of treatment delay on satisfaction. May found that, while attrition rates were high, they were not necessarily related to dissatisfaction.

Treatment Issues and Satisfaction

Lebow (1982), in his article, "Consumer Satisfaction with Mental Health Treatment", presented a contemporary,
comprehensive review of the following issues: (a) evaluation of consumer satisfaction, (b) methodological issues inherent in studying satisfaction, (c) results of studies conducted, and (d) the value of consumer satisfaction. This is a significant review relied upon by a number of researchers interested in the issue of consumer satisfaction.

Type of treatment. Lebow indicates that most work was "suggestive" and "insufficiently well developed" (p. 251).

Length of treatment. Lebow states that satisfaction appears to be unrelated to treatment length although it is augmented if mutual termination (i.e., between therapist and client) has occurred (p. 251). This is further supported by May's (1991) study mentioned above.

Process variables. "Almost no research has explored the relationship between satisfaction and other process variables" (Lebow, 1982, p. 251).

Client characteristics. Lebow (1982) stated that "data suggest that demographic characteristics are not good predictors of satisfaction" (p. 251). Lebow cited numerous studies where demographic data (with the exception of race which is described as a controversial variable) such as age, gender, marital status, income level or education appeared unrelated to satisfaction. Lebow did state, however, that future research was warranted to explore the relationship between various client variables and satisfaction.
Attkisson and Greenfield (1995, p. 125), in discussing future research, however, stated that investigators need to introduce improved control for variables they view as functioning as covariates of satisfaction. These covariates include demographic and personal characteristics, attitudes about health care, and socioeconomic status. They go on to cite studies where "age and gender effects are perhaps the most important candidates as covariates that may contribute variance to service satisfaction ratings" (p. 125).

In agreement with Lebow (1982), Attkisson and Greenfield (1995) state that life satisfaction and general attitudes toward the health care system were not found to be significantly related to direct measures of service satisfaction (p. 125). Burke (1994) found that men and women were equally aware of and likely to have used the employee assistance program with similar satisfaction. Women were, however, more likely to indicate the intention to use the employee assistance program if it was needed.

Lebow (1982) found the relation of psychological, diagnostic, and prognostic client variables to be more promising. Satisfaction was determined to be lower for the following categories: (a) drug abusers, (b) suicidal clients, (c) psychotic clients, (d) those having a poor prognosis, and (e) for those who return to the same program for additional treatment. Satisfaction does appear to be related to the fulfillment of client expectations (p. 251).
A study to determine the relationship between satisfaction and type of provider was conducted by Tessler, Gamache, and Fisher (1991). Their research consisted of studying 1,198 separate contacts with mental health professionals made by 274 relatives or close friends of 168 mental health clients. Findings indicate that satisfaction varied significantly for different types of professionals.

Methods of determining satisfaction. Eisen, Grob and Dill (1991) indicate that multiple methods, both solicited and unsolicited, have been utilized to investigate consumer satisfaction and include the following: (a) personal interviews, (b) letters from clients, (c) telephone surveys, and (d) questionnaires (p. 228). Harris and Heft (1992) state that "for the most part, research on employee and supervisor reactions has been conducted independently. Given the apparent importance of informal networks, it is essential more studies be conducted that simultaneously examine the effects of supervisor reactions, employee willingness to participate, and various organizational characteristics" (p 258). This study addressed this issue by exploring whether the referral source, supervisory or self-referral, prompting an employee’s participation in the employee assistance program had an impact on the level of satisfaction.

Dickman and Emener (1988), studied employee assistance program participant satisfaction over a 26-month period.
(March, 1979 through May, 1981). They used an ex post facto survey questionnaire developed specifically for their study. According to Oher (1993) "the use of a survey questionnaire to gather information about an organization is an accepted, widely used technique in the organizational development field" (pp. 41-42). Respondent satisfaction endorsed what continues to be recognized by employee assistance program professionals to be the key ingredients of any employee assistance program if it is to be considered effective. Dickman and Emener (1988) list the five key components as confidentiality, referral, early intervention, impact on job performance, and resolution of problems (pp. 283-286).

Self Report

History of self-report. The origin of self-report can be traced to the early tradition of experimental psychology. In the latter part of the nineteenth century and the early part of this century, Wilhelm Wundt and E. B. Tichener, in their effort to apply methods of introspection, attempted to map the inner structure of the mind. Tichener (1912) proposed that theory and fact be separated by letting individuals report only experienced conscious content. He believed that all mental states and experiences could be described in terms of sensory and imaginal components. He did recognize, however, that mediating processes could occur and wrote of his concern regarding the imprecision of
communication. He said that communication should contain the elementary components of experience.

Freud (1950), in his effort to apply newly-emerging methods of psychology in the diagnosis and treatment of neuroses and other disorders, utilized self-report in a variety of ways in order to: (a) clarify his patient's condition, (b) confront problems, (c) offer interpretations, and then (d) move toward corrective action. Although many contemporary psychodynamic theorists tend to distrust self-reports due to belief in what are considered to be elaborate defense mechanisms of individuals, they do consider self-reports of: (a) retrospective accounts, (b) free associations, and (c) projective test results. These are viewed as replicable, important sources of information.

Today, clinical interviews typically begin with questions such as, "Can you tell me about your problem?" and "What brought you in today?" Rogerian (e.g., Rogers, 1954) and other humanistic clinicians consider self-reports to be veridical (i.e., the client can and will provide reliable, valid responses).

On the other hand, practitioners of behavioral psychology have placed an emphasis on nonverbal behavior. It should be noted, however, that from the very inception of behavioral psychology, measurements of verbal report have also been considered. As Boring (1950) stated, Watson did not rule out of psychology all use of introspection. He
allowed, in the case of human subjects, discriminatory verbal reports as a form of behavior when they were accurate and verifiable. The effort here was to count and measure with reliability the observable reports and actions of the subjects. Statistical analysis of multiple changes led to the reliability of self-report. In the late 1960s through the 1970s, behavioral psychologists such as O'Leary and O'Leary (1972) used self-report. Self-report has continued to be a critical factor in the measurement and intervention of behavior and behavior change.


Borg and Gall (1983) state that self-report devices "are only accurate to the degree that the self-perceptions are accurate and to the degree that the person is willing to express them honestly. This problem has been, and continues to be a matter of concern to many educational and psychological researchers" (p. 336).

Park (1992), for example, discussed how her study's results from assessing a university-based employee assistance program were limited precisely because the survey
relied on self-report. She states that "oftentimes the individuals who have used the service may be concerned about confidentiality and may not feel secure in responding to such an instrument" (p. 24).

Borg and Gall (1983) also discuss response bias using the term response sets. This is defined as a variable that leads to "spurious responses" (p. 336). They indicate that "if self-report inventories are to be used effectively in practical applications and in research settings, it is important to investigate the extent to which subjects are responding to the content of each item and the extent to which their responses are determined by a general 'set'" (pp. 336-337). Borg and Gall (1983) discuss three different response sets which include social desirability, acquiescent response sets, and negative response sets. The first, social desirability, represents the desire to present oneself in a favorable light. The second, acquiescent response set, represents the tendency to respond "true" or "yes" regardless of the content of the question. The third, negative response set, represents the tendency to respond in a deviant fashion.

Under sources of distortion in the area of consumer response, Lebow (1982) indicates that self-reported data may also be altered based on: (a) who will read the survey, (b) perception regarding how the surveyor will regard the respondent, and (c) how the survey might affect future
service requests or the career of the practitioner (p. 247). In addition, it should be noted as Oher (1993) states that "the EAP research literature offers few references regarding the use of such survey questionnaires as a vehicle to provide feedback about EAP functioning or effectiveness" (p.42). He goes on to say that "this fact is not surprising when one considers that the employee assistance field is still in the early evolutionary phase of development" (p. 42).

Steps to minimize response bias. Eisen, Grob and Dill (1991) state that the following steps can be taken by a researcher to minimize response bias: (a) guarantee confidentiality and anonymity, (b) separate program evaluators from clinical treatment staff, and (c) offer a complete explanation to clients regarding the goals and procedures of the evaluation process (p. 216). Lebow (1982) presented the same steps but added the following to decrease respondent reactivity: (a) explain that the purpose of the assessment is to evaluate service received and not the clients receiving the service, (b) emphasize that the focus of the analysis will be aggregate - not individual data, and (c) provide reassurance regarding the use of the data (p. 247). It should be noted that this study abided by these guidelines.

Advantages of self-report. A major source of information is overlooked or neglected if the consumer is
not asked to be involved in the reporting and evaluation of their own experience. Kaplan and Ware (1989) believe it is important to incorporate consumers in treatment “and to make their evaluations of the care they receive part of routine quality assessment” (p. 25).

Validity and reliability. According to Lebow (1982), utilization of self-report in studies of consumer satisfaction research has been criticized because of the following three issues. First, “validity problems are inherent in consumer assessments.” Second, self-report involves a restricted response range and a tendency toward halo responses resulting in little practical value. Third, Lebow believes consumers cannot adequately evaluate involvement in treatment due to: (a) impaired mental status, (b) lack of experience, (c) transference projections, (d) cognitive dissonance, (e) unconscious processes, (f) folie a deau, (g) client character, and (h) naivete (p. 254).

Problems have also occurred with sampling bias (i.e., the selection of clients contacted for the research and those who respond). In the first case, consumers are sometimes excluded perhaps because they are “unable” to respond. One might consider, for example, a group of inpatients who are psychotic or severely depressed. Or, in some studies the response rate might be large enough to influence results (Lebow, 1982, p. 246).
Lebow, in his review of consumer satisfaction studies, indicates that those who choose to respond to a survey are: (a) more likely than nonrespondents to have mutually-agreed upon terminations, (b) more likely to have longer treatments, and (c) those treatments were judged to be successful by the therapist (p. 246).

Shrauger and Osberg (1981) reviewed studies with self-reports coming primarily from outpatient respondents. Only one study reviewed covered psychiatric inpatients. Shrauger and Osberg found that self assessments were at least as good, if not better, predictors of reactions to therapeutic interventions.

Kaplan and Ware (1989) support this position by stating that patients' evaluation of quality of care are "the most practical source of information" (p. 26). Eisen, Grob and Dill (1991) state that it is feedback from the service consumer that is a critical factor in treatment evaluation (p. 227). In citing Kalman (1983), they identify four potential areas of client satisfaction studies which include: (a) treatment compliance, (b) service utilization, (c) program design, and (d) treatment outcome.

Client Satisfaction Questionnaire-8

Criteria for Self-Report Measure

Several well-normed instruments are available for measuring satisfaction. In this study, the Client
Satisfaction Questionnaire-8 (i.e., CSQ-8) was used as a self-reported general measure of satisfaction. Eisen (1991), a noted researcher in the area of satisfaction studies, led this researcher to the document that she says outlines "five major criteria that must be considered in the attempt to find the 'ideal' self-report measure for evaluation of mental health treatment outcome" (p. 223). The Client Satisfaction Questionnaire-8 was selected for this study because it met each of these five criteria suggested by Ciarlo, Brown, Edwards, Kiresuk, and Newman (1986).

First, the Client Satisfaction Questionnaire-8 is designed to be used with the specific target group (i.e., employees using an employee assistance program) in this study. Second, the instrument needs to have simple, teachable methodology and procedures. The CSQ-8 is very easy to learn to administer. Third, Ciarlo et al. (1986) emphasize the importance of the instrument having psychometric strength. The material available on this instrument addresses its reliability and validity as being more than adequate. Fourth, the CSQ-8, at its current price, was not outside the range this researcher would consider reasonable. Lastly, it should possess utility. The CSQ-8 is easy to understand and very easy to interpret and provide feedback, is useful to clinical services, and is compatible with clinical theories and practices.
Most consumer satisfaction studies rely on self-report. Lebow (1982) states that "survey methods are the most widely used means of gathering data. Their outstanding advantage is directness, the purpose is clear, the responses straightforward, and the tie to satisfaction is unequivocal" (p. 244). While unobtrusive measures of satisfaction (e.g., unsolicited letters of compliment or complaint, measures of utilization, case records, tapes) may reduce respondent reactivity, "there are no perfect unobtrusive measures of satisfaction" (p. 245).

Development of the CSQ-8

Since Lebow made that observation, "over ten years of empirical research has produced valid, reliable, and feasible measures of patient satisfaction with care that can now be used in practice settings" (Kaplan & Ware, 1989, p. 26). According to Eisen, Grob, and Dill (1991), it was the lack of a standard satisfaction scale that motivated Larsen and colleagues to construct an empirically-based scale, the Client Satisfaction Questionnaire (CSQ) (p. 228). Levois, Nguyen, and Attkisson (1981) state that "the CSQ was developed as a general measure of client satisfaction" (p. 140). They describe in detail the developmental components that lead to a factor analysis that "showed one general or global satisfaction factor which accounted for 43% of the total and 75% of the common variance" (p. 141). Levois,
Nguyen, and Attkisson (1981) state that "the authors concluded that the only salient dimension in the client responses to the questionnaire was a general or global one" (p. 141). The CSQ-8 possesses psychometric qualities with the potential to provide meaningful comparisons across programs.

The CSQ-8 is an eight-item scale with high internal consistency that has been widely used for the evaluation of general satisfaction (p. 228). According to Attkisson and Greenfield, 1995), "the CSQ instruments are self-report questionnaires constructed to measure satisfaction with services received by individuals and families" (p. 120). The researchers discuss the target populations where the CSQ-8 has been adopted in research. It has been used across a wide variety of service settings including employee assistance programs (p. 121).

According to Nguyen, Attkisson, and Stegner (1983), "a major problem encountered in using satisfaction measures is the ubiquitous finding that service recipients report high levels of satisfaction" (p. 299). The authors cite several studies and believe this may be due to a variety of factors including the following: (a) a client's desire to give positive testimony to treatment received (i.e., perceived demand characteristics), and (b) "observed data are taken at face value as unquestioned 'proof' of the effectiveness of the program" (p. 299).
Participation in the Employee Assistance Program

"Clients seek employee assistance program services either voluntarily through their own motivation or sometimes following the request or suggestion of a supervisor, union steward, company or personal physician, family member, friend, or a representative of the legal community" (Keaton, 1990, p. 57). Examination of participation in work-sponsored health programs such as an employee assistance program have, according to Wilson (1990), yielded some contradictory findings. This points to the complexity of the factors associated with an employee choosing or being referred by supervisors to participate in the employee assistance program. Wilson (1990), for example, reports that results from preliminary studies appear to show a relationship between one's participation in the employee assistance program and the following: (a) behavioral and psychosocial variables, (b) age of participants, (c) higher educational level, and (d) higher income levels. Hall, Vacc, and Kissling (1991), in their survey of 62 employees, assessed factors associated with employee assistance program utilization. Findings indicated that 7 percent of the participants had actually used the employee assistance program. A total of 67 percent reported that they would self-refer if needed. Those who would be most likely to use the employee assistance program included the following
categories: (a) women, (b) those with higher incomes, and (c) those with higher levels of education.

Supervisory Referrals

Supervisors are a primary referral source and key to the success of the employee assistance program (Love, 1989). Blum and Roman (1992) have developed a core technology that addresses employee assistance program liaison with supervisory management consisting of three components (pp. 121-122). First "supervisory management in the EAP core technology includes the identification of troubled employees based on documented evidence of impaired job performance" (p. 121). This does not mean focusing only on suspected alcohol or drug symptoms. Rather, it is a matter of focusing on documented impaired performance, attendance, and conduct issues that are specific to the workplace. Second, the employee assistance program provides professionals who are available to consult with a manager, supervisor, or union steward in developing familiarity with the employee assistance program policy and in learning how to use the employee assistance program and workplace rules so the employee understands that there is organizational support behind the referral. The third subcomponent of the core technology involves the supervisor setting up a situation whereby a crisis is provoked which will hopefully lead to an employee's seeking assistance through the employee
assistance program (p. 122). This is referred to as constructive confrontation and "uses evidence of job problems to precipitate crises that lead to assistance in an atmosphere of confidentiality" (p. 122). While a number of studies have addressed supervisory confrontation and referral to the employee assistance program of employees experiencing a decline in performance, attendance, or conduct, little has been done to assess coaching or early intervention referrals. "Softer approaches by supervisors usually precede use of constructive confrontation (indeed, informal referrals by supervisors are especially prominent in EAP practice)" (p. 122).

Jesko (1992) compared two groups of supervisory responses to Facilitative Counseling Skills Training (i.e., FCST) in terms of referral to the EAP. Supervisors who received FCST demonstrated increased proficiency in helping troubled employees find help with the result that employees were more likely to accept referrals from them to the EAP. In addition, the higher the supervisors scored on the Listen, Clarify, Refer, and Document (i.e., LCRD) instrument, the higher the referral rate. This emphasizes the importance of the employee assistance program's role in training supervisors on how to make appropriate referrals of the troubled employee for help.

According to Boone (1995), "supervisory training serves a dual purpose for employee assistance programs. It enables
EA (sic) practitioners to solicit the support of top and middle management in the organization for the EAP. It also enables supervisors to make use of another tool to add to their repertoire of management skills” (p. 17). Schneider, Colan, and Googins (1990) add that “most EAPs have strong, positive feelings about their supervisor training and view training as critical to the mission of the EAP” and also state that “those programs with more skilled trainers showed significantly higher referral rates” (p. 146). What other factors play a contributing part to supervisory referrals?

Gerstein, Eichenhofer, Bayer, Valutis, and Jankowski (1989) investigated the relationship between employee assistance program training and supervisory interaction with troubled employees. “Supervisors have been trained to recognize workers in distress through the monitoring of attendance, productivity, and co-worker relationships” (p. 16). “One variable that has been consistently related to supervisors’ utilization of constructive confrontation is this group’s participation in training programs designed to teach this skill” (p. 16).

While the percentage of supervisory referrals is usually significantly lower than the percentage of self-referrals, my professional experience has been that these low frequency referrals are high impact. This means that other supervisory interventions have typically been
unsuccessful in turning around inappropriate performance, attendance, or conduct issues.

Two of my hypotheses were derived from a major national study conducted by Blum and Roman (1992) with support from NIAAA. Data was collected on 6,400 employees from 84 worksites who had utilized their employee assistance program services. Their study titled, "A Description of Clients Using Employee Assistance Programs," found that "approximately 36 percent of the clients were reported, either by the client or by the EAP administrator, to have been referred by supervisors. However, only 65 percent of the 36 percent represented agreement between the two sources (client and administrator)" (p. 125). They also found that women were less likely than men to be referred by their supervisors. Based on their results, for purposes of my study, I predicted that there would be a significantly greater number of self-referrals as compared with supervisory referrals (i.e., Hypothesis 1), and women would be significantly more likely to self-refer than men (i.e., Hypothesis 2).

There are numerous studies that report factors believed to affect a supervisor's tendency to refer. Nord and Littrell (1989) conducted a study of supervisory referral in predicting what supervisory characteristics would result in referrals to the employee assistance program. Three categories of supervisors which were surveyed included 164
who had referred an employee, 194 supervisors who had recognized a problem but did not refer an employee, and 108 non-referring supervisors who noticed no problem. Results pointed to referral being significantly more likely when the following four conditions are present. First, it is important for the supervisor to have familiarity with the employee assistance program. Second, supervisors who refer to the employee assistance program are more likely to be in middle or upper management. Third, the supervisor is likely to have an opinion about how much support the employee assistance program receives from management, union, and their own immediate supervisor. Last, referring supervisors are not likely to have worked as a peer in a nonsupervisory capacity with the subordinate most recently referred or identified as having a problem.

Bayer and Gerstein (1990) examined supervisory referral decisions made by 75 supervisors to the employee assistance program. Results suggest that referral is linked to four behaviors of troubled employees. They include resistance (i.e., absenteeism), acrimoniousness (i.e., irritability), industriousness (i.e., decreased productivity), and disaffection (i.e., apathy).

Gerstein et al. (1993), as part of their study, asked how many males and females had been referred to the employee assistance program in the last year. Responses showed that females were more likely than males to refer females and
males did not differ in their referral of male or female troubled employees.

Smith (1995) researched two major factors by exploring supervisory perceptions of poorly performing employees, and what factors would increase the chances that a supervisor would refer an employee to the employee assistance program. Supervisors (N=345) were surveyed by written questionnaire regarding three main components: (a) perception of one poorly performing employee, (b) circumstances surrounding the poor performance, and (c) whether the employee was referred to the employee assistance program. A referral is considered more likely if the employee's poor performance is attributed to either substance abuse or personal crisis. Referral is less likely if the poor performance is attributed to a lack of motivation. Two other factors that contribute to a referral include whether the supervisor feels sympathy toward the employee and whether the supervisor perceives the EAP as helpful. Smith also found a significant interaction between the level of the supervisor and the interdependence between the supervisor and the employee. To the extent that a supervisor was lower level and not dependent on the employee, the less likely they were to refer (this is an example of cost-benefit analysis in the bystander-equity model).

According to Jerrell and Rightmeyer (1988), it is important to train supervisors and managers in the "early,
effective recognition of troubled employees and in making confidential referrals to the coordinator" (p. 253). When a pattern (i.e., a change in appropriate normative behavior) is recognized as impaired job performance, attendance or conduct on the part of the employee, verbal coaching by the supervisor normally takes place. Some company procedure and policy manuals may require that formal verbal counseling take place at this point.

In any event, the goal is to provide, informally or formally as determined by policy, the employee with a clear understanding of what needs to be corrected, in what manner, and according to what time frame. It is important that the employee assistance program be offered as an aid at this point and a time frame is usually established to evaluate progress in meeting the behavioral objectives. If adequate progress has not been made and the employee's performance, attendance, or conduct continues to show a decline, a meeting is usually held to review the situation. Such meetings may include a human resource and/or union representative (if applicable), the manager and/or supervisor, and the employee. At this point, a referral to the employee assistance program typically becomes mandatory (if permitted by company policy). A mandatory referral takes place when an employee is required to participate in the employee assistance program if they are to continue employment with the company.
Since participation in the employee assistance program is always considered voluntary, the employee may refuse to see the employee assistance professional. If this occurs under mandated circumstances, however, the employee is usually terminated. If the employee does agree to go to the employee assistance program for assessment, brief counseling (if appropriate), and/or referral, the employee is typically given a probationary period by the company during which time they are expected to correct their deficiencies.

The employee assistance program counselor, with the employee's written, informed consent, keeps the named company representative(s) appraised of job-related recommendations, employee assistance program and programmatic attendance, and compliance until discharged.

This referral process is described by Frisch and Leepson (1986) as consisting, therefore, of three steps: (a) preliminary arrangements, (b) the meeting (i.e., defining the problem, referring for assistance), and (c) follow-up. The manager and/or supervisor is considered a key component in the entire process. They begin with the referral and remain involved until the referred employee completes all recommendations from the employee assistance program and work performance, attendance, and conduct reach satisfactory levels.

Braid (1983) posits seven rules to be applied when discipline is used by supervisors to change performance,
attendance, and conduct problems. These include remaining calm, gathering information, being consistent, maintaining focus on job-related issues, choosing appropriate responses, carrying out discipline, and documenting any interventions. The session ends with the development of a behavioral plan to correct identified problems.

It should be noted, as stated by Keaton (1990) that mandated referrals tend to result in employees who are "resistant to counseling and to making a commitment for change" (p. 58). In her study, "The Effect of Voluntarism on Treatment Attitude in Relationship to Previous Counseling Experience in an Employee Assistance Program," Keaton (1990) cites several studies that show a negative impact when referral occurs under mandated conditions. Keaton's study had some significant limitations, however, in that she evaluated a specific organization, used a non-standardized instrument, and due to the nature of the design could not determine the direction of the voluntarism-experience relationship (p. 63).

While supervisors are a referral source to the EAP they only account for a percentage of total referrals. Bayer and Babbkin (1990) found that self-referral outpaced all others.

Self-Referral

According to Blum and Roman (1992, p. 127), "the range of reports from diverse settings emphasizes the prominence
of self-referrals to EAPs." They continue "These reports...support an image of EAP referral as a cognitive process involving the individual's receipt of information about EAP services and a comparison of the services with his or her perceived needs" (p. 127). Backer and O'Hara (1991) support the finding that the majority of employees who seek help from an employee assistance program do so through self-referral methods.

Keaton (1990) conducted a study of the effects of self-referral as related to attitude toward the employee assistance program, and to the employee's experience of the employee assistance program. A survey of 67 employee assistance program clients was conducted that resulted in a significant relationship for both factors. Keaton indicates that her findings are consistent with cognitive dissonance theory; that is, one who freely chooses treatment will be more likely to view it in a positive light.

In fact, encouragement of employee self-referral may be promoted when the following conditions are present. First, it is important that the employees understand what services are actually available under the employee assistance program. Second, employees need to be aware of the procedures needed to access the employee assistance program. Third, the employees need to have developed a sense of trust regarding the confidentiality of the program (Frost, 1990). The first two conditions may be met by the employee
assistance program professionals and/or the company representatives holding employee and/or family orientation meetings. Another means would be through the dissemination of printed materials. Letters may be sent to the employee's home describing the program, services, and means of utilizing services. Often, brochures are developed and distributed that provide additional information such as answering questions employees might have regarding the connection between voluntary participation in the employee assistance program and their place of employment.

The issue of confidentiality, while it might be addressed in the above, often develops over time. As employees utilize the program, they frequently talk about the help they have received with their coworkers. As they determine that information does not get back to the company, confidence grows.

Sonnenstuhl (1982), conducted in-depth interviews and case record reviews on thirty employees to study the shift away from constructive confrontation to self-referral to the employee assistance program. He found that the referral process involved social controls (both formal and informal), a mix of the presenting problem embedded in a focus of disrupted relationships, and the importance of viewing the supervisor as part of the process.

In another study, Sonnenstuhl (1990) found that employees tend to have four questions that appear to be
significant when an employee is considering self-referral to the employee assistance program. First, they are often concerned about what it will cost, if anything, to access the actual employee assistance program services. Second, employees question whether they can access the employee assistance program during work hours. This is a pertinent question since employees may come into the employee assistance program stating that their reason for accessing services is a work-related issue; and, the program itself is sponsored by their work organization. Also, if the employee assistance program does not have flexible hours, it might result in personal hardship for the client. Third, since the employee assistance program also covers assessment of emotional and behavioral issues, employees tend to want to know if medication will be prescribed. Fourth, employees want to know the degree to which the employee assistance program is confidential? Sonnenstuhl (1990) reports that employees tend to use both formal and informal (e.g., coworker and supervisory information) when deciding to use employee assistance program services.

Harris and Heft (1992) cite a study by Harris and Fennell (1988) that indicates an employee’s willingness to use an employee assistance program is based on three factors. First, the employee must have familiarity with the program and services offered. Second, personal attention is important. Third, the employee must have a reasonable trust
in what will occur if the employee seeks assistance (p. 254).

Increases in self-referrals appear to be related currently to increases in on-the-job stress (Miller, Jones, & Miller, 1992). Also, companies are currently utilizing employee assistance program professionals to provide on-site consultation in the area of stress management as well as other behavioral health concerns.

**Estimates of Differences Between Supervisory and Self-Referrals**

Blum and Roman (1992) believe official EAP records overestimate the role of the self and underestimate the role of supervisors, co-workers, and family members in the referral process. In their NIAAA-supported study of 6,400 employees from 84 different work sites, they found some interesting discriminators. First, most self-referrals were employees with non-alcohol related problems (46 percent) as compared to alcohol-related problems (39 percent). Second, formal supervisory referrals were greater for clients with alcohol-related problems (17.2 percent). Supervisory referral of employees with non-alcohol related problems was over fifty percent lower (8.8 percent). Informal coaching referrals executed by supervisors was nearly double for employees with non-alcohol related problems (17.1 percent) and 13.4 percent for alcohol-related problems (p. 125).
Hobson (1981), in a descriptive study of a systems approach to develop, implement, and evaluate an employee assistance program, found that employees were more willing to refer others than themselves. In addition, Hobson believes there are certain employee groups that might feel more at risk if they did reach out through employee assistance program participation. Hobson lists the following groups as being more hesitant to access services: (a) lower-level staff, (b) first-line supervisors, (c) union stewards, (d) female clinical staff, (e) support staff, and (f) higher level professionals. Hobson reviews methods to increase employee assistance program utilization by these groups.

Stollak (1994), gathered survey data from a field study of three Midwestern organizations using a multiple constituency evaluation approach (i.e., the constituents define: (a) effectiveness, (b) activities, and (c) evaluation criteria of the employee assistance program) in order to investigate the effectiveness of the employee assistance program. Differences were found to exist between blue and white collar workers in a number of areas. Blue collar workers emphasized activities related to career development, union and organizational linkage with the employee assistance program, program monitoring, and the special assistance provided by employee services. Managers and supervisors, however, placed a greater emphasis on
training. Individuals who utilized employee assistance program services emphasized activities related to counseling. Nonusers emphasized activities related to career development, program monitoring, and linkages between the union and the work organization. These are factors that may influence areas which bring an employee to the employee assistance program.

Pearson and Maier (1995), in their assessment of employee assistance program services, found that self-reported improvement was negatively related to being a person of color and to being a supervisory referral. This may be a consideration in terms of how a person of color should be referred.

As has been indicated in this section, satisfaction is an important outcome to consider as research on employee assistance program services continues. In reviewing the literature, I found a large number of doctoral dissertations in this area. I believe this bears witness to the interest in contributing to our understanding of employee assistance program effectiveness. While it is true that employee assistance programs have a reported effectiveness, there is still a long way to go in carrying out research that is theoretically and methodologically sound in this regard. Since employees come to receive EAP services through a variety of means, no published study to date using the Client Satisfaction Questionnaire-8 has assessed whether how
an employee comes in affects their level of satisfaction. This is what this study purported to do by its attempt to delineate any differences in satisfaction based on supervisory as compared to self-referral.
CHAPTER 3
METHOD

Participants

Participants for this study were selected from a census sample of all employees who utilized their company's employee assistance program services during a six-month period beginning January 1, 1996 and ending June 30, 1996. Only employees who came in alone (i.e., not accompanied by a family member) and who indicated on their Client Information Data Form (see Appendix A) a willingness to receive a follow-up questionnaire were selected for the study. The participants came from seventeen companies located throughout the southeastern region of the United States with data collapsed across companies. For comparison purposes, participants were placed in one of two groups as determined by their source of referral to the employee assistance program: (a) supervisory referral or (b) self-referral.

To be eligible for the study, participants were required to satisfy each of the following criteria:

1. Be an employee who came to the EAP through either supervisory or self-referral.

2. Work for a company that has had a broadbrush employee assistance program in place a minimum of one year.
3. Work for a company whose employee assistance program consisted of up to six visits for the purpose of assessment, brief counseling, and referral.

4. Receive employee assistance program services between January 1, 1996 and June 30, 1996.

5. Respond "yes" on the client information form to the question: May we send a follow-up questionnaire to your home?

Client Groups

Selection of the client groups. Selection was made of all clients who responded in the affirmative to their willingness to receive a questionnaire at their home following their reception of employee assistance program services. The determination of whether the individual met the criteria of one group as opposed to the other resulted from reviewing the Client Intake Form (see Appendix B) filled out by the clinician after the first visit. Here the referral source, as reported by the client and determined by the clinician, is one of the pieces of data indicated.

Criteria for the supervisory referral group. This group was comprised of clients who were referred to the employee assistance program by individuals who function in a supervisory capacity. No distinction was made between coaching or mandated referrals or between supervisory hierarchical status. Referring individuals included representatives of the Human Resource Department, managers, and supervisors.
Criteria for the self-referral group. This group was comprised of clients who came in to the employee assistance program of their own volition. For some clients the decision to participate in the employee assistance program was purely their own idea. Although others may have come in as a result of the suggestion of family, friend, or other employee, clients were still free to participate or not.

Instruments

A cover letter was mailed to all participants selected for the study and described the purpose of the study, the method (briefly), and requested participation (see Appendix C).

Data was collected from three specific sources for each employee who agreed to voluntarily participate in this study which included: (a) a client information sheet from which it was determined if the client had indicated a willingness to receive a questionnaire and from which demographic data for the study were derived (see Appendix A), (b) the clinician’s employee assistance program intake data form (see Appendix B), and (c) the Client Satisfaction Questionnaire-8 which was mailed (Attkisson & Greenfield, 1995). A self-addressed return postage-paid envelope also was sent as part of the packet. The study and pertinent instruments were reviewed and approved by the Institutional Review Board at the University of Florida prior to being
sent to participants. It was determined that if a large enough response rate (i.e., n=25 per group) was not received from the first mailing, a follow-up would be made by telephone (see Appendix D).

Cover Letter

The cover letter (see Appendix C), developed by this researcher, was mailed along with a standardized instrument, the Client Satisfaction Questionnaire-8 (CSQ-8). The letter and the CSQ-8 was mailed to all employees who participated in their employee assistance program over the six-month period noted above and who indicated on the client information sheet that a follow-up questionnaire could be sent. The letter clearly explained the purpose of the study. Due to possible confounds related to self-reported data, a special effort was made in the letter to explain to participants that their confidentiality would be maintained. Envelopes were coded in order to track responses for purposes of determining follow-up. Once the necessary data had been collected, they were then destroyed. The Client Satisfaction Questionnaire-8 was color-coded in order to determine three factors: (a) gender, (b) whether it was a supervisory or self-referral, and (c) if an alcohol or drug problem was the presenting issue rather than some other concern. No particular individual or company was identified. All data were aggregate in nature when
reported. A self-addressed stamped envelope was included to facilitate participant response. Participants were asked to return their questionnaires within one week of receiving their packet.

Client Information Form

This form can be found in Appendix A. It was filled out by a client in the office waiting room just prior to seeing the employee assistance program clinician for the first time. The form indicated whether the individual utilizing the employee assistance program was an employee, spouse or dependent, or other. For this study only the data derived from employee participation were used since they were the only employee assistance program participants who could come in under supervisory referral as defined by this researcher. The name of the employee's company was requested. Address, home and work telephone numbers, and client birthdate were solicited. Educational level was listed by the following categories (a) eighth grade or less, (b) ninth grade through eleventh grade, (c) high school graduate, (d) some college, (e) college graduate, and (f) advanced degree(s). Marital status was requested according whether the client was single, married, divorced, separated, widowed, or living with someone. The individual's ethnic group was an optional category. Clients wishing to respond to this category, could choose from options which included
(a) Caucasian, (b) African-American, (c) Hispanic, (d) Native American, (e) Asian, and (f) other. Space also was provided for clients to indicate gender and previous participation in the employee assistance program. Clients also were asked for the name of their health care plan. The latter piece of information allowed the clinician to interface with the health care provider in case services outside the usual and customary scope of those offered by the employee assistance program were necessary. The clients were asked how they became aware of the employee assistance program based on the following selections: (a) prior participation, (b) posters, (c) brochures, (d) co-worker suggested, (e) inservice training or orientation, (f) newsletter, (g) payroll stuffers, (g) supervisor suggested, (h) family suggested, or (i) other. They also were asked to check either yes or no in response to whether a follow-up questionnaire could be sent to their homes. This information, as well as a signature authorizing diagnosis and treatment was provided by all participants in the employee assistance program regardless of whether they were employees or family members.

Those who were employees filled out an additional section specifically geared to the workplace. They provided their social security number, work location, and job title. They indicated their status as full time, part time, as needed, temporary, and other. They provided information
regarding their shift (if applicable) by specifying days, evenings, night, rotating, and other. Length of service was divided by (a) under one year, (b) one to three years, (c) four to six years, (d) seven to nine years, (e) ten to fifteen years, and (f) sixteen or more years. Employees were asked to indicate whether they were salaried or hourly wage earners. They were asked if they have had any reported injuries in the last twelve months by checking yes or no. In addition, information was collected regarding their reported days absent in the prior twelve months by selecting (a) no days, (b) one to five days, (c) six to ten days, (d) eleven to fifteen days, and (e) sixteen or more days. The employee indicated their occupational status as being either management or non-management. Finally, employees were asked whether they belonged to a union (if applicable) and to specify which union.

Client EAP Intake Data Form

The EAP Intake Data Form (see Appendix B), was filled out by the clinician at the conclusion of the participant's first visit. The clinician filled in the participant's name and sponsoring company. The date of the first visit was recorded. The clinician indicated the recipient of service by specifying one of the following: (a) employee, (b) family member, (c) employee and family member, (d) employee and other, and (e) other. The referral source was
checked by selecting (a) self, (b) family, (c) fellow employee, (d) supervisor, (e) employee relations, (f) union, (g) physician, and (h) other. For the latter, the clinician wrote in the exact referral source. Under problem identification, the clinician chose the category (or categories) that were applicable: (a) on-the-job problem, (b) presenting problem, and alcohol/drug related problem.

The on-the-job problem category included concerns such as (a) quality of work, (b) quantity of work, (c) attendance and/or tardiness, (d) safety, (e) interpersonal relations, (f) job knowledge, (g) positive for alcohol or drugs, and (h) other problems. If this category was applicable, the clinician checked one or more of the subcomponents. This might have been the only major category checked by the clinician. Or, it might have been determined that the employee had presented concerns under the other major categories (i.e., presenting problem or alcohol/drug related).

Presenting problems included one or more of the following (a) alcohol, (b) drug, (c) drug testing, (d) emotional, (e) marital, (f) family, (g) child or adolescent, (h) AIDS, (i) legal, (j) financial distress, (k) financial planning, (l) physical, (m) career planning, (n) academic, (o) elder care, (p) gambling, (q) social services, (r) child care, (s) domestic violence, (t) other interpersonal relationships, and (u) other. The appropriate subcomponents
were checked by the clinician. Any additional problem was specified. This, too, may have been the only major category selected by the clinician or it may have accompanied one or more of the others (i.e., on-the-job problem or alcohol/drug related).

Under the alcohol/drug related category, the clinician checked either employee, dependent, other or family member. This major category may have stood alone or may have accompanied either on-the-job problem or the presenting problems category.

The type of treatment recommended at the conclusion of the first meeting was both checked and specified. Treatment choices may have included one or more of the following: (a) EAP counselor, (b) outpatient (either alcohol/drug or mental health), (c) inpatient (either alcohol/drug or mental health), (d) medical, (e) legal, (f) financial counseling, (g) self-help group(s), (h) other or (i) a lab that does drug testing. The name of the employee assistance program clinician who provided the assessment was provided. The clinician then listed any referral (i.e., facility or provider) that was recommended to the employee. If a particular self-help group such as Alcoholics Anonymous or Nar-Anon was suggested by the clinician, it was recorded on the form. Finally, the clinician indicated the client's response to the recommendation as either (a) accepted, (b) declined, or (c) undecided.
Client Satisfaction Questionnaire-8

The Client Satisfaction Questionnaire-8 instrument, developed by Attkisson and Greenfield (1995), is a self-report questionnaire that is used to measure general levels of satisfaction. This instrument provided data for determining if any differences in satisfaction existed between employees who were referred by supervisors and those who came in through self-referral.

In discussing use of the Client Satisfaction Questionnaire-8, Eisen (1996) indicated that a major advantage is that "assessment only needs to be done once per client, usually following completion of a treatment episode at a particular level of care" (p. 71).

The questionnaire consists of eight questions related to the participants' general level of satisfaction after utilizing services received. The participant responded by circling one of four possible responses. The participant was asked to rate the following eight components: (a) quality of service received, (b) whether the kind of service received was what was wanted, (c) the extent to which the program met the client's needs, (d) whether the client would recommend the services to a friend, (e) satisfaction level with the amount of help received, (f) the degree to which the services received assisted the client in dealing more effectively with their problems, (g) general level of
satisfaction, and (h) whether an individual would return to the program if further assistance was needed. Permission for use was received in writing from Dr. Clifford Attkisson when the instrument was purchased for this study.

For statistical analyses purposes, a follow-up call was made if an n=25 for each comparison group was not received as a result of the first mailing. This occurred for two specific groups consisting of supervisory referrals and those whose presenting problem was drug or alcohol related. A phone script used for this follow-up is found in Appendix D. As a result of the phone follow-up, most participants simply requested that another mailing of the packet be done. Some asked whether it would be possible to simply do it orally over the phone since they were already talking about the questionnaire.

Data collection. Attkisson and Greenfield (1995, pp. 121-122) address various approaches that have been used in data collection with the CSQ-8. While a main disadvantage in the use of surveys being distributed by mail has been a low response rate (with an estimated 40-50% being the highest with one postcard follow-up reminder), it has been used successfully in many survey studies. An advantage is that it allows for what Docherty and Streeter (1995) refer to as "psychological distance" (p. 13). Attkisson and Greenfield (1995, p. 122) state that "follow-up surveys after cessation or completion of services is also very
important." This was the procedure used in this study with the survey being mailed to a "census sample" of all clients seen within the time frame of January 1, 1996 through June 30, 1996 who had checked yes on the question of whether a follow-up questionnaire could be sent. Utilizing a census sample had the advantage of "assuring that most eligible clients are included" (p. 122). In addition, "completion rates tend to be above 90% when this approach is used" (p. 122).

Psychometrics of the CSQ-8. Attkisson and Greenfield (1995) cite twelve studies occurring during the development and refinement phases indicating that the psychometric properties of the CSQ-8 are quite good. Attkisson and Greenfield present five points for consideration which include the internal consistency of the instrument, as measured by Cronbach's alpha coefficient for the CSQ-8 as being .93. The item-total correlations of the CSQ-8 are moderately high and are consistent with the "underlying single factor structure of the CSQ scales derived from factor analyses of the underlying data" (p. 122). The inter-item correlation is moderately high. The CSQ has been compared with other measures and methods. And, finally, the CSQ scales "almost always produce negatively skewed rating distributions when total raw scores or mean of item means are analyzed" (p. 122). This information seemed to indicate that the CSQ-8 would be a good instrument for the purposes
of this study. According to Attkisson and Zwick (1982), the shorter form of the Client Satisfaction Questionnaire (e.g., CSQ-8) which yields an alpha value of .93, "is not entirely surprising in that the CSQ-8 items were initially selected mainly on the basis of internal consistency" (p. 234).

Utility. Scoring is uncomplicated and "because of the scale's single factor structure, interpretation of CSQ-8 data involves a straightforward comparison of results obtained for a given service or client group with external data that constitute an appropriate norm" (p. 124).

Use. The CSQ-8 has been chosen for extensive applied use within service settings and in research. "The primary use of the CSQ scales, within practice settings, is to assess the aggregate satisfaction of groups of respondents" (p. 124). It was of interest to this researcher that Attkisson and Greenfield (1995) state that "the next generation of research studies will report on the use of the service satisfaction construct as an independent variable in relation to service use, cost, and outcome" (p. 125).

Procedure

Participants were drawn from 17 companies with employees located throughout the southeastern part of the United States. Selected companies had a broadbrush employee assistance program that had been in place for a minimum of one year and provided for up to six visits.
Steps

Step 1. The researcher procured a list (using the DayBreak computer program) of all individuals who accessed their EAP for services between January 1 and June 30, 1996.

Step 2. Utilizing the same program, the researcher reviewed a client intake data form for each individual on the list to determine who fell into the category of "employee" in terms of who accessed the employee assistance program.

Step 3. The researcher sorted through the client information forms for those employees who said they would be willing to receive a follow-up questionnaire mailed to their home. Those forms were then printed.

Step 4. The client intake data forms filled out by the clinician were printed for the individuals who said they would be willing to receive the questionnaire.

Step 5. The individual client information and client intake data forms were sorted according to whether the employee came in under supervisory or self-referral.

Step 6. A list was compiled of individuals who met the above criteria since they were then selected as participants in this study. Each individual received a code number that also was placed on the self-addressed, stamped envelope provided for return of the questionnaire. This was for response tracking only and both the list and the envelopes
were destroyed prior to analysis of data in order to protect the identity of the participants. To further protect confidentiality, there was no way to identify the employee’s company.

**Step 7.** Participants were mailed a package containing a letter requesting participation (see Appendix C) and the Client Satisfaction Questionnaire-8. The CSQ-8 was color coded in order to determine which responses were from: (a) a male or a female (n=25 per comparative group), (b) a supervisory or self-referral (n=25 per comparative group), and (c) if the referral problem was related to alcohol or drugs as compared to other problems (n=25 per comparative group).

A stamped, self-addressed return envelope had a numeric code on the outside that matched the code on the list of participants. As described above, this was for response tracking only and was destroyed once necessary data were obtained. Since a response rate of n=25 for each test group was not obtained on the first mailing, there was a telephone follow-up (see Appendix D). According to Frost (1990), enclosing a self-addressed stamped envelope results in a higher yield of returned surveys. In her study a response rate of 45% was yielded.

Telephone follow-ups were necessary for two groups after four weeks had passed following the initial mailing. The two groups were supervisory referrals (n=6) and those
who had come in with a drug or alcohol problem (n=11). A few individuals who were contacted indicated they did not want to participate. Some participants asked for a remailing and others asked if they could just answer the questionnaire over the phone (for further information, please refer to the results section).

**Step 8.** Demographic data were compiled from the client information sheets for presentation in tables.

**Step 9.** Analysis of data was conducted.

**Analysis**

Five hypotheses derived from prior research were studied. To indicate directionality (if present) the hypotheses were not stated in the null.

Chi-square was used to analyze categorical data:

**Hypothesis 1.** The percentage of self-referrals will be significantly greater compared to supervisory referrals.

**Hypothesis 2.** Women will be significantly more likely to self-refer.

The two independent groups compared in this study were those employees who were referred by supervisors, and employees who were self-referred. The dependent variable was the employee’s level of satisfaction with services received through their participation in the employee assistance program. Factorial analysis of variance was used to analyze hypotheses involving differences in the dependent variable. This procedure allowed the researcher to test for
main effects pertaining to the following hypotheses:

Hypotheses 3. There will be a higher mean level of satisfaction from self-referrals as compared to supervisory referrals.

Hypothesis 4. There will be no difference in mean level of satisfaction as determined by gender.

Hypothesis 5. Mean level of satisfaction will be lower for those who present with drug problems as compared to those who present with other presenting problems.

An alpha level of .05 was used for all statistical tests.
CHAPTER 4
RESULTS

A Client Satisfaction Questionnaire-8 protocol, letter of informed consent, and an enclosed stamped self-addressed envelope were mailed to each of the participants who used their employee assistance program as a result of supervisory referral (n=64) and each of the individuals who had come in under self-referral conditions (n=229). This resulted in a combined total of 293. Data collection was closed about six weeks later when it appeared that no more questionnaires were forthcoming by mail or through phone follow-up.

Survey Dispositions from First and Second Mailing

Table 1 shows the results of the survey disposition response rates from both the first and second mailings. A packet went to all individuals in the census sample (n=293). The number of completed questionnaires refers to those that were returned with a response for each of the CSQ-8’s eight questions. Incomplete refers to one or more of the CSQ-8 questions that were not answered by a particular respondent. It should be noted that one individual returned a questionnaire with no responses circled. In this first mailing, undeliverable refers to packets that came back to
the researcher marked "return to sender" or "no forwarding address". Not returned refers to those packets that were sent out and simply not returned.

The second mailing listed in Table 1 refers to what occurred with packets that did come back with a forwarding address. Category descriptions (e.g., complete, incomplete, undeliverable, not returned) are the same as for the first mailing. In this case, undeliverable refers to a packet that had come back from the first mailing with a forwarding address that was no longer correct.

Table 1. Response Rates from Survey Approach: First and Second Mailing

<table>
<thead>
<tr>
<th>Survey Disposition</th>
<th>Supervisory Referral (n=64)</th>
<th>Self-Referral (n=229)</th>
<th>Total (n=293)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Mailing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete</td>
<td>6</td>
<td>61</td>
<td>67</td>
</tr>
<tr>
<td>Incomplete</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Undeliverable</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Not returned</td>
<td>49</td>
<td>141</td>
<td>190</td>
</tr>
<tr>
<td>Returned with forwarding address</td>
<td></td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Second Mailing (due to change of address)</td>
<td>(n=4)</td>
<td>(n=13)</td>
<td>(n=17)</td>
</tr>
<tr>
<td>Complete</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Incomplete</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Undeliverable</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Not returned</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

Two groups (i.e., supervisory referrals and those with drug or alcohol problems) required follow-up by telephone after the first attempt resulted in an n<25.
Survey Follow-up

Table 2 summarizes response rates from the survey telephone follow-up for both supervisory and self-referral groups. If an n=25 was not obtained from the first mailing (including re-mailing to addresses that had expired; i.e., the second mailing) for any of the categories related to the research hypotheses, a follow-up telephone call was attempted by the researcher. According to Table 2, follow-up telephone calls were attempted for all non-respondents who came in as a result of supervisory referral or who had drug or alcohol problems regardless of referral source. In all cases the telephone script was used (see Appendix D). Some respondents indicated they had the questionnaire, planned to participate in the study but had not mailed it yet. Each participant in this category (n=6) agreed to return the questionnaire. Some asked if they could respond over the phone (n=17). Eleven of the respondents who answered orally had been referred by a supervisor. Two of the self-referrals who had been contacted chose to respond over the phone. Others asked that the researcher remail the questionnaire (n=18). Six respondents, all referred by supervisors, declined to participate. Response categories for each of these groups is presented in Table 2.

The unreachable category refers to the researcher's inability to contact respondents. This was possibly due to
the intervening period of time between reception of employee assistance program services and this study. A fairly large sample of telephone numbers had been changed or were no longer in service. Unlike remailing in Table 1 which occurred as a result of change of address, remailing in Table 2 occurred as a result of a phone request.

Table 2. Response Rates from Survey Follow-up

<table>
<thead>
<tr>
<th>Survey Disposition Phone Follow-up</th>
<th>Supervisory Referral (n=51)</th>
<th>Self-Referral (n=17)</th>
<th>Total (n=68)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaires presented orally</td>
<td>(n=17)</td>
<td>(n=2)</td>
<td>(n=19)</td>
</tr>
<tr>
<td>Complete</td>
<td>10</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Incomplete</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Refused</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Questionnaires remailed at respondent's request</td>
<td>(n=16)</td>
<td>(n=2)</td>
<td>(n=18)</td>
</tr>
<tr>
<td>Complete</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Incomplete</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Unreturned</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Questionnaires respondents had and would mail</td>
<td>(n=4)</td>
<td>(n=2)</td>
<td>(n=6)</td>
</tr>
<tr>
<td>Complete</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Incomplete</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unreturned</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Unreachable</td>
<td>(n=15)</td>
<td>(n=11)</td>
<td>(n=26)</td>
</tr>
</tbody>
</table>

Demographic Data

Demographic characteristics are presented in two categories (i.e., personal and professional) for each of the
two referral groups (i.e., supervisory and self) that are addressed in this study. The first category includes personal demographic data from employees who came in under supervisory referral and is presented in Table 3. Personal demographic information from employees who came into the employee assistance program under self-referral conditions are presented in Table 4. Demographic data related to the employees' professional life are presented in Table 5 for those who were referred by supervisors and in Table 6 for those who came into the employee assistance program under self-referral conditions.

**Personal demographic data.** Personal demographic data are presented for those who responded from either the first mailing or follow-up. The first mailing includes the original mailing plus any remailing as the result of getting an accurate forwarding address. Follow-up is defined as the choice made by those contacted by telephone made up of (a) those who had questionnaires and indicated they would be mailed, (b) those who answered the questionnaire by phone, and (c) those who asked for a remailing. Information was taken from the client information forms filled out in the employee assistance office before the first clinical session (see Appendix A).

All information was reported in aggregate form. The information was separated according to supervisory or self-referral conditions.
### Table 3. Personal Demographic Characteristics: Supervisory Referrals

<table>
<thead>
<tr>
<th>Personal Demographic Characteristics</th>
<th>First Mailing (n=6)</th>
<th>Follow-up (n=22)</th>
<th>Total (n=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>31-40</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>41-50</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>51-60</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>60+</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th grade or less</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9th-11th grade</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>High school degree</td>
<td>3</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Some college</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>College graduate</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Advanced degree(s)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Married</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Living together</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

A comparison of Table 3 and Table 4 allows the reader to get some idea of both the similarities and differences of the various categories. It should be noted that a significant number of follow-ups (n=22) had to be made for employees who had been referred by supervisors. This represented 78.57 percent of this sample. An additional six employees, who had been referred by supervisors, declined to participate in the study when contacted by phone. Several indicated that they were no longer with the same company.
Table 4. Personal Demographic Characteristics: Self Referrals

<table>
<thead>
<tr>
<th>Personal Demographic Characteristics</th>
<th>First Mailing (n=72)</th>
<th>Follow-up (n=6)</th>
<th>Total (n=78)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>34</td>
<td>4</td>
<td>38</td>
</tr>
<tr>
<td>Female</td>
<td>38</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>31-40</td>
<td>25</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>41-50</td>
<td>26</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>51-60</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>60+</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th grade or less</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9th-11th grade</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>High school degree</td>
<td>13</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Some college</td>
<td>38</td>
<td>1</td>
<td>39</td>
</tr>
<tr>
<td>College graduate</td>
<td>15</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Advanced degree(s)</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Married</td>
<td>31</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>Divorced</td>
<td>17</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Separated</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Living together</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Professional demographic data. Professional demographic characteristics of respondents are presented in the next two tables. This will allow the reader to make some comparisons and develop a potential profile that will be further discussed in Chapter 5. For example, prior research indicates that individuals that have had prior usage of a program tend to express less satisfaction (Lebow, 1982). Surprisingly, a little over one third of respondents who came in as a result of supervisory referral had used the
employee assistance program while over half of the respondents who came in under self-referral conditions had used the employee assistance program services earlier. This particular sample was too small to conduct an analysis for within group significance but does open up questions for further research. It should also be noted that the majority of employees who utilized employee assistance program services under both supervisory and self-referral conditions were non-management.

Table 5. Professional Demographic Characteristics:
Supervisory Referrals

<table>
<thead>
<tr>
<th>Professional Demographic Characteristics</th>
<th>First Mailing (n=6)</th>
<th>Follow-up (n=22)</th>
<th>Total (n=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior EAP Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>6</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td>Part time</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>As needed</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Temporary</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Length of Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1 year</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1-3 years</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4-6 years</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7-9 years</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>10-15 years</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>15+ years</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Occupational Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Non-management</td>
<td>5</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>
Table 6. Professional Demographic Characteristics: Self Referrals

<table>
<thead>
<tr>
<th>Professional Demographic Characteristic</th>
<th>First Mailing (n=72)</th>
<th>Follow-up (n=6)</th>
<th>Total (n=78)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior EAP Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>41</td>
<td>2</td>
<td>43</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>70</td>
<td>6</td>
<td>76</td>
</tr>
<tr>
<td>Part time</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>As needed</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Temporary</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Length of Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1 year</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>1-3 years</td>
<td>11</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>4-6 years</td>
<td>11</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>7-9 years</td>
<td>14</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>10-15 years</td>
<td>18</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>15+ years</td>
<td>12</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Occupational Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>15</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Non-management</td>
<td>57</td>
<td>4</td>
<td>61</td>
</tr>
</tbody>
</table>

Statistical Analysis and Results

All statistical analysis procedures were computed using SAS (Statistical Analysis Software, Version 6.12, 1997). An alpha level of .05 was used for all statistical tests. A total of 106 participants responded representing 36.18 percent of the total sample. There was one respondent who returned a questionnaire with no answers provided. This participant was considered in the demographic descriptions and chi-square analysis (n=106) of the first two hypotheses.
but not the last three hypotheses using factorial analysis of variance due to the missing data.

Model Assumptions

The first analysis tested for equality of variance. Analysis of variance is robust to a threat to the assumption of homogeneity of variance except when cells are unequal in size. Since sample size was so different for the various categories in this study (e.g., male and female, referral source, and type of problem), homogeneity of variance was tested using Levene's test. Results indicate the assumption for homogeneity of variance was not violated (p=.53). A Spearman Rank Correlation Coefficient was conducted to determine whether variances were correlated with the number of respondents in each cell. Results indicate that no correlation was present. The sample had a skewness of -.90 indicating that overall there were higher levels of satisfaction for the entire sample. This is consistent with prior studies using the Client Satisfaction Questionnaire-8 (cf. Attkisson & Greenfield, 1994). It should be noted that analysis of variance is robust to skewness with a large enough sample such as was the case in this study.

Internal Consistency

Cronbach's coefficient alpha for internal consistency of the standardized variables was .96. This was slightly
higher than previous research reporting .93 with this instrument (Attkisson & Zwick, 1982). This is not surprising given the manner in which this instrument was developed (see discussion in Levois, Nguyen, & Attkisson, 1981).

**Category Frequency and Percent**

Table 7 presents the frequency of gender, type of problem, referral source, and whether responses were written or oral. Due to sample size, no comparison for significance was made between the written or oral format of response. The percent of the total sample represented by each grouping is presented.

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>50.9</td>
</tr>
<tr>
<td>Female</td>
<td>52</td>
<td>49.1</td>
</tr>
<tr>
<td><strong>Type of Problem</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug</td>
<td>25</td>
<td>23.6</td>
</tr>
<tr>
<td>Other</td>
<td>81</td>
<td>76.4</td>
</tr>
<tr>
<td><strong>Referral Source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisory</td>
<td>28</td>
<td>26.4</td>
</tr>
<tr>
<td>Self</td>
<td>78</td>
<td>73.6</td>
</tr>
<tr>
<td><strong>Type of Survey Response</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written</td>
<td>92</td>
<td>86.8</td>
</tr>
<tr>
<td>Oral</td>
<td>14</td>
<td>13.2</td>
</tr>
</tbody>
</table>

As can be seen from this table, the percent of males and females using the employee assistance program was fairly
close. More individuals used the EAP for problems other than alcohol or drugs and came in at their own initiative.

**Chi-square Analysis**

**Hypothesis 1.** Hypothesis 1 predicted there would be a significant difference in referral source with the percentage of self-referrals being greater than supervisory referrals. Chi-square analysis was performed with the result that this hypothesis was supported. Since the degree of freedom was one, Yate's Correction formula was used resulting in a chi-square of 22.65 (n=106, df=1, p<.05, 3.84).

**Hypothesis 2.** Hypothesis 2 predicted that women would be more likely to participate in employee assistance program services as a result of self-referral initiative rather than coming in under supervisory referral conditions. Table 8 presents frequency and percent of gender differences by referral source.

**Table 8. Category Frequency and Percent for Gender Differences by Referral Source**

<table>
<thead>
<tr>
<th>Frequency Percent</th>
<th>Supervisory Referral</th>
<th>Self-referral</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16</td>
<td>38</td>
<td>54</td>
</tr>
<tr>
<td>Male</td>
<td>29.63</td>
<td>70.37</td>
<td>100.00</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>40</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>23.08</td>
<td>76.92</td>
<td>100.00</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>78</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td>26.42</td>
<td>73.58</td>
<td>100.00</td>
</tr>
</tbody>
</table>
Chi-square analysis was performed, using Yates' Correction formula. Chi-square results of .297 (n=106, df=1, p=.586) did not support Hypothesis 2.

Factorial Analysis of Variance

Factorial (three-way) analysis of variance (two by two by two design), main effects model, was conducted for Hypotheses 3, 4, and 5. This procedure was used to test for main effects. There were three independent variables each having two levels: (a) gender (male or female), (b) type of referral source (supervisory or self), and (c) type of presenting problem (alcohol/drug or other). General level of satisfaction was the single dependent variable.

<table>
<thead>
<tr>
<th>Source</th>
<th>F Value</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.24</td>
<td>0.626</td>
</tr>
<tr>
<td>Referral Source</td>
<td>5.03</td>
<td>0.027*</td>
</tr>
<tr>
<td>Type of Problem</td>
<td>0.35</td>
<td>0.553</td>
</tr>
</tbody>
</table>

Table 9. ANOVA to Test for Main Effects

One can see from Table 9 that the only main effect that was significant was referral source. Hypothesis 3 which stated that there would be a higher mean level of satisfaction from self-referrals (mean of 25.45, standard deviation of 6.099) as compared to supervisory referrals (mean of 22.428, standard deviation of 7.094) was supported. Therefore, employees who were referred by supervisors were less satisfied with services received.
Table 10 presents mean levels and standard deviations for each main effect category.

Table 10. Main Effect Means and Standard Deviations

<table>
<thead>
<tr>
<th>Level of Satisfaction</th>
<th>Gender</th>
<th>Referral</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>Sup.</td>
</tr>
<tr>
<td></td>
<td>n=54</td>
<td>n=51</td>
<td>n=28</td>
</tr>
<tr>
<td>Mean</td>
<td>24.94</td>
<td>24.33</td>
<td>22.42</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>6.69</td>
<td>6.3</td>
<td>7.09</td>
</tr>
</tbody>
</table>

Support was found for Hypothesis 4 which stated there would be no difference in mean level of satisfaction as determined by gender (F=.24, p=.62). There was no support for Hypothesis 5 which stated that the mean level of satisfaction would be lower for those who presented with drug problems as compared to all other categories of presenting problems (F=.35, p=.55).
Workplace-sponsored employee benefits similar to what is now known as the employee assistance program have been available in some form since the 1800s. Since it is a workplace-sponsored program typically offered to employees and family members, and described as a benefit, one might think that this is an altruistic approach on the part of employers. It is, in fact, however, a productivity-driven model intended to reward its sponsor (i.e., employer) with employees who perform better, are present, and engender fewer interpersonal or conduct-related problems. Schramm’s (1980) model, referred to as human capital theory, posits that an employer capitalizes these services in much the same way as buying new machinery or providing training. One would hope then that employees would voluntarily access the program and be satisfied with the services received.

**Referral Source**

There are two ways to access the employee assistance program through either supervisory referral or through a self-referral process. This study looked at whether there would be a significantly greater portion of self-referrals.
compared to coming to the employee assistance program under supervisory-referred conditions. This hypothesis was supported. This is of interest since it is a work-oriented model, yet, many people choose to utilize the program for personal concerns. While this seeking of assistance is most likely going to indirectly affect their performance, attendance, and conduct at work, it does appear to indicate that individuals do not need to wait until a supervisor recognizes that a problem is present. This finding is consistent with a number of studies that indicate a majority of employees seek help through self-referral (e.g., Backer & O'Hara, 1991, Blum & Roman, 1992).

Referral by Gender

This study also explored whether there would be a significant difference in referral source by gender. Chi-square analysis failed to support this hypothesis. This is in contrast to prior studies (Brodzinski & Goyer, 1987; Hall, Vacc & Kissling, 1991) where women were more likely to self-refer. It also contrasts Blum and Roman’s (1992) findings that supervisors were more likely to refer men.

Satisfaction

Client Satisfaction Questionnaire-8

This research further explored whether a difference in satisfaction, as determined by a general satisfaction
measure (the Client Satisfaction Questionnaire-8), would be significant. This particular instrument was selected because it has had a solid research history, only needed to be administered once, was brief, and most important, it was easily understood. This last factor was of particular importance to this researcher because of the wide potential for variability in participant's educational level. The sample could have potentially included individuals who had only an early high school education (or possibly less) through advanced degrees, were involved in labor positions through management levels, and some who could have felt intimidated by a more involved instrument or been pressured by time constraints. Generally, this instrument requires only a few minutes of the respondents' time. The use of the Client Satisfaction Questionnaire-8 in this particular study supported prior findings that individuals tend to respond in a more positive manner resulting in more positive levels of satisfaction; thus, this research also wound up with negative skewness (Attkisson & Greenfield, 1994). A Cronbach's coefficient alpha of .96 was slightly higher than that reported by prior research (Attkisson & Zwick, 1982).

Factorial Analysis of Variance

A three way factorial analysis of variance (two by two by two design), main effects model, was used to examine the last three hypotheses. The three independent variables were
referral source (supervisory or self), gender (male or female) and type of problem (alcohol/drug or other presenting problems). The dependent variable was general level of satisfaction with services received through the employee assistance program.

**Satisfaction and referral source.** The only main effect to be significant beyond $p < .05$ was referral source. This would be consistent with cognitive dissonance theory that says that those who seek help on their own tend to view the experience and results in a more positive light. This study lends support to findings from prior studies. Keaton (1990), for example, found that voluntary participants were more positive regarding treatment than involuntary participants.

**Satisfaction and gender.** Hypothesis 4, which posited that there would be no difference in mean level of satisfaction as determined by gender, was supported. It should be remembered that Attkisson and Greenfield (1995) indicated that future research should control for variables they viewed as functioning as perhaps the most important covariates of satisfaction (i.e., gender effects).

**Satisfaction and type of problem.** Hypothesis 5, predicated on Lebow’s (1982) positing that satisfaction would be lower for an individual with a substance problem was not supported. Several individuals contacted by phone voluntarily expressed gratitude for help received through
their employee assistance program and commented on their current recovery status.

**Limitations**

**Sample**

**Sample size.** One limitation of this study was sample size. While every effort was made to contact individuals with remailings and follow-up calls, and while the response rate was within similar reported ranges (e.g. responses represented 43.75% of the total supervisory referral group and 34.06% of the total self-referral group), several within group comparisons were not possible.

**Within-group comparisons.** Due to sample size, it was not possible to do a within-group comparison to see if those who came in after being referred by their supervisor had a different mean satisfaction score from one who came in after being referred by a member of Human Resources or under mandated conditions. Records were not available to determine if satisfaction would vary by number of actual employee assistance program visits.

**Employees accompanied by others.** A second possible limitation is that only employees' who came in to the employee assistance program by themselves were studied. While this was done because family members could not be referred by a supervisor, satisfaction levels of employees that come in with others might be different.
Time. A third limitation, that may have contributed to sample size, is time. I believe that the time frame for collecting data is an important consideration for future research. Employees in this study used their EAP services between January and June, 1996. This means that the respondents selected had slightly over a year before being asked to participate in this study. This resulted in a significant number of difficulties such as changes of address or phone numbers. It also resulted in more cost for additional mailings and a delay in getting the questionnaires returned.

While a sufficient period of time between reception of services and assessment of satisfaction allowed for psychological distance, it is probably a good idea for future researchers to carry out their studies within a sixth month period. At least more forwarding addresses would not have expired. Nguyen, Attkisson, and Stegner (1983) state that a longer length of time after service delivery may result in a more positive bias (p. 300). On the other hand, they state that if a researcher collects data too early, the clients haven’t received full delivery of services (p. 300). Also, collecting data through mailed questionnaires “after clients have left the program also has its problems: The return rate is often very low, usually below 35%, and satisfied clients often are more likely to return the questionnaire than are dissatisfied clients” (p. 300).
Follow-up

During the follow-up by phone, many individuals volunteered information not requested by the researcher. Several of the supervisory referrals (n=4) indicated that they no longer worked for the company. Six individuals refused to participate in the study each of whom had been referred by a supervisor. It should be remembered, however, that follow-up phone calls were made only when less than an n of 25 per comparative group was obtained. It is possible that individuals who came in through self-referral may also have refused had they been contacted. Thirteen participants requested to do the questionnaire orally.

Future Research

Prior EAP Use

Prior research (Keaton, 1990) found a significant relationship between prior employee assistance program experience and voluntarism (p. 64). “In contrast, no significant relationship was found to exist between experience and attitude” (p. 64). In this study, a little over a third of employees who came in under supervisory referral had used an employee assistance program in the past. Over half of those who came in under self-referral conditions had used an employee assistance program in the past. It would be helpful to explore further whether prior
use of an employee assistance program results in the same conclusion. From this study, if over half of the 78 employees who came in through self-referral used their EAP before and still had more significant satisfaction levels than the supervisory referrals, it would be of interest to try and determine why.

Hierarchical Position and Education

A majority of individuals, under both conditions, who used the employee assistance program were non-management. This is consistent with prior studies (Hobson, 1981; Kotschessa, 1994). If the sample were large enough it would be of interest to determine level of satisfaction by educational level. Wilson (1990) reports that preliminary studies reflect a relationship between employee assistance program participation and higher educational levels.

Mode of Administration

Prior research has looked at differences in mode of administration. All of the oral respondents in this study belonged to one of two categories: (a) supervisory referrals or (b) individuals with a drug or alcohol concern as their presenting problem. With an n=28 for the supervisory referral group and an n=25 for the drug and alcohol problem category, the samples were not large enough to do a within-group comparison regarding potential
differences in satisfaction based on mode of response (i.e., written or oral). This would be helpful in future research. In Levois, Nguyen, Attkisson (1981), "it was hypothesized that the three modes of collecting client satisfaction data (oral, written, and graphic) would differ in several respects. The oral mode of administration was expected to produce less missing data than the written mode due to the additional control over this factor afforded to an interviewer. Additionally, the oral mode of administration was expected to be a more 'reactive arrangement' than either the written or graphic mode, making it more sensitive to 'demand characteristics'. This was because data collection was carried out by staff members at the time and place of regular service delivery. For these reasons, it was predicted that oral administration would elicit higher client ratings than written administration" (p. 142). They go on to state that "one approach to obtaining satisfaction data from more psychologically disturbed patient populations is through oral questionnaire administration. Oral administration has the advantage of flexibility. The interviewer is available to restate instructions, check on client's understanding of the items and answer questions. Oral administration, on the other hand, is much more susceptible to demand characteristics and is likely to elicit a higher level of positive reactivity on the part of clients than would the written mode" (p. 142).
Nguyen, Attkisson, and Stegner (1983) referred to client satisfaction ratings as being easily influenced by social-psychological artifacts. "Test administration situations that amplify the effects of these artifacts can be expected to decrease comparability of client satisfaction data even if a standardized scale is used. This possibility prompted us to compare the two most often used modes of administration: written and oral" (p. 304). It should be noted that the sample they were testing consisted of participants who were diagnosed as suffering from chronic mental illness who tended to leave multiple questions on the alternate forms of the CSQ-31 blank; but, with coaching and human interaction wound up with approximately a ten percent better score.

Obviously this study differed on a number of these conditions. First, respondents were individuals who were at least adequately adjusted since they were able to hold jobs. Second, a majority of the respondents answered all of the questions with no prompting. Only, a few skipped one of the questions. Third, the questionnaires were not administered in the same environment as the services were received; nor were they administered in a face-to-face condition. It should be noted that a cursory review of scores from the phone respondents does not appear to differ from the written responses of supervisory referrals. This would, however, need to be tested further.
Differences Between Initial and Follow-up Responses

Another factor that would be of interest is whether there would be a significant difference in satisfaction between those who initially responded and those the researcher had to contact as a follow-up. Park (1992), in her study, states that "the low response rate from employees who had used the EAP services may be an indication that individuals were concerned about the confidentiality of the 1991 Client Satisfaction Survey and did not feel comfortable in returning it. It also may be an indication that employees who were not satisfied with the services they received did not return surveys" (p. 31). It was clear from the oral respondents that they had clear positive or negative reactions to their experience. Some indicated that they were dissatisfied with a particular person but not with the program itself. Some indicated that while they did not personally like an aspect of their program, they would still recommend it to coworkers. It would be helpful to test for factors related to response pattern.

Differences by Location

While the employees for this study came from seventeen different companies with varying business orientations, the sample was from the southeastern part of the United States. It would be of interest to see if differences in levels of
satisfaction occurred in samples from other parts of the country.

**Testing for Dissatisfaction**

Last, Nguyen, Attkisson, and Stegner (1983) state that "the key issue in future research will be the enhancement of our capacity to detect dissatisfied consumers. Current measures are relatively insensitive to dissatisfaction while being very sensitive to satisfaction. The true extent of this insensitivity is unknown but may not be as extensive as many anticipate" (p. 312).
LIST OF REFERENCES


Employee assistance programs: A basic text (pp. 48-53). Springfield, IL: Charles C. Thomas, Publisher.


programs. (Doctoral dissertations, Peabody College for Teachers of Vanderbilt University, 1989). Dissertation Abstracts International, 50(07), 3200B.


## APPENDIX A

### CLIENT INFORMATION

<table>
<thead>
<tr>
<th>COMPANY</th>
<th>EMPLOYEE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| _____ | EMPLOYEE   | DATE   |
|       | SPOUSE/DEPENDENT | OTHER |
| NAME  | HOME PHONE | |
| PARENT NAME IF MINOR | WORK PHONE | |
| ADDRESS | CLIENT’S BIRTHDATE | |

<table>
<thead>
<tr>
<th>EDUCATION:</th>
<th>ETHNIC GROUP: (OPTIONAL)</th>
<th>MARITAL STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>8TH GRADE OR LESS</td>
<td>CAUCASIAN</td>
<td>SINGLE</td>
</tr>
<tr>
<td>9TH-11TH GRADE</td>
<td>AFRICAN-AMERICAN</td>
<td>MARRIED</td>
</tr>
<tr>
<td>HIGH SCHOOL GRADUATE</td>
<td>HISPANIC</td>
<td>DIVORCED</td>
</tr>
<tr>
<td>SOME COLLEGE</td>
<td>NATIVE AMERICAN</td>
<td>SEPARATED</td>
</tr>
<tr>
<td>COLLEGE GRADUATE</td>
<td>ASIAN</td>
<td>WIDOWED</td>
</tr>
<tr>
<td>ADVANCED DEGREE(S)</td>
<td>OTHER (SPECIFY)</td>
<td>LIVING</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENDER: HAVE YOU BEEN TO THE EAP</th>
<th>HEALTH INSURANCE CARRIER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE BEFORE: <em>NO</em> <em>YES</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYEE'S NAME</th>
<th>EMPLOYEE SS#</th>
<th>LOCATION</th>
<th>JOB TITLE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>STATUS:</th>
<th>SHIFT:</th>
<th>LENGTH OF SERVICE:</th>
<th>IS EMPLOYEE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>FULL TIME</td>
<td>DAYS</td>
<td>UNDER 1 YEAR</td>
<td>SALARIED</td>
</tr>
<tr>
<td>PART TIME</td>
<td>EVENINGS</td>
<td>1 - 3 YEARS</td>
<td>HOURS</td>
</tr>
<tr>
<td>AS NEEDED</td>
<td>NIGHT</td>
<td>4 - 6 YEARS</td>
<td>REPORTED INJURIES</td>
</tr>
<tr>
<td>TEMPORARY</td>
<td>ROTATING</td>
<td>7 - 9 YEARS</td>
<td>IN LAST 12 MONTHS:</td>
</tr>
<tr>
<td>OTHER</td>
<td>OTHER</td>
<td>10-15 YEARS</td>
<td>YES NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UNION STATUS:</th>
<th>OCCUPATIONAL STATUS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMBER (SPECIFY)</td>
<td>MANAGEMENT</td>
</tr>
<tr>
<td>NON-MEMBER</td>
<td>NON-MANAGEMENT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REPORTED DAYS ABSENT</th>
<th>AWARE OF EAP FROM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN THE LAST 12 MONTHS:</td>
<td>PRIOR PARTICIPATION</td>
</tr>
<tr>
<td><em>NO DAYS</em></td>
<td>NEWSLETTER</td>
</tr>
<tr>
<td>1 - 5 DAYS</td>
<td>POSTERS</td>
</tr>
<tr>
<td>6 - 10 DAYS</td>
<td>PAYROLL STUFFERS</td>
</tr>
<tr>
<td>11 - 15 DAYS</td>
<td>BROCHURE</td>
</tr>
<tr>
<td>16+ DAYS</td>
<td>SUPERVISOR SUGGESTED</td>
</tr>
<tr>
<td>(SPECIFY)</td>
<td>CO-WORKER SUGGESTED</td>
</tr>
<tr>
<td>(SPECIFY)</td>
<td>FAMILY SUGGESTED</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>IN-SERVICE TRAINING/ORIENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

| MAY WE SEND A FOLLOW-UP QUESTIONNAIRE TO YOUR HOME: |
| YES _NO |

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I AUTHORIZE DIAGNOSIS AND TREATMENT AS CONSIDERED NECESSARY AND APPROPRIATE BY THE COUNSELOR. I FURTHER UNDERSTAND THAT IF THE COUNSELOR RECOMMENDS SPECIAL EVALUATION (TESTS, ETC.) OR REFERS ME TO A COMMUNITY RESOURCE, I WILL BE RESPONSIBLE FOR ANY EXPENSES INCURRED THAT ARE NOT COVERED BY MY MENTAL HEALTH INSURANCE.

SIGNATURE (PARENT IF MINOR)
APPENDIX B

EAP INTAKE DATA FORM

___Drug Testing*  COMPANY___________________________

NAME____________________________________________

DATE____________________________________________

SERVICE RECIPIENT(S)  REFERRAL SOURCE:

_____EMPLOYEE* ______________________ _SELF

_____FAMILY MEMBER _______________________ _FAMILY

_____EMPLOYEE & FAMILY MEMBER ____________ _SUPERVISOR*

_____EMPLOYEE & OTHER ____________________ _EMPLOYEE RELATIONS*

_____OTHER (SPECIFY) ________________________ _UNION

_____SELF ________________________________ _PHYSICIAN

_____FAMILY _______________________________ _OTHER

(SPECIFY)__________________

PROBLEM IDENTIFICATION:

ON-THE-JOB PROBLEM:  PRESENTING PROBLEM: ALCOHOL/DRUG

RELATED:

_____QUALITY OF WORK __ALCOHOL __EMPLOYEE

_____QUANTITY OF WORK __DRUG __DEPENDENT

_____ATTENDANCE/TARDINESS __DRUG TESTING* __OTHER FAMILY

_____SAFETY __EMOTIONAL __MEMBER

_____INTERPERSONAL __MARITAL

_____RELATIONS __FAMILY

_____JOB KNOWLEDGE __CHILD/ADOLESCENT

_____POSITIVE FOR DRUG/ __AIDS

ALCOHOL __LEGAL

_____OTHER PROBLEM __FINANCIAL DISTRESS

(SPECIFY) __FINANCIAL PLANNING

__PHYSICAL

__CAREER PLANNING

__ACADEMIC

__ELDER CARE

__GAMBLING

__SOCIAL SERVICES

__CHILD CARE

__DOMESTIC VIOLENCE

__OTHER INTERPERSONAL RELATIONSHIPS

__OTHER

(SPECIFY)__________________

TYPE OF TREATMENT:  NAME OF FACILITY/PROVIDER:

___EAP COUNSELOR

___OUTPATIENT  1.____________________________

___ALCOHOL/DRUG  2.____________________________

___MENTAL HEALTH  3.____________________________

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___INPATIENT
___ALCOHOL/DRUG
___MENTAL HEALTH
___MEDICAL
___LEGAL
___FINANCIAL COUNSELING
___SELF HELP ROUP(S)
___OTHER (SPECIFY)

CLIENT RESPONSE TO RECOMMENDATIONS:
___ACCEPTED      ___DECLINED      ___UNDECIDED
APPENDIX C
COVER LETTER

July, 1997

Dear Employee Assistance Program Participant,

I am working on a research project for my Doctor of Philosophy degree (Ph.D.) in Mental Health Counseling at the University of Florida and am working under the supervision of Silvia Echevarria Rafuls, Ph.D. The purpose of my study is to determine how satisfied users of employee assistance programs are and how helpful the program has been to employees in particular.

You are being asked to participate in this study since you used your employee assistance program between January and June, 1996. In addition, you responded "yes" to a question on your client information form (filled out at your first visit to the employee assistance program) asking if a follow-up questionnaire could be sent. Your participation in this study is completely voluntary and you may choose to not respond without any penalty. There is no compensation being provided for those who do take the time to fill out the questionnaire.

While the outcome of this study will be available in my dissertation project, you should know that every precaution will be taken to protect your identity and that your responses will remain confidential to the extent provided by law. You might note a code number on the return, stamped and self-addressed envelope. This is so I will know that you have returned your questionnaire. This will prevent my having to unnecessarily follow-up people who have already responded. The coded envelopes will be destroyed once your return is received and necessary data is gathered (further protecting your confidentiality).

I will be taking some demographic information (that is, your gender, age grouping, etc.) from the client information form you filled out in the EAP office at your first visit. Please remember that NO INDIVIDUAL INFORMATION will be presented that could identify you or your company. ALL INFORMATION WILL BE BY GROUPINGS (for example, number of
males and females). THIS IS TO FURTHER PROTECT YOUR CONFIDENTIALITY.

I have selected an eight-item questionnaire. It is enclosed with this letter and should take only about five minutes of your time. Please fill it out upon receiving it and mail it in the enclosed stamped, self-addressed envelope. You do not have to answer any of the eight questions you do not want to answer. In fact, you are free to not even respond. If you have any questions, you may call me at: (813) 870-0392 (Hillsborough County, Florida) or 1-800-343-4670 (toll free). Questions or concerns about research participant's rights may be directed to the University IRB Office, P.O. Box 112250, University of Florida, Gainesville, Florida 32611-2250. The telephone number for the IRB Office is: (352) 392-0433.

There are no known risks, or direct benefits, to you for agreeing to voluntarily participate in this study. Your participation will contribute to better understanding what contributes to employee satisfaction with employee assistance programs. If you choose to participate, please return the questionnaire within one week. Thank you for your time, effort, and participation.

Sincerely,

Patricia N. Alexander, ABD
Licensed Mental Health Counselor
APPENDIX D
PHONE SCRIPT

Hello. My name is Patricia Alexander and I recently sent 
you a brief questionnaire asking you how you felt about your 
participation in your company employee assistance program. 
I am calling to see if you would like to participate or if 
you have decided that you did not care to participate in my 
study.

(If they say they are not interested in participating, I 
will thank them for their time and hang up.)

If they say they are interested in participating, I will 
continue with the following:

Do you have a few minutes for me to go through the 
questionnaire now or would you like me to call at another 
time. (If they want me to call at a different time, I 
will.) If they want me to go over the questionnaire at the 
time of the initial call, I will review with them the main 
points of the letter sent out (see Attachment C) and will 
then read the standardized directions and eight questions.

I will then thank them for their time and hang up.

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BIOGRAPHICAL SKETCH

Patricia Nelle Alexander has been involved in employee assistance program work since 1985 when she was an Internal Coordinator at a psychiatric hospital. She became an employee assistance program counselor with a firm specializing in the provision of employee assistance services in 1990. She is a Licensed Mental Health Counselor in the state of Florida and is a National Certified Counselor. Her decision to pursue a Ph.D. in Mental Health Counseling was driven by her desire to provide the best services possible and to contribute to the professional literature of the counseling profession.
I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Silvia Echevarria Rafuls, Chair
Assistant Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Peter A. D. Sherrard
Associate Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Stephanie G. Puleo
Assistant Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

M. David Miller
Professor of Foundations of Education

This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

May, 1998

Dean, College of Education

Dean, Graduate School