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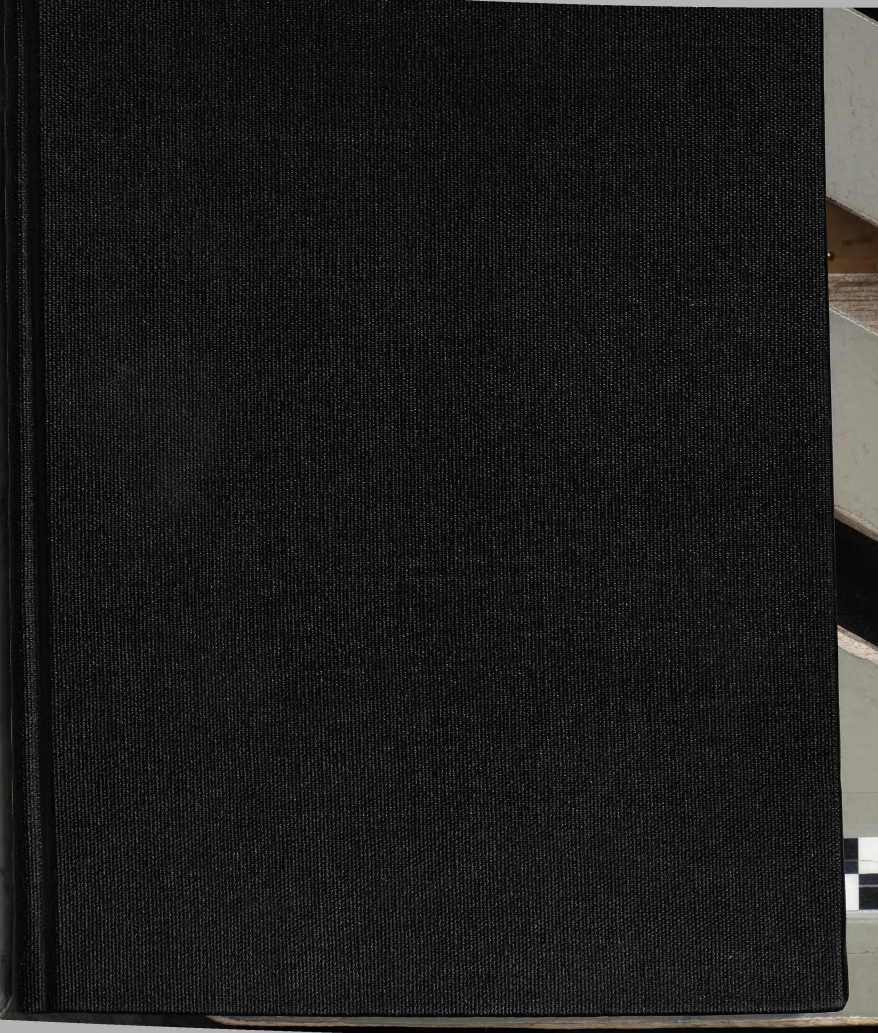
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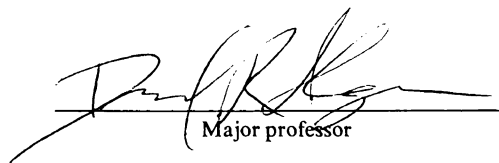
Factors Influencing EAP Utilization:
A Control Theory Perspective

presented by

Suzanne Marie Crampton

has been accepted towards fulfillment
of the requirements for

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FACTORS INFLUENCING EAP UTILIZATION:
A CONTROL THEORY PERSPECTIVE

By

Suzanne Marie Crampton

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
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DOCTOR OF PHILOSOPHY

Department of Management

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ABSTRACT

FACTORS INFLUENCING EAP UTILIZATION: A CONTROL THEORY PERSPECTIVE

By

Suzanne Marie Crampton

The purpose of the present research was to examine factors which may influence an individual's decision to utilize services at an Employee Assistance Program (EAP). Past research that explored EAP usage typically examined demographic characteristics of EAP users and the types of problems presented at the EAP in order to create a profile of EAP users. The major problem with this research is that organizations gained little practical knowledge because it did not help us understand why individuals decide to use/not use an EAP. In addition, there was little theoretical basis for including research variables.

The present research incorporated into this decision process individual personality variables (Health Locus of Control, or HLOC), beliefs held by individuals regarding health-related issues (health goals, social group health norms, past and present health status) and perceptions regarding an EAP (expectations regarding its ability to improve one's health and perceived support, pressure, and barriers to using an EAP). A Control Theory Model of EAP Utilization was developed based on control theory which assumes that behavior is goal directed, and this model was used to provide a structure to studying factors hypothesized to influence the EAP decision process.

A questionnaire was mailed to a sample consisting of both EAP users and non-users who were employed by a large organization and who had equal access to the on-site EAP. Seven hypotheses were examined using multiple regression analyses. Three

factors were predicted to influence an individual's desired health goal level, but only one hypothesis was partially supported when Chance HLOC was found to have a negative relationship to one's desired goal level. Of the variables hypothesized to influence the EAP utilization decision, Internal HLOC and Chance HLOC were found to moderate the relationship between a perceived discrepancy in one's current and desired health and the decision to utilize EAP services. In addition, perceptions of both personal and work-related sources of support, pressure, and barriers to using an EAP were found to significantly impact an individual's decision to seek EAP assistance. Implications of these results, limitations, and recommendations for future research are discussed.

To my best friend and husband, Dave,
without whose years of love, support and encouragement
this would not have been possible
and to my parents, Eugene and Mary Churchill,
with thanks for their love, prayers, and support
throughout all my educational experiences.

This is dedicated to each of them as a
way to express all they have done for me.

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I also appreciate the assistance received from the director of MSU's Employee Assistance Program, Thomas Helma, who helped me obtain the necessary approval and access to the research site and sample. The completion of my doctoral program was facilitated by my colleagues and the faculty and staff in the Department of Management. They were instrumental in my professional development and their efforts are also reflected in this research.

I would also like to express my appreciation for the financial assistance provided toward this project by The International Foundation of Employee Benefit Plans for their research grant which assisted in the completion of the study. I am also very appreciative for being awarded the Harvey Wilson/SHRM Foundation Doctoral Dissertation Research Grant to aid in completing this project.

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CHAPTER 1

STATEMENT OF THE PROBLEM

Introduction

The traditional barrier that has existed between an employee's personal problems and an employer's involvement in the personal lives of employees has been breaking down during the past two decades as more and more employers have extended help to employees through the establishment of employee assistance programs, or EAPs. Employees often experience personal problems, such as alcoholism, drug abuse, social and psychological problems that negatively impact their work performance. Organizations have found these problems can manifest themselves in the form of excessive absenteeism, tardiness, industrial accidents, insurance claims, and grievances along with decreases in efficiency, employee health and morale--which, in turn, affect organizations' overall profit, quality and efficiency. Thus, maintaining a healthy workforce will result in economic benefits for the employee, the firm, and for society.

Health is currently defined as "a state of complete physical, mental, and social well-being" (Stone, 1979). Health behavior is concerned with factors influencing one's choice among alternative methods of dealing with bodily threats (Stone, 1979). Health is viewed not only as the absence of disease but as both an ideal "state" to be achieved as well as a "motive" where one strives to develop and adapt behaviors to respond more appropriately to the environment (Dubos, 1965; Stone, 1979). Experts distinguish between health and illness behaviors where health behavior refers to activity undertaken by a healthy individual to prevent disease while illness behavior is activity undertaken by someone who feels ill in order to obtain relief (Kasl & Cobb, 1966).

In 1980, a national study found that the annual economic cost of alcohol, drug, and mental disorders was \$190.6 billion--with over \$75 billion of the costs related to reduced productivity at work (DHHS, 1982). In 1987, health costs were \$400-500 billion, or 10% of the nation's GNP (Bureau of the Census, 1986; Terborg, 1986). It has been estimated that these expenditures will exceed \$1 trillion before the year 2000 (Wriston, 1982). Employers typically pay 27-30% of these costs (Terborg, 1986). Good employee health is an industrial policy that helps to serve the self-interests of industry. Melvin Glasser of the United Auto Workers stated in 1969 that the workplace should be used as a focal point for providing health service for job-related diseases as well as preventive health services, health education, and all health problems.

Business and labor organizations have endorsed interventions to enhance employee health and contain health costs--one of which is the employee assistance program (EAP). Employee Assistance Programs are defined as:

Policies, procedures and services which respond to employees whose personal, emotional or behavioral problems interfere directly or indirectly with work performance by providing confidential counseling and/or professional information, care or referral to appropriate sources for help (Schmitz, 1982, p.3).

The term EAP is a generic term for all occupational programs that enable troubled employees (i.e., those whose work history is characterized by productivity problems, absenteeism, accidents and other job-related problems) to receive help for a variety of problems--ranging from alcohol and drug abuse, gambling addiction and eating disorders to child-care and pre- and post-retirement counseling--by either identifying or responding to employees whose problems interfere with their work performance (Bureau of National Affairs, 1987; Leavitt, 1983; McCroskey, 1982; Thomas, 1982). Diverse

educational, physical fitness and recreational programs may also be included in such programs (Thomas, 1982).

A more extensive review of the relevant literature will be presented in the second chapter. Based on the review in that chapter, the following conclusions will be drawn. First, despite the diversity and scope of EAPs today, and the fact that a significant number of employees may be in need of assistance, there are many employees reluctant to utilize the services when needed. Second, to date most research has been atheoretical in nature. There appears to be an absence of theory surrounding the relationships influencing health and help-seeking behaviors. Third, several variables have been neglected surrounding EAP research. For example, McKinlay (1975) argued that "organizational phenomena may be as highly related to utilization behavior as the personal characteristics of users" (p. 257).

It is concluded that there is a limited theoretical basis guiding the study of organizational assistance programs. While there have been conceptual models of the EAP referral process developed by a number of researchers (e.g., Savoca, 1986; Wrich, 1980b), a specific model outlining factors which influence an individual's decision to seek assistance from an EAP has not been developed. A number of variables have been examined to gain knowledge on what a typical profile of an EAP user resembles. However, most of the data gathered to date have focused on factors that can be obtained directly from EAP records--gender, race, age, job status, income, problem type, etc. These factors offer little understanding of why some employees utilize EAP services while others do not. Furthermore, many of the conclusions reached on EAP participation factors have often been inconclusive or contradictory.

The purposes of the present research are (1) to examine factors which might influence an employee's decision to seek EAP assistance and (2) to develop a conceptual model to help guide future research on employee usage of EAP services. A model of the utilization process will be developed based on a control theory perspective. Control theory has been applied to behavioral issues in many areas of study, including the areas of cognitive, clinical, and health psychology (Carver & Scheier, 1981, 1982; Wiener, 1948).

Control theory is based on the key concept of a standard or reference value and a process whereby sensed information, or feedback, is compared to this standard or goal (Carver & Scheier, 1981; Miller et al., 1960; Powers, 1973; Von Bertalanffy, 1968; Wiener, 1948). If a discrepancy between these variables exists, a force is created to motivate an individual to reduce the standard-feedback discrepancy via affective, behavioral, and/or cognitive responses (Taylor, Fisher & Ilgen, 1984).

Because "good health" is considered a standard and since many factors influencing the development, amelioration, or prevention of disease and illness are considered under the control of an individual, control theory is seen as an acceptable model to use as a guideline in examining health-related behaviors (Carver & Scheier, 1982; Karoly, 1985). Specific health activities where control theory has provided a useful framework are behaviors related to monitoring one's current health state (e.g., examining one's pulse, blood pressure, or temperature) to determine if one's health is less than ideal and, if not, motivating the individual to action (Carver & Scheier, 1982; Leventhal, Meyer & Nerenz, 1980; Schwartz, 1978, 1979).

The present study attempts to examine relationships among variables of interest in health and help-seeking behaviors--specifically, variables influencing an employee's



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seeking assistance at an EAP. Ilgen (1990) suggests that the timing, frequency and nature of access to health care services by those in need have important consequences to employees (e.g., health, quality of life) and organizations (e.g., financial, productivity); however, these health care system access behaviors are not well understood. The aim of the present study is a scientific one by contributing to our knowledge of help-seeking behaviors in an EAP setting and to the development of a theoretical basis for examining the relationships involved. The aim is also a practical one by enabling organizations, human resource managers, and EAP staff members to better understand the utilization process. In the following section, an overview of EAPs will be presented.

Employee Assistance Programs

Employee Assistance Programs exist within a variety of organizational environments--business, sports, government, hospitals, public utilities, entertainment, educational, and labor unions (Castro, 1986). Employers generally agree that personal problems are still a private domain, except when such problems have a negative impact on work behavior. More and more these problems are being addressed at work through EAPs, with the expectation that the benefits will be greater than the costs incurred in establishing such programs; e.g., decreases in absenteeism and in the costs of hiring and training replacements, and increases in morale and productivity (Lyons, 1987, p. 38).

Many forces began to evolve that changed both the attitude of the employee as well as the employer since the 1960's. For example, American workers have been in a state of transition during the last couple of decades. The transitions have occurred for many reasons, which include: the median educational level for employees has increased from 8.7 years in 1940 to 12.7 years by 1984; 44% of the workforce is made up of women; only



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one-third of the households in the U.S. have only one spouse employed; 52% of female employees have children less than six years of age; and increased automation and technology have resulted in increased specialization of workers and training costs (Hayghe, 1984; McClellan, 1985). These transitions have, in turn, brought about changes in employee attitudes and expectations whereby workers expect more from work than just a job and a paycheck. Employees demand a healthy work environment, and good jobs are assessed based on a variety of social and psychological needs. "Workers are no longer content to be just economic tools in the production of goods and services. They want to be treated as human beings who have hopes, aspirations, anxiety, and fears that need to be recognized" (Ozawa, 1980, p. 466).

Societal changes have also taken place during the last several years. The number of alcoholics, drug abusers, divorced couples, single parents, step-parents, and those caring for elderly relatives has increased (Masi, 1984; Myers, 1984). These changes, along with the higher educational levels of employees, increasing numbers of women and minorities in the labor force, high requirements of technical competence, changing management practices, and foreign competition all impact on the workplace. As society and workforce attitudes changed over the years, a humanization of the workplace began to emerge (Cascio, 1986).

As we begin the 1990's, business realizes the importance of human resources to successful operations, and nearly all believe that the most productive workers are healthy--not only physically but also mentally. The effects of increasing threats of foreign competition have further compelled the business world to modify its practices and programs to meet the challenges faced.



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While the above changes in society and the workforce were occurring, organizations began recognizing the need to take a more holistic approach when dealing with their employees. In a 1974 survey of management personnel by the American Management Association, 90% thought corporations should be concerned with the total person and not just with daily output (Work, 1974). Based on his research for the National Institute of Business and Industrial Chaplains, Brown (1983) identified the following as major industrial concerns: marriage and family, alcohol abuse, pastoral care, crisis situations, other personal concerns (e.g., anxiety, depression), job-related problems, financial problems, mental illness, drug abuse, and court/legal issues (pp. 14-15). Employers have also been forced to pay more attention to the interpersonal and personal concerns of employees due to the legal constraints and requirements placed on organizations. Examples of such federal and state legislation include Title IX and Title VII of the Civil Rights Act of 1964, as amended, Title VI (apprenticeships), and Executive Order 11246, as amended (sex discrimination) (Bloom, 1986). These acts mandate that organizations avoid discrimination based on non-work related factors and take affirmative action to increase job opportunities of members of protected classes.

As a result of these forces, firms developed human resource programs to address the needs and welfare of employees and assist workers in dealing with both personal and work-related problems; i.e., programs such as participative management, expanded benefits, improved organizational structure, and employee counseling services (Carr & Hellan, 1980; Shamir & Bargall, 1982). While these all improved organizational life, they did not address the needs of the employee as well as the EAP has (Carr & Hellan, 1980).

Management and unions both recognized that EAPs were effective for meeting both competitive challenges and employee needs. The work site was also viewed as an

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effective location for the delivery of health programs since the workplace is where employees spend one-third or more of their time (Alderman, 1984; Fielding, 1984a). Terborg (1988) cited three additional reasons why the work site is an excellent place to conduct health promotion activities: (1) a large number of people are employed on a regular basis, (2) there is a potential for manipulating the social and physical environments, and (3) there is the possibility of reducing health-care costs and increasing productivity. Other forces that make the work site an effective EAP environment and move troubled employees to seek EAP assistance include the fact that serious personal problems often impair work performance in some manner, organizations expect employees to maintain certain standards of performance, there is a strong desire on the part of an employee to keep his/her job, the employee often is under pressure from external sources (e.g., coworkers, spouse, friends) to get some help, and the fact that help is often available and easily accessible in the form of an EAP (Masi, 1984; Myers, 1984).

One question that might still be asked is whether the employer's involvement in an EAP is an unwarranted encroachment into the personal lives of employees. The answer is "no" for several reasons. Most employees, for instance, keep their personal problems from affecting their job performance because income is important to them, so employers only become involved when the problem is beyond what the individual can handle and deteriorating job performance is observed. Also, many employees do not know where to receive help for problems or can not afford help from external resources, so EAPs at the workplace are useful for assisting employees. For example, Pardue (1987) found that if the company had not established an EAP, of the 200 clients interviewed, only 25% stated they would have sought assistance for their problem at an external resource.

Finally, employers do not become directly involved in the specific personal problems of an employee since confidentiality is a requirement for any EAP to succeed and survive.

Initial efforts on the part of employers to assist employees were in the area of alcohol-related problems. Threatt (1976) noted that researchers have accumulated a substantial amount of evidence to support the assumption that the use of alcohol causes alterations in human physical and cognitive functioning. Consequently, the first occupational programs were typically low-keyed and designed along the lines of Alcoholics Anonymous (Roman, 1983a).

The EAPs of today evolved out of these original alcoholism programs. Major federal initiatives undertaken in 1972 resulted in more formal Occupational Alcoholism Programs (OAPs) (Masi, 1984). The early OAPs functioned mostly on a trial and error basis because of the lack of experience with such programs. Since society during the 1940's and 1950's viewed an employee with an alcohol problem as weak or immoral, program effectiveness was hampered as companies took a more punitive approach to dealing with employees by threatening or dismissing them. However, by the 1960's OAPs were reported to save money and production time (Trice & Schonbrunn, 1981). It was this success that led to the realization that help might be successfully provided for other employee problems, which further lead to the development of EAPs (Trice & Schonbrunn, 1981).

Since the 1960's, EAPs have changed in form, grown in numbers, and gained in popularity. By 1980, Wrich estimated that EAPs had been adopted by approximately 60% of the Fortune 500 companies and thousands of others (Wrich, 1980b). There are now over 10,000 EAPs operating in the U.S. covering millions of workers (BNA, 1987; Champion, 1988). Five significant factors have influenced this growth. First, the

enactment of the Hughes Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, in 1970 provided federal funding for state programs and created the National Institute of Alcoholism and Alcohol Abuse in 1971 (Forrest, 1983; Masi & Teems, 1983). Second, the Secretary of Health and Human Services was authorized to promote the development of "screening, consultation, referral and education programs at employment sites to detect and prevent early mental health problems" (Mental Health Systems Act of 1980, Section 208). This made the EAP concept a public policy issue and corporations became interested as a matter of "social responsibility" (Scanlon, 1986). Third, the passage of the Rehabilitation Act of 1973 prohibited discrimination against any handicapped employee and required employers to provide services for troubled employees before terminating them. In addition, "handicapped" was interpreted to include those suffering from alcohol, drug, mental or emotional problems (Masi & Teems, 1983; Roman, 1981). Fourth, the U.S. labor force experienced its first drop in the productivity level for hourly employees and employers became concerned that the drop may be due partly to employees experiencing personal or work-related problems (Shuster, 1978). A final factor was that organizations were faced with increased foreign competition and needed to develop new ways to improve profit (Forrest, 1983; Googins, 1975).

Employee assistance programs today cover a broad array of personal problems and, thus, are able to reach a larger population than the more narrowly-focused alcohol programs. They have also demonstrated their positive impact on health costs, productivity, and job performance (Masi, 1984; Myers, 1984; Wrich, 1980b).

The Pervasiveness of the Need for EAPs

While some employees can successfully separate their work from their personal life and continue to function well on the job, others bring their problems to work, resulting in a variety of dysfunctional behaviors (e.g., tardiness, poor performance, poor inter-relationships with supervisors and coworkers, increased accidents and grievances, etc.). Experts differ in their perception of the pervasiveness of "troubled" employees. Storm (1977) has pointed out that in any given employee population, at least ten percent will be seriously troubled by personal problems, which include medical, alcohol and drug related, emotional, marital, family, financial, or other problems. However, others suggest this figure is much higher (Baxter, 1981; Cahill, 1983; Egdahl & Walsh, 1980; Weiner et al., 1973; Wrich, 1980).

There are over 110 million drinkers in America with an estimated 10.2 million adult problem drinkers, an additional 3 million problem drinkers ranging from age 14 to 17, and 100,000 to 200,000 new cases of alcoholism annually (New York Executive Chamber, 1982; NIAAA, 1978). In a 1985 Gallup poll, one-third of all families reported substance abuse in a family member (BNA, 1987). Baxter (1981) estimated that alcohol problems affect between 5-15% of the workforce and Applebaum (1982) cited estimates that alcoholics cut across all organizational levels--25% white collar, 30% manual workers, and 45% professional and managerial. Others have estimated that another 3 to 5% of the workforce is involved in drug abuse (Baxter, 1981) and that as many as 20 to 30% of the U.S. working population has a serious personal problem (Cahill, 1983; Egdahl & Walsh, 1980; Weiner et al., 1973; Wrich, 1980b).

In a survey of top executives, however, Roman (1978) found that most failed to perceive the problems as severe as those researchers cited in the preceding paragraph,

although they agreed that no organization is exempt from these problems. Trice and Roman (1972) estimated that alcohol and drug abuse problems in the workplace affect between 3 and 4% of the workforce, and the frequency of other employee problems is another 3 or 4%. While experts may disagree as to the size of the problem, no one can question whether a problem exists. For instance, according to Trice and Roman (1972):

When the potential impact of any one deviant drinker is considered, . . . the relevance of the problem for organizational functioning mounts rapidly. In other words, the disruptive consequences of deviant drinking may far exceed the cost entailed if 4% of the work force were absent or simply sat at their jobs and did practically nothing. The very essence of a work organization is the interdependence of job performances. Deviance by one employee may "reverberate" beyond his work station or desk, sometimes disrupting an entire organization. Thus the prevalence figures alone do not tell the full story. (p. 2)

Thus, it seems a snowball effect is produced as a result of any one employee's dysfunctional work behavior in the form of direct costs of the worker (absenteeism, poor productivity) and indirect costs as work group activities and morale are disrupted and supervisors must spend time and attention dealing with deviant behaviors.

While employees are affected by non-work related problems, the unique characteristics of the work setting have also been recognized as influencing the emotional health of employees. For example, much has been written about stress and burnout at work. Industrial stress has been estimated to account for \$32 billion annually in work-related accidents, and contributes to heart disease--which is responsible for losses of over 135 million work days annually (McClellan, 1985, pp. 29-30). Vicary and Resnik (1982) reported that job-related stress is one of the most frequent reasons for drug abuse and other health problems.

Examples of job stress include: physical environment factors (e.g., temperature, illumination, noise, office design) (Quick & Quick, 1984), organizational stressors (e.g., deadline pressures, failure to obtain promotions, fear of failure, job insecurity,

competition, task demands, long working hours, hazardous conditions, organizational tolerance for deviant behavior) (Brodsky, 1977; Landy & Trumbo, 1976; Martin & Schermerhorn, 1983) and individual level workplace stressors (e.g., personality clashes, social density, group pressure, labeling, social support) (House, 1981; Levinson, 1976). Yankelovich (1978) adds there is stress resulting from the tension between the old cultural values where employees become subsumed in their job, which still prevail in the workplace, and the new values of workers today who expect personalized, self-fulfilling work.

Trice and Roman (1972) discuss four work environment factors which increase the probability of substance-related deviance: (1) lack of visibility, such as job positions with flexible hours and those which keep the employee isolated from supervisors and coworkers; (2) absence of structure; (3) absence of social controls, such as when drinking is part of the work role; and (4) miscellaneous factors, such as roles which place individuals under severe strain, competitive work climates, and employees who are illegal drug users. House (1974) suggested the following aspects should be investigated regarding work stress: objective work conditions conducive to stress, individual perceptions of stressful work situations, individual responses and outcomes to perceived stress, and individual or social situational characteristics that condition the relationship between the first four factors. Specific employee groups have been found to be under a great deal of stress, such as employees who work on rotating shifts who suffer stress due to irregular sleep patterns, poor nutrition, and other pressures as a result of irregular work patterns (e.g., flight attendants, nurses, police officers, factory workers) (Fever, 1983). Women also are often under great stress from the multiple role expectations and conflicting demands placed on them (Roth, 1981).

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Role conflict (when an employee receives ambiguous and/or conflicting demands from others at work) and role ambiguity (responses to behavior are unpredictable or role requirements are unclear) are the most heavily researched aspects of job stress (Knapp, 1985). Role ambiguity and conflict have been positively associated with somatic complaints, depression, irritation, anxiety and tension (Caplan et al., 1975; French, Caplan & Van Harrison, 1982; Margolis, Kroes & Quinn (1974).

No longer are employees today satisfied with just receiving a wage, and when other needs are unmet, many employees feel frustration and stress. One reason found by researchers for alcohol abuse is that alcohol may be used as a coping strategy against stress (Lazarus, 1974; Pearlin & Radabaugh, 1976; Williams, Calhoun & Ackoff, 1982). However, the effect of stress on health appears to depend on the context of the stressful agent, how individuals perceive it, and the social supports and resources available to the individual (Breznitz & Goldberger, 1982; Cohen & Syme, 1985). Occupational stress management programs typically focus on treatment and helping employees cope with stress through such methods as assertiveness training, biofeedback, and coping skills training, rather than on prevention or removing the sources of stress (Everly, 1984; Ganster, Mayes, Sime & Tharp, 1982; Pelletier & Lutz, 1988).

The Costs of Troubled Employees

In presenting the costs involved in employing and assisting troubled employees, one type of cost to employers is represented in the many costs associated with the deteriorating work performance of troubled employees. It has been estimated that 70 million American workers function at only half their daily capacity (United States Congress, 1982). As mentioned in the previous section, for example, a major health

problem in the U.S. is alcohol abuse where over half of the adult problem drinkers are employed across all organizational levels (Applebaum, 1982). These employees cost American business over \$42 billion annually (White House Office of Drug Abuse Policy, 1978)--costs which are manifested in a variety of work behaviors of alcoholic employees: excessive absences, on-the-job accidents, and health benefits (Kuzmits & Hammonds, 1979). In addition, Wrich (1980b) estimates a 25% loss of efficiency per alcoholic employee--or \$5,000 a year for an employee earning \$20,000. Furthermore, alcoholism has been cited as a possible cause in 70% of all filed grievances (Wrich, 1980b).

Employees with substance abuse problems average between two and three times more absences, three times more sick leave and accident benefits, and five times more compensation claims than employees without such problems (Pattison & Kaufman, 1983; Wrich, 1980b). Hall (1983) added that 10% of the employed population that abuses alcohol or other drugs produce at 25% below capacity and the average firm has a loss of 2.5% in payroll costs.

In addition to the costs of substance-abuse problems described above, it has been estimated that employees' emotional problems and stresses cost industry billions of dollars in absenteeism and turnover costs, excessive tardiness, negative work attitudes, increased employee alienation from the workplace, decreased American productivity, annual increases in health insurance claims and other costs (Baxter, 1981; Berry & Boland, 1977; Busch, 1981; Carr & Hellan, 1980; Follman, 1978; Masi, 1984; Murray, 1983; Shain & Groeneveld, 1980; Trice & Roman, 1972). For example, it has been reported that business loses from \$1,622 to over \$3,000 per employee annually due to emotional problems (Myers, 1984).



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Experts have found that workers experiencing stress from job-related factors are less efficient, experience reduced concentration, greater absenteeism, decreased morale, have greater problems handling job pressures, increased turnover, and increased negative health outcomes (Cooper, 1981; Fly, 1980; House, 1974; Matteson & Ivancevich, 1982). It has also been estimated that 80-90% of all industrial accidents may be traced to personal problems, while emotional problems are implicated in 65-80% of all employee terminations (Brown, 1973; Egdahl & Walsh, 1980; Pati & Adkins, 1983). Smoking is another major health issue that has been reported to reduce mental efficiency by 23% and result in 77 million work days lost per year (Myers, 1984).

It has been reported that a person's psychological makeup is often associated with ulcers, obesity, migraine headaches, arthritis, colitis, and some forms of cancer--costs which organizations experience in increased health costs (Compcare, 1981). In a recent article, it was reported that it was costing companies an average of \$1,985 per worker each year in health-care benefits (Employee Health Care, 1988). Others have estimated that costs of lost productivity in American industry range from 8-29 billion dollars a year, and when drug abuse and other problems are included, the figures increase from 30-70 billion dollars each year (Applebaum, 1982; Berry & Boland, 1977; Egdahl & Walsh, 1980; Follman, 1978; United States Congress, 1982).

While the costs of troubled employees have been great to organizations, there are also high personal costs involved for troubled employees and their families. For example, researchers have stated that suicide rates are 58% higher for alcoholics compared to the national average, alcohol is cited as a cause in 55% of all auto accidents, in 64% of all fatal auto accidents, in 40% of all cases brought before family courts, in 11% of all annual deaths, in 50% of home accidents, that from 25 to 50

percent of patients in the hospital are suffering from an alcohol-related illness, and that 20% of all referrals to child-guidance clinics are children of alcoholics (BNA, 1987; Kinney & Leaton, 1983; Matsunaga, 1983; McClellan, 1982; United States Congress, 1978). Non-alcoholic family members (in families with an alcoholic) are also a financial burden to business since these individuals have been found to have sick leave costs ten times more than a control group (Compcare, 1981; Wrich, 1986). Substance abuse has also been cited as a contributing factor in 50 to 60 percent of drownings and 80 percent of all suicide cases (Wrich, 1986).

There are other costs incurred by the organization which involve the implementation and administration of an EAP. Some of these costs include: (1) the compensation of the EAP staff; (b) office expenses for renting/leasing office space, paying for utilities, furniture, equipment, and supplies; (c) training expenses for renting/buying materials and time spent in training (training of supervisors, employees, and EAP staff); (d) provision of EAP services; and (e) liability and health benefits insurance (Myers, 1984, p. 109). Various estimates have been cited for these costs. James Wrich's cost estimate is \$67,220 for the first year of operation for a company with 1,000 employees with long-term costs over 25 years estimated at \$426,740 (Masi, 1984, p. 198). Weststrate (1983) estimated that the average cost per employee at one EAP was \$1.50 a month, or \$18.00 annually. Others have estimated the cost to be approximately \$5.00 per employee annually (Masi, 1984; Schlenger & Hayward, 1975).

The Benefits of EAPs

Despite the various costs involved in establishing and maintaining EAPs, many researchers have indicated the benefits outweigh the costs. Several early evaluation



studies conducted on OAP effectiveness (Asma, Eggert & Hilker, 1971; Googins & Kurtz, 1981; Hoffman & Roman, 1984; Kurtz, Googins & Howard, 1984) generally reported positive results. For example, a 1980 cost-benefit study at the Illinois Bell alcohol-related EAP tracked 752 problem drinkers referred to the EAP. The study found that after referral to the EAP, 66% of the employees had "good" job performance ratings compared with 90% having "fair to poor" ratings prior to referral, and that disability claims decreased 52%, off-duty accidents decreased 42.4%, and on-duty accidents decreased 61.4% after referral (BNA, 1987).

Similarly, evaluative studies of broad-brush EAPs have generally reported positive outcomes (County of Alameda, 1978; DuPont, 1979; Foote et al., 1978; Washington Business Group on Health, 1978). Unfortunately, there appears to be little or no consensus on how to measure EAP effectiveness. Most evaluation measures relate to the goals of the particular program. Jerrell and Rightmyer (1982) reviewed 38 empirical EAP studies published from 1958 to 1980 which focused on four types of measures employed in EAP evaluation. The first set covers accidents, sick leave, and medical-surgical costs. The second group focuses on outcome measures that include absenteeism, tardiness, and leaving work early. The third set looks at rehabilitation rates. The last group examines employee morale and satisfaction variables, job performance ratings, grievances, disciplinary actions.

A few examples of EAP evaluation studies that have been conducted are summarized below:

- (1) Foote, Erfurt, Straugh, and Guzzardo (1978) conducted a detailed analysis of costs and benefits of eight programs. Significant reductions were found on the organizational outcome variables examined (e.g., absenteeism, grievances, on-the-job



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accidents, health benefits), but they concluded that much work and more data were needed to develop an accurate and reliable cost-benefit analysis.

(2) The Washington Business Group on Health (1978) concluded that most companies report benefits in improved productivity, absenteeism rates, morale, and health insurance costs.

(3) Featherston & Bednarek (1981) reported reduced replacement, training, and unemployment insurance costs.

(4) General Mills American Family Forum (1980) provided evidence of improved productivity, morale, self-esteem, and more satisfying personal relationships and reductions in hospitalizations, medical utilization, and absenteeism.

(5) DeFuentes (1986) reported improvements in absences, disciplinary actions, performance reviews, and medical leaves. Those self-referred showed more promotions, higher resolution of the problem, and higher performance ratings while those referred by others showed reduced disciplinary actions, increased absences, and reduced medical leaves.

Table 1 provides a chart identifying the major EAP cost-benefit studies which were gathered by the Minnesota-based Hazelden Foundation (taken from BNA, 1987, pp. 27-29). It seems that most evaluative studies track improvements in employment-related criteria that are easily quantifiable, such as decreased absenteeism rates, medical costs, on-the-job accidents, disability claims, grievances, and quantifiable measures of work performance. There is little information on cost savings achieved through broad-brush EAPs for employees in areas such as eating disorders, gambling compulsions, legal or financial problems, and personal relationships because these benefits are more indirect and more difficult to measure (BNA, 1987).

Table 1: EAP Cost-Impact Studies

Source	Type of Company	Sample Characteristics(N)	Type of EAP	Type of Treatment	Length of Follow-up	Criteria	Outcome
Heyman, 1976	4 large service and manufacturing	182	Alcoholism			Self reported work performance	87% of covered clients and 33% of voluntary clients improved
Manello, 1979	7 railroads	1,571	Alcoholism			"Return to adequate work levels"	"About 70% of those who accepted treatment were successfully rehabilitated"
Milstead-O'Keefe, 1980	10 companies in community Agency of Labor Management	13 women alcoholics	Broadbrush			5 measures of work performance	Success rate equaled "71-88% across the work performance criteria"
Prennall, 1980	Not given	167 problem drinking men	Alcoholism			Amount of drinking absenteeism	73/167 improved, decrease from 47-61 work shifts lost annually prior to treatment to 12-31 work shifts lost annually after treatment, depending on drinking outcome
Footle, et al., 1978	4 companies	Company A: N-343 Company B: N-22 Company C: N-57 Company D: N-158 mainly men	Broadbrush		13 months after referral	Absenteeism	Company A: no data; Company B: Increase from 344 to 298 average hours annually; Company C: decrease from 307 to 133; Company D: decrease from 428 to 493
						Disciplines	Company A: decrease from .8 to .5 average number annually; Company B: decrease from 1.1 to .7; Company C: decrease from 1.0 to .2; Company D: decrease from 1.6 to .7
						Grievances	Company A: no data; Company B: decrease from .3 to 0 average number annually; Company C: decrease from 1 to 0; Company D: decrease from 1.4 to .9
						On the job accidents	Company A: decrease from 2.3 to 1.7 average number annually; Company B: decrease from 1 to .9; Company C: decrease from .3 to 0; Company D: no data
						Visits to medical unit	Company A: decrease from 7.3 to 5.9 average number annually
						Amount paid in worker's compensation benefits	Company A: decrease from \$103 to \$124 average annually; Company B: decrease from \$320 to \$237; Company C: decrease from \$130 to \$5
						Amount paid in sickness & accident benefits	Company A: increase from \$425 to \$679 average annually; Company B: increase from \$123 to \$205; Company C: decrease from \$2035 to \$824; Company D: increase from \$503 to \$629

Source: The Hazelden Foundation

Table 1 (cont'd)

Source	Type of Company	Sample Characteristics(N)	Type of EAP	Type of Treatment	Length of Follow-up	Criteria	Outcome
Chopra et al., 1978	Not given	88 coerced clients and 100 voluntary clients (all men)	Alcoholism	3 wk. in-patient program	Max. of 14 months	Abstinence	88% of coerced and 34% of voluntary clients reported abstinence
Freedberg & Johnson, 1980	200 businesses & industries	370 coerced clients and 88 voluntary clients (85% men)	Alcoholism	3 week in-patient program followed by 90 90 hours of after-care	12 months	Abstinence	31% of coerced and 38% of voluntary clients reported abstinence; 92% & 31% reported improvement
Anonymous, 1980	Illinois Bell	782 referred problem drinkers with at least 3 years of employment before and after referral	Alcoholism	Varied; hospital recommended for 80%	At least one year	Work status	15% of coerced and 7% of voluntary were fired
						Ontario Problem Assessment Battery	"Significant Improvement"
						Supervisor's Rating Form	"Significant Improvement"
						Abstinence	88% reported abstinence; 19% reported improvement
Schramm, et al., 1978	3 companies	206 referred problem drinkers	Alcoholism	Varied; in-patient recommended for 10%	3-30 months	Supervisor's ratings	Prior to referral 90% had fair to poor ratings. After referral 86% had good ratings.
						Disability claims	Decreased by 83%
						Off duty accidents requiring > 7 day absence	Decreased by 42.4%
						On-duty accidents	Decreased by 61.4%
						Job retention	83.3% remained employed in the company
					12-30 months	Treatment outcome	38.3% successfully completed treatment or were still actively involved in treatment

Source: The Hazelden Foundation

Table 1 (cont'd)

Source	Type of Company	Sample Characteristics(N)	Type of EAP	Type of Treatment	Length of Follow-up	Criteria	Outcome
Spicer, Barnett & Kilner, 1979	Referrals from many companies to a treatment center. (Hazelton)	N = 191 (Mostly males)	N/A	4 week residential treatment	12 Months	Self reported alcohol use	89% abstinent (compared with 63% in total patient population)
						Self-reported drug use	78% abstinent (compared with 70% in total patient population)
						Self-reported improvement in: relationship with spouse, general physical health, self-image, ability to manage finances	78-91% improvement
						Self-reported improvement in job performance	85% reported improvement
						A.A. attendance $\geq 1 \times$ week	88% reported improvement
						Self-reported improvement in overall quality of life	88% reported improvement
						Self reported:	
						quality of work	46% improved
						quantity of work	35% improved
						relationship with co-workers	33% improved
						relationship with supervisors	32% improved
						# of times arrived to work late	Decrease from 196 times to 41 times total
						# of times left work early	Decrease from 120 times to 43 times
						# of times other absenteeism	Decrease from 56 times to 9 times
						times used health insurance plan	Decrease from 96 to 90
						sick days	Decrease from 158 to 128
						medical leave days	Increase from 41 to 75
						accidents on job	No change (2)
						times used Workers' Compensation	Decrease from 8 to 0
						short term disability	No change (0)

Source: The Hazelton Foundation

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In general, EAPs have been shown to make improvements in monetary areas since many firms have been able to decrease absenteeism by 300%, medical costs by 200%, and terminations for those using the EAP by ten times compared to those not using the EAP (Busch, 1981; Sager, 1979). Additionally, EAPs have been shown to improve non-monetary areas, such as staff morale, quality of performance, and improved relationships with coworkers (Roth, 1981). When EAP success has been defined as an improvement in job performance or in an individual's overall functioning relationship, several companies have reported success rates ranging in improvements from 60% to 80%--E.I. DuPont de Nemours & Co. with a 66% success rate with 950 alcoholics receiving treatment; Bethlehem Steel Corporation with a 60% success rate; and Minnesota Mining and Manufacturing Company with a reported 80% success rate (Storm, 1977). Annual savings have been noted as follows at other EAPs: \$2 million by the U.S. Postal Service, \$1.5 million by the New York Telephone Company, and \$.5 million by DuPont (Scanlon, 1983). Otto Jones, the president of a Salt Lake City EAP, cites a return of \$3.10 for every EAP dollar spent (Lovenheim, 1979). Others cite average returns of \$5.78 per EAP dollar spent (Scanlon, 1983), \$8.00 (United States Congress, 1982), \$14.00 (at Burlington Northern Railroad), and \$16.35 (at a "major airline") (BNA, 1987, p. 25). Wrich (1980b) found that "companies that have developed cost effectiveness data report that the benefit to cost ratio in employee assistance programs is frequently over 1,000 percent" (p. 113). Wrich (1980b) also determined that helping all troubled employees in an organization costs about one-tenth what only one alcoholic employee will cost the organization.

While research has reported on the cost-effectiveness of most EAPs, several problems have been noted with this research. Albert, Smythe, and Brook (1985) and

Steidinger (1985) reviewed EAP evaluation research and practices and concluded that conceptual and methodological problems are inherent in this research and that most studies were poorly designed and used non-standardized performance measures. The thoroughness and validity of many studies has also been criticized. Most of the published literature concerning the success of EAPs is anecdotal and, of the empirical work, much is primarily descriptive data (Jerrell & Rightmyer, 1982; Kurtz, Googins, & Howard, 1984). In addition, there is a basic difficulty facing EAP evaluators which is a resistance by EAPs and affiliated companies to conduct evaluations (Kilburg, 1980; Masi & Teems, 1983). For example, Ford and McLaughlin (1981) found that only 13 of 110 companies with an EAP calculated any dollar or productivity benefits; rather they focused primarily on changes in absenteeism rates. In a survey of EAPs by Straussner (1986), only 52% of the EAPs conducted an evaluation of their programs and the purpose was not to examine their services, but to validate the value of the program to management. Similarly, Coleman (1984) found that only 40.6% of the EAPs examined in higher educational institutions had a formal mechanism used in evaluating their programs and that only 37.5% do so annually. Finally, 34 San Francisco area EAPs were surveyed by Steidinger (1985) but only 59% reported conducting program evaluations and the majority of these were external/off-site EAPs.

As previously mentioned, often employees are able to confront and resolve their problems before the problems negatively impact their work performance. However, there are times when these problems cannot be resolved and employees experience decreased job effectiveness, increased absenteeism and tardiness, and other negative effects. Methodological problems notwithstanding, EAPs can help combat these problems.

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Diversity of EAPs

There is no typical EAP. There are variations in the EAP model utilized, structure, size, administrative policies and procedures, services provided, service delivery, funding, management support, staffing, etc. What they have in common is the basic premise that healthy employees are more productive/better employees and are valued assets and the basic goal to reduce or eliminate the basis of an employee's impairment (Roman, 1983a). Thus, an EAP exists because the organization recognizes the value of employees and the need to maintain employees' health (Lovenheim, 1979; Scanlon, 1983; Wrich, 1980b).

EAPs are diverse in their ideological basis (Trice, 1980), although many typically are grounded in both a "humanitarian" concern for the overall well-being of employees (Trice & Roman, 1978) and a need to utilize controls to attain high productivity from employees (Trice, 1980). Diversity is also evident in the type of EAP model utilized. There are two basic EAP models. One model deals primarily with substance abuse difficulties, primarily those that continue their original focus on alcohol-related problems. The second model is referred to as "broad brush." The latter model provides services that deal with more than alcohol-related problems which may negatively affect job performance (Starr & Byram, 1985). Examples of "broad-brush" services include crisis intervention, short-term counseling and/or referrals for employees experiencing difficulties related to marital problems, domestic violence, child abuse, emotional stressors, psychological disorders along with providing information on financial, legal, and vocational issues.

There are also generally three basic structural models or approaches of EAPs: internal/on-site, external/off-site, or combination models. These will be discussed in more detail in chapter two. Each approach accepts a variety of referral types: self-

referrals, supervisor-referrals, union-referrals, significant-other referrals, or any other method by which employees come to seek assistance. It is assumed that many who are identified and referred to an EAP will again become "good" employees.

Assumptions of the Research

The following assumptions are important to this study:

1. An employee's personal and work life are interdependent; thus, some employees have problems which will affect their work performance.
2. An employer has an obligation to its employees and also to its constituencies, students, and general public, and an employer cannot adequately meet the public's needs unless it also attends to the human needs of its employees.
3. Behavior is goal-directed.
4. Understanding an individual's motivation to perform health-related behaviors requires identifying the expectations of future performance regarding health behaviors, the individual's value placed on health, and the perceived benefits of health behaviors (Pender, 1982; Rotter, 1954; Wallston, Maides, & Wallston, 1976).
5. The occurrence of a behavior is determined by the nature or importance of goals or reinforcements and by a person's expectancy that these goals will occur.
6. Employees who either participate or do not participate in EAPs have the necessary resources and equal access to participate in the EAP if they choose to do so.

Organization of the Research

Chapters of this dissertation are organized as follows. Chapter two provides a comprehensive review of the related EAP literature while chapter three presents a

discussion of both control theory in general and the Control Theory Model of EAP Utilization developed in the present research. Chapter four outlines the research design and method. Chapter five presents the results and analyses of the study. Chapter six includes a summary of major conclusions, implications, and recommendations drawn from the results. In Appendix A, common terms referred to in this research are defined. Appendix B illustrates the survey instruments completed by the participants in this study.

CHAPTER 2

REVIEW OF EAP AND HEALTH-RELATED LITERATURE

Interest in work site assistance programs crosses several disciplinary fields. In 1986, Molloy indicated that "organizational and management theories have not addressed the employee assistance field per se" (p. 47). Assistance programs should fall under the human resource management (HRM) and organizational behavior (OB) fields because they focus on organizational activities that are concerned with affecting the behavior of the human resources (Ivancevich & Matteson, 1980). Since the HRM and OB fields integrate research and perspectives from several other disciplines, such as sociology, economics, psychology, and medical science, EAPs which focus on treating the physical and mental health problems of employees encompass concerns and concepts from these fields as well. Employee health, the rising costs associated with employee health, and the social and cultural variables which impact one's health behaviors makes employee health a social, organizational, medical, economical, and psychological concern (BNA, 1983).

Historical Background

Historical Background to 1940--Welfare Movement

Little concern for the workers and their needs seemed to exist during the early phases of the Industrial Revolution. The Industrial Revolution has been characterized by three specific developments: "the development of machinery, the linking of human power to the machines, and the establishment of factories in which a large number of people were employed" (Cascio, 1986). Labor was considered a commodity to be

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bought and sold at will and the environment was characterized with dangerous working conditions, children forced to work long hours under hazardous conditions, low wages, and productivity as the primary goal. This was also a time when a great deal of job specialization developed. While Adam Smith (1776), Charles Babbage (1835) and others noted the many advantages produced by a division of labor (e.g., reduced training time, less raw materials wastage, better worker placement, greater worker expertise on tasks and tools), there were also disadvantages which we are still dealing with today. Adam Smith and Karl Marx stressed the psychological consequences of workers who perform only a few simple operations: they argued that a person becomes ignorant, is viewed as only an appendage to a machine, and exists without the need for intellectual processes (Cascio, 1986).

One of the first moves toward a concern for employees came around the beginning of the 19th century. In 1799, Robert Owen became a partner in a cotton-weaving mill and was one of the first managers who believed employers and communities should work harder to develop human talents and eliminate practices that stifle individual ability and lead to poor health (Cascio, 1986). By 1810, Owen was busy attacking the practices of child employment, long working hours, and unsafe working conditions. He also advocated better housing for his apprentices and instituted one of the first performance appraisal systems (Cascio, 1986). Because of his efforts, he has been recognized as "the pioneer of personnel management" (Urwick, 1956).

By the early 1900's, several U.S. corporations became engaged in what has been called the "industrial welfare" movement (Shain, Suurvali & Boutilier, 1986), or "welfare capitalism" (Brandes, 1976). Welfare capitalism was defined by Brandes (1976) as "any service provided for the comfort or improvement of employees which was neither a

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necessity of the industry nor required by law" (p. 6). Welfare capitalism was motivated by a number of factors: a humanitarian and paternalistic concern for employees (Nelson & Campbell, 1972), an attempt to deal with social problems resulting from industrialization (Brandes, 1976), a desire to keep employees loyal and to avoid unionism (Popple, 1981), a need to reduce production costs (Nelson & Campbell, 1972), and a need to help immigrants, young workers, and females enter the workforce and adjust (Popple, 1981).

During this movement, full-time welfare assistants or welfare/social secretaries were employed to help employees with personal and work-related problems, particularly as more women and immigrant groups began entering the workforce and bringing with them a unique set of problems for business. Brandes (1976) has suggested that "the beginnings of industrial social work are rooted in what might be considered a form of sexism . . . [and] as businesses grew and employers faced growing numbers of female employees, they found themselves at a loss about treating their workers' peculiar 'female' problems; one answer was the hiring of 'specialists'."

These welfare assistants/secretaries were often educated as teachers or nurses and, generally, had four basic roles: (1) physical welfare (e.g., health, safety, sanitation and housing of workers), (2) cultural welfare (e.g., recreation, libraries, education), (3) economic welfare (e.g., loans, pensions, hiring, firing, wage setting of employees), and (4) personal welfare (e.g., social work services for workers and their families) (Popple, 1981). Other specific services offered during this movement included programs providing medical benefits with sick pay, clinics, doctors, nurses, schools and training for immigrants, lunch rooms, company stores, housing, recreational programs and counselors (Popple, 1981). The first recorded social secretary was Mrs. Aggie Dunn

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Paternalistic attitudes are evident in an early industrial welfare program specifically designed to increase profits and decrease labor problems (and prevent unionization) developed at Amoskeag Textile Mills in Massachusetts. Amoskeag developed its own community of houses, churches, clubs, and parks and took it upon itself to act as parents for the unmarried female employees by setting curfews and establishing regulations forbidding smoking and drinking (Shain, Suurvali & Boutilier, 1986). In 1914, the Ford Motor Company provided counselors who advised employees on personal and legal problems (Bellows, 1961). Paternalistic programs were implemented by Goodyear Rubber Company which was committed to hiring and maintaining healthy employees and was only the second U.S. organization to establish a factory hospital. Goodyear also provided for paid vacations, eight-hour workdays, pensions plans, and quality family housing which could be purchased through the organization (Shain, Suurvali & Boutilier, 1986).

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By the late 1920's the growth of welfare programs began to decrease. In his book Principles of Scientific Management, Taylor (1911) outlined ways to increase productivity. The scientific management movement then began to catch on, with its emphasis on efficiency, financial motivations, an intolerance for non-productive workers, and a lack of interest in humanistic programs. At the same time, the Industrial Revolution had led to much worker discontent and fostered the need for workers to organize themselves against the abuses in the workplace. As a consequence, a strong adversarial relationship existed between labor and management during this time. The anti-union sentiment by management along with unions' belief that the monies for these programs should be distributed to employees in the form of wages affected the attitude toward the welfare programs. In the case of the Ford Motor Co., their counseling program was abandoned after employees developed a mistrusting attitude toward management and began to resist the paternalistic interference into their private lives (Bellows, 1961). Two additional reasons for the decline in these early welfare programs were the deaths of the primary people who were involved in their initial establishment within these organizations and a decline of the textile industry where many of these programs had been implemented.

While the number of welfare secretaries decreased after the first World War, many of their functions moved into two directions--one which lead to the development of the personnel management field and the other which lead to the field of industrial health and occupational mental health (Graham, 1984; Nelson & Campbell, 1972; Popple,

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1981). The merging of elements from these two fields is the foundation of the occupational programs which are now referred to as EAPs.

Occupational Alcoholism Programs (OAPs)

Alcohol abuse was reported as a problem as early as 5000 B.C. and employers often contributed to this abuse because consumption of alcohol on the job during the eighteenth and nineteenth centuries was not only condoned but expected by U.S. employers (Meyers, 1985). Employers offered employees wine, whiskey, and brandy breaks, similar to our coffee breaks today (Trice & Schonbrunn, 1981, pp. 172-173). Also, alcohol became a problem as immigrants and other transient workers frequented saloons as a substitute for the homes and families left behind (Brandes, 1976).

Addictive drinking usually takes hold between the ages of 35 to 50 when employees are most productive and valuable to their employer. From the 1880's to the 1920's, efforts to eliminate alcohol from the workplace were undertaken in order to build a more disciplined and dependable workforce. During this time, the Temperance Movement along with the emergence of workmen's compensation laws helped to remove alcohol from the workplace (Trice & Schonbrunn, 1981, pp. 173-174).

A major impetus to the revival of corporate counseling programs came after the founding of Alcoholics Anonymous (AA) in 1935, two years after the repeal of prohibition. This was also a time when alcoholism first began to be viewed as a sickness rather than a "moral or spiritual deficiency" (BNA, 1987). This "disease concept of alcoholism" was originally introduced by Dr. E. M. Jellinek in 1939 whose theory stated that alcoholism follows a pattern of progressive psychological and physiological bodily damage similar to contagious diseases (Jellinek, 1960). Defining alcoholism as a disease

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helped pave the way for medical intervention in its treatment. Today alcohol has been reported as the most widely used mood-altering drug in the U.S. and is a problem that cuts across all professions and occupations equally (Pattison & Kaufman, 1983; Trice & Roman, 1978).

With the help of AA, alcoholic employees were able to maintain sobriety and their jobs and improve their work productivity. The success of AA led to the establishment of occupational alcoholism programs (OAPs) which focused on recognizing alcoholic employees and providing help before their reduced performance resulted in termination (Masi, 1984). These programs were initially supervised by recovered alcoholic employees. The threat of job loss had a major impact on an alcoholic employee admitting to a problem and seeking help.

During this time, the Federal Government also began implementing employee counseling services. In 1938, the Social Security Board established a counseling program providing services related to guidance, psychiatric and social work, personnel and recreational work, housing and transportation problems (Bowler & Dawson, 1948).

Some of the first OAPs that were established in the mid-1940's to rehabilitate employees with alcohol-related difficulties were offered by E.I. DuPont de Nemours & Co., Eastman-Kodak Co., Kemper Insurance, Allis-Chalmers Manufacturing Co., Consolidated Edison of New York, Standard Oil of New Jersey, and Caterpillar Tractor Co. (BNA, 1987; Roman, 1980a). Implementation of the DuPont program was prompted by both humanitarian and economic motives since the termination rate of employees was on an increase. Similarly, management's interest at Allis-Chalmers focused on the economic advantages, while the union's interest was based on a humanitarian concern and a desire to save jobs (Baxter, 1978). Impressive results were often reported with

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World War II was another strong force in the establishment of OAPs due to the labor conditions at the time. Industries were forced to mass produce, but selection of skilled workers was limited so companies were forced to lower employment standards, which resulted in the hiring of more workers who brought their diverse problems to work with them (BNA, 1987). Additionally, as soldiers returned with alcohol and other problems, organizations realized they needed to take an active part in helping employees. Long work hours and shift work, pressure to improve productivity to meet the war demands, and inexperienced supervisors unable to deal with employees' personal problems which interfered with their job performance further exacerbated the problems. Consequently, mental health and social service programs in industry were established to help integrate workers into the workplace (BNA, 1987; Lewis, 1981).

Occupational Alcoholism Programs were established to identify alcoholic employees and encourage them to seek treatment. The early programs in existence during the post World War II era often depended on the fervor of recovered alcoholics who wanted to share their sobriety with other employees (Baxter, 1978). While these programs claimed an average recovery rate of 60-70 percent, growth of such programs began to slow down (Masi, 1982). After the war, the majority of companies shut down their mental health programs, and throughout the 1950's the number of businesses with programs remained small" (Sonnenstuhl & Trice, 1986 cited in BNA, 1987).

Several reasons account for this slow growth. First, it was typically the supervisors' responsibility to identify employees with drinking problems and encourage their participation in the organization's program. This method worked well in identifying

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rank-and-file personnel but not managerial-level employees. Therefore, a large segment of the working population was not only ignored, but management avoided treatment because alcoholism was seen as afflicting only the lower echelons. Second, employees attempted to hide their drinking problem since they viewed a supervisor's confrontation as a witch-hunt of non-managerial personnel, and thus an us-versus-them atmosphere prevailed (Masi, 1984). Third, alcoholics not only deny they have problems but when confronted, they typically blame their problem on anyone or anything but themselves. Fourth, often there is a social stigma attached to alcoholism so supervisors were hesitant about making accusations until the problem was in advanced stages. Fifth, organizations sometimes feared that by offering a visible program they would be acknowledging that they have an alcoholism problem in the organization (Holden, 1973). Sixth, often there was a lack of available resources and of trained professionals to administer the programs (Masi, 1984). Thus, by 1959, only 50 American companies had implemented occupational counseling programs--35 which focused exclusively on alcohol rehabilitation programs (Carr & Hellan, 1980; Masi, 1984).

During the 1960's, however, the number of OAPs began to grow. Three major factors influenced this growth--growth in community health services, a shift in focus from alcohol symptoms to impaired job performance and work behaviors, and acceptance of alcoholism as a disease. First, during the 1960's community mental services were greatly expanding and a concern about developing other effective, briefer methods of therapy developed in order to serve more people. Gelso and Johnson (1983) cite several factors influencing this search for other methods: increased demands for service had left mental health agencies over-taxed; long waiting lists resulted in service delays; heightened public awareness of the influence psychological factors have on human functioning caused

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many types of people to seek treatment; mental health services became available to populations other than the middle class; and demands on health insurance policies to pay for mental health treatment lead to insurance companies examining the efficacy of treatments.

The second impetus for OAP growth was that, during this time, organizations began to focus on a "job performance model" where dysfunctional work behaviors and the job performance of employees were used to help identify those who might be helped by occupational programs. These behaviors were believed to be less stigmatic than alcoholism symptoms. The focus on work behaviors also removed the supervisor from the uncomfortable role of diagnostician (Wrich, 1980b). Since deterioration in job performance was manifested in the early stages of some problems (e.g., alcoholism), the employer could legitimately intervene to bring about change (Roman & Trice, 1976). Supervisors were now trained to observe declining job performance rather than to spot alcoholic behaviors. Job behaviors are more difficult for employees to deny compared to a supervisor's subjective evaluation. By focusing on declining job performance and not directly accusing the employee of being an alcoholic, supervisors may be more successful in getting the employee to admit to having a drinking problem. Since problem-drinking employees must support their habit, they don't want to lose their job. The confrontational approach toward employees' job performance was viewed as a way to motivate workers to help themselves and modify their destructive behavior (Roman & Trice, 1976).

Finally, the "disease model" of alcoholism was officially accepted by the American Medical Association in 1956 (Masi, 1984), and in 1959 the AFL-CIO followed suit (Follman, 1978). Viewing alcoholism as a treatable disease moved organizations away

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from taking a punitive approach to one that was more positive toward the employee. The new approach was coined "tough love," which used the confrontational strategy previously mentioned that focused on breaking down an alcoholic's denial system. Thus, OAPs were the basis of the development of "broad-brush" EAPs which address the emotional, psychological, and social needs of employees and problems negatively impacting work performance.

The 1970's to the Present--The Legal Influences on EAPs

In a 1979 survey, Roman (1980a) found that most OAPs were housed in the broader-focused EAPs. Occupational programs were also expanded to include assistance to family members of employees. During the late 1960's and 1970's, several forces occurred to further influence the growth and development of EAPs.

For example, the evolution from alcoholism to other personal problems continued into the late 1960's and 1970's as drug abuse became more of a societal problem. Initially, industry's response to the increased occurrence of drug abuse was similar to that of alcoholism; i.e., initial denial or punitive actions toward those employees suspected of abusing drugs (Johnston, 1971; Rush & Brown, 1971; Stevens, 1970).

In addition to the types of problems addressed by EAPs, the growth of EAPs was enhanced due to the legal climate during the 1970's. Federal legislation in the 1970's prohibiting discrimination against handicapped individuals, such as the Vocational Rehabilitation Act of 1973, which was extended to include alcoholics and drug abusers in the definition of "handicapped", was a major force in the development of a more humane approach to drug abuse (Vicary & Resnik, 1982, p. 16). The federal government (e.g., Department of Defense) also established programs during this time which focused

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The Hughes Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, is also considered to be a major impetus to the resurgence of occupational programs during the 1970's. This law established the NIAAA (National Institute on Alcohol Abuse and Alcoholism) in the Department of Health, Education, and Welfare to coordinate efforts in combatting alcohol problems in both the private and public sectors. The Hughes Act also mandated the implementation of alcoholism programs in all federal agencies and military installations. In 1972, drug abuse was included (Masi, 1984). Through the NIAAA, states could obtain federal funding to pay for services of trained consultants who could help establish rehabilitation programs (Masi, 1984).

Several factors influenced the tremendous growth of EAPs during the 1970's and 1980's. First, there was a broadening of worker's compensation/handicap coverage where employers were held more liable for employees' alcohol, drug, and emotional problems as a result of court rulings and arbitration decisions. Employers were also held financially responsible for on-the-job accidents regardless of fault (BNA, 1987). Second, in 1977 affirmative action programs were implemented requiring the hiring of qualified drug addicts and alcoholics by federal contractors and subcontractors. Third, organizations expanded the benefits offered to employees to include counseling and psychotherapy. Fourth, unions began demanding alcoholism and mental health insurance benefits and programs as part of their collective bargaining agreements (BNA, 1987; Tersine & Hazeldine, 1982, pp. 69-70). Fifth, passage of the Occupational Safety and Health Act, equal employment opportunity legislation, and environmental protection legislation also spurred a change in corporate attitudes and culture toward a

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Additional forces cited as influencing the growth and development of EAPs since the 1970's are discussed in the following section.

The 1970's to the Present--Additional Influences on EAPs

During this period other problems were recognized as having a negative impact on job performance. Consequently, EAPs focused on alcoholism, drug abuse, and other personal problems such as depression, phobias, divorce, domestic violence, child-rearing problems, retirement, anxiety, relocation issues, etc. (BNA, 1987; Carr & Hellan, 1980; Shain & Groeneveld, 1980; Trice & Roman, 1972).

We have also moved towards a technological society that requires highly skilled workers--workers who tend to hold different values regarding their job and working conditions compared to the factory worker of the past. In 1974, Drucker stated:

The shift in the structure and character of work has created a demand that work produce more than purely economic benefits. To make a living is no longer enough. Work also has to make a life (p. 179).

The focus of EAPs was also broadened as a result of increased foreign competition and the realization that technology is not enough to maintain high productivity levels. While American industry spent a great deal of time automating factories and trying to eliminate the human element--which was believed to be a major cause of error and decreased productivity--industry began realizing that machines are not enough; rather, it is the people who operate the machines who are valuable resources that must also be maintained because they are so costly to train and replace (Lewis, 1981). Also, as workers experience increased alienation from the workplace and as limited dollars are

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available for salary increases, both employers and employees have had to become more concerned with the overall quality of life within the workplace.

In 1979, there were over 5,000 EAPs in the private sector and 677 in the public sector (DHHS, 1982). By 1983 the total figure had increased to 8,000 EAPs with an additional 1,000 outside consultants providing a variety of services (Roman, 1983b), and by 1987 over 10,000 EAPs were operating in the U.S. (BNA, 1987; Champion, 1988), which included 80% of the Fortune 500 companies (BNA, 1987). The broader concern of most programs today is considered to result in less stigma attached to those utilizing the program and to relieve the supervisor of having a primary role as diagnostician rather than performance evaluator (Wrich, 1980b). Organizations have also been increasing the professionalism of the counseling staff within the EAP and their training to improve their ability to handle and/or refer employees with all types of problems (Birkland, 1983; Forrest, 1983).

EAPs have typically relied on supervisory referrals to get employees with alcohol and other substance-abuse problems to seek treatment. However, as a result of the increase in the number of problems handled by EAPs today and the more humanistic approach taken by organizations, a greater emphasis has been placed on employee self-referrals. Thus, the EAP of today has a dual focus--it is used in the workplace to help firms identify troubled employees and control problems such as alcoholism and drug abuse, and it is aimed at helping employees with a broad range of problems (Shain & Groeneveld, 1980).

The Wellness Concept

The broad-brush definition of wellness programs includes many programs including health promotion programs-in addition to traditional substance abuse programs. Under the more traditional definition, wellness programs may be offered in a variety of formats (e.g., group, individual, nutrition, fitness, stress management, etc.). There is a large amount of evidence that wellness programs can reduce health care costs (Belloc & Breslow, 1972). Therefore, in addition to health care problems, organizations are increasingly being asked to maintain a healthy workforce (Laranger, 1987; Perham, 1987).

The relationship between wellness programs and health care costs has been a topic of interest for many years. The success of corporate wellness programs in reducing health care costs down, maintain healthy employees, and reduce absenteeism has been well documented (Levine, 1983). The concept of a "mega-brush" program, which combines a variety of health promotion programs, has been shown to be effective in reducing health care costs (Levine, 1983; Jacobs, 1983).

The Wellness Concept

The broad-brush approach to EAPs has most recently expanded to the point where many programs include a third component--employee wellness or prevention-oriented programs--in addition to the rehabilitative and disciplinary components. Along with the typical substance abuse, financial, child-rearing, stress, and other problems handled under the more traditional broad-brush EAPs discussed above, a variety of other programs may be offered under the wellness umbrella. Such programs may include nutrition, fitness, stress management, and weight control which may be offered in a variety of formats (e.g., classes, lectures, workshops, and brochures). There is a great amount of evidence that lifestyle factors influence one's health status (Belloc, 1973; Belloc & Breslow, 1972; Fielding, 1984b; Palmore, 1971; Public Health Service, 1979). Therefore, in addition to their continued interest in helping employees with existing problems, organizations are now emphasizing the need to deter problems and promote and maintain a healthy lifestyle among employees (Brink, 1983; Goodstadt, Simpson & Loranger, 1987; Perham, 1984).

The relationship between one's health behavior and health status is evident, and wellness programs have attempted to influence a variety of employee health behaviors. The success of corporate wellness programs has come in their ability to keep company costs down, maintain healthy employees, and to reach many more workers than the troubled employees typically assisted under the broad-brush concept (Jeuchter & Utne, 1982; Levine, 1983). These expanded programs are developing into what have been called "mega-brush" programs (Delaney, 1983). Some have estimated that there are now over 50,000 organizations involved in some type of work site health promotion (Howe, 1983; Jacobs, 1983).

Summary of Models/Approaches

The above section discusses the evolution of EAPs in the workplace. These models have evolved over the years and are helpful to summarize the current state of their health.

Ilgen and colleagues (Swisher, 1989) describe three models of health at work. These have been used to describe employee health. First, the safety model. A brief discussion of each model for the current focus on health.

In the early 1900s, the focus was primarily concerned with safety. This was given to employee health. Ilgen (1990), the first model, was the result of public concern over the "safety" model since the conditions of employees were poor. This was followed by the formation of government regulations (e.g., the National Compensation plans which were designed to protect health was viewed as a major impact on the worker.

Summary of Models/Attitudes Regarding Employee Health

The above sections have provided an historical overview of the development of EAPs in the workplace and outlined how employers' attitudes toward employee health have evolved over the years. Before continuing the discussion of EAPs, it might be helpful to summarize the evolutionary process that has occurred regarding employees and their health.

Ilgen and colleagues (Hollenbeck, Ilgen & Crampton, 1990; Ilgen, 1990; Ilgen & Swisher, 1989) described five general models or approaches that have been applied to health at work. These have progressed from a focus on safety to a broader systems view of employee health. Figure 1 outlines the basic models and the primary concerns of each. A brief discussion of the models will follow to provide an understanding and basis for the current focus on a systems perspective to health.

In the early 1900's when scientific management was popular, employers were primarily concerned with the productivity and efficiency of employees and little concern was given to employee health and problems. According to Ilgen and Swisher (1989) and Ilgen (1990), the first model of health at work emerged in the 1930's and 1940's as a result of public concern over dangerous working conditions. This first model was called the "safety" model since its primary focus was on the job environment and working conditions of employees (Ilgen, 1990; Ilgen & Swisher, 1989). This model was spurred on by the formation of government agencies formed specifically to address safe working conditions (e.g., the National Safety Council) along with the development of workers' compensation plans which aided employees injured on the job (Ilgen, 1990). Under this model, health was viewed as unidirectional--factors from the job environment have an impact on the worker.

Summary of Models/Approaches

The above sections describe the evolution of EAPs in the workplace and how they have evolved over the years. This summary is helpful to summarize the different models and their impact on their health.

Ilggen and colleagues (1990) described the evolution of health at work. These have been the main models of employee health. Figure 1 shows each. A brief discussion of each model is provided for the current focus on a health at work model.

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The above sections have provided an historical overview of the development of EAPs in the workplace and outlined how employers' attitudes toward employee health have evolved over the years. Before continuing the discussion of EAPs, it might be helpful to summarize the evolutionary process that has occurred regarding employees and their health.

Ilgen and colleagues (Hollenbeck, Ilgen & Crampton, 1990; Ilgen, 1990; Ilgen & Swisher, 1989) described five general models or approaches that have been applied to health at work. These have progressed from a focus on safety to a broader systems view of employee health. Figure 1 outlines the basic models and the primary concerns of each. A brief discussion of the models will follow to provide an understanding and basis for the current focus on a systems perspective to health.

In the early 1900's when scientific management was popular, employers were primarily concerned with the productivity and efficiency of employees and little concern was given to employee health and problems. According to Ilgen and Swisher (1989) and Ilgen (1990), the first model of health at work emerged in the 1930's and 1940's as a result of public concern over dangerous working conditions. This first model was called the "safety" model since its primary focus was on the job environment and working conditions of employees (Ilgen, 1990; Ilgen & Swisher, 1989). This model was spurred on by the formation of government agencies formed specifically to address safe working conditions (e.g., the National Safety Council) along with the development of workers' compensation plans which aided employees injured on the job (Ilgen, 1990). Under this model, health was viewed as unidirectional--factors from the job environment have an impact on the worker.

Goal

SAFETY

Working Conditions

DAILY ERGONOMICS

Working Conditions

WELLNESS

Life Style <-> All

MEDICAL

Illness/Injury <-> All

HEALTH

Work Environment

Social Systems (S)

Individual Systems

Source: Hollenbeck

Figure 1: Approaches

Model	Target of Concern
SAFETY Working Conditions ↔ Workers	Job Environment (Safe Working Conditions)
EARLY ERGONOMICS Working Conditions ↔ Workers	Job Environment (Safe Working Conditions and Safe working Behaviors)
WELLNESS Life Style ↔ All Employees	Employee Behaviors (Diet, Smoking, Substance Abuse)
MEDICAL Illness/Injury ↔ All Employees	Physical Symptoms
HEALTH Work Environments (WE) --- Social Systems (SS) --- Individual Systems (IS) ---	WE SS IS All Components in Interaction

Source: Hollenbeck, Ilgen & Crampton, 1990

Figure 1: Approaches To Health At Work

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The impetus for the development of the second model--the "early ergonomics" model--came about with the realization that since work environments interact so closely with employees, improvement in safe working conditions must include not only a focus on the environment but also on the safe working behaviors of the workforce, the incentives provided to encourage safe behaviors, and the safe selection and/or placement of individuals. This new bi-directional relationship between workers and their working conditions played a major role in training workers in safe behaviors and in developing regulations as a result of the Occupational Health and Safety Act (OSHA) of 1970. The ergonomics model coincides with the greater occupational concern during the 1940's and 1950's for the alcohol-related problems of employees--which, as outlined above, lead to the development of OAPs (Occupational Alcoholism Programs).

As previously discussed, eventually employers realized that the overall health of employees is important to the performance of the employee, the organization, and society. Consequently, EAPs, wellness programs, and other occupational health promotion programs developed in the 1970's and 1980's as a dual concern evolved to include not only the prevention of injuries but the encouragement of healthy physical and psychological life-styles (Brink, 1983; Delaney, 1983; Goodstadt, Simpson & Loranger, 1987; Ilgen, 1990; Perham, 1984). This third approach toward employee health is referred to as the "wellness" approach because it focuses on the inter-relationships between employee behaviors (e.g., diet, exercise, smoking, substance abuse) and their life-style, rather than simply focusing on job conditions as the causes of health problems (Ilgen, 1990; Ilgen & Swisher, 1989).

The fourth model, according to Ilgen and Swisher (1989), actually predated the above three and is still in use today. This is known as the "medical" model and focuses

on the physical symptoms of injury or are ill. The work of one or a few definitions of health problems today are psychological, social, and dealing with employee health.

The last model of health by emphasizing the interaction of individual systems (Hollnagel) systems consist of individual beliefs and communication to the biopsychosocial model consideration the biological impact on the health of workers.

Humans are influenced by cellular, organ, organ systems (Snyder, 1989). These levels of complexity, defined as (Swisher, 1989). To understand the effect one has on others examine the lower levels (community, culture, etc.) the focus of the past and current approach, bio/psycho/soci

on the physical symptoms of workers who are referred to physicians when they have an injury or are ill. The weakness of this approach is that illnesses are assumed to result from one or a few definable causes, which can be isolated and treated. However, many health problems today are caused by a complex set of interdependent systems (biological, psychological, social, etc.) and thus a broader systems perspective is required when dealing with employee health.

The last model or approach to health at work takes on the "systems" perspective by emphasizing the inter-relationships among the work environments, social systems, and individual systems (Hollenbeck et al., 1990; Ilgen, 1990; Ilgen & Swisher, 1989). Social systems consist of individuals interacting with others according to a shared system of beliefs and communication means (Wiseman, 1966). The "systems" perspective is similar to the biopsychosocial model of medicine espoused by Engel (1977) which takes into consideration the biological, psychological, and social environments and their combined impact on the health of workers.

Humans are influenced by and made up of many organizational levels--molecular, cellular, organ, organ system, psychological, behavioral, environmental, social, etc. (Snyder, 1989). These levels are arranged hierarchically in Figure 2 in ascending order of complexity, defined as the number of interactions possible at a specific level (Ilgen & Swisher, 1989). To understand the major influences impacting on an employee and the effect one has on other levels, we must take on a broader systems perspective and examine the lower levels (systems, organs, tissues, etc.) and the upper levels (family, community, culture, etc.) which man frequently interacts with. Figure 2 also identifies the focus of the past and current perspectives (i.e., bio-medical approach, psycho/social approach, bio/psycho/social approach) in examining health and work behaviors.

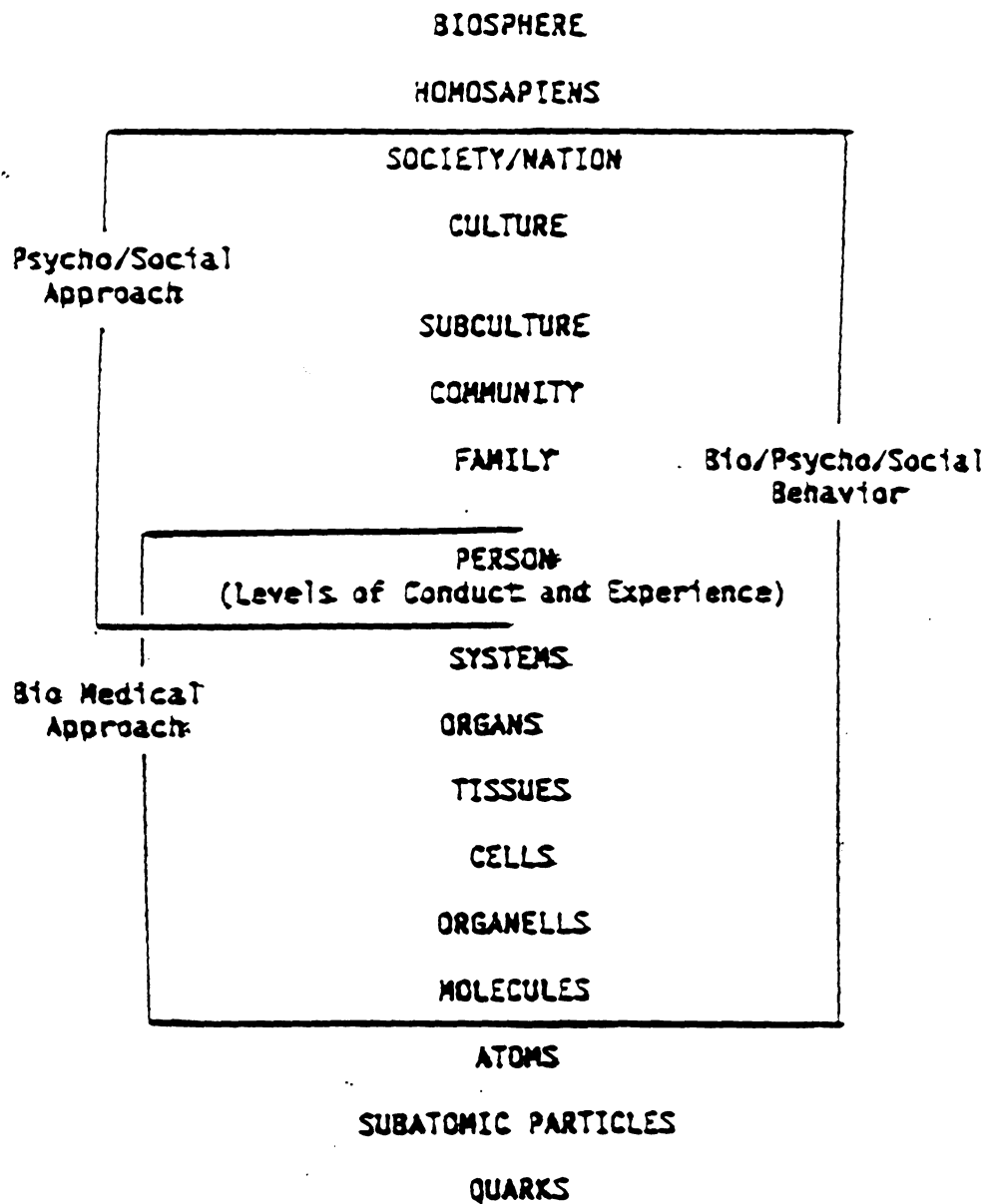
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Source: Ilgen & Swisher, 1989

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This evolution in the approaches toward health at work coincides with the evolution of EAPs. Today, industry has taken on this broader "systems" perspective toward employee health by recognizing that many factors (e.g., biological, social, environmental, psychological, etc.) influence an employee's overall health and, in turn, the employee's health influences all areas of his/her life--both the work and non-work environments.

This systems perspective has been applied in the development of the Model of EAP Utilization for the present research, which will be presented in the next chapter. The remainder of this chapter will continue the discussion of EAPs by focusing on the current status and structure of EAPs and specific areas of research.

The Structure and Diversity of EAPs

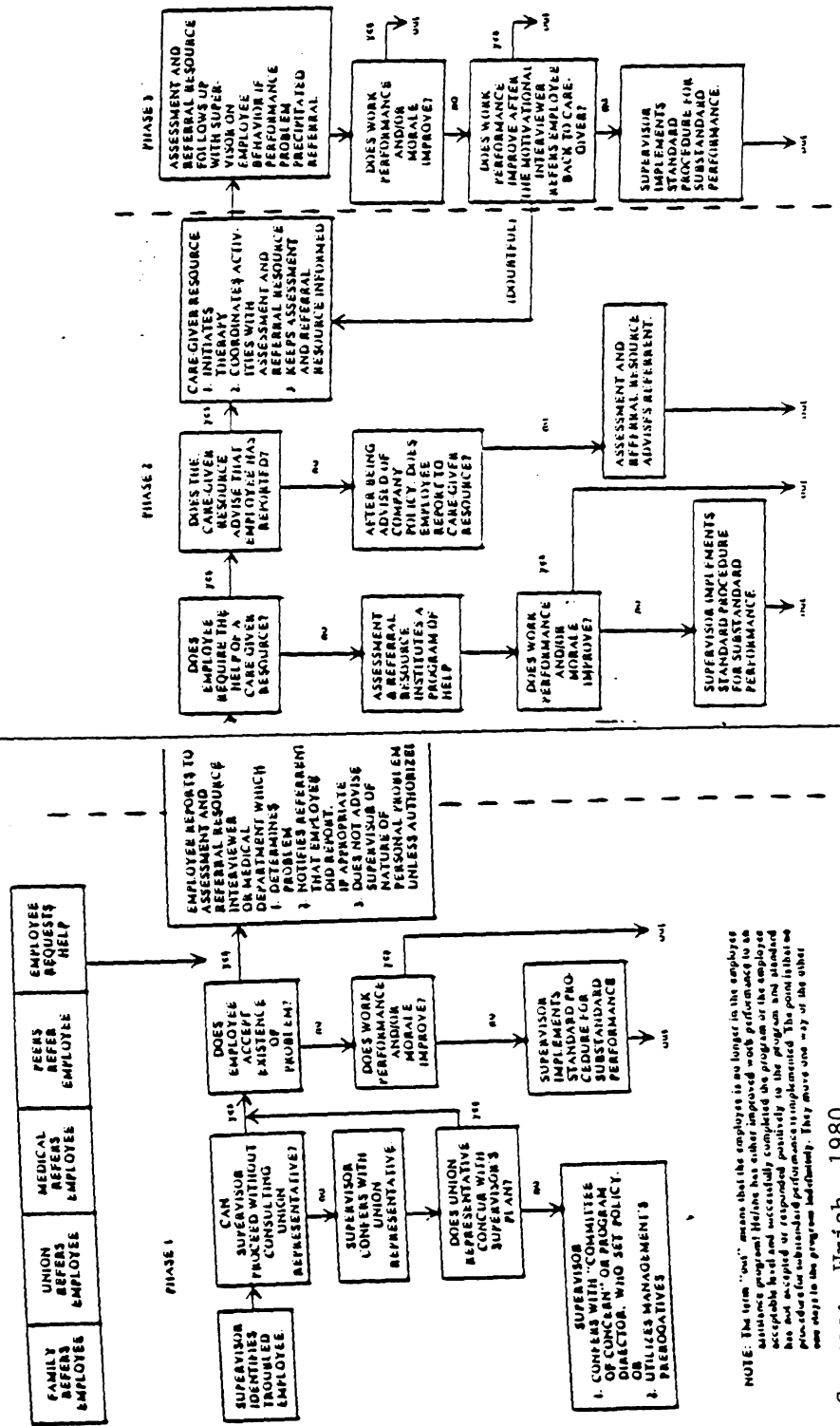
As mentioned in chapter one, EAPs today are very diverse in composition, depending on the organizational setting, needs, and the labor-management relationship. There are no guidelines or mandates on the structure, functioning, or breadth of individual programs. Employee Assistance Programs vary in the model implemented, policies established, degree of management support, services provided, and service delivery, depending to a great extent on the size of the organization and employee needs.

Regardless of the model implemented, the most successful EAPs have top management support and are jointly designed, implemented, and maintained by both management and labor (Beyer & Trice, 1978; Minter, 1983). In addition, confidentiality is a key to obtaining employee trust and utilization. A flow-chart of activities involved in a typical assessment and referral process, regardless of the model utilized, is diagrammed by Wrich (1980b) in Figure 3. While standardized procedures do exist, the

Flow Diagram of Key Activities

LOCAL ACTIVITIES	REGIONAL ACTIVITIES	NATIONAL ACTIVITIES	INTERNATIONAL ACTIVITIES	GLOBAL ACTIVITIES
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Flow Diagram of Key Activities



NOTE: The term "out" means that the employee is no longer in the employee assistance program. Having not either improved work performance to an acceptable level and successfully completed the program or the employee has not accepted or responded positively to the program and standard procedures for substantial performance improvement were implemented. The points that he or she earned for substantial performance improvement were 0-25 of the other program days in the program and, therefore, they were not used.

Source: Wrich, 1980

Figure 3: Flow Diagram of Key EAP Activities

process an employee may have a problem (Wrich, 1980b). The employee must also possess the necessary resources to solve the problem. The employee and recommender must be able to identify the problem and its causes.

The two most popular methods of EAPs are the "broad-brush" EAP and the "narrow-brush" EAP. The "broad-brush" EAP is a general service that provides a variety of services that can be offered to all employees. The "narrow-brush" EAP is a specific service that is provided to a specific group of employees. Administration includes the development of policies and procedures, the selection of personnel, and the evaluation of the program. The program should be designed to provide management with the information needed to make decisions about the appropriate treatment of the employee.

As stated earlier, the administration of EAPs is a complex task. The administrator must be able to identify the employee who has a problem, provide confidential counseling, and maintain confidentiality. Management's attitude toward the program is also important. Management's attitude toward the program, as well as the program's structure, as well as the program's location, both geographically and organizationally, are important factors in EAP's success. Most EAPs are administered under the personnel function, but some are administered under the medical function. It is clearly the concern of management to provide a program that is effective and efficient.

The location of EAPs is also an important factor. The location of EAPs has changed over the years. Early programs were located in the personnel department, but they have since moved to the medical department.

Over the years, Early programs were located in the personnel department, but they have since moved to the medical department.

process an employee may take within an EAP is individualized according to the worker's problem (Wrich, 1980b). The EAP counselor must understand the resources available and possess the necessary assessment, diagnostic, and clinical skills for evaluating an employee and recommending treatment.

The two most popular models of service for employee counseling are the OAP and the "broad-brush" EAP model, both discussed above (Forrest, 1983; Wrich, 1980b). Regarding specific services offered, Winkelpleck (1984) states that most EAPs provide services that can be classified into two functions: administration and counseling. Administration includes activities such as implementing, marketing, staffing, maintaining and evaluating the program. Counseling includes problem assessment and referral to appropriate treatment resources. In addition to these functions, some EAPs may also provide management consultation, education, and organizational development.

As stated earlier, confidentiality is a critical issue influencing the successful administration of EAPs (Masi, 1984; Myers, 1984; Wrich, 1974, 1980a). Since it is the employee who has a problem, it is his or her perceptions of the EAP policies (including confidentiality) and management's attitude toward the EAP that are critical. Management's attitude can be influenced by how the EAP fits into the organizational structure, as well as the physical location of the EAP; therefore, the location of the EAP both geographically and within the organization's structure is often a key issue impacting an EAP's success. Masi (1984, p. 34) argues that "it is vital that the EAP be located under the personnel functions . . . (since) EAPs are connected to job performance which is clearly the concern of personnel."

The location of EAP services within an organization's hierarchy has also changed over the years. Early programs focusing primarily on alcohol-related problems were

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typically started and directed by a company's medical department. Today, however, most programs fall under the personnel/industrial relations division and are staffed by professionals such as social workers and psychologists (Erfurt & Foote, 1977). The location of an EAP within an organization's hierarchy is often influenced by the sponsorship of the EAP. According to Masi (1984), there are basically four funding alternatives (i.e., sponsorship approaches) available to an organization: (1) the organization assumes all expenses and maintains its own staff; (2) the organization performs some functions but contracts out for referral and counseling services on a fee-for-service basis which is covered by the organization's insurance carrier; (3) the organization pays an outside contractor a flat administrative fee per employee (typically for supervisor training and administrative management by the contractor) plus a fee for services rendered which are covered by the organization's insurance carrier; or (4) the organization pays a flat fee to an outside contractor, who is not reimbursed by an insurance carrier for specific services rendered.

It is also critical to the success of an EAP to consider its physical location. The EAP should be accessible by all employees and should be located to maximize confidentiality (Masi, 1984). Geographical diversity in the structure of EAPs is illustrated by the existence of both on-site, or internal, EAPs and off-site, or external, EAPs. We really do not know which approach is more critical. In research conducted by Hung (1988) on existing EAPs, approximately an equal distribution was found between internal/on-site and external/off-site programs. The physical location of an EAP is often influenced by the sponsorship or funding of the EAP. In addition to the internal and external programs, other methods of providing EAP services include a hybrid of both the internal and external models, a union model, peer model, the 800-number, and

the consortium model.

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the consortium model. Each of these will be discussed in more detail below.

The internal model is used mostly in larger organizations which employ either a full- or part-time counseling staff that functions within an organization's structure to coordinate employees' needs with treatment resources (Myers, 1984). Internal programs typically provide services in-house, which usually include employee assessment with subsequent referrals to external community services. The programs may also undertake short-term counseling with referral to outside providers if longer-term treatment is recommended (BNA, 1987). Researchers cite the following advantages of on-site programs: EAP counselors are often more attuned to a company's needs and to the working environment, on-site programs tend to have more managerial support--which is a vital factor in the success of an EAP (Fabricatore & Rogal, 1984), and access is often easier for employees when the EAP is in close proximity to their workplace. However, concerns about confidentiality and trust may be greater with on-site programs, though the Regional Manager of Counseling Services for AT&T, Dan Caliendo, indicates these concerns may not be eliminated even with off-site programs (BNA, 1987).

External programs are those in which typically smaller organizations contract out for services which are provided primarily off-site by a large, multi-service provider. For example, COPE (Center for Occupational Programs for Employees, Inc.) in Washington, D.C. provides EAP services for 45 companies with approximately 35,000 employees (BNA, 1987). External programs insure a great amount of confidentiality, but at the same time remove the EAP from the daily operations of the company and the ongoing communication that is needed with employees (Lewis, 1981). McClellan (1985) suggests that in order to justify an on-site full-time EAP worker, the work site must employ a minimum number of 2,000 workers. However, 80% of all non-government workers

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today are in work sites with less than 100 employees; therefore, the external, or contracting-out system, has become the fastest growing EAP model because of the lower program costs (BNA, 1987). Straussner (1985) cites other benefits of external programs, such as the legal advantages of a program that exists outside the organization, faster start-up time for companies using contractors who have established programs, and aggressive marketing methods of EAP contractors.

Combination internal/external approaches to providing services are often used by organizations spread out in several geographic locations. These programs are able to provide a certain level of treatment internally by a professional staff to those employees in close enough proximity of the services while in other locations, which usually are too small in size to justify a full-time staff, contractual relationships are established with local EAP providers (BNA, 1987).

While the above approaches are common, other approaches exist to serve specific markets and work populations. In 1979, the AFL-CIO adopted a resolution in favor of EAPs supported jointly by labor and management. According to Lane Kirkland, president of the AFL-CIO, "American trade unions have a fundamental concern with the well being of their members and their families" (Myers, 1984, p. 54). A union/peer referral program, such as the one in use by the Association of Flight Attendants, is supported by the union and comprised of union and employee/peer members who are responsible for educating and referring troubled employees to available EAP services (BNA, 1987; Myers, 1984). Flight attendants are trained to detect and intervene in behavioral/medical problems of troubled flight attendants in order to help the employee obtain professional help. There are also programs offered directly by unions. By confronting troubled employees whose job performance has deteriorated, shop stewards

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The 800-Number is a telephone-based counseling service where employees from several locations within an organization can call in for assistance (BNA, 1987; Myers, 1984). This program provides for short-term counseling via listening along with referral to other treatment resources if needed. It has the advantages of low cost, 24-hour service, and increased comfort of clients who do not have to wait or look counselors in the eye (BNA, 1987). However, typically hot-lines offer minimal problem assessment and referral services (Myers, 1984). A final approach to be discussed is a consortium in which several organizations pool their resources and develop a program to serve employees in the participating organizations (Myers, 1984).

It should be noted that in all the above approaches, EAP services may be available not only to employees but to their dependents as well whose personal problems could affect an employee's job performance or personal well-being. However, while Straussner (1986) found that 83% of the EAPs were available to families, 39% counseled only family members whose problems were specifically related to an employee's problem.

Another manner in which EAPs exhibit diversity and flexibility is in the different employee referral strategies EAPs handle. These include: (1) a voluntary, self-referral model where an employee voluntarily seeks assistance, and his or her participation in the EAP is held in strict confidence; (2) a peer or significant others model where significant others (e.g., family, coworkers) encourage the impaired employee to seek assistance (Wolf, 1982) and where participation in the EAP is held in strict confidence; and (3) a supervisory-referral, confrontation model where a third party within an organization (e.g., supervisor, union, medical department) actually refers an employee whose performance is suffering to an EAP (Featherston & Bednarik, 1981; Fisher, 1983;

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Wrich, 1980b). In this case, supervisors are notified regarding whether the employee showed up and participated, but they are not advised of the nature of the employee's problem or treatment.

Experts suggest that in order for programs to be considered successful, 40% of all EAP users should be voluntary, self-referrals (Hobson, 1982; Wrich, 1980b). Education about the EAP is a key component to obtaining support and usage from employees. Regardless of the education a company may provide, however, many employees will still refuse to acknowledge the existence of a problem and will fail to seek assistance. Supervisors can play a key role in breaking employees' denial pattern by using job performance ratings and other documentation (e.g., absenteeism, irritability, inability to get along with coworkers) to identify troubled employees and refer them to an EAP. Thus, supervisory-referrals are considered important to EAP effectiveness. Trice and Roman refer to the process whereby a supervisor confronts an employee with his or her declining work performance in order to refer the worker to professional help as "one of the few legitimate avenues, save police power," to effectively intervene in a worker's life and motivate a change in behavior (1972, p. 171). Although confidentiality is important, maintaining the impaired employee's accountability for his or her own job performance is also critical to successful intervention. Being treated cannot be used as an excuse for inadequate performance.

EAPs also vary in the training and educational backgrounds of the staff. Staffing is often considered the most critical issue in an EAP (Masi, 1984). During the 1940's when programs emphasized alcohol-related interventions, programs were typically staffed by recovering alcoholics. These programs relied a great deal on referrals from supervisors who were trained to detect and confront alcoholics. Today, EAP counselors

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are also responsible for training supervisors to detect "troubled employees," to document dysfunctional work behaviors, and to recommend and/or refer employees to EAPs if job performance is impaired; i.e., supervisors are not expected to counsel or confront employees about the problem. Employee Assistance Program counselors today are staffed by individuals with diverse mental health backgrounds, which may include social workers, psychiatrists, psychologists, Alcoholics Anonymous members, nurses, trained counselors, and personnel employees (Masi, 1984).

Finally, while EAPs vary in structure, models, and services provided, there does appear to be consensus on the basic components that encompass an effective EAP:

- (1) Management support;
- (2) Union support;
- (3) Assurance of confidentiality;
- (4) Written policies and procedures delineating the responsibilities of the company and employees regarding unacceptable work behaviors, disciplinary consequences, and methods of problem identification, such as supervisory training programs;
- (5) An employee education program to teach employees to take responsibility for their health, recognize symptoms, and refer themselves;
- (6) Access of services by dependents;
- (7) A supervisory training program which centers around identifying a troubled employee (e.g., tardiness, absenteeism, inability to get along with coworkers, defensiveness, etc.), documenting deteriorating performance, confrontational methods, and the referral process;
- (8) Breadth of counseling and clinical services which provide easy and convenient

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(9) Labor and management orientation and labor-steward training;

(10) Health insurance coverage;

(11) Adequate communication of the existence, objectives, functions and services of the EAP to employees (via newsletters, brochures, payroll stuffers, posters, presentations, etc.); and

(12) Professional leadership (Dickman & Emener, 1982; Greenwood, 1983; Shain & Groeneveld, 1980).

While the above are all desirable components, Wrich (1982) indicates that assessment and referral are the critical links between the troubled employee and the EAP and that the staff specialist/counselor must be trained to assess and refer appropriately.

EAP Research

There has been a minimal amount of empirical research related to EAPs compared to the fast growth of these programs (Jones, 1983; Roman, 1984). Employee Assistance Programs have not been required to report their activities, except to their sponsors (e.g., management, unions) since they are not subject to any voluntary or governmental agency regulations or accountability requirements, as are mental health and drug and alcohol abuse programs (Jones, 1983). Roman (1984) characterized the current state of EAP research as "a hodgepodge of materials which have been prepared by persons whose credentials range from experienced social scientists to cynical self-promoters, all of which comprise a shapeless bag of 'findings' and 'data'." In addition, much research that does exist focuses primarily or is intertwined with research on OAPs (Fielding,

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In a review of alcoholism programs, Tersine and Hazeldine (1982, p. 72) stated that "most studies indicate a success rate of 50 to 85%." They further cite an estimate that there is a 10:1 payback from alcoholism programs due to less turnover and absenteeism and improved productivity. In a review of OAPs by Kurtz et al. (1984), a variety of measures used in OAP evaluations were found, which were grouped into four classes: changes in drinking behavior (abstinence, rehabilitation), work performance level (e.g., absenteeism, illness, accidents, turnover, efficiency), cost reduction (savings from absenteeism, job efficiency), and penetration rates of risk groups (i.e., the extent a program reaches a target population). Favorable outcomes were reported in over 60% of the cases examined, although also noted was the lack of rigorous standards and concerns of validity applied to the evaluation processes (e.g., lack of control groups, too-brief follow-up times, subject selection problems, poor employer documentation and treatment staff).

Most of the literature directly examining EAPs dates from the early 1970's and focuses on characteristics of the EAPs themselves, company practices related to the scope and administration of such programs, and provides primarily descriptions of individual programs and anecdotal reports (Akabas et al., 1979; Bierman, 1981; Bloom, 1986; BNA, 1974; Googins, 1984; Gould & McKenzie, 1984; Masi, 1979; Miller, 1977; Rivera, 1984; Skidmore et al., 1974; Smirnow, 1980; Straussner, 1986; Weissman, 1976), surveys related to EAPs (Erfurt & Foote, 1977; Ford & McLaughlin, 1981; Grimes, 1980; Opinion Research Corporation, 1972, 1974, 1976, 1979), and current reviews of the field (Leavitt, 1983; Roman, 1981).

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A major area of EAP research which companies are interested in focuses on the effectiveness of the programs. Effectiveness also refers to program "success," "impact," and "outcome." Research on EAP effectiveness was reported in the first chapter in the section on EAP benefits. Since the purpose of the present research is to gain a better understanding of the factors influencing one's decision to seek assistance from an EAP, the following section will present EAP research on utilization/participation rates and factors found to influence EAP utilization/participation.

Research on EAP Utilization/Participation

Terms which have been used synonymously with EAP "utilization" include "participation" and "penetration", particularly when referring to utilization/participation/penetration rates. "Employee Assistance Program utilization" refers to the actual usage of an EAP by an employee, or the total number or percentage of troubled employees who participate in EAP services. The term "EAP usage" refers to an in-person visit to the EAP office or a call for an appointment, information, or a referral. When the term "utilization" is used in this paper, it will also refer to the term "participation" or "usage" in an EAP. Utilization does not refer to employees who may have personal or work-related problems but have chosen not to participate in an EAP. The EAP "utilization rate" typically refers to the ratio of EAP clients to the employee population (Myers, 1984), which is similar to the "penetration rate"--or the rate at which employees have penetrated the EAP.

If the reported EAP success rates of 60-90% (Baxter, 1981; Holden, 1973; Judd, 1980; Shetty, 1982; United States Congress, 1982) are to have meaning, we have to assume that a significant percentage of troubled employees are participating in the

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program. Therefore, in order for any program to be judged successful, one component in its evaluation process should include employee utilization. Unfortunately, when discussing utilization rates, one major problem found in an EAP study by Weiss (1980) is the fact that a "great many" of the responding companies who had an EAP did not keep systematic data regarding usage of their program.

For example, in an examination of 14 EAPs by Uyeno (1988), nine maintained records on utilization rates--which ranged from a low of 1.1% to a high of 36%, with an average rate of 13%. In other research, there have been a variety of estimates on utilization rates cited--ranging from lows of 1% to 5% (Busch, 1981; Cahill, 1983; Champion, 1988; Dunkin, 1981; Featherston & Bednarek, 1981; Marino, 1985; Shain & Groeneveld, 1980; Straussner, 1986), to a 7% utilization rate at General Motors during a four-year period (United States Congress, 1982), to reports ranging from 9% to 30% cited by specific EAPs; e.g., Boston College--9%, Michigan State University--3-14%, Steelcase, Inc.--20%, University of Missouri--30% (Grimes 1980; Masi, 1978; Thoresen et al., 1977). Since the range of reported utilization rates is extremely broad, it seems it would be extremely useful to better understand factors which might influence this rate.

In his research on EAPs, Donald Jones (1983) developed benchmarks or standards on which to compare programs. One of these standards was the percentage of employees who should utilize a company's EAP--which was estimated to be between 5-10% after the first year of operation. Some question this figure since this utilization rate was based on an externally-contracted EAP that served many organizations. Also, while Kurtz, Googins and Howard (1984) examined penetration or utilization rates of risk groups when evaluating occupational programs, Herring (1987) suggests that what constitutes a "successful" penetration rate is not known and that not all populations are

equally penetrable.

Regardless of the programs and their results, they are designed to assist people who never receive treatment. The Department of Health, Education, and Welfare (1987, p. 140). If it is the programs fall far short of seeing only about 4 percent of the population (1987, p. 140). If it is personal problems, this is not obtaining the assistance.

A variety of variables have been used in research. One approach has been to use EAP services. Research has used EAP services to collect client statistics regarding race, occupational level, stress, financial problems, significant other-referrals, and inconsistent. Research has found that problem type, and referral

Marital Status

Many researchers have found that married (Cromidas, 1987)

equally penetrable.

Regardless of the standard and despite the need for occupational assistance programs and their reported effectiveness, EAPs often remain underutilized by those they are designed to assist. For example, it has been estimated that 85% of all alcoholics never receive treatment (Matsunaga, 1983). Joseph Califano, Jr., the former Secretary of Health, Education, and Welfare, argues that despite the successes reported by EAPs, the programs fall far short of their potential. He adds that "even the 'effective' programs are seeing only about 4 percent of the problem drinkers among their employees." (BNA, 1987, p. 140). If it is true that up to 30% of the U.S. workforce may have serious personal problems, this would suggest EAPs are underutilized and many employees are not obtaining the assistance that could improve their work and personal lives.

A variety of variables and approaches have been represented in EAP utilization research. One approach consists of researchers examining profiles of employees who have used EAP services. This research, however, has focused primarily on examining client statistics regarding participation by demographics (e.g., age, gender, marital status, race, occupational level, education, income, tenure), problem type (e.g., substance abuse, stress, financial problems), and referral source (i.e., self-referral, supervisory-referral, significant other-referral). In addition, much of the research on utilization is often inconsistent. Research findings regarding EAP utilization/participation by demographics, problem type, and referral source are reported below.

Marital Status

Many researchers have found that the majority of individuals utilizing the EAP are married (Cromidas, 1987; Marino, 1985; Uyeno, 1988) with the second most common

user being divorced (in spouses encouraging employees may not feel other problem areas substance abuse, financial

Gender

Research findings researchers have concluded more than males (Chambers, 1988), others have found (1986), while still others females (Grimes, 1980).

Research has also shown again the results are in females use services more (1984) while others conclude frequently and female (Straussner, 1986).

Race

Race is another demographic as with gender, conclusions have been found to have

user being divorced (Uyeno, 1988). In general, it is assumed that being married results in spouses encouraging one another to seek assistance (Serxner, 1988). While single employees may not feel the need to use an EAP for marital or child-rearing problems, other problem areas are still endemic to this group which the EAP could assist (e.g., substance abuse, financial problems).

Gender

Research findings on utilization rates and gender are mixed. While many researchers have concluded that females utilize EAP and occupational health services more than males (Champion, 1988; Hung, 1988; Jorrich, 1986; Serxner, 1988; Uyeno, 1988), others have found that males tend to use the services more frequently (DeFuentes, 1986), while still other researchers conclude utilization rates are equal among males and females (Grimes, 1980; Straussner, 1986; Sudduth, 1984).

Research has also been conducted on EAP usage by gender and program type, but again the results are inconclusive. For example, some researchers have found that females use services more if the program is on-site/internal (Champion, 1988; Sudduth, 1984) while others concluded that males tend to use on-site/internal EAPs more frequently and females tend to make more use of off-site/external contractors (Straussner, 1986).

Race

Race is another demographic characteristic examined with regard to utilization, and, as with gender, conclusions are often mixed. Regarding general health behavior, Blacks have been found to have fewer physician visits and telephone consultations than Whites

but twice the rate of

However, others have

Hung, 1988; Jorrich,

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Usage by race and

internal/on-site and external

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internal, in-house programs

Age

The age of most

research conducted. In

ages of 20-29 with the

(1988) reported an average

users ranged from 18 to

Tenure/Seniority

Leavitt (1983) found

EAP services more frequently

but twice the rate of hospital outpatient utilization than Whites (Serxner, 1988). However, others have found that Whites are the primary EAP users (Champion, 1988; Hung, 1988; Jorrich, 1986; Uyeno, 1988; Straussner, 1986) as well as the primary users of health services in general (Rosenstock & Kirscht, 1979). The second major user group seems to depend on the particular research conducted. For example, while Uyeno (1988) and Hung (1988) found Hispanics were the second major user group after Whites, Champion (1988) found that Blacks were second with Hispanics third. In general, Mexican-Americans have been found to underuse mental health services, due probably to the presence of informal family support discouraging such use (Keefe & Casas, 1980 as cited in Serxner, 1988).

Usage by race and EAP type has also been examined. Straussner (1986) compared internal/on-site and external/off-site usage rates and concluded that White employees tend to use external, contracted-out programs more often while minority employees use internal, in-house programs more frequently.

Age

The age of most EAP users also appears to vary depending on the particular research conducted. In research by Uyeno (1988), most EAP users were between the ages of 20-29 with the second most common age group between 40-49. However, Hung (1988) reported an average age of 38.6, while DeFuentes (1986) found that the age of users ranged from 18 to over 60 with the majority in the 26-44 age group.

Tenure/Seniority

Leavitt (1983) found that employees with more organizational seniority utilize the EAP services more frequently, as was shown in a 1975 study at Oldsmobile where the

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Hung (1988) also fou

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Occupational Level

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average seniority was ten years. A similar result was found three years later in a 1978 study of four firms where tenure of users averaged from 8 to 18 years (Leavitt, 1983). Hung (1988) also found the greater one's seniority, the greater the willingness to use an EAP.

When seniority was examined by program type, Sudduth (1984) found that employees with greater seniority utilized internal, on-site programs more than external, off-site programs. Sudduth suggested that external programs may receive less management support so they are utilized less.

Occupational Level

DeFuentes (1986) and Roman (1984) suggested professionals, supervisors and salaried employees use EAPs more often. However, there appears to be greater support that lower occupational levels, such as the office/technical group and hourly-paid employees, are the highest EAP users (Hung, 1988; Ford & McLaughlin, 1981; Jorrich, 1986; Suddeth, 1984; Uyeno, 1988). For example, Uyeno (1988) found blue collar employees utilized EAPs more frequently (50.2%) compared with white collar (46.1%) and executive (3.5%) employees. Other studies have identified the under-representation of executives and managers who tend to be reluctant to seek help for work and non-work related problems (NIAAA, 1982; Trice & Beyer, 1980). Leavitt (1983) suggested that top-level managers tend to use EAP services less frequently because they are less subject to coercion from the employer to seek assistance. Other reasons cited for managerial under-utilization include the lack of supervision which makes performance problems less visible (Myers & Myers, 1985) and the fear of jeopardizing future career opportunities (Hung, 1988). It often takes a serious event such as an automobile

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The type of EA

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accident, heart attack, or emotional breakdown for a problem to be acknowledged, and denial even then is very strong without additional influence from significant others (Johnson, 1973).

The type of EAP model or program (internal or external) may moderate the relationship between occupational level and EAP usage. For example, Straussner (1986) examined occupational level and program type. In that research, it was found that off-site, contracted-out programs were over-represented by higher-level employees and under-represented by lower-level workers while internal, on-site programs better reflected the status of the workforce (Straussner, 1986).

Baxter (1976) examined the organizational level of employees and the degree of EAP usage by family members at Rutgers University and found that in a two-year period, the majority of the users were at the general staff level (49%), then family members (22%), faculty (18%), and administrative and professional workers (10%).

Income

In a review of data prior to 1965 on income and utilization rates, Serxner (1988) found that lower income employees used health services the least; however, by 1968 it was the middle income group which underutilized physicians and health care while the lowest and highest income groups used health services most frequently. Rosenstock and Kirscht (1979) also found that those below poverty level used medical services less frequently, while those in the higher socioeconomic groups tend to use health services more frequently.

On the other hand, Hung (1988) reached the opposite conclusion regarding EAP usage. Hung reported that in his examination of EAPs, the highest-income employees

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Problem Type and EA

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were the lowest EAP users (\$50-69,000) and the lowest-income group (less than \$30,000) was the second lowest user group. The two middle income employee groups (\$30-39,000 and \$20-30,000) utilized the services most frequently. If we assume those in the highest income group are also in the higher occupational levels, then Hung's research appears to agree with research on occupational levels where executives were found to use the services the least.

Education

There was not much available literature found on education and EAP usage. Hung (1988) examined this variable as it related to employees' willingness to use an EAP in the future if needed and found that those who were more educated were more willing to use an EAP in the future.

Problem Type and EAP Utilization/Participation

The preceding sections focused on demographic factors influencing EAP utilization. This section will examine research on utilization and the types of problems employees/clients seek assistance on at the EAP. These findings also tend to be mixed.

Champion (1988) and Wells (1988) found marital, family, child, and psychological problems were the main ones handled at EAPs. However, Savoca (1986) and Baxter (1976) found EAP clients sought help mainly for job-related, emotional, and drinking problems. Others agreed in part with each of the above researchers. For example, Cromidas (1987), Jorrich (1986), and Straussner (1986) found the primary problems presented at an EAP were for emotional, chemical dependence, and marital problems. DeFuentes (1986) found the primary problems encountered were for alcohol, legal, and

emotional problems.

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emotional problems. Substance abuse, financial, legal, emotional, and marital problems along with poor job performance and absenteeism were the primary problems encountered at the 14 EAPs examined by Uyeno (1988).

DeFuentes (1986) examined gender and ethnicity and the type of problem presented at the EAP. Both males and females equally experienced family problems. In addition, males, Whites, and Hispanics most frequently experienced alcohol and substance abuse problems while females and Blacks sought assistance primarily on emotional problems (DeFuentes, 1986).

Bloom (1986) examined the primary types of problems which supervisors referred employees to an EAP for and found the following were frequently cited as reasons for referrals: tardiness/absenteeism, deteriorating work performance, preoccupation with personal problems, emotional problems, and suspected alcoholism and drug abuse.

Referral Source and EAP Utilization/Participation

The last area of research on EAP utilization to be discussed focuses on EAP utilization and referral source. There are three basic referral approaches to EAP utilization: self-referral, supervisory referral, and referral by significant others. Self-referral or "voluntarism" has been shown to be a key factor influencing the success of an EAP (Wrich, 1974). Supervisory referrals are another major source since deterioration of an employee's job performance is one of the basic reasons referrals are made to an EAP. Supervisors are able to get employees whose work performance has deteriorated to seek assistance because supervisors can threaten them with disciplinary action (Wrich, 1974). Significant others, defined as "those persons who exercise major influence over the attitudes and behavior of individuals" (Woelfel & Haller, 1971, p. 75),

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is the last major referral method and includes referral by peers, coworkers, family, etc.

In general, self-referrals are the most common source by which employees/clients seek assistance at an EAP, with supervisory referrals second and significant others the last main source (Bloom, 1986; Coleman, 1984; DeFuentes, 1986; Pardue, 1987; Straussner, 1986; Uyeno, 1988). For example, in a study of 14 companies with EAPs, Uyeno (1988) found all programs examined reported the majority of referrals were self-referrals and the second major source came from supervisors, with significant others next. Similarly, Bloom (1986) found that approximately 80% of the clients in the EAPs examined were self-referred and 20% were supervisory referred. In Coleman's (1984) examination of 32 EAPs in higher education, most users were self-referred, followed by supervisory and peer (significant others) referred. Pardue (1987) found 79% of the 200 EAP clients interviewed stated they realized the need for assistance on their own while 6.5% were referred by supervisors and 6.5% came because a fellow employee suggested it. Finally, while Straussner (1986) found self-referrals (54%) and supervisory-referrals (25%) were the main referral sources, medical (13%) and other referrals by union, family members, etc. (8%) were secondary sources.

In a look at gender and referral type, DeFuentes (1986) found that both male and female users were primarily self-referred (52.4%), followed by males and females who were referred by the medical department (16.9%), the supervisor (14.7%) and the union (.8%).

Several explanations have been provided to help us understand why employees seek assistance at an EAP. In describing the referral process, most research has focused either on the self-referral (voluntary) process or the supervisory-referral process. The major referral sources (self, supervisory, significant others), however, are not completely

independent of one another

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process as being influenced

(1) a family member

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(2) financial considerations

from seeking help;

(3) the degree to which

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(4) the amount of pressure

and its services and about

provided to help employees

(5) the existence of a

encouraging voluntary participation

(6) EAP tenure since

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A number of additional

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(7) fear of a breach of

1974);

(8) the perception

independent of one another since many of the factors influencing one type of referral may also equally influence another type. In addition, more than one referral source may simultaneously recommend/pressure an employee to seek EAP assistance. Beyer and Trice (1978), Myers (1984), Scanlon (1986), and Wrich (1974) describe the referral process as being influenced by the following factors:

(1) a family member, a friend, or a coworker seeks information regarding the EAP and influences an employee to seek help--this factor may affect both self-referrals and referrals by significant others;

(2) financial considerations regarding the cost of services may discourage employees from seeking help;

(3) the degree to which the employee feels free of hassle from the EAP staff's insistence on the employee modifying his or her behavior;

(4) the amount of publicity and education received by employees about the EAP and its services and about particular problems (i.e., the amount of self-analysis literature provided to help employees recognize behavioral patterns of a troubled employee);

(5) the existence of a supportive climate on the part of the company and union in encouraging voluntary participation; and

(6) EAP tenure since new EAPs must overcome initial employee skepticism because employees' belief in program effectiveness is necessary to gain credibility.

A number of additional reasons affecting EAP utilization by employees have been suggested in the literature. Some of these include:

(7) fear of a breach of confidentiality (Myers, 1984; Myers & Myers, 1985; Wrich, 1974);

(8) the perception of a possible adverse affect on tenure or promotional

opportunities (Myers, 1979);

(9) fear of a social

an alcoholic, a drug addic

& Roman, 1978);

(10) the degree of co

(11) lack of a writte

(12) type of progr

Scanlon, 1986);

(13) EAP model ty

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1981; Hung, 1988; Jorris

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(19) the general valu

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From the above list,

opportunities (Myers, 1984; Myers & Myers, 1985; Wrich, 1974);

(9) fear of a social stigma attached to EAP utilization (e.g., label person as being an alcoholic, a drug addict, in a troubled marriage, etc.) (Brewer & McAvoy, 1986; Trice & Roman, 1978);

(10) the degree of convenience and accessibility of the EAP services (Wrich, 1980a);

(11) lack of a written policy statement defining responsibilities (Wrich, 1980a);

(12) type of program sponsorship (union, management, joint) (Roman, 1984; Scanlon, 1986);

(13) EAP model type (internal/on-site vs. external/off-site) (Straussner, 1986);

(14) the occupational level of the employee (DeFuentes, 1986; Ford & McLaughlin, 1981; Hung, 1988; Jorrich, 1986; Leavitt, 1983; Roman, 1984; Suddeth, 1984; Trice & Beyer, 1980; Uyeno, 1988); and

(15) fear of giving the impression of being unable to manage one's own problems (Hung, 1988).

In related research by Rosenstock and Kirscht (1979), several factors were found to influence an individual's decision to seek professional help in the presence of illness symptoms. These factors may also have an effect on seeking EAP assistance. Factors identified include:

(16) the perceived urgency and severity of the condition;

(17) availability of alternative paths of action open to individuals;

(18) the costs of the different courses of action; and

(19) the general value an individual places on medical care (Rosenstock & Kirscht, 1979).

From the above list, it may be concluded that the employee's perception of the

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Roman (1980b) adds

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utility of utilizing EAP services is a key factor influencing his/her behavior. Even though the employee has a problem, the individual's decision to participate in an EAP is affected by the perception of the positive consequences of such a decision.

As previously mentioned, supervisory referrals have been recognized as an important means of encouraging employees to utilize EAP services because supervisors are in a good position of identifying "unsatisfactory job performance" of employees who might benefit from EAP participation (Gam, Sauser, Evans, & Lair, 1983). Supervisors, however, often resist becoming involved in a formal referral process. Some factors which have been found to influence supervisory referrals include the following:

(1) there usually has to be sufficient deterioration in job performance before a supervisor will confront and refer an employee (Wrich, 1980a);

(2) often ambivalence permeates the relationship between a supervisor and a troubled employee so both parties frequently utilize cover-up strategies (Myers, 1984);

(3) many supervisors have failed to develop "good" human relations skills which are required in order to deal with troubled employees (Googins & Kurtz, 1980);

(4) organizations differ in the extent supervisors are required to monitor workers' behaviors (Molloy, 1986);

(5) the type of EAP model (on-site vs. off-site) influences referrals by supervisors (e.g., Sudduth, 1984, concluded that there were more supervisory referrals to on-site, internal programs compared with external programs, presumably because supervisors feel that on-site EAPs are more integrated into the organization and accepted by top management).

Roman (1980b) adds that supervisors fail to become involved in an EAP referral process for the following reasons:

(6) supervisors expect

(7) supervisors fail

(8) supervisors do not

(9) supervisors are a

and

(10) supervisors don't

sigma that may be attached

Summary

This chapter provides a historical perspective on the evolution of employee assistance programs in the United States. Business and industry have been responsible for providing troubled employees over the years. Taylor in the early 1900s recognized that management's failure to recognize and negatively influence the behavior of employees tried to ignore the personal lives of employees and their specific duties in exchange for higher productivity due to problems outside the workplace. Employees were encouraged to shape up or ship out (BNA, 1990).

By the 1940's and 1950's, the role of employee assistance programs evolved and developed in the form of Alcoholism Programs were developed to address problems and mental health issues. The success of these programs

- (6) supervisors expect the dysfunctional behaviors will disappear;
- (7) supervisors fail to see an EAP as a legitimate organizational strategy;
- (8) supervisors do not want to be involved with employees;
- (9) supervisors are afraid they will lose power over employees after they refer them;

and

(10) supervisors don't want to label or mis-label an employee or be involved in any stigma that may be attached to the employee once referred.

Summary

This chapter provided an historical overview of organizational assistance programs in the United States. Businesses have changed their perspective and treatment toward troubled employees over the years. Initially, the scientific management attitudes of Taylor in the early 1900's, with the emphasis solely on efficiency and productivity, negatively influenced the treatment and attitude toward problem employees. Employers tried to ignore the personal problems of employees and expected employees to perform specific duties in exchange for wages. If an employee's performance at work suffered due to problems outside the control of managers, then the employee was expected to shape up or ship out (BNA, 1987; Wrich, 1980b).

By the 1940's and 1950's, however, a concern about the alcohol-related behaviors of employees evolved and precursors of Employee Assistance Programs (EAPs) developed in the form of Occupational Alcoholism Programs (OAPs). Occupational Alcoholism Programs were considered an innovation in resolving job performance problems and mental-health issues by attempting to help alcoholics in the workplace. The success of these programs was typically based on the employee's return to an

acceptable level of job
expansion of occupation
legal, medical and other
brush EAPs.

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While EAPs have be
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acceptable level of job performance. By the 1970's, early OAP successes led to the expansion of occupational programs to focus on a broader range of personal, social, legal, medical and other problems that hinder job performance--known today as broad-brush EAPs.

Organizations now recognize that untreated troubled employees cost more in the long-run than if their problems were diagnosed and treated early. Employees with personal, social, emotional, and other problems are less productive, have higher rates of illnesses, absenteeism, accidents, and disability than those who are "healthy" (Fielding, 1984b). Human resource managers have realized that by attacking the problems affecting troubled employees, the corporation can experience measurable savings (Scanlon, 1983). As EAPs have replaced alcohol-based programs, the supervisor's role in the workplace has also changed. The supervisor is now perceived as an agent who refers employees whose performance has deteriorated to specialists. Employee Assistance Programs today advocate not only supervisory referrals but attempt to promote voluntary/self-referrals as well.

EAPs vary in both management philosophy and structural dimensions (e.g., program format, services provided, evaluation methods) (Myers, 1984). They have continued to evolve over time as employee needs, foreign competition, and legislative activity make it necessary for employers to take a pro-active stance in maintaining and retaining their human resources. Employee Assistance Programs have the ability to provide assistance to employees/clients who have not traditionally used social service agencies.

While EAPs have become an integral part of American business and are capable of addressing both work and nonwork-related problems of employees through a

comprehensive system of
they are most designed
identification increases
(Busch, 1981; Farber,
Progression of substance
intervention and treatment
benefit--through reduction
performance, and improvement
Wrich, 1980b).

While descriptive research
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comprehensive system of services, EAPs often remain underutilized by those employees they are most designed to reach. Most professionals agree that early problem identification increases treatment success and is necessary to obtain maximum results (Busch, 1981; Farber, 1982; Ford & McLaughlin, 1981; Witte & Cannon, 1979). Progression of substance-abuse and other personal problems may then be avoided. Early intervention and treatment are important because both the employee and the employer benefit--through reduced absenteeism, sick time and accidents, improved job performance, and improved work and spousal relationships (Googins & Kurtz, 1980; Wrich, 1980b).

While descriptive research on EAP models, services provided, and clients of EAPs has been conducted along with empirical research on the effectiveness of these programs, more research is required to examine factors influencing why individuals use or do not use EAP services. Researchers have presented a multitude of factors that affect EAP utilization. However, much of the present research emphasizes demographic profiles of users and lacks a theoretical base. Therefore, there is a need to understand the underlying factors influencing the EAP utilization process. Researchers have focused on what the employee has done (i.e., used or not used EAP services) but not on understanding why the behavior occurred.

The variables of interest in examining factors influencing EAP usage in the present research have been conceptualized in a control theory framework. Control theory was selected as a guiding framework because its underlying premise attempts to understand an individual's decision-making behavior. The following chapter will provide an overview of control theory and its relation to organizational health models and approaches found in the literature. The model developed in the present research to

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examine factors influencing the process involved in the decision to utilize EAP services will then be presented along with the hypotheses of interest.

While control theory has been widely accepted in such diverse fields as psychology, sociology, and medicine until Wieners (1948, 1949, 1962). The theory has also been applied to the study of individuals due to the work of Carver and Scheier (1982) on the self-regulation of human behavior and in social psychology, particularly in the work of Higgins (1982 for a review) and others (e.g., Higgins, 1989; Hollenbeck & Briggs, 1989; Hanges, 1987; Taylor, Fisher, & Klein, 1988). In general, control theory has been applied to a wide range of phenomena, including the study of individual differences in the way people regulate their behavior. This paper focuses on the application of control theory to the study of individual differences in the way people regulate their behavior.

CHAPTER 3

CONTROL THEORY AND A MODEL OF EAP UTILIZATION

Control Theory

As previously stated, control theory has been used to explain factors influencing an individual's decision-making behavior. Control theory is based on a cybernetic or general systems theory perspective. General systems theory is a meta-theory or strategy that utilizes the basic concepts of feedback, self-regulation, and disregulation--i.e., disconnection of feedback loops among the system's parts (Schwartz, 1979). The framework is based on the view that to understand the behavior of a system as a whole, one must understand the interaction of its parts. Control theory is based on this general systems perspective.

While control theory has been around for a long time, it did not gain wide acceptance in such diverse disciplines as engineering, applied mathematics, economics, and medicine until Wiener (1948) published his book on cybernetics (Carver & Scheier, 1982). The theory has also been applied in the fields of psychology and the behavior of individuals due to the work of Miller, Galanter, and Pribram (1960), Powers (1973), and Carver and Scheier (1982). For example, many theorists have applied control theory to the self-regulation of human behavior in the fields of cognitive psychology, personality and social psychology, clinical psychology, health psychology (see Carver & Scheier, 1982 for a review) and organizational behavior (Campion & Lord, 1982; Hollenbeck, 1989; Hollenbeck & Brief, 1987; Hollenbeck & Williams, 1987; Klein, 1989; Lord & Hanges, 1987; Taylor, Fisher & Ilgen, 1984).

In general, control theory deals with the manner in which systems (e.g., humans)

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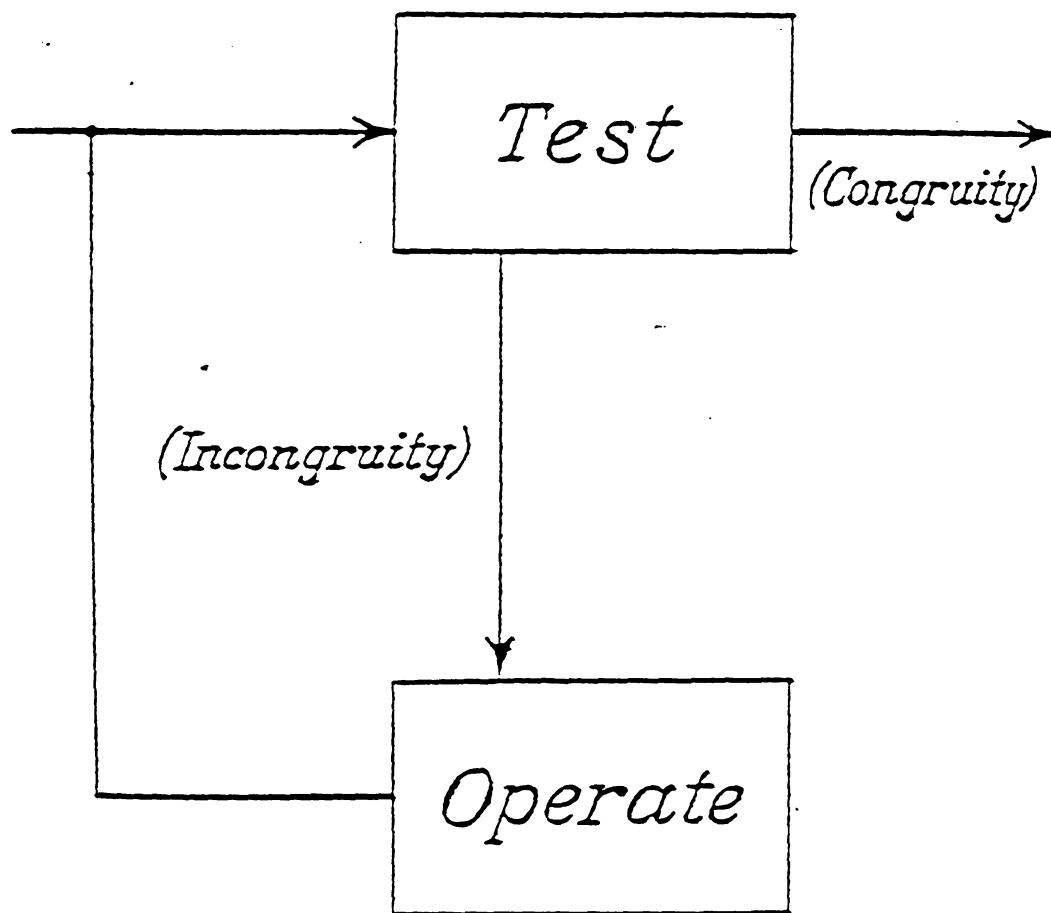
collect and process information in order to achieve and maintain a desired state (Campion & Lord, 1981; Carver & Scheier, 1981; Lord & Hanges, 1987). Control theory emphasizes goals (also called standards or referent values) and feedback to regulate behavior by focusing on goal-feedback discrepancies. A discrepancy exists when there is a difference between what is desired and what one currently has. For example, when an individual is drinking more than desired or is experiencing more stress than desired, a discrepancy exists between the desired and current state. It is the detection of a discrepancy which is the basis for action because a discrepancy may motivate an individual to respond in some way in order to reduce the discrepancy.

Control theory of human motivation is an elaboration of the test-operate-test-exit (TOTE) cybernetics principle proposed by Miller et al., (1960). Miller et al. (1960) called the feedback loop the TOTE sequence. The TOTE sequence (see Figure 4) detects discrepancies between the current and desired states by engaging in a self-monitoring process of testing input data on the current state against the desired state (also called the goal, standard, or referent value). According to the theory, when a discrepancy is perceived, the system (e.g., the individual) initiates (operates) some activity to reduce the discrepancy. The test-operate sequence is repeated until the discrepancy is perceived to be eliminated or reduced to an acceptable level--at which time the sequence is terminated via an exit process. An example illustrating this process is when an individual monitors his/her current body temperature (for example, using a thermometer) and compares it to the desired temperature or goal (usually 98.6 degrees). If a discrepancy is found between the desired and current states, then the individual attempts to reduce the discrepancy through some response (e.g., taking aspirin, going to a doctor). The monitoring process continues until the temperature returns to the

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Figure 4: The TOTE Unit

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Other models have been developed by control theorists which are based on a discrepancy-reducing process similar to that proposed by Miller et al. (1960). These models include additional elements and are typically more detailed to help us better understand the decision-making process. Two useful models of control theory discussed below are Carver and Scheier's (1982) and Campion and Lord's (1982) models.

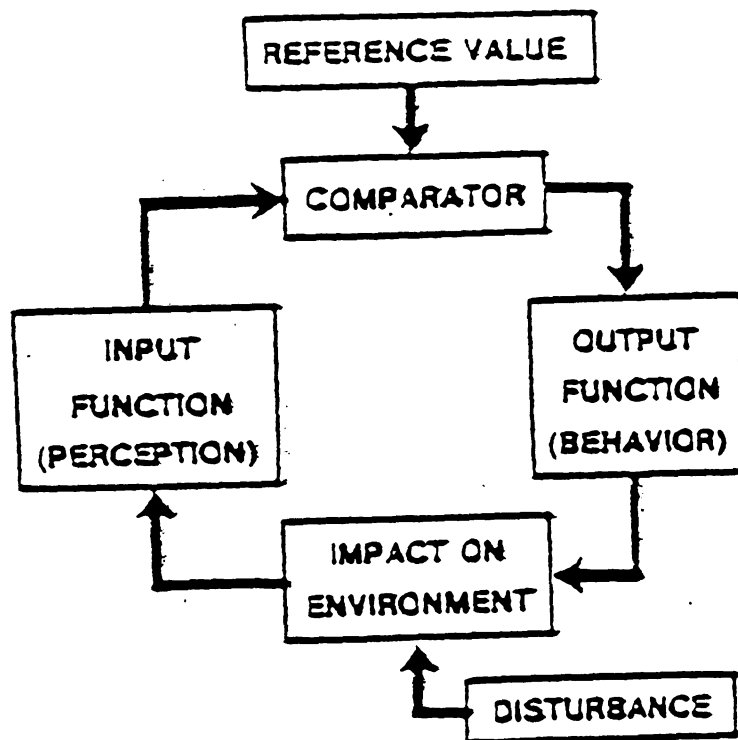
Carver and Scheier's (1982) model applied control theory to human behavior. Their illustration of the negative feedback loop in Figure 5 consists of four main elements: (1) a referent value which is also called a standard or goal, (2) an input/sensor/perception function, (3) a comparator, and (4) an output or effector function. A fifth element known as "disturbance" is the external environment which impacts on the four main system elements. Disturbance is included because the feedback loop is an open system and is influenced by external environmental forces. Three of the elements originate within the loop: the input or perception function, the comparator, and the output function. The standard or reference value originates outside the loop along with the "disturbance" (Carver & Scheier, 1982). These elements can be further divided into cognitive and affective components as described below.

In the Carver and Scheier (1982) model, goals may be either explicit or implicit standards or objectives. The input function senses the present state or condition, which is then compared against the goal/standard through the comparator mechanism. The goals and the process of matching inputs to standards encompass the cognitive component of the model. According to the model, if a discrepancy is detected, negative affect may occur (the affective component) which may be in the form of dissatisfaction, frustration, or anger (Carver & Scheier, 1981). Based on the model, it is this negative

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Figure 5: The Negative Feedback Loop

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affect which motivates an individual to initiate a discrepancy-reducing response, or some behavioral output function. The behavioral output is not expected to reduce the discrepancy directly, but rather it does so through its impact on the system's environment. This impact is then hypothesized to create a change in the present state, which leads to a different perception, which is then again compared to the standard. It is the perception of the current compared to the desired state that results in a perceived discrepancy, rather than an objective state. The entire process of sensing, comparing, and responding continues until the discrepancy disappears. Thus, control theory provides a dynamic perspective to understanding human behavior.

A feedback loop may be either positive or negative. A "negative" loop is one where a system (e.g., individual) attempts to decrease the discrepancy between the current and desired state and a "positive" feedback loop would attempt to increase the discrepancy between the current and desired state. According to control theory, it is the sensing of a discrepancy and the subsequent response to eliminate or reduce it that regulate human motivation and performance (Powers, 1973). Feedback provides crucial information on the current state. While sensing any type of discrepancy is equally undesirable in mechanical systems, regardless of the direction (positive or negative), this is often not necessarily true in human systems (Carver & Scheier, 1981). Carver and Scheier (1981) suggest that positive and negative feedback results in different consequences, and that often in human systems dissatisfaction from an "over-shot" standard may not occur as it typically would when a standard is "under-shot".

In the present study, the focus is on the perceived health of individuals and their help-seeking behaviors when they "under-shoot" or are below their "health" standard. It is assumed that if an individual is healthier than one's health standard, the

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To understand how feedback loops regulate behavior, it is also necessary to introduce the idea of a hierarchical system. Miller et al. (1960) suggested that there may be strings of TOTE units functioning within each operation's phase. Carver & Scheier (1982) and Powers (1973) also discussed the possibility that control systems may be connected hierarchically through a system of superordinate and subordinate goals. The superordinate system sets standards or referent values for the subordinate systems, and lower-level standards must be attained prior to the attainment of higher-level standards.

When applied to human systems, Powers (1973) proposed a hierarchy of nine levels of control systems where each level in the hierarchy controls different behaviors. Thus, when simple cybernetic systems are applied to human systems, the system becomes more complex. For example, individuals are limited in their information processing capabilities (Carver & Scheier, 1981; March & Simon, 1958). Carver and Scheier (1981) contend that an individual does not have the ability to monitor all possible control loops, nor do all individuals have similar abilities in carrying out the self-regulation process. In Carver and Scheier's model of self-regulation (Carver, 1979; Carver, Blaney & Scheier, 1979b; Carver & Scheier, 1981), it is proposed that the loop engaged in depends on one's focus of attention. Carver and Scheier (1981) suggest that there are two directions in which an individual's attention can be focused, and that the direction influences attitudes and behaviors. Attention can be directed inward, or toward the self, in which case the individual engages in self-focus or self-attention. Attention can also be directed outward, or toward the environment.

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Self-focus has implications for control theory because Carver and Scheier suggest that the negative feedback loop operates when specific attentional requirements exist. Motivation to alleviate a discrepancy requires an awareness of the standard and a negative reaction regarding the discrepancy--both of which are suggested to be more salient among self-focused individuals (Carver & Scheier, 1982; Hollenbeck, 1989). High self-focused individuals have been found to have more salient internal standards, to initiate the comparator, or matching-to-standard, process, and to seek out information to facilitate this comparison more often than low self-focused individuals (Carver, 1974, 1975; Carver & Scheier, 1982; Gibbons, 1978; Scheier, Fenigstein & Buss, 1974). If a discrepancy is discovered, self-focused individuals are also more likely to initiate behaviors to counter the discrepancy and attain the standard.

At this point, one additional dimension must be included in the goal-feedback-discrepancy-reducing process. This is an individual's expectancy regarding his/her ability to reduce the discrepancy and future discrepancies through some behavior. Carver and Scheier (1982) suggest that an individual will attempt to reduce a discrepancy when the current and desired states are dissimilar, and that a discrepancy-reducing response will occur automatically. However, this process may be interrupted as a result of an individual's expectancy regarding one's ability to reduce the discrepancy. According to Carver and Scheier (1981), a self-focused individual's expectancy of being able to match the standard impacts whether the individual will actually attempt to reduce the discrepancy or will withdraw from any such attempt (either physically/behaviorally or mentally/cognitively). Thus, in control theory, there are two distinct functions which occur: an expectancy-assessment process and a discrepancy-reduction process. The expectancy-assessment process involves synthesizing information from several sources

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(e.g., physical constraints, social constraints, resources available, importance of standard). Once this process is completed, the theory suggests that either a positive affect will occur if the expectancy to meet the standard is positive or a negative affect will occur if the expectancy is negative (Carver & Scheier, 1982).

Figure 6 (Carver, 1979) presents a flow of activities in the expectancy-assessment process and the behavioral responses that are expected to occur according to control theory. Research has provided evidence that self-focus increases the congruence between standards and behavior and that, when self-focus and expectancies are combined, researchers have found that for those high in self-focus, favorable expectancies lead to increased effort to reduce the discrepancy while unfavorable expectancies lead to early withdrawal (Archer, Hormuth & Berg, 1979; Brockner, 1979; Carver, 1974; Carver, 1975; Carver, Blaney & Scheier, 1979a, 1979b; Duval, Wicklund & Fine, 1972; Scheier, Fenigstein & Buss, 1974; Steenbarger & Aderman, 1979). Factors which may influence one's expectancies include: prior success and failure, locus of control, social influence, and causal attributions made regarding one's failure to match the standard (Carver & Scheier, 1981).

The valence one has regarding the standard has also been recognized as a factor influencing one's discrepancy-reducing behavior (Carver & Scheier, 1981). If a standard has a positive valence, then the standard is assumed to be a goal or objective that is desired. According to control theory, if a discrepancy exists between the current state and the standard, then a behavioral output will likely be triggered to reduce the discrepancy. If a standard has a negative valence, then the standard is assumed to not be desired (thus, a discrepancy from the standard is acceptable).

Another model of control theory (see Figure 7) presented by Campion and Lord

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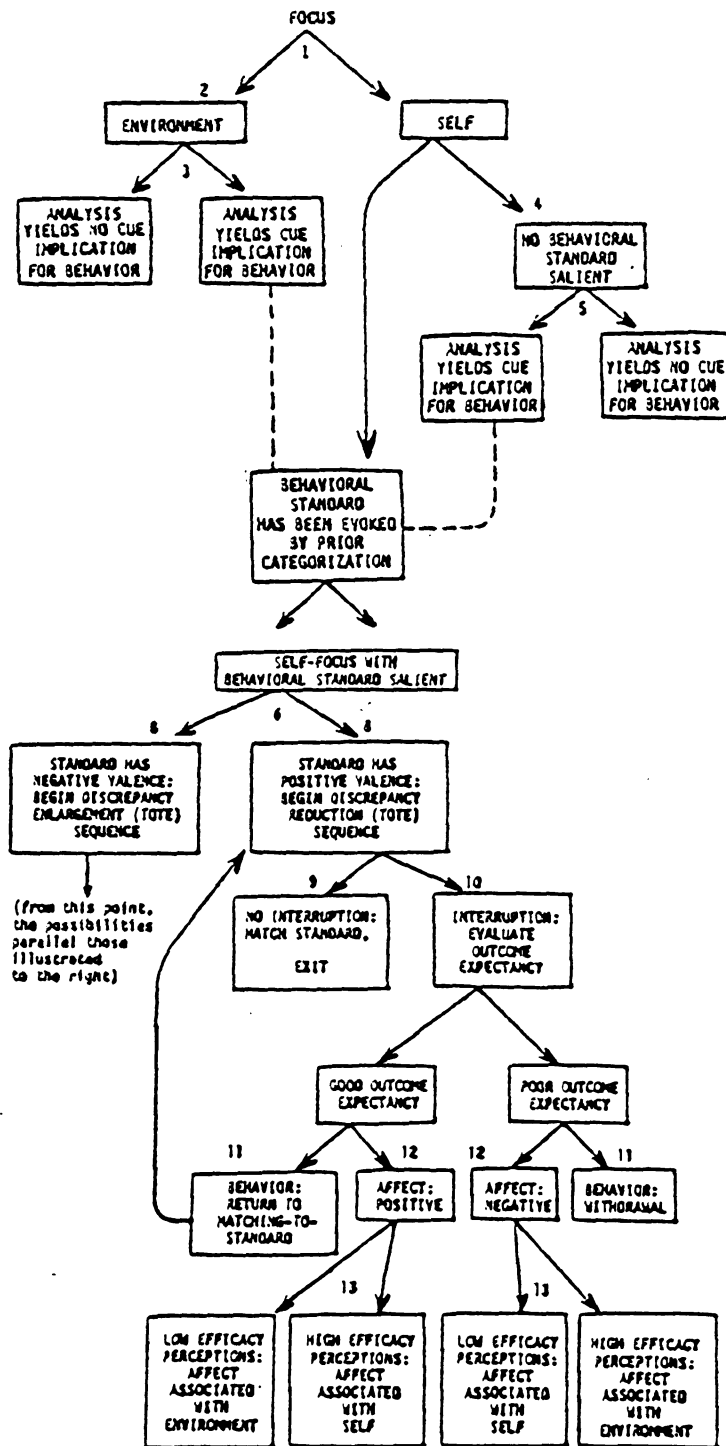
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Figure 6: Cybernetic Model of Self-Attention Process

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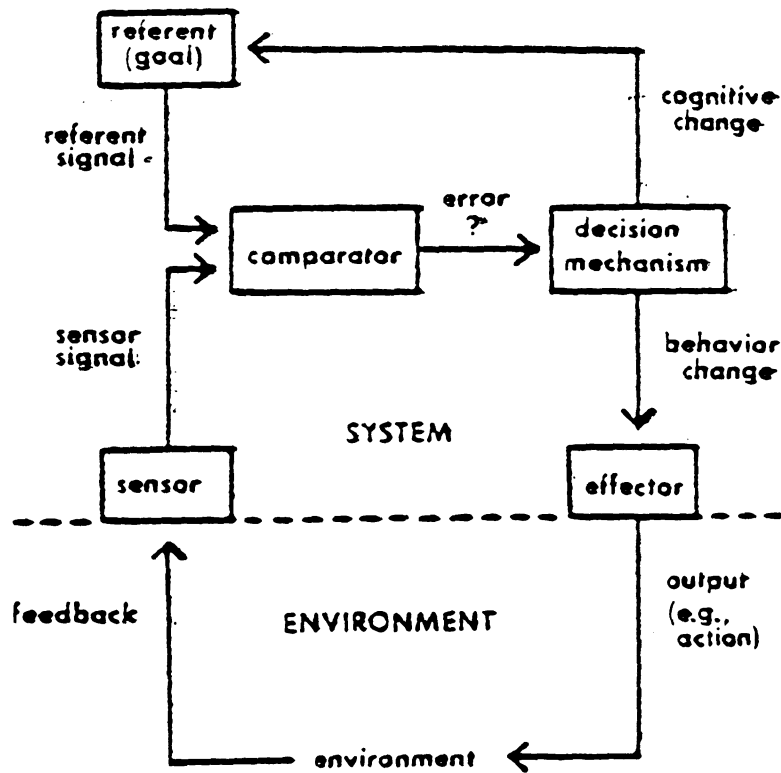
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Source: Campion & Lord, 1982

Figure 7: Control Systems Model of Motivation

(1982) focused on goal components-four of which are: standard or goal, the current state, the comparison information from the environment, and the mechanism invoked after comparison. According to Campion and Lord, the model is made explicit.

Campion and Lord (1982) proposed because it differentiates between (1) a cognitive change where the person modifies a strategy or the sensing device. It is behavioral responses for expectancies (Campion and Lord (1987) initially encountered different cognitive responses, but an increase in order to reduce them. The three models (1982; Miller et al., 1966) are based on understanding the self-regulatory process.

(1982) focused on goal-setting behavior. The Campion and Lord model consists of five components--four of which are similar to those in Carver and Scheier's model: the standard or goal, the sensor which inputs feedback from the environment about the current state, the comparator mechanism which compares the standard to the information from the environment, and the effector. The fifth element is a decision mechanism invoked after the standard-to-current-state comparison is made. According to Campion and Lord, if a discrepancy or error is detected, a decision must be made. Of course, in Carver and Scheier's model, this decision process also exists but it is not made explicit.

Campion and Lord's model is more detailed than the other models presented here because it differentiates between two possible outcomes used to reduce the discrepancy: (1) a cognitive change where an individual modifies the standard or (2) a behavioral change where the person attempts to modify the environment, through the effector (e.g., modify a strategy or the amount of effort utilized), which then provides feedback to the sensing device. It is important to note that Lord and colleagues suggested that behavioral responses follow high expectancies while cognitive responses result from low expectancies (Campion & Lord, 1982; Lord & Hanges, 1987). Campion and Lord (1982), Kernan and Lord (1987), and Sibley and McFarland (1974) have also suggested that for initially encountered discrepancies, behavioral responses are more likely to result than cognitive responses, but as discrepancies persist over time, cognitive responses tend to increase in order to reduce discrepancies.

The three models presented above (Campion & Lord, 1982; Carver & Scheier, 1982; Miller et al., 1960) are important in that they provide a basic foundation to understanding the self-regulation process, although they differ somewhat in their focus,

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types of responses, and procedures by which these responses are invoked (for a comparison of models see Klein, 1989). In summary, control theory generally focuses on the following basic components: a mechanism that senses the environment, a goal/standard that is compared to this sensed environment via a comparator mechanism, a decision mechanism which determines what action to take when a discrepancy is detected, and an effector or discrepancy-reducing response if a discrepancy is detected which allows the system to interact with its environment (Lord & Hanges, 1987). Based on control theory, when a sufficiently large goal-feedback discrepancy is detected, three types of strategies or responses may be enacted: (1) behavioral responses, such as increasing one's effort to improve performance, (2) cognitive responses, such as distorting the feedback, modifying the standard, or altering expectancy beliefs, and (3) affective responses (Taylor et al., 1984).

In his book Measurement Strategies in Health Psychology, Karoly summarized a number of key concepts and assumptions of control theory: (1) control theory assumes behavior is goal-directed; (2) goals are explicit or implicit standards used to compare against the current status; (3) self-regulation of goals requires an openness to feedback regarding one's behavior; (4) goals are arranged hierarchically within an individual; (5) affect/emotion may be an input, output or a mediating factor in the control process; (6) human behavioral control systems can operate at various levels of automaticity; (7) control systems do not operate in a vacuum; i.e., social and nonsocial factors influence the system; (8) standards/goals change due to internally or externally mediated processes; and (9) control systems are subject to various disruptions; e.g., disconnections may occur between people and the environment (1985, p. 26).

Finally, Klein (1989) used control theory as a basis for developing a meta-theory

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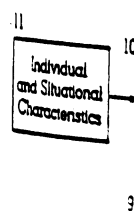
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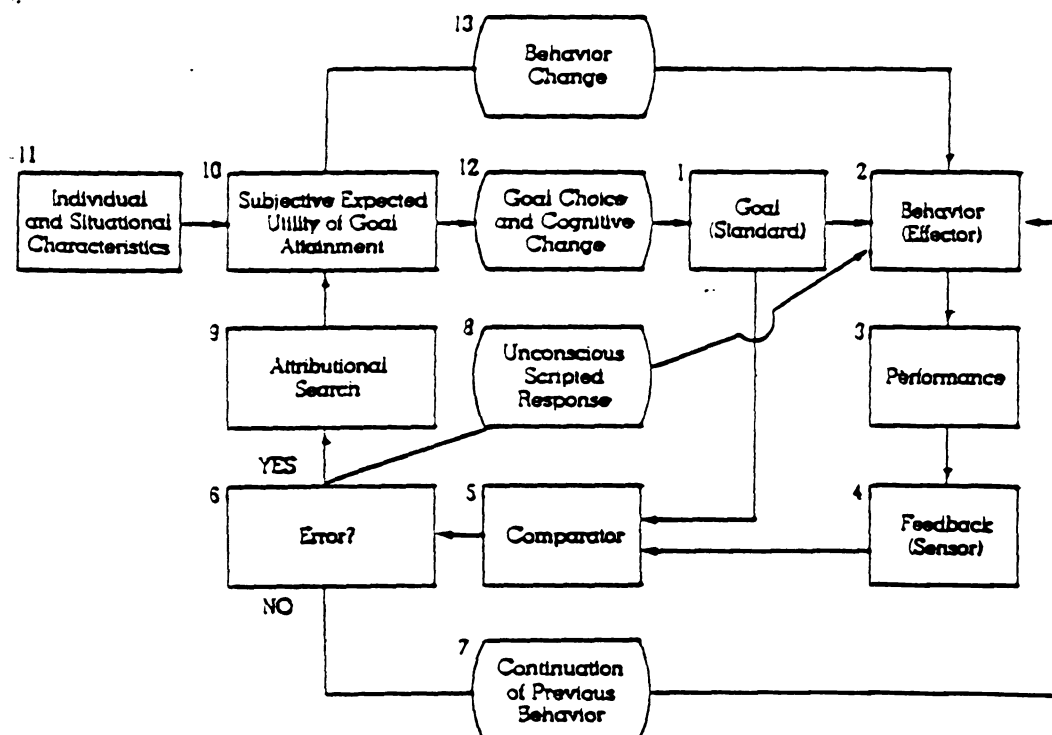
for understanding work motivation (see Figure 8). From his review of control theory, Klein identified several advantages to applying a control theory perspective to behavioral issues, which include the following: (1) it provides a dynamic framework for integrating other theories--e.g., goal setting, feedback, expectancy, equity, cognitive dissonance, job satisfaction, turnover, decision making, attribution, social learning, need, and information processing theories; (2) it synthesizes the work of authors applying control theory to motivated behavior; (3) it is a simple heuristic framework; (4) it focuses attention on the cognitive processes underlying motivation; and (5) it focuses attention on the self-regulation and internal influences of behavior.

In chapter two, a discussion of the evolution of organizational attitudes toward the health of employees was presented. This discussion focused on the evolution from a lack of concern by employers toward the personal lives and problems of employees during the scientific management-Taylor era to a concern about alcohol-related problems in the workplace and the subsequent development of OAPs, to finally a broader concern about the overall health of employees--which lead to the development of occupational EAPs and wellness programs. It was noted that there has been a lack of a theoretical base to the research on employee health--particularly with reference to EAP research on utilization. A general overview of control theory has been presented in the present chapter to provide a basis for understanding control theory and the Control Theory Model of EAP Utilization developed for the present research. However, prior to presenting this model, examples of health-related activities based on a control theory, or systems, perspective will be discussed.



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Figure 8: An Integrated Control Theory Model of Work Motivation

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A Control Theory Perspective on Health-Related Activities

The emerging field of health psychology today has found a control or systems-oriented perspective useful. This system perspective to health has evolved from general systems theory (Von Bertalanffy, 1968) and from cybernetic theory (Wiener, 1948). Ludwig Von Bertalanffy (1966) has defined a system as a "complex of components, in mutual interaction . . . any whole consisting of interacting parts" (p. 709). A system may be closed (it is isolated from its environment) or open (interacts with the environment within and outside its own boundaries). The health psychology field has examined the concept of the "brain as a health care system" (Schwartz, 1979) and developed a framework known as the "biopsychosocial" model of health and illness (Engel, 1977; Karoly, 1985; Kimball, 1981; Snyder, 1989; Stone et al., 1979).

The biopsychosocial perspective used in the health field has its historical roots in the biomedical and medical paradigms of health--which were the prevailing views of disease and medical treatment in Western society until the popularization of the systems perspective (Fabrega, 1974). Under the biomedical paradigm, disease is defined as "a disruption in or deviation from biological norms caused by some physical or chemical factor," and treatment is via some corrective physical or chemical manipulation (Snyder, 1989, p. 3). The second perspective traditionally in use has been the medical paradigm of helping which focuses on individuals who seek the aid of an expert when they notice a physical problem beyond their own ability to cure. Patients are viewed as not being responsible for their problem but only for the seeking of treatment, while the health providers are responsible for diagnosing and providing treatment (Snyder, 1989).

The biomedical and medical paradigms are different from the biopsychosocial perspective. The former two focus on people as passive, uninformed organs requiring

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physical or chemical treatment due to factors beyond their control. The latter biopsychosocial perspective includes psychosocial and behavioral factors and preventative interventions taken on the part of the individual. The biopsychosocial or systems view was developed for two basic reasons: (1) the inability of the biomedical and medical paradigms to address a number of health problems and (2) the recognition that chronic diseases have behavioral and sociocultural causes as well as biological, biochemical, and physical causes. Furthermore, the passivity and lack of responsibility assumed by the individual under the medical paradigm disregards a person's self-evaluation of his or her health, the timely use of the health care system, or adherence to treatment and places immense responsibility and power on health providers (Snyder, 1989).

In contrast to the biomedical and medical perspectives, the systems perspective recognizes the complexity of humans and the need for individuals to not only accept responsibility for their behavior but to be responsible for modifying it if necessary (Snyder, 1989). The systems framework takes on a heuristic perspective by viewing health and illness as the interdependence of physical/biological, social, psychological, and environmental (e.g., physical, social, etc.) dimensions. In a systems perspective, the individual must continually obtain feedback from the external environment and adapt to it as well as to changes present in his or her internal environment. Individuals are considered healthy when they successfully adapt to these environmental changes (Fabrega, 1974).

Carver and Scheier (1982) identified areas in health psychology where theorists have used a cybernetic or control system framework to understand how people maintain their health. Health protection and promotion are often considered to be self-mediated

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behaviors. A common assertion in health psychology is that many illnesses and their symptomologies and antecedents are the result of personal life-style behaviors, which are believed to be largely under the individual's control (Karoly, 1985). Therefore, with its emphasis on the self-management process, control theory has been found to provide a useful set of guidelines for examining self-management and health-related behaviors.

Examples of health activities where control theory has provided a useful framework include checking one's pulse, blood pressure, or temperature because the results of this "current state" are only meaningful when compared to a standard or normal state in order to determine if one's health is less than ideal and thus motivate the individual to respond (Carver & Scheier, 1982; Leventhal, Meyer & Nerenz, 1980; Schwartz, 1978, 1979). These examples illustrate how the elements of control theory provide a framework for understanding health-related behaviors: there is a standard, an input sensing function, a comparator mechanism, and an outcome or behavioral function. Individuals often monitor their current health and compare it to a standard, which induces a certain behavioral or cognitive response.

Other factors previously discussed within a control theory framework are also relevant to health behaviors. For example, self-focus has been shown to influence health-relevant behaviors. Mullen and Suls (1982) provide evidence that self-focus helps determine the degree to which people attempt to remove stress. In addition, the section above on control theory outlined the idea that a hierarchy of goals and feedback loops exists within the context of an individual's behavior. Hierarchically-ordered levels of self-regulation also are relevant in one's health behavior (Carver & Scheier, 1982). For example, monitoring one's blood pressure to compare it to a "normal" range is a subordinate goal to the higher-level goal of staying healthy and maintaining a normal

condition.

The basic principles of EAPs are the identification of behaviors, but little attention has been given to the decision-making process. EAPs have recognized the need for a more comprehensive approach. As previously stated, continued research in this section will present specific findings. This model of EAP utilization is based on the present research which indicates that

A Systems Perspective

The general systems approach is a philosophy underlying the design and implementation of EAPs. As open systems, human beings are influenced by their internal and external environments. The EAP is not the result of a single cause, but rather the result of a complex interaction of the individual, the organization, and the environment, interacting with each other. The EAP is a system of Assistance Programs and services designed to help the employee, in a healthy, all aspects of his or her life. The EAP is a financial, legal, social, and medical service that can be maintained in a healthy state. The EAP is a general systems model of health care that provides a useful framework for the design and implementation of EAPs. As described above, the EAP is a system of Assistance Programs and services designed to help the employee, in a healthy, all aspects of his or her life. The EAP is a financial, legal, social, and medical service that can be maintained in a healthy state. The EAP is a general systems model of health care that provides a useful framework for the design and implementation of EAPs.

condition.

The basic principles of control theory have been applied to various health-related behaviors, but little attention has been given to applying it to understanding EAPs and the decision-making process influencing EAP usage. However, some researchers have recognized the need to take a general systems view regarding the EAP process. As previously stated, control theory is based on general systems theory. Therefore, the next section will present specific EAP research that has utilized a systems perspective. The model of EAP utilization based on a control theory perspective that was developed for the present research will then be outlined.

A Systems Perspective on EAPs

The general systems perspective and control theory tie in very well with the philosophy underlying EAPs. Control theory, EAPs, and humans are all open systems. As open systems, humans are subject to dynamic interchanges with both their internal and external environments. Learning theorists recognize that "behavior is not the result of a single cause, but of multiple causes. It is the result of heredity interacting with environment, interacting with time" (Sprinthall & Sprinthall, 1981, p. 56). Employee Assistance Programs are based on the view that for an employee to be considered healthy, all aspects of one's life need to be healthy--emotional, psychological, physical, financial, legal, social, etc. In other words, all systems influencing an individual must be maintained in a healthy state. Since individuals are open systems, models based on a general systems model, a control theory model, and the biopsychosocial model of health provide a useful foundation for examining EAPs.

As described above, EAPs are "systems" for identifying and treating individuals for

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a variety of problems (Wrich, 1980b). To do this, an EAP must function as an open system interacting with the human, organizational, and community environments it must maintain contact with. Savoca (1986) has identified several environmental influences on an EAP: internal organizational influences (e.g., supervisor, management, employee, personnel and medical departments, union), the family, external social services, outpatient and inpatient services, and self-help groups. A systems model provides an excellent framework for understanding the EAP process because it can utilize a feedback loop.

Savoca (1986) developed a systems model of EAPs which consisted of the following components: (1) input function, which encompasses EAP resources (e.g., staff, funds, services) and the clients involved in EAP usage (e.g., employees, supervisors, personnel and medical departments); (2) through-put or transformation process, which involves the relationship between the EAP staff and clients and client assessment; (3) output function, which consists of the services provided to the client; e.g., counseling, referral, follow-up; (4) outcome function, which refers to the impact the services have on the clients; i.e., the results; and (5) feedback which flows from the results back to the input-sensing function which feeds into the process so it can cycle through the loop again. "Feedback enables the system to correct its own functioning or seek changes in the environment" (Savoca, 1986, p. 49).

In order for EAPs to be considered successful, the major ingredient is for employees to utilize the services. As discussed in chapter two, employees may be referred to an EAP by a third party (e.g., supervisor, union steward, etc.) or a person may self-refer--i.e., utilize the services voluntarily. The purpose of the present study is to examine factors which may influence an individual's decision to seek assistance from

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an EAP. Since control theory is based on a general systems perspective and is concerned with the self-regulation of behavior, the present research will examine its usefulness as an analytic tool that can be applied to the EAP utilization process. As noted above, Wrich (1980b) and Savoca (1986) have applied a systems view to illustrate the entire EAP process (from the initial EAP appointment to referral, to treatment, and problem resolution). However, a detailed systems model has not been applied to more specific procedures involved within the entire EAP process. For the current research, a model based on a control theory perspective was developed to help examine the decision-making process influencing an employee's utilization of EAP services. The Control Theory Model of EAP Utilization will be presented in the following section. The model conceptualizes the interrelationships among control theory components, system variables, and EAP usage to help contribute to our knowledge about the decision-making process influencing an employee's seeking of health assistance.

A Control Theory Model of EAP Utilization

Overview of the Model

The model presented in this section retains the basic components of control theory to help us better understand a specific health behavior--the utilization of EAP services. However, the Model of EAP Utilization expands on the basic control theory model presented in the preceding section by including variables which may influence some of the basic control theory components.

Prior to presenting the Model of EAP Utilization, it would be helpful to understand the rationale for basing the model on a control theory perspective. Past research on EAP usage has typically been conducted by measuring specific variables that might be

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related to usage and that were of interest to the particular researcher. These variables were typically demographic factors and the types of problems clients presented, and often there was little or no theoretical or conceptual basis for the inclusion of variables in a study. The analysis was conducted by either correlating the demographic factors with EAP usage or by simply examining the percentage of EAP users by demographics or problem type (e.g., percentage of usage by males and females, by various ages and education levels, etc.). While this research familiarized us with types of EAP clients, there are two problems with this past research. First, although organizations and EAP staffs want to know who is utilizing their services (i.e., demographic characteristics), it is impossible for management or EAP counselors to apply this information to influence usage. Existing workforce characteristics cannot be modified in order to create a labor force of employees who tend to avail themselves of EAP services since these characteristics are a constant. Second, even though relationships have been found between specific demographic variables and EAP usage, we are still no closer to understanding why such relationships exist. Therefore, organizations and EAP staffs still do not know how to influence or improve utilization rates. Consequently, while past EAP utilization research has been interesting, the practical knowledge gained from this research is limited.

As discussed in the preceding chapters, EAPs have been found to improve the effectiveness of both employees and organizations. Current EAP utilization research is based on the belief that EAPs are successful in eliminating or improving employees' problems. However, as previously mentioned, experts recommend that 40% of all EAP users should be self-referred in order for programs to be considered successful (Hobson, 1982; Wrich, 1980b). Therefore, interest should be focused on how to get employees to

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voluntarily make use of EAP services. Before organizations can influence EAP utilization, however, they must first understand what factors affect employees' decisions to choose to seek or not seek assistance. The current literature fails to provide a way for us to understand this decision-making/choice process or how to get employees to make better choices.

In research on factors influencing health decisions, it has typically been assumed that in order for individuals to be motivated to modify their present behaviors (e.g., exercise more, take medication, stop drinking, etc.) or to seek some type of assistance (e.g., visit a physician or health clinic), it is necessary for individuals to perceive that there is something wrong--that is, that there is a discrepancy between their desired goal and their current health behaviors or health status. For example, this has been found to be true in research on alcoholics who tend to deny there is a problem and hide their drinking from others. This conduct continues until problems develop that are too serious to hide or ignore (e.g., deteriorating job performance, excessive absenteeism, drunk driving, excessive accidents) and the alcoholic is forced to seek treatment in order to save his/her job, marriage, etc. (Scanlon, 1986; Trice & Roman, 1972). It is argued here that a necessary condition for seeking EAP assistance is the awareness by the individual that a health discrepancy exists.

In the present study, control theory was selected as a framework to gain a better understanding of the decision-making process for seeking EAP assistance and to suggest ways to help increase the likelihood of voluntary EAP usage among employees. There are three basic reasons for utilizing this framework: (1) control theory explicitly recognizes that behavior is goal-directed; (2) according to control theory, behavioral and/or cognitive changes of an individual are motivated by an individual's perception

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of a problem or discrepancy existing between what is desired (the goal) and what the individual currently has (the current state). In the present research, it is argued that it is an employee's perception that a health problem exists that motivates the employee to seek EAP assistance; and (3) control theory provides a framework for examining key variables which might influence the decision to seek EAP assistance. Thus, control theory may provide a guiding framework for the present research because it focuses on behavior (e.g., using an EAP) which is motivated by the sensing of a discrepancy between a desired state (the goal) and current health state (e.g., a health problem).

Figure 9 presents a Control Theory Model of EAP Utilization developed for the present research and identifies factors hypothesized to affect an individual's decision to seek EAP assistance. In the model in Figure 9, past research that has examined demographic variables focused only on the last component in the model--the behavioral component--where demographic factors would typically be correlated with EAP usage. However, there is a wide gap between knowing the characteristics of clients who have used EAP services and understanding the complex interrelationships of factors that influence the utilization decision. In the model in Figure 9, it is proposed that the other three control theory components (goal, sensor, and comparator mechanism) also affect the decision-making process of EAP utilization. The present study examines specific variables which might affect some of the control theory model components. It is proposed that control theory will help us to better understand this decision process and will suggest ways to increase the likelihood of use by those individuals who need assistance.

The variables of interest in the present study and the hypotheses of the research will be presented in detail throughout the rest of this chapter. While Figure 9 presents

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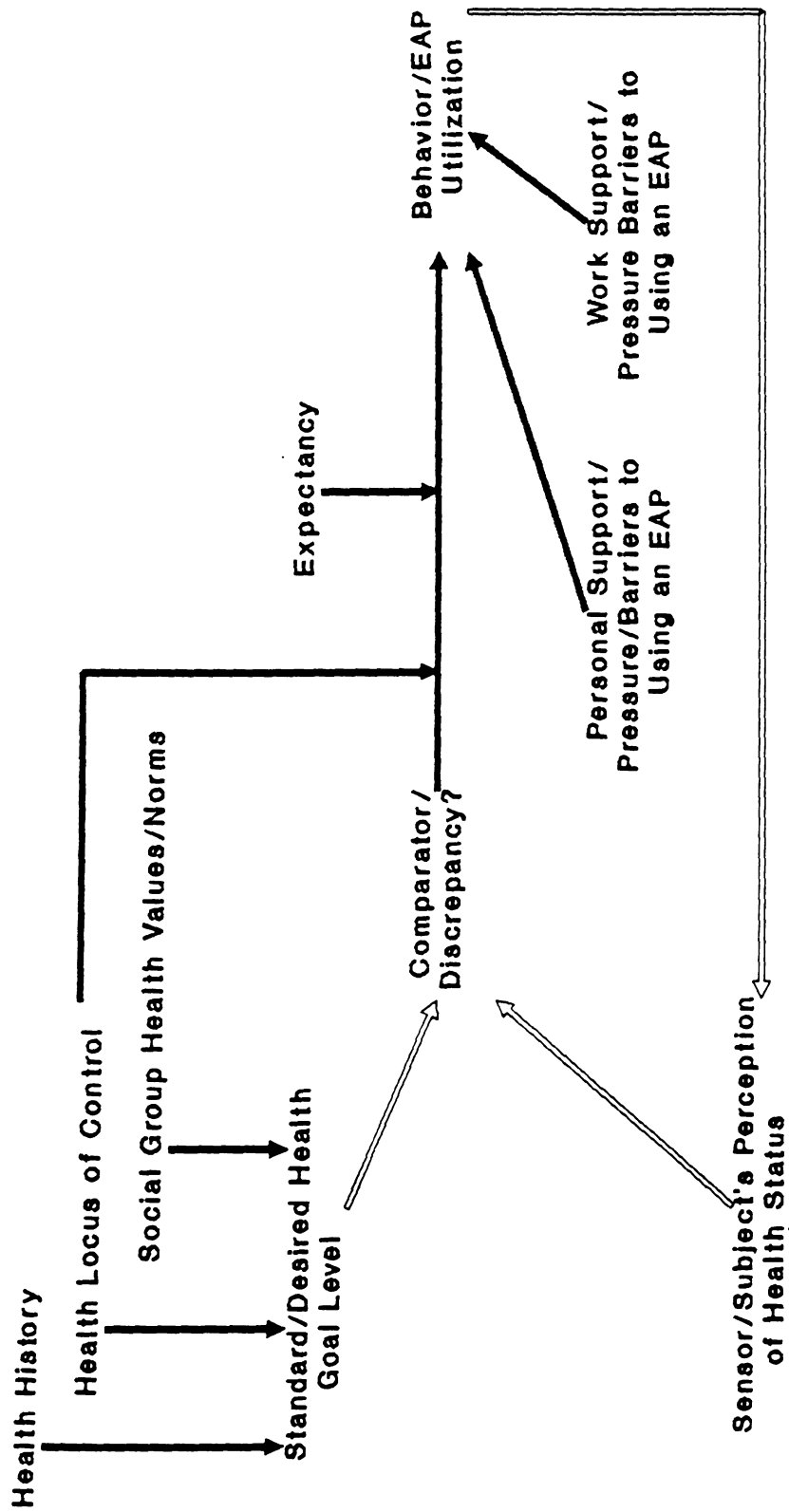


Figure 9: Control Theory Model of EAP Utilization

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the complete model developed for the present study, the model will be tested in sections. There are two types of models that are typically diagrammed like the model shown in Figure 9. The first type consists of causal models where the variables on the left-hand side of the model are hypothesized to influence the variables identified on the right-hand side. The diagram from left to right represents a causal pattern. In the social and behavioral sciences, we are capable of dealing with these types of causal relationships where variable A predicts variable B, or where A and B may be moderated or mediated by a third variable C. The second type of model is similar to a flowchart which diagrams the flow of activities and variables within some process but attempts to make no statement about the nature of the relationships as we progress from one side of the diagram to another.

In the model in Figure 9, it is not possible to test the complete model all at once using typical statistical techniques (such as path analysis or causal modeling) because the comparator/discrepancy variable is not "caused" by the two variables which enter the comparator process. Figure 9 actually represents a combination of both model types--there are two causal models connected by a flow model where the comparison process occurs. Two variables are input into this comparison process--the goal/standard and the sensor data perceived by the individual on the current state. A new variable is created as a result of the comparison process--the individual's perception as to whether a discrepancy exists between the input variables. The comparator mechanism in the model is actually a flow process that represents a connection of the causal left-hand side of the model to the causal right-hand side. Flow and causal models have different purposes. Since the flow model or connection is descriptive, no hypotheses are developed on this aspect of Figure 9. While hypotheses are developed for the causal parts of the model,

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they will have to be tested separately because the flow throughout the model is not completely causally connected. The solid lines in Figure 9 represent predicted relationships among variables in the present research that were examined while the double lines indicate aspects of the flow model which were not directly examined. While the model may not be fully tested, it still might prove to be useful in examining the research question. Once the model is tested in parts, implications of how the parts of the model might fit together will be discussed.

The model will be tested in sections as follows: (1) the causal relationships between the health goal and its predictors will be tested (see Figure 10); (2) the causal relationship between the comparator/perceived discrepancy variable and EAP utilization will be tested along with the moderator and predictor variables hypothesized to influence EAP usage (see Figure 11); and (3) the correlation will be calculated between an individual's perceived discrepancy as measured in #2 above and the discrepancy variable that will be calculated using the goal and sensor inputs to test whether there is a relationship between the actual and perceived discrepancy. Because control theory is based on the motivating influence of the discrepancy variable as calculated using the difference between one's desired goal and current state, it is important to examine the relationship between this calculated discrepancy and an individual's perceived discrepancy as a method check to determine whether the model and relationships might exist as expected.

The Goal/Standard

It has been suggested by various researchers that health behaviors, like other behaviors, are influenced by a person's desired goals regarding health along with a few

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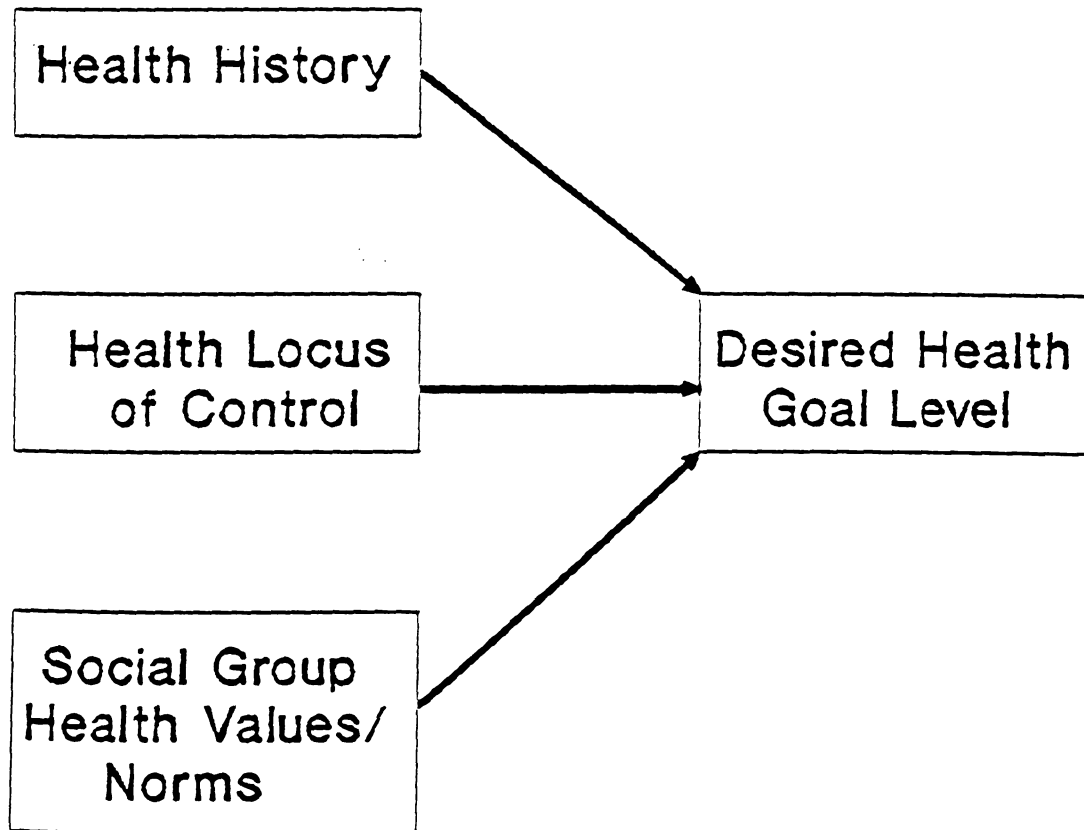


Figure 10: Factors Affecting Desired Health Goal Level

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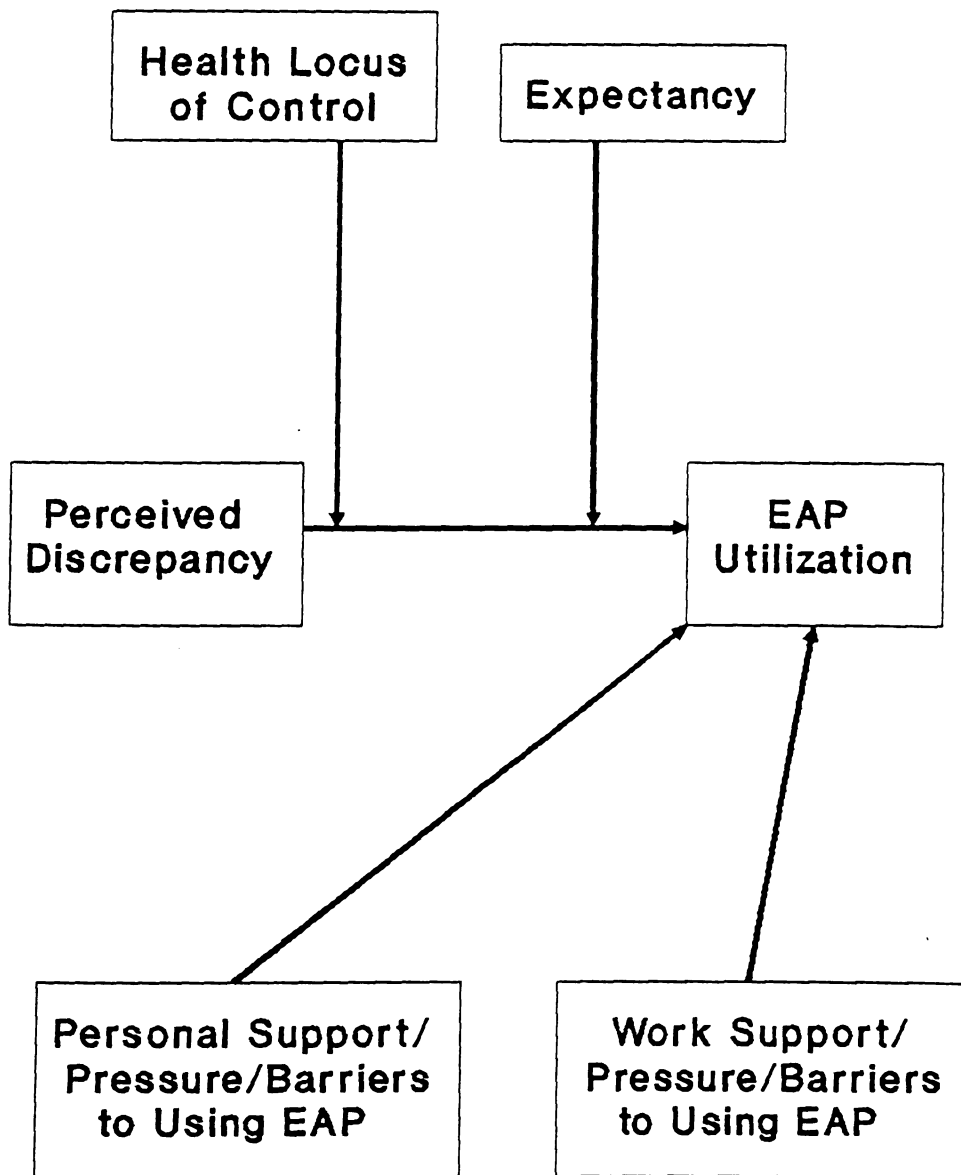


Figure 11: Relationship Between Perceived Discrepancy and EAP Utilization

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other key variables (Christiansen, 1981; DiMarco, 1985; Parcel, Nader, & Rogers, 1980; Richards, 1988). For example, DiMarco (1985) suggested that an individual's concept and attitude regarding health and illness and the nature of health-related activities engaged in are influenced by the life the person leads, his/her values and goals, and the people with whom the individual associates. According to Richards (1988) and Parcel, Nader, and Rogers (1980), whether an individual's behavior is conducive to health is influenced by three factors: (1) the individual's desire to maintain good health; (2) knowledge of behaviors conducive to health and which can minimize health risks; and (3) the individual's belief that his/her behavior can influence his/her well-being (Health Locus of Control). Similarly, Christiansen (1981) found that the importance of health and perceived control were significant predictors of health behaviors and added perceived health status as a third important predictor.

Research supports the conclusion that individuals' goals and values affect behavior. For an individual to be motivated to perform or modify his/her behavior, it is generally assumed that the individual holds some goal or standard regarding that behavior; i.e., behavior is goal-directed (Karoly, 1985; Pender, 1982). A goal is defined as "an aim, a desired end, or a valued outcome" (Pender, 1982). The goal of interest in the present research focuses on the overall health standard an individual desires to maintain--i.e., the level of health desired. It is argued in the present research that for an individual to decide to utilize an EAP, the individual must desire good health in order to be motivated to do something about his/her health when he/she recognizes a health problem (i.e., a discrepancy between desired health goal and current health state).

Health has been defined by the World Health Organization as a "state of complete physical, mental, and social well-being and is not merely the absence of disease or

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infirmity" (Stone, 1979, p. 7). In an examination of perceived health and wellness needs of over 400 university employees, Barker (1987) found the primary concerns of employees included their physical and mental/emotional well-being. It seems reasonable that most individuals will maintain a general goal or desire to be healthy--in fact, individuals have been found to invariably rank health as one of the most valued things in their life (DiMarco, 1985). However, being healthy may take on different meanings for individuals, such as not being under high levels of stress or pressure, being free of physical pain, not being on an emotional roller-coaster, not being overweight, or feeling in control of one's life. In EAP research, an individual's health goal encompasses more than physical health and includes emotional and psychological or mental health since one's health may be influenced by a variety of problems which are typically handled by an EAP (e.g., financial, marital, legal, child-rearing, care of elderly, substance abuse, etc.).

Since human beings prioritize goals and behaviors available to them, not all individuals will necessarily hold the same desired health goal level (Pender, 1982). For example, one individual may be interested in doing something about his/her health only once the individual becomes ill (e.g., visit a doctor) while another individual will desire to take more proactive measures to maintain a healthy state (undertake healthy lifestyle activities such as maintaining a proper diet and sleep habits, exercising regularly, not smoking and drinking, etc.). According to Pender (1982), specific goals desired are a function of internal cognitive processes which determine "what information is received from the environment and how it will be interpreted and structured" (p. 13-14).

Research supports the use of desired health goal level as a significant predictor related to health behavior (Richards, 1988). In research by Kegeles (1969) and Seeman

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and Seeman (1983), the saliency of health (i.e., the desired level) was found to be an important motivator in preventive/protective health behavior. Desiring a healthy state has also been found to be an important predictor in decreasing levels of smoking behaviors (Kaplan & Cowles, 1978). Other research has found that individuals who participate in free medical examinations are those who consider health to be highly desired (Attitudes Toward Co-operation in a Health Examination Survey, 1961; Borsky & Sagan, 1959). However, the relationship between desired health goals and health behavior appears to be inconsistent. In a study by Baughman (1978) on the relationship of locus of control and health goals with health status and behavior, it was concluded that health goals did not predict one's health status or behavior. Similarly, desiring a healthy state did not correlate with the practice of a specific health behavior (breast self-exam) in research conducted by Gramse (1982).

In the present study, based on a control theory view and the belief that behavior is goal-directed, it is suggested that the higher an individual's desired health goal level, the more likely an individual will be to seek EAP assistance when the health goal is not being met. The level of an individual's health goal is hypothesized in the present research to be influenced by three variables: health history, Health Locus of Control, and the health value/norms of one's social group. These variables will be discussed below.

Health History

The first variable hypothesized to influence one's desired health goal level is the individual's health history, or past health status. This variable was selected because it seems logical that the more an individual has previously experienced problems regarding

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his/her health, the more likely the individual will be concerned about preserving a state of good health. When an individual does not feel he/she is in good health, whether it be physically, emotionally, mentally, etc., the individual frequently experiences negative disruptions which impede his/her normal lifestyle. The more frequent one experiences these disruptions, it is assumed that the individual would be more concerned about his/her health. Previous research on the relationship between health history and health goals was not found. However, studies examining the general goal-setting process have reported that some individuals raised their goals after failure while others lowered their goals following success (Campion & Lord, 1982; Kernan & Lord, 1985). If we apply this research to the present study, it might be that the more health problems individuals have previously experienced (failures), the more the individuals would desire to obtain a healthy state. Thus, the hypothesis of interest in the present research is:

Hypothesis #1: An individual's health history will affect the health goal level desired such that individuals who have had more health problems in the past will have a higher health goal level desired than individuals who have had fewer past health problems.

Health Locus of Control

A second variable that has been found to have an impact on health goal levels is an individual's Health Locus of Control. Health Locus of Control (HLOC) is defined as the degree to which individuals believe their health is determined by their own behavior; i.e., the degree to which individuals believe their health is controlled internally or externally (Wallston, Wallston, Kaplan & Maides, 1976; Wallston, Wallston & DeVellis, 1978).

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The general concept of locus of control was included in Rotter's Social Learning Theory where an internal-external locus of control scale was developed to measure beliefs concerning the control of personal destiny. Social Learning Theory is a molar theory of personality that attempts to integrate two diverse trends in psychology--the stimulus-response/reinforcement theories and the cognitive theories of motivation (Rotter, 1975). In the social learning approach, a person is neither driven by inner forces nor controlled entirely by his/her environment (Bandura, 1971). Rotter (1966) dealt with motivation as it related to locus of control and used the term "locus of control" to refer to the expectancy that rewards were contingent upon or controlled by internal or external resources.

According to Rotter (1966), an individual's reaction to an event (reward or reinforcement) is determined by the degree the individual perceives the reward follows from or is contingent upon his/her own behavior or occurs independently of his/her own actions. The locus of control theory postulates that individuals perceive their outcomes or reinforcements as being controlled by forces that fall along a continuum going from almost exclusively self-control (internal) at one end to being controlled primarily by events beyond the control of the individual (external) at the other end. Typically the two extremes describe individuals as follows. If an individual has an "external" locus of control, outcomes following personal actions are believed to be attributed by him/her to luck, chance, fate, the influence of powerful others, or as unpredictable due to the complexity of forces around him/her, rather than resulting from his/her own action. An "internal" locus of control individual perceives outcomes as being determined by his/her own ability, skills, or effort (Rotter, 1966). Research has revealed that internals exhibit more initiative in their efforts to attain goals and control their environment (DiMarco,

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1985). Evidence also exists that those labeled "internals" are more likely to (a) be more aware of environmental cues that provide useful information influencing future behavior, (b) try to improve their conditions, (c) emphasize skill or achievement reinforcements and value their own ability, and (d) show more resistance to others' influence attempts (Rotter, 1966). Individuals are viewed as being predisposed to behave in line with the characteristics at the end of the continuum with which they are associated.

The locus of control construct has been found to be related to a variety of health behaviors (Balch & Ross, 1975; Sonstroem & Walker, 1973), including smoking reduction, birth control utilization, weight loss, adherence to medical regimens, immunization and preventive dental care (Malen, 1982; Pender, 1982). In a review of research on locus of control and health-related behaviors, Strickland (1978) concluded that the majority of research on the relationship between locus of control and precautionary health practices provides evidence that individuals with an internal locus of control seek more information on health maintenance and take more responsibility for their health behavior than externals. For example, Seeman and Evans (1962) compared locus of control and the learning of behaviorally relevant information in a hospital population and found that a person's sense of personal control was a factor in determining the level of interest and the degree of knowledge possessed concerning his/her illness. Internally-controlled individuals possessed more knowledge about their illness than externally-controlled individuals.

Others have concluded, however, that the early studies did not produce consistent results (Wallston & Wallston, 1978). For example, in studies on smoking behavior, locus of control was found to be a relevant factor where non-smokers tended to be internals (James, Woodruff & Werner, 1965) and individuals who valued health and who were

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internally-oriented on health were more successful in changing their smoking behaviors (Kaplan & Cowles, 1978). However, conclusions from research on birth control utilization (Fisch, 1974; Harvey, 1976) and weight loss (Balch & Ross, 1975; Wallston & Wallston, 1978) are more ambiguous.

The locus-of-control construct distributes individuals based on the degree they accept personal responsibility for what happens to them, which is influenced by past reinforcement experiences. The idea that an individual develops a belief about an internal or external locus of control is now thought to be situation-specific (DiMarco, 1985). Therefore, it was suggested that one reason for the inconsistent research findings is that the initial scale was not designed as a specific health measure but as a global measure of reinforcement expectancy across a wide range of potential situations. Therefore, to better apply this concept to the field of health, Wallston, Wallston, Kaplan, and Maides (1976) developed a unidimensional Health Locus of Control (HLC) scale to measure the degree to which people believe their health is determined by their behavior (i.e., is internal or external). Another revision of the I-E scale was undertaken because it was felt that the definition of externality was too broad. Thus, in 1978, the HLC scale was modified when it was found that Health Locus of Control did not appear to be a unidimensional construct--some health-externals believed fate or chance was responsible for their health while other health-externals saw powerful others (e.g., health care professionals) responsible for their health. The new scale is known as the Multidimensional Health Locus of Control (MHLC) Scale and includes three sub-scales: the Internal Health Locus of Control (IHLC) Scale, the Powerful Others Health Locus of Control (PHLC) Scale, and the Chance Health Locus of Control (CHLC) Scale (Wallston, Wallston, & DeVellis, 1978). Individuals are still classified as being either

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"internals" (using the IHLC scale) or "externals" (using the PHLC and CHLC scales since these are both dimensions of externality). It should be noted that while the developers of this scale found it useful, they cautioned that it should not be the only factor used to explain health behavior--that "only in interaction with one, or preferably more of a multitude of contributing factors, will beliefs in the locus of control of health play a significant role in the explanation of health behavior" (Wallston et al., 1978, p. 168).

The new scales have been administered in health research. For example, Schultz (1981) found that using the Health Locus of Control Scale, adolescent cystic fibrosis patients who were internals were more likely to arrange and keep clinic visits than externals. Seeman and Seeman (1983) found that one's health motivation (i.e., value or concern placed on health) and an internal locus of control resulted in individuals practicing more positive health behaviors than those with an external locus of control.

In the present study, the perception of control over one's health is suggested to be a key factor in influencing one's desired health goal level. It has been suggested that individuals with an "internal" locus of control are less likely to reject setting difficult goals; however, it would be unrealistic for "externally oriented" individuals to set difficult goals (Hollenbeck & Brief, 1987). The hypothesis to be examined is:

Hypothesis #2: An individual's Health Locus of Control will affect the health goal level desired such that individuals who score higher on the Internal Health Locus of Control subscale will have a higher desired health goal level than individuals who score lower on the internal scale or higher on either of the External Locus of Control subscales (Powerful Others or Chance).

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Social Group Health Values/Norms

The third set of variables hypothesized to influence an individual's desired health goal level are the health values and norms of members of one's social group--past and present. It was hypothesized that the health attitudes and norms possessed by members of one's social group would influence the degree individuals desired to maintain healthy goals. A norm is defined as a "generally agreed upon pattern of appropriate behaviours, beliefs, attitudes, etc." (Winefield & Peay, 1980, p. 234). Meanings are given to physical and psychological experiences as a result of "cultural conditioning in the family, by exposure to peers, and through the mass media" (Mechanic, 1982). A person's attitude is a function of one's personal nature and attitudes as well as one's social group influences (Ajzen & Fishbein, 1980; Fishbein, 1966). Social influence occurs when "one person or group induces a change in the behaviour (overt behaviour or internal thoughts and feelings) of another" (Winefield & Peay, 1980, p. 225). It is an individual's socialization process which determines how the individual learns to participate and function in society through exposure to other individuals and the transmission of values, norms, attitudes, preferred behavioral patterns and expectations, and sanctions of a group (Clausen, 1968a; Goslin, 1969; Hammitt, 1984; Loy & Ingham, 1973).

Social agents or social group members include an individual's family, social class, ethnic group, and others who contribute to the development of social roles (Clausen, 1968a). "Socialization" is a continual interactive process between an individual and the values and expectations held by the larger social group (Brim, 1968; Clausen, 1968a). This lifelong process varies by the situations and socializing agents an individual interacts with (Inkeles, 1968). For example, socializing agents vary as one ages, with the family and school groups acting as primary socializing agents for children, and peers, work and

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other groups becoming more influential as one matures (Clausen, 1968b; Loy, McPherson & Kenyon, 1978).

The medical field has recognized the importance of social factors on disease etiology and health behaviors, as evidenced by the emerging field of cultural medicine with its interest in examining the influence of social factors on health behaviors (Mayer, 1988). An individual's social group can influence an individual's health behavior by affecting attitudes and beliefs or by forcing an individual to conform to group behavioral norms (Pender, 1982). According to Pender (1982), "family patterns of health care influence the emerging values and lifestyles of offsprings" (p. 73). Mechanic (1978) examined the antecedents of various health and illness responses and behaviors over a 16-year period and concluded that sick-role behavior is, in part, learned during one's childhood. Children learn through the health behaviors they observe in others as well as through their own health experiences (Pender, 1982). Rosenstock (1975) cited the importance socialization into one's family had on an individual's lifelong health patterns. Mothers appear to be important role models for the health behavior of their children since a high correlation was also found by Tyroler, Johnson and Fulton (1965) between the behavior of mothers and their children. Bruhn and Cordova (1977) stated the "value placed on health and the level of knowledge about health by parents represents an important influence on how a child will be reared with respect to health attitudes and behavior" (p. 248). It is this "parental modeling" which helps a child develop a health concept, health goals, and perceive a responsibility and control over one's own health (Bruhn, Cordova, Williams & Fuentes, 1977).

Concepts of health and illness are influenced by "parents' attitudes and actions before children understand the significance of these attitudes and actions on their own

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Hypothesis #3

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health behavior" (DiMarco, 1985). However, other members of one's social group can also influence an individual's attitude toward health and health behaviors. "When children grow older . . . their attitudes and habits . . . are influenced by new health information, varying social contacts, and demands made upon them by school, jobs, and family relationships" (DiMarco, 1985). "Conversations with others regarding their patterns of exercise, nutrition habits, rest and relaxation, management of stress, and interpersonal relationships" have been found to act as cues for one's health behaviors (Pender, 1982). Health norms may exist both within an individual's nonwork and work groups and within an entire organization, which all act as regulators of health attitudes and behaviors. Different groups may desire to maintain health-related behaviors differently.

Of particular interest in the present study is whether the health values and norms of others influence the level of health goals desired by an individual. Because an individual typically chooses members of his/her social group, it is likely that a certain degree of uniformity of goals, attitudes, and norms will prevail among group members. In the present research, an individual's perception of the health norms and values of members of his/her social group will be examined to assess their impact on the individual's health goal level desired. The hypothesis of interest is as follows:

Hypothesis #3: An individual's perception of the health values and norms of his/her social group members will affect the health goal level desired such that an individual who perceives high general health goals and positive health norms of members of his/her social group will have a higher health goal level desired than an individual who perceives members of his/her social group hold lower health norms and values.

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Summary of the Health Goal Component

The specific overall goal or standard of interest in the present research is the individual's desired health goal level--which includes the desire to avoid illness or problems as well as recover from illness or problems. It is suggested that individuals vary in the extent they desire to maintain good health. Three specific variables were hypothesized to impact on the level of one's health goal: health history, Health Locus of Control, and the health attitudes, values, and norms held by members of one's social group. The next section will discuss the second major component of the Control Theory Model of EAP Utilization--the Sensor Function.

The Sensor/Feedback Function

The second primary element in the Control Theory Model of EAP Utilization is a sensor function which activates the process through which an individual perceives environmental stimuli and responds to them. In the present model, the sensor function receives feedback from the environment regarding one's present health status and health symptoms. Research has indicated that for the effective regulation of behavior, a control system depends on the interaction of goals and feedback to affect performance (Bandura & Cervone, 1983; Erez, 1977; Locke, Shaw, Saari & Latham, 1981). Feedback, therefore, is necessary along with the goal or standard in order to initiate a discrepancy-reducing response if a discrepancy exists. It is the discrepancy between the goal and the present state that leads to behavior (Winefield & Peay, 1980). According to the model, the sensing process is a dynamic one where an individual is continually monitoring his/her health status.

In the Control Theory Model of EAP Utilization presented in Figure 9, initially an

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individual's current health status is perceived by the sensor function. The individual's health status is then compared to the standard or desired health goal level via the comparator mechanism. This sensing-comparison process is repeated until a discrepancy is perceived between the desired health goal and perceived health state. Once a discrepancy is perceived and a behavioral response occurs (e.g., seek treatment), then the behavioral outcome (i.e., from the treatment) along with the current health status/symptoms are fed back into the sensor function and the sensing process is repeated.

While this sensor component is an important element in the Control Theory Model of EAP Utilization, no hypothesis will be examined on this aspect of the model. An individual's perceived current health state will be measured using the Current Health Problems scale developed for this research (see Part VII, Appendix B).

The Comparator Mechanism

The comparator mechanism is the third primary component in control theory. Two variables are input into the comparator mechanism to create a third variable--the perceived discrepancy between the desired and current state. Once the sensor function is activated whereby an individual perceives his/her current health status, the comparator mechanism compares the individual's desired health goal with his/her current health status as perceived by the sensor function. The outcome of this comparison process is a perception or decision regarding whether a discrepancy exists between the desired goal and current state. According to control theory, if an individual perceives no discrepancy, then a discrepancy-reducing response need not necessarily be undertaken. Instead, the individual continues to monitor and compare his/her current health

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As previously discussed, it is not possible to test this aspect of the model directly using a causal model because the comparator process is a flow-type model and the two variables which are input into the comparator/discrepancy process (the goal and the sensor/perceived health status) are not predictor or causal variables of the outcome of the comparator/discrepancy process (i.e., the discrepancy variable). Rather, the model in Figure 9 is one of a flow-chart type of model connecting two causal models and at the connecting point the model is discontinuous. Two variables are input into the connection or comparator process (an operator) and a third variable flows out of that process. In the case of the model in Figure 9, the variables going into the flow model are the health standard and the sensor (health status) data (shown via double lines) and the variable coming out is a perceived discrepancy variable.

In control theory, the perceived discrepancy variable is typically created by subtracting the sensing function's output from the desired goal to determine whether they are similar--i.e., whether a discrepancy exists. Therefore, to study this aspect of the model, an examination was conducted on whether there was a correlational relationship between the discrepancy variable computed using measures of the desired goal and

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current health state and a variable of perceived discrepancy as measured by an individual's perception of whether a discrepancy exists. This relationship was examined as a method check on the validity of the discrepancy variable to see if the model might be working as expected. If a strong relationship existed, then use of control theory as a framework for understanding the EAP decision process might be considered useful. If there was not a strong relationship, then control theory may not be as helpful as has been suggested here in understanding an individual's motivation to seek EAP treatment because it may not be the actual discrepancy between an individual's desired goal and health state which motivates a response. There is no hypothesis covering the relationship to be examined here, but a method check will be conducted to verify the usefulness of this framework. The next section will present the last main component of the Control Theory Model of EAP Utilization--the behavior/effector component.

The Behavior/Effector Component

The behavior/effector component is the discrepancy-reducing response undertaken when an individual perceives there is a discrepancy or error between the desired and current state. In the present study, the behavior of interest, which is the dependent variable, focuses on whether an employee utilizes EAP services after an individual has compared his/her desired state with his/her current health state.

This aspect of the Control Theory Model of EAP Utilization to be tested is presented in Figure 11 where it is hypothesized that two variables will moderate the relationship between perceived discrepancy and EAP utilization: (1) Health Locus of Control, which consists of three subscales or variables, and (2) expectancy of goal attainment. Two additional variables, personal support/pressure/barriers and work

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support/pressure/barriers, are hypothesized to have a direct effect on EAP utilization, regardless of whether a discrepancy is perceived. These relationships will be discussed below.

In general, it is suggested that whether an individual responds to a discrepancy depends on whether an individual possesses an internal or external Health Locus of Control and a high or low expectancy that the EAP will help lead to goal attainment. Based on the model in Figure 9, if an individual is high on the Internal Health Locus of Control (HLOC) subscale or perceives a high expectancy, then the individual is more likely to behaviorally respond to a discrepancy and utilize EAP services. However, if an individual is low on the Internal HLOC subscale or high on either of the External HLOC subscales (Powerful Others or Chance) or perceives a low level of expectancy, then the individual is more likely to cognitively respond when a discrepancy is perceived. A cognitive response might be in the form of modifying the individual's health goal or altering the interpretation of health symptoms/status. The interest in the present study is on whether the individual responds behaviorally by seeking EAP assistance. The variables hypothesized to influence the behavioral response will be discussed below.

Health Locus of Control

Health Locus of Control has previously been discussed as a variable potentially affecting the level of an individual's desired health goal. The present research will also examine this variable as to whether it has a moderating influence on the relationship between a perceived discrepancy in a person's health and the decision to seek health assistance at an EAP. As previously mentioned, individuals tend to hold primarily an

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internal or external view of power. Health Locus of Control is the degree to which individuals believe their health is determined by their own behavior (Wallston, Wallston, Kaplan & Maides, 1976; Wallston, Wallston & DeVellis, 1978). If an individual has an external locus of control, outcomes following one's actions are perceived as being determined by luck, chance, fate, the influence of powerful others, or as unpredictable due to the complexity of forces around him/her, rather than being entirely contingent on one's own action. An individual with an internal locus of control perceives outcomes as being determined by his/her own ability, skills, or effort (Rotter, 1966) and generally is more assertive in shaping his/her environment (Pender, 1982).

Health Locus of Control was chosen as potentially having a moderating impact on the health behavior decision process because it involves an individual's belief that his/her personal behavior can make a critical difference in the individual's present and future health. Lau (1982) utilized the Multidimensional Health Locus of Control scale (with its three subscales--Internal, Powerful Others, and Chance) and concluded that self-control over health was a good predictor of self-care behavior (p. 328). It seems that unless an individual believes his/her behavior can have a direct impact on his/her current and future health, little motivation will exist to seek health assistance and take responsibility for his/her health. According to Rosenstock (1975):

Ongoing research suggests that external control, alienation or powerlessness are associated with higher rates of morbidity, lower rates of compliance, lower health motivation, reduced tendency to seek behaviorally relevant information, reduced utilization of health care services, and reduced ability to control weight, smoking and use of alcohol and other drugs (p. 135).

Health Locus of Control was examined in studies on smoking behavior, and it was found that nonsmokers and those who quit smoking tended to be more likely to have an internal orientation (Best, 1975; Coan, 1973; James, Woodruff, & Werner, 1972; Platt,

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1969; Williams, 1972 as cited in Pender, 1982, p. 63). Health Locus of Control has also been examined in relation to weight and weight loss; however, the results are equivocal. For example, O'Bryan (1972) found that overweight individuals tend to be more externally controlled than those of normal weight, and Balch and Ross (1975) concluded success in a weight loss program was found to occur more among those internally oriented. However, Bellack, Rozensky and Schwartz (1974) found no significant correlation between weight loss and locus of control.

In other health-related research, individuals who are internally controlled have reported more frequent use of seat belts than those externally controlled (Williams, 1972). In addition, the importance of an individual's HLOC has also been supported in research on the use of birth control where internals tended to practice birth control more compared with externals (McDonald, 1970). Finally, the MHLC was administered to participants and nonparticipants in a work site fitness program by O'Connell and Price (1982) who found that participants in the program were more internally oriented than nonparticipants.

There is evidence that locus of control is relevant to predicting health behaviors. The following set of hypotheses, which are outlined in Figures 12a to 12c, are to be examined in the present research:

Hypothesis #4a: Internal Health Locus of Control (HLOC) will moderate the relationship between perceived discrepancy and EAP utilization. Individuals who are high on the Internal HLOC subscale will respond to a perceived discrepancy between their desired and current health by utilizing an EAP more than those who are low on the Internal HLOC subscale.

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Figure 12a:

Hypothesis #4a

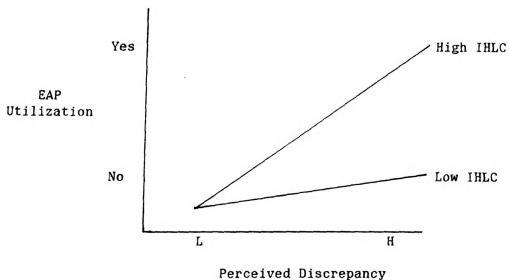


Figure 12a: Hypothesized Relationship of Internal Health Locus of Control (IHLC)

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Figure 12b:

Hypothesis #4b

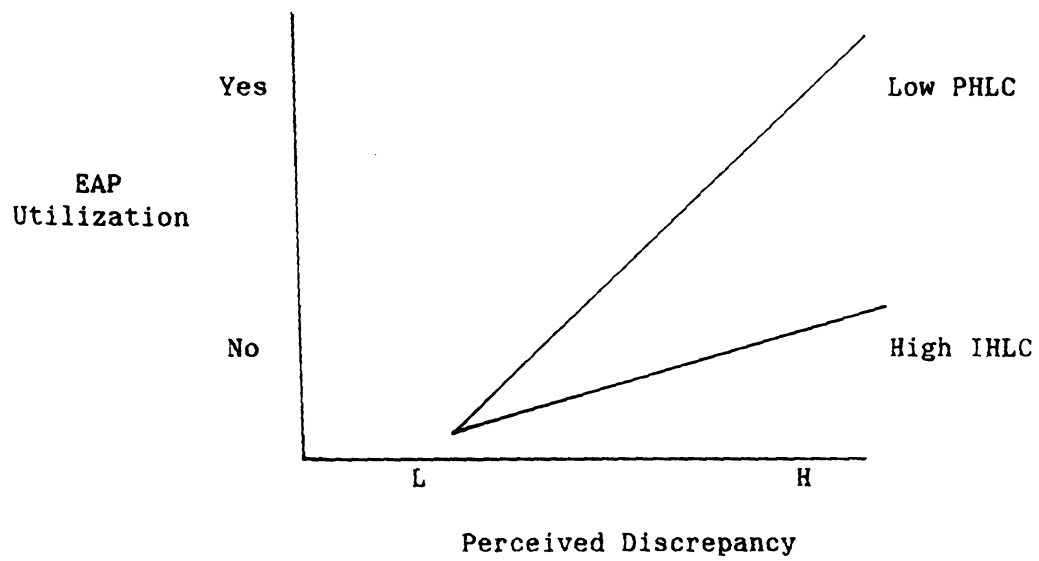


Figure 12b: Hypothesized Relationship of Powerful Others Health Locus of Control (PHLC)

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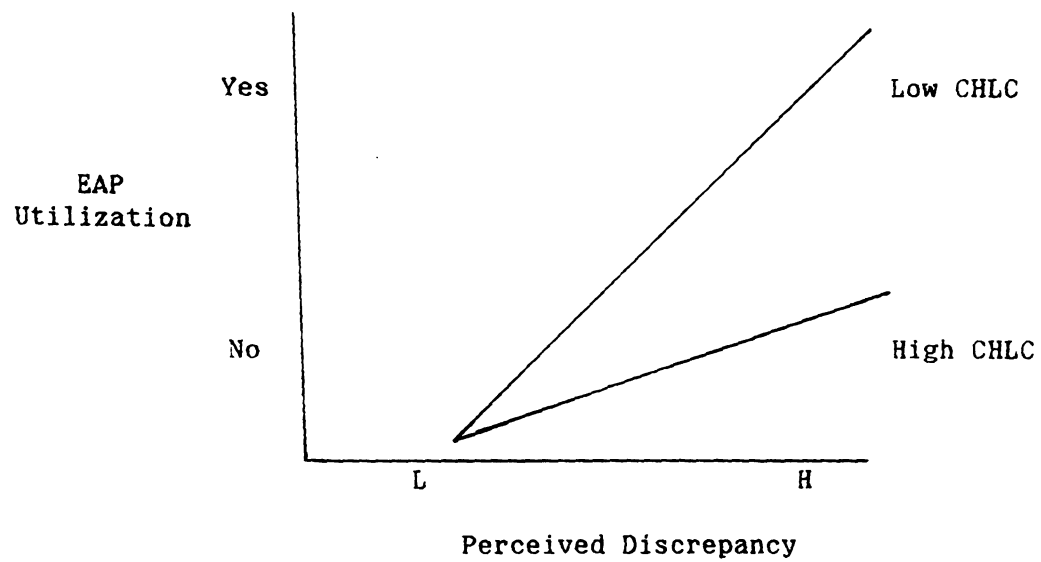


Figure 12c: Hypothesized Relationship of Chance Health Locus of Control (CHLC)

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Hypothesis # 4b: Powerful Others Health Locus of Control (HLOC) will moderate the relationship between perceived discrepancy and EAP utilization. Individuals who are low on the Powerful Others HLOC subscale will respond to a perceived discrepancy between their desired and current health by utilizing an EAP more than those who are high on the Powerful Others HLOC subscale.

Hypothesis # 4c: Chance Health Locus of Control (HLOC) will moderate the relationship between perceived discrepancy and EAP utilization. Individuals who are low on the Chance HLOC subscale will respond to a perceived discrepancy between their desired and current health by utilizing an EAP more than those who are high on the Chance HLOC subscale.

Expectancy

The second variable hypothesized to moderate the relationship between a perceived health discrepancy and the discrepancy-reducing response is the individual's expectancy, which refers to the individual's perception that a given action will achieve the desired goal; i.e., the belief that a specific health action will prevent or ameliorate illness. Expectancies are considered to be important in determining whether behavior will be initiated, the amount of effort exerted, and whether effort will be sustained over time (Bandura, 1977b; 1982).

Expectancy ties into Rotter's (1954) social learning theory, which postulates that behavior is influenced by the expected probability of an outcome occurring. An individual will act if he/she believes the behavior will lead to the goal/reinforcements (expectancy). Control theory models have also emphasized the importance of outcome expectancies in determining whether (a) behavioral or cognitive changes occur (e.g.,

Taylor et al., 1984) and (b) whether the individual withdraws or persists (e.g., Carver & Scheier, 1981).

As previously discussed, self-regulation is also a key concept in control theory. The concept of expectancy is relevant to the self-regulation of health process since an individual's expectancy regarding a particular health behavior has been found to have an important influence on behavior and on the direction of actions. For example, one's expectancy of being able to eliminate a discrepancy (e.g., high blood pressure) in order to meet the goal (e.g., normal blood pressure range) can have an influence on the type of outcome that occurs (i.e., whether an individual takes medication, modifies diet, etc. depends on whether the person feels the behavior will reduce his/her blood pressure).

In the present research, expectancy refers to the employee's perception of the likelihood that utilizing an EAP will help lead to the achievement of the individual's health goal and the reduction or elimination of the perceived discrepancy between the desired and current state. According to the model developed in the present research, if an individual's expectancy regarding the attainment of his/her goal is high, meaning that he/she believes the seeking of assistance at an EAP will improve one's current and future health state and reduce the perceived discrepancy, then it is more likely the individual will seek EAP assistance. However, if an individual's expectancy regarding the EAP's ability to achieve the health goal is low or poor, then the individual will decide to not make use of EAP services.

Expectancy that an EAP will help reduce/resolve health problems can be influenced by an individual's expectations regarding the benefits to seeking EAP assistance. Thus, the more benefits perceived by an individual to using EAP services, the higher one's perceived expectancy might be regarding the EAP's ability to help. Prior research

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examining health behaviors has identified a number of benefits or motivators that have been found to influence not only an individual's belief that seeking assistance will help but also influence the actual seeking of assistance. Some of these benefits or motivators for health and help-seeking behaviors include:

(1) a desire for social approval (Gochman, 1971; Haefner & Kirscht, 1970; Pender, 1982);

(2) a desire to avoid disease, improve health, or receive approval from significant others (Antonovsky & Kats, 1970);

(3) the ability of the program to provide strategies to reduce stress, reduce depression, improve one's self-concept, improve overall health, improve one's work performance/career (Straussner, 1986), help employees recover from alcoholism, save employees' jobs, improve morale, save money (Straussner, 1986), promote psychological well-being, and decrease anxiety (Sidney & Shephard, 1976).

In addition to the above motivators or benefits that might influence one's belief in the success of an EAP (i.e., expectancy), another factor hypothesized to influence a person's expectancy is an employee's prior experience with an EAP and whether that experience was positive or negative. Prior experience has been found to be a factor influencing one's future behavior (Bandura, 1982; Carver & Scheier, 1981). For example, Ajzen and Fishbein (1980) suggested the strength of the attitude-behavior relationship may be moderated by the direct experience one has with the object.

Expectancies have been found to increase after success and fall after failure regarding the specific behavior (Feather, 1966, 1967; Feather & Saville, 1967). Prior experience regarding usage of an EAP has also been found to influence an individual's future expectancy on the EAP's ability to assist employees. Pardue (1987) found that

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of 200 clients surveyed, 98% stated they would recommend the EAP to others, 71% were very satisfied with the service provided, and 85% reported they experienced improvement in their problem situation. Ford and McLaughlin (1981) found that the highest group willing to use EAP services was the group of former EAP users.

In the present research, expectancy is hypothesized to moderate the health-seeking behaviors of an individual. Therefore, the hypothesis to be examined regarding the expectancy variable, which is presented in Figure 13, is:

Hypothesis #5: Expectancy regarding the ability of the EAP to resolve or improve an individual's perceived health problems will moderate the relationship between perceived discrepancy and EAP utilization. Once a discrepancy is perceived between an individual's desired and current health, an individual with a high expectancy regarding the EAP will seek assistance from the EAP more than an individual with a low or poor expectancy.

Support/Pressure/Barriers

The next variables hypothesized to influence whether an individual seeks assistance at an EAP are the perceived social support or social pressure along with perceived barriers from both work and non-work sources that encourage/discourage the individual to make use of EAP services. House (1981) has defined social support as a "flow of instrumental aid, information, and/or appraisal (information relevant to self-evaluation) between people" (p. 26). Social support involves interpersonal transactions that include one or more of the following elements: affect, affirmation, and aid (Kahn & Antonucci, 1980). Others have identified different types of social support in terms of the functions served by each type: emotional, informational, instrumental, and belongingness (Cohen

Hypothesis #5

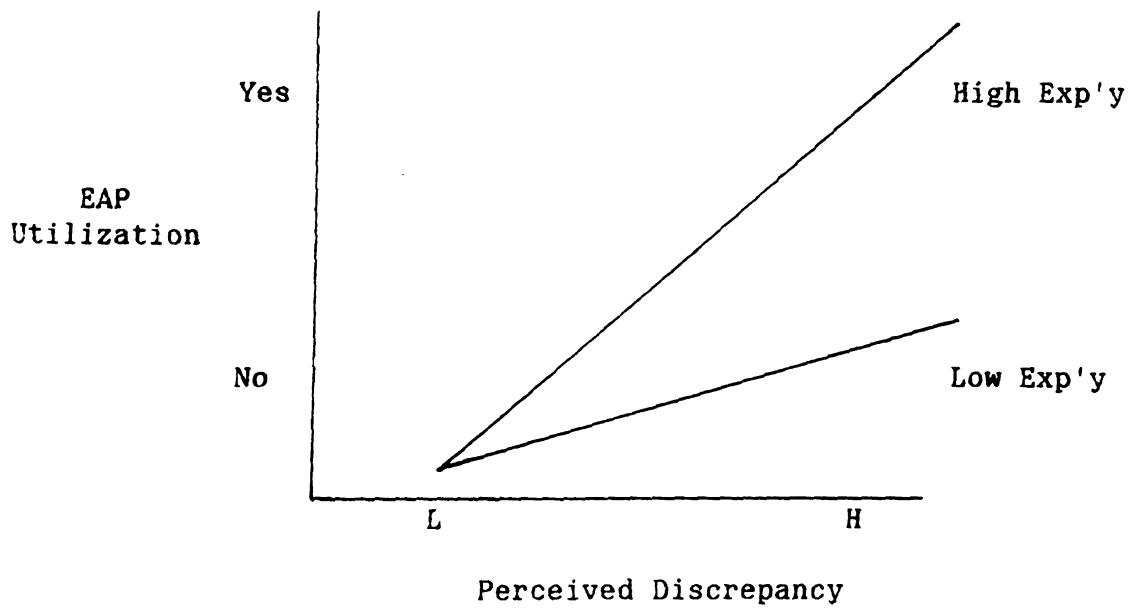


Figure 13: Hypothesized Relationship of Expectancy (Exp'y)

Hoberman, 1983; Spacapan, 1988).

People within an individual's social environment (e.g., family, social group, peer group, school, coworkers, supervisors, etc.) may provide strong support in goal attainment and problem-solving in a variety of social situations (Loy, McPherson & Kenyon, 1978; Wynne, 1986). Haskell and Blair (1980) emphasize that the attitudes and actions of those with whom a person interacts determine whether an individual will participate and adhere to some activity. Similarly, Fishbein (1966) predicts a person will engage in a specific behavior if the behavior is evaluated positively and if the individual perceives that others within his/her social group think it should be performed. This subjective norm may exert pressure to perform or not perform a behavior that may be independent of a person's attitude toward the behavior (Hammitt, 1984). Therefore, one's personal perception of the social pressure to perform or not to perform a behavior is a key influence on behavior (Ajzen & Fishbein, 1980). For example, Anderson and Markus (1973) examined the health behaviors of students enrolled in a university health center and found that the more positive students perceived the attitude of others was toward the student health center, the more positive was the students' own view toward health services, which in turn influenced their utilization of services. Of interest in present research is the encouragement/discouragement received by other individuals regarding the seeking of assistance and the utilization of EAP services.

Also of interest are the perceived barriers to using an EAP. While individuals may believe an EAP can help reduce/resolve their problem(s), they still may not seek assistance because of perceived barriers or costs. These barriers might also be classified into two categories--those perceived to exist that are not related to the work environment and those that are related.

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In the present research, it is hypothesized that social support/pressure from both individual's personal life as well as work life along with perceived barriers related to one's personal and work environments will directly influence the decision to seek help. It is suggested that these variables will directly influence an individual's behavior rather than moderate the relationship between a perceived discrepancy and EAP usage because an individual may seek EAP assistance due to pressures from sources in one's work or non-work environment even when the individual does not perceive there is something wrong with his/her health (a discrepancy). However, when combined with barriers, social support/pressure may have a different influence on EAP utilization. These combined variables will be examined in the present research.

In this research, support/pressure from the work environment was separated from support/pressure received from other individuals in one's personal life because it has been suggested that these may be separate constructs. Mayer (1988) noted that there has been a sparse evaluation of management support as a significant variable in health research and that there appears to be no empirical evidence that management support has a significant effect on health promotion efforts at the work site. Mayer notes that for social system variables, such as norms and social support, have been examined as their influence on health behavior and suggests that management support is often incorporated into the global construct of "social support," which generally refers to all types and forms of support behavior provided to an individual, rather than being defined as a separate concept. Mayer and others suggest that social support from family, friends, and significant others one socializes with is not the same construct as management-based support within an organization (Broadhead et al., 1983; Bruhn & 1987; Mayer, 1988). Therefore, the present research will examine social

support/pressure regarding the seeking of assistance at an EAP that is received from individuals both outside and within the workplace. In addition, as previously mentioned, barriers to using an EAP can also be classified into those related to one's personal or work environments. Sources of support/pressure that might be received from individuals within one's personal life along with personal barriers will be discussed first and then possible sources of support/pressure and barriers from the work environment will be presented.

Personal Sources of Support/Pressure and Barriers

There are several sources of social support within an individual's personal life which might influence the person's behavior. These include support from parents and relatives, friends, and others with whom an individual socializes with outside the workplace. Social support has been examined in health research and found to influence participation in health activities (Hammitt, 1984; Merriman, 1984; Snyder & Spreitzer, 1973), adherence, and changes in health behaviors (Terborg, 1988 as cited in Mayer, 1988). However, while social support has been examined in health research, such as its effect on participation and adherence to treatment, (Broadhead et al., 1983; Leavy, 1983), Terborg (1988, as cited in Meyer, 1988) suggests the results from this research are equivocal.

Blackwell (1979) believes that the family plays an important role in reinforcing appropriate health behaviors and eliminating inappropriate health behaviors. Caplan (1976) found that individuals reporting high levels of social support tend to perceive their hypertension treatment as more beneficial than costly. Individuals who discussed mental problems with their family and friends have also been found to be more likely to

seek preventive dental visits compared with those reporting no such discussions (Antonovsky & Kats (1970). Haskell and Blair (1980) found that pressure from one's social group influenced the success of motivating individuals to maintain a more active lifestyle.

Warren (1982) indicates that health-seeking behaviors often require informed referral agents to encourage the seeking of assistance. He estimates that 90% of those who self-refer for help do so after talking with a natural helper. In EAP research, Champion (1988) demonstrated that external sources of support influence whether clients follow through on EAP referrals. In another study by Pardue (1987) on 200 users of an internal EAP, clients stated their awareness of the EAP's existence came through company publications (30%), company training (24%), fellow employees (17%), and a supervisor (11%). While most clients in the Pardue (1987) study stated they were self-referred (79%)--primarily because they saw their own job performance deteriorating--the remaining used the EAP as a result of suggestions by the supervisor, fellow employees, family members.

In addition to support, encouragement, and pressure from sources in one's personal life that might influence an individual's decision to seek assistance at an EAP, there may be a number of barriers or obstacles that exist that can influence an individual's decision to not seek EAP assistance. A number of EAP experts have identified several barriers that might deter EAP usage. The present research has classified some of these barriers as being from "personal" sources, which means they are barriers perceived by an individual to exist outside of his/her workplace. Some of these barriers include:

- (1) inconvenience, unavailability, or difficulty in attending the EAP (Ultsch, 1983);
- (2) competing responsibilities (Langlie, 1977);

(3) a stigma associated with many problems which an EAP addresses (e.g., alcoholism, drug dependency, and mental and behavioral problems) where an individual is afraid friends/family will perceive the person as being weak or deviant (Roth, 1981; Vrich, 1980). Such stereotyping has been associated with mental health issues (Nunnally, 1961), where an employee may be perceived as pathological, uncooperative, incurable, untreatable, or has having some inherent character defect because of such problems (Mierkiewicz-Alleva, 1986);

(4) financial problems, such as poor insurance benefits or limited coverage for some treatments (Dickman & Emener, 1982; Straussner, 1986);

(5) perceived barriers regarding the EAP itself: limited EAP staff availability, lack of 24-hour coverage, lack of attention on prevention (Straussner, 1986), failure to provide services to meet all the person's needs, lack of follow-up (Dickman & Emener, 1982; Straussner, 1986), lack of confidence in the EAP staff (Hung, 1988), and lack of appropriate relationship with community mental health, drug, and alcoholism agencies (Thoresen, 1978);

(6) lack of knowledge on how to contact the EAP;

(7) availability of other resources (Marino, 1985).

It is hypothesized that the combination of both support/pressure and barriers from "personal" sources will have a direct influence on an individual's decision to utilize EAP services. This new "combined" variable called "personal support/pressure/barriers" will be examined in the present study. In the Control Theory Model of EAP Utilization developed in the present research, it is predicted that this variable may influence an individual's seeking of EAP assistance regardless of whether the individual has actually perceived a discrepancy in his/her health between the desired and current health state.

For example, while an individual may not think he/she has a health problem, such as when an alcoholic denies such a problem, the person may still go to an EAP because his/her spouse encourages/pressures him/her to go. However, if the person also perceives too many barriers to seeking assistance, then despite this spousal pressure, the person may still not seek assistance.

The hypothesis to be examined is:

Hypothesis #6: An individual's perception of the combination of support/pressure and barriers from "personal" sources to seeking EAP assistance will have an effect on the individual's utilization of EAP services. Individuals who perceive high levels of support or pressure to seek EAP assistance and few barriers will tend to have contacted the EAP for assistance more than individuals who report low levels of support or pressure and many barriers to seeking assistance.

Work-related Sources of Support/Pressure and Barriers

The second form of support and barriers which might influence an individual's decision to seek EAP assistance occurs at the workplace. Glasgow and Terborg (1988) and Syme (1986) indicate that organizational factors are likely to influence occupational health interventions and outcomes. Individuals at the workplace are a captive audience of coworkers, managers/supervisors, members of the labor union, and the organization itself.

Four different types of support at the work site will be discussed: from coworkers, immediate manager/supervisor, unions, and the organization itself. Following this discussion, work-related barriers to EAP utilization will be discussed. While work group studies (Coburn & Pope, 1974; Green, 1970; Kirscht, 1983) and management support

have frequently been cited as two key organizational factors influencing behavior (Beer, 1980; Everly & Feldman, 1984; Felix et al., 1985; French & Bell, 1984; Mayer, 1988), empirical evidence regarding their influence on EAPs is minimal (Mayer, 1988).

The first potential source of work site support/pressure is an individual's coworkers or work group. Gottlieb (1982) views coworkers as natural helpers at the workplace who can help an individual change a situation by providing assistance and information about available services. Coworkers can also serve as influential mediators between the troubled employee and professional assistance and can either block or facilitate the path to assistance. Work groups can provide rewards or sanctions in order to influence the health behaviors of members.

Social group attitudes and norms are informal regulators of behavior that have been found to be an important factor in understanding organizational behavior (Albrecht & Goldman, 1985; Blau & Scott, 1962; Burawoy, 1979; Goldman, 1983; Gouldner, 1954; Katz & Kahn, 1966). As discussed above, the health norms and values of members of an individual's social group were hypothesized to influence the individual's desired health goal. In this section, it is suggested that other individuals' norms may also influence health behaviors of employees. For example, work group norms have been found to influence both health benefit use and health-related absences from work (Mayer, 1988). Mayer (1988) found that employees' perceptions of pro-health work group norms were related to fewer absences for illness and injury and lower health care costs compared to work groups with adverse health norms. The findings, however, were inconclusive regarding the overall impact since Mayer (1988) concluded that work norms had no influence on health risk behaviors (smoking, etc.). Allen and Meyer (1986) examined negative health norms and found such norms can have a negative

impact on health behaviors and the reduction of health risks.

In the present study, work group attitudes toward seeking assistance will be examined as one form of support or pressure generated to influence another's health-related behavior. Employees who are in a work group that does not support seeking assistance and encourage good health behaviors and the use of the EAP may be discouraged from using EAP services for fear of job loss, alienation or ridicule from others.

A second potential source of work site influence on an individual's behavior is the immediate manager or supervisor. Management support has been recognized as an important factor influencing work behaviors related to work site health promotion programs (e.g., Everly & Feldman, 1984; Felix et al., 1985; Orlandi, 1986). It seems logical that managers would also play a key role in influencing employees in seeking EAP assistance. Past EAP research has identified management support as a critical factor impacting on EAP effectiveness (Dickman & Emener, 1982; Greenwood, 1983; Shain & Groeneveld, 1980) and also on the number of supervisory referrals made to EAPs (Myers & Myers, 1985; Roman, 1984).

A third potential source of work site support or pressure may come from the labor union/labor stewards. While supervisors and coworkers may have an impact on one's decision to seek EAP assistance, for the utilization of EAP services to occur, the full participation and support of any organized labor group/union within the organization required (Gordon, 1973; Trice & Roman, 1972). According to Trice and Roman:

An established fact of industrial relations is that management programs involving employee welfare must have the full consent and cooperation of the labor union or other employee organizations if they are to be effective and durable (1972, p. 197).

pp stewards as well as coworkers and supervisors are often able to identify fellow

employees in trouble and to maintain a closer working relationship--thus, an employee may be more open to advice from the union or peers compared to a supervisor. Therefore, labor is in a good position to encourage an employee's seeking of treatment, and labor's opposition would result in a reluctance on the part of employees to self-refer.

A last source of support or pressure at the workplace to be discussed comes from the organization itself. This form of support encompasses the extent to which an employee perceives that the organization encourages or discourages the employee to maintain his/her health and seek EAP treatment when needed. As previously mentioned, human beings learn to participate in society through a process called socialization, defined as "an interactional process whereby a person acquires a social identity, learns appropriate role behavior, and in general conforms to expectations held by members of the social systems to which he belongs or aspires to belong" (Loy & Gham, 1973, p. 258). Organizational socialization occurs at the work site to regulate employees' behavior through a process whereby employees learn the organization's acceptable norms (rules) of behavior. Mitchell and Hurley (1981) indicated that "an important area for future research is how various social settings influence the development of helping networks and supportive transactions" (p. 295). Some settings promote or deter guidance and support.

An organization can develop social norms just as an employee's work group does, these also play a big part in human behavior in organizational settings. Organizational health norms differ from the work group health norms in that the organizational health norms are a much broader concept and consist of an employee's perception regarding the organization's general attitude toward health and toward the

EAP in particular. Work group norms are focused on a narrower field of perception in that only the group of coworkers the employee regularly interacts and works with are considered part of his/her work group.

Glasgow and Terborg (1988) and Syme (1986) state that it is very likely that organizational factors affect work site health programs and their outcomes. Research has suggested that organizational support is needed for the success of EAPs to occur (Dickman & Emener, 1982; Greenwood, 1983; Shain & Groeneveld, 1980). Organizational sponsorship and support of a program helps legitimize a project, provides rewards, and helps to control worker behaviors, just as the withdrawal of this support or sponsorship from a project causes the new work behaviors to decline (Crockett, 1977; Frank & Hackman, 1975; Mayer, 1988; Miller, 1975). More employees are likely to use EAP services when managers are given the support and authority they need to act in their referral role, and when the program is given high visibility throughout the organization with adequate training provided on implementation, use, and location (Googins & Kurtz, 1981). Wrich (1978) claims that regardless of the work setting (e.g., industrial, government, university), EAPs are established to help people with problems and the key ingredient is whether an environment is created that will encourage voluntary referrals. Such an environment stresses trusting relationships, a nonpunitive program policy, confidentiality, absence of labels to users, provides a choice of action for those seeking assistance (Wrich, 1978), a climate of acceptance of trust, open communication, and a control system that optimizes individual freedom (Crookston, 1975).

Mayer (1988) examined health promotion activities at the work site and proposed that some organizations are more likely to develop strong norms to support health

activities while others may develop equally strong norms to discourage them. However, we found that supportive organizational health norms had no relationship with employees' health behaviors. The only empirical research found in the literature review which specifically examined EAP usage and organizational support was conducted by Hung (1988) who measured employees' perceptions of their organization's climate in general. Organizational climate may be defined as "a set of measurable properties of the work environment, perceived directly or indirectly by the people who live and work in this environment and assumed to influence their motivation and behavior" (Litwin & Linger, 1968, p. 2). Hung did not examine employee perceptions regarding a specific organizational "health" climate or norm; rather, a "general" climate measure was utilized and climate was then dichotomized as being either "warm" or "cool". What is interesting about this research is that Hung (1988) found that EAP use was not significantly related to employees' climate perceptions, although many employees commented on the lack of their company's concern for its employees as a barrier to EAP usage.

The research by Mayer (1988) and Hung (1988) contradicts the traditional assertion that organizational support is essential in influencing employee behaviors. However, while Hung (1988) concluded the perception of a warm or cool organizational climate had no influence on actual EAP usage, Hung did conclude that organizational climate perceptions had an influence on responses by both EAP users and non-users regarding future willingness to use an EAP--with those perceiving a warmer climate being more willing to use the EAP in the future if needed. Organizational climate also influenced perceptions of whether using the EAP would hurt one's career where employees perceiving a warmer organizational climate strongly disagreed that using the

AP would hurt their careers (Hung, 1988).

While support and pressure from work-related sources might influence an individual's decision to seek assistance at an EAP, there may also be a number of barriers or obstacles that can be classified as "work-related" that can deter an individual from seeking EAP assistance. Some of these barriers have been identified by EAP experts and include:

- (1) a stigma associated with seeking assistance where an employee may be labeled weak or deviant by his/her peers if they find out the employee sought help or the employee fears that using the EAP would be held against them--e.g., future promotions, etc. (Nunnally, 1961; Roth, 1981; Wrich, 1980);
- (2) perceived lack of confidentiality--which remains a primary concern of both employees and EAP providers (Dickman & Emener, 1982; Lovenheim, 1979; Marino, 1985; Pardue, 1987);
- (3) lack of support by all organizational levels--e.g., supervisors, unions, top management (Beyer & Trice, 1978);
- (4) inaccessibility to entire workforce or to dependents (Straussner, 1986);
- (5) failure to provide services to meet all the needs of employees (Dickman & Emener, 1982; Straussner, 1986);
- (6) lack of union support or labor-steward training (Dickman & Emener, 1982);
- (7) inadequate communication to all employees regarding the EAP--the existence, alternatives, functions, and services (Greenwood, 1983; Shain & Groeneveld, 1980);
- (8) belief that problems should be resolved outside the workplace by the employees themselves (Marino, 1985).

Of particular interest in the present research is the influence that work-related

sources might have on an employee's utilization of an EAP. It is postulated that employees' perceptions regarding the concern for their health from managers, coworkers, labor unions, and the organization and the support/pressure received to seek assistance is important in influencing employee behavior. In addition, the perceived barriers within the workplace are also predicted to influence an employee's decision to seek assistance. It is hypothesized that the combination of both support/pressure and barriers from "work" sources will have a direct influence on an individual's decision to utilize EAP services. This new "combined" variable called "work support/pressure/barriers" will be examined in the present study. It is hypothesized that this variable may influence an individual's seeking of EAP assistance regardless of whether the individual has actually perceived a discrepancy in his/her health between the desired and current health state.

The hypothesis to be examined is:

Hypothesis #7: An individual's perception of the combination of support/pressure and barriers from "work" sources to seeking EAP assistance will have an effect on the individual's utilization of EAP services. Individuals who perceive high levels of support or pressure at work to seek EAP assistance and few barriers will tend to have contacted the EAP for assistance more compared with individuals who report low levels of support or pressure and many barriers to seeking assistance.

Summary

Human behavior is very complex and control theory is one theoretical framework that has been applied to help us better understand behavior. Control theory has been

used in research in a variety of disciplines, such as engineering, applied mathematics, economics, organizational behavior, clinical and health psychology, etc. This chapter began with an overview of control theory which emphasizes goals, feedback (current state), and goal-feedback discrepancies as key influences on an individual's behavior. Various models based on a control theory perspective were presented along with a description of the basic control theory components (Campion & Lord, 1982; Carver & Scheier, 1982; Klein, 1989; Miller, Galanter & Pribram, 1960).

The present research is focused on a specific health behavior (EAP usage) and examples of how control theory has been applied to the field of health were discussed. The physical and social environments in which an individual lives have profound effects on the individual's concepts and attitudes toward health and illness. Health behavior is influenced by several interrelated variables including cultural, social, psychological and organizational determinants. Identifying and understanding the underlying causes of health behavior should help us develop and implement more effective health programs.

A Control Theory Model of EAP Utilization developed for the present research is then discussed (see Figure 9) along with the hypotheses to be tested. The basic components of the model were presented as they relate to the present research on EAP utilization: the goal/standard, sensor function, comparator mechanism, and the behavior/effector. The overall goal or standard of interest in the present study is an individual's health goal and it was hypothesized that three variables would influence an individual's desired health goal level: health history, Health Locus of Control, and social support health values/norms. Two variables were also hypothesized to have a moderator influence on EAP utilization: Health Locus of Control (with three subscales) and

expectancy of goal attainment. Finally, personal and work sources of support/pressure and barriers were hypothesized to directly influence seeking EAP assistance. The next chapter will outline the method to be used to test the hypotheses presented in this chapter.

CHAPTER 4

METHODOLOGY

This chapter describes the data and methods used to examine factors influencing employees' decision to utilize or not utilize EAP services. The variables to be studied have been conceptualized based on a control theory framework (refer to Figure 9).

Power Analysis

A power analysis was conducted to determine the sample size required in order to acquire an adequate level of power to detect significant effects. The hypotheses presented in the preceding chapter were tested primarily with regression analysis. The statistic of interest is the standardized regression coefficient.

Assuming that the standardized regression coefficient for the moderator explains at least a small effect ($R^2 = .10$, Cohen & Cohen, 1983), it was determined that 137 individuals would provide a power of .80 at an alpha level of .05 based on seven independent variables (determined using the section of the model to be tested that includes the greatest number of independent variables). Barker (1987) notes that the usual rate of return by university employees for mail surveys is approximately 30 percent. Therefore, to account for a 30% return rate, questionnaires had to be mailed to at least 457 employees.

In the present study, participants were categorized into two groups--those who had used an EAP and those who had not. In addition, analyses of employees in the group that had not used an EAP were to be conducted only on those who might be classified as "needing" some form of EAP service (if individuals have no health problems, there

would be no reason for them to seek any assistance and, therefore, they should not be included in the analyses comparing individuals who use/do not use an EAP despite having similar problems). It has been estimated that up to 30% of an employer's workforce has serious personal problems (Cahill, 1983; Egdahl & Walsh, 1989; Weiner et al., 1973; Wrich, 1980b). To ensure this 30% was included in the analyses, it was determined that the non-user group would be divided in half based on the level of current problems being experienced. Utilizing 50% of the group in the analyses (those with more problems) was viewed as a conservative approach (i.e., if only 30% potentially require EAP services and significant results are obtained by including an additional 20% that may not require assistance, then more confidence might be placed in the findings). To ensure an adequate number of surveys would be returned by employees who had used and not used an EAP, the following number of questionnaires were mailed to employees: 300 to EAP users and 600 to non-EAP users (to account for the fact that only half of those returned from non-EAP users would be utilized in the analyses).

Research Site

Michigan State University (MSU) was the data collection site selected. This research site was chosen for several reasons. First, the characteristics of the university's labor force made it ideal to examine participation/non-participation in an EAP, since there was a large proportion of full-time employees, a large number of males and females, and a variety of occupational levels that included clerical, maintenance, and supervisory employees. Second, a positive response for conducting the research was received from university personnel, particularly from the EAP staff, who indicated the present area of research had not been studied extensively in the past. Third, the

accessibility of the EAP to the majority of employees minimized the constraints of time, distance, and cost. Fourth, the use of a single research site provided a means of controlling for the potentially confounding effects of organizational and logistical differences extraneous to the research.

Finally, there has been a great deal of concern about the plight of the troubled employee in the post-secondary educational setting. The primary resources in higher education are human resources. Researchers have suggested there is an urgent need for colleges and universities to implement the EAP concept and provide services for the recognition, treatment, and rehabilitation of employees whose behavior affects their work performance (Trice, 1980; Trice & Roman, 1972; Von Wiegand, 1974). Post-secondary educational institutions rely on the quality and well-being of the staff, who are subject to the same personal and work problems that employees working in other business and industrial settings face. While industrial organizations have been dealing with the mental and emotional health of employees for almost a century, the programs are relatively new in higher education. Due to the labor intensity within a university setting and the need to maintain healthy human resources, programs have been implemented in institutions of higher education and today there are approximately 300 university-based EAPs. Wrich (1978) suggests that the impact of programs established by universities is much greater on the community at large than all the money the federal government could spend promoting such programs on its own. University programs not only help the employees directly involved in their usage but the community as a whole due to the inter-relatedness and interdependence of us all.

Michigan State University established an internal (on-site) employee assistance program as a benefit available at no cost to employees and their immediate family

members to assist them with personal problems or difficulties that could negatively affect job performance in order to help "employees resolve their difficulties and return to a more satisfactory work and personal life" (Employee Assistance Program Services, 1990). Like most EAPs, the MSU program had its beginnings in a substance abuse program developed in the 1970's which included such services as confidential professional consultation, referral, and follow-up care. By the late 1970's, the program was expanded to encompass a broad range of personal problems, such as personal, medical, psychological, work-related, substance-abuse, and financial and legal problems (though individuals may be referred to other resources depending on the type and severity of the problem). In 1985 the EAP became a division of the Department of Human Relations and the program was expanded to include prevention and educational services along with its existing assessment, consultation, and referral services. The university's internal EAP is a broad-brush model located in a building on the university's campus which is easily accessible to employees. Initial consultations/interviews were scheduled with an EAP counselor at a convenient time for the employee and information revealed by an employee through consultation with the EAP staff does not become a part of the individual's employment record.

Sample

The final sample consisted of full-time employees of Michigan State University who had the availability of the EAP as part of their benefits package and who had equal accessibility to EAP services (i.e., employees were located on campus). In order to obtain an adequate sample of employees who had utilized the EAP and to be able to compare these employees with similar employees who had not utilized the EAP, EAP

utilization was examined by union groups at the university and employees who were members of the unions with the highest EAP utilization rates were selected. It is argued that if union/employee groups were selected whose utilization was extremely low, then there would not be enough variance in the dependent variable (EAP usage) to adequately examine differences between EAP users and non-users. Following are the union/employee groups selected along with their respective EAP utilization rate for the fiscal year from July 1, 1989 to June 30, 1990: the Administrative Professional Association (APA) and Administrative-Professional Supervisors' Association (APSA) unions with a combined utilization rate of 10.3%; the Clerical-Technical (CT) union with a 12% utilization rate; the American Federation of State, County, and Municipal Employees (AFSCME) Local 1585 with a 4.6% utilization rate; and the AFSCME Local 999 with a 14.5% utilization rate.

A list of university employees who were classified as being members of the selected union/employee groups was obtained from the university. The employees were then classified as being EAP users or non-EAP users based on data provided by staff from the university's EAP. A total of 900 employees were then randomly selected from within these two groups as follows: 100 EAP users and 200 non-EAP users from the APA/APSA group, 100 EAP users and 200 non-users from the CT group, and 100 EAP users and 200 non-users from a combination of both AFSCME (999 and 1585) locals.

Questionnaires were returned from 426 employees for an overall return rate of 47%, or 59% for EAP users and 42% for non-EAP users. Of these 426 questionnaires, responses from 406 employees were examined (12 surveys were returned late and 8 were incomplete). Of the 406 surveys examined, there were 168 EAP users and 238 non-EAP users. The non-user group was then divided approximately in half based on the median

level of current problems (where 131 were classified as employees with the lowest level of current health problems and 107 were classified as having the highest level of current health problems). The final sample included in the analyses consisted of 168 EAP users and the 107 non-EAP users with the highest level of current health problems, for a total of 275 employees.

General characteristics of the final sample are provided in Tables 2 and 3. Frequencies were run on all demographic variables, and Table 4 displays the total number and percentage of individuals possessing each characteristic by EAP usage/non-usage. Crosstabulation analyses were also conducted to examine the respondents' characteristics in more detail. This procedure provides information about the relationships between variables--i.e., about their independence. A Pearson chi-square statistic is obtained to test the hypothesis that the variables are independent. If the statistic is small enough (e.g., $< .10$) then the hypothesis that the two variables are independent is rejected. In the final sample, there was a significant disparity between the job position held and gender where females tended to hold primarily clerical positions while males were more distributed among four of the other positions--maintenance, skilled, professional, and managerial ($p < .01$). No significant differences were found in the sample when examining race and gender, marital status and gender, job position and race, job position and marital status, and marital status and race. Crosstabulation analyses were also calculated to compare EAP usage/non-usage on the various demographic factors. In this sample, there was no significant difference between EAP users and non-users on race, education, job position, age, and tenure with the organization.

Table 2: Descriptive Statistics of Sample

<u>Variable</u>	<u>Code</u>	<u>N*</u>	<u>Percent</u>	<u>Mean</u>	<u>Median</u>	<u>SD</u>
Gender				1.74	2.00	.44
Male	1	71	25.8			
Female	2	204	74.2			
Race				1.18	1.00	.68
White	1	250	90.9			
Black	2	9	3.3			
Hispanic	3	4	1.5			
American Indian	4	5	1.8			
Asian	5	4	1.5			
Other	6	2	.7			
Missing Value		1	.4			
Education				4.04	4.00	1.27
Some High School	1	3	1.1			
High School	2	45	16.4			
Trade School	3	26	9.5			
Some College	4	101	36.7			
Undergraduate	5	63	22.9			
Graduate	6	36	13.1			
Missing Value		1	.4			
Job Position				3.51	3.00	1.51
Maintenance	1	31	11.3			
Skilled	2	23	8.4			
Clerical	3	114	41.5			
Technical	4	19	6.9			
Professional	5	47	17.1			
Manager	6	37	13.5			
Other	7	3	1.1			
Missing Value		1	.4			
Marital Status				2.74	3.00	1.24
Single w/o children	1	72	26.2			
Single w/children	2	40	14.5			
Married w/o children	3	52	18.9			
Married w/children	4	111	40.4			

* Total N=275

1900
1901
1902

1903

1904
1905
1906
1907

1908

Table 2 (cont'd)

Descriptive Statistics of Sample

<u>Variable</u>	<u>Code</u>	<u>N*</u>	<u>Percent</u>	<u>Mean</u>	<u>Median</u>	<u>SD</u>
Family Income				4.51	4.00	1.65
Less than \$10,000	1	1	.4			
\$10,000 - \$19,999	2	22	8.0			
\$20,000 - \$29,999	3	74	26.9			
\$30,000 - \$39,999	4	55	20.0			
\$40,000 - \$49,999	5	36	13.1			
\$50,000 - \$59,999	6	32	11.6			
\$60,000 Or More	7	53	19.3			
Missing Value		2	.7			
Age				4.49	5.00	1.96
Under 25	1	9	3.3			
26 - 30	2	45	16.4			
31 - 35	3	42	15.3			
36 - 40	4	41	14.9			
41 - 45	5	52	18.9			
46 - 50	6	43	15.6			
51 - 55	7	22	8.0			
56 - 60	8	15	5.3			
Over 60	9	6	2.2			
Tenure At Organization				4.13	5.00	1.11
Less than 1 year	1	4	1.5			
1 to < 3 years	2	30	10.9			
3 to < 5 years	3	38	13.8			
5 to < 8 years	4	55	20.0			
8 Or More Years	5	148	53.3			

* Total N=275

Table 3: Descriptive Statistics of Sample (Means of Demographics Provided Based on Demographic Code)

<u>Variable</u>	<u>Code</u>	<u>Sex</u>	<u>Race</u>	<u>Educ</u>	<u>Job</u>	<u>Marital Status</u>	<u>Income</u>	<u>Age</u>	<u>Tenure</u>
Gender									
Male	1	---	1.07	4.04	3.14	2.93	4.85	4.68	4.37
Female	2	---	1.22	4.03	3.65	2.67	4.39	4.43	4.06
Race									
White	1	1.73	---	4.04	3.51	2.76	4.55	4.47	4.14
Black	2	2.00	---	4.33	4.11	2.33	4.22	4.89	4.22
Hispanic	3	1.75	---	3.50	2.75	3.50	4.25	4.25	4.25
American Indian	4	1.80	---	3.40	2.60	2.40	3.40	4.80	4.40
Asian	5	2.00	---	4.50	4.00	2.00	4.50	5.25	3.50
Other									
Missing Value									
Education									
Some High School	1	1.67	2.67	---	1.33	2.33	2.67	8.00	4.67
High School	2	1.80	1.11	---	2.93	2.76	4.05	4.87	4.47
Trade School	3	1.54	1.11	---	3.08	2.58	4.15	4.88	4.54
Some College	4	1.79	1.19	---	2.96	2.68	4.15	4.13	3.99
Undergraduate	5	1.71	1.10	---	4.21	2.78	5.02	4.14	3.91
Graduate	6	1.75	1.28	---	5.25	2.89	5.58	4.89	4.25
Missing Value									

Table 3 (cont'd)

Descriptive Statistics of Sample (Means of Demographics Provided Based on Demographic Code)

[illegible]

Table 3 (cont'd)

Descriptive Statistics of Sample (Means of Demographics Provided Based on Demographic Code)

<u>Variable</u>	<u>Code</u>	<u>Sex</u>	<u>Race</u>	<u>Educ</u>	<u>Job</u>	<u>Marital Status</u>	<u>Income</u>	<u>Age</u>	<u>Tenure</u>
Age									
Under 25	1	1.78	1.00	4.11	3.11	2.22			
26 - 30	2	1.73	1.30	4.22	3.44	2.76	4.00		2.67
31 - 35	3	1.86	1.00	3.91	3.61	2.69	4.09		3.56
36 - 40	4	1.76	1.15	3.88	3.35	2.93	4.29		3.95
41 - 45	5	1.67	1.22	4.29	3.63	2.90	4.29		4.34
46 - 50	6	1.70	1.17	4.49	4.02	2.81	4.81		4.27
51 - 55	7	1.77	1.23	3.32	3.25	2.64	5.05		4.44
56 - 60	8	1.73	1.13	3.47	2.87	2.00	4.95		4.41
Over 60	9	1.67	1.67	3.17	2.83	2.50	4.07		4.80
							4.00		4.67
Tenure At Organization									
Less than 1 year	1	2.00	2.00	5.50	4.75	3.00			
1 to < 3 years	2	1.77	1.03	4.20	3.43	2.67	4.50	2.50	
3 to < 5 years	3	1.84	1.13	4.14	3.53	2.68	4.30	3.47	
5 to < 8 years	4	1.78	1.31	4.15	3.33	2.46	4.05	3.68	
8 Or More Years	5	1.69	1.14	3.90	3.56	2.86	4.02	4.11	
							4.82	5.10	

Table 1. Summary of the results of the analysis of variance for the different parameters measured.

Parameter	Source of variation	df	Mean square	F-value	P-value	Significance
Growth	Replication	1	0.0001	0.00	0.99	ns
	Genotype	1	0.0001	0.00	0.99	ns
	Environment	1	0.0001	0.00	0.99	ns
	Error	1	0.0001	0.00	0.99	ns
Chlorophyll content	Replication	1	0.0001	0.00	0.99	ns
	Genotype	1	0.0001	0.00	0.99	ns
	Environment	1	0.0001	0.00	0.99	ns
	Error	1	0.0001	0.00	0.99	ns
Stomatal conductance	Replication	1	0.0001	0.00	0.99	ns
	Genotype	1	0.0001	0.00	0.99	ns
	Environment	1	0.0001	0.00	0.99	ns
	Error	1	0.0001	0.00	0.99	ns
Transpiration rate	Replication	1	0.0001	0.00	0.99	ns
	Genotype	1	0.0001	0.00	0.99	ns
	Environment	1	0.0001	0.00	0.99	ns
	Error	1	0.0001	0.00	0.99	ns
Relative water content	Replication	1	0.0001	0.00	0.99	ns
	Genotype	1	0.0001	0.00	0.99	ns
	Environment	1	0.0001	0.00	0.99	ns
	Error	1	0.0001	0.00	0.99	ns

ns = not significant.

Table 4: Frequencies of Demographic Variables by EAP Usage/Non-usage

<u>Variable</u>	<u>Total</u>	<u>Non-EAP Usage</u>		<u>EAP Usage</u>	
	<u>N</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Gender					
Male	71	37	.52	34	.48
Female	204	70	.34	134	.66
Race					
White	250	96	.38	154	.62
Black	9	6	.67	3	.33
Hispanic	4	0	0	4	1.00
American Indian	5	2	.40	3	.60
Asian	4	2	.50	2	.50
Other	3	1	.33	2	.67
Education					
Some High School	3	3	1.00	0	0
High School	45	15	.33	30	.67
Trade School	26	13	.50	13	.50
Some College	101	37	.37	64	.63
Undergraduate	63	25	.40	38	.60
Graduate	36	13	.36	23	.64
Missing Value	1	1	1.00		
Job Position					
Maintenance	31	18	.58	13	.42
Skilled	23	11	.48	12	.52
Clerical	114	38	.33	76	.67
Technical	19	8	.42	11	.58
Professional	47	20	.43	27	.57
Manager	37	11	.30	26	.70
Missing Value	4	1	.25	3	.75
Marital Status					
Single w/o children	72	28	.39	44	.61
Single w/children	40	8	.20	32	.80
Married w/o children	52	23	.44	29	.56
Married w/children	111	48	.43	63	.57

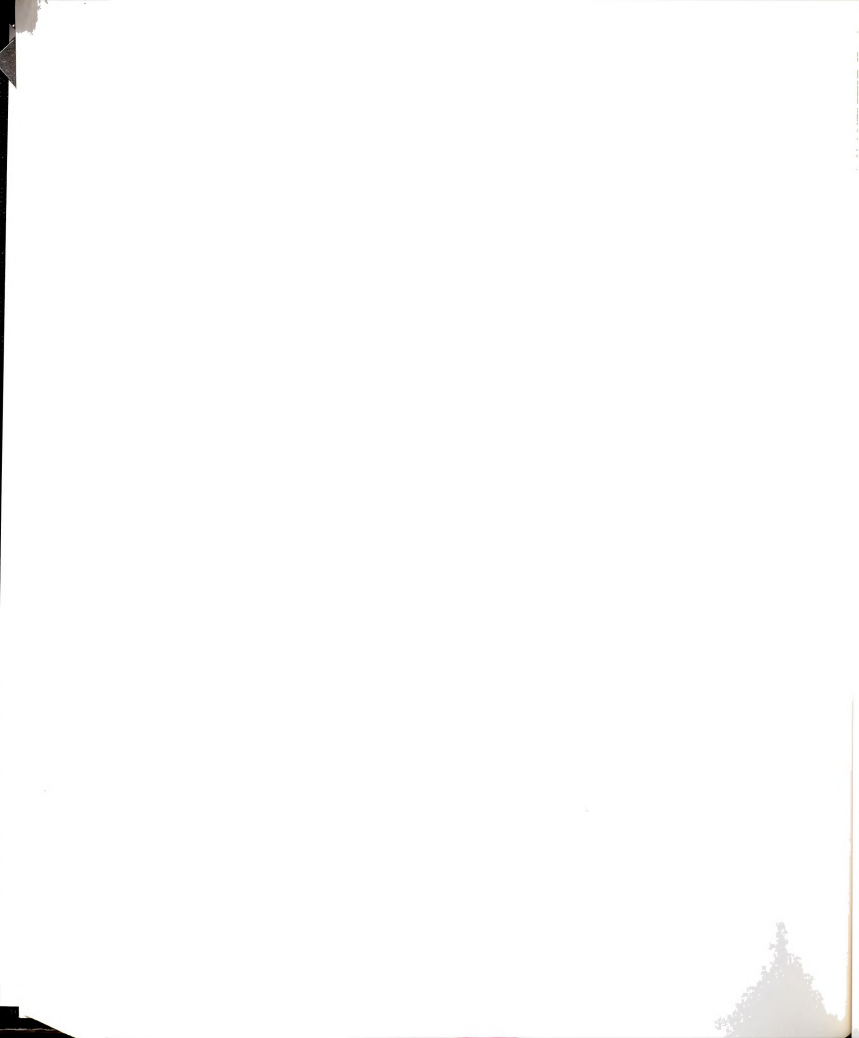


Table 4 (cont'd)

Frequencies of Demographic Variables by EAP Usage/Non-usage

<u>Variable</u>	Total	Non-EAP Usage		EAP Usage	
	<u>N</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Family Income					
Less than \$10,000	1	1	1.00	0	0
\$10,000 - \$19,999	22	6	.27	16	.73
\$20,000 - \$29,999	74	27	.36	47	.64
\$30,000 - \$39,999	55	18	.33	37	.67
\$40,000 - \$49,999	36	19	.53	17	.47
\$50,000 - \$59,999	32	20	.63	12	.37
\$60,000 Or More	53	16	.30	37	.70
Missing	2			2	1.00
Age					
Under 25	9	4	.44	5	.56
26 - 30	45	14	.31	31	.69
31 - 35	42	18	.43	24	.57
36 - 40	41	15	.37	26	.63
41 - 45	52	20	.38	32	.62
46 - 50	43	15	.35	28	.65
51 - 55	22	9	.41	13	.59
56 - 60	15	7	.47	8	.53
Over 60	6	5	.83	1	.17
Tenure At Organization					
Less than 1 year	4	2	.50	2	.50
1 to < 3 years	30	13	.43	17	.57
3 to < 5 years	38	12	.32	26	.68
5 to < 8 years	55	20	.36	35	.64
8 Or More Years	148	60	.41	88	.59

Human Rights

To insure protection of employees' rights, approval for this study was obtained from the Human Subjects Committee of MSU. A letter identifying the purpose of the study was included with the questionnaire to employees for their approval. Employees were informed they would derive no benefits nor incur any risks from the study and complete confidentiality was guaranteed.

Study Design/Procedures

The research explored a self-motivated health behavior--EAP utilization--and was conducted in a natural setting using a cross-sectional, nonexperimental research design since no variable is manipulated and the individuals could not be randomly assigned to the EAP usage or non-usage group. Regarding the value of nonexperimental research designs, Abdellah and Levine (1979) stated:

An important value of nonexperimental research is the broader scope that such studies can have, since it is less costly to use large samples of study subjects than in experiments. Therefore, more independent variables can be studied, with perhaps a greater depth of analysis possible than in an experimental approach to the same problem. Moreover, the artificiality of the experimental situation is eliminated, thereby providing findings that can have more relevant application to the real world (pp. 237-238).

The research involved the collection of data by means of a survey mailed to the employee sample described earlier. It was mailed during the Spring 1992 academic term. The questionnaire packets contained: (1) a cover letter explaining the project and use of the data; (2) an informed consent form; (3) an explanation of the voluntary nature of participation and a statement informing participants that they could decline to answer any or all questions; (4) the questionnaire; (5) a letter (A or B) on the cover of the survey used to identify the respondent as a member of the EAP user group (A) or the

non-user group (B); (6) assurance of confidentiality and an explanation that results would not be included in any personnel record or provided to the university for any reason; (7) an offer to pay respondents \$5.00 upon return of the questionnaire; and (8) a stamped, addressed return envelope for direct mailing of responses to the researcher via U.S. Mail.

Pilot Tests

Three pilot tests were conducted. The first pilot study was conducted to determine the potential for obtaining enough employees who would volunteer to participate in a research project examining their health and health-related behaviors. Seventy employees were randomly selected from the university's staff phone book and mailed a letter in August 1990 describing the proposed research and asking whether they would be willing/unwilling to participate in such research if they were randomly selected. Responses were obtained from 40% ($n=28$) of the original letters mailed. Of those returned, 75% ($n=21$) of the employees stated they would be willing to participate, 18% ($n=5$) stated they would be unwilling to participate, and 7% ($n=2$) were returned with responses that the employee was no longer employed at the university.

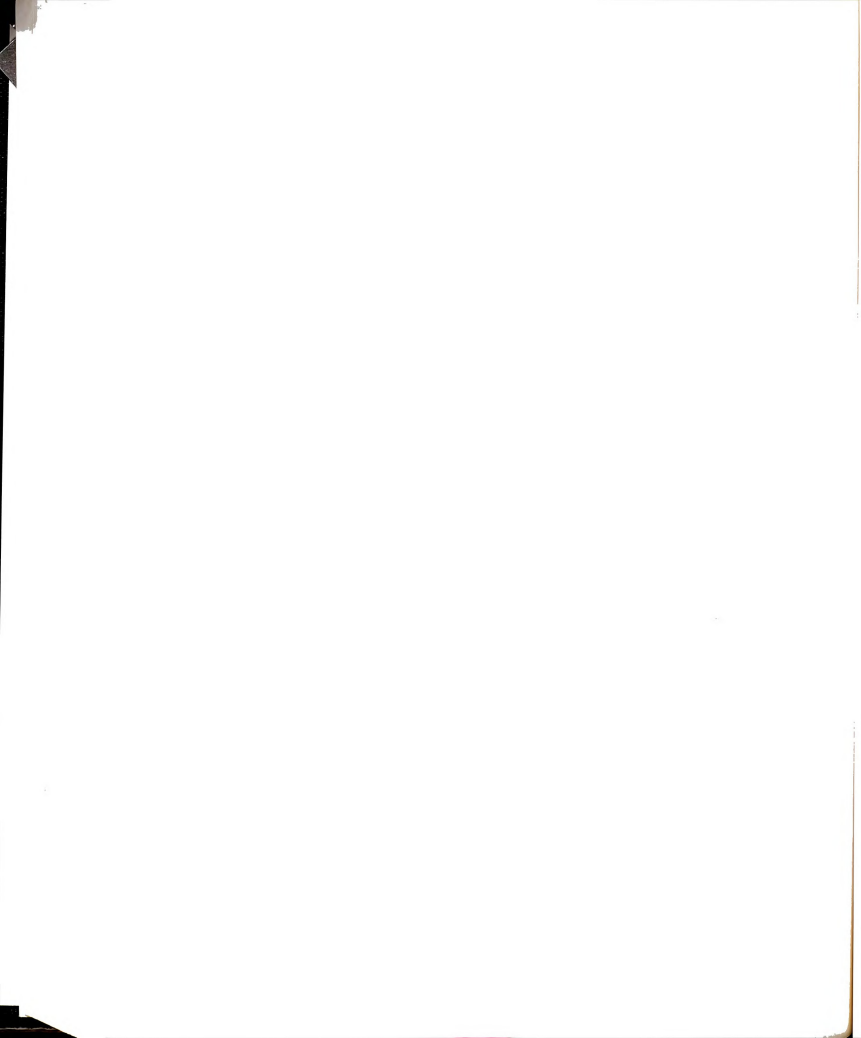
A second pilot study was conducted to determine whether employees who had actually utilized the EAP would be willing to participate in the research to see how willing they would be to admit to EAP usage and to respond to questions about their health. A letter describing the proposed research and requesting their response to whether they would be willing to participate was given to all employees who came to the EAP offices for assistance during a one-week period in September 1990. Because this week happened to be the first week of the Fall academic term at the university, which



traditionally is a low EAP-usage week, and because there was only one EAP counselor working during that week due to recent turnover, only six letters were distributed to clients and returned to the researcher. However, all six employees responded positively, thus 100% stated they were willing to participate in the research if randomly selected in the future. Based on these first two pilot tests, approval was given by the dissertation committee to continue the research project.

A third pilot study was conducted to test the format, factor structure, and reliability of the survey instrument prior to administering it to the final sample. There were 145 college students from management courses who volunteered for this pilot study in exchange for research credit provided by their instructor toward their course grade. The questionnaire tested in this pilot study included items for all measures except for those included in the support/pressure/barriers scales (discussed below). Participants attended two sessions approximately two weeks apart during which they completed the same survey in order to examine the stability (Cronbach alpha or test-retest reliability) of the measures. Most of the items and scales included in the final questionnaire were those found to have a reliability of .70 or higher from this pilot test. These items and scales will be discussed below in the "Measures" Section.

A fourth pilot test was conducted to examine the items developed for the perceived support/barriers/pressures scales (personal and work-related items). It was felt that actual employees would be the appropriate sample to test these items on. MSU employees were randomly selected from among the three employee groupings utilized in this study. Three-hundred questionnaires were mailed along with a cover letter to the following employees: 100 to employees who were members of the APA and APSA unions (50 employees in each union), 100 to employees who were members of the CT



union, and 100 to employees who were members of the 999 and 1585 AFSCME unions (50 employees in each). The overall return rate was 39% ($n=118$ with 115 fully completed surveys returned). Items included in the final survey are reported in the following section regarding the Support/Pressure/Barriers scales.

Measures

This section describes the measures used to operationalize the variables in the study. The independent variables are: health history, Health Locus of Control (3 subscales), social group health values/norms, general health goal, self-focus, current health status, perceived discrepancy between the individual's health goal and health status, expectancy of goal attainment, and personal and work-related support/pressure/barriers to using the EAP. The dependent variable is a measure of whether the employee has used or not used EAP services. All measures are included in Appendix B. Each variable will be discussed based on results from the pilot studies conducted above and from the analyses conducted on the surveys returned from the final sample (i.e., 168 EAP users and 107 non-EAP users). Descriptive statistics of the variables discussed below are provided in Table 5.

Health History. A series of questions regarding an individual's past health were developed for purposes of the present research. The following areas of health were focused on: general physical health, head, cardiovascular/respiratory, eyes/ears/nose/throat/mouth, and miscellaneous. Of the 72 questions included in the pilot study, the most reliable items (test-retest reliabilities ranging from .70 to .94) most representative of the above health areas were included in the final survey (see Part III of the survey in Appendix B). Test-retest reliability was calculated and used to



Table 5 : Descriptive Statistics of Major Variables in the Model

<u>Variable</u>	<u>N</u>	<u>Number of Items In Measure</u>	<u>Range</u>	<u>Mean</u>	<u>Median</u>	<u>SD</u>	<u>REL'Y</u>
Health History	275	15	0-15	4.47	4.00	3.05	.70-.94 (T) .62 (A)
Health Locus of Control							
Internal HLOC	275	6	15-35	26.54	27.00	3.96	.78 (A)
Powerful Others HLOC	275	6	6-30	15.52	15.00	4.64	.58 (A)
Chance HLOC	275	6	6-31	15.64	15.00	5.11	.67 (A)
Social Health Values/Norms	275	17	24-57	41.68	42.00	6.85	.79 (A)
Desired Health Goal Level	275	12	25-55	43.54	44.00	4.72	.65-.81 (T) .38 (A)
Current Health Problems	275	37	76-185	148.51	153.00	18.93	.97 (A)
Perceived Discrepancy	275	37	27-188	74.59	70.00	25.44	.97 (A)
Expectancy EAP Will Help	275	37	1-172	93.78	101.00	34.83	.98 (A)
Personal Support/Pressure	275	6	.11-.80	.30	.26	.14	.81 (A)
Personal Barriers	275	7	.20-1.18	.48	.45	.22	.83 (A)
Pers'l Supp/Presr/Barriers	275	13	-.79 to .22	-.19	-.15	.18	n/a
Work Support/Pressure	275	10	.66-1.59	1.21	1.26	.15	.71 (A)
Work Barriers	275	6	.15-1.21	.54	.49	.22	.79 (A)
Work Supp/Presr/Barriers	275	16	-.28 to 1.26	.67	.72	.31	n/a

(A) = Cronbach Alpha Reliability (calculated from final study results)

(T) = Test-Retest Reliability (calculated from pilot test #3 results)

determine the items to include because it was not expected that the items included in health history measure were similar enough to utilize Cronbach alpha reliability--i.e., just because an employee may have high blood pressure does not necessarily indicate the employee also has cancer, diabetes, liver disease, allergies, etc. However, in the final study, Cronbach alpha reliability was calculated based on the responses from actual employees (this was low at .62).

Employees responded either yes/no to 14 health problems presented in the survey and also responded to an open-ended question where they were asked to identify the number of additional health problems they had experienced that were not included in the survey. An overall health history score was obtained for each individual by adding up the number of "yes" responses along with the number of additional problems identified in question 15. Scores ranged from 0 to 15.

Health Locus of Control. Rotter (1966) devised one of the first instruments to measure locus of control. This I-E scale consisted of 29 forced-choice items which has received extensive validation (Herring, 1987; Rotter, 1975). To better apply this concept to the field of health, Wallston, Wallston, Kaplan, and Maides (1976) developed a unidimensional Health Locus of Control (HLC) scale to measure the degree to which people believe their health is determined by their behavior and is under their control (i.e., is internal or external). The HLC scale was composed of 11 items. Individuals with high HLC scores were "health-externals" who perceived factors such as luck, fate, chance, or powerful others determined their health. Low scorers were labeled "health-internals" for those who believed one became healthy or sick as a result of one's own behavior. The HLC was based on Rotter's (1966) I-E Locus of Control Scale but used a Likert-type scale response format (rather than a forced-choice format) and was found

to correlate .33 with the I-E Scale (Wallston et al., 1976).

Wallston, Wallston and DeVellis (1978) employed the HLC scale on other samples and found that the original alpha reliability of .72 decreased to somewhere in the range of .40 to .54. The dimensionality of the scale was then re-examined and, based on the work of Levenson (1974), the scale was modified when it was found that some health-externals believed fate or chance was responsible for their health while other health-externals saw powerful others (e.g., health care professionals) were responsible for their health (Levenson, 1974). Therefore, three new scales were constructed: internal, powerful others, and chance. Wallston, Wallston, and DeVellis (1978) further developed and tested this more specific tool, which they referred to as the Multidimensional Health Locus of Control (MHLC), with the idea that: "by assessing more than one dimension of Health Locus of Control, the probability of increasing understanding and prediction of health behaviors could be increased" (p. 167). The three sub-scales were referred to as the Internal Health Locus of Control (IHLC) Scale, the Powerful Others Health Locus of Control (PHLC) Scale, and the Chance Health Locus of Control (CHLC) Scale, where the last two are dimensions of externality. All three subscales were used in this study. Internal Health Locus of Control (IHLC) is the perception that the reinforcement for participation in the EAP is contingent upon the individual's own behavior. Powerful Others Health Locus of Control (PHLC) is the perception that reinforcement for participation in the EAP is under the control of powerful others. Chance Health Locus of Control (CHLC) is the perception that reinforcement for participation in the EAP is a result of chance.

Form A of the MHLC scale was selected for this study which contained a total of 18 statements (six from each of the three dimensions). Internal consistency values, or

alphas, which were reported by Wallston, Wallston, and DeVellis (1978) for the IHLC, PHLC, and CHLC scales were .77, .67, and .75 respectively. Wallston and Wallston (1981) reported test-retest reliabilities (over a four- to six-month period) for the three scales as .66, .71, and .73 respectively. Results of the third pilot test indicated reliability was lower than Wallston and Wallston (1981) reported on two of the scales: IHLC .78, PHLC .67, CHLC .66. The MHLC scales are intended for use with adults with at least an eighth grade reading level and no functional impairment (Malen, 1982). Each scale consists of six items which utilize a six-point Likert-type scale that ranges from "strongly agree" (1) to "strongly disagree" (6), with no neutral midpoint so respondents were forced to make a decision. This was done to eliminate the inability of a person to make a decision as a variable in scale development. The scores on each scale can range from 6 to 36. The higher the score for each dimension (36 being the highest obtainable for any dimension), the more indicative of that particular locus of control influence. Total IHLC, CHLC, PHLC scores were calculated for all individuals by adding up scores from the six items in each scale.

The MHLC scales can be found in Part I of Appendix B (Form A). Questions included in the IHLC subscale are 1, 6, 8, 12, 13, 17; questions included in the PHLC subscale are 3, 5, 7, 10, 14, 18; questions included in the CHLC subscale are 2, 4, 9, 11, 15, 16. Reliability for the three subscales based on the final sample (IHLC .64, PHLC .58, CHLC .67) was found to be lower than that calculated from the pilot test results. Other descriptive statistics on the three scales are provided in Table 4.

Social Group Health Values/Norms. This scale measures employees' perceptions of the health values and norms (past and present) of members of their social group (parents, friends, spouse, coworkers, etc.). This scale examines the following areas:

general health norms, physical health, mental health, nutrition and fitness, lifestyle/habits, and current influence. Of the 34 items pilot-tested, 17 were included in the final measure (see Part V, Appendix B) based on test-retest reliabilities calculated on items in the third pilot study (reliabilities of the 17 items ranged from .70 to .75). Cronbach alpha reliability calculated on the final survey responses was .79. Responses to each question were scored so that the more positive the response, the higher the score assigned to that response. For example, if a question had five responses to choose from and the first one, or "a", was the most positive regarding health influence, then this response was assigned a score of "5" while the least positive response, or "e", was assigned a score of "1". Item responses were then summed to obtain a final score. The higher the score, the more positive the individual perceived the health value/norms of his/her social group. Scores ranged from 24 to 57, with a mean of 41.68.

Desired Health Goal Level. An individual's desired health goal level refers to the desired level of health aspired to. As stated in the previous chapter, it seems reasonable that most individuals will maintain a general goal or desire to be healthy. Thus, in order to measure the degree individuals vary in their desired health goal, it was felt that it would take more than just asking employees "Do you desire good health?" because of the demand characteristics present. Therefore, employees were asked about their desires and aspirations regarding specific aspects of their health (e.g., weight, nutrition, smoking, sleep, stress level, etc.). Of the 17 items included in the pilot test, 12 were included in the final measure (see Part VI, Appendix B) based on test-retest reliabilities (which ranged from .65 to .81). Test-retest reliability was used to examine items in this scale because it was not expected that the items would be internally consistent--i.e., just because an individual desires to not smoke or drink alcoholic beverages does not mean

the individual also desires to regularly exercise or refrain from eating unhealthy snack foods. (Cronbach alpha reliability was calculated on the final survey responses, and it was .38). Individuals' scores ranged from 25-55 (see Table 4). Responses to each question were scored so that the more positive the response, the higher the score assigned to that response. Item scores were then summed to obtain an overall Desired Health Goal Level score where the higher the person's score, the greater the health goal level desired.

Current Health Status. Health status refers to the physical and mental well-being of employees (Levey & Loomba, 1984). Health status was operationalized with a series of questions focusing on the following areas of health: physical, mental/emotional, nutrition and fitness, lifestyle/habits, and general. Employees were asked to measure their current health on several items using a Likert-type scale ranging from "Very Poor" (1) to "Excellent" (5). Of the 71 items pilot-tested, 37 were included in the final questionnaire (see Part VII, Appendix B). Cronbach alpha reliability calculated on the final responses was .97. Employees' responses to the items were summed to obtain an overall Current Health Status score. The lower the number, the more health problems perceived by the individuals. Scores ranged from 76-185 (for EAP users and non-users in the final sample). Other descriptive data are shown in Table 4.

This variable was used to determine initially which of the non-EAP using employees were to be included in the analyses. The group of non-users who responded (total $n = 238$) were divided based on their overall Current Health Status score (refer to the "Power Analysis" section above for an explanation). While the intent was to divide the group based on the median score (median = 153), upon examination of the data a more natural dividing point in the sample was indicated at a score of 162. Therefore,

100-100000

100-100000
100-100000
100-100000
100-100000
100-100000

all employees whose score was less than 162 were included in the final non-EAP usage group ($n = 107$) while the remaining employees whose health was perceived as better were not included in any additional analyses ($n = 131$).

Health Goal-Health Status Discrepancy. In a control theory model, it is predicted that an individual is motivated to act based on the existence of a discrepancy between his/her goal and his/her current status regarding that goal. In the present research, the discrepancy of interest was the perceived discrepancy between a person's desired health goal level and current health status. Unfortunately, the variables in the current EAP control theory model are not quantifiable as they often are in other control theory studies so calculating a discrepancy cannot be calculated in an objective manner. (For example, in a quantifiable measure, if one's production goal is 20 pieces per hour and the current rate is 15, then there is a discrepancy of 5.) Two measures were developed to examine the existence of a discrepancy for use in the present research.

The first measure developed was used for the "perceived discrepancy" variable identified in Figure 11 in order to test this aspect of the model. For each of the items included in the Current Health Status measure, employees were asked to identify the change in their health which they desired on each of the items using a five-point scale ranging from "No Change Desired" (1) to a "Very Large Change Desired" (5) (see Part VII, Appendix B). An employee's discrepancy score was calculated by summing the item responses. The higher the score, the more an employee perceived a discrepancy between his/her current and desired health. Scores ranged from 27 to 188 with a mean of 74.59 (see Table 4). Cronbach alpha reliability of the final survey responses was .97.

The second discrepancy measure was calculated by standardizing the scores on the Desired Health Goal Level measure and the Current Health Status measure to examine

whether each participant's score on each variable fell within the same percentile (e.g., upper 25th, 51-75th, 26-50th, or lower 25th on both measures). If both scores for an individual did not fall within the same percentile, a discrepancy existed. For example, if a person's Desired Health Goal score was within the upper 25th percentile (high health goal level), a discrepancy between the desired and current health existed if the person's Current Health Status score did not also lie in the upper 25th percentile. Quartile cut-off scores for the Desired Health Goal Level measure were under 41, 43, 46, and over 46 and cut-off scores for the Current Health Status scale were under 138, 152, 160, and over 160. Based on the quartile scores, individuals were classified as either having a discrepancy or not. This discrepancy measure was used as a method check to examine whether the model and the relationships hypothesized existed by correlating it with the "perceived discrepancy" measure calculated above using the responses on the "Desired Change" scale in order to examine whether the control theory framework might be useful in guiding this type of research.

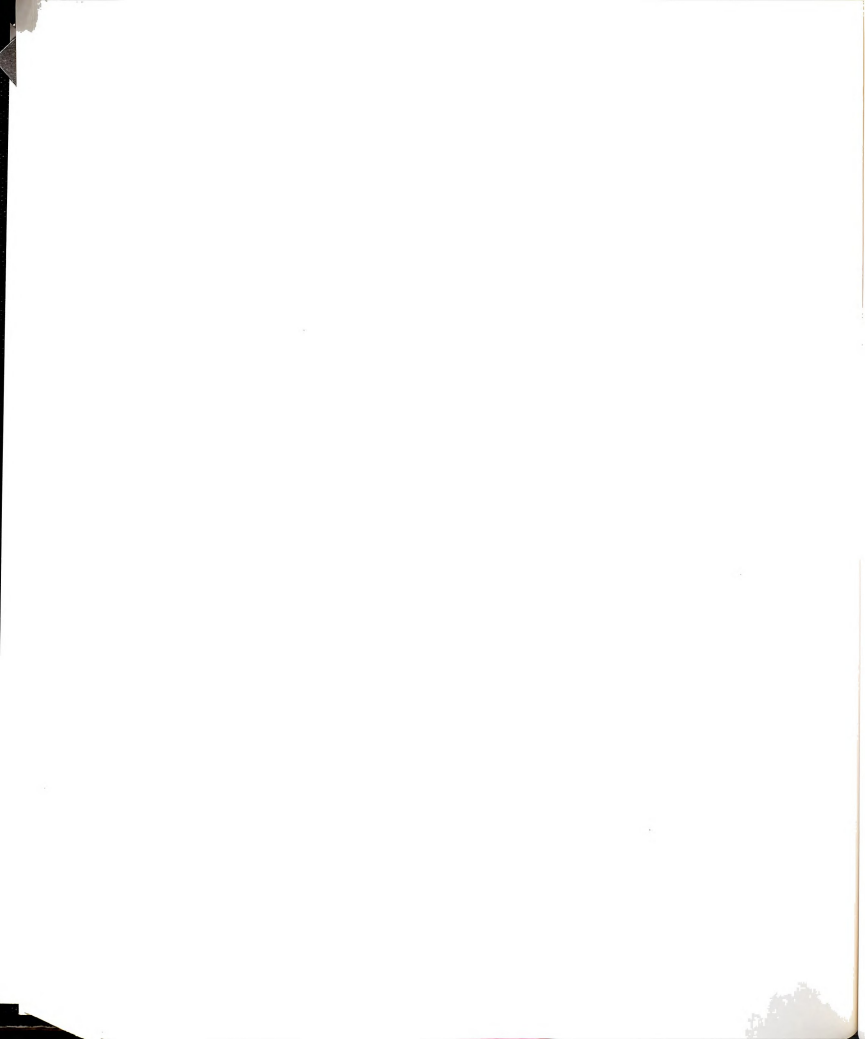
Expectancy of Goal Attainment. Perceptions have been the basis of most research on health-protective behaviors, with particular emphasis on beliefs (Ultsch, 1983). Expectancy in the present research refers to the perception or belief an individual has that utilizing the EAP will help attain his/her desired health goal--i.e., eliminate the perceived discrepancy between desired and current health.

In the present research, expectancy was measured by asking participants whether they perceived going to an EAP would help resolve the specific health problems they were experiencing, as identified in their Current Health Status survey. Individuals responded to each item based on a scale ranging from "Very Poor/EAP Would Be of No Help" (1) to "Excellent/EAP Would Help a Lot" (5). An individual's scores on all items

were summed to obtain an overall Expectancy score. Scores ranged from 1 to 172 with a mean of approximately 94 (see Table 4). Cronbach reliability based on responses from the final survey was .98.

Support/Pressure/Barriers to Using the EAP. Two scales were created to measure perceived support/pressure/barriers to using the EAP--a scale representing items from sources or barriers perceived in one's personal life (parents, friends, other relatives, self) and from sources or barriers perceived in one's work life (supervisor, coworkers, union, the organization). The questions in these scales addressed participants' perceptions regarding others' encouragement of, discouragement of, and involvement in EAP participation along with various pressures or barriers which may influence the use of EAP services. A high score on either scale indicates that a high level of support and few barriers were perceived from the particular source (personal or work).

The Personal Support/Pressure/Barriers scale was developed based on the fourth pilot test discussed above that was conducted using 115 MSU employees (note that pilot-study participants were not included in the final sample). This pilot test was conducted in order to develop weights in analyzing the final survey data for each source of support or pressure or barrier category. Actual employees were used in the pilot study because it was felt that their responses to perceived support and barriers would have greater external validity for determining the items best to include in the final survey to be mailed to other "similar" employees. A number of support and barrier items were included in the pilot test. In order to determine which items may be perceived as more important in influencing EAP behavior, weights were calculated based on responses from the pilot which were then used to calculate scores for the personal support/pressure and barriers scales for employees in the final study.



To calculate these weights, pilot study participants were asked to respond to 24 statements regarding perceived support, encouragement, discouragement and barriers from sources in their personal lives (i.e., friends, spouse/significant other, family, and others) using a six-point scale ranging from "Strongly Disagree" (1) to "Strongly Agree" (6). Ten statements were related to "personal" sources of perceived support/pressure/encouragement. For each statement all individuals' scores were summed (e.g. Item 1 scores for individuals 1 to 115 were summed together for a total item 1 score). Items were then grouped together based on the particular source (i.e., three questions referred to support from friends, two related to spouse, two to family and two to other sources). Item scores were then added together for each source and an average score was calculated per source. Next, the 14 items relating to "personal" barriers were divided into eight categories and item scores were added together for each category and averages were calculated. Finally, an overall percentage was calculated for each personal source/category in order to obtain weights to assign to each for use in analyzing results from the final survey responses (i.e., a percentage was calculated by summing all averages to use as the total score and calculating the percentage of this total accounted for by each personal category).

Refer to Part IV in Appendix B for the final items included in the personal and work support/pressure/barriers measures. The measure of personal sources of support/pressure calculated for the final sample consisted of six items with weights based on the above pilot results (see Part IV, Appendix B, for items 1, 4, 5, 9, 11, 12, weighted .027, .022, .034, .022, .038, .028 respectively). Individuals' weighted scores were summed on these six items to create the Personal Support/Pressures scale where the higher the score the more support perceived. The final measure of personal barriers consisted of

seven items (2, 3, 6, 7, 8, 10, 13) weighted according to the pilot results (.036, .029, .038, .030, .033, .038, .031, respectively). Cronbach alpha reliability for the Personal Support/Pressures scale was .81. Individuals' weighted scores were summed on these seven items to create the Personal Barriers scale where the higher the score the more barriers perceived. Finally, one score was developed to include all the "personal" related perceptions regarding support/pressure and barriers to using EAPs in order to examine the overall influence of people and things (barriers) from personal sources. This overall Personal Support/Pressure/Barriers variable was calculated by subtracting the total personal barriers score for each individual from his/her total personal support/pressure score. This score was then interpreted as the higher the score the more support and fewer barriers perceived from personal sources, and this score was used to examine the impact of personal influences on EAP utilization.

A similar procedure was used to develop weights for the Work Support/Pressure/Barriers measure. Participants in the fourth pilot study were asked to respond to 28 statements on perceived support, encouragement, discouragement and barriers from work sources using a six-point scale. The items were then categorized by source (6 items related to supervisor, 3 to union, 8 to coworkers, 3 to the university/organization) and by barrier type (8 items). Total participants' scores were summed by item and weights were calculated for each category based on the percentage of the total each accounted for (same as the procedure described above). These weights were used in analyzing data from final sample participants. The Work Support/Pressure measure was calculated using the following items and weights (Part IV, Appendix B, items 14 to 19, 21, 24, 25, 27 weighted .026, .026, .028, .021, .030, .028, .039, .032, .084, .043 respectively). Cronbach alpha reliability for this measure based on the final survey

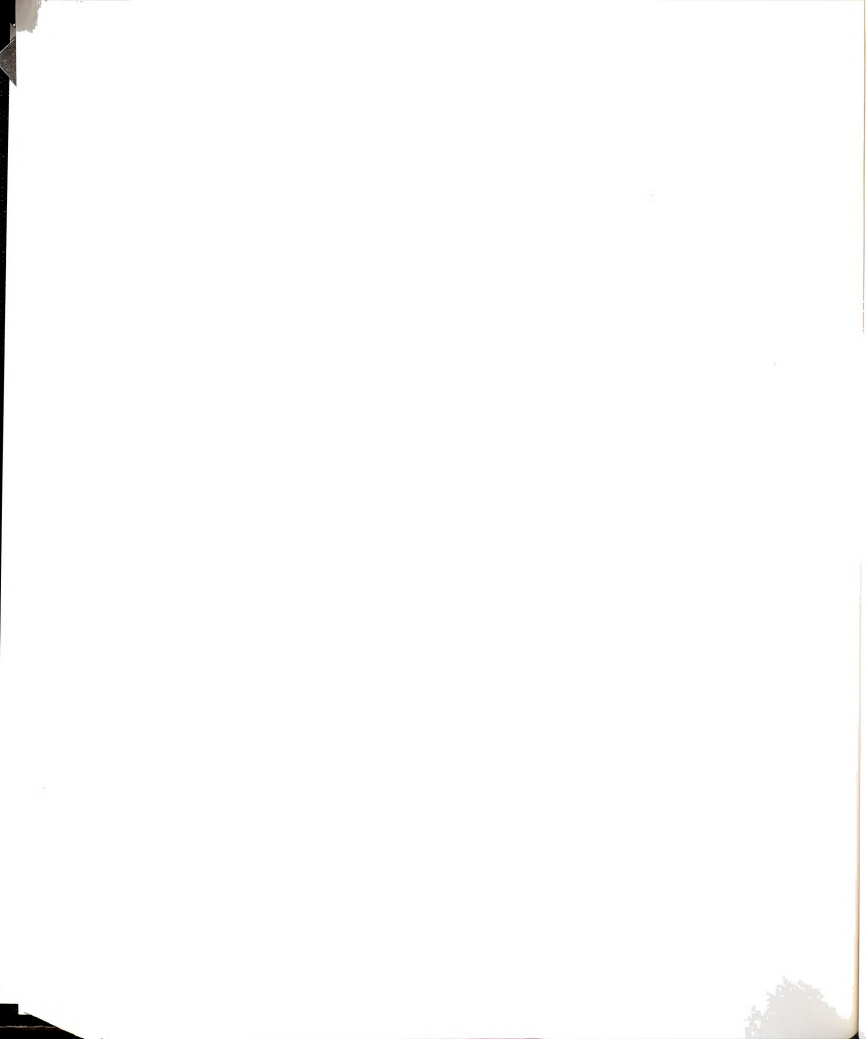
responses was .71. The Work Barriers measure was calculated using the following items and weights (items 20, 22, 23, 26, 28, 29 weighted as .037, .029, .030, .055, .029, .057 respectively). Cronbach alpha reliability for the Work Barriers scale was .79. Finally, in order to examine the overall influence of work-related factors on EAP utilization, an overall Work Support/Pressure/Barriers variable was calculated by subtracting the total work barriers score for each participant from his/her total personal support/pressure score. This score was then interpreted as the higher the score the more support and fewer barriers perceived from work sources.

EAP Utilization. This dependent variable was a dichotomous variable representing the employee's utilization or non-utilization of the EAP. This measure was obtained from three sources: (1) EAP records, (2) a question on the survey regarding EAP usage (see Part VIII, Appendix B, question # 3), and (3) a series of questions relating to EAP usage to be completed only if employees had used EAP services (Part VIII, Appendix B, questions 4-12). If all three sources indicated the individual had utilized an EAP, the individual was classified as an EAP-user. If all sources did not agree, the individual was classified as a non-user.

Other Variables. Demographic information was collected on the participants for additional analyses and information. Employees were asked to provide information regarding their age, gender, education, marital status, income, occupational status, race, and organizational tenure.

Analytic Methods

This section describes the statistical procedures used to analyze the hypotheses. Frequency distributions for all items were obtained for the entire sample and by group



(EAP users and non-users). Matrices of Pearson Correlation Coefficients were developed to examine the intercorrelations for the variables in each scale and to assist in examining the discrimination and validity of the scales.

Regression and hierarchical multiple regression was utilized to analyze the hypotheses. The multiple correlation coefficient (R) represents the degree to which a dependent variable can be predicted from simultaneous consideration of independent variables. The model and hypotheses will be tested in stages (refer to Figures 10 and 11).

Hypotheses 1 to 3 suggest similar predictions regarding the relationship of health history, Health Locus of Control, and social group health values/norms with an individual's desired health goal. Each hypothesis was stated as a main effect for the specific variable on health goal level and was tested by regressing health goal level on each variable. Support for each hypothesis was indicated by the specific variable explaining a significant amount of variance in desired health goal level.

Hypotheses 4a, 4b, 4c and 5 each predicted specific variables (the three Health Locus of Control variables and expectancy of goal attainment) would moderate the relationship between the perceived goal-sensor discrepancy and EAP utilization. Each hypothesis was tested via hierarchical multiple regression where the perceived goal-sensor discrepancy variable was entered in the first step, the particular moderator variable in the second step, and the discrepancy by moderator interaction in the third step. Support for each hypothesis was indicated by a statistically significant beta coefficient corresponding to the interaction variable.

Hypotheses 6 and 7 suggest similar predictions regarding the relationship of personal support/pressure/barriers and work support/pressure/barriers with an

individual's use of an EAP. Each hypothesis was stated as a main effect for the specific variable on EAP utilization and was tested by regressing EAP utilization on each variable. Support for each hypothesis was indicated by the specific variable explaining a significant amount of variance in EAP utilization.

Post-hoc analyses were conducted to further examine relationships among the variables and to compare demographic characteristics of EAP users and non-EAP users.



CHAPTER 5

RESULTS

Descriptive statistics (Ns, means, and standard deviations) of variables in the model are presented in Table 6. Sample sizes vary across scales because of missing values. Intercorrelations among key variables were also calculated and are shown in Table 7. Few variables are highly correlated with one another. Those that significantly correlate over .40 (at $p < .01$) worth noting are personal support/pressure to using an EAP with personal barriers ($r = .61$) and with work barriers ($r = .45$) (note that these are the individual variables that are used to create the personal and work support/pressure/barriers variables), indicating that those perceiving more personal sources of support/pressure to use an EAP also perceive more barriers. In addition, the personal barriers to using an EAP measure is significantly correlated with work barriers ($r = .67$) and with using an EAP ($r = -.46$) so those perceiving more barriers tend to not use an EAP. Work-related support/pressure to use an EAP is negatively related with work-related barriers ($r = -.44$), indicating those individuals perceiving more support to use an EAP from sources at work (e.g., coworkers, supervisor, union) perceive fewer barriers in the workplace to using an EAP. In general, when the perceived barriers measure is subtracted from the perceived support/pressure measure (both personal and work sources), those perceiving more support/pressure and fewer barriers from personal sources also tend to perceive more support/pressure and fewer barriers from work sources ($r = .51$). It is also important to note that the correlation ($r = -.77$) between personal support/pressure/barriers (PSPB in Table 7) and personal barriers (PBAR) is artificially high because of the differential score used to develop the personal

Table 6: Means and Standard Deviations of Major Variables in the Model

Variable	Overall			EAP Users			EAP Non-Users		
	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>
Internal HLOC	275	26.54	3.96	168	26.87	3.95	107	26.02	3.95
Powerful Others HLOC	275	15.52	4.64	168	15.04	4.54	107	16.28	4.72
Chance HLOC	275	15.64	5.11	168	15.54	5.14	107	15.80	5.09
Social Health Values/Norms	275	41.68	6.85	168	41.71	7.12	107	41.63	6.44
Desired Health Goal Level	275	43.54	4.72	168	43.52	4.84	107	43.58	4.55
Current Health Problems	275	148.51	18.93	168	150.72	20.95	107	145.05	14.68
Perceived Discrepancy	275	74.59	25.44	168	74.15	26.68	107	75.27	23.48
Expectancy EAP Will Help	273	93.78	34.83	167	93.19	35.84	107	94.71	33.31
Health History	275	4.47	3.05	168	4.36	3.04	107	4.65	3.08
Personal Support/Pressure	275	.30	.14	168	.27	.12	107	.34	.16
Personal Barriers	275	.48	.22	168	.40	.18	107	.61	.23
Personal Supp. - Barriers	275	-.19	.18	168	-.13	.14	107	-.28	.19
Work Support/Pressure	275	1.21	.15	168	1.22	.14	107	1.19	.16
Work Barriers	275	.54	.22	168	.49	.20	107	.62	.23
Work Supp. - Barriers	275	.67	.31	168	.73	.29	107	.58	.33

Table 7: Intercorrelations Among Major Variables in the Model

	IHLC	PHLC	CHLC	HHST	PSUP	PBAR	WSUP	WBAR	PSPB	WSPB	SHVN	DHGL	CRPR	PDSC	EXP	EAP
IHLC	1.00															
PHLC	-.06	1.00														
CHLC	-.26**	.23**	1.00													
HHST	-.16**	.23**	.06	1.00												
PSUP	.02	.23**	.18**	-.07	1.00											
PBAR	-.08	.21**	.14*	-.00	.61**	1.00										
WSUP	.13*	-.02	-.06	-.06	-.02	-.30**	1.00									
WBAR	-.12*	.16**	.14*	.05	.45**	.67**	-.44**	1.00								
PSPB	.12*	-.08	-.03	-.05	.03	-.77**	.36**	-.49**	1.00							
WSPB	.15*	-.12*	-.13*	-.07	-.32**	-.61**	.77**	-.91**	.51**	1.00						
SHVN	.11	.12*	-.10	-.12	-.04	-.09	.23	-.14*	.09	.21**	1.00					
DHGL	.07	-.05	-.24**	.02	-.11	-.05	.02	-.02	-.03	.02	.06	1.00				
CRPR	.22**	-.16**	-.21**	-.32**	-.15*	-.20**	.23**	-.22**	.14*	.26**	.23**	.03	1.00			
PDSC	-.12	.19**	.00	.33**	.05	.10	-.16**	.12	-.09	-.16**	-.12	.08	-.63**	1.00		
EXP	.11	.10	-.18**	.03	-.05	-.15*	.11	-.13*	.14*	.14*	.13*	.11	-.01	.13*	1.00	
EAP	.11	-.13*	-.03	-.05	-.23**	-.46**	.07	-.29**	.40**	.24**	.01	-.01	.15*	-.02	-.02	1.00

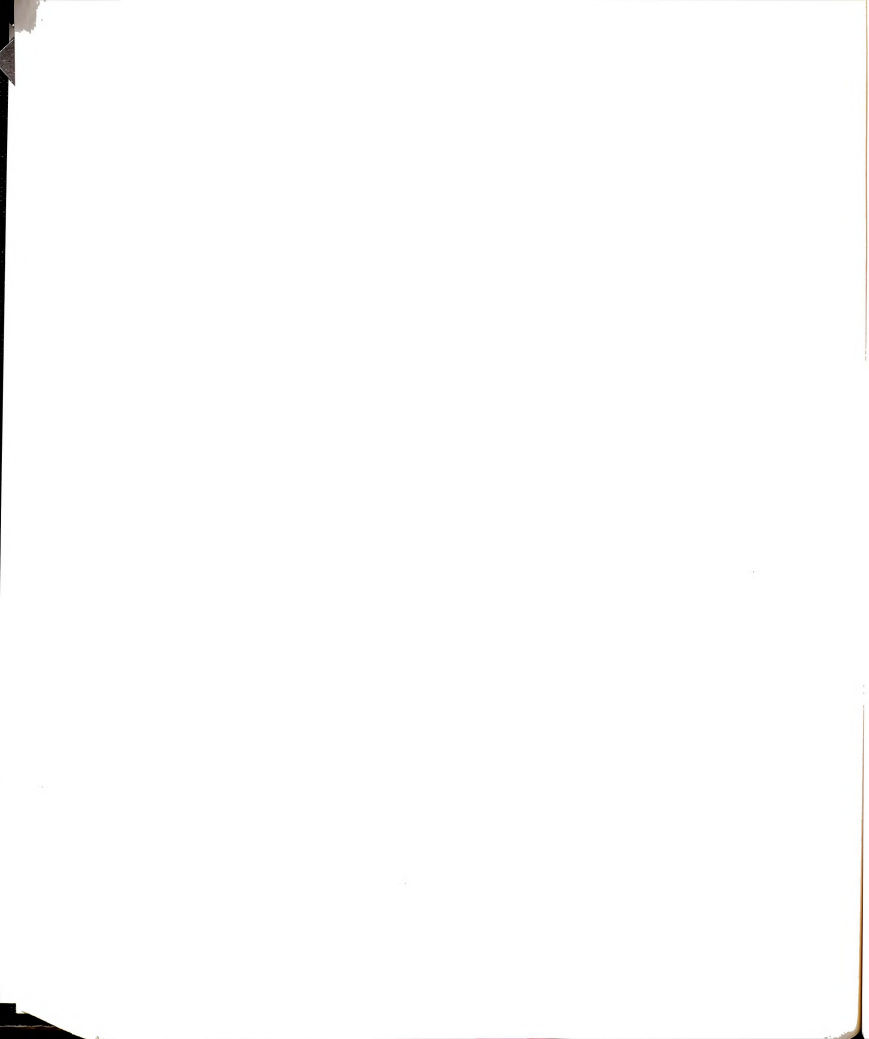
*p < .05 **p < .01

IHLC	= Internal Health Locus of Control	PSPB	= PSUP minus PBAR
PHLC	= Powerful Others Health Locus of Control	WSPB	= WSUP minus WBAR
CHLC	= Chance Health Locus of Control	SHVN	= Social Health Values/Norms
HHST	= Health History (Past Health)	DHGL	= Desired Health Goal Level
PSUP	= Personal Support/Pressure to Use EAP	CRPR	= Current Health Problems
PBAR	= Personal Barriers to Using EAP	PDSC	= Perceived Discrepancy Between DHGL & CRPR
WSUP	= Work Support/Pressure to Use EAP	EXP	= Expectancy that EAP Will Help
WBAR	= Work Barriers to Using EAP	EAP	= EAP usage/non-usage

support/pressure/barriers measure--i.e., the personal barriers measure is used as one variable to calculate the personal support/pressure/barriers measure. Similarly, correlations are artificially high between work support/pressure/barriers (WSPB) and the two sources used to develop this variable (work support/pressure or WSUPP with $r = .77$, and work barriers or WBAR with $r = -.91$).

The correlation between current problems and desired change (i.e., perceived discrepancy) is also significant ($r = -.63$) where those who have more health problems (a low score on the current problems scale) tend to perceive more of a discrepancy between their desired and current health (a high score on the desired change scale).

Finally, as previously mentioned, a health goal-health status discrepancy measure was calculated to use as a method check to determine whether the model and relationships exist as predicted within the control theory framework. This health goal-health status discrepancy variable was calculated by standardizing each employee's scores on both the desired health goal and current health problems measures. These scores for each employee were then compared to determine whether the scores fell within the same percentile--i.e., if an employee's standardized score on desired health goal was in the upper 25th percentile and the person's standardized score on current health problems was also in the upper 25th percentile of scores then no discrepancy exists. If both scores for an individual did not fall within the same percentile, a health goal-health status discrepancy existed. Once all participants' scores were calculated, a t-test was conducted using the "perceived discrepancy" measure as the dependent variable to examine whether a significant difference was found between individuals without a discrepancy and those with one (with individuals categorized with/without a discrepancy based on standardized scores). The t-test indicated a significant difference between the two groups

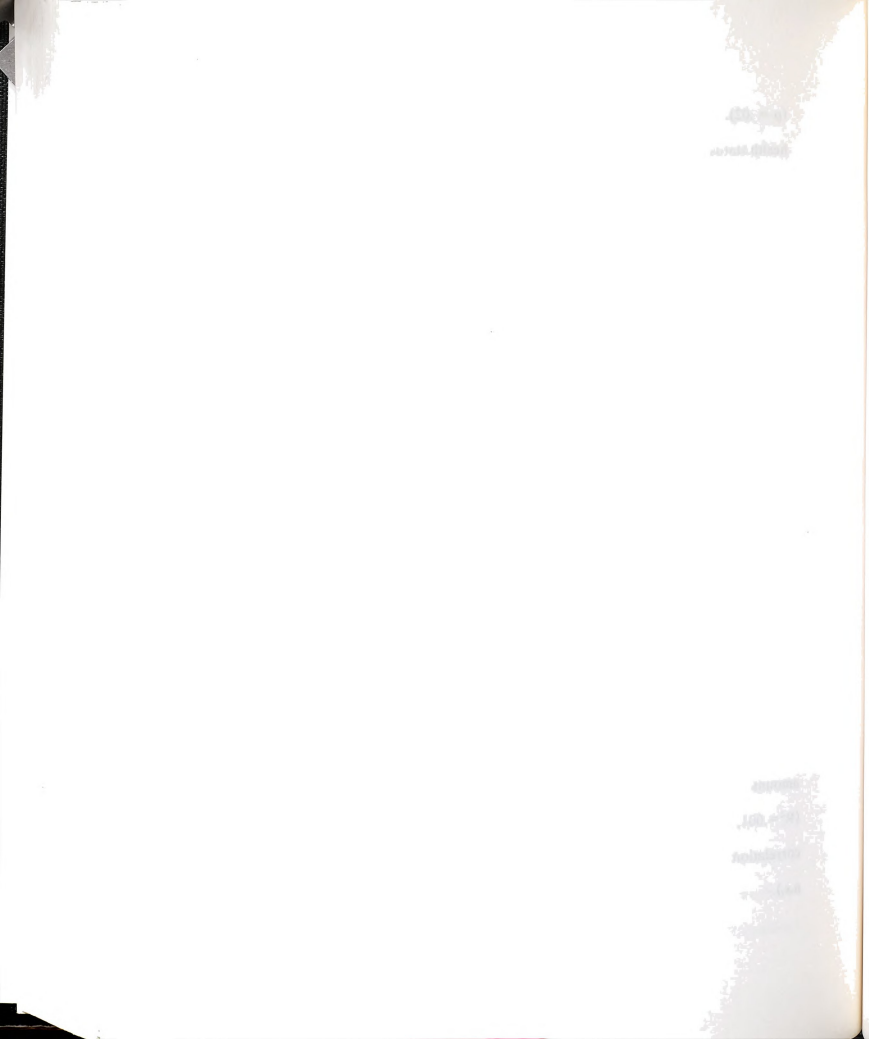


($p = .02$). As a method check on the control theory model, this calculated health goal-health status discrepancy measure (called the "actual" discrepancy) was also correlated with the "perceived" discrepancy measure created by the desired change variable ($r = .13, p < .05$). To determine whether the relationships within the model might exist as predicted, these two variables should be significantly correlated. The correlation between the variables was found to be significant but weak. Thus, additional research may be required to assess how useful control theory may be as a framework for understanding the EAP decision process.

Hypothesis # 1

The first set of hypotheses (# 1, # 2 and # 3) suggested similar predictions regarding the relationship of a specific independent variable with an individual's desired health goal. Each hypothesis was tested by regressing desired health goal level on the particular variable.

Hypothesis # 1 suggests that an individual's past health (health history) will influence his/her desired health goal level. A main effect was predicted for health history such that individuals with more prior health problems would demonstrate a higher desired health goal level than individuals with fewer prior health problems. This hypothesis was tested by regressing desired health goal on health history. A significant amount of variance in the desired health goal level was not explained by health history ($R^2 = .001, n.s., n = 274$); thus, support for the hypothesis is not indicated. The correlation between health history and health goal level was also not significant ($r = .02, n.s.$).



Hypothesis #2

Hypothesis #2 predicted that an individual's Health Locus of Control (HLOC) will have an effect on the person's desired health goal level such that individuals who are internals will have a higher desired health goal level than those who are externals (i.e., score higher on either the powerful others or chance subscale). To test this, a separate regression was conducted on each of the three HLOC subscales. Table 8 displays the results of these regressions.

Internal HLOC was not a significant predictor of desired health goal. The correlation was also not significant ($r = .07$, n.s.). Similarly, the Powerful Others HLOC subscale was not a significant predictor. However, the Chance HLOC subscale was a significant predictor of desired health goal level. In addition, Chance HLOC correlated negatively with an individual's desired health goal level, and the correlation between these variables was significant ($r = -.235$, $p < .01$).

Hypothesis #3

Hypothesis #3 suggested that an individual's perception of the health values and norms of members of his/her social group would affect the individual's desired health goal such that individuals who perceived more positive health norms among family and friends, past and present, would hold higher health goals than those who perceived lower health norms among their family and friends. This hypothesis was tested by regressing desired health goal on the social health values/norms measure. The regression results indicate that support for this hypothesis was not found ($R^2 = .004$, n.s., $n = 274$).



Table 8: Regression Results for the Health Locus of Control (HLOC) Subscales on Desired Health Goal Level

Regression Results for the Internal Health Locus of Control (HLOC) Subscale on Desired Health Goal Level

Variable	B	R	R ²	p of R ²
Internal HLOC	.084	.071	.005	n.s.

Regression Results for the Powerful Others Health Locus of Control (HLOC) Subscale on Desired Health Goal Level

Powerful Others HLOC	-.052	.051	.005	n.s.
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Regression Results for the Chance Health Locus of Control (HLOC) Subscale on Desired Health Goal Level

Chance HLOC	-.217	.235	.055	.0001**
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* p < .05

** p < .01



Hypotheses #4a, #4b, and #4c

The fourth set of hypotheses stated that the Health Locus of Control variables would moderate the relationship between perceived discrepancy and EAP utilization. Hypothesis #4a predicted that individuals who are high on the Internal HLOC subscale would respond to a perceived discrepancy between their desired and current health status by utilizing an EAP more than those who are low on the Internal HLOC subscale. Hypothesis #4b predicted that individuals who are low on the Powerful Others HLOC subscale would respond to a perceived discrepancy between their desired and current health status by utilizing EAP services more compared to those who are high on this scale. Similarly, hypothesis #4c predicted that individuals who are low on the Chance HLOC subscale would respond to a perceived discrepancy between their desired and current health status by utilizing an EAP more than those who are high on this scale. Thus, it was predicted that those individuals who were internals (i.e., high on Internal HLOC) would respond to their perceived discrepancy by utilizing an EAP more than individuals who were externals (i.e., high on Powerful Others or Chance HLOC).

These hypotheses were tested by running separate moderated regression analyses for each of the Health Locus of Control subscales. EAP usage was regressed on perceived discrepancy, each of the Health Locus of Control subscales, and the perceived discrepancy by Health Locus of Control subscale interaction term. These results are displayed in Table 9 and plotted in Figures 14 to 16. The interaction term for Internal HLOC by perceived discrepancy was marginally significant (at the $p < .10$ level). The interaction term for Chance HLOC by perceived discrepancy was also significant ($p < .05$). However, the interaction of Powerful Others HLOC by perceived discrepancy was

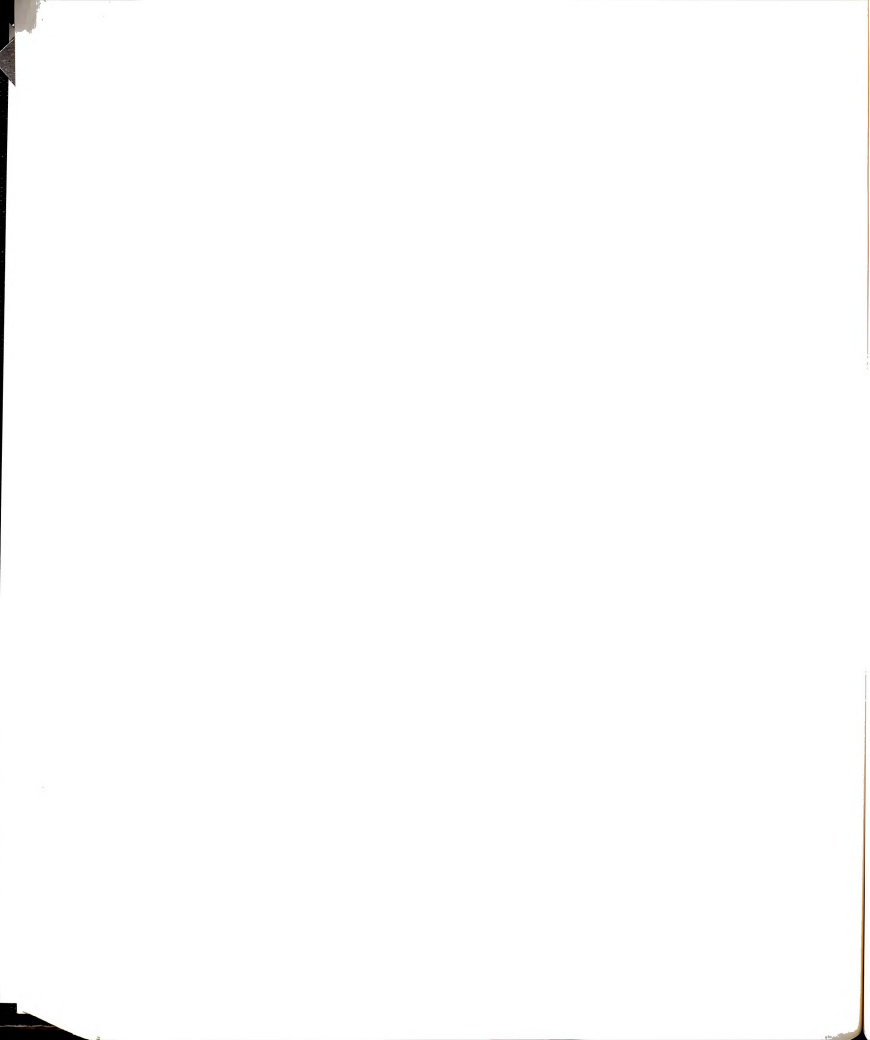


Table 9: Results of Regressing EAP Utilization on Health Locus of Control Subscales, Perceived Discrepancy, and the Interaction

Hypothesis #4a: Results of Regressing EAP Utilization on Internal Health Locus of Control (HLOC), Perceived Discrepancy, and the Interaction

Hierarchical Step	Variable	Beta	R	Adj R ²	Change R ²
1	Perceived Discrepancy	.682	.022	-.003	.001
2	Internal HLOC	.417	.105	.004	.011*
3	Perceived Discrepancy x Internal HLOC	-.732	.144	.001	.001*

Hypothesis #4b: Results of Regressing EAP Utilization on Powerful Others Health Locus of Control (HLOC), Perceived Discrepancy, and the Interaction

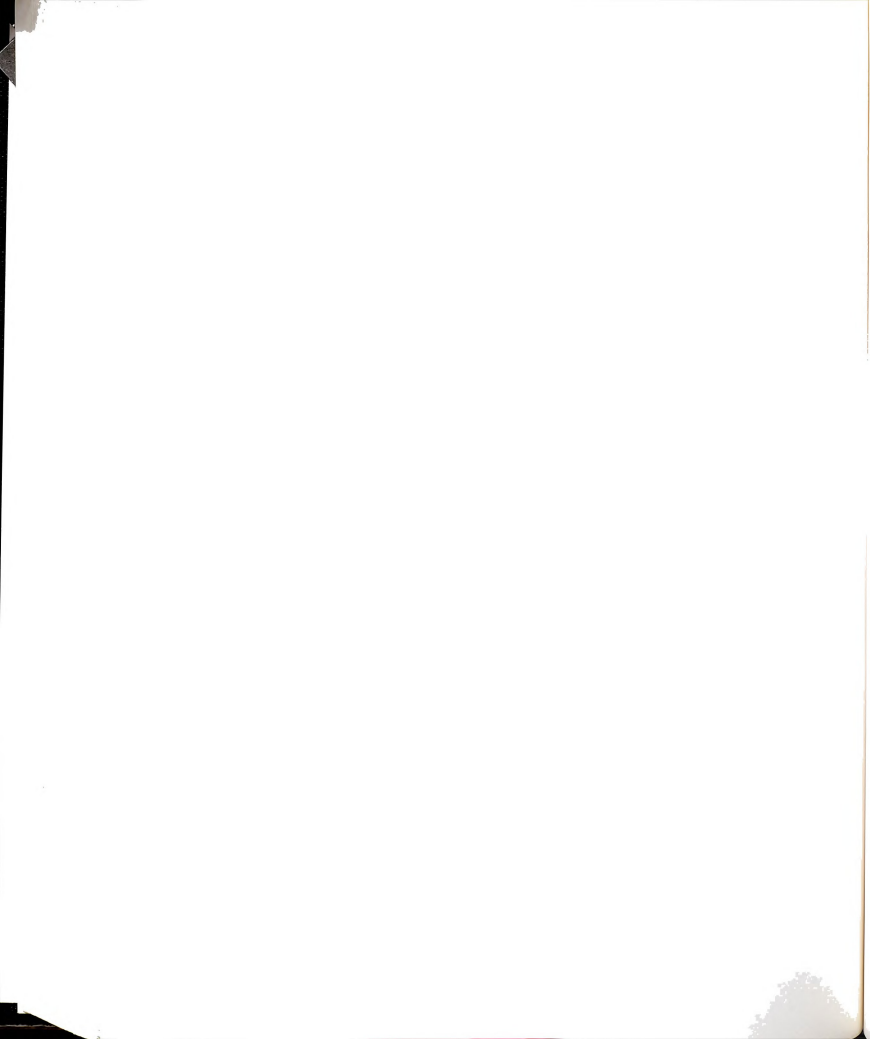
Hierarchical Step	Variable	Beta	R	Adj R ²	Change R ²
1	Perceived Discrepancy	-.263	.022	-.003	.001
2	Powerful Others HLOC	-.352	.130	.010*	.017**
3	Perceived Discrepancy x Powerful Others HLOC	.386	.154	.013*	.007

Hypothesis #4c: Results of Regressing EAP Utilization on Chance Health Locus of Control (HLOC), Perceived Discrepancy, and the Interaction

Hierarchical Step	Variable	Beta	R	Adj R ²	Change R ²
1	Perceived Discrepancy	-.399	.022	-.003	.001
2	Chance HLOC	-.410	.033	-.006	.001
3	Perceived Discrepancy x Chance HLOC	.556	.136	.008	.018**

* p < .10

** p < .05



Hypothesis #4a

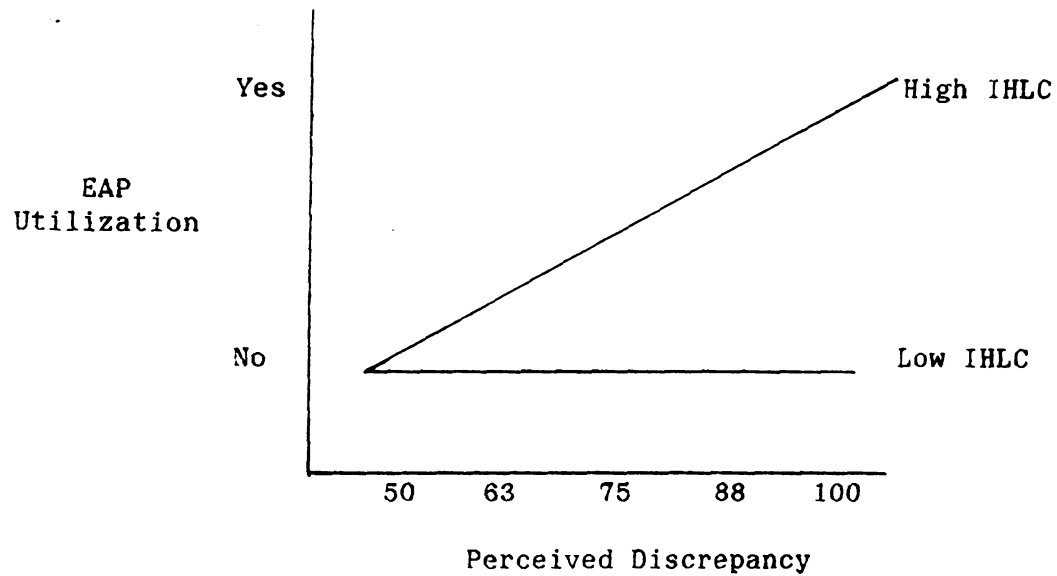
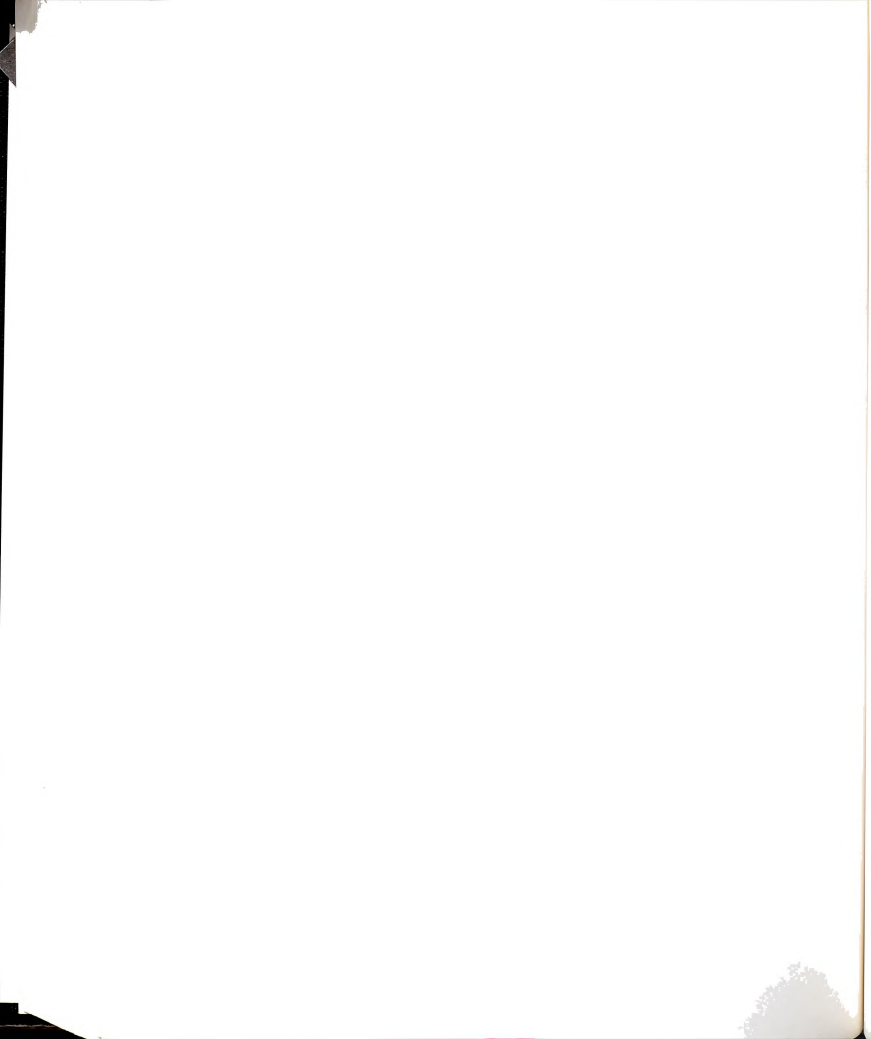


Figure 14: Results of Regressing EAP Utilization on Perceived Discrepancy by Internal Health Locus of Control (IHLC)



Hypothesis #4b

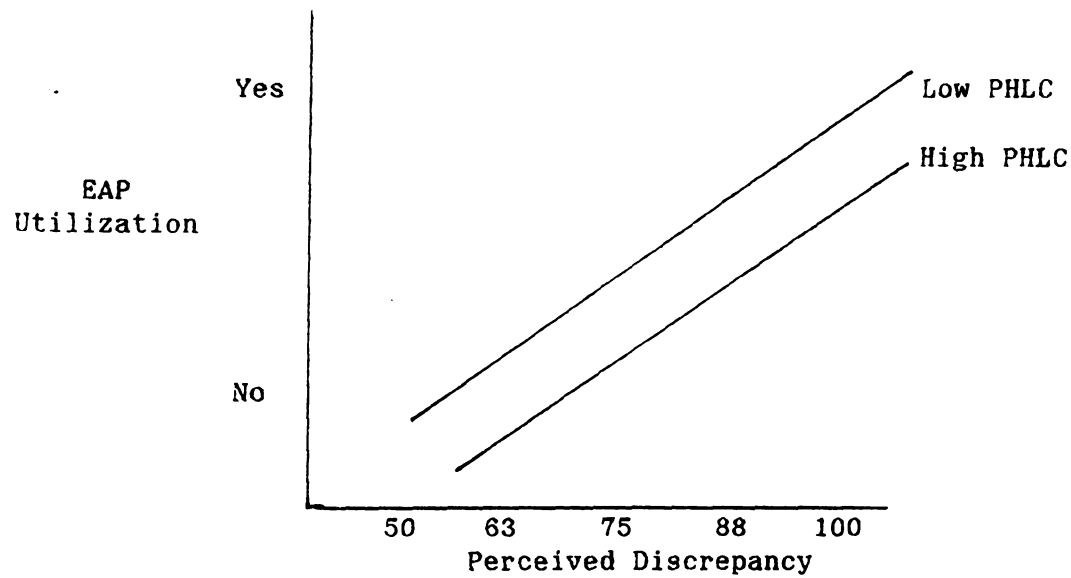


Figure 15: Results of Regressing EAP Utilization on Perceived Discrepancy by Powerful Others Health Locus of Control (PHLC)

Hypothesis #4c

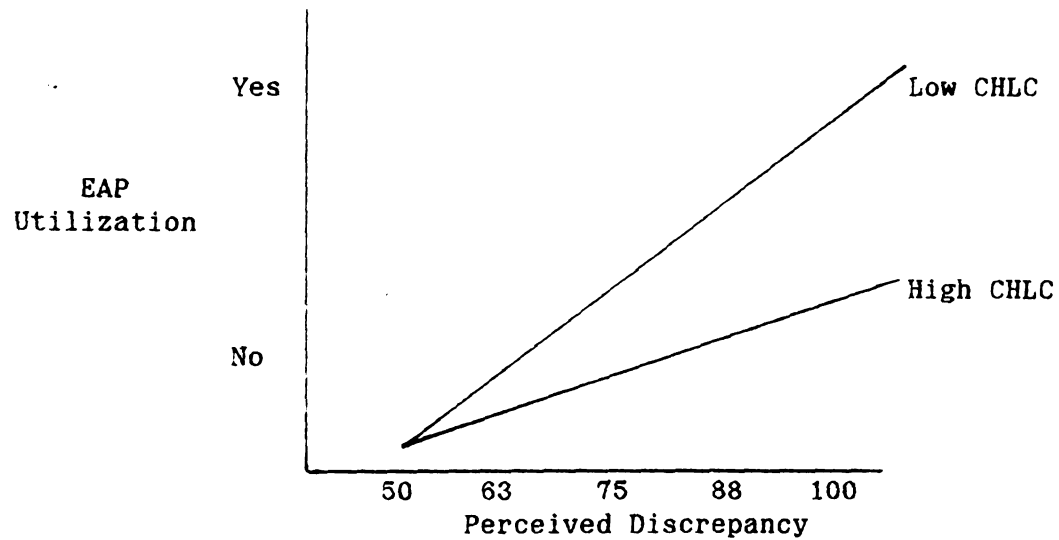


Figure 16: Results of Regressing EAP Utilization on Perceived Discrepancy by Chance Health Locus of Control (CHLC)



not significant. Moderator effects for Internal and Chance HLOC were found, thus hypotheses # 4a and # 4c were supported.

Hypothesis # 5

Hypothesis # 5 predicted that an individual's expectancy regarding the ability of the EAP to resolve or improve his/her current health problems would moderate the relationship between perceived discrepancy and EAP utilization. It was predicted that individuals who are high on the expectancy measure will respond to a perceived discrepancy between current and desired health by utilizing an EAP more compared to individuals who are low on the expectancy scale. Employees' EAP usage was regressed on perceived discrepancy, expectancy, and the perceived discrepancy by expectancy interaction term. Table 10 and Figure 17 display the regression results which indicate that expectancy is not significant as a moderator between perceived discrepancy and EAP utilization.

Hypothesis # 6

This hypothesis predicted a main effect for personal support/pressure/barriers to seeking EAP assistance such that individuals who perceive higher levels of support/pressure and fewer barriers from personal sources will tend to have used an EAP for services more compared to individuals who report low levels of support/pressure and perceive more personal barriers to seeking EAP assistance. This hypothesis was tested by regressing the personal support/pressure/barriers measure on EAP utilization. A significant amount of variance in EAP utilization was explained by this variable, thus the hypothesis is supported ($R^2 = .158$, $p < .01$, $n = 274$).



Table 10: Results of Regressing EAP Utilization on Expectancy, Perceived Discrepancy, and the Interaction

Hierarchical Step	Variable	Beta	R	Adj R ²	Change R ²
1	Perceived Discrepancy	-.118	.026	-.003	.001
2	Expectancy	-.635	.031	-.006	.000
3	Perceived Discrepancy x Expectancy	.567	.047	-.009	.001

* p < .10

** p < .05



Hypothesis 5

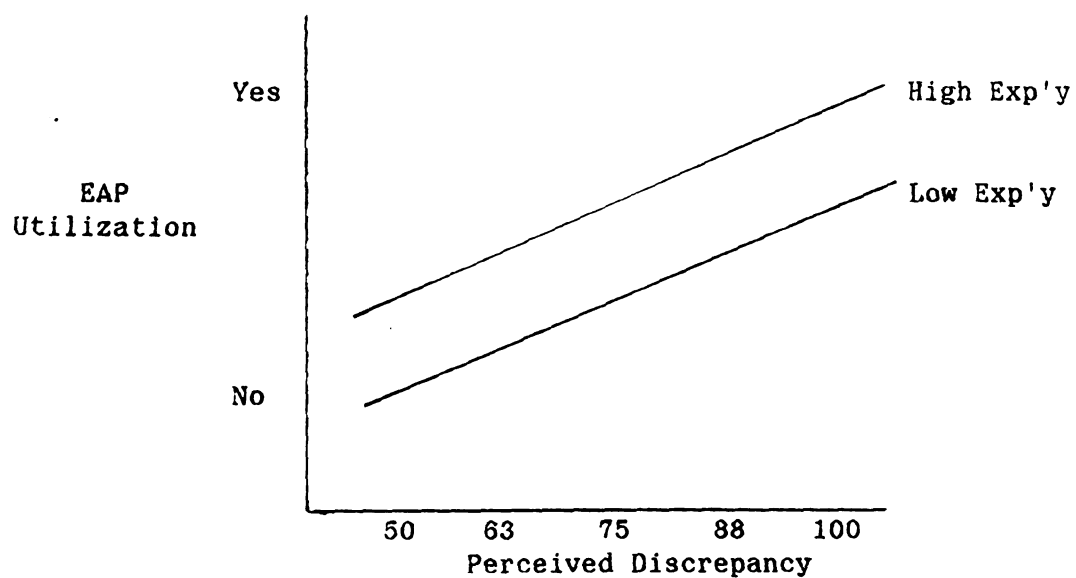


Figure 17: Results of Regressing EAP Utilization on Perceived Discrepancy by Expectancy



Hypothesis #7

Hypothesis #7 suggested a main effect for work-related support/pressure/barriers to seeking EAP assistance such that individuals who perceive higher levels of support/pressure and fewer barriers from sources within the organization will tend to have used an EAP for services more compared to individuals who report low levels of support/pressure and perceive more work-related barriers to seeking EAP assistance. This hypothesis was tested by regressing the work support/pressure/barriers measure on EAP utilization. A significant amount of variance in EAP utilization was explained by this variable, thus the hypothesis is supported ($R^2 = .058$, $p < .01$, $n = 274$).

The work support/pressure/barriers variable was calculated by subtracting an individual's perception of work-related barriers to using an EAP from his/her perception of work support/pressure to use an EAP. The correlation between this new variable created called work support/pressure/barriers and EAP utilization was significant ($r = .24$, $p < .01$). The work-related barriers variable alone was also significantly correlated with EAP utilization ($r = -.294$, $p < .01$). The correlation between work support/pressure and EAP utilization was not significant ($r = .074$, n.s.).

Post-Hoc Analyses

Most past EAP research has examined demographic variables and EAP utilization to understand the profile of EAP users. The purpose of the present research was to examine additional factors which potentially may influence EAP utilization. These additional variables might be classified into two categories: those that are related to perceived support, pressures, and barriers to using EAP services and those that are related to personal attitudes, characteristics, and beliefs. A post-hoc analysis was

F. B. I.

Investigative Division

San Francisco

Report

Subject: [illegible]

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Date: [illegible]

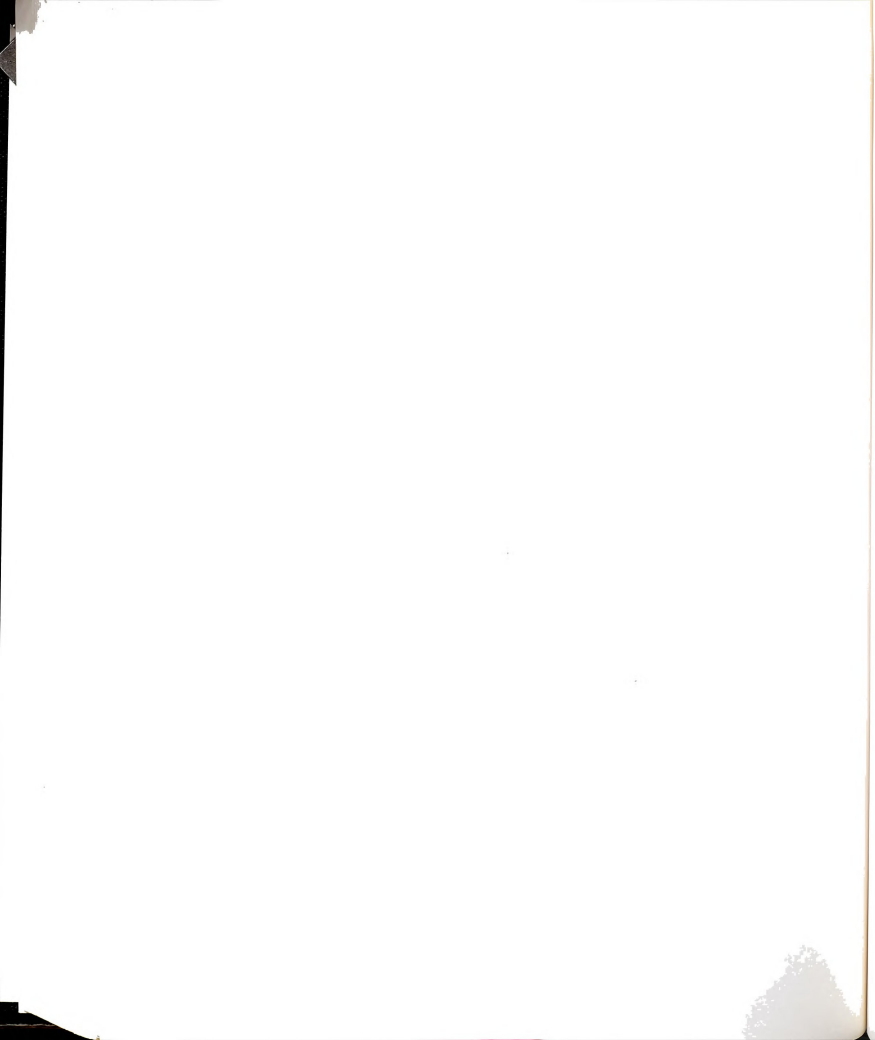
conducted to examine whether the two additional categories of variables significantly added to our understanding of EAP utilization beyond demographic characteristics. To do this, a hierarchical regression was conducted where demographic variables were entered in the first step, the support/pressure/barriers variables were entered in the second step, and the attitudes and belief variables were entered in the third step. Results of this regression are displayed in Table 11. The regression indicates that demographics had no significant influence on EAP utilization (R^2 change = .039, n.s., $n = 262$) while the addition of the personal and work support/pressure/barriers variables had a significant impact on EAP usage (R^2 change = .175, $p < .01$, $n = 262$). Also, adding the attitudes and beliefs variables (Health Locus of Control and Expectancy) significantly added to explaining EAP utilization beyond the demographic and support/pressure/barriers variables (R^2 change = .008, n.s., $n = 262$). This regression indicates that Health Locus of Control and the expectancy that an EAP will help resolve problems may be key variables influencing EAP utilization along with perceptions of personal and work-related sources of support/pressure and barriers to utilizing EAPs.

A few additional variables measured on all participants were examined next and individuals were again compared by EAP-usage and non-usage. Employees were asked whether they had the opportunity to utilize affordable assistance services other than the organization's EAP. This question was asked separately to examine the relationship between having other resources available and EAP utilization. The potential availability of other resources was not included in the personal support/pressure or barriers measures described above because these resources were not viewed as a potential source of support nor as a potential barrier to EAP usage. While it might be argued by some that the availability of other resources might decrease EAP usage, the present research

Table 11: Results of Regressing EAP Utilization on Demographic Variables, Support/Pressure/Barriers Variables, and Personal Beliefs/Value Variables

Hierarchical Step	Variable	Beta	R	Adj R ²	Change R ²
1	Demographics		.197	.008	.039
	Tenure	.042			
	Job Position	.106			
	Race	-.021			
	Marital Status	-.057			
	Gender	.122			
	Age	-.082			
	Education	-.004			
	Family Income	-.007			
2	Support/Pressure/Barriers		.462	.182**	.175**
	Personal	.409			
	Work	.029			
3	Health Locus of Control and Expectancy		.471	.178**	.008**
	Internal HLOC	.056			
	Powerful Others HLOC	-.029			
	Chance HLOC	.027			
	Expectancy	-.067			

** p < .01



did not view EAP utilization in this manner. EAP services include the referral of clients to external resources, thus EAPs typically operate in an environment where a variety of other assistance services are available and EAPs are often viewed by clients as the first source of assistance.

A t-test was conducted examining the differences in the means between EAP users and non-users on this variable. This test was significant ($p < .05$) and indicated that EAP users also perceived more access to other resources. A crosstabulation analysis was performed between EAP usage and perceived opportunity to use other services, and results are presented in Table 12. Those who perceive an opportunity to utilize other assistance services (e.g., spouse's EAP, church counselors, psychiatrist) still tend to take greater advantage of the organization's EAP services. Also, those who do not use the organization's EAP also do not perceive there are other services available.

Individuals were also asked about their willingness to use the organization's EAP if the services were needed. A t-test was conducted comparing the means of the EAP users and non-users on this variable and the t-test was significant ($p < .01$). While it may not be surprising to find that EAP users tend to be more willing to use an EAP in the future compared with non-users, it is encouraging to find that the experience of using an EAP did not turn EAP users against future utilization.



Table 12: Crosstabulation Analysis of Availability of Other Resources and EAP Utilization

<u>Variable</u>	<u>Total</u>	<u>Non-EAP Usage</u>		<u>EAP Usage</u>		<u>Chi-Square</u> <u>Significance</u>
	<u>N</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	
Other Resources						.024**
Yes	150	49	.33	101	.67	
% of N by Usage			.46		.60	
No	124	57	.46	67	.54	
% of N by Usage			.53		.40	

* p < .05

** p < .01



CHAPTER 6

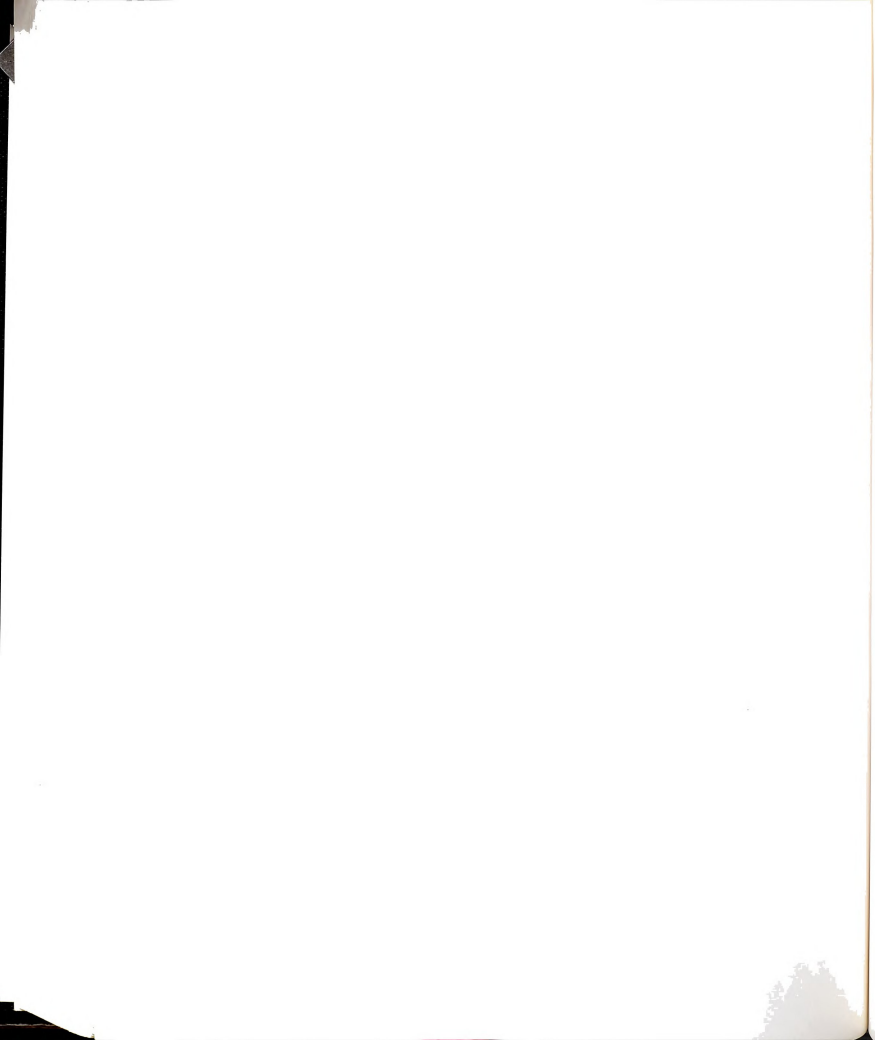
DISCUSSION

The purpose of the present research was to examine factors which may influence an employee's decision to seek EAP assistance and to develop a conceptual model to guide research in this area. A Control Theory Model of EAP Utilization was developed and parts of the model were tested in order to gain a better understanding of the EAP utilization process. The setting was an organization which provided a number of EAP services to all employees as part of its employee benefits package. All employees in the sample had equal access to the EAP.

Seven main hypotheses were studied. Three hypotheses examined factors influencing the goal/standard variable, i.e., the desired health goal, within the control theory model. None of these hypotheses was fully supported. In addition, two hypotheses predicted a moderator effect on the relationship between perceived discrepancy and EAP utilization for Health Locus of Control and expectancy that an EAP will help improve one's health problems. Health Locus of Control was found to moderate this relationship, though the hypothesis was not completely supported. The last two hypotheses tested for a direct relationship with EAP utilization for the following two variables: personal support/pressure/barriers and work support/pressure/barriers. Both variables were found to be significantly related to usage. The following sections will provide a discussion of these findings.

Hypothesis # 1: Effect of Health History on Desired Health Goal

Hypothesis # 1 predicted that an individual's health history would significantly affect his/her desired health goal level such that the more health problems an individual



has experienced, the more likely he/she would hold higher health goals. The regression analysis found no significant relationship between health history and desired health goal, thus this hypothesis was not supported.

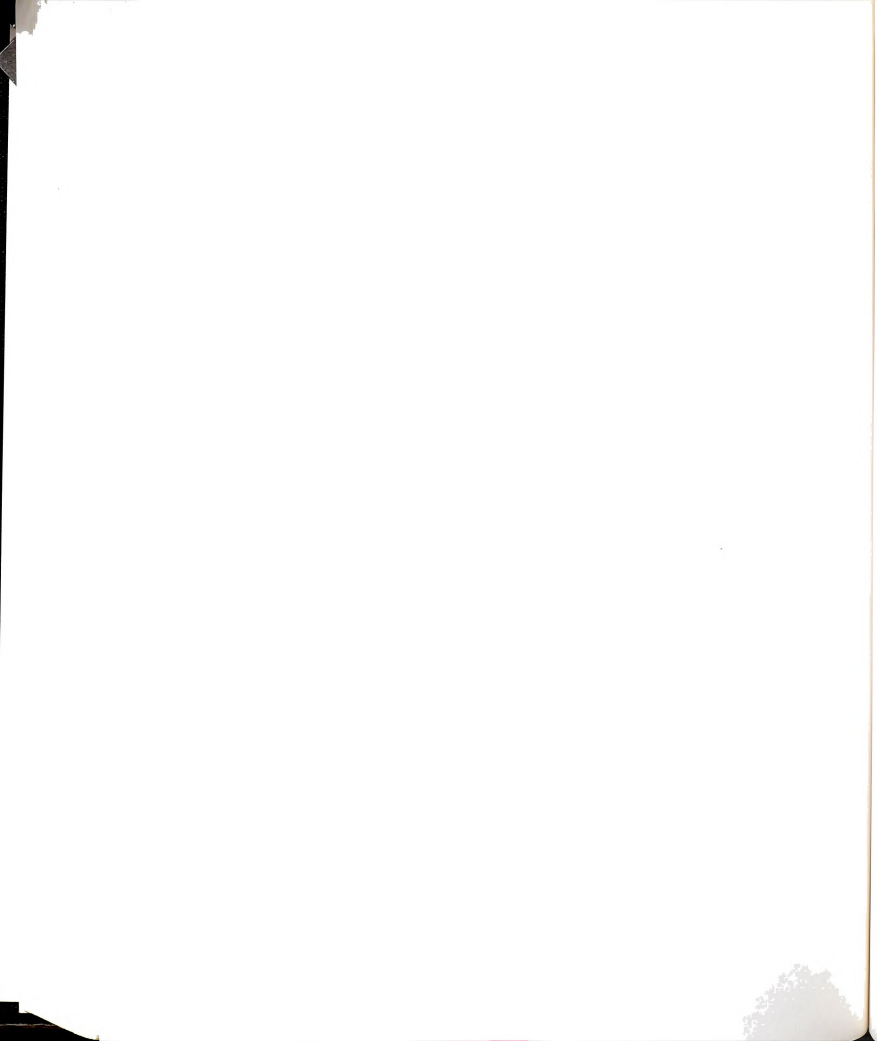
There are a number of potential reasons for the failure to observe a significant relationship between a person's past health experiences and his/her desired health goal. First, there may be problems with the measurement of the health goal construct. For example, it may be difficult to obtain variability among individuals when measuring what they desire their health to be because how many individuals would desire or admit to desiring poor health? A second possible explanation for the lack of an observed relationship is that the expectations for the effect may have been overly optimistic. Since there was no previous research found that suggested a relationship might exist between these two variables, the hypothesis was based on an inferred relationship. This relationship assumed that poor health would lead to a heightened desire for good health, and thus to higher health goals.

An alternative explanation might be that the lack of a relationship suggests that some individuals with poor health may actually want to try to improve their health and desire higher health goals while others with poor health may become more realistic about their health status and actually feel they will have to learn to live with their problems. Thus, due to their past health experiences, individuals may actually lower their health goals to what may be more realistic health expectations. It could be that no relationship between past health and desired health goal was observed due to the two potential responses among individuals that may have cancelled each other out.

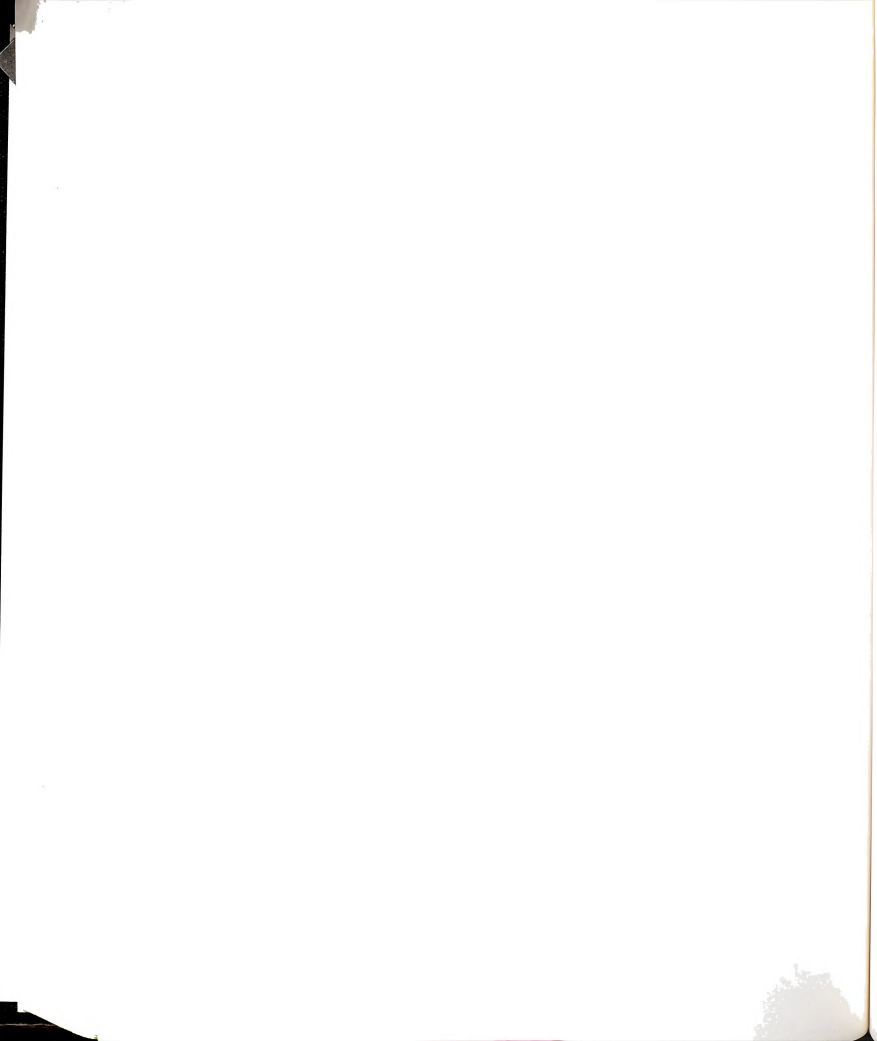
Research on goal-setting may further help to explain the lack of an observed relationship. Champion and Lord (1982) have stated that the literature indicates that past

performance and ability are primary determinants of initial goal levels, which then serve as referents for future behavior. Subsequent discrepancies between feedback and this referent goal creates a motivation to reduce the discrepancy. However, depending on individual or situational characteristics, a person may reduce the discrepancy by modifying either his/her behavior or goals (Campion & Lord, 1982). Campion and Lord found that past success and high ability tend to lead to higher goal levels. Hollenbeck and Williams (1987) also concluded that those individuals setting the highest goal levels held perceptions of high past performance levels. However, others examining the goal-setting process have reported that some individuals raised their goals after failure while others lowered their goals following success (Kernan & Lord, 1985).

Two additional variables that have been found to influence the goal-setting process may explain the ambiguity. These are goal importance and self-focus. According to Carver and Scheier (1981), a person's attention can be directed in one of two directions: inward toward the self or outward toward the environment. When attention is inward, the individual is engaging in self-focus or self-attention. Hollenbeck and Williams (1987) found that individuals high in self-focus are more aware of the discrepancy between goals and feedback, and thus are more likely to undertake discrepancy-reducing behavior compared to individuals who are low in self-focus. They also found that the setting of a goal is an interactive function of perceptions of one's past performance, self-focus, and perceived goal importance where the more successful the performance and the higher the level of self-focus and goal importance, the more the individual sets higher goal levels. Future research should examine the influence of self-focus and goal importance on desired health goal level.



Another variable that may be important in understanding the goal-setting process is self-efficacy. Self-efficacy refers to the judgments people make about their ability to execute courses of action, where those who are high in self-efficacy feel they can master some task. It differs from Internal Health Locus of Control because those high in Internal HLOC believe their actions are responsible for outcomes received but having an Internal HLOC does not necessarily mean the person believes he/she has the ability to actually execute the actions to obtain desired outcomes (Bandura, 1982). Individuals high in self-efficacy tend to perceive they have the ability to execute the actions. Self-efficacy is not the same as believing one has control, although there may be a relationship between Health Locus of Control and self-efficacy (it seems logical that individuals who have an internal health locus might also be high in self-efficacy, although the relationship between self-efficacy and external locus of control is uncertain). Self-efficacy has been found to be related to a person's past accomplishments where past successes increase feelings of self-efficacy if attributable to unchanging factors, like personal ability, while past failures tend to reduce these feelings (Bandura, 1982). If individuals have been relatively healthy in the past (health success), their self-efficacy may increase, depending on what they attribute the cause of their success to. These individuals may increase or hold a high desired health goal level because they believe they have the ability to carry out their tasks/goals. On the other hand, if individuals have had poor health in the past, their self-efficacy may be lower, and thus they may tend to hold lower health goals because they fail to perceive they have the ability to achieve these goals anyway. Thus, self-efficacy may be an additional individual characteristic that might interact with past history to determine future goal



levels. Future research might examine the relationship among self-efficacy, prior health status, and health goals.

Hypothesis #2: Effect of Health Locus of Control on Desired Health Goal

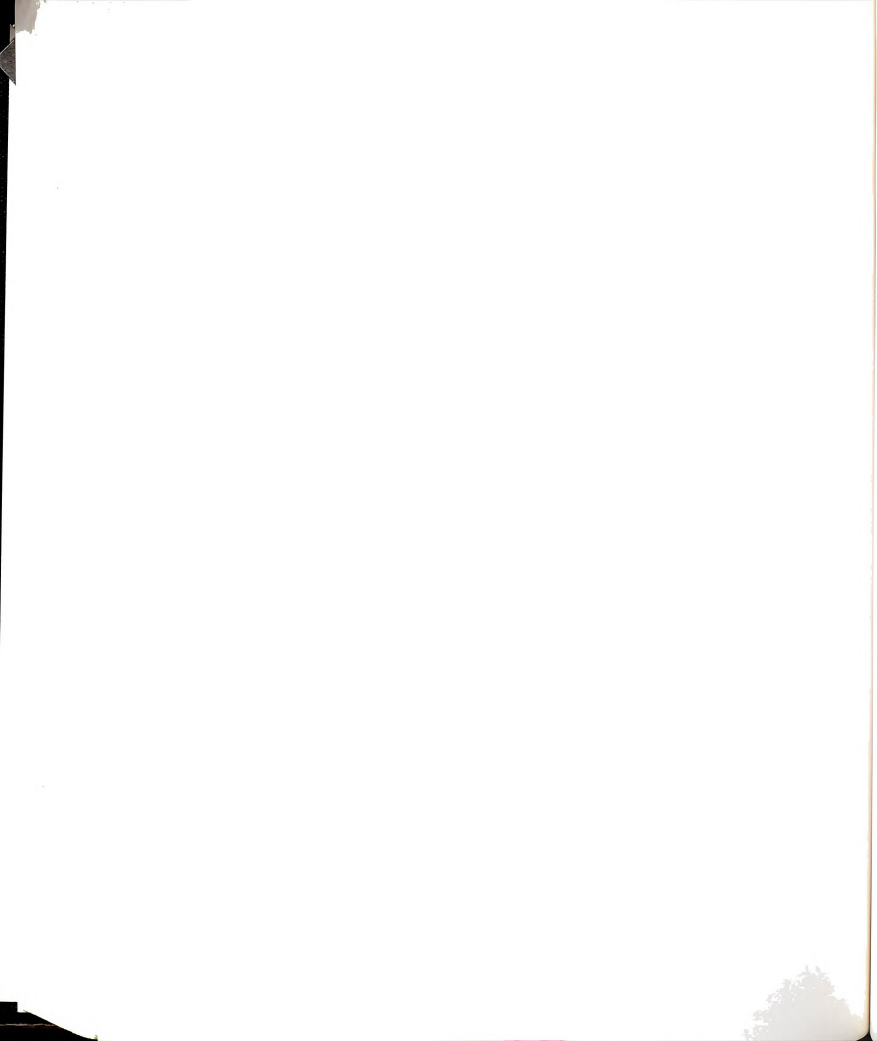
In the second hypothesis, individuals with an Internal HLOC were predicted to hold a higher desired health goal level compared to individuals with an External HLOC (either Powerful Others or Chance). There was no statistically significant relationship found between desired health goal level and Internal HLOC or between desired health goal level and Powerful Others HLOC (an external subscale). However, the regression analysis found a statistically significant relationship between desired health goal level and individuals' beliefs about the extent their health is a function of luck or fate--i.e., Chance HLOC (External). Thus, while the hypothesis is not fully supported, it is interesting to note that those individuals who believed their health was determined by chance also held lower desired health goals. After all, belief in chance suggests the individual has no control over his/her health.

It is interesting to note that the present research provides more explanation on why individuals lower their health goals but few guidelines as to why individuals may be more health conscious. While chance may be associated with a reduction in desired health goals, no explanation was provided in the research as to factors that enhance an individual's health goals. Also, a potential problem in observing an effect, as previously discussed, is that it may be difficult to obtain adequate variation in the desired health goal level. Being healthy is such a desired state that little variation may exist in the population regarding this factor.

Past research on Health Locus of Control has examined its relationship with actual healthy and health-seeking behaviors. The relationship between Health Locus of Control and what one desires, i.e., desired health goals, has not been previously examined. Also, no research was found on health decisions and the difference between what an individual desires and what the person actually does. Thus, further research needs to be conducted to understand personality factors which may be involved. Certainly it's not unique for there to be a discrepancy between what people say and what they do.

Hypothesis #3: Effect of Social Group Health Values/Norms on Desired Health Goal

Hypothesis #3 predicted a relationship between an individual's desired health goal level and the health values and norms held by members of the individual's social group. It was hypothesized that the more positive the perceived health values/norms are of one's social group members, the higher the individual's desired health goal level. Similar to Mayer's (1988) conclusion that health norms within an organizational setting had no relationship with an employee's health attitudes and behaviors and Hung's (1988) finding that EAP use was not significantly related to perceptions of the organization's "climate" (warm or cool toward employees), the regression analysis in the present study found no significant relationship between health norms/values of social group members and the individual's health goals. However, this finding is contrary to past research that has concluded that sick-role/healthy attitudes and behaviors are, at least partly, learned from others (Bruhn & Cordova, 1977; Mechanic, 1978; Pender, 1982; Rosenstock, 1975). This is an area that may require additional clarification.



One explanation for the lack of a relationship may be that there are perhaps two effects going on simultaneously which would tend to cancel each other out. For example, a person's social ties may result in one of two responses. Social relationships have been found to help reduce stress levels among individuals with close relationships (Cassel, 1976; Hirsch, 1980; Kaplan & Cassel, 1977). In addition, Lin, Simeone, Ensel and Kuo (1979) found that social support contributed significantly and negatively to illness symptoms such that individuals with more social support experienced fewer symptoms. Therefore, if social ties are close, individuals may actually experience fewer health problems/symptoms (Eaton, 1978; Hirsch, 1980; Lin, Simeone, Ensel & Kuo, 1979). In addition, close social ties have been found to encourage individuals to be more positive and proactive in their health attitudes and behaviors when they feel they have problems (Haskell & Blair, 1980; House, 1981). It thus seems that an important factor influencing attitudes and behaviors is that individuals must perceive a need or problem.

On the other hand, if social ties are weak or disrupted, the influence of the members of one's social group on an individual may actually increase the person's susceptibility and perception of illness (Pilisuk & Minkler, 1985). Thus, the perception of the norms and values of social group members may result in different responses depending on the closeness of the individual members. The actual relationship might be as follows: Social Group Health Values/Norms ----> Health History -----> Desired Health Goal Level. If the two responses discussed were occurring simultaneously, then no effect would have been found between social group health values/norms and desired health goal level or between health status and desired health goal level (hypothesis # 1).

Another potential problem is that in the present research, social health norms/values were examined regarding past social group members (parents, family,

friends growing up) as well as present members (spouse, children, etc.) and these perceptions were formed into one measure. Current levels of "closeness" to past/present social group members were not measured in the present research, nor was the present "quality" of the relationships measured; thus, positive norms of social group members may exist or have existed, but depending on whether these members are still an important aspect of an individual's life could determine the degree of influence the norms/values currently have on individuals.

In further examining the relationship between social group health values/norms and desired health goal, the correlation between these two variables was also found to not be significant. However, it is interesting to note the variables with which the social group health values/norms measure was found to be significantly correlated. For example, the social group health values/norms measure was significantly correlated with the number of current health problems reported by an individual ($r = .23, p < .01$) as well as the expectancy that an EAP will help resolve these problems ($r = .13, p < .05$). This might suggest that, while peer pressure/norms may not affect an individual's health goals, these social influences could be related to the person's perception of his/her current health such that individuals who perceive more positive health norms of social group members (i.e., the more health conscious the social group is perceived) also tend to perceive more health problems in themselves and to believe the EAP will help resolve these problems. Thus, a person's social group may be influencing his/her perceptions when the person compares his/her own health to the health and health-consciousness of his/her social group. Therefore, although the regression analysis suggests there is no significant relationship between social group health values/norms and desired health goal

level, correlationally an individual's perceptions of the health values/norms of social group members appear to be related to other issues.

The issue of how one's social group influences an individual's desired health standard/goal is an important concern within organizations. With the amount of effort and money being spent by firms to encourage employees to be more health conscious, a greater understanding of the role of peer pressure and social group norms is required. We don't know enough about these influences, and, in fact, there were contradictory findings in the manner others may influence individuals' health behavior. For example, in the present research Powerful Others Health Locus of Control had no influence on what an individual wanted regarding his/her health (desired health goal). However, when an individual perceived his/her social group to be health conscious, then the individual tended to report more health problems. This suggests that on the one hand there may be a relationship between perceptions of the health consciousness of one's social group and the health problems reported by that same individual. However, when individuals specifically perceive others are in control of them (i.e., their health) then these others may have less of an impact on the person. The interplay between what a person sees others doing (being health conscious) and its effect on the person and the effect others have on individuals when they are perceived to be in control of the person needs further study.

Summary of Relationships with Desired Health Goal

It could be concluded that an individual's perception of his/her health history, perceiving being in control of his/her health (Internal HLOC) and the health values and norms of one's social group did not influence the individual's desired health goal level

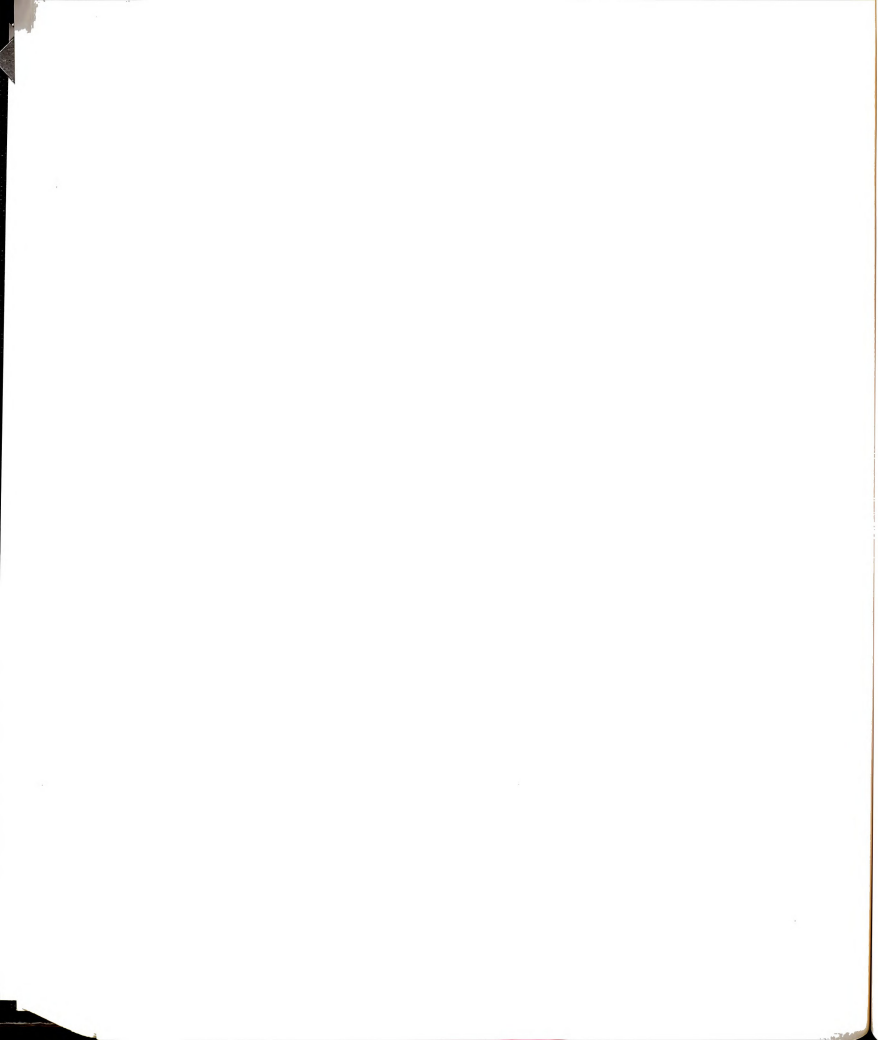
in this study. However, while prior health problems and feeling in control over one's health may not have affected the person's health goal, believing chance controls the person's health may be an important factor because the person who believes that chance is the controlling factor tends to hold lower health goals. Also, if individuals that the person associates with are health conscious, these individuals may influence the person to perceive that he/she is not as healthy (and thus report more health problems, or possibly influence the person to do something to improve his/her health, such as seeking EAP assistance).

On the one hand, it may be helpful to understand how the belief in chance/fate/luck controlling one's health might operate to influence a person's health goal. The suggestion in the present research that the belief in chance controlling one's health might influence a person to lower his/her health goals is intriguing. For instance, could the relationship between Chance Health Locus of Control and desired health goal level be influenced by a person justifying or rationalizing his/her health beliefs and behaviors? Might a person believe that chance controls his/her health because it's a good excuse to not have to work toward good health? For example, how often does a person who smokes say "I know smoking causes cancer but it won't happen to me" or say "it doesn't matter what I do, if I'm supposed to get sick I will"? Thus, a person can justify smoking or other unhealthy behaviors and thus not have to make any changes in his/her life since "it won't do any good anyway" because the person believes his/her health is based on luck (or chance).

On the other hand, future research examining influences on the desired health goal level may not produce a greater understanding of EAP utilization behavior. Given the fact that the variables hypothesized to influence desired health goals were not

significantly related to the desired health goal level, along with the finding that an individual's desired health goal level was not correlated with EAP utilization, it may be that health goals do not significantly impact EAP utilization. However, as previously suggested, the lack of an observed relationship with desired health goal level may have been due to the operationalization of the desired health goal construct in the present study. One criticism of the measure is that it failed to discriminate among individuals holding high or low desired health goals. The range of scores that was possible for the desired health goal level measure was 11 to 58. In the present research, scores ranged from 24 to 56, with a mean and median of 44 and a standard deviation of 4.68. Over 84 percent of the respondents scored over 40 and less than one percent scored under 30. When comparing the scores from the top and bottom third of the respondents, the lower third scored 42 or less while the upper third scored 46 or more. It may be that individuals will not vary greatly in the extent they desire to be healthy, or not be consciously aware of a lower desired health goal level.

Another potential problem with the measure used is that the questions were worded in an absolute sense so that it was difficult to tell if a person's desire to be in good health was the same whether expressed by a healthy or less healthy individual. For example, individuals were asked what their desired health level was compared to others their age. Over 82 percent reported they desired above average or way above average health level and less than two percent desired to be less than average. In another example, individuals were asked how many pounds within their ideal weight they would like to fall. Over 43 percent desired to be within two to five pounds of their ideal weight and a total of 77 percent responded they desired to be within ten pounds of their ideal weight. Only 8 percent reported they desired to be 25 pounds or over 25 pounds from

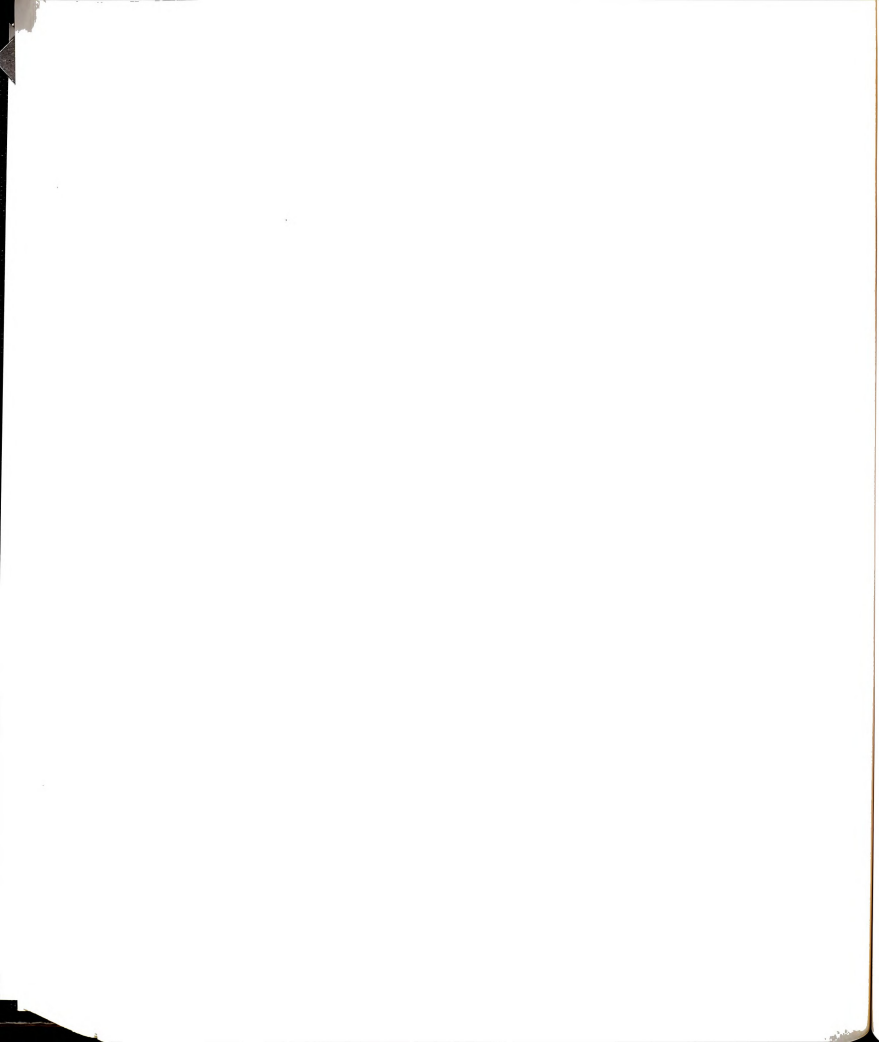


their ideal weight. The wording of the questions did not make it possible to differentiate among the different degrees of desired health. An individual who weighed 350 pounds and desired to be within 30 pounds of his/her ideal weight would be classified as desiring to be less healthy than the person who weighs 140 pounds but desires to be within ten pounds of his/her ideal weight. It may be necessary to develop a measure of desired health that is corrected for the absolute level on the variable to adequately distinguish among different desired health goal levels. A final issue regarding the health goal measure may involve whether individuals consciously hold specific health goals, or at least goals that go beyond simply a "general desire to be healthy."

How behavior and goals are influenced is a complicated matter. For example, one factor predicted to be central to EAP utilization behavior is the perceived discrepancy variable (in the present study this is the perceived discrepancy between desired and current health). The remaining hypotheses focus on factors which were predicted to influence actual help-seeking behavior regarding EAP usage.

Hypotheses # 4a, # 4b and # 4c: The Moderator Influence of Health Locus of Control

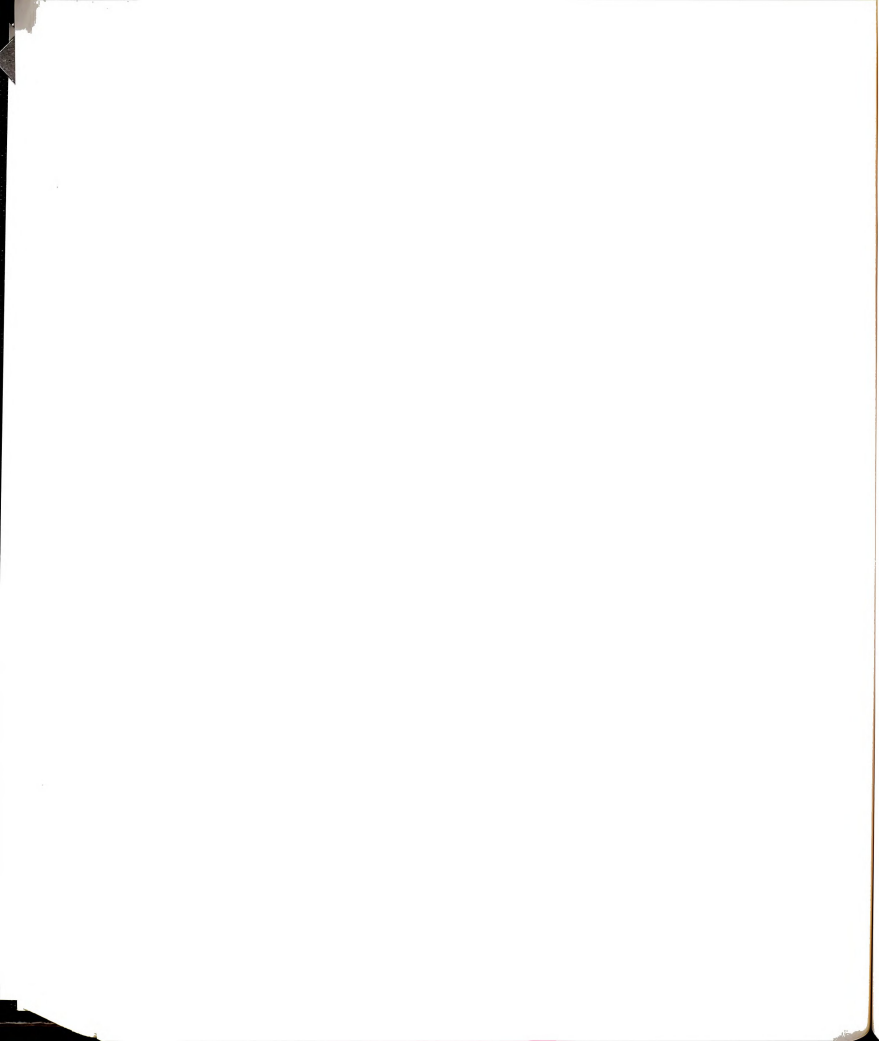
The fourth set of hypotheses predicted that Health Locus of Control would moderate the relationship between perceived discrepancy and EAP utilization. In other words, it was predicted that the strength of the relationship between the difference between desired and current health and EAP utilization will be stronger for those individuals who are high on Internal HLOC than it will be for those with who have a low Internal HLOC. It was also predicted that the strength of the relationship between the difference between desired and current health and EAP utilization will be weaker for those individuals who are high on either of the External HLOC subscales (Powerful



Others or Chance) than it will be for those with who are lower on either of these subscales. The regression analysis indicated that Internal HLOC and Chance HLOC were both significant moderators between perceived discrepancy and EAP utilization. Hypotheses #4a and #4c were supported in that those with an Internal HLOC did tend to use the EAP while those believing luck controlled their health tended to not use the EAP. However, Powerful Others HLOC had no significant moderator effect, just as it had no significant direct effect on desired health goal (see hypothesis #2). In other words, the belief that powerful others control an individual's health had no significant relationship with the individual's health goals or health behavior (EAP usage).

It is interesting to find that Internal HLOC was significantly related to a person's EAP use but was not related to the person's desired health goal (see hypothesis #2). Prior research on HLOC compared internals and externals on a specific behavior--smoking/stop smoking, weight loss, use of seat belts or birth control, etc.--and has typically found internals to be more proactive. In the second hypothesis, however, HLOC was examined in its relationship to something desired (goal) not an actual behavior undertaken. It is possible that there might be a difference between a health goal, which is what one desires, and using an EAP (hypothesis #4), which is what one actually does. On the other hand, it is also possible that the lack of a relationship with desired health goal level was due to the operationalization of the construct, as previously discussed.

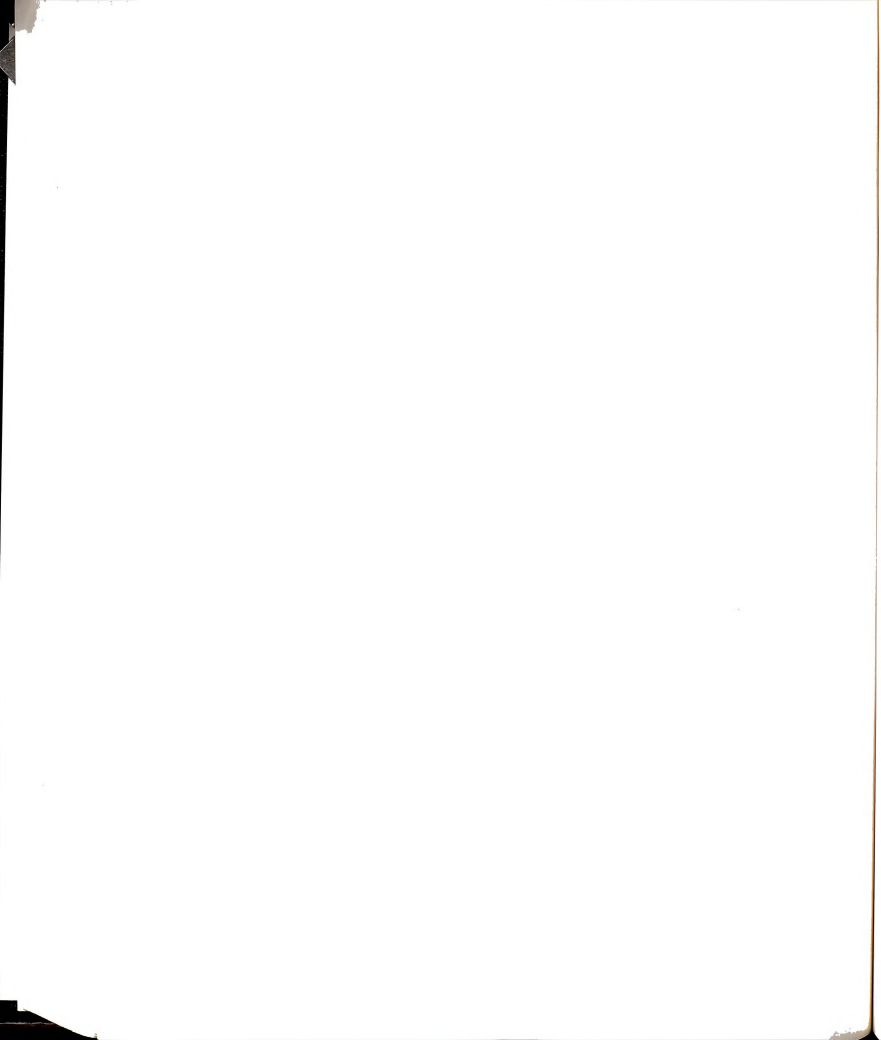
Another explanation as to why individuals who believe chance controls their health do not tend to use an EAP might be that those who believe chance controls their health simply see no need to undertake such a behavior (going to an EAP) in order to influence their health. This explanation is consistent with the relationships reported in



the present research. For example, Chance HLOC was found to be negatively related to the belief that an EAP will help ($r = -.18, p < .01$) and positively related to the number of barriers perceived to using an EAP from both personal and work-related sources ($r = .14, p < .05$ for both personal barriers and work barriers). In addition, Chance HLOC was also negatively correlated with perceived current health problems ($r = -.21, p < .01$), thus believing that chance controls one's health is related to an individual perceiving fewer health problems.

The regression analysis suggested that Powerful Others HLOC had no impact on EAP utilization. Previous research has typically found that individuals with an External HLOC (including Powerful Others HLOC) tend to take less control over their health behaviors--e.g., External HLOC individuals don't tend to quit smoking or lose weight, "external" cystic fibrosis patients don't tend to keep doctor appointments--because presumably they believe their behaviors will not impact their health ((Best, 1975; Coan, 1973; James, Woodruff, & Werner, 1972; O'Bryan, 1972; Platt, 1969; Schultz, 1981). However, regarding some health behaviors the findings have been equivocal. For example, Bellack, Rozensky and Schwartz (1974) found no significant relation between weight loss and locus of control. The present analysis indicated that usage and non-usage of an EAP occurred by both employees who scored high and employees who scored low on the Powerful Others HLOC subscale. In the present research the correlation between Powerful Others HLOC and the belief or expectancy that an EAP will improve one's health was also not significant.

The lack of a relationship between Powerful Others HLOC and EAP utilization might be due to the low reliability of the Powerful Others HLOC subscale in the present study. While Wallston and Wallston (1978) previously found reliability for this subscale



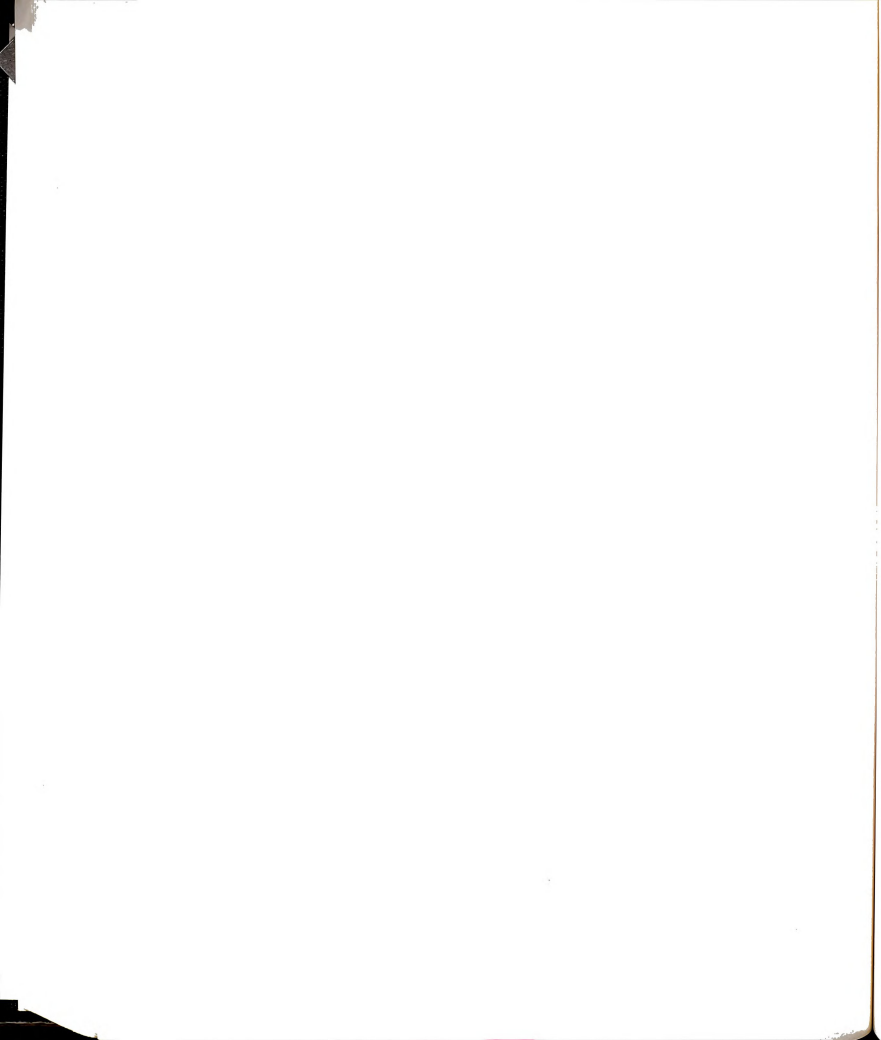
to be .71 (Cronbach Alpha), results from the third pilot test conducted for the present research indicated a reliability of .67 while results from the actual study data indicated a reliability of only .58. Also, in examining the data, almost 67% of the employees were classified as "low" on this measure and only .4% (one person) were classified as "high" (refer to the "Measures" section in Chapter 4 on Health Locus of Control). Thus, there may also be a restriction of range problem on this measure.

Another explanation is that individuals who tend to hold a Powerful Others HLOC have been found to be more susceptible to external or social pressures (Saltzer, 1978). For some, social pressures may be viewed as a form of support. House (1981) has suggested three ways in which support may reduce the impact of stress on an individual: it may reduce the importance of the perception that a situation is stressful, it may tranquilize the individual's system (neuroendocrine system) so people are less reactive to perceived stress, and it may facilitate health behaviors. Consequently, for some individuals, believing that others control one's health may be viewed as a form of support so that when a "powerful" person in the individual's life encourages/supports the individual in seeking help, the individual tends to seek assistance. For others, control by Powerful Others may be viewed as a form of social support that may tend to actually reduce the number of perceived health problems.

For instance, as previously mentioned, Lin, Simeone, Ensel and Kuo (1979) found that social support contributed significantly and negatively to illness symptoms such that individuals with more social support experienced fewer symptoms. Eaton (1978) studied life events, social support and psychiatric symptoms and concluded that social support among household members helps prevent mental disorders. Hirsch (1980) compared individuals who had recently been divorced and found that support enhances

one's adaptation to stress. Cassel (1976) and Kaplan and Cassel (1977) concluded that social support may actually ameliorate the effects of stress for individuals and, thus, reduce the need for treatment. It is possible that feeling others are controlling or concerned about one's health may act as a buffer and protect individuals from feeling under as much stress and in need of some form of assistance. Thus, Powerful Others HLOC may have failed to have a significant impact on EAP usage because two responses might be possible for individuals who believe others control their health. These individuals may see the situation as less in need of their seeking assistance because others are taking care of them or because others reduce the impact of their problem, or individuals may perceive more support and encouragement to do something about their health problem as being positive and thus may tend to follow the advice of these powerful others in their lives.

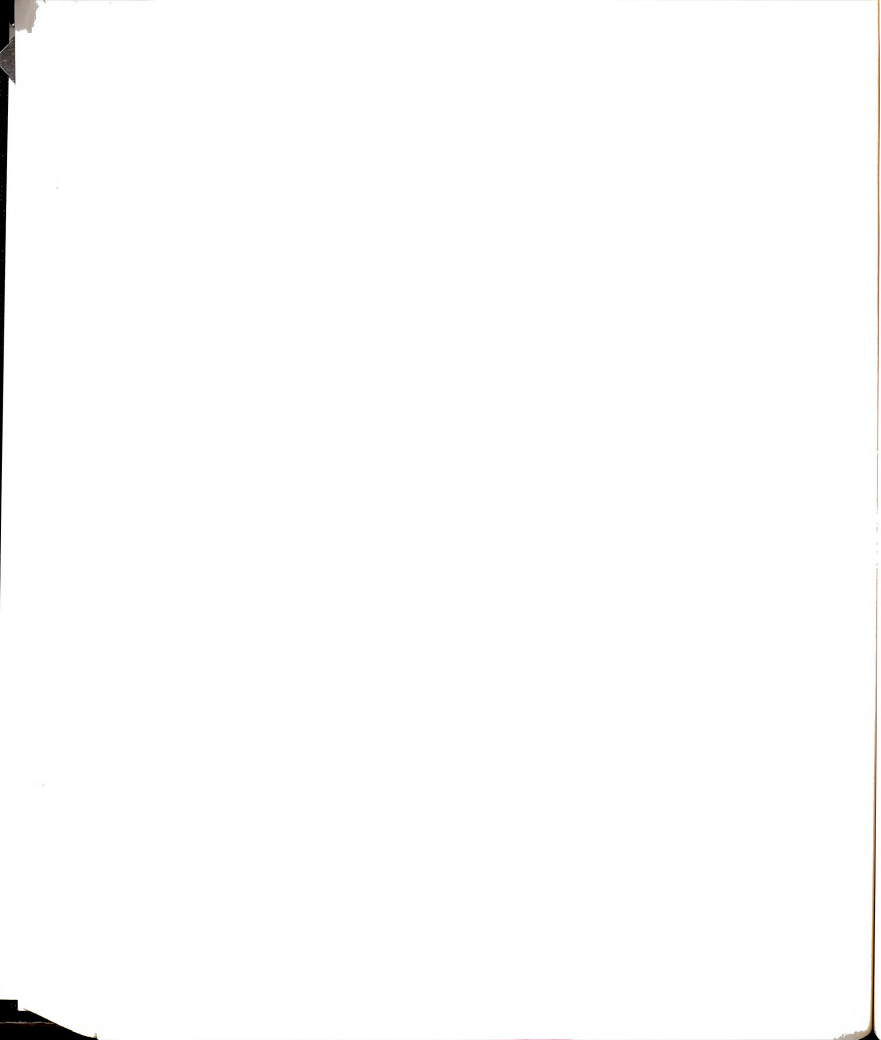
To further explore why Powerful Others HLOC did not seem to significantly affect what a person desires (health goals) or what the person does (seek EAP assistance) when a problem is perceived, an examination of the intercorrelations between Powerful Others HLOC and other key variables was undertaken. Powerful Others HLOC was found to be significantly correlated with: the number of reported past health problems/health history ($r = .23, p < .01$), reported current health problems ($r = -.16, p < .01$), and EAP utilization ($r = -.13, p < .05$). It is interesting to note the direction of the relationships. Believing that powerful others have control over a person's health is related to an increase in the number of health problems the individual reports he/she experienced in the past but to a decrease in the number of health problems the individual reports he/she currently has.



While the negative relationship between Powerful Others HLOC and current health problems does not allow us to make a causal conclusion, the relationship might suggest that believing powerful others control one's health may actually be viewed as a form of support that might influence (reduce) the current number of perceived health problems. The negative relationship might also suggest some form of denial process. It could be argued that believing others control an individual's health may influence the problems reported but may have less influence on whether the person will do something about it--i.e., go to an EAP (since the individual reports fewer current problems). We need to better understand the nature of Health Locus of Control and how perceptions of who or what controls health (Internal, Powerful Others, or Chance) impact health attitudes and behaviors. A focus of future research could be to explore this relationship between powerful others and chance. Since the data indicate that both are related (correlationally) to an individual's reporting fewer health problems, the influence of external factors on an individual's decision making process regarding health-related matters is obviously a complicated phenomenon that deserves more study. Perhaps efforts designed to encourage more health-related behaviors need to consider the importance of first making the individual think he/she is in control of his/her health before others can influence (tell) the individual what to do.

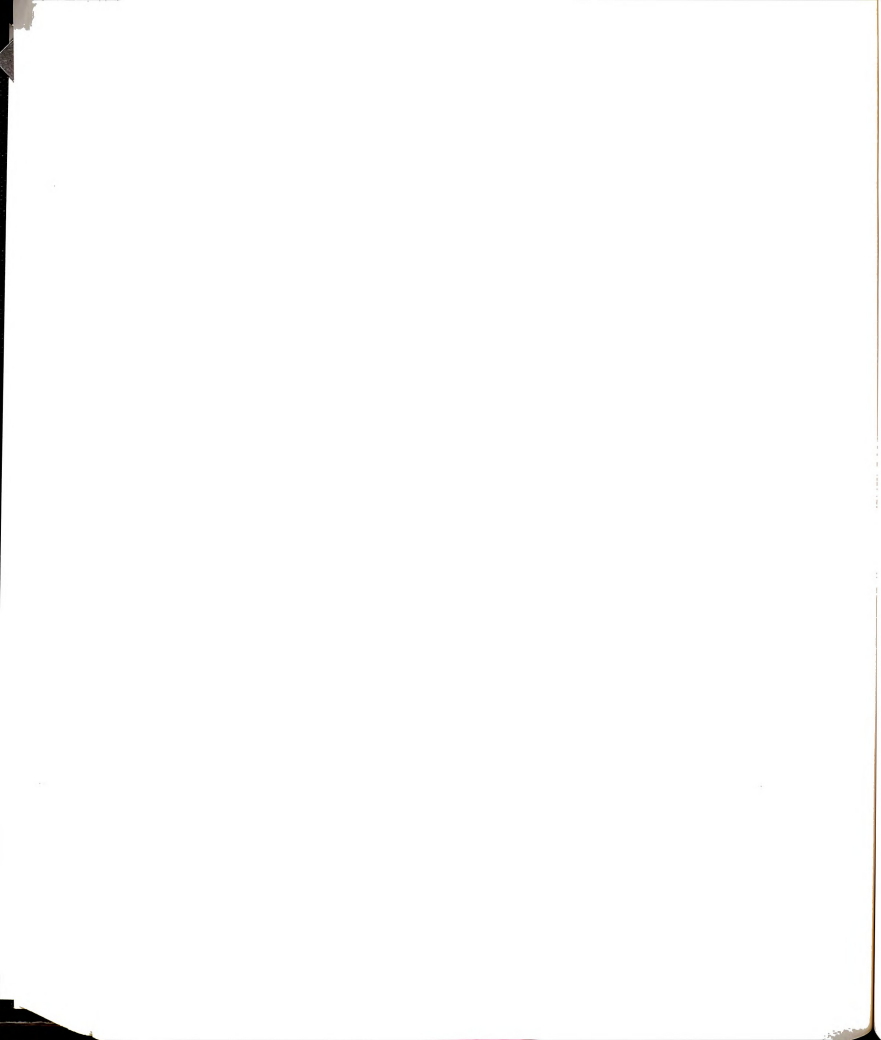
Hypothesis # 5: The Moderator Influence of Expectancy

It was hypothesized that an individual's belief that an EAP will help reduce/resolve current health problems identified by the individual (referred to as the "expectancy" that an EAP will help) would moderate the relationship between perceived discrepancy and EAP utilization. If individuals perceive a discrepancy between their



current and desired health and believe that the EAP will help reduce this discrepancy, it was predicted that the individuals would be more likely to go to an EAP. However, if individuals perceive a discrepancy but do not believe the EAP will help, then they will tend to not use the EAP. In the moderated regression analysis, an individual's expectancy that an EAP will improve one's health was not found to be a significant moderator between an individual's perception of a health discrepancy and EAP utilization. The zero-order correlation between expectancy and EAP utilization was also not significant ($r = -.02$, n.s.).

Expectancies have been found to be important in determining whether behavior will be initiated, and the amount of effort exerted and sustained over time (Bandura, 1977b, 1982). However, it has also been recognized that human beings do not go through rational patterns when making decisions about their behavior (Swanson, 1972). Irrational emotions and motivations are also driving forces in health behavior (DiMarco, 1985). Knowledge about one's health and belief in treatment effectiveness to improve it do not ensure one will act wisely, due to emotions and motives (DiMarco, 1985; Moriyano, Kreuger & Stamler, 1971). According to Rotter (1954), the occurrence of a behavior is a function of the individual's expectancy that the given behavior will secure a reinforcement and the value of that reinforcement. An individual seeks to maximize positive rewards or reinforcements (Rotter, Chance & Phares, 1972). Thus, while an individual may believe an EAP can help improve his/her health, the person may not feel compelled or motivated enough to actually seek treatment. Bandura and Walters (1963) suggest that for behavior to occur in a given situation, it must be available to the person and must have been reinforced during previous learning experiences. Thus, individuals who have a positive or high expectancy that an EAP will help and believe a high

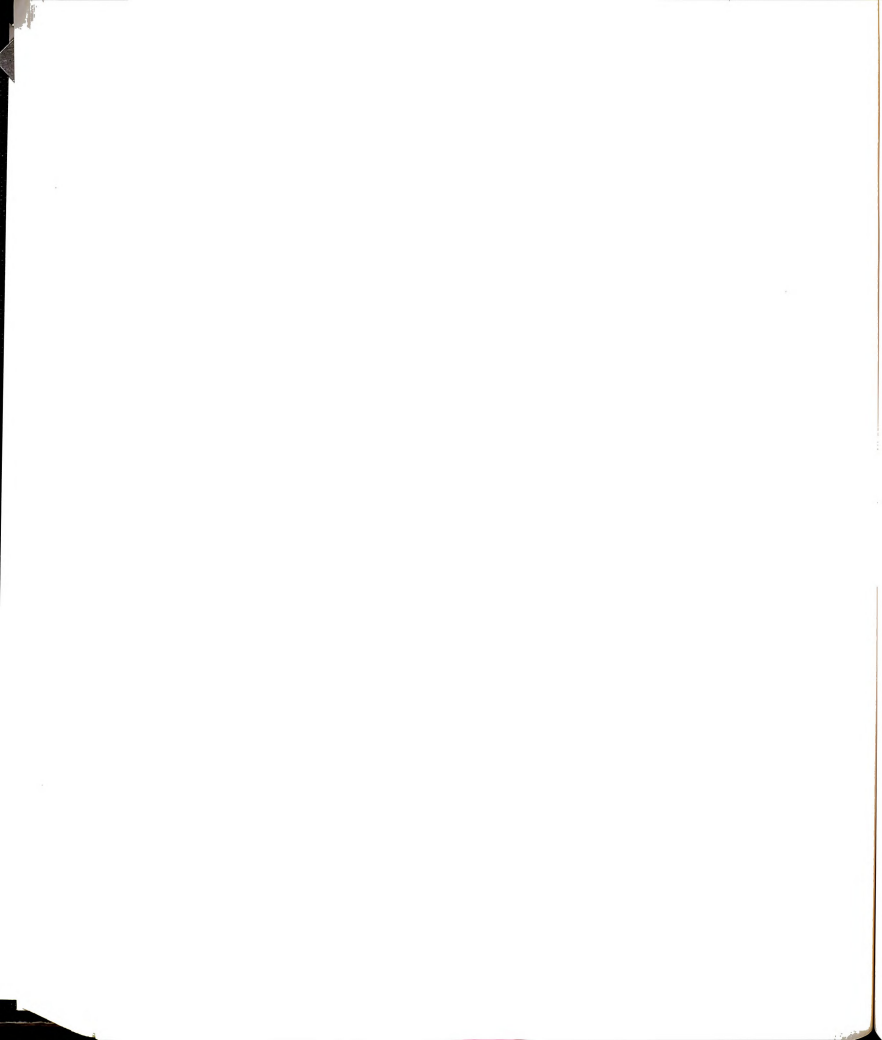


incentive or reinforcement exists may tend to seek treatment while others who have a high expectancy may not necessarily perceive enough incentive or reinforcement to act.

To better understand why expectancy was not a significant variable in the present study, a post hoc analysis was conducted to examine the relationship between expectancy and other major variables within the model. The correlation between expectancy and Chance HLOC was significant and negative ($r = -.18, p < .01$). Thus, it could be that the more an individual believed his/her health was due to chance (and less to internal factors) the less the person believed the EAP would help reduce/resolve any problems the individual may have had.

The correlations between expectancy and perceived barriers to using an EAP from both personal sources ($r = -.15, p < .05$) and work sources ($r = -.13, p < .05$) were also significant. Based on these relationships, it appears that there is a relationship between barriers and expectancy and that as an individual perceives more barriers to using an EAP, the individual also tends to place less faith in the EAP's ability to help resolve problems.

When combining the two variables of perceived personal support/pressure and perceived personal barriers to using an EAP into a new variable identified as Personal Support/Pressure/Barriers and the two variables of perceived work support/pressure and work barriers into a new variable called Work Support/Pressure/Barriers, the correlations of these new variables with expectancy were positive and significant (both at $r = .14, p < .05$). Thus, this suggests that the more perceived support to using an EAP and the fewer barriers perceived, the more likely an individual was to also believe the EAP would help. Roadblocks or barriers seem to be key factors influencing expectancy perceptions because if an individual obtains support from both work and



personal sources, the individual may be more likely to believe the EAP will help as long as the person perceives few hassles/barriers involved in using it. In fact, the effect of perceived hassles on EAP usage again may be influenced by irrationality. The decision making process associated with the health-related behavior (EAP usage) seems to be compromised by emotions. Going to a doctor (or counselor) often includes a little fear for many individuals. I can understand how perceptions of hassles (along with a belief in chance controlling one's health) could encourage employees to not perceive EAP services to be of benefit and thus to not use EAP services. After all, for some individuals, no news is good news.

In examining other significant correlations with expectancy, two additional variables were found to be significantly and positively related. An individual's perception of the health values and norms of members within his/her social group was significantly related to the expectancy that an EAP will help ($r = .13, p < .05$). The more positive the health norms of those within one's social group, the more the individual tended to believe the EAP would help. It could be that discussing problems and solutions with others influenced one's belief that help was available. In addition, expectancy and perceived discrepancy were significantly related ($r = .13, p < .05$) which might suggest that when individuals perceived a discrepancy between their current and desired health they may also have tended to believe the EAP could resolve this.

The only significant correlation between expectancy that the EAP will help and the Health Locus of Control subscales was the correlation with the Chance HLOC subscale ($r = -.18, p < .01$). Based on the relationship between expectancy and Chance HLOC and between expectancy and the work and personal barriers variables, it appears that if a person believes his/her health is a function of chance and also perceives barriers

to using an EAP, the person is less likely to believe the EAP will help. In addition, as discussed above, the more positive the perceptions of the health norms and behaviors of a person's social group, along with the more encouragement received to go to an EAP from both a person's social and work group, the more likely the person was to believe the EAP would help. So, why wasn't a relationship found between expectancy and EAP utilization? Perhaps the lack of a relationship may be due to the low test-retest reliability of some of the items, as determined by the third pilot test (reliability of the items in the expectancy measure ranged from .51 to .75).

Hypotheses #6 and #7: Effect of Personal Support/Pressure/Barriers and Work Support/Pressure/Barriers on EAP Utilization

The final two hypotheses predicted a significant relationship between EAP utilization and the two support/pressure/barriers variables. The first variable was calculated by combining the personal support/pressure and personal barriers variables into Personal Support/Pressure/Barriers to examine the overall influence of support and barrier factors in one's personal life on EAP usage. The second variable was created by combining the work support/pressure and work barriers variables into Work Support/Pressure/Barriers to examine the overall influence of support and barrier factors perceived in one's work situation. Results of the two regression analyses found both variables to be significantly related to EAP utilization. This coincides with other researchers who have concluded that social pressure and attitudes are a key factor influencing behavior (Ajzen & Fishbein, 1980; Anderson & Bartkus, 1973; Gottlieb & Green, 1984; Hockbaum, 1958; Shephard, 1985).

For example, Hockbaum (1958) found that social support was a decisive factor leading to participation in a preventive tuberculosis screening. Hockbaum found that individuals who voluntarily participated knew others who had also participated, while those not participating knew fewer people who intended to participate or recalled unfavorable discussions about the screening. Similarly, Shephard (1985) studied employees participating and not participating in the General Foods Corporation fitness program and found that participants had more social support from spouses and friends than nonparticipants. Gottlieb and Green (1984) found that social support was positively related to five positive health practices: smoking, exercise, alcohol use, weight maintenance, and sleep.

The present research indicates that perceptions of support and/or pressure appear to have a great impact on the utilization of EAP services. Given the fact that there was little relationship between desired health goal level and EAP utilization ($r = -.01$, n.s.) or between perceived discrepancy in health and EAP utilization ($r = -.02$, n.s.), individuals in the sample who sought assistance at an EAP may have done so, not for health enhancement purposes, but due to some overarching non-health reason.

In addition to the regression analyses, further examination was undertaken on the relationships between the Personal and Work Support/Pressure/Barriers variables and the other major variables in the model. For example, the Personal Support/Pressure/Barriers variable was significantly and positively correlated to the following four variables: Internal HLOC ($r = .12$, $p < .05$), perceived current health problems ($r = .14$, $p < .05$), expectancy that an EAP will help ($r = .14$, $p < .05$), and going to an EAP ($r = .40$, $p < .01$). In other words, a person tended to perceive more support and fewer barriers to using an EAP when the person also had an Internal

HLOC, perceived more current health problems, and believed the EAP would help. In addition, the more a person perceived support and few barriers to using an EAP, the more likely the person was to use an EAP.

Significant correlations were also found between Work Support/Pressure/Barriers and other key variables of interest. These are: Internal HLOC ($r = .15, p < .05$), Powerful Others HLOC ($r = -.12, p < .05$), Chance HLOC ($r = -.13, p < .05$), current problems ($r = .26, p < .01$), social group health values/norms ($r = .21, p < .01$), perceived discrepancy between current and desired health ($r = -.16, p < .01$), expectancy that an EAP will help ($r = .15, p < .05$), and EAP utilization ($r = .24, p < .01$).

With regard to the Health Locus of Control variables (Internal, Powerful Others, and Chance), their relationships with Work Support/Pressure/Barriers might indicate that an Internal HLOC is related to an individual perceiving a higher level of Work Support/Pressure/Barriers (i.e., higher support and fewer barriers) while having an External HLOC (Powerful Others or Chance) is related to an individual perceiving a lower level of Work Support/Pressure/Barriers (i.e., less support and more barriers). The significant relationships outlined above indicate that individuals who perceive a higher level of Work Support/Pressure/Barriers also tend to perceive more current health problems, more positive health values/norms of members within their social group, a more positive belief that an EAP will help, and have a greater likelihood of going to an EAP.

The positive relationship between Work Support/Pressure/Barriers and perceived level of current problems might suggest that a positive work environment could potentially make it easier for individuals to recognize or identify health problems. The

fact that this relationship was higher between current problems and Work Support/Pressure/Barriers ($r = .26, p < .01$) than with Personal Support/Pressure/Barriers ($r = .14, p < .05$) might suggest that an individual is under different types of pressures when sharing problems in a work environment versus a personal environment. A supportive, barrier-free (regarding EAP usage) environment might be one of the key elements toward improving EAP utilization. As discussed earlier, it seems to be the employee's perception of the absence of barriers (hassles) from both personal and work environments that could significantly influence EAP utilization.

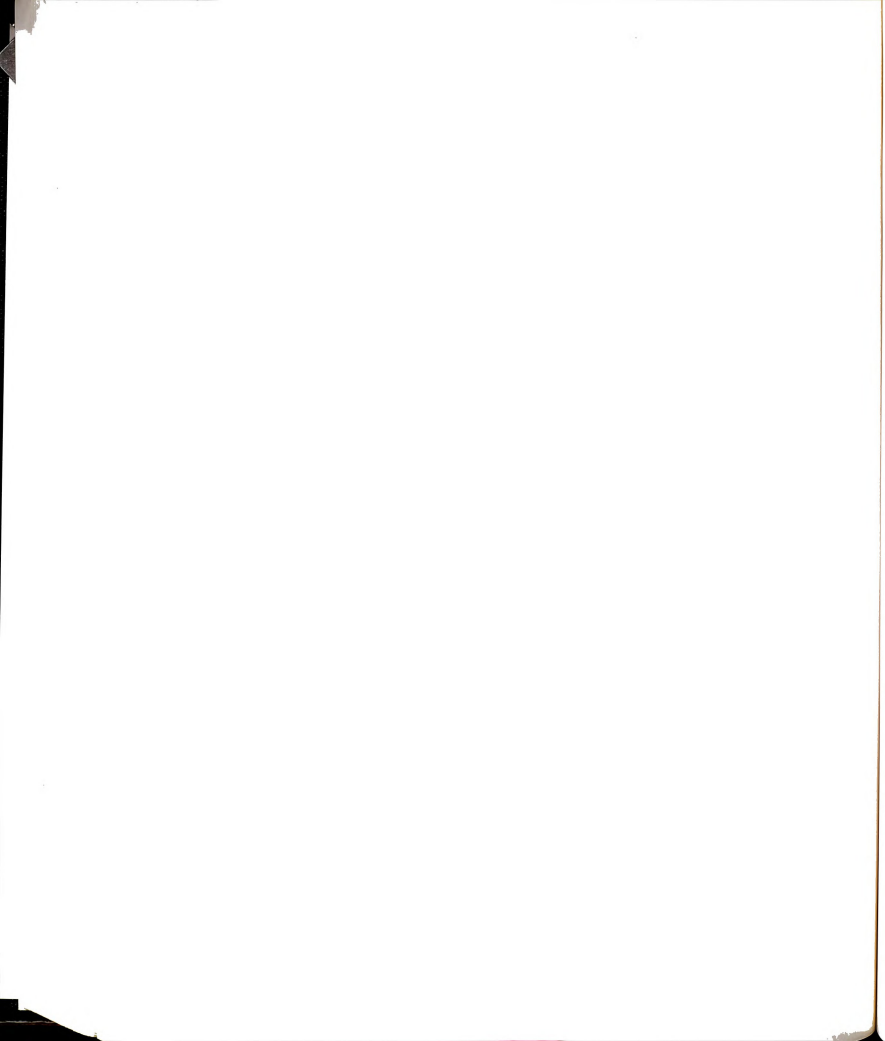
It has also been suggested that support/pressure from work sources and personal sources are separate constructs even though most research has incorporated them into one global support construct (Broadhead et al., 1983; Bruhn & Philips, 1987; Mayer, 1988). Social support from personal sources has been found to influence participation in health activities (Hammit, 1984; Merriman, 1984; Snyder & Spreitzer, 1973). While many have suggested that organizational factors such as management support are likely to affect occupational health outcomes (Dickman & Emener, 1982; Glasgow & Terborg, 1988; Greenwood, 1983; Syme, 1986), Mayer (1988) has noted there has been little examination of management support in health research and "no empirical evidence that management support has a significant effect on health promotion efforts at the work site." However, there is available research on the importance of supervisors in the effectiveness of alcohol-related programs (e.g., Trice & Roman, 1972) so that, although individual decision making is often compromised by emotional factors, the role of the organization and of management cannot be overlooked and additional research is needed to examine their influence.

In examining just the personal support/pressure and work support/pressure variables (without barriers) and their relationship with EAP utilization in the present research, personal support/pressure was significantly correlated with utilization ($r = -.23$, $p < .05$) while work support/pressure was not ($r = .07$, n.s.). As Mayer has suggested, these may in fact be separate constructs. Contrary to prior research (Antonovsky & Kats, 1970; Blackwell, 1979; Champion, 1988), however, personal sources of support/pressure did not have a positive influence on health behavior (EAP usage) but rather these sources were negatively related to utilization. As discussed above, the personal sources of support/pressure measure was negatively related to EAP utilization ($r = -.23$, $p < .01$) as was the personal barriers measure ($r = -.46$, $p < .01$).

Finally, the negative correlation between Chance HLOC and Work Support/Pressure/Barriers is consistent with previous discussions and seems to suggest that since Chance HLOC is less influenced by the organization, a greater challenge to organizations exists in attempting to understand other factors they may be able to influence that encourage EAP utilization behavior.

Limitations and Future Research

Previous EAP research has examined primarily demographic variables of EAP users to gain an understanding of what a typical profile of an EAP user resembles. Most of the data gathered to date have focused on factors that can be obtained directly from EAP records--gender, race, age, job status, income, etc. These factors offer little understanding of why some employees utilize EAP services while others do not. Furthermore, many of the conclusions reached on EAP participation factors have often been inconclusive or contradictory.



The present research has contributed to prior research on EAP utilization in the following ways. The research is based on the premise that EAP usage is a function of a decision that is made by an individual to utilize EAP services. Simply studying the means and variances of various demographic variables of EAP users, as conducted by past researchers, does not aid in understanding this decision process. It is necessary to better understand this decision process by examining factors which might influence the decision. To aid in this understanding, the present research incorporated the following. First, individual personality variables predicted to influence health attitudes and behaviors were examined. Second, beliefs held by individuals which were hypothesized to be critical in making a decision regarding EAP utilization were analyzed--in particular, beliefs examining expectations regarding the EAP's ability to improve one's health, beliefs about the health consciousness of one's social group, and beliefs about one's health-related goals were explored. Third, a control theory framework was developed to provide a structure to studying the EAP decision process. The potential influences were incorporated into a control theory model which was based on the concept of a standard or goal being used as a reference value in a process where sensed information about one's current state is compared to this standard or goal. If a discrepancy between the goal and current state existed, it was predicted that a force is created that motivates an individual to reduce the discrepancy (e.g., to seek EAP assistance).

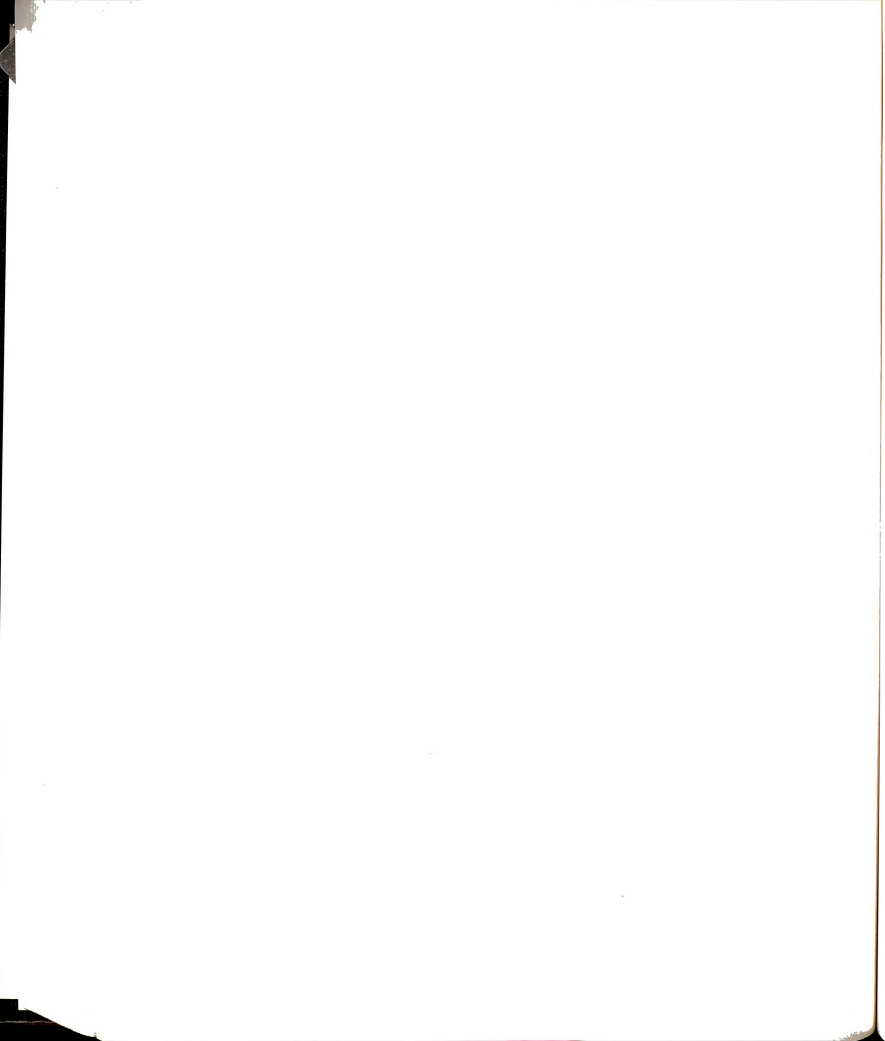
The present research also went beyond past EAP utilization research by not only including EAP users in the sample (as past research has done) but also individuals who had not used EAP services despite the fact that these non-EAP users may have had problems that EAP's could provide assistance on. Thus, the dependent variable was

expanded to include EAP usage and non-usage so a better understanding of factors influencing this decision might be obtained. In addition, a positive factor in measuring the dependent variable, EAP usage, is that this behavior was measured in two ways--via a self-report measure as well as via EAP records--so verification of usage/non-usage was able to be undertaken.

While the above presents some contributions to EAP utilization research, there are some limitations to the present research which should be considered when examining the results of this study. First, the research was conducted with employees who were all members of one of five unions included in the sample. Thus, the generalizability of the results to other employees who are non-union may be questionable. However, while the sample selected may have been limited to the unions included in the research, on the positive side is the fact that the unions represented positions that included clerical, maintenance, technical, and supervisory occupations. In addition, the overall return rate was excellent at 47%, which was well represented by both EAP users (with a 59% return rate) and non-EAP users (with a 42% return rate).

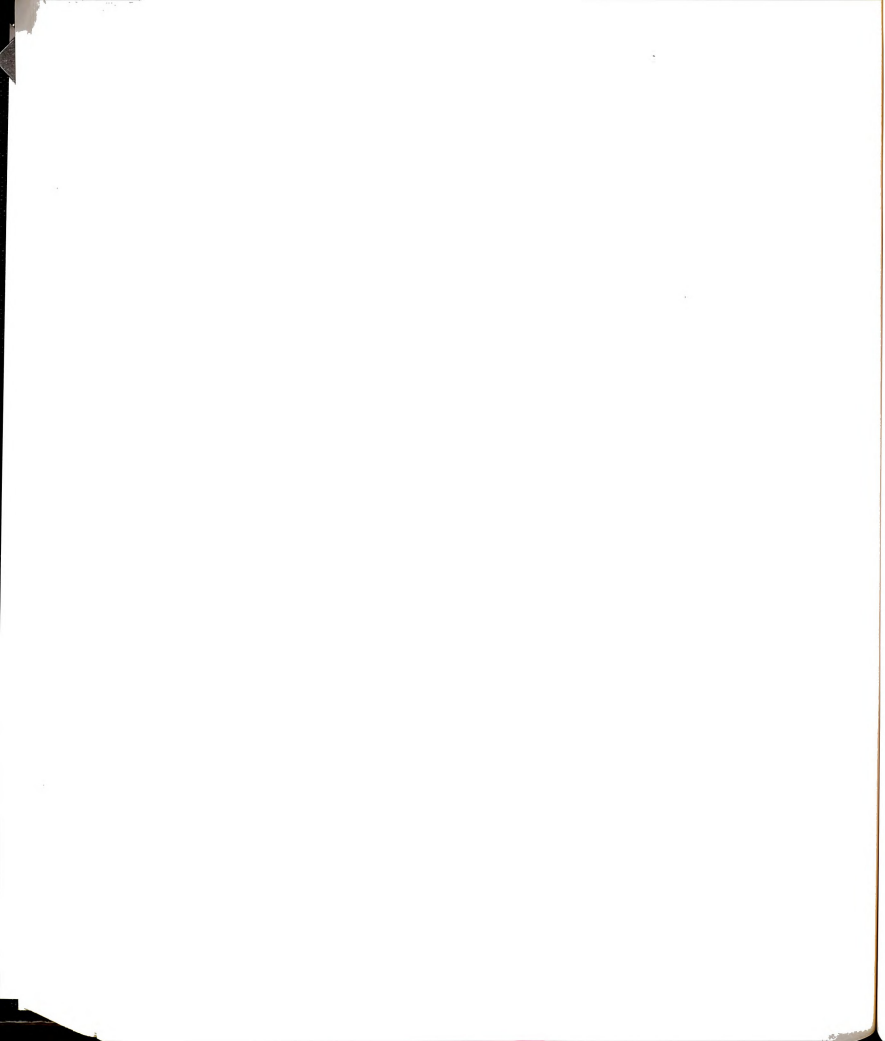
A second limitation to the research may be the setting under which the present study was undertaken. All employees included in the sample had equal access to an on-site (internal) EAP which had offices located on the premises of the organization. The extent the results are generalizable to external or contracted-out EAPs is uncertain.

A third potential limitation is that the model in Figure 9 cannot be fully tested (from left to right) using causal modeling techniques. Because the model developed is a flow model rather than a causal model, it was not possible to directly examine relationships among all the control theory components (i.e., health goals, feedback on health status, discrepancy) and EAP utilization. While some of the components within



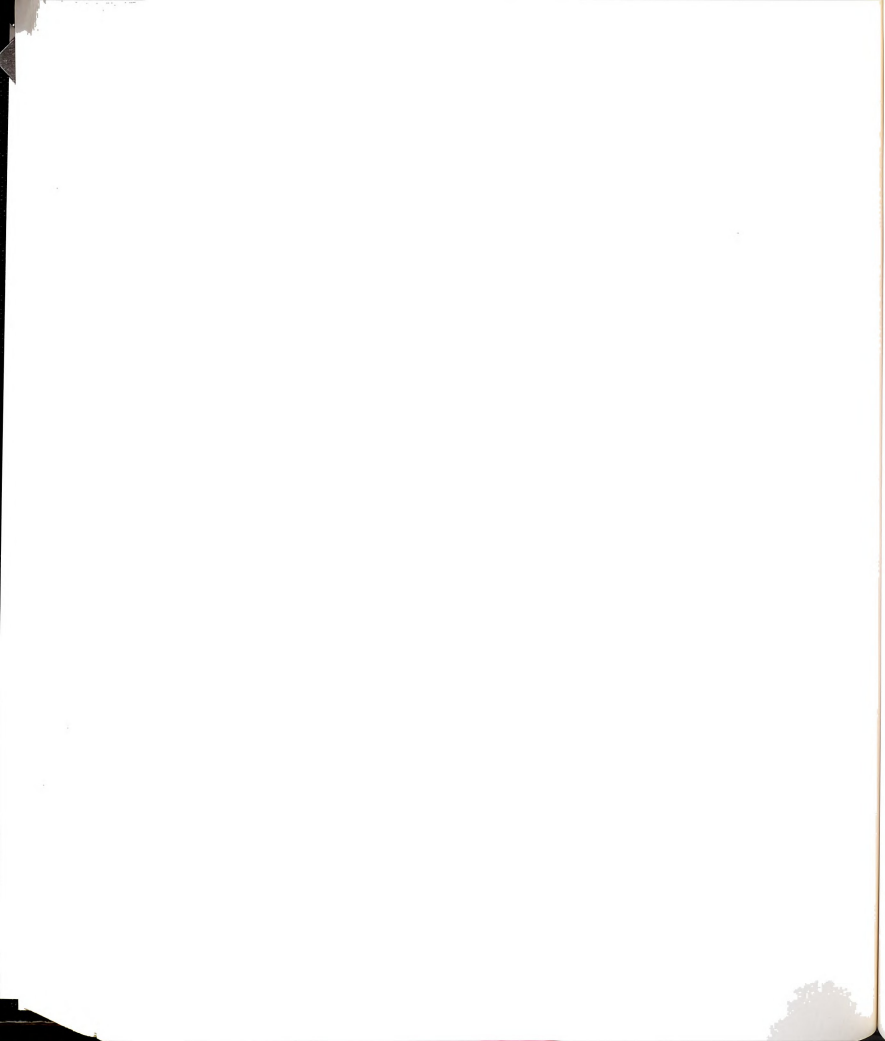
the model might be useful conceptually in guiding future research on EAP utilization, at the present time the relative usefulness of utilizing a control theory framework to examine EAP usage behavior is questionable. Because human behavior tends to be goal directed, the present study predicted that a perceived discrepancy between an individual's desired health and current health state would motivate the person to reduce this discrepancy. The goal that was examined as the basis for motivating an individual to improve his/her health was a person's desired health goal level. However, the present study found no relationship (at least correlationally) between desired health goal level and EAP utilization so the idea that an individual's health goal directs his/her behavior may not be the appropriate goal to examine. Also, as previously discussed, the present research also indicated that it may be difficult to obtain variance on the desired health goal measure. Thus, it is unlikely that a control theory model of EAP utilization that is guided by a discrepancy between a person's desired and current health state will contribute much to understanding this decision process. Since control theory is based on the concept of behavior being goal-directed, the use of this theory may still be relevant in examining health-seeking behaviors if we can determine the proper goal that is driving this behavior. Future research might focus on trying to understand the specific factors or goals involved; that is, exactly what goal the individual is attempting to attain when seeking EAP assistance--the one to be healthy or the one to avoid a negative consequence?

The present research suggests some interesting findings regarding the variables examined. For example, much of the past research has indicated that influences from others regarding their attitudes, beliefs, norms, etc. have a significant effect on an individual's own beliefs, attitudes and behaviors (e.g., Haskell & Blair, 1980; Loy,



McPherson & Kenyon, 1978; Wynne, 1986). However, the present research suggests that social influences alone may have little influence on health goals and on a specific health behavior--EAP utilization. This may be because individual characteristics/personality traits may have more of an influence on usage than has previously been examined. For example, the control issue seems to be important as it relates to EAP utilization. An individual's decision to seek help seems to be influenced by his/her perception of who primarily controls one's health (internal forces or external forces of chance/luck) as well as personal and work-related factors. The issue of control arises not only with regard to control over one's health (i.e., Health Locus of Control) but also control over the situation. For example, while the belief that luck or chance controls one's health can influence non-EAP utilization behavior, is there a point where the support/pressure from one's boss or spouse encourages (forces) the employee to seek EAP services despite this belief in "chance" (e.g., the threat of losing one's job or the threat of divorce)? Also, in addition to the Health Locus of Control subscales, there may be other individual characteristics that significantly affect EAP usage which might be examined in the future (e.g., coping style, degree of self-focus).

The issue of influence from others requires future study in several other areas. In the present research, the social group health values and norms measure was not significantly related to health goals. However, this does not necessarily imply these factors don't influence other health-related beliefs or behaviors. The social group health values/norms measure was found to be significantly correlated with (1) believing others control one's health (i.e., Powerful Others HLOC), (2) the individual's perception of his/her current health status, and (3) the belief that an EAP will be helpful. Therefore, social influences may still be important in influencing other attitudes and behaviors.

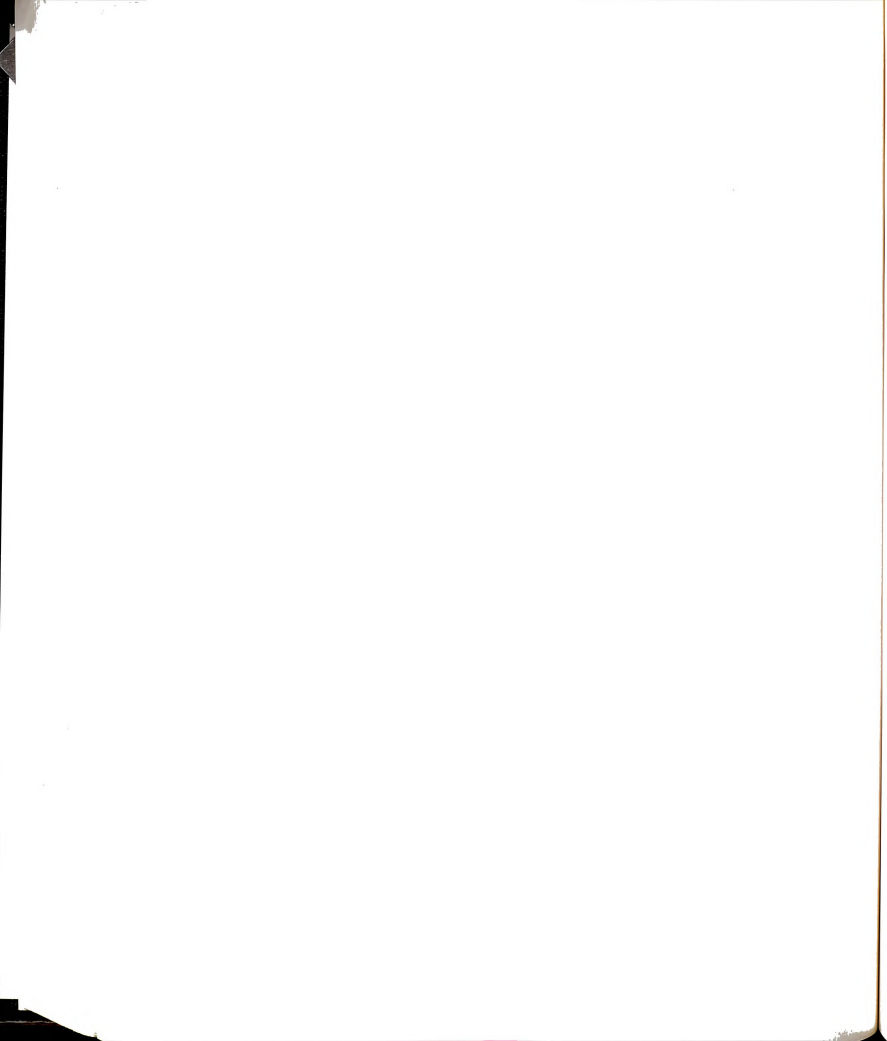


Since one of the organization's goals is to encourage EAP usage among "troubled" employees, further research examining how employees are potentially influenced by others in the health area should be examined.

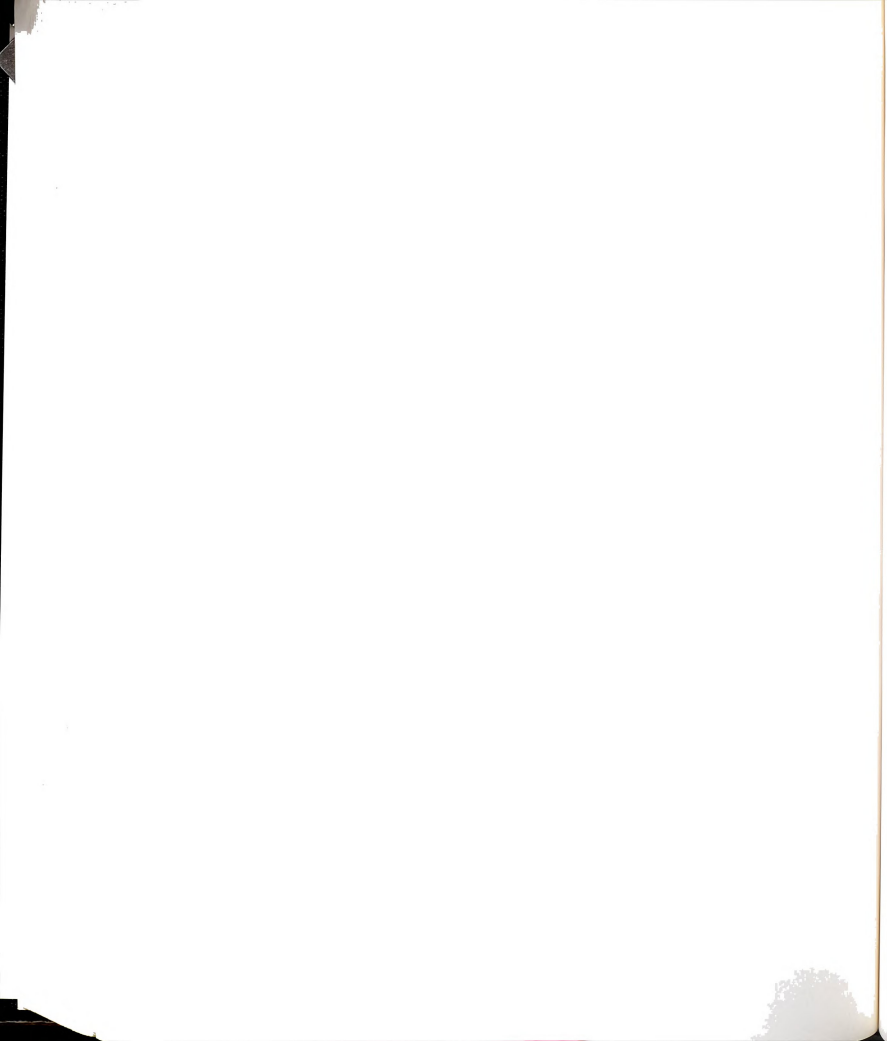
Summary

Organizations have recognized that troubled employees cost the organizations more in the long-run than if the employees' problems were diagnosed and treated early. Employees who have personal, social, emotional, and other problems are less productive and have higher illness, absenteeism, accident, and disability rates. Therefore, it is in the organizations' own best interest to understand factors that encourage troubled employees to seek or not seek assistance. The assistance examined in the present research focused on Employee Assistance Programs.

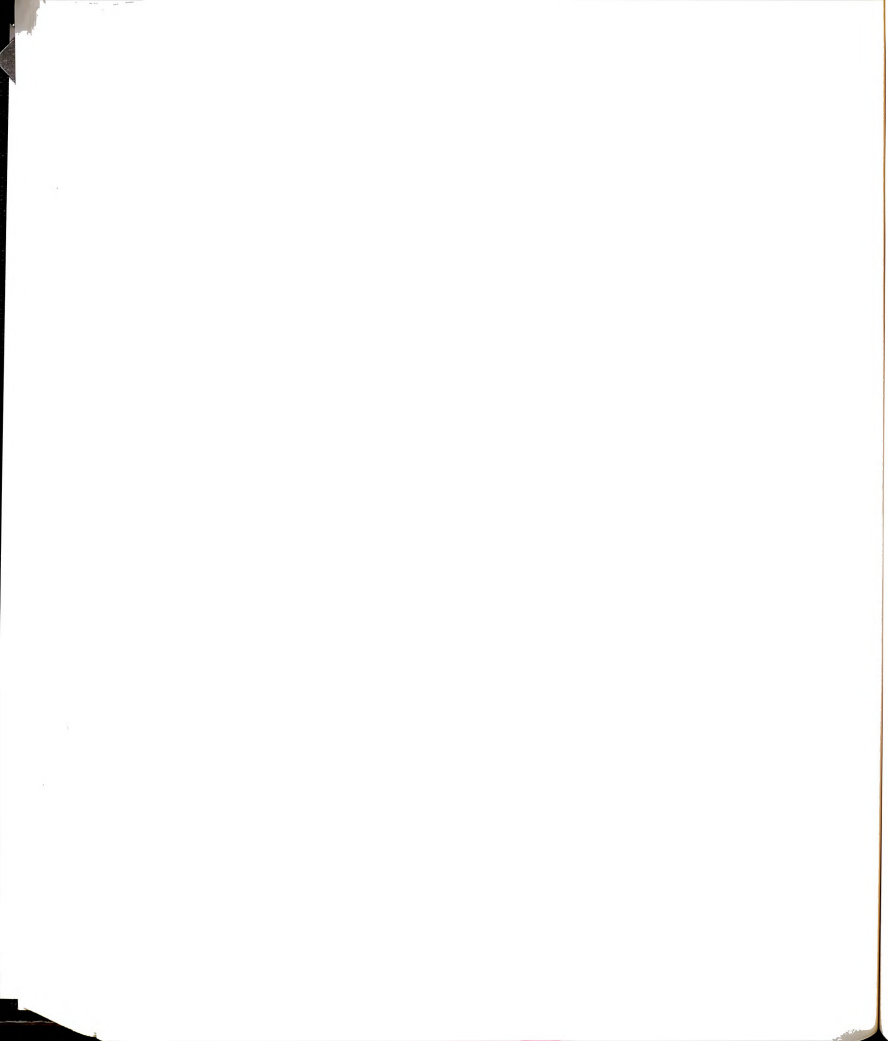
The purpose of the present research was twofold: to develop a control theory framework that might be useful in guiding future EAP utilization research and to test this conceptual framework. The model incorporated variables that have previously not been examined in EAP utilization research. Health history and social group health values and norms were found to have no significant influence on health goals. While not all hypotheses were fully supported, in general the perception of who (self or others) or what (chance or luck) controls one's health seems to be an important variable influencing both health goals and EAP utilization. In addition, the combined effects of support/pressure and barriers had a significant impact on EAP usage. However, the expectancy or belief that an EAP can help reduce/resolve health problems was found to have no significant impact on seeking EAP assistance. Explanations as to why these results may have occurred were offered.



An individual's perception of control, support, pressure and barriers, like anyone's perception, appears to be a complicated phenomenon. No single variable is robust enough to predict EAP participation alone. Cultural, social, psychological and other variables all interact to influence health behavior. EAP utilization is a complicated decision-making process and organizations face a challenge when attempting to determine how they might influence this behavior. By examining a combination of variables, we may significantly increase the ability to explain participation factors. Future research is necessary to examine the separate and combined effects of Health Locus of Control and social influences from both personal and work environments on EAP utilization.

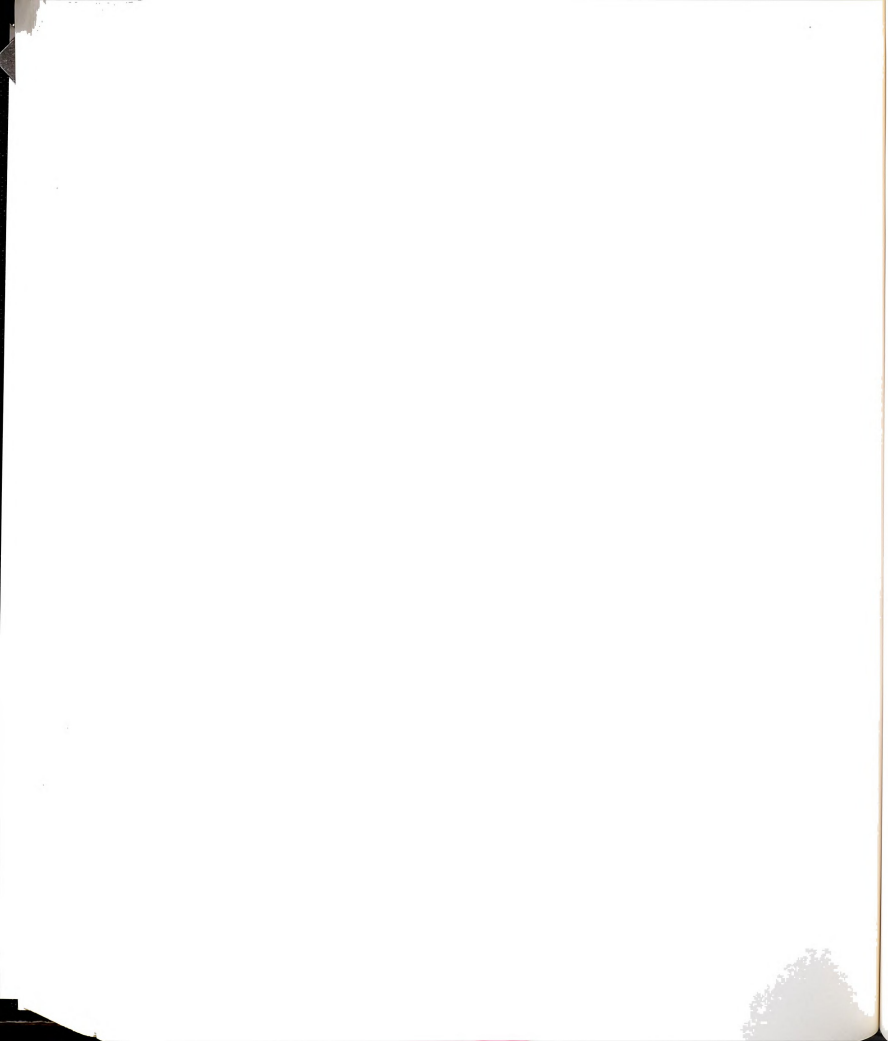


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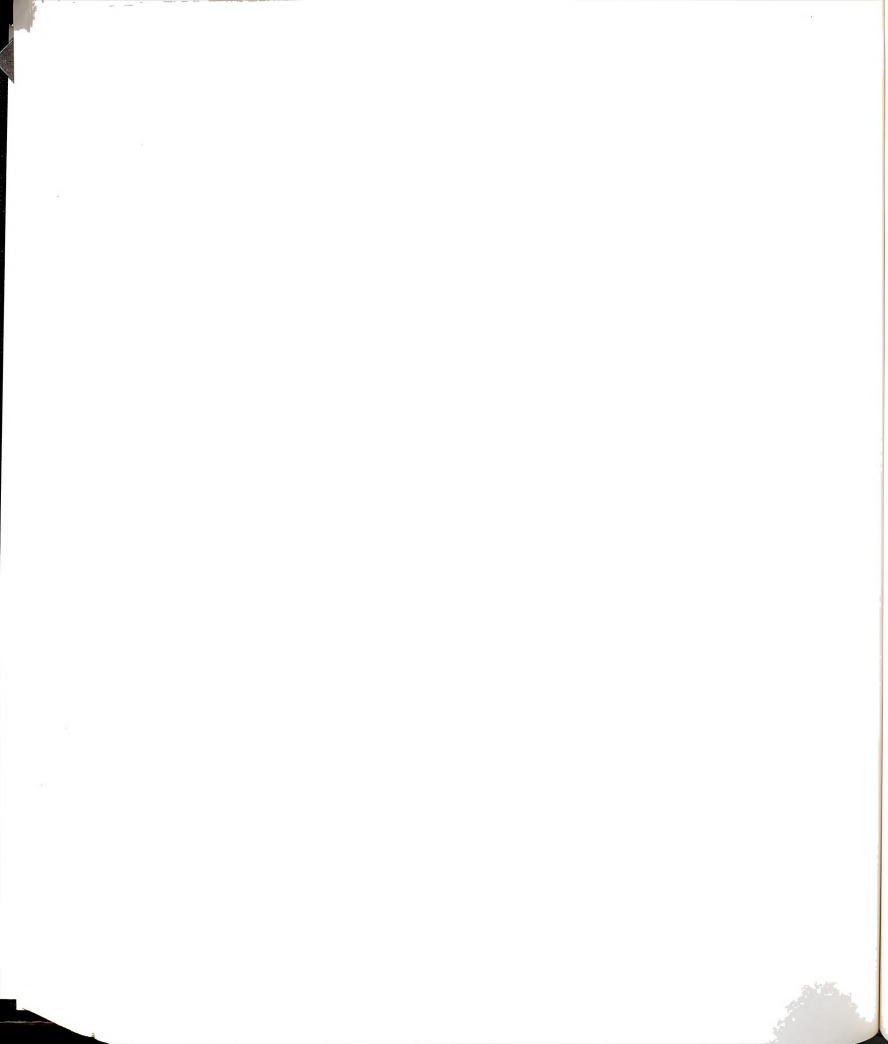


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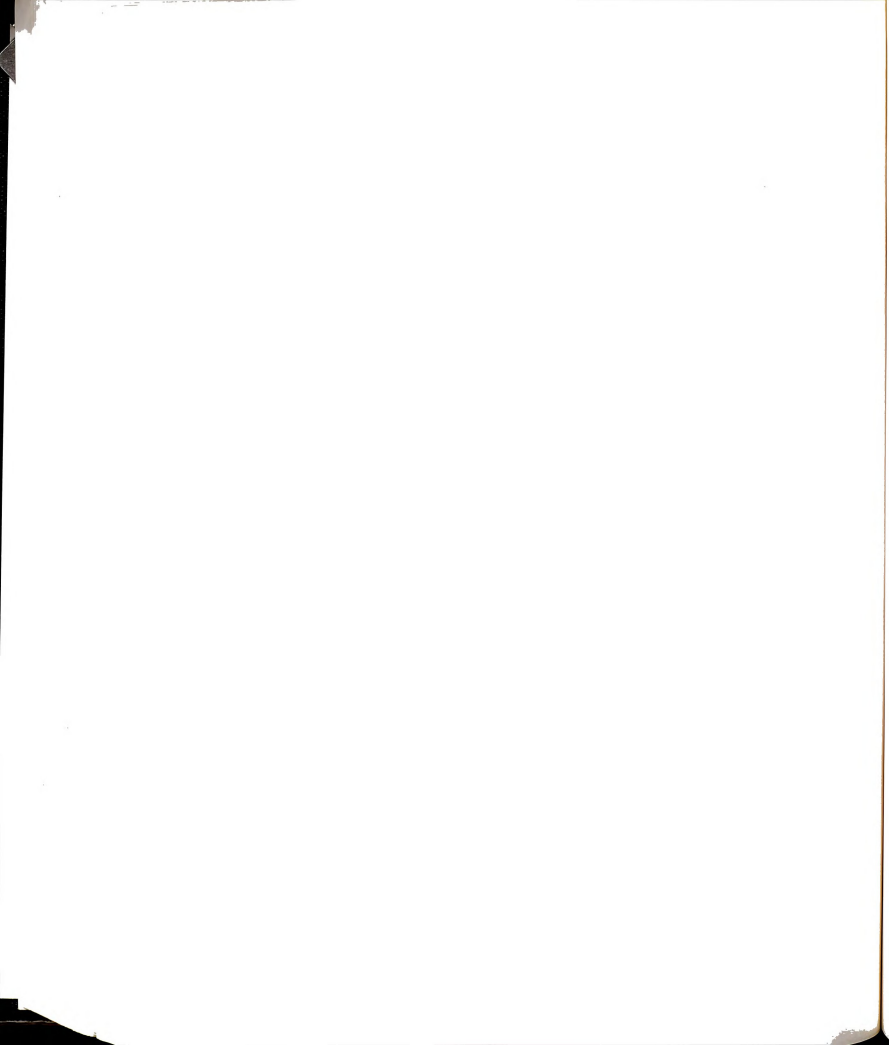
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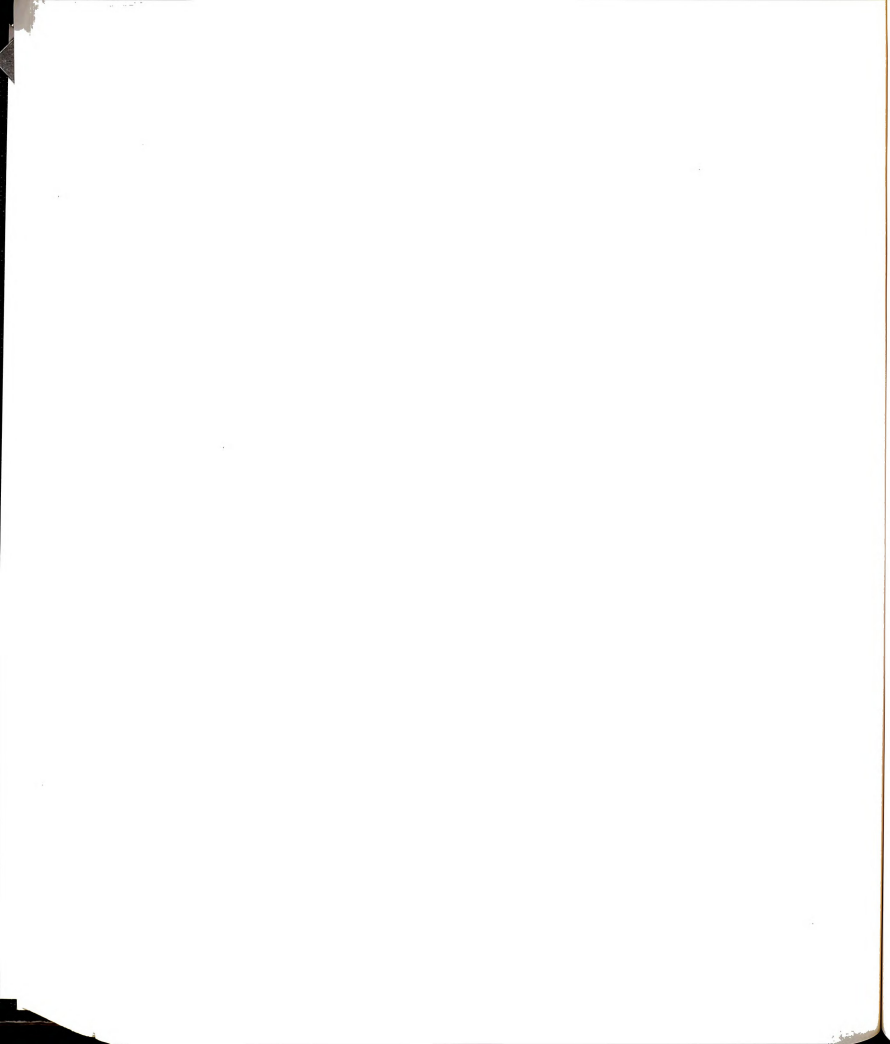
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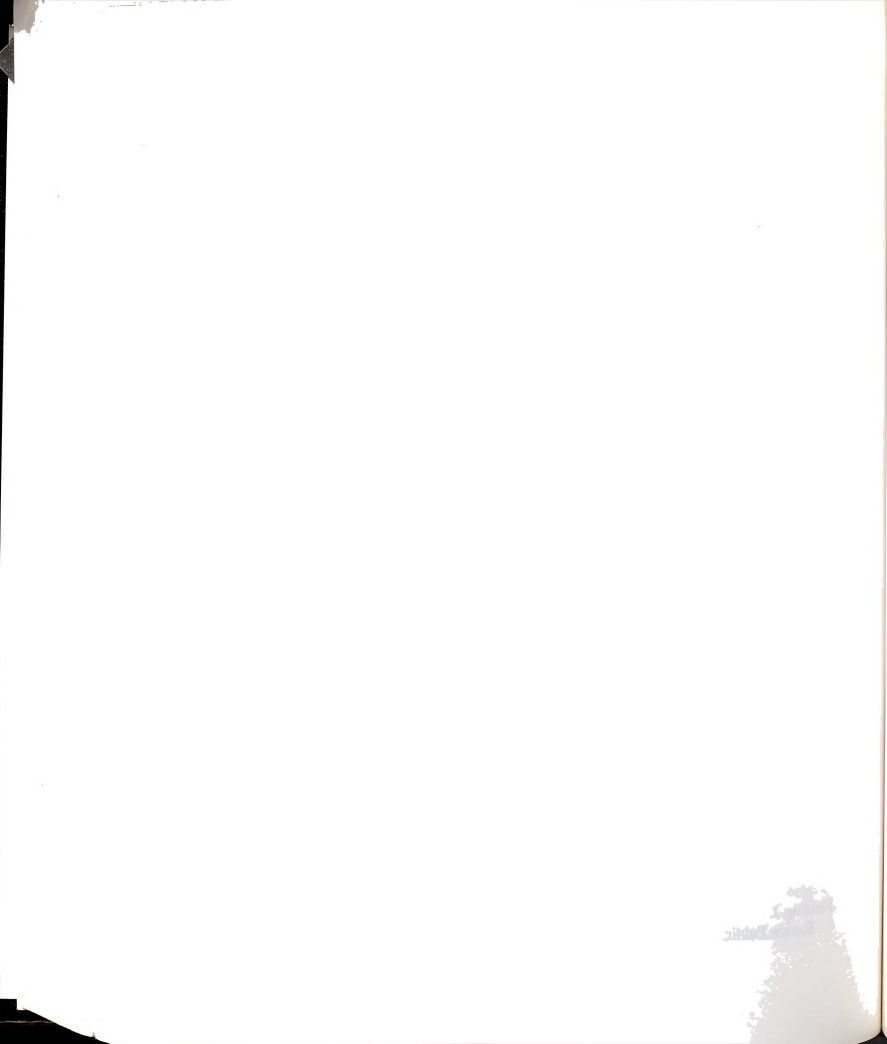
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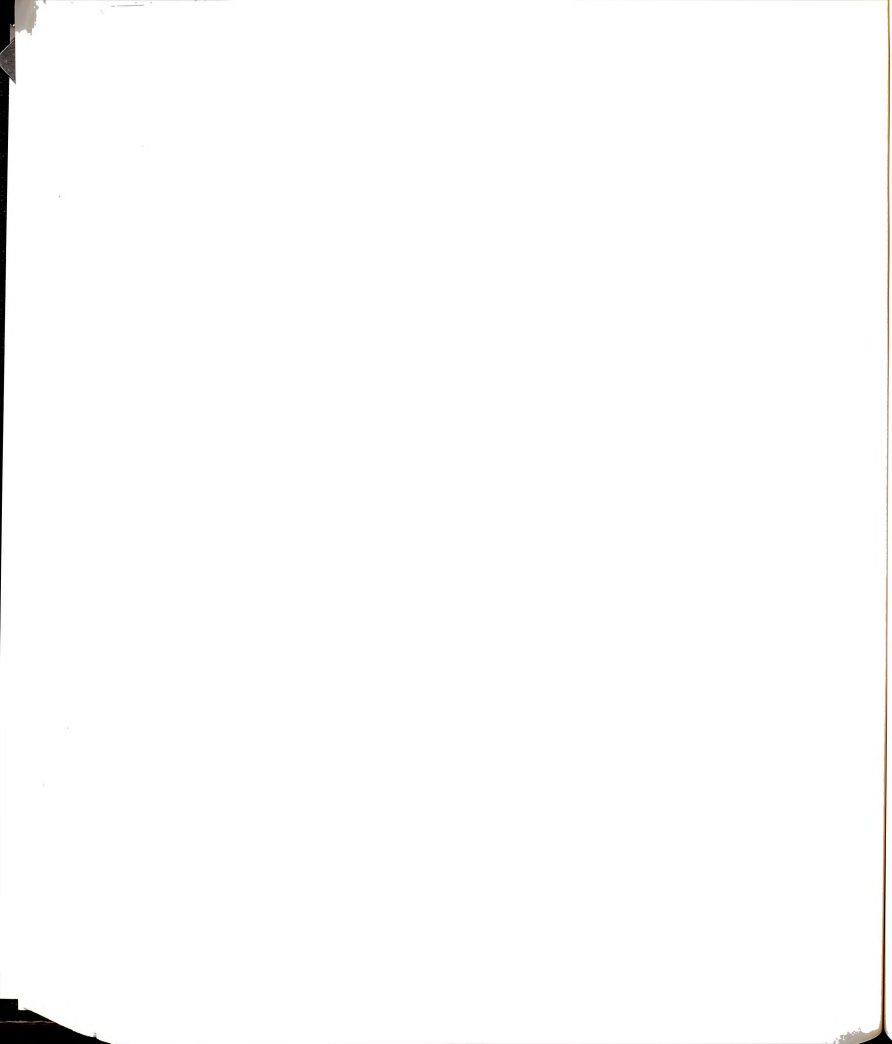
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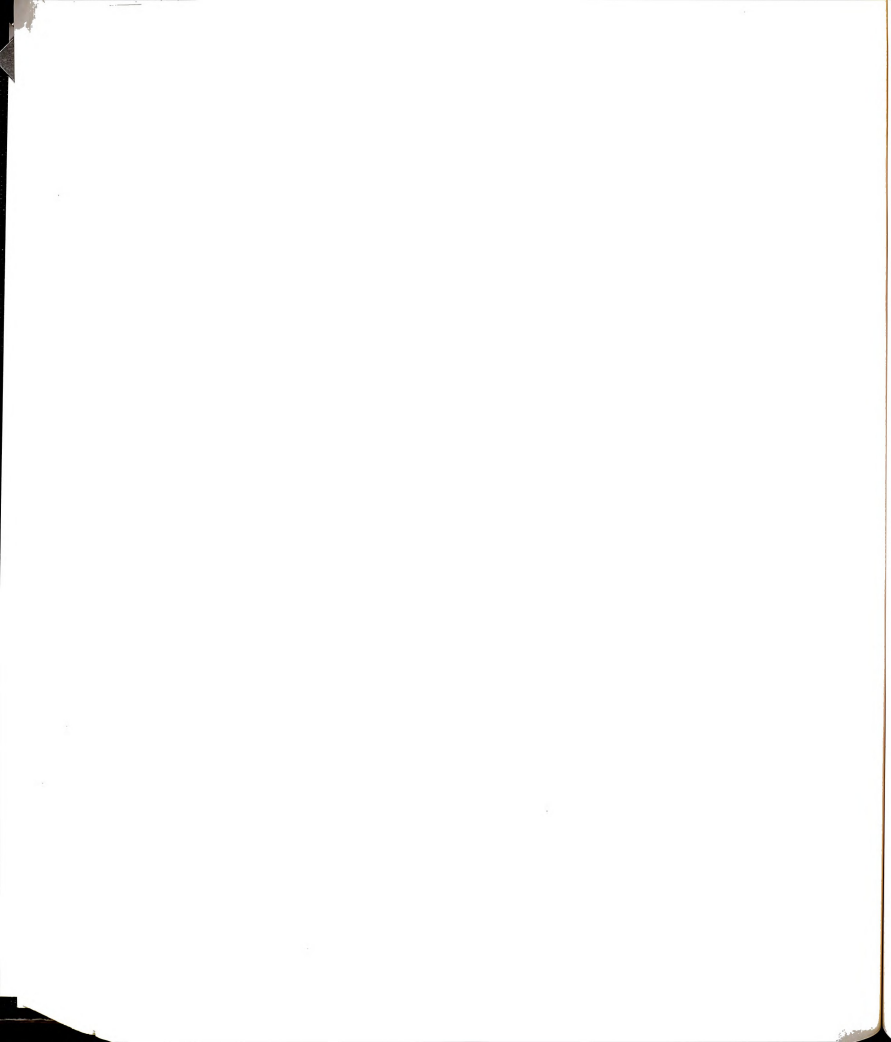
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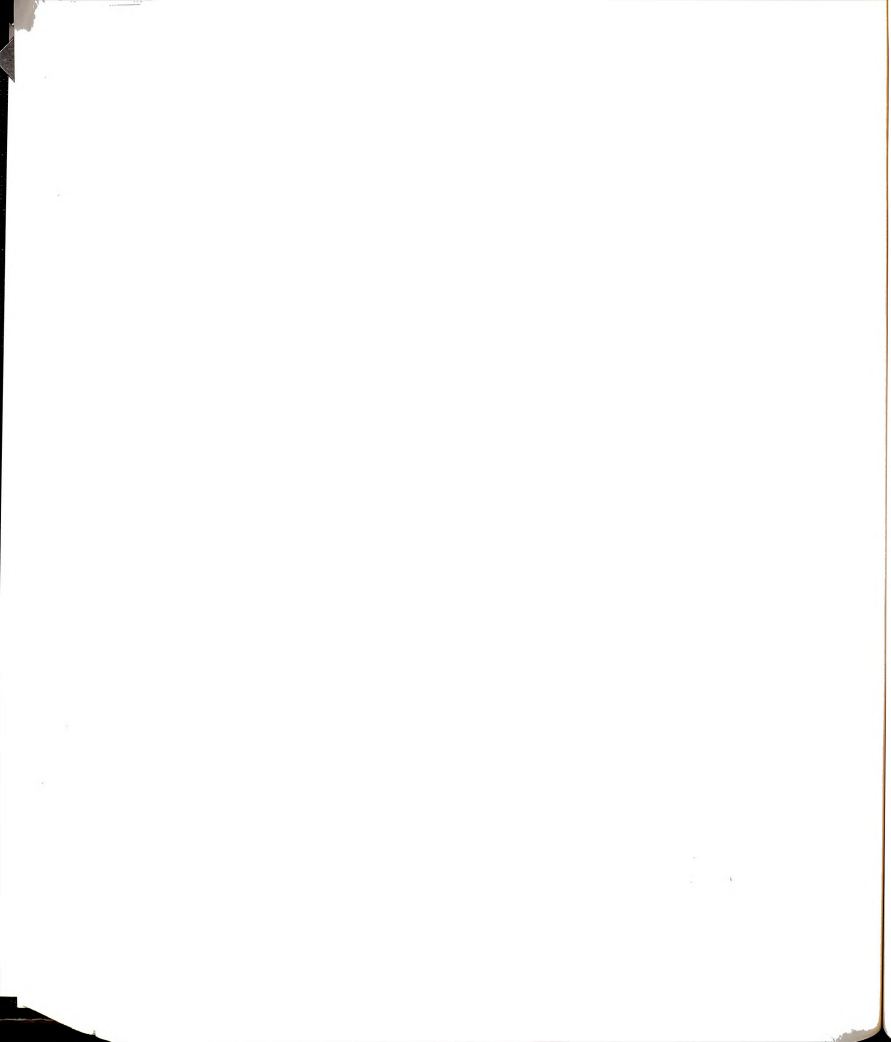
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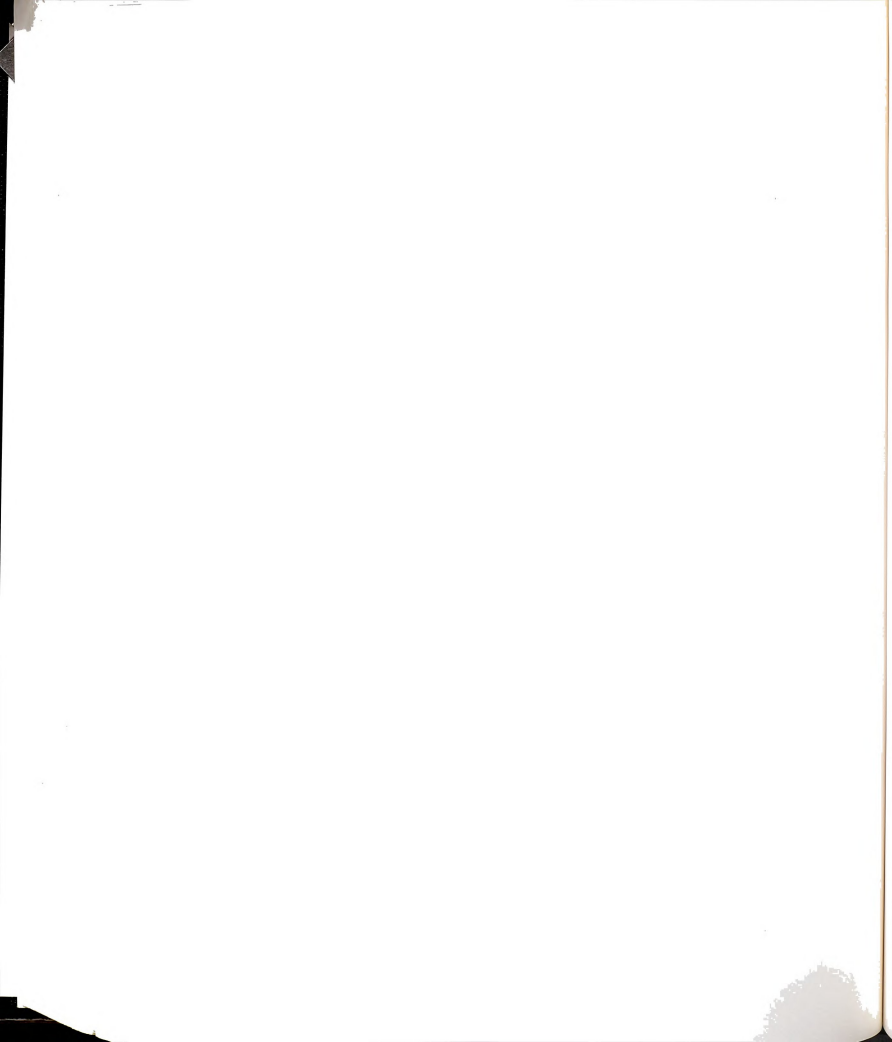
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APPENDIX A
DEFINITION OF TERMS

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APPENDIX A

DEFINITION OF TERMS

Broad-Brush EAP refers to an EAP designed to address a wide variety of employee concerns and problems, including alcoholism, drug abuse, divorce, marital discord, child rearing, stress, financial management, behavioral and psychological concerns, and legal problems. Its purpose is to reach as many workers and their dependents as possible.

Comparator Mechanism is a component within the control theory model of EAP utilization which compares an individual's goal (i.e., to remain healthy) with the individual's current health status to determine whether a discrepancy exists.

Current Health Status refers to the current health-related symptoms and current health condition of the employee.

EAP Effectiveness refers to the cost-benefit evaluation used to assess the success of an EAP and help justify the disbursement of funds allocated to the implementation and administration of an EAP. Unfortunately, there is no consensus on how to measure EAP effectiveness.

EAP Usage refers to an in-person visit to the EAP office or a call for an appointment, information, or a referral. (Also see Utilization/Referral Rate.)

Emotional Stress (Distress) refers to intrapersonal tension which may influence ineffective physical and/or emotional functioning.

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Employee Assistance Program refers to an intervention strategy designed to assist employees in resolving work and non-work related problems that impair job performance. These problems may include substance abuse, eating disorders, compulsive gambling, mental and emotional problems, financial, legal, and marital concerns. Help is provided through a variety of assessment, counseling, and referral methods--though EAP's stress self-referrals in addition to supervisory referrals which the narrower alcohol-related programs relied on.

Expectancy is a component within the Control Theory Model of EAP Utilization which refers to an individual's perception regarding his/her ability to attain his/her goal (i.e., remain healthy).

External EAP refers to an intervention strategy involving counseling off the actual job site, typically provided by agencies or firms who contract with an organization. These include multi-service agencies which provide easy access to a variety of resources.

Goal/Standard is a component within the Control Theory Model of EAP Utilization which refers to the end result an individual strives for; i.e., in the present research the goal of interest is to be healthy. This is also called the referent value.

Health Locus of Control is a measure of people's beliefs regarding whether their health is or is not determined by their behavior (Wallston, Wallston & DeVellis, 1978, p. 160).

Internal EAP refers to a company-hired counseling staff housed at the work site.

Management Social Support refers to "the social support provided by immediate supervisors and managers to employees who are interested in adopting and

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maintaining health-related behaviors or in participating in health-related activities" (Mayer, 1988).

Multidimensional Health Locus of Control (MHLC) is defined as the degree to which individuals believe their health is determined by their own behavior; i.e., the degree to which individuals believe their health is controlled internally or externally (Wallston, Wallston, Kaplan & Maides, 1976; Wallston, Wallston & DeVellis, 1978). The MHLC expands the original HLC scale to reflect three Health Locus of Control dimensions: "internality (IHLC), powerful others (PHLC), and chance (CHLC) externality" (Wallston, Wallston & DeVellis, 1978, p. 162).

Occupational Alcoholism Programs provide services for alcoholic employees in industry, and include diagnostic, treatment, and rehabilitation programs.

Problem/Troubled Employee is one whose work history is characterized by productivity problems, tardiness and absenteeism, accidents, and other on-the-job problems.

Referral Source/Model is the strategy utilized in obtaining employee utilization of EAP services. The major models include: (1) a self-referral model where an employee voluntarily seeks assistance, and his or her participation in the EAP is held in strict confidence; (2) a supervisory-referral, confrontation model where a third party within an organization (e.g., supervisor, union, medical department) actually refers an employee whose performance is suffering to an EAP; and (3) a peer or significant others model where significant others (e.g., family, coworkers) encourage the impaired employee to seek assistance (Wolf, 1982), and where participation in the EAP is held in strict confidence (Featherston & Bednarik, 1981; Fisher, 1983).

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Sensor/Feedback is a component within the Control Theory Model of EAP Utilization which receives feedback from the environment regarding one's present health status and symptoms, perceptions regarding past usage of an EAP, and other environmental stimuli.

Social Support is "input provided by another person (or group) which moves the receiving person towards goals which the receiver desires" (Caplan et al., 1976) or activities provided by an individual's social environment which reinforce and encourage an individual to undertake some behavior (Levy, 1980 as cited by Wynne, 1986). Input may be physical, verbal/information, or social/emotional.

Social Systems are sets of "individuals who are . . . interacting with others on the basis of a minimal degree of complimentary expectations by means of, and according to . . . a shared system of beliefs, standards and means of communication" (Wiseman, 1966, p. 5).

Socialization is "an interactional process whereby a person acquires a social identity, learns appropriate role behavior, and in general conforms to expectations held by members of the social systems to which he belongs or aspires to belong" (Loy & Ingham, 1973, p. 258).

Troubled/Problem Employee is one whose behavioral/medical problems adversely affect on-the-job performance or which would motivate the employee to seek help.

Utilization/Referral Rates refers to the percentage of actual EAP service utilization; i.e., the ratio of EAP clients to the employee population (Myers, 1984). This rate has also been referred to as the "participation" rate or the "penetration" rate, which is the rate at which employees have penetrated the EAP.

Wellness refers to pro-active, preventative strategies designed to prevent the development of employee problems within or outside the workplace. Examples of such programs might include seminars on nutrition, weight control, physical fitness, stress recognition and management, pre-retirement counseling, and improvement of social skills.

Work-group Health Norms refers to the informal health rules and "social pressures generated by an employee's referent work group in influencing health-related behavior" (Mayer, 1988).

APPENDIX B

SURVEY INSTRUMENT

Dear M.S.U. Employee:

I am a Ph.D. student at M.S.U. interested in Employee Assistance Programs (EAPs). My dissertation is on factors affecting the use or non-use of one particular EAP--the one at M.S.U. To complete this research I need your participation.

At Michigan State University, the Employee Assistance Program is offered as part of employees' benefits package and is designed to deal with employees' problems and needs in both work and nonwork-related areas. You, as an employee, are eligible to use its services if the need arises. My research is being conducted with the approval of M.S.U.'s Employee Assistance Program.

The purpose of this letter is to ask you to complete the attached survey. I really need your assistance in completing this survey because I have only sent this to a randomly selected sample of M.S.U. employees. To encourage you to volunteer to participate in the study, I will pay you \$5.00 upon your completion and return of the survey in the enclosed envelope within two weeks. It should only take you about a half hour to complete.

It is critical that I receive responses from two groups of individuals--those who have previously used the EAP and those who have not. Therefore, it is very important to me that you respond. Please be assured your responses will be kept completely confidential. I will need your name and CAMPUS address on the next page so I know where to send your payment. However, as soon as I receive your survey, this page will be separated from your survey and you will be paid. I will have no way of matching survey responses to specific individuals. (If you do not wish to provide your name and do not wish to be paid, then you can return your survey without this data.) The only other identification on the survey is the letter "A" or "B" which identifies those who have or have not used the EAP services at the university.

I thank you in advance for your time in completing the survey. If I don't receive a response from you in two weeks, I will send a follow-up letter. Obviously, if the costs of the follow-up can be avoided, I would appreciate it.

Please return the survey to me in the enclosed envelope via U.S. MAIL as soon as possible. I feel the research subject is an important one and I need your responses to continue my work on this topic.

Sincerely,

Suzanne Crampton
Ph.D. Student

Thomas Helma
M.S.U. EAP Coordinator

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INFORMED CONSENT FORM

I understand the purpose of this research is to study factors influencing health attitudes and behaviors. I am participating voluntarily. I understand that the Group Identification (A or B) is only to be used to match my responses to either the group that has used or not used an Employee Assistance Program in the past.

In exchange for my participation, I will be paid \$5.00 when I return the survey in the enclosed envelope within two weeks. I understand that my responses will be kept completely confidential. My name must be provided only so payment can be sent to me. Once I return the survey, I understand my name will be detached so there will be no way to match survey responses with specific individuals.

NAME (Please Print): _____

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SURVEY GROUP _____

SURVEY ON HEALTH BELIEFS & BEHAVIORS
INFLUENCING USAGE OF EMPLOYEE ASSISTANCE PROGRAMS

INSTRUCTIONS:

This survey asks about your beliefs regarding your health and your experiences pertaining to specific health behaviors. It is important that you think about each statement and answer it honestly.

There are no right or wrong answers.

Please try to answer each item independently when you are making your choice--do not be influenced by your previous choices. Answer all questions using only the response choices given.

Your answers will be kept completely confidential. Once each survey is completed and returned, your name will be removed from the survey so it will not be possible to match responses to any specific individual.

PLEASE TURN THE PAGE TO BEGIN THE SURVEY!

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PART III (Continued)

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| 10. Have you ever been diagnosed as having high cholesterol levels? | 0 | 1 |
| 11. Have you ever had any kind of trouble with your blood (blood dysfunction, bleed longer from cuts than most people, anemia, excessive bleeding with periods, etc.)? | 0 | 1 |
| 12. Have you ever had any serious respiratory problems (lungs, bronchitis, pneumonia, frequent heavy chest colds, etc.)? | 0 | 1 |
| 13. Have you had frequent infections (kidney, urinary, throat, skin, etc.)? | 0 | 1 |
| 14. Have you had problems with allergies? | 0 | 1 |
| 15. <u>HOW MANY</u> serious health problems have you had not listed above? Write number:_____ | | |

PART IV

The questions in this section refer to an Employee Assistance Program (EAP). M.S.U. provides an EAP as a benefit to all its employees to help them resolve any type of problem they may be experiencing (e.g., personal, emotional, physical, nutritional, legal, substance abuse, financial, marital, child-care, etc.). M.S.U.'s EAP is located in a building on campus and provides a variety of services which include diagnosis of the problem, short-term and long-term counseling services, seminars on a variety of topics, and referral to community resources if needed.

Please circle the one best response for each item using the following scale:

(SD) Strongly Disagree 1	(MD) Moderately Disagree 2	(SD) Slightly Disagree 3	(SL) Slightly Agree 4	(MA) Moderately Agree 5	(SA) Strongly Agree 6
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1. My friends outside the workplace have supported, encouraged, or pressured me to use the EAP services OR they would need to support my going to the EAP for me to seek assistance at the EAP					
1 2 3 4 5 6					
2. I think the EAP is too inaccessible or inconvenient for me to use					
1 2 3 4 5 6					
3. I would never use the EAP because I'm too shy or would be embarrassed to discuss any problem I might have with a counselor					
1 2 3 4 5 6					
4. My friends outside the workplace would need to have utilized an EAP before I would go to an EAP to help resolve any problem I may have					
1 2 3 4 5 6					
5. My family would need to support my using the EAP before I would go to the EAP to help resolve any problem I may have					
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6. Going to the EAP would interfere with my other activities/ take too much time					
1 2 3 4 5 6					
7. I think people should handle their problems on their own without seeking any type of counseling					
1 2 3 4 5 6					
8. I would never use the EAP because it doesn't provide the types of services or staff I need to help me with any problems I might have					
1 2 3 4 5 6					
9. Members of my family would need to have used an EAP before I would use any of the EAP services available					
1 2 3 4 5 6					
10. I would not use the EAP because either I don't know how to contact the EAP or I just don't know anything about the EAP					
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PART IV (Continued)

	(SD) Strongly Disagree 1	(MD) Moderately Disagree 2	(SD) Slightly Disagree 3	(SL) Slightly Agree 4	(MA) Moderately Agree 5	(SA) Strongly Agree 6
11. My spouse/significant other would have to pressure me into seeking assistance at the EAP before I would use any of the EAP's services	SD	MD	SD	SL	MA	SA
12. My close acquaintances would need to encourage me and understand why I felt I needed to seek assistance at the EAP before I would utilize any of the EAP's services	1	2	3	4	5	6
13. I would not use M.S.U.'s EAP because I am afraid the EAP staff would NOT keep my problem confidential	1	2	3	4	5	6
14. My supervisor at work would need to encourage, pressure, or require me to use M.S.U.'s EAP before I would seek assistance at the EAP office . .	1	2	3	4	5	6
15. The union I belong to at work would have to encourage employees to use the EAP before I would ever use any of its services	1	2	3	4	5	6
16. The only way I would use M.S.U.'s EAP is if I knew one or more of my coworkers had already used the EAP services at some time	1	2	3	4	5	6
17. My supervisor would need to have used the EAP for me to use it for resolving any problem I may have	1	2	3	4	5	6
18. It is important to me to do what my coworkers think is best so they would need to encourage/support my using the EAP before I would use any of its services	1	2	3	4	5	6
19. My supervisor doesn't care about my health or my problems so I wouldn't go to M.S.U.'s EAP even if I had a problem	1	2	3	4	5	6
20. I would be too embarrassed to have anyone at work find out I went to the EAP	1	2	3	4	5	6
21. M.S.U. would have to promote and encourage employees to go to the EAP before I would use any of its services	1	2	3	4	5	6
22. I would be afraid my coworkers at work would think I was weak if I went to the EAP	1	2	3	4	5	6
23. I would not use the EAP because I am afraid someone at work would find out and it would hurt my career/job at M.S.U.	1	2	3	4	5	6
24. M.S.U. doesn't care about my health or my problems so I wouldn't go to M.S.U.'s EAP even if I had a problem	1	2	3	4	5	6
25. My coworkers don't care about my health or my problems so I would not listen to their advice about going to the EAP	1	2	3	4	5	6
26. My coworkers think people should handle their own problems so I would never go to the EAP	1	2	3	4	5	6
27. I would not go to the EAP because M.S.U. doesn't keep employees informed about the services available	1	2	3	4	5	6
28. I would contact M.S.U.'s EAP if I had a problem because I feel the EAP is a good benefit provided to employees	1	2	3	4	5	6
29. I would prefer using counselors/resources outside of the workplace if I ever had a problem which required counseling	1	2	3	4	5	6

PART V
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PART V

Please circle the one best response (letter) to each question.

1. Looking back to when you were growing up, how would you describe your family's practice of healthy behaviors (exercising, sleeping, eating, seeking medical aid when necessary, etc.)?
 - a. It was a very important part of our daily lives
 - b. It was moderately important to us
 - c. It was somewhat important, but only carried out haphazardly
 - d. It was not seen as having priority
2. Looking back to when you were growing up, how would you describe your friends' practice of healthy behaviors (exercising, healthy diet and sleeping habits)?
 - a. It was a very important part of their lives
 - b. It was moderately important
 - c. It was somewhat important
 - d. It was not at all important
3. How would you currently describe your family's practice of healthy behaviors (exercising, sleeping, eating, seeking medical aid when necessary, etc.)?
 - a. It is a very important part of their lives
 - b. It is moderately important
 - c. It is somewhat important
 - d. It does not seem to be important
4. How would you currently describe your friends' practice of healthy behaviors (exercising, healthy diet and sleeping habits)?
 - a. It is a very important part of their lives
 - b. It is moderately important
 - c. It is somewhat important
 - d. It does not seem to be important
5. How frequently would you say you visited a health professional (medical doctor, dentist, health clinic, hospital, etc.) while you were growing up?
 - a. Never
 - b. Seldom
 - c. Often
 - d. Very often
6. Which of the following would best describe the seeking of health assistance by members of your family today (parents, spouse, etc.)?
 - a. They go to a doctor for regular check-ups as well as any time they feel ill
 - b. They only go to the doctor when they feel they have something wrong
 - c. They seldom go to the doctor even when they are in pain
 - d. They never go to the doctor or seek any medical assistance
 - e. I don't know

PART V (Continued)

7. Do you feel your parents/family were good at handling stress and emotional problems in their lives when you were growing up?
 - a. Most of the time
 - b. Some of the time
 - c. Rarely
 - d. Never
 - e. Not sure
8. Which of the following would best describe the seeking of health assistance by your friends today?
 - a. They go to a doctor for regular check-ups as well as whenever they feel ill
 - b. They only go to the doctor when they feel they have something wrong
 - c. They seldom go to the doctor even when they are in pain
 - d. They never go to the doctor or seek any medical assistance
 - e. I don't know
9. Did any of your family members or friends ever seek professional assistance/counseling to help cope with their emotional problems (such as marital or child-rearing problems, depression, job stress, handling grief, etc.) while you were growing up?
 - a. Yes
 - b. No
 - c. Not sure
10. How often did members of your family take part in regular exercise/sports while you were growing up?
 - a. Never
 - b. Not often
 - c. Often
 - d. Very often
11. How often do members of your current family (spouse, children, parents, brothers, sisters, etc.) currently take part in regular exercise/sports?
 - a. Never
 - b. Not often
 - c. Often
 - d. Very often
12. How often do your current friends take part in regular exercise/sports?
 - a. Never
 - b. Not often
 - c. Often
 - d. Very often
13. Does your immediate supervisor exercise or appear to value being physically fit?
 - a. Yes
 - b. No
 - c. Don't know

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PART V (Continued)

14. How often did your friends encourage you to maintain healthy behaviors (proper sleep patterns, no smoking, limited alcohol, no non-prescription drugs, etc.) while you were growing up?
 - a. Never
 - b. Not often
 - c. Often
 - d. Very often
15. Do you feel your family members or friends ever abused prescription or non-prescription drugs while you were growing up?
 - a. Yes
 - b. No
 - c. Not sure
16. In general, how strong are your current social ties with your family and friends?
 - a. Very strong
 - b. Mostly strong
 - c. Somewhat strong
 - d. Not very strong
17. How often do your current family members and/or friends encourage you to participate in exercise/sports?
 - a. Never
 - b. Not often
 - c. Often
 - d. Very often

PART VI

This section examines different health desires of individuals. The following questions ask you about your DESIRED health goals and behaviors IF YOU COULD CHOOSE THESE TODAY. There are no right or wrong answers. Please respond honestly to what you really DESIRE regarding your health, not what you think might be a correct response, by circling the one appropriate response.

1. Compared to other persons your age, what do you DESIRE your general health to be?
 - a. Far ahead of the average
 - b. Somewhat above average
 - c. Average or same as others
 - d. Somewhat below average
 - e. Way below average
2. If you could select your level of exercise, what would you DESIRE your current level of aerobic exercise to be per week (e.g., biking, jogging, swimming, aerobics class, etc.)?
 - a. Less than once
 - b. Once
 - c. Twice
 - d. Three or four times
 - e. Five or more times

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PART VI (Continued)

3. How many times per week would you LIKE to make a conscientious effort to manage your stress by utilizing progressive relaxation, exercise, religion, music, or other stress reduction techniques?
 - a. 0-1 time per week
 - b. 2-3 times per week
 - c. 4-5 times per week
 - d. 6-7 times per week
4. Considering your height and body build, how many pounds within your ideal weight would you LIKE to fall?
 - a. Within 2-5 pounds (either over or under)
 - b. Within 10 pounds (either over or under)
 - c. Within 15 pounds (either over or under)
 - d. Within 20 pounds (either over or under)
 - e. Within 25 pounds (either over or under)
 - f. It's OK to be more than 25 pounds from my ideal weight (either over or under)
5. Which statement most closely describes your DESIRED daily eating pattern?
 - a. Eating snack foods whenever I feel hungry (potato chips, soda pop, cookies, candy, pastry, etc.)
 - b. Eating one balanced meal per day and eating snack foods at other times during the day
 - c. Eating two balanced meals per day and eating snack foods at other times during the day
 - d. Eating three balanced meals per day and eating snack foods at other times during the day
 - e. Eating three balanced meals per day and not snacking
6. What stress level do you DESIRE to achieve in your personal/home life?
 - a. I would like to be completely free of stress
 - b. A minimal amount of stress is OK
 - c. A moderate amount of stress is OK
 - d. A high level of stress is OK
7. Which statement best describes how you would LIKE to feel about anxiety?
 - a. It never bothers me to frequently feel anxious/uptight
 - b. Feeling anxious/uptight occasionally does not bother me
 - c. I dislike feeling anxious/uptight even occasionally
 - d. I hate ever feeling anxious/uptight and wish I would never have these feelings
8. Which statement best describes your DESIRED level of cigarette smoking behavior?
 - a. I would like to have no desire to smoke at all
 - b. I would like to smoke 1/2 pack or less per day
 - c. I would like to smoke between 1/2 and 1 pack per day
 - d. I would like to smoke from 1 to 1 1/2 packs per day
 - e. I would like to smoke over 1-1/2 packs but less than 2 packs per day
 - f. I would like to smoke 2 packs or more per day

PART VI

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- b. 1 d
- c. 2 d
- d. 3 d
- e. 4 d
- f. 2 d
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- c. 4-6
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PART VI (Continued)

9. Which choice best describes the consumption of alcoholic beverages which you DESIRE?
- a. 0 drinks per day (I would like to never drink)
 - b. 1 drink or less per day
 - c. 2 drinks per day
 - d. 3 drinks per day
 - e. 4 drinks per day
 - f. 2 drinks or less per weekday, and more than 1 drink per day on weekends
 - g. None of the above
10. How many cups of caffeinated beverages (coffee, tea, cola, etc.) do you DESIRE to drink per day?
- a. Less than 1 cup
 - b. 1-3 cups
 - c. 4-6 cups
 - d. 7 or more cups
11. Which best describes your DESIRED drug use pattern (over the counter, prescription, and non-prescription drugs)?
- a. Use drugs I want whenever I want
 - b. Use drugs I feel I need while following common sense
 - c. Use only medically required drugs exactly as directed
 - d. Rarely use drugs of any kind
12. How often do you DESIRE to have a medical checkup?
- a. Never or only when something is wrong
 - b. Only for Pap tests or other regular checks
 - c. Every 3-5 years
 - d. At least every 2 years
 - e. At least every year

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PART VII

This section presents a list of problems or concerns which you may currently be experiencing or may have experienced during the past year. There are three types of responses you should make regarding each problem or area of concern. Some of the questions refer to an Employee Assistance Program (EAP), which was defined in the previous section. The three scales to be used in this section of the survey are:

1. CURRENT PROBLEMS SCALE

In the FIRST column following each statement, please rate your current status regarding each of the health concerns or problem areas listed. Use the following scale and circle your best response under the "CURRENT PROBLEMS" column. The items refer to your health unless otherwise noted.

EXAMPLE 1: If you feel your GENERAL PHYSICAL HEALTH is "Poor" then you should circle the number "2" for question 1a.

EXAMPLE 2: If you feel you have no BLOOD OR ANEMIA PROBLEMS then you should circle the number "5" for "Excellent/No Problem" for question 13a.

(VP)	(P)	(A)	(G)	(E)
Very Poor/ Have a Problem	Poor	Average	Good	Excellent/ No Problem
1	2	3	4	5

2. DESIRED CHANGE SCALE

In the SECOND column following each item, please indicate the extent you would LIKE to change your health or improve your health in each of the problem areas by using the following scale and marking your responses under the "DESIRED CHANGE" column.

EXAMPLE: If you desire a "Very Large Change" in your current "GENERAL PHYSICAL HEALTH" then you should circle the number "5" for question 1b.

(NO)	(SL)	(MD)	(LG)	(VL)
No Change Desired	Slight Change Desired	Moderate Change Desired	Large Change Desired	Very Large Change Desired
1	2	3	4	5

3. EXPECTANCY SCALE

In the THIRD column following each item, please respond whether you believe going to an Employee Assistance Program (EAP) would help you either eliminate or decrease the problem listed, regardless of whether you currently are experiencing that problem or not. Use the scale below.

EXAMPLE: If you believe the EAP would be "Excellent/Help a great deal" in handling your "GENERAL PHYSICAL HEALTH" problems, then circle "5" for question 1c.

(VP)	(P)	(A)	(G)	(E)
Very Poor	Poor	Average	Good	Excellent
1	2	3	4	5
(EAP would be no help)			(EAP would help a lot)	

PART V

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1. General
2. Cancer
3. Serious
4. Other
5. Weight
6. Blood
7. Cholesterol
8. Diabetes
9. Cardiac
10. Respiratory
11. Vision
12. Ulcers
13. Infections
14. Blood
15. Handling
16. Legal
17. Marital
other p
18. Financial

PART VII (Continued)

EXPECTANCY THAT EAP WOULD HELP SCALE:

(VP)	(P)	(A)	(G)	(E)
Very Poor	Poor	Average	Good	Excellent
1	2	3	4	5
(EAP would be no help)			(EAP would help a lot)	

DESIRED CHANGE SCALE:

(NO)	(SL)	(MD)	(LG)	(VL)
No Change	Slight Change	Moderate Change	Large Change	Very Large Change
Desired	Desired	Desired	Desired	Desired
1	2	3	4	5

CURRENT PROBLEMS SCALE:

(VP)	(P)	(A)	(G)	(E)
Very Poor/ Have Problem	Poor	Average	Good	Excellent/ No Problem
1	2	3	4	5

	CURRENT PROBLEMS VP P A G E	DESIRED CHANGE NO SL MD LG VL	EXPECTANCY THAT AN EAP WOULD HELP VP P A G E
1. General physical health	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
2. Cancer/cysts/growths	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
3. Serious backaches	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
4. Other serious aches	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
5. Weight problem	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
6. Blood pressure/hypertension	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
7. Cholesterol level	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
8. Diabetes	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
9. Cardiovascular/heart problem	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
10. Respiratory problem(s)	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
11. Vision or hearing	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
12. Ulcer(s)	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
13. Infection(s)	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
14. Blood problems/anemia	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
15. Handling stress	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
16. Legal problems	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
17. Marital/significant other problems	(a) 1 2 3 4 5 (a) 1 2 3 4 5	(b) 1 2 3 4 5 (b) 1 2 3 4 5	(c) 1 2 3 4 5 (c) 1 2 3 4 5
18. Financial problem(s)	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5

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19. Caring
20. Child care
21. Family
22. Divorce
23. Dealing
24. Burnout
25. Depress
26. Suicidal
27. Anxiety
28. Trouble
29. Feel alienated
30. Feel insecure
31. Proper nutrition
32. Eating disorders (anorexia)
33. Regular
34. Alcohol
35. Use of drugs

PART VII (Continued)

EXPECTANCY THAT EAP WOULD HELP SCALE:

(VP)	(P)	(A)	(G)	(E)
Very Poor	Poor	Average	Good	Excellent
1	2	3	4	5
(EAP would be no help)			(EAP would help a lot)	

DESIRED CHANGE SCALE:

(NO)	(SL)	(MD)	(LG)	(VL)
No	Slight	Moderate	Large	Very Large
Change	Change	Change	Change	Change
Desired	Desired	Desired	Desired	Desired
1	2	3	4	5

CURRENT PROBLEMS SCALE:

(VP)	(P)	(A)	(G)	(E)
Very Poor/ Have Problem	Poor	Average	Good	Excellent/ No Problem
1	2	3	4	5

	CURRENT PROBLEMS	DESIRED CHANGE	EXPECTANCY THAT AN EAP WOULD HELP
	VP P A G E	NO SL MD LG VL	VP P A G E
19. Caring for aged (parents, etc.)	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
20. Child care problems	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
21. Family/parenting problems	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
22. Divorce/separation	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
23. Dealing with death/loss	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
24. Burnout/mental fatigue	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
25. Depressed/unhappy feeling	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
26. Suicidal feelings	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
27. Anxiety/phobias	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
28. Trouble with relatives	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
29. Feel alienated/withdrawn	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
30. Feel insecure	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
31. Proper nutrition	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
32. Eating disorders	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
(anorexia, bulimia)	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
33. Regular exercise	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
34. Alcohol use/abuse	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
35. Use of drugs/medications	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5

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PART VII (Continued)

EXPECTANCY THAT EAP WOULD HELP SCALE:

(VP)	(P)	(A)	(G)	(E)
Very Poor	Poor	Average	Good	Excellent
1	2	3	4	5
(EAP would be no help)			(EAP would help a lot)	

DESIRED CHANGE SCALE:

(NO)	(SL)	(MD)	(LG)	(VL)
No	Slight	Moderate	Large	Very Large
Change	Change	Change	Change	Change
Desired	Desired	Desired	Desired	Desired
1	2	3	4	5

CURRENT PROBLEMS SCALE:

(VP)	(P)	(A)	(G)	(E)
Very Poor/ Have Problem	Poor	Average	Good	Excellent/ No Problem
1	2	3	4	5

	CURRENT PROBLEMS	DESIRED CHANGE	EXPECTANCY THAT AN EAP WOULD HELP
	<u>VP</u> <u>P</u> <u>A</u> <u>G</u> <u>E</u>	<u>NO</u> <u>SL</u> <u>MD</u> <u>LG</u> <u>VL</u>	<u>VP</u> <u>P</u> <u>A</u> <u>G</u> <u>E</u>
36. Smoking habits	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
37. Absences from work	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5

Please list below any other health problems (physical, nutritional, emotional, etc.) not mentioned above that you may be experiencing. If you have no other problems, please continue with PART VIII on the following page.

List:

38. _____	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
39. _____	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5
40. _____	(a) 1 2 3 4 5	(b) 1 2 3 4 5	(c) 1 2 3 4 5

PLEASE CONTINUE WITH PART VIII

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PART VIII

This section focuses on any previous experience you have had with an EAP and your attitude toward utilizing an EAP. Please circle the appropriate letter for each question.

1. Do you have an opportunity to utilize other assistance services other than those at M.S.U.'s EAP that are either free or affordable (e.g., spouse's EAP, church counselors, psychiatrist, psychologist, etc.)?
 - a. Yes
 - b. No
2. How willing would you be to use M.S.U.'s EAP if you needed the services?
 - a. Very willing
 - b. Willing
 - c. Neither willing nor unwilling
 - d. Unwilling
 - e. Very unwilling
3. Have you used any of the following resources for help with a problem that has bothered you? Circle ALL THAT APPLY.
 - a. EAP counselor—either at M.S.U.'s EAP or an EAP where you may previously have worked
 - b. Mental health center (other than EAP counselor)
 - c. Private counselor/psychologist
 - d. Psychiatrist
 - e. Clergy
 - f. Family member (circle which: spouse, child, parent, brother, sister, other _____)
 - g. Friend
 - h. Self-help group (Alcoholics Anonymous, Parents Anonymous, weight-control group, etc.)
 - i. Work supervisor
 - j. Other, specify: _____

If you HAVE used ANY EAP in the past, please respond to the following questions in this section (continue with question 4 below).

If you HAVE NOT ever used an EAP, please continue with PART IX on page 19.

4. Circle the one response which best describes the improvement you experienced in your problem situation as a result of contacting the EAP:
 - a. My problem was resolved
 - b. I can see great improvement
 - c. I can see some improvement
 - d. I cannot see any improvement
 - e. My situation has become worse
 - f. I didn't contact the EAP referral
5. Was the problem you sought assistance on affecting your job performance?
 - a. Yes
 - b. No
 - c. Don't know

PART VIII (Continued)

6. To what extent do you think your job performance improved as a result of contacting the EAP?
 - a. To a great extent
 - b. To some extent
 - c. No change
 - d. Deteriorated somewhat
 - e. Deteriorated a lot
7. How satisfied were you with the EAP?
 - a. Very satisfied
 - b. Satisfied
 - c. Neither satisfied nor dissatisfied
 - d. Dissatisfied
 - e. Very dissatisfied
8. Would you recommend the EAP to others?
 1. Yes
 2. No - If no, why not? _____
9. If there had been no EAP where you work, would you have sought some other assistance on your own at that time?
 - a. Yes, I would have
 - b. I probably would have
 - c. Uncertain
 - d. Probably not
 - e. No
10. How do you feel about using the EAP's services again?
 - a. Very willing
 - b. Willing
 - c. Neither willing nor unwilling
 - d. Unwilling
 - e. Very unwilling
11. Who initially referred you to the EAP?
 - a. Self-referral
 - b. Supervisory-referral
 - c. Significant other in personal life referral (family member, close friend, spouse)
 - d. Coworker referral
 - e. Union (official union representative)
 - f. Other, please specify: _____
12. How long would you estimate the problem(s) which brought you to the EAP had been affecting you or your job before you contacted the EAP?
 - a. Less than 6 months
 - b. 6 months to 1 year
 - c. Over 1 but less than 3 years
 - d. 3 years or more

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PART IX

Please answer the following questions about yourself for background and analyses purposes. Remember, your responses will be confidential and anonymous once you return the survey and your name is detached.

1. What is your gender?
 - a. Male
 - b. Female
2. What is your race or ethnic background?
 - a. White
 - b. Black
 - c. Hispanic
 - d. American Indian/Alaskan
 - e. Asian/Pacific Islander
 - f. Other
3. What is your educational level?
 - a. Some or no high school
 - b. High school graduate
 - c. Trade/vocational school
 - d. Some college
 - e. Undergraduate college degree
 - f. Graduate college degree
4. What type of job position do you hold at M.S.U.?
 - a. Service or maintenance worker
 - b. Skilled labor/trade
 - c. Clerical
 - d. Technical
 - e. Professional
 - f. Administrator/manager
 - g. Other
5. What is your current marital status?
 - a. Single (or divorced, widowed) with no dependents/children
 - b. Single (or divorced, widowed) with dependents/children
 - c. Married with no dependents/children
 - d. Married with dependents/children
6. What is your family income?
 - a. Less than \$9,999
 - b. \$10,000 to \$19,999
 - c. \$20,000 to \$29,999
 - d. \$30,000 to \$39,999
 - e. \$40,000 to \$49,999
 - f. \$50,000 to \$59,999
 - g. \$60,000 or more
7. In what age group are you?
 - a. Under 25
 - b. 26-30
 - c. 31-35
 - d. 36-40
 - e. 41-45
 - f. 46-50
 - g. 51-55
 - h. 56-60
 - i. 61 or over
8. How long have you been employed at M.S.U.?
 - a. Less than 1 year
 - b. At least 1 but less than 3 years
 - c. At least 3 but less than 5 years
 - d. At least 5 but less than 8 years
 - e. 8 years or more

THANK YOU FOR YOUR PARTICIPATION! YOU HAVE COMPLETED THIS SURVEY!
PLEASE RETURN IT VIA U.S. MAIL IN THE ENCLOSED ENVELOPE TO RECEIVE YOUR PAYMENT!

If there are any comments you wish to make about the questionnaire or any aspect of the questionnaire administration process, please feel free to do so below. Thank you.





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