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The effectiveness of psychotherapeutic intervention in the reduction of client symptoms in an employee assistance program

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Seymore, Judy Irene, M.A.

University of Nevada, Las Vegas, 1991

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**300 N. Zeeb Rd.
Ann Arbor, MI 48106**

The Effectiveness of Psychotherapeutic Intervention
in the Reduction of Client Symptoms in an
Employee Assistance Program

by

Judy Irene Seymore

A thesis submitted in partial fulfillment
of the requirements for the degree of

Masters

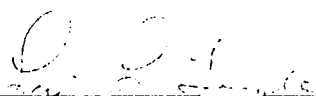
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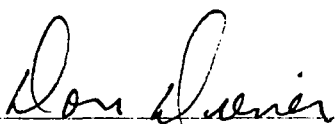
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The thesis of Judy Seymore for the degree of Masters in Psychology is approved.



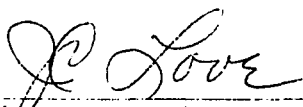
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Abstract

The primary purpose of the current study was to determine the efficacy of short-term therapy in the reduction of symptoms and overall emotional distress for clients seeking help through a privately contracted Employee Assistance Program (EAP). A review of EAP literature is presented as well as research findings related to psychotherapeutic outcome studies. Clients' noncompliance in returning Post and Follow-up assessments resulted in a small sample size. For clients who returned Post and Follow-up assessments, results indicate that short-term psychotherapy offered in the EAP was effective in reducing symptoms and emotional distress for clients who received therapy. Methodological problems encountered in the study and directions for future research are discussed.

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An Employee Assistance Program is defined as an industrial clinical intervention whose purpose is to identify, confront, diagnose, treat, and follow-up on employees whose personal and or emotional problems have led to deteriorating and unacceptable job performance (Gam, Sauser, Evans, & Lair, 1983). Over the past two decades, there has been a marked increase in the number of employee assistance programs (EAPs) adopted by industries in the United States and other western nations (Dickman, Challenger, Emener, & Hutchison, 1988; Roman, 1981). At present, there are approximately 10,000 private companies with Employee Assistance Programs, in addition to local and state public agencies and organizations (Roman, Blum, & Bennett, 1987).

Organizations have adopted EAPs in an effort to deal with troubled employees whose problems may be contributing to poor work performance. Research has indicated that employees affected by mental and emotional problems have exhibited such dysfunctional work behaviors as lowered productivity, absenteeism, low morale, and poor work relationships with coworkers and supervisors (Gerstein & Bayer, 1988; Levine, 1985). Emotional and personal problems have also been shown to be linked to increased tardiness, sick leave, accidents, injury,

property damage, medical claims, and high turnover rates (Kemp, 1985; White, 1983). The costs related to these problems are high. Lieboweitz (1982) estimated the annual economic cost of alcohol problems alone at 42.75 billion dollars and the cost of drug abuse at more than 40 billion dollars. According to McClellan (1987), the number of inpatient hospital beds assigned to the treatment of chemical dependency increased by 300 percent between 1981 and 1985. Furthermore, General Motors reported a 50 percent increase in claims related to substance abuse treatment from 1980 to 1983 (Hotchkiss, 1985 as cited by McClellan, 1987).

The Birth of Employee Assistance Programs

Alcoholism rehabilitation is currently one of the most frequently called for services of EAPs and previously formed the basis for the earlier Occupation Alcohol Programs (OAPs) that began in the 1940s. At that time, recovering alcoholic employees approached their management concerning the problem of alcohol in the workplace (Dickman et al., 1988; Masi & Goff, 1987). Many of the earlier programs were organized and run by recovering alcoholics and at times were somewhat covert in nature. For example, the Dupont corporation, after implementing an alcohol rehabilitation program,

went to extended measures to "keep quiet what was being done" for a period of about three years (Dickman et al., 1988). The early programs were often described as "informal" and "unwritten." It is probable that the programs remained secretive due to the negative stigma associated with alcoholism. Companies may have been reluctant to admit that problems resulting from alcohol usage existed within their industry.

Recent literature (Myers, 1990; Trice & Sonnenstuhl, 1988) suggests that there may be several underlying factors related to "institutional denial" of the existence or severity of chemical abuse, and that these factors may play an important role in the employment and effectiveness of an alcohol or chemical abuse treatment program. Possible factors include: (1) cultural norms related to drinking behavior within the job setting (i.e., alcohol consumption on or off job considered recreational "time out"); (2) the need to maintain appearances; (3) immunity for individuals with valued attributes or who have connections to powerful persons within the industry; (4) individuals who are already overworked may resent and resist additional and new tasks associated with implementing a new and effective treatment program; (5) reluctance to change the overall

structure of the organization to include new innovative programs; and (6) the reluctance of persons who abuse chemical substances to confront their problem (Myers, 1990). Any or several of these factors may be present in an industry and may interact in unique ways to prevent the confrontation of deleterious and costly chemical abuse behaviors.

For reasons related to the factors mentioned above, the decision to accept or reject an OAP in an industry sometimes depended on the attitude of the company manager toward alcoholism. The Dupont corporation and Standard Oil were two of the first companies to adopt an OAP (Masi & Goff, 1987). The Dupont program in particular was adopted partly because of severe drinking problems of highly valued employees. Dupont found it to be cheaper to rehabilitate these valued employees than to train new ones (Masi & Goff, 1987). It is important to note that recovery rates for alcoholic employees rehabilitated through OAP or EAP services have been reported as high as 50% (Quayle, 1983; Schultz & Schultz, 1990).

As companies began to realize the cost effectiveness of rehabilitating valued employees (i.e., lower turnover rate, less absenteeism), the number of OAPs increased. One company, for example, stated that the average cost to

train a new employee was \$1,800; a second company stated the cost was \$2,200. At an average cost of \$2,000 savings per employee for 18 employees who were rehabilitated, the two companies together saved \$36,000 (Decker, Starrett, & Redhorse, 1986). Other cost reductions for employers come as a result of reduced use of health care services. White (1981) indicated that the availability of mental health care services could reduce the overutilization of primary health care services by as much as 30 percent. In a review of several studies, White (1981) found that a high number of people who sought primary medical health care because of a medical complaint had diagnosable emotional problems ranging from substance abuse and mild depression to psychotic illness.

In addition to substance abuse problems, during the 1970s, more employees began to seek counseling services for a variety of problems. The focus of the OAPs shifted to a "broad brush" program, and hence the term Employee Assistance Program (Dickman et al., 1988; Masi & Goff, 1987). In a study of 39 EAPs Levine (1985) found that problems most frequently encountered were substance abuse, marital problems, financial problems, personality clashes with supervisors or coworkers, and legal problems. Other problems also treated include disruptive

family interactions, stress related problems, medical related problems, and compulsive gambling. In one study that compared findings of different industries, a national consultant firm's EAP reported that the most common problems encountered were stress and psychologically related problems whereas a medium-sized manufacturer's EAP reported that the most common problems encountered were drug or alcohol related problems (Levine, 1985).

The Need for Employee Assistance Programs

Stress and job related tension in the workplace are not a new phenomenon. In a study of 7,000 employees at Equitable Life Assurance Society in New York, Manusco (1981 as cited in White, 1983) lists the following ten major stressors:

- * work overload--too much or too little to do
- * ambiguity or rigidity in relation to one's tasks
- * extreme role conflicts--is the fit right with regard to the job?
- * extreme amounts of responsibility, particularly responsibility for people
- * negative competition--"Your job stinks, but mine is very good"--or no competition.

- * constant change and daily variability, or deadening stability
- * ongoing contact with stress carriers- workaholics, highly anxious individuals, indecisive individuals, or depressed people who influence others' stress levels-or, at the other extreme, social isolation
- * an organizational climate that encourages containment of emotional reactions and that forces ego identification with the organization (this can lead to suppressed hostility and stress-related disorders)(p. 6).

Other major occupation stressors include job relocation, performance appraisal, organization restructuring, impending retirement, managerial work, and two-career marriages (White, 1983).

Problems related to occupational stress have been shown in employees who function in certain occupations such as nursing (Marshall, 1980), teaching and school administration (Phillips & Lee, 1980; Tung and Koch, 1980), and police work (Davidson & Veno, 1980).

In light of these findings it seems important for EAPs to pay particular attention to and engage in future research that assesses the different needs of employees

in different industries, and in particular, to find out the types of relationship that may exist between the types of problems presented by troubled employees and the type of industry in which they work.

Research further indicates that not only is there a wide of variety of problems encountered by EAPs, but that there is a high prevalence of employees experiencing problems (Kemp, 1985; Madonia, 1985). An analysis of insurance literature indicates that close to 9 percent of the work force are shown to suffer from some form of psychological disorder that interferes with job performance (Madonia, 1985). This figure is approximate at best, and does not include those individuals who seek counseling services but do not apply for insurance benefits. It is suggested that, at any given time, as high as 18 percent of the work force experiences such personal difficulties as alcoholism, drug abuse, and impaired mental health (Kemp, 1985).

As mentioned earlier, in order to meet the needs of employers and their employees who are experiencing difficulties that may be affecting job performance, Employee Assistance Programs have broadened their scope to include a wide variety of services. In addition to referral services which are widely used and form an

integral part of EAP interventions (Fizek & Zare, 1988), many programs offer a full range of services such as crisis intervention in the workplace, supervisory training for recognition of troubled workers, and psychological and other forms of individual and family counseling (Dickman et al., 1988; White, 1983).

The Components of an Employee Assistance Program

Although to date, there are no mandated requirements or formal guidelines to which EAPs must adhere in setting up service programs (Dickman et al., 1988; McClellan, 1985; Roman, 1983; Roman, Blum & Bennett, 1987), there are several components that are considered essential in the development of an effective EAP. They include:

1. Endorsement of both management and labor force. If appropriate, joint labor-management agreement and cooperation in regard to all aspects of program implementation;
2. A written policy statement as to the philosophy and intent of the program. The statement should outline the expectations for management, union, and employees associated with an EAP;
3. Procedural guidelines that specify the steps for EAP utilization by managers, union representatives, and employees;

4. Orientation for managers, supervisors, and union representation and general education of the workforce about the EAP;

5. Special consideration toward employee benefits, financial aspects and/or insurance coverage for EAP referrals and services;

6. Information systems, record keeping, and procedures for program evaluation (Dickman & Emener, 1982; Dunkin, 1982; Roman et al., 1987).

In setting up an EAP, it is essential to have the support and cooperation of administrative and managerial staff so as to circumvent problems related to "institutional denial" mentioned earlier. Supervisory training sessions that acquaint management personnel as to the purposes, benefits, and proper referral procedures of the EAP are necessary for maximal utilization and effectiveness of the program.

Criteria for Referral of Employees

Many employees who are experiencing personal and/or job related problems voluntarily seek help through the EAP before their distress becomes apparent to supervisory personnel. For self-referred employees, the employee orientation program provided by the human resource department or designated individuals should acquaint the

employee with the procedure for obtaining services from the EAP. Other employees, however, are referred for EAP services by immediate supervisors or other management officials. Supervisory referral of employees is a sensitive process that calls for preestablished guidelines that meet the needs of both the employee and the employer.

In accordance with their overall philosophy and policy statement, the employee assistance provider establishes the criteria for supervisory referral and provides guidelines for the "supervisor versus employee" interaction. The following section defines and discusses the advantages and disadvantages of using job performance as the criteria and constructive confrontation as the process of interaction.

The Job Performance Model. Literature indicates that the majority of EAPs specify deterioration of job performance as the main (and often only) criterion for referral of employees for counseling services (Dickman et al., 1988; Sonnenstuhl, 1988; Sonnenstuhl, Staudenmeier, & Trice, 1988). Focusing on job performance provides supervisors with a more objective and standardized means of detecting troubled workers and helps eliminate the need for supervisors to be "diagnosticians" in areas for

which they are poorly trained (Googins, 1975).

Sonnenstuhl et al. (1988) contend that the job performance model serves to define emotional and mental problems operationally within the context of the work place, and allows troubled employees the opportunity to change their behavior using their own resources. The troubled employees may also receive continued social support from their coworkers and peers for changing their behavior. By giving employees the opportunity to solve problems on their own, the job performance model prevents them from being unnecessarily rushed into treatment. Premature entrance into treatment may interfere with the employee's opportunity to be self-reliant and may reduce the cost effectiveness of the EAP. The performance model also provides a distinct and verifiable measure of the effectiveness of a treatment intervention.

According to Googins (1975), the main objective of the EAP system is to help restore an employee to normal work behavior and productivity. An employee should only be referred for assistance in the case of impaired work performance; personal issues or problems not affecting job performance should be the responsibility of the employee. Since underlying problems eventually manifest themselves in poor work performance, supervisors can

readily identify troubled workers solely on job performance criteria.

Despite the successful utilization of job performance as a criterion for the referral of troubled employees to seek help through EAP counseling services, there is controversy concerning the emphasis on the needs of the employers (i.e., higher productivity and cost effectiveness) versus the clinical needs of the employees (Roman et al., 1987; Sonnenstuhl, 1988). Mental health specialists have argued that the job performance criteria for referral serves too late in helping some employees, and that improved job performance does not necessarily represent the resolvment of underlying problems (Shain & Groeneveld, 1980).

Several members of the national labor force have also criticized the job performance model as being a threat to the solidarity of workers (Sonnenstuhl et al., 1988). Former director of the AFL-CIO Community Services Department, Leo Perlis (1980 as cited by Sonnenstuhl et al. 1988) states that the troubled workers should be helped for humanitarian reasons (i.e., to become well-adjusted human beings) not just as a means to increase production, reduce absenteeism, and increase profits.

Other problems associated with the performance

model pertain to inconsistencies of ratings scales in performance evaluations of employees and the belief that a management-supported program that focuses on mental health diagnosis might be used as a means to control employees are further criticisms against the performance model for referring impaired workers (Roman, 1981; Trice, Hunt & Beyer, 1977 as cited by Sonnenstuhl et al., 1988). In addition, some organizations make mandatory referrals of employees to the EAP, and it is argued that such practices are counter to the original formulation of the constructive confrontation strategy that allows employees to choose freely whether or not to seek help from an EAP or to improve their job performance through self-efforts (Sonnenstuhl, 1988).

The Constructive Confrontation Model. Constructive confrontation is the process whereby the supervisor discusses problem work behaviors with the employee. The employee is given an opportunity to correct the problem behaviors before more disciplinary action is taken.

Constructive confrontation has received much attention and support in the literature in relationship to industrial interventions for problem work behaviors (Roman et al. 1987; Sonnenstuhl & Trice, 1986; Trice & Beyer 1984) and a variety of factors have been shown to

affect a supervisor's decision to confront and/or refer an employee for treatment (Gerstein & Bayer, 1988; Googins & Kurtz, 1981; Nord & Littrell, 1989).

Several factors found to be positively associated with higher referral rates by supervisors include: (1) increased personal knowledge of their company's EAP and favorable impression of the effectiveness of the EAP's usefulness (Googins & Kurtz, 1981; Nord & Littrell, 1989); (2) participation in EAP referral training (Belasco & Trice, 1969); (3) supervisors who had not previously worked or been coworkers with an employee in a nonsupervisory capacity are more likely to refer that employee for treatment; (4) having an opinion of the perceived support the EAP receives from management, the union, and other immediate supervisors; (5) higher level or position in management (Nord & Littrell, 1989); (6) sex of the impaired worker in relation to type of problem (i.e., supervisors may be more reluctant to refer female employees suspected of alcohol related problems (Brodzinski & Goyer, 1989); and (7) type and severity of job-related impaired behavior (Bayer & Gerstein, 1988; 1990).

In summary, most EAPs specify job performance as the criteria for supervisory referral of employees for

treatment and the interaction between the employee and the supervisor occurs primarily through the mechanism of constructive confrontation. Although job performance is often viewed as an objective criteria for referral and has been used effectively, inconsistencies of rating scales in performance evaluations may prove detrimental to the referral process.

The Bystander Equity Model. In an effort to explain a supervisor's dilemma when faced with the decision to refer an employee, Bayer and Gerstein (1988) proposed The Bystander Equity Model of Supervisory Helping Behavior. The theory suggests that various characteristics of the employee, supervisor, and problem situation interact in complex ways to affect a supervisor's level of arousal, perceptions about the costs for helping, and the final helping response. The proposed theory served as the theoretical foundation for the development and construction of the Behavioral Index of Troubled Employees (BITE), an instrument designed to assess how supervisors identify workers who might benefit from OAP/EAP services.

The researchers found that supervisors associate four sets of behaviors with troubled employees: (1) resistance--reflects impaired work attention and conduct

(i.e., absenteeism and unexcused absences); (2) acrimoniousness--reflects the affective demeanor (i.e., irritability, hostility toward others) of troubled workers; (3) industriousness--employees productivity and work performance; and (4) disaffectation--reflects an employee's apathy, alienation, and discontent (i.e., lack of interest in work). Employees who exhibited impaired performance in the above categories were more likely to be referred for EAP counseling services. Acrimoniousness or irritability was one of the strongest predictors of referral rates by supervisors (Bayer & Gerstein, 1990).

In a study of 1,340 clients in an EAP over a 3-year period researchers (Martin, Heckel, Goodrick, Schrieber, & Young, 1985) found that, for formal supervisory referrals, absenteeism was the most common work performance problem. In informal supervisory referrals, awareness of slipping was the most cited problem. Self-referred employees were more apt to seek help for interpersonal relations problems and represented 85 percent of the referrals in the client sample. The increase in self-referred employees may occur as a result of the "broad brush" approach of current EAPs, increased employee awareness of EAP services and possible benefits, and also because some supervisors are reluctant to make

formal and/or mandatory referrals (Martin et al., 1985).

Types of Employee Assistance Programs.

The initiation of an employee response to seek help through an EAP and the decision of a referred employee to follow through on a referral is sometimes affected by whether an EAP is internally or externally based.

Employee Assistance Programs may either be internally based, maintained within and by the company, or contracted by an outside agency. Hofman (1988) cited advantages and disadvantages of both.

Internally Based Programs. First, an internal program may be better able to ascertain the needs of the company and may be more familiar with management expectations and policies regarding troubled employees. An in-house EAP administrator has the opportunity to see both formal and informal company policies and may be in a better position to organize the program in terms of specific company needs. The in-house administrator also has a personal interest in terms of career advancement and subsequently may monitor client progress more assiduously.

An in-house administrator also has greater access to personnel information that may lend valuable employee background information (e.g., length on job, promotions,

etc.) as well as work-related performance documentation (e.g., absenteeism, productivity) needed in assessing employee progress and the effectiveness of intervention.

Disadvantages of an internal program include the question of divided allegiance (i.e., betterment of the employee versus greater good of the company), and confidentiality. The in-house administrator may be caught between the need to answer to company officials and the need to protect the rights of employees seeking help. Confidentiality is also a pertinent issue in providing and receiving psychological counseling. Fear of being seen entering or exiting an in-house facility as well as disclosure of confidential records may deter some troubled employees from seeking help through the EAP. Employees may be afraid that supervisors will find out they are having difficulties and that this information may lead to denial of job opportunities or job termination. As a result, employees are sometimes reluctant to seek help in an on-site based program.

Internal programs are also expensive to maintain and need a high rate of utilization by employees in order to justify the expense of hiring individuals to set up and provide EAP services within the company. The added costs of salaries, retirement benefits etc. that are

incurred in an internally based program may prohibit smaller companies from establishing programs that provide help for troubled workers.

Externally Based Programs. In contrast, the lower costs of services contracted through external EAPs independent of the worksite allows both large and small companies to take advantage of needed services (Riggio, 1990). The contract provider also has a direct monetary interest in providing adequate services. Companies can be selective in their choice of external EAP providers and retain the option to cancel a contract if not satisfied with services rendered. The organization may make certain demands as to the qualifications of persons rendering services. In addition, increased employee trust in the confidentiality of employees' records regarding involvement in counseling that is provided by the off-site location of externally based EAPs may increase employee utilization.

One of the obstacles encountered in externally based EAP program evaluation is the denial of access to personnel files that contain important data such as absenteeism, accidents, grievances, disciplinary actions including supervisor's time in disciplinary process, and job efficiency decline or progress (Decker et al., 1986).

This information may be essential to effective program evaluation of the EAP provider.

In order to obtain necessary records and to remain aware of specific needs of the occupational organization, the external EAP provider has to maintain constant contact with company officials. This may be time consuming and costly. In addition, it may not be possible to obtain records because of the employee's rights of confidentiality.

In view of the differences found in internally based and externally based programs, it is essential that industries know how to choose the best program to fit their specific needs. Industries need to be able to obtain information that relates to the costs of setting up an EAP, and also guidelines for implementation and evaluation of the EAP. To date, however, there are problems in terms of the degree to which consumers are educated about EAPs. Much of the information in the media as to consumer education of EAPs is related to marketing (i.e., cost effective benefits of EAPs) and is provided by EAP service providers. There is very little outside interest or independent research related to the evaluation and implementation of EAP programs. This raises the question of possible bias in reporting

benefits (Roman et al., 1987). A lack of consensual criteria by which individual EAPs can be judged and no means to enforce standards of implementation are further criticisms of EAPs (Dickman et al. 1988; Roman et al., 1987).

It has only been recently that a certification examination and procedure for setting up an EAP was established by the Employee Assistance Certification Commission, an independent body selected by members of the Association of Labor and Management Administrators and Consultants on Alcoholism (ALMACA). It is not clear that the certification requirements will be accepted and enforced by organizational consumers (Roman et al., 1987). It is therefore difficult for consumers to know which type of program best fits their needs and which providers are giving adequate and effective services. It is also difficult to determine what actual benefits may be derived as a result of EAP programs.

Benefits of Employee Assistance Programs.

Currently the benefits cited in regard to EAPs include: (1) early recognition, intervention, and resolution of business and personal problems; (2) retention of valued employees with training, skills, and experience; (3) increased productivity and profits; (4)

reduced absenteeism; (5) reduced accidents; (6) improved employee morale; and (7) fewer discipline problems (Dickman et al., 1988; Levine, 1985).

Benefits of an EAP are shown in a study conducted by Allander and Campbell (1975). They compared 117 blue-collared alcoholics and drug abusers to 24 suspected abusers one year before and after a treatment of variable length. The results indicate that grievances decreased by 79 percent and disciplinary actions decreased by 67 percent among those treated. An 82 percent reduction of accidents was also found, and was accompanied by a 33 percent reduction in industry costs relative to the aforementioned factors for the treated group. Other cost related benefits for EAPs were shown through an evaluation of the EAP at Kennecott Copper. Kennecott Copper was able to reduce absenteeism by 53 percent and cut sickness and accident costs by 75 percent as a result of its alcohol treatment program (Schultz & Schultz, 1990).

Although the aforementioned benefits may indicate a cut in losses and raised profits, much evaluative research to cost-effectiveness, is subject to criticism. For example, MacDonald (1985) indicated that General Motors Corporation reported a 40 percent drop in

absenteeism and a 50 percent reduction in accidents and discipline problems after instituting an EAP, however no details of data collection, therapy procedures used, or methods for deducing cost savings were presented.

McClellan (1989), in a cost-benefit analysis of the Ohio state EAP, also discussed the lack of continuous, complete, and systematic data necessary to determine the impact of the Ohio EAP on health care costs, absenteeism, accidents, and productivity etc.

Myers (1984), in a review of studies in which the cost effectiveness of EAPs was evaluated, also found inadequate reporting of data and evaluation methodology. The studies as a whole, claimed up to eight dollars in savings for each dollar spent on EAPs, however in most of the studies, the authors did not report how the data were collected or what variables were included to arrive at the cost benefit ratios.

In an effort to establish more reliable data, Klarreich, DiGiuseppe, and DiMattia (1987) conducted research investigating the effectiveness of Rational-Emotive Therapy in dealing with EAP clients, as well as absenteeism, employee satisfaction, savings in supervisors time, and cost benefit. Of 295 employees on whom data were available, there was a reduction of

more than 70 percent in absenteeism. Seventy-five percent of the employees who used the service rated the program as helping them improve. The other categories, "somewhat helpful" and "not helpful," received 14 percent and 12 percent, respectively. It was estimated that 1880 hours of supervisory help at a cost rate of twenty-three dollars per hour was saved. The combination of reduced absenteeism and supervisory time lost led to a savings of \$2.74 for each \$1.00 spent in a large North American oil company (Klarreich et al., 1987).

The Need for Research. As cited, much of the literature indicates that economic gains may be accomplished by helping troubled employees, however, for Employee Assistance Programs to continue to grow at the present rate and to maintain continued support of industries and work organizations, more independent and methodologically sound research needs to be conducted.

Also, as shown in the above review, the major emphasis of EAP research to date has been placed on implementation, referral practices, cost-effectiveness, and marketing issues. Empirical research directed toward establishing the clinical effectiveness of short-term psychotherapeutic interventions encountered in Employee Assistance Programs is almost non-existent. The lack of

empirical data related to the effectiveness of short-term psychological treatment found in EAPs and the need for more independent and university-based research served as a motivator in the current study.

The current research project was conducted as part of an evaluation procedure of an EAP that services both gaming and non-gaming industries in Nevada. Before describing the research project, theoretical and clinical issues as well as additional historical and research information relative to the project will be discussed.

Therapy in the Work Environment.

From a theoretical, ethical, clinical, and client point of reference, it is of prime importance to establish the effectiveness of services rendered by EAPs with regard to the reduction of personal and or emotional problems that may or may not have led to deteriorating and unacceptable job performance. Although client improvement may be logically assumed in the presence of cost reductions and improved job performance, due to the "broad brush" approach of current EAPs, many employees voluntarily seek help for issues that have not yet affected job performance (Dickman et. al. 1988; Martin et. al., 1985). Also, as mentioned earlier, there is concern as to whether the troubled employee's improved

job performance necessarily represents resolved underlying personal and emotional issues (Shain & Groeneveld, 1980). Some employees may be motivated to improve job performance as a result of supervisory confrontation, but may continue to experience emotional distress.

The "Spillover" Theory. From a theoretical perspective, it is important to explore the situational and individual variables that help form the relationship between job related behaviors and emotional well being. It is hypothesized that there is a unique interaction between work or work related attitudes and emotional well-being (Kornhauser, 1965; Meissner, 1971). According to the "spillover" theory, positive or negative feelings toward work may affect or carry over into other areas or facets of life and a variety of life experiences may carry over and affect job attitudes and feelings (Kornhauser, 1965; Meissner, 1971). The "spillover" theory suggests a direct and positive relationship between job attitude (i.e., satisfaction) and mental health (Wiener, Vardi, & Muczyk, 1981). Accordingly, low job satisfaction was shown to be significantly related to independently assessed symptom levels in the following areas: general distress, behavioral disturbance,

inadequate impulse control, alcohol abuse, and problems in job functioning (Kavenagh, Hurst, & Rose, 1981). However, the nature of the relationship is problematic. Warr (1987) asks the question "Is the association (between job and job related behaviors and mental health) due to the effect of the environmental feature? Or has it occurred because a person's emotional condition has determined perception of the environment?" (18). In sum, personal distress may influence the individual's capacity to view the work environment favorably. It is difficult, however, to determine whether poor job satisfaction contributed to emotional distress or vice versa.

Goals of Therapy. Given the relationship between mental health and work performance (Gam et al., 1983; Warr, 1987), the end goals of a clinician in an Employee Assistance Program is two-fold. First, the verifiable effectiveness of the EAP program is evidenced in relationship to the employee's improved work performance and cost effective provision of mental health service, whereas the effectiveness of psychotherapeutic intervention for the individual manifests itself in the amelioration of the employee's underlying emotional or personal problems (i.e., reduction of symptoms) that may or may not be related to job behavior. Ethical concerns

are particularly salient in situations where these goals may conflict. Extended care and utilization of higher paid qualified mental health professionals in order to provide maximum care for clients may lessen the amount of money saved for the industry following the implementation of the EAP.

For a clinician, the monitoring of client improvement or change is an essential part of the therapeutic process. It allows the therapist to evaluate treatment effectiveness and to modify intervention strategies to meet the needs of the individual client (Kazdin, 1986; Lambert, Shapiro & Bergin, 1986; Rachman & Wilson, 1980). Monitoring participating employees for changes that occur as a result of treatment and not as a result of extraneous factors also serves as an important component in impact evaluation of EAP intervention (Masi & Teems, 1983). EAP evaluation procedures help provide concrete evidence of the benefits that may be derived for both the client and the industry.

Spontaneous Remission. Historical background shows that increased activity in research designed to test the effectiveness of psychotherapy occurred following the controversial findings of Hans Eysenck (1952). Eysenck, after examining data provided by Landis

(1937) and Denker (1946) came to the conclusion that roughly two-thirds of patients suffering from neurotic disorders would recover or improve to a marked extent within about two years of the onset of their illness, whether or not they received psychotherapy. Eysenck concluded that the spontaneous remission rate for neurotic control groups was about 66 percent, approximately the same improvement rate as that of experimental groups that had received therapy (Rachman & Wilson, 1980).

Eysenck has been criticized extensively for poor methodological design that included bias in selection of data, overly stringent criteria for categorizing client improvement, and an insufficient sample of studies (Bergin & Lambert, 1971; Lambert, 1976; Meltzoff & Kornreich, 1970). In contrast to Eysenck, Bergin and Lambert (1978) suggest that the spontaneous recovery rate in untreated cases is close to 40 percent, however this figure may vary as a function of the diagnosis and severity of the mental dysfunction as well as type of outcome measures used to assess client change (Lambert et al., 1986).

Contrary to Eysenck's conclusion that therapy was no more effective in the amelioration of mental problems

than no therapy, through the use of meta-analysis, recent research findings indicate that psychological treatments are beneficial. Lambert et al. (1986) conclude that research has shown psychotherapy intervention to be effective in reducing symptoms, speeding up the healing process, and providing the client with additional coping strategies for dealing with future problems.

Smith, Glass, and Miller (1980), in an analysis of 475 studies, found an average effect size of 0.85 standard deviation units when comparing treated and untreated groups. At the end of treatment, the average treated person was better off than 80 percent of the untreated sample.

As cited, literature indicates that, in general, psychotherapy often leads to client improvement. A variety of factors, however, may affect psychotherapeutic outcome, and recent research has focused on the effects of using brief therapy methods as opposed to long term therapy on client improvement (Koss & Butcher, 1986; Lambert et al., 1986).

Emergence of Brief Psychotherapy.

During recent years, brief psychotherapy has emerged as a "treatment of choice" for most patients (Koss & Butcher, 1986). The current emphasis upon brief

treatment methods has been affected by a variety of factors. First, clients may expect that their problems can be treated in a few sessions. Second, research has indicated the efficacy of brief therapy procedures for severe problems if goals are limited to specific areas (Binder, Strupp, & Schacht, 1983). Finally, insurance companies impose limits on the amount of coverage available to clients for mental health care services (Garfield, 1978; Koss & Butcher, 1986; Koss, Butcher & Strupp, 1986).

Characteristics of Brief Psychotherapy. The upper limits of brief psychotherapy is approximately 20 sessions (Hoyt, 1990), however treatment duration for individuals and marital/family therapy tends to fall in the range of six to ten sessions (Fisher, 1984). Brief psychotherapy may be considered qualitatively different than unlimited or unplanned treatment strategies (Koss, Butcher, & Strupp, 1986; Ewing, 1990; Hoyt, 1990) in the following ways:

1. Time limits give the therapy a definite beginning, middle, and end. Setting limits may give the clients the expectancy that they will improve in a relatively short period of time and may encourage them to become more actively involved in therapy.

2. It is important to set definite and limited goals. Goal setting facilitates monitoring client change and keeps the therapist and client on track.

3. Psychotherapists select a specific area in which to maintain focus. The client is encouraged to stay centered on the problem or area of concern.

4. Therapists tend to take a more active role in therapy sessions and in general may be more directive. The therapist may give homework assignments, teach problem solving, and offer support and guidance.

5. Because brief therapy focuses on current life issues or problems, intervention tends to require prompt attention. Brief therapy may take the form of crisis intervention for individuals who are in an acute emotional state (Wolkon, 1972).

Crisis Intervention. Crisis intervention is similar to brief therapy in terms of their limited goals, focus of current issues, therapist directiveness, early assessment, and prompt intervention. Two widely accepted primary goals of crisis intervention are symptom relief and a return to a precrisis state of functioning (Kolotkin & Johnson, 1983). These goals are similarly important for EAP treatment specialists who seek to help employees resolve current issues and to help them return

to an acceptable standard of work performance in cases where work behaviors have deteriorated.

Effectiveness of Brief Psychotherapy. Research indicates that brief psychotherapy is as effective as unlimited or long term psychotherapy (Koss & Butcher, 1986; Wells & Phelps, 1990). Brom, Kleber, and Defares (1989) investigated the effectiveness of brief psychotherapy in the treatment of posttraumatic stress disorders. Results indicated that clients treated with trauma desensitization (mean length of treatment 15.0 sessions), hypnotherapy (mean length of treatment 14.4 sessions), and psychodynamic therapy (mean length of treatment 18.8 sessions) exhibited significantly lower trauma-related symptoms than the control group. In another study, a one year follow-up evaluation also found no deterioration effects for families treated by treatment methods involving time-limited brief therapy (Fisher, 1984).

Long Term Effects of Brief Therapy. In determining the long term treatment effects on clients who undergo brief psychotherapy and/or crisis intervention, problems encountered in brief therapy and crisis evaluation research include the following: (1) heterogeneity of the population; (2) difficulty in obtaining follow-up

information; (3) self-limiting nature of crises (i.e., spontaneous recovery); (4) collateral interventions; and (5) client involvement in subsequent therapy (Kolotkin & Johnson, 1983).

Target symptoms and problems tend to vary greatly for individuals seeking help during crisis, so it may be difficult to explore commonalities. In the case of crisis intervention for EAPs, however, one commonality that may be explored is the type of industry in which clients are employed in relation to the type of problems presented.

Spontaneous recovery is another confounding variable in research related to crisis intervention. The self limiting nature of crises make it difficult to demonstrate that treatment interventions produce greater recovery (as compared to no intervention). Caplan (1964) found that most individuals recover spontaneously within six weeks regardless of the kind of care received. In contrast, Kolotkin and Johnson (1983) in a review of crisis intervention literature concluded "That in general, brief crisis-oriented therapy can facilitate client improvement and return to precrisis functioning" (p. 145). Although studies have indicated a high degree of improvement following crisis intervention (Auerbach &

Kilmann, 1977; Greer & Bagley, 1971), other studies have also shown that clients experience deterioration at the time of follow-up (Green, Gleser, Stone, & Seifert, 1975).

One of the reasons that may contribute to the lack of difference between treated and non-treated individuals at the time of measured outcome concerns possible interactions between the client and others in the environment. The heightened level of arousal experienced by persons in crisis may prompt them to seek help from the environment (i.e., friends, family members) instead of or in addition to the crisis therapist (Kolotkin & Johnson, 1983).

Assessment of the Effectiveness of Brief Therapy.

In order to assess client improvement and/or psychotherapeutic effectiveness using brief therapy or crisis intervention techniques, it is important to consider that the source of measurement plus the time of measurement can influence client outcome. It has been found that counselors' improvement ratings tend to be positively correlated with length of therapy (Johnson & Gelso, 1980). Counselors' beliefs and biases toward the efficacy of short-term intervention as well as the need to justify time invested in treatment may affect their

rating of client improvement.

In contrast to therapists' ratings, researchers found that client ratings in one half of the studies reviewed showed greater client ratings of improvement with longer treatment, while the other half found no relationship between improvement and length of treatment. Overall, objective tests do not confirm that more treatment means more improvement and Johnson and Gelso (1980) suggest that the tests may either rule out subjective client and/or therapist bias, or they may be insensitive to subtle change. Client ratings of improvements may tend to be higher than counselor ratings of improvement because clients may be focusing on specific problem relief, whereas therapists may be focusing on more extensive or deeper change (Weitz, Abromowitz, Steger, Colabria, Conable, & Yarus, 1975).

The time of assessment also shows a relationship with outcome ratings. Crisis intervention is very brief and focuses on a specific problem rather than overall global level of distress. At the time of termination, clients may still be experiencing residual anxiety and uncertainty and therefore may show lower ratings of improvement than clients who terminate from longer therapy (Johnson & Gelso, 1980). The differences tend to

disappear however at follow-up. For that reason, instead of simple pretest-posttest models of evaluation, Butcher and Kolotkin (1979) recommend a repeated measures design that allows for ongoing assessment during and after therapy. Researchers also emphasize the importance of adequate control groups in order to help determine whether improvements occur as a result of therapy intervention or as a result of spontaneous recovery (Kolotkin & Johnson, 1983; Koss & Butcher, 1986).

It is also important to choose instruments that are highly sensitive to change both during and following treatment intervention. Instruments that measure the "state" of the client rather than "trait" may be more appropriate in brief and crisis oriented research. Symptom checklists that may indicate reductions in symptoms as well as changes in patterns of symptoms have also been shown to be effective measures for the effectiveness of brief therapy and crisis intervention (Kaltreider, DeWitt, Weiss & Horowitz, 1981; Thompson, Gallagher, & Breckenridge, 1987). Limited time for the administration of tests also must be considered when choosing an appropriate assessment tool for evaluative purposes in private practice.

When assessing clients for change, premorbid level

of functioning is also a factor that may affect the outcome of treatment (Butcher & Herzog, 1982; Sifneos, 1979). Butcher and Herzog suggest that crisis intervention works best with individuals who are experiencing transitory pathology as opposed to chronic personality problems or neuroses. Other clinicians, however, believe that even fairly disturbed individuals are amenable to brief therapy (Malan, 1976).

Brief Psychotherapy and the EAP. Due to cost-benefit ratios, brief psychotherapy is the treatment modality most often employed in EAPs. It is essential for EAP mental health professionals to provide the most effective intervention possible in a short amount of time. EAP counselors are encouraged to get employees in and out of treatment quickly and back to optimal job performance (Sonnenstuhl & Trice, 1986). Webb (1990) suggests that the type of short-term therapy chosen by EAP counselors may be important (e.g., Cognitive Behavioral). In contrast, Burlingame, Fuhrman, Paul & Ogles (1989) found that teaching brief therapy skills (i.e., therapeutic focusing, active use of client and therapist expectations, and time limits) improved therapeutic outcome regardless of the theoretical basis of therapy used.

In implementing a time-limited therapy program, Burlingame et al. (1989) showed that therapists who received increased levels of training in planned short-term treatment methods had clients who displayed greater improvement on several measures of outcome. The researchers also found a significant positive relationship between level of experience and client improvement.

These findings indicate that EAP counselors may need specific training in brief psychotherapy skills in order to provide maximal service, in terms of both client outcome and cost reductions. The EAP literature does suggest that one of the qualifications needed in order to be an effective provider of EAP services is expertise in short term treatment, assessment, and crisis intervention (Lewis & Lewis, 1986; Masi, 1983). In addition, the Burlingame study also suggests the importance of using more experienced, qualified therapists. There has been some concern in the literature, that due to the cost factor, EAPs may employ less experienced and possibly less qualified individuals to provide services to troubled employees (Penzer, 1987).

The Current Project.

The current project was conducted as part of an evaluation study of the services offered by an externally based EAP. The employee assistance provider is a private contractor who services major gaming and non-gaming industries in Nevada. The EAP is based on the "performance model" and stresses the use of deteriorating job performance criteria for mandatory referrals of employees.

Supervisory training designed to teach supervisors and managers how to recognize, confront, and refer troubled employees is an important component of the program and supervisors are provided definite guidelines for referral procedures. The EAP director also works closely with the human relations and personnel departments as well as management in providing appropriate educational information so that employees will be adequately informed of the services provided through the EAP. Information regarding the services available through the EAP are introduced by the use of management seminars, employee orientation, pamphlets and posters. Similar to other current EAPs, the program is "broad based" and offers a variety of services in addition to treatment for drug and alcohol related

problems.

Assessment, crisis intervention, and psychotherapeutic treatment for individual employees referred to the program primarily occurs in the form of outpatient treatment away from the job site. When necessary, however, the provider also conducts on-site crisis intervention. EAP clients who come to the program for help are allowed from two to three employer paid visits of counseling depending upon the services contracted by a particular industry. Following the brief crisis-intervention period, EAP clients may continue for counseling at a rate that is less than the normal rate for non-Eap clients.

Hypotheses.

The primary purpose of the current study is to determine the effectiveness of the crisis oriented short-term psychotherapeutic intervention offered by the EAP. The study focuses on the reduction of symptoms associated with problems experienced by clients seeking services through a private contracted employee assistance provider. The hypotheses are as follows:

1. Due to the "broad brush" approach and the wide variety of services offered by the Employee Assistance Provider in the current study, the

majority of employees will be self-referred.

2. Clients from gaming and non-gaming industries will not differ in terms of types of problems presented for therapy.
 3. Initial level of distress will be greater for all clients (EAP and non-EAP) as compared to control groups consisting of employees and students who are not currently in counseling.
 4. In view of research related to the high stress level experienced by students, it is hypothesized that the overall level of distress on the Brief Symptom Inventory (Derogatis & Spencer, 1982) for the student population serving as a control will be higher than that found in the normal population (Cochran & Hale, 1985).
 5. It is hypothesized that the symptoms and overall distress level for all participating clients will diminish following therapeutic intervention and that these changes will be maintained at a follow-up assessment.
- Furthermore, clients who show more improvement will show greater satisfaction with therapy.

6. It is further hypothesized that job satisfaction, as measured on the Minnesota Satisfaction Questionnaire, will vary as a function of emotional well-being.
7. There will be no differences in terms of efficacy of treatment for EAP clients versus non-EAP clients.

Method

Subjects

Treatment Groups. The subjects involved in the current study included 61 employees and their dependents (26 males with mean age of 33.70, $sd = 10.29$; and 35 females with mean age of 31.97, $sd = 8.99$) from gaming and non-gaming industries who received brief therapy intervention for emotional and personal problems through an independent Employee Assistance Program. A comparison group consisted of 24 (11 males with mean age of 33.30, $sd = 9.93$; and 13 females with mean age of 31.60, $sd = 6.68$) non-EAP clients who sought private counseling through the same mental health facility. All questionnaire packets were completed strictly on a voluntary basis.

The Employee Assistance Program provider is an independently based mental health service that provides

crisis intervention and counseling for employees from gaming and non-gaming industries in Nevada. The provider signed a consent form allowing the researcher to use all relevant data from the intake sheet and questionnaire packets completed by clients. The provider participated strictly on a voluntary basis. The information gathered from the research project was used as part of a program evaluation.

Non-treatment Control Groups. Out of 60 employees contacted, 18 (7 males, mean age of 44.57, sd = 8.30); and 11 females, mean age of 37.18, sd = 11.77) completed the demographic data sheet and the questionnaire packets as part of the EAP evaluation study. The employees received free feedback concerning their responses on the questionnaires at the completion of the third questionnaire.

Fifty seven undergraduate psychology students (15 males, mean age of 25.4, sd = 6.86; and 42 females, mean age of 25.02, sd = 6.56) also volunteered to participate in the study. The students received extra credit for their involvement in the study, and were provided feedback upon the completion of the final packet if requested.

Materials

The questionnaire packet consisted of an intake sheet, the Brief Symptom Inventory (BSI), the Profile of Mood States (POMS), and the Minnesota Satisfaction Questionnaire (MSQ). At the follow-up assessment, the client groups were also asked to complete a client satisfaction questionnaire. All questionnaires, excluding the intake sheet are included in Appendix A.

Intake Sheet. The intake sheet was specifically designed by the EAP provider in order to gain pertinent demographic information about each client and to aid in program evaluation procedures. In addition to demographic information, the sheet asks for EAP referral source, current problem and severity, and whether or not employee job performance was being affected at the time of intake. Due to company policy, the intake sheet could not be included as an appendix.

Brief Symptom Inventory (BSI). The Brief Symptom Inventory is a 53-item self-report inventory measuring symptom patterns for psychiatric and medical patients as well as non-patient individuals (Derogatis & Spencer, 1982). The BSI measures current psychological symptom status as opposed to more stable personality traits and is appropriate for use in short-term therapy treatment.

It was developed from the SCL-90-R (Derogatis, 1975; 1977) and takes about seven to ten minutes to complete. Test-retest reliability coefficients range from $r = .68$ to $r = .91$ on the nine symptom dimensions and from $r = .80$ to $r = .90$ on the global indices. Alpha coefficients measuring internal consistency range from .71 on psychoticism to .85 on depression. The BSI has been shown to be an effective measure of short-term change in the evaluation of clients (See Derogatis, 1990 for a complete bibliography).

Items are grouped into nine primary symptom dimensions that reflect specific areas of possible pathology and three global indices that provide a measure of overall level of psychological functioning. The scores for each primary dimension are obtained by averaging the items within that dimension. Respondents rate each item on a five-point scale ranging from 0 (Not at all) to 4 (Extremely).

The three global scores reflect overall psychological level of functioning; the Global Severity Index (GSI) is the most sensitive to change (Derogatis, 1982). Normally, all items are summed and divided by 53 in order to obtain the General Severity Index (GSI). The Positive Symptom Total (PST) is the number of items that

are scored above zero and the Positive Symptom Distress Index (PSDI) is the sum of the scores from all items divided by the PST. The nine primary dimensions and three global indices are listed below.

Primary:

1. Somatization
2. Obsessive-Compulsive
3. Interpersonal Sensitivity
4. Depression
5. Anxiety
6. Hostility
7. Phobic Anxiety
8. Paranoid Ideation
9. Psychoticism

Global:

1. Global Severity Index (GSI)
2. Positive Symptom Distress Index (PSDI)
3. Positive Symptom Total

Profile of Mood States (POMS). The Profile of Mood States is an adjective checklist that assesses present mood state (McNair, Lorr, & Droppleman, 1981). Factor scores for each of six dimensions; tension-anxiety, depression-dejection, anger-hostility, vigor-activity, fatigue-inertia, and confusion-bewilderment, are obtained

from responses to 65 adjectives rated on a five point scale ranging from zero, (not at all), to four, (extremely). Higher scores represent greater intensity of a particular factor. All items within each factor are scored in the same direction except for the "Relaxed" item in the Tension Anxiety Scale and the "Efficient" item in the Confusion Scale; these items receive negative weights. Raw scores may be converted into standard T scores; the mean standard score is 50 for each scale and the standard deviation is ten. Norms are provided for psychiatric outpatients and for college students. A Total Mood Disturbance score (TMD) may be obtained by summing the scores from all of the six primary factors. The TMD may be used as a global indice of psychological mood state, however, no normative or validity data are given.

The POMS may be used to assess affective state over varied time limits (e.g., one hour, today, right now, during the past week including today). In the current study, the respondents were asked to best describe "HOW YOU HAVE BEEN FEELING DURING THE PAST WEEK INCLUDING TODAY." Validation studies have indicated high internal consistency within mood dimensions and test-retest reliability coefficients range from $r = .65$ to $r = .74$

(Lorr, Daston, & Smith, 1967; McNair & Lorr, 1964). The lower reliability scores reflect the transient nature of the affective state. The POMS has been shown to be sensitive to change associated with brief psychotherapeutic intervention (Malouff, Lanyon, & Schutte, 1988; Pugatch, Haskell, & McNair, 1969).

Minnesota Satisfaction Questionnaire (Short Form) (MSQ). The short form of the MSQ was used as a measure of job satisfaction. It was derived from the Long-Form MSQ and contains 20 items that represent each of the scales on the parent form (Weiss, Dawis, England, & Lofquist, 1967). The short form yields three scales: intrinsic satisfaction, extrinsic satisfaction; and general job satisfaction. The scale weight for each item ranges from one to five, with one representing "Very Dissatisfied" and five representing "Very Satisfied." Total scores are obtained by summing the items scores. Higher scores represent higher job satisfaction. One week Test-Retest reliability coefficients range from $r = .66$ to $r = .91$. General satisfaction coefficient was $r = .89$ at a one-week interval and $r = .70$ at a one-year interval.

Client Satisfaction Questionnaire. Client satisfaction was measured by summing the responses on ten

items chosen by the EAP administrator and the researcher. The items allowed clients to rate how they felt about the services that they received through the mental health facility. The clients were asked to rate how satisfied they were with a particular aspect of treatment intervention according to a five point scale, with 0 (Not at all) and 4 (Extremely). Space was also provided for comments regarding services received through the facility. Examples of the items are: (1) "How much would you say that the therapy helped you with your problem/s?" and, (2) "Were you satisfied with the way that your therapist handled your situation/problem?"

Procedure

Treatment. As part of treatment intervention clients were requested, at intake, to complete a demographic data sheet and the questionnaire packet that included, in the following order, the BSI, POMS, and MSQ. Clients were given a consent form explaining that the information would be used to help monitor their progress during therapy and would also be used as part of a research evaluation study currently being conducted at the facility. The clients were informed that all materials would be placed into the chart and that no identifying information would be included in the overall

evaluation procedure. Guidelines pertaining to client confidentiality were adhered to as part of the project.

The second questionnaire packet was placed into the patient's chart and the therapist was instructed to have the client complete the packet following the second or third EAP visit. Clients in the EAP received two or three employer paid visits depending on how the contract was set up for a particular industry. Clients in the non-EAP control group were given or mailed the second packet at the end of their third visit.

Due to time constraints and lack of available space, clients were informed that they could take the questionnaire packet home and either bring it back on the next visit, or they could mail it back to the center in the provided prestamped enveloped. If clients failed to complete their second or third visit within a four week period, the second packet was mailed to their home. Therapists were requested to remind clients to complete the packets if they were still in therapy and had not yet returned them. All clients were mailed the third and final packet nine weeks after the initial visit. Clients who did not return the final packet within a reasonable time period, were sent another final packet with a request to return the completed packet as soon as

possible.

All clients were informed at each packet administration that completion was on a strictly voluntary basis and that the completion of the packets was not required as part of the treatment intervention. All information included in the study was taken from the demographic sheets and questionnaires completed by the patients. Mailings, scoring, and analyses were done by the researcher.

Completion Rates. Out of the 61 EAP clients that completed the initial assessment at intake, only two (3%) completed all three assessments. Nine EAP clients (15%) completed the first and second assessments, and 8 EAP clients completed the first and third followup assessment (11%). The average number of visits for EAP clients who completed the first and third follow-up assessment was 3.75 (sd = 3.28). Out of 24 non-EAP clients who completed the initial assessment at intake, 4 clients (16%) completed all three assessments, and 4 (16%) completed the first and second assessments. The average number of visits for non-EAP clients that completed first and third packets was 8.5 (sd = 4.20).

Control Groups. Because of ethical considerations and contract obligations to clients, it was not possible

to use a wait-list control. However, a group of employees who worked in the same gaming and non-gaming industries but who were not seeking counseling services through the EAP or other mental health facilities served as a comparison group. The EAP administrator and researcher contacted the Human Resource Department in order to describe and explain the current research project. Permission was requested so that packets could be distributed to a representative sample of employees not currently participating in counseling through the EAP. Envelopes containing an information and instruction sheet, demographic data sheet, three questionnaire packets (BSI, POMS, and MSQ) and prestamped envelopes, were given to the Human Resource Department manager to be handed out at random to employees. In order to maintain confidentiality, employees were instructed to return the completed questionnaires directly to the EAP provider and not to their respective employers. The instructions also requested that the employee use a fake name in order to receive feedback by phone upon the completion of all three packets. Sixty envelopes containing instructions and questionnaire packets were distributed across four industries (three gaming and one non-gaming). Seventeen employees participated in the project, approximately a

25 percent return rate across industries. Out of the 17 employees who participated, 11 employees (65%) completed all three packets, 2 employees (18%) completed one packet, and 5 employees (29%) completed two packets.

Undergraduate students enrolled in either a statistics class or a social psychology class also served as a normal control group. Instructions and the first assessment packets were distributed by the instructor and researcher at the end of class period. Packets were collected by the instructor at the beginning of the following class period and given to the researcher directly after class. The same format for distribution and collection was used three weeks later for the second assessment, and six weeks later for the third assessment. Out of 57 students who participated, 39 (68%) completed all three assessments, 9 (16%) completed two packets, and 9 (16%) completed one packet.

Table 1 illustrates the research design, control groups and time of assessment.

Table 1
Research Design, Control Groups, and Time of Assessment

Group	Time of Assessment		
	Pre	Post	Followup
Eap & non-EAP client groups	Before 1st visit	After 2nd or 3rd visit	9 weeks after 1st assessment
Students	Week 1	Week 3	Week 9
Employees	Week 1	Week 3	Week 9

Results

Referral source. Table 2 contains the demographic information on client and comparison groups. As shown, the majority of the EAP clients were self-referred. Out of 61 EAP clients 50 were self referred and only 4 were referred through supervisors (source of referral was not indicated for 7 EAP clients). Approximately 58 percent of those EAP clients who responded indicated that job performance was affected as a result of current problems.

Types of Problems for Gaming Versus Non-Gaming EAP Clients. Table 3 shows the frequencies for types of problems presented for gaming and non-gaming employees in the following categories: (1) family, marital, and relationship; (2) substance abuse; (3) emotional and eating disorders; (4) medical, financial, and legal

problems; and (5) job related issues.

A 2 x 5 contingency table was used to assess the type of problem. Results indicate that there was no relationship between type of industry (gaming versus non-gaming) and type of problem presented, ($\chi^2 = (4) = 1.74$, $p > .05$). EAP clients employed in both the gaming and non-gaming industries experienced the most problems in family, marital, and relationship and in emotional and eating disorders.

Table 2

Demographic Information for Client and Control Populations

<u>Variable</u>	<u>Population</u>			
	<u>EAP</u>	<u>Non-EAP</u>	<u>Employee</u>	<u>Student</u>
Sex				
Male	26	11	7	15
Female	35	13	11	42
Age*	32.71	32.76	40.06	25.12
Yrs. Education*	13.12	12.81	14.56	14.75
Marital Status				
Single	9	4	7	33
Married	7	10	9	5
Divorced/Sep.	4	0	2	1
Race				
Caucasian	35	20	13	24
Black	1	0	0	5
Other	3	0	5	3
Industry				
Gaming	44	4	17	2
Non-gaming	17	14	1	52
Referral				
Self	50	15	N/A	N/A
Supervisory	4	3		
Affected Job				
Yes	22	N/A	N/A	N/A
No	16			

Totals vary due to missing data.

* Those variables marked with an asterisk indicate that a mean is presented. All other numbers and frequencies are exact.

Table 3

Frequencies for Types of Problems of Gaming and
Non-gaming Employees

	<u>Industry</u>	
	<u>Gaming</u> (N=52)	<u>Non-Gaming</u> (N=11)
<u>Types of Problems</u>		
Family, Marital, Relationship	26	5
Substance Abuse	6	1
Emotional and Eating Disorders	15	5
Medical, Financial, and Legal	3	0
Job Related Issues	2	0

Initial Level of Distress for Clients Versus Non-Treatment Control Subjects. An independent t test showed that the initial level of distress (as measured by the Global Severity Index, GSI) for client populations (mean = 1.00, sd = .68) was significantly higher than non-treatment control groups (mean = .53, sd = .42), $t(144) = 5.39$, $p < .001$). For both treatment and control groups, a Pearson Product-Moment Correlation indicated a significant negative relationship between emotional well being (GSI) and general job satisfaction (MSQ), $r(156) = -.2631$, $p < .001$. The more distressed the individual,

the lower the job satisfaction.

Initial Level of Distress for Students. Results on the GSI also indicated that the non-treatment control group of students was significantly more distressed overall than was the non-treatment control group of employees ($t(33) = 1.80, p < .05$).

Reduction of Symptoms for Combined Treatment Groups. In order to test the hypothesis that the symptoms and overall distress level for all participating clients would diminish following therapeutic intervention and that these changes would be maintained at follow-up assessment, the EAP and non-EAP clients were combined into one group. Preliminary investigation of the data indicated that sex was not an intervening variable, consequently it was not included in subsequent analyses. Due to missing data that resulted from clients and employees not completing assessment packets, it was not possible to make overall comparisons across the three time periods. Instead, two separate 3 X 2 mixed design multiple analyses of variance for repeated measures were conducted in order to compare the combined client population and control groups.

Group affiliation or population (student, employee, client) served as the between subjects variable, and time

of assessment served as the within subjects variable. Dependent measures included the nine dimension scales of the BSI, the six dimension scales of the POM, and General Satisfaction on the MSQ.

Comparison One. The first multiple analysis of variance compared scores received on dependent measures during assessment one with scores received during assessment two. For all clients who returned packet one and two, a Wilkes Lamda indicated a significant main effect for group ($F(2,67) = 3.02, p < .000$), no main effect across time of assessment ($F(1,67) = 1.25, p > .05$) and no interaction between group and time of assessment ($F(2,67) = .72, p > .05$).

Results of Univariate Analyses for Comparison One. Univariate analyses indicated significant group differences for initial levels of somatization, hostility, depression, anxiety, phobia, paranoid ideation, psychoticism, interpersonal sensitivity, and overall emotional distress (GSI, PST, PSDI) as measured on the Brief Symptom Inventory, and Depression-dejection, Anger-hostility, Vigor and Confusion as measured on the Profile of Mood States. Table 4 gives the F values for the univariate analyses for comparison one. The means and standard deviations for the combined client group and the

two control groups can be found in Appendix B.

Table 4

Results of Univariate Analyses of Variance for Combined
Client (EAP, Non-EAP), Student, and Employee Group
Differences of Initial Level of Distress on the BSI, POM,
and MSQ.

Source	Dependent Measure	MS Between Groups	Uni-variate F	p =
Treatment and Control Groups	Somatization	.429	3.049	.054
	Hostility	.549	4.398	.016
	Depression	.727	19.840	.000
	Anxiety	.618	5.001	.009
	Phobic Anx.	.198	10.784	.000
	Paranoid Idea.	.852	5.771	.005
	Psychoticism	.539	12.945	.000
	Interpersonal Sensitivity	.893	7.207	.001
	Obsessive Compulsive	.624	2.676	.076
	GSI	.385	9.884	.000
	PST	189.395	7.462	.000
	PSDI	.0001	10.689	.000
	Tension-anx.	42.207	2.648	.078
	Depression-dejection	156.357	18.310	.000

Anger-Hos.	101.752	8.615	.000
Vigor	70.396	3.730	.029
Fatigue-Iner.	57.218	2.018	.141
Confusion	27.749	14.500	.000
General Job Satisfaction	411.953	.558	.575

Tukey HSDs were used to determine the group means between which significant differences existed. It was found that the combined client group showed significantly higher levels of distress on all measures compared to employee controls except obsessive compulsive on the BSI and tension-anxiety and fatigue-inertia on the POM. Clients showed significantly higher levels of distress on all measures except somatization, interpersonal sensitivity, hostility, PST, vigor and confusion as compared to student controls. General job satisfaction was not significantly different across the three groups.

Comparison Two. The second analysis compared the scores on assessment one with those on assessment three (Pre and Follow-up assessments for all clients, and first and ninth week assessment for control groups). As not all clients returned all three packets, comparison two does not necessarily compare the same individuals as did

comparison one. A Wilkes Lamda indicated a significant between groups main effect of group differences for dependent measures on the BSI and POM ($F(2,52) = 3.13, p < .000$), a main effect of time of assessment ($F(1,52) = 2.15, p < .025$), as well as an interaction between group scores and time of assessment ($F(2,52) = 1.66, p < .032$).

Results of univariate analyses of variance for the significant interaction are shown in Table 5. Means and standard deviations of dependent measures for the three groups for comparison two are found in Appendix C. Figures 1 to 8 indicate that clients show significant improvement in emotional well being from Pre to Follow-up assessments on measures of hostility, paranoid-ideation, depression-dejection, tension, anger-hostility, confusion, and global measures of distress (GSI, PSDI), whereas employee and student control groups remain relatively stable across time. Again, general job satisfaction did not differ significantly across the three groups nor did it show significant improvement across time for the clients following treatment.

Table 5

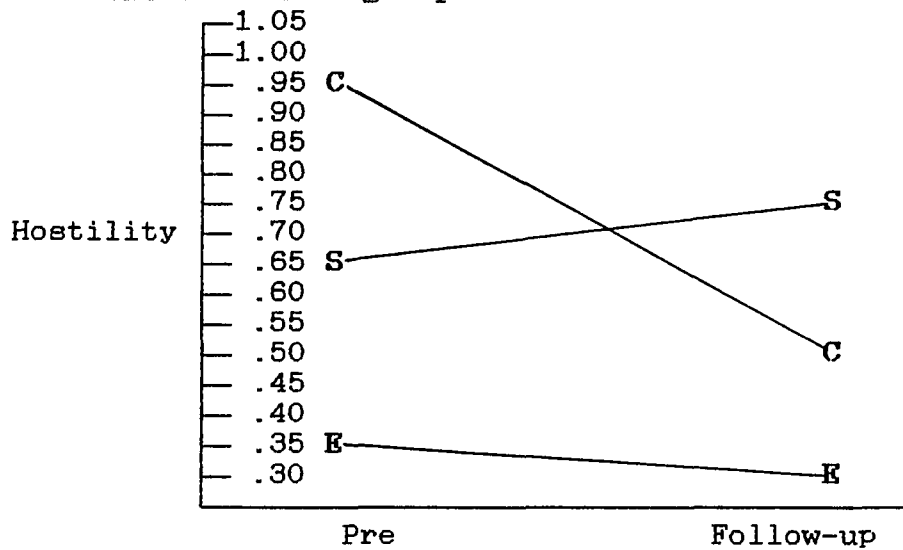
Results of Univariate Analyses of Variance for
Significant Interaction for Combined Client Group (EAP,
Non-EAP), Student Control Group, and Employee Control
Group at Pre and Follow-up Assessments.

Source	Dependent Measure	Error MS	Uni-Variat F	p =
Treatment	Somatization	.067	2.362	.104
and Control	Hostility	.139	5.544	.007
Groups	Depression	.115	2.628	.082
	Anxiety	.142	2.638	.081
	Phobia	.047	1.071	.350
	Paranoid Idea.	.144	4.548	.015
	Psychoticism	.095	.883	.420
	Interpersonal Sensitivity	.127	1.183	.314
	Obsessive Compulsive	.222	.236	.790
	GSI	.059	3.894	.027
	PST	26.293	.642	.530
	PSDI	.000	4.782	.012
	Tension-anx.	11.136	3.310	.044
	Depression-dejection	31.571	5.227	.009
	Anger-Hos.	18.712	11.041	.000

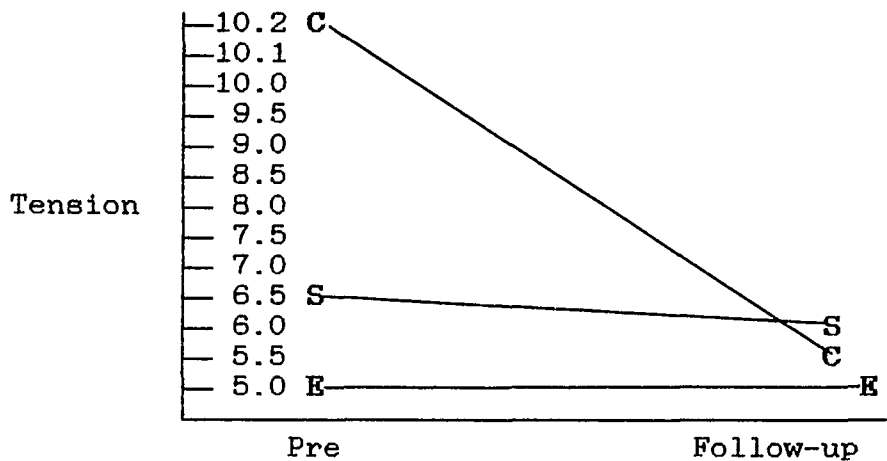
			66
Vigor	10.368	1.362	.265
Fatigue-Iner.	13.810	.404	.670
Confusion	8.621	5.091	.010
General Job Satisfaction	55.117	1.649	.202

Figures 1 - 8 illustrate that clients' level of emotional distress for hostility, tension, anger-hostility, confusion, depression-dejection, and global emotional well-being (GSI) paranoid ideation, and confusion improved significantly from pre to follow-up assessment. Control groups remained stable across time.

S = student control group.
E = employee control group.
C = client treatment group.

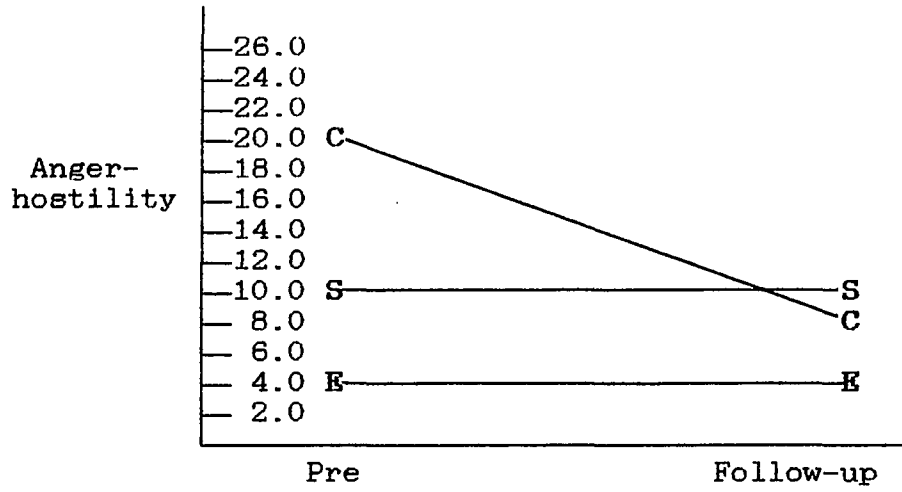


1. Group means for hostility.

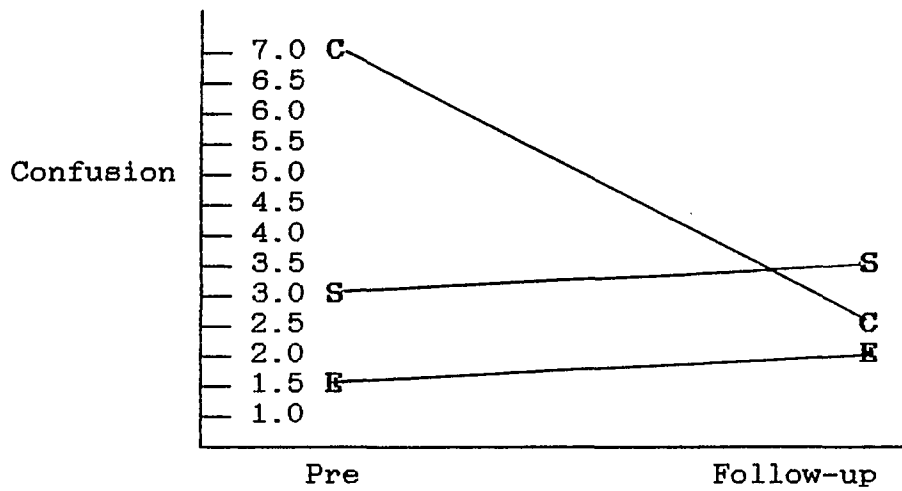


2. Group means for tension.

S = student control group.
E = employee control group.
C = client treatment group.

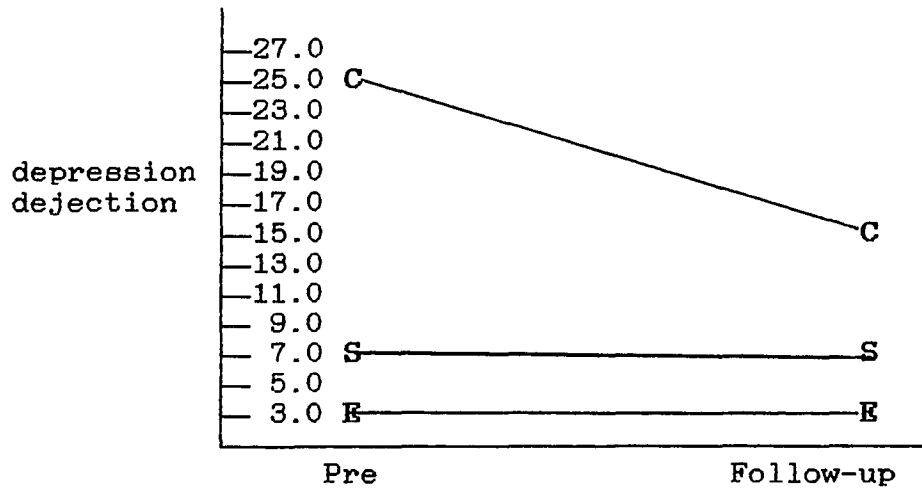


3. Group means for Anger-hostility.

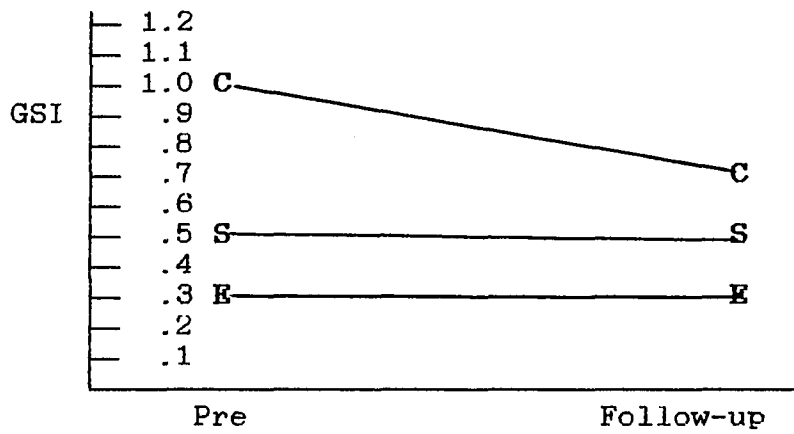


4. Group means for Confusion.

S = student control group.
E = employee control group.
C = client treatment group.

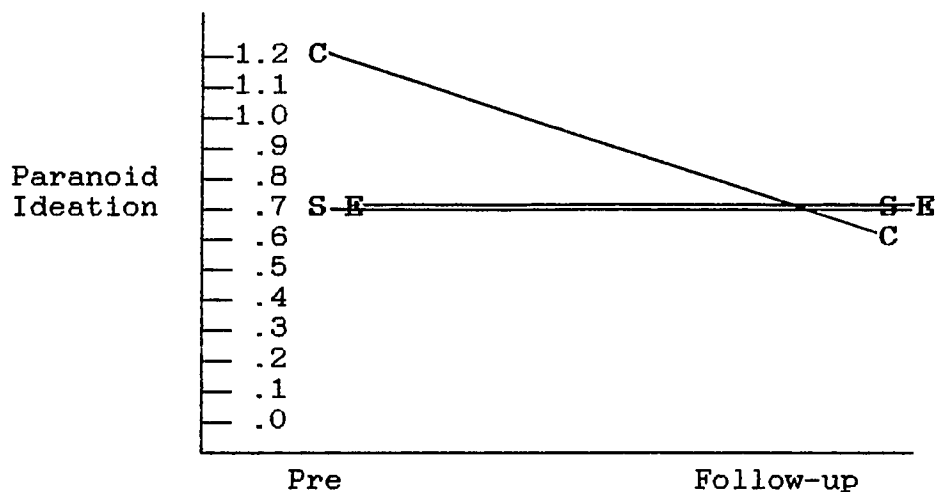


5. Group means for depression-dejection.

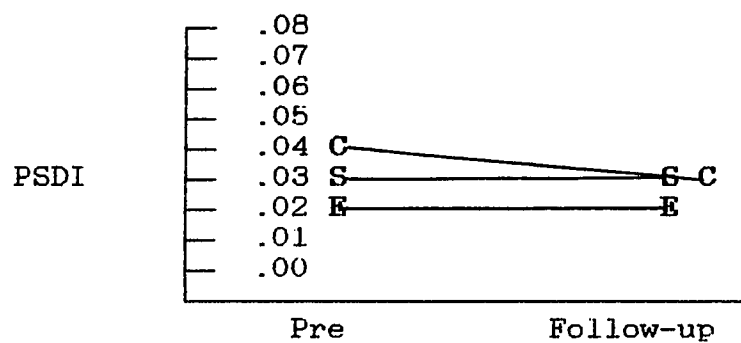


6. Group means for GSI.

S = student control group.
E = employee control group.
C = client treatment group.



7. Group means for Paranoid Ideation.



8. Group means for PSDI.

Client Satisfaction. A Pearson Correlation Coefficient was used to test the hypothesis that clients who showed more improvement would show greater satisfaction with therapy. The difference between clients' Pre and Follow-up assessment scores for the Global Severity Index were correlated with the average score received on the Client Satisfaction Questionnaire. The relationship was nonsignificant ($r(14) = .1425$, $p < .05$).

Effectiveness of Treatment Intervention for EAP Clients. In order to determine the effectiveness of psychotherapy in the reduction of symptoms for EAP clients versus non-EAP clients, a 4 x 2 mixed design multiple analysis of variance repeated measures that compared all four groups (EAP client, Non-EAP client, Student Control, and Employee Control) was conducted for Pre and Post assessments and for Pre and Follow-up assessments.

Multiple Analysis of Variance for Pre and Post Assessments Across Four Groups. For all individuals who returned assessment one and two, a Wilkes Lamda indicated a significant main effect for groups ($F(3,66) = 2.581$, $p < .000$), no main effect of time of assessment ($F(1,66) = 1.48$, $p > .05$) and no interaction between group and time of

assessment ($F(3,66) = .78, p > .05$). Results of univariate analysis are shown in Table 6.

Table 6

Univariate Analyses for Main Effect of Population (EAP, Non-EAP, Student, Employee) at Pre and Post Assessments.

<u>Source</u>	<u>Dependent Measure</u>	<u>Ms Between Groups</u>	<u>Uni-variate F</u>	<u>p =</u>
Treatment and Control Groups	Somatization	.433	2.162	.101
	Hostility	.553	3.089	.033
	Depression	.728	13.496	.000
	Anxiety	.626	3.347	.024
	Phobic Anx.	.198	7.603	.000
	Paranoid Ideation	.805	5.734	.002
	Psychoticism	.544	8.719	.000
	Interpersonal Sensitivity	.829	7.262	.000
	Obsessive Compulsive	.633	1.780	.159
	GSI	.390	6.577	.001
	PST	188.107	5.496	.002
	PSDI	.000	7.055	.000
	Tension-anx.	42.793	1.769	.162
	Depression-dejection	156.691	12.472	.000
	Anger-hos.	103.281	5.661	.002

Vigor-Activity	71.281	2.513	.066
Fatigue-iner.	57.986	1.366	.261
Confusion	28.140	9.557	.000
General Job Satisfaction	418.194	.367	.777

Tukey HSDs were used to determine the where significant groups differences existed. Results indicated that EAP clients who returned assessment packets one and two (Pre, Post), were significantly more distressed than control groups in interpersonal sensitivity, depression, paranoid ideation, phobic anxiety, anxiety, psychoticism, GSI, PST, PSDI, depression-dejection, anger-hostility, and confusion. Non-EAP clients were significantly more distressed than controls for depression, hostility, psychoticism, GSIA, PSDI, depression-dejection, and confusion. Means and standard deviations for Pre and Post Assessments for EAP, Non-EAP clients and Student and Employee Control groups are shown on Appendix D.

Multiple Analysis of Variance for Pre and Follow-up Assessments Across Four Groups. For all individuals who returned assessment one and three a Wilkes Lamda indicated a significant main effect for groups ($F(3,51) = 2.44, p < .000$), a significant main effect of time of assessment ($F(1,51) = 2.94, p < .003$) and a significant interaction

between group and time of assessment ($F(3,51) = 1.64, p < .015$). Results of univariate analyses for significant interaction are shown in Table 7. Means and standard deviations for EAP and Non-EAP clients and student and employee control groups are shown in Appendix E.

Table 7

Results of Univariate Analyses of Variance for Significant Interaction For EAP, Non-EAP, Student, and Employee Groups at Pre and Follow-up Assessments.

Source	Dependent Measure	Error MS	Uni-Variate F	p =
Treatment and Control Groups	Somatization	.065	2.505	.069
	Hostility	.124	6.619	.001
	Depression	.105	3.946	.013
	Anxiety	.133	3.397	.025
	Phobia	.040	3.821	.015
	Paranoid Idea.	.141	3.783	.016
	Psychoticism	.093	1.359	.266
	Interpersonal Sensitivity	.128	.989	.405
	Obsessive Compulsive	.221	.525	.667
	GSI	.053	5.112	.004
	PST	26.043	.931	.432

PSDI	.000	.000	.008
Tension-anx.	10.550	3.626	.019
Depression- dejection	30.838	4.311	.009
Anger-Hos.	18.693	7.717	.000
Vigor	9.929	2.047	.119
Fatigue-Iner.	14.032	.323	.808
Confusion	8.782	3.347	.026
General Job Satisfaction	56.079	1.116	.351

Tukey HSDs indicated that for individuals who completed the Pre and Follow-up assessments, that Non-EAP clients were significantly more distressed than EAP clients and control groups on measures of depression, phobic anxiety, anxiety, paranoid ideation, GSI, tension, depression-dejection, and anger-hostility. Non-EAP clients were also significantly more distressed than control groups on measures of PSDI, and confusion. At Follow-up, Non-EAP clients improved significantly on all of the above measures except hostility and anxiety, whereas non-treatment control groups (students and employees) remained relatively stable.

When compared to the EAP clients who returned Pre and Post assessments, the EAP clients in the Pre and Follow-up analysis were less emotionally distressed at the onset of treatment. Only one EAP client included in the Pre and Post

analysis also returned the Follow-up assessment. EAP clients were significantly more distressed than both students and employees for measures of depression, phobic anxiety, PSDI, depression-dejection, and anger-hostility; and significantly more distressed than employees in confusion. When compared to control groups, EAP clients improved significantly for measures of anger-hostility, and confusion.

Non-EAP Versus EAP. A final analysis was conducted to test the hypothesis that no differences in efficacy of psychotherapeutic intervention would exist for EAP versus Non-EAP client. In order to determine whether the changes experienced by Non-EAP clients were significantly greater than EAP clients, a 2 x 3 multiple analysis of variance repeated measures was conducted on scores received at Pre and Follow-up assessments. The two groups were compared only on measures in which both EAP and Non-EAP clients were significantly more distressed than the control groups (students and employees). The dimensions included in the comparison were depression, phobic anxiety, PSDI, depression-dejection, and anger-hostility and confusion. Results from a Wilkes Lamda indicate that differences in rates of improvement for EAP and Non-EAP groups were non-significant ($F(1,11) = .893, p > .553$).

Discussion

Methodological Weaknesses. Major flaws encountered in the present research include the use of nonequivalent control groups, low return rate for Post and Follow-up assessment information for clients, and inadequate control in questionnaire distribution for subjects in the employee control group.

Due to ethical considerations, it was not possible to assign clients to wait-list control groups. The employee control group included in the study showed significantly less emotional distress at the onset and remained so through the follow-up assessment. The stable scores across time lend support for the reliability of the assessment instruments. However, had the employee control groups been more similar to the client group at Pre assessment in terms of overall emotional distress level, findings would have been more conclusive with regard to the effects of treatment intervention.

The student control group reflected a higher emotional distress level that remained stable across time, which lends support both for the reliability of the instruments and for the efficacy of treatment. Again, however, any conclusions related to treatment efficacy must be viewed with caution given that the student population may be uniquely different

than that of an employee population.

A major problem also occurred as a result of lack of participation of clients and employees in returning Post and Follow-up assessment packets. Although the research method included a repeated measures design for Pre, Post, and Follow-up evaluations, not enough clients or employees completed all three packets to justify a comparison across the three time periods. In addition, the same EAP clients did not return both second and third assessment packets, therefore, the Pre and Post comparison compared essentially different EAP clients than did the Pre and Follow-up comparison.

The low client return rate may have been associated with a number of factors such as lack of client interest once therapy had terminated, premature termination of therapy, inadequate testing area, time constraints, and inconsistent cooperation on the part of some therapists in encouraging the clients to complete questionnaires. It may be that some therapists and maybe even some clients considered the evaluation project as invasive and time consuming and irrelevant to the process of therapy.

The low return rate is consistent with previous literature findings concerning patient attrition (Kazdin, 1986). More thorough preparation of clients may help future

evaluation procedures. In order to promote therapist cooperation which may help in collecting data, future research should involve adequate staff conferences so that therapists can have input into the project, make suggestions and voice pertinent concerns relative to the research.

Another area of concern in the current research project relates to obtaining cooperation of industries in order to insure adequate control group participation. A major task of personnel and human resource directors is to protect the employees who work for their industries and they appropriately approached the research project with caution. The main worry expressed by the industry directors was that employees might view the project with distrust and as a management ploy to gain information. Researchers were not allowed into the industries for purposes of distributing questionnaire packets to potential control group subjects. The human resource department assumed the responsibility for distributing packets within a particular industry. There was no specific procedure that insured a non-bias distribution of packets.

Procedures for distribution of research materials to the employee control group population needs to be more clearly defined and controlled if possible. Thorough discussion of confidentiality issues and safeguards for

protecting the identity of participating employees may help alleviate some of the concerns voiced by industry officials.

As indicated, several methodological problems occurred during the current study. The research findings presented in the following section should be interpreted in light of the previously discussed methodological weaknesses.

Primary Purpose. The current study focused on determining the efficacy of short-term psychotherapy in the reduction of emotional distress for clients seeking services through a private contracted employee provider. Several hypotheses were offered and will be discussed in order of presentation.

Type of Referral. The hypothesis that the majority of clients seeking help through the EAP services would be self-referred was substantiated in the current study and is reflective of previous research concerning EAPs (Martin et al., 1985). As is indicated in Table 1, 50 out of 54 clients (92 percent) indicated they were self-referred. The 92 percent rate of self-referral is slightly higher than the 85 percent rate indicated in Martin's study (1985) and may be attributed to several factors.

First, the employee assistance provider in the current study is "broad based" and offers a variety of services.

Although it is based on the performance criteria model of referral (Googins, 1975; Sonnenstuhl et al., 1988) for supervisory referral, the provider's extensive educational program geared toward informing employees about available services may have prompted employees to seek help before more serious decline in job performance occurred (Dickman et. al., 1988). Secondly, the fact that the EAP is externally based and offers off site treatment may have contributed to the employee's sense of security in terms of confidentiality issues (Hofman, 1988). And finally, unless referral is mandatory, employees are not obligated to indicate whether or not they were referred through their supervisor. Regardless of whether or not a supervisor recommends that the employee seek help, the employee makes the final decision to seek help. Although the supervisor may have recommended that an employee contact the EAP, the employee's decision to seek help may be viewed as self-referral by some employees.

Problems Presented by Gaming and Non-Gaming Employees.

The hypothesis that gaming and non-gaming EAP employees would not differ significantly in the types of problems presented when seeking help was supported. Employees from gaming and non-gaming industries experienced the most problems in the family, marital, and relationship category,

and in emotional and eating disorders. This finding is congruent with that of Martin et. al. (1985) that found that self-referred employees were more apt to seek help for interpersonal relations problems.

Six (9 percent) of the EAP clients sought help for substance abuse problems, and constituted the next highest category of problems presented. As mentioned earlier, alcohol related problems in the workplace formed the basis for earlier EAP programs (Dickman et al., 1988; Masi & Goff, 1987) and are considered a high cost factor in modern industry (Liebouweitz, 1982). The rehabilitation of the employees seeking help for substance abuse related problems may constitute a savings for the companies represented by the EAP provider in the current study (Schultz & Schulz, 1990).

Also as mentioned earlier, emotional and personal problems have been linked to deteriorating job performance (Gam et. al., 1983; Gerstein & Bayer, 1988). For the clients in the current study, that link appears to be true, at least in the eyes of the employee. Approximately 58 percent of the EAP clients indicated that their job performance had been affected as a result of their current problems.

In view of the research conducted by Bayer and Gerstein

(1988) concerning problem behaviors of employees who are referred for treatment, it is of particular interest that on the BSI and POM, EAP clients were found to experience significantly more symptoms than non-troubled employees in the areas of interpersonal sensitivity, depression, anxiety, anger-hostility, and confusion. These symptoms are similar to the problems behaviors that previously surveyed supervisors used to identify troubled workers (i.e., impaired work attention and conduct, acrimoniousness or affective demeanor, irritability, hostility toward others).

Initial Level of Distress. Clients were expected to show greater levels of distress at the initial assessment as compared to non-treatment control groups. Significantly higher levels of emotional distress for clients as compared to controls were reflected on a variety of dimensions on both the BSI and on the POM. The Global Severity Index (BSI) proved to be a sensitive global measure of distress and differentiated between client and control groups. Overall, the levels of distress reported by the combined group of EAP and non-EAP clients on the BSI were similar (for some dimensions slightly less, in others slightly higher) to those reported by Derogatis (1982) for psychiatric outpatients. The initial level of distress for the employee control group was slightly lower when compared

to the norms given in the BSI manual for non-patient normals.

Students Initial Level of Distress. As hypothesized, students exhibited significantly higher levels of emotional distress than did employee controls. This finding supports previous research conducted by Cochran and Hale (1985) that found that means for college students on the BSI were significantly higher than other non-patient adults. These findings emphasize the importance of using appropriate norms when working with college students as well as the importance of using appropriate comparison groups when conducting research.

Reduction of Symptoms and Overall Distress Level. The hypothesis that clients would show a reduction in symptoms and overall distress level following therapeutic intervention and that these changes would be maintained at follow-up was only partially supported.

Pre to Post Assessments. Reductions in emotional distress as measured on the BSI and POM from Pre to Post assessments were found to be non-significant for the combined group of EAP and Non-EAP clients compared to controls. Furthermore, in the Pre and Post assessment analysis that compared the four groups separately (EAP, Non-EAP, student, and employee), results were again

nonsignificant. The lack of significant differences in change may be interpreted as indicating that therapy was ineffective in reducing client distress. Butcher and Kolotkin (1979), however, suggest that following crisis intervention, that clients may still be experiencing residual anxiety and uncertainty at the time of termination which may result in lower client ratings of improvement. They found that clients who showed lower levels of improvement at the time of termination from short-term therapy showed equivalent ratings of improvements at the time of follow-up when compared to clients who received greater amounts of therapy.

From a clinical viewpoint, it may be important to note that although the differences in distress levels from Pre to Post assessment were non-significant statistically, that on the Post assessment, that all EAP clients showed trends in lower ratings of distress on all measures. Non-EAP clients also showed a trend in lower distress levels at the second assessment on all measures except for the Obsessive-Compulsive and the Somatization dimension on the BSI. In addition, the return rate for assessment packets was minimal and resulted in a very small sample. A larger sample may have yielded different results.

Pre and Follow-up Comparison. In contrast, clients who returned Pre and Follow-up assessments showed significant improvement on several measures at the time of the Follow-up assessment. The fact that the emotional distress level for employees and students serving as controls remained relatively stable across time lends support for the efficacy of the short-term psychotherapeutic treatment in the amelioration of emotional distress for those in therapy. The control group data helps to rule out the alternative explanation of spontaneous recovery, but results must be interpreted with caution due to the small sample of clients who returned follow-up assessment packets. Also, due to the self-limiting nature of distress related to crises (Caplan, 1964), it is still possible that clients may have improved in the absence of therapeutic intervention.

Client Satisfaction. The hypothesis that clients who reported more improvement would show greater satisfaction for therapy was not supported. For those individuals who returned follow-up packets, client satisfaction was not shown to be significantly related to higher client rates of improvement. The lack of association may be attributed to the limited range of scores received on the Client Satisfaction Questionnaire as well as the limited number of clients who responded.

Clients as a whole reported improvement at Follow-up and rated all therapists from moderate to extremely comfortable to talk to. For those clients who rated therapy as being "not at all helpful" and "a little helpful", the major complaint was that the therapist failed to focus on problem issues. It would seem that clients did not find empathy alone to be beneficial in resolving problem issues. These findings are consistent with previous literature that suggests that for short-term therapy to be optimally effective, that definite and limited goals should be decided on at the onset of therapy (Koss et al., 1986; Ewing, 1990; Hoyt, 1990).

EAP Versus Non-EAP Clients. The differences between rates of improvement on the BSI and POM for EAP versus Non-EAP clients were shown to be statistically non-significant. This finding suggests that longer therapy did not necessarily mean greater improvement following therapy.

Job Satisfaction. Clients who reported higher levels of emotional distress also tended to report lower levels of job satisfaction. This finding supports previous research that found that low job satisfaction was significantly related to independently assessed symptom levels in areas of general distress, behavioral disturbance, alcohol abuse, and problems in job functioning (Kavenagh et al., 1981). The

significant negative correlation between subject's emotional distress level and job satisfaction in the current study should be viewed with caution; it only accounted for approximately seven percent of the variance.

The hypothesis that job satisfaction would vary as a function of emotional well-being was not supported. Job satisfaction did not improve significantly with the reduction of client emotional distress. Job satisfaction may be a relatively stable characteristic and not subject to significant fluctuation regardless of emotional well-being.

Conclusions and Future Directions. Previous and current literature suggests the importance for industries to provide adequate means for helping distressed individuals within the workplace. High prevalence of emotional distress and the effects on job performance as well as high cost factors were discussed in detail. The high percentage of EAP clients in the current project that experienced a self-reported decline in job performance serves to support previous findings and serves to underline the need for adequate industrial clinical intervention for troubled workers. EAP clients also experienced a variety of personal problems which is congruent with the more recent "broad based" approach adopted by current EAP providers.

In terms of EAP efficacy in resolving client emotional

and personal problems, results of the current project suggests that short-term psychotherapeutic intervention is effective in the reduction of client symptoms and overall emotional distress. The current project may serve as a pilot study for academic researchers who wish to become involved in psychotherapeutic outcome research that focuses brief psychotherapy offered by EAPs. Future research needs to involve larger sample sizes, more equivalent non-treatment control groups, more emphasis on therapist input and cooperation, and more adequate means for collection of data.

References

- Allander, R., & Campbell, T. (1975). An evaluative study of an alcohol and drug recovery program; a case study of the Oldsmobile experience. Human Resources Management, 14, 14-18.
- Auerbach, S. M., & Kilmann, P. R. (1977). Crisis intervention: A review of outcome research. Psychological Bulletin, 84, 1189-1217.
- Bayer, L., & Gerstein, L. (1988). Supervisory attitudes toward impaired workers: A factor analytic study of the Behavioral Index of Troubled Employees (BITE). The Journal of Applied Behavioral Sciences, 24, 413-422.
- Bayer, L., & Gerstein, L. (1990). EAP referrals and troubled employees: An analogue study of supervisors decisions. Journal of Vocational Behavior, 36, 304-319.
- Belasco, J., & Trice, H. (1969). The assessment of change in training and therapy. New York: McGraw-Hill.
- Bergin, A. E., & Lambert, M. J. (1978). The evaluation of therapeutic outcomes. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change, (pp. 139-191). New York: Wiley & Sons.

- Binder, J. L., Strupp, H. H., & Schacht, T. E. (1983). Countertransference in time-limited dynamic psychotherapy. Contemporary Psychoanalysis, 19, 605-623.
- Brodzinski, J. D., & Goyer, K. (1989). Employee assistance program utilization and client gender. Employee Assistance Quarterly, 3, 1-13.
- Brom, D., Kleber, R. J., & Defares, P. B. (1989). Brief Psychotherapy for Posttraumatic Stress Disorders. Journal of Consulting and Clinical Psychology, 57, 607-612.
- Burlingame, G. M., Fuhrman, A., Paul, S., & Ogles, B. (1989). Implementing a time-limited therapy program: Differential effects of training and experience. Psychotherapy, 26, 303-313.
- Butcher, J. N., & Herzog, J. G. (1982). Individual assessment in crisis intervention: Observation, life history, and personality approaches. In C. Spielberger & J. N. Butcher (Eds.), Advances in personality assessment, 1, 115-168). Hillsdale: Erlbaum.
- Butcher, J. N., & Kolotkin, R. L. (1979). Evaluation of outcome in brief psychotherapy. Psychiatric Clinics of North America, 2, 157-169.

- Caplan, G. (1964). Principles of preventive psychiatry. New York: Basic Books.
- Cochran, C. D., & Hale, D. (1985). College student norms on the brief symptom inventory. Journal of Clinical Psychology, 41, 1985.
- Davidson, M.J., & Veno, A. (1980). Stress and the policeman. In C. L. Cooper & J. Marshall (Eds.), White Collar & Professional Stress. New York: Wiley.
- Decker, J., Starrett, R., & Redhorse, J. (1986). Evaluating the cost effectiveness of employee assistance programs. Social Work, 70, 391-393.
- Denker, P. G. (1946). Results of treatment of psychoneuroses by the general practitioner. New York State Journal of Medicine, 46, 2164-2166.
- Derogatis, L. R. (1975). Brief Symptom Inventory. Baltimore: Clinical Psychometric Research.
- Derogatis, L. R. (1977). The SCL-90 Manual I: Scoring, Administration and Procedures for the SCL-90. Baltimore: Clinical Psychometric Research.
- Derogatis, L. R., & Spencer, P. M. (1982). Administration and Procedures: BSI Manual-I. Baltimore: Clinical Psychometric.

- Derogatis, L. R. (1990). BSI: A complete bibliography.
Baltimore: Clinical Psychometric Research.
- Dickman, F., & Emener, W. (1982). Employee assistance programs: Basic concepts, critical attributes, and an evaluation. Personnel Administrator, 27, 55-62.
- Dickman, F., Challenger, R., Emener, W., & Hutchison, W. (1988). Employee assistance programs: A basic Text. Springfield, Il:Thomas.
- Dunkin, W. S. (1982). The EAP Manual, The National Council on Alcoholism, Inc.
- Ewing, C. P. (1990). In R. A. Wells and Vincent J. Gionetti (Eds.), Handbook of Brief Psychotherapies, p. 277-294. New York: Plenum Press.
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. Journal of Consulting Psychology, 16, 319-324.
- Fisher, S. G. (1984). Time-limited brief therapy with families: A one-year followup study. Family Process, 23, 101-106.
- Fizek, L. S. & Zare, N. (1988). Factors affecting referrals from employee assistance programs to community agencies. Employee Assistance Quarterly, 4, 31-43.

- Gam, J., Sauser, W., Evans, E., & Lair, E. (1983).
The implementation of an employee assistance
program. Journal of Employment Counseling, 20, 61-
69.
- Garfield, S. L. (1978). Research on client variables
in psychotherapy. In S. L. Garfield & A. E. Bergin
(Eds.), Handbook of psychotherapy and behavior change
(rev. ed., pp. 199-232). New York: Wiley.
- Gerstein, L., & Bayer, G. (1988). Employee
assistance programs: A systemic investigation
of their use. Journal of Counseling and
Development, 66, 294-297.
- Googins, B. (1975). Employee assistance programs.
Social Work, 20, 464-466.
- Googins, B., & Kurtz, N. (1981). Discriminating
participating and nonparticipating supervisors in
occupational alcoholism programs. Journal of Drug
Issues, 11, 199-216.
- Green, B. L., Gleser, G. C., Stone, W. N., & Seifert, R. F.
(1975). Relationships among diverse measures of
psychotherapy outcome. Journal of Consulting and
Clinical Psychology, 43, 689-699.

- Greer, S., & Bagley, C. (1971). Effect of psychiatric intervention in attempted suicide: A controlled study. British Medical Journal, 1, 310-312.
- Hofman, J. (1988). Future EAPs: An internal vs external debate. Almacan, 18, 10-13.
- Hotchkiss, S.N. (1985). GM benefits official presents talk at OPA. The Ohio Psychologist, 32, 14.
- Hoyt, M. F. (1990). On time in brief therapy. In A. E. Bellack & M. Hersen (Eds.), Handbook of the Brief Psychotherapies (pp. 115-143). New York: Plenum Press.
- Jerell, J., & Rightmyer, J. (1982). Evaluating employee assistance programs: A review of methods, outcomes, and future directions. Evaluation and Program Planning, 5, 255-267.
- Johnson, D. H., & Gelso, C. J. (1980). The effectiveness of time limits in counseling and psychotherapy: A critical review. The Counseling Psychologist, 9, 70-83.
- Kaltreider, N., DeWitt, K., Weiss, D., & Horowitz, M. (1981). Patterns of individual change scales. Archives of General Psychiatry, 38, 1263-1269.
- Kavenagh, M. J., Hurst, M. W., & Rose, R. (1981). The relationship between job satisfaction and psychiatric health symptoms for air traffic controllers. Personnel Psychology, 34, 691-707.

- Kazdin, A. E. (1986). The evaluation of psychotherapy: Research design and methodology. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (pp. 23-68). New York: Wiley & Sons.
- Kemp, D. (1985). State employee assistance programs: Organization and Services. Public Administrative Review, 8, 278-382.
- Klarreich, S., DiGiuseppe, R., & DiMattia, D. (1987). Cost effectiveness of an employee assistance program with rational-emotive therapy. Professional Psychology: Research Practice, 18, 140-144.
- Kolotkin, R. L., & Johnson, M. (1983). Crisis intervention and measurement of treatment outcome. In M. J. Lambert, E. R. Christensen, & S. S. DeJulio (Eds.), The assessment of psychotherapy outcome (pp. 132-159). New York: Wiley & Sons.
- Kornhauser, A. (1965). Mental health of the industrial worker. New York: Wiley.
- Koss, M. P., & Butcher, J. N. (1986). Research on brief psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (pp. 627-670). New York: Wiley & Sons.

- Koss, M. P., Butcher, J. N., & Strupp, H. H. (1986).
Brief Psychotherapy methods in clinical research.
Journal of Consulting and Clinical Psychology, 54,
60-67.
- Lambert, M. J. (1976). Spontaneous remission in adult
neurotic disorders: A revision and summary, Psychological
Bulletin, 83, 107-119.
- Lambert, M. J., Shapiro, D. A., & Bergin, A. E. (1986).
The effectiveness of psychotherapy. In S. L.
Garfield & A. E. Bergin (Eds.), Handbook of
psychotherapy and behavior change (pp. 157-212).
New York: Wiley & Sons.
- Landis, C. (1937). A statistical evaluation of
psychotherapeutic methods. In L. E. Hirsie (Ed.),
Concepts and problems in psychotherapy.
New York: Columbia University Press.
- Levine, H. (1985). Employee assistance programs.
Personnel, 62, 14-19.
- Lewis, J. A., & Lewis, M. D. (1986). Counseling
programs for employees in the workplace.
Monterey: Brooks/Cole.
- Liebouwitz, B. (1982). Employee assistance programs
and employee benefit versus risk management.
Employee Benefits Journal, 1, 15.

- Lorr, M., Daston, P., & Smith, I. R. (1967). An analysis of mood states. Educational Psychological Measurement, 27, 89-96.
- MacDonald, D. (1985). Counseling programs for workers problems save companies money. New England Business, 7, 27.
- Madonia, J. F. (1985). Handling emotional problems in business and industry. Social Casework, 66, 587-593.
- Malan, D. H. (1976). Toward the validation of dynamic psychotherapy: A replication. New York: Plenum.
- Malouff, J. M., Lanyon, R. I., Schutte, N. S. (1988). Effectiveness of a brief group RET treatment for divorce-related dysphoria. Journal of Rational Emotive and Cognitive Behavior Therapy, 6, 162-171.
- Manuso, J. S. (1981). Psychological services and health enhancement: A corporate model. In A. Broskowski, E. Marks, & S. H. Budman (Eds.), Linking Health and Mental Health. Beverly Hills: Sage.
- Marshall, J. (1980). Stress among nurses. In C. L. Cooper & J. Marshall (Eds.), White Collar and Professional Stress. New York: Wiley.

- Martin, D. W., Heckel, V. M., Goodrick, G. K., Schreiber, J. M., Young, V. L. (1985). The relationship between referral types, work performance, and employee problems. Employee Assistance Quarterly, 1, 25-36.
- Masi, D. A. (1983). Designing employee assistance programs. New York: American Management Associations.
- Masi, D., & Goff, M. (1987). The evaluation of employee assistance programs. Public Personnel Management, 16, 323-327.
- Masi, D., & Teems, L. (1983). Employee counseling services evaluation system: Design issues and conclusions. Evaluation and Program Planning, 6, 1-6.
- McClellan, K. (1985). Exploring EAP credentialing. Employee Assistance Quarterly, 1, 19-24.
- McClellan, K. (1987). Utilization of mental health and chemical dependency services: An EAP perspective. Employee Assistance Quarterly, 2, 29-35.
- McClellan, K. (1989). Cost-benefit analysis of the Ohio EAO. Employee Assistance Quarterly, 5, 67-85.

- Mc Nair, D. M., & Lorr, M. (1964). An analysis of mood in neurotics. Journal of Abnormal Social Psychology, 69, 620-627.
- McNair, D. M., Lorr, M., & Droppleman, L. F. (1981). Profile of Mood States Manual. San Diego: EDITS.
- Meissner, M. (1971). The long arm of the job. Industrial Relations, 10, 239-260.
- Meltzoff, J. & Kornreich, M. (1970). Research in psychotherapy. New York: Atherton Press.
- Myers, D. (1984). Measuring cost effectiveness of EAPs. Risk Management, 31, 56-61.
- Myers, P. L., (1990). Sources and configurations of institutional denial. Employee Assistance Quarterly, 5, 43-53.
- Nord, J. L., & Littrell, J. M. (1989). Predictors of supervisors' referrals of employees to an employee assistance program. Employee Assistance Quarterly, 5, 21-40.
- Penzer, W. N. (1987, March/April). Toward sustaining quality mental health services. EAP Digest, 35-40.
- Phillips, B. W., & Lee, M. (1980). The changing role of the american teacher: current and future sources of stress. In C. L. Cooper & J. Marshall (Eds.), White-Collar and Professional Stress. New York: Wiley.

- Pugatch, D., Haskell, D., & McNair, D. M. (1969).
Predictors and patterns of change associated with the
course of time-limited therapy. Mimeo Report.
- Quayle, D. (1983). American productivity: The
devastating effect of alcoholism and drug abuse.
American Psychologist, 38, 454-458,
- Rachman, S. J., & Wilson, G. T. (1980). The effects
of psychological therapy. New York: Pergamon Press
Inc.
- Riggio, R. E., (1990). Introduction to industrial/
organizational psychology. Glenview: Scott,
Foresman and Co.
- Roman, P. (1981). From employee alcoholism to employee
assistance. Journal of Studies on Alcohol, 42,
244-272.
- Roman, P. (1983). Employee assistance programs in
Australia and the United States: Comparisons of
origins, structure, and the role of behavioral
science research. The Journal of Applied Behavioral
Science Research, 19, 367-379.
- Roman, P., Blum, T., & Bennett, N. (1987). Educating
organizational consumers about employee assistance
programs. Public Personnel Management, 16, 299-312.

- Schultz, D., & Schultz, S. (1990). Psychology and industry today: An introduction to industrial and organizational psychology. New York: Macmillan Publishing Co.
- Shain, M., & Groeneveld, J. (1980). Employee assistance programs. Lexington, MA: D.C. Heath
- Sifneos, P. E. (1979). Short-term dynamic psychology therapy: Evaluation and technique. New York: Plenum.
- Smith, M. L., Glass, G. V., & Miller, T. I. (1980). The benefits of psychotherapy. Baltimore: Johns Hopkins.
- Sonnenstuhl, W. J. (1988). Contrasting employee assistance, health promotion, and quality of work life programs and their effects on alcohol abuse and dependence. The Journal of Applied Behavioral Science, 24, 347-363.
- Sonnenstuhl, W. J., Staudenmeier, W. J., & Trice, H. M. (1988). Ideology and referral categories in employee assistance program research. The Journal of Applied Behavioral Science, 24, 383-396.
- Sonnenstuhl, W. J., & Trice, H. M. (1986). Strategies for employee assistance programs: The crucial balance. Ithaca: ILR Press.

- Thompson, L. W., Gallagher, D., & Breckenridge, J. S. (1987). Comparative effectiveness of psychotherapies for depressed elders. Journal of Consulting and Clinical Psychology, 55, 385-390.
- Trice, H., & Beyer, J. (1984). Work-related outcomes of the constructive-confrontation strategy in a job-based alcoholism program. Journal of Studies on Alcohol, 45, 393-404.
- Trice, H. M., Hunt, R., & Beyer, J. M. (1977). Alcoholism programs unionized work settings: Problems and prospects in union-management cooperation. Journal of Drug Issues, 7, 103-115.
- Trice, H., & Sonnenstuhl, W. (1988). Drinking behavior and risk factors related to the work place: Implications for research and prevention. The Journal of Applied Behavioral Science, 24, 327-346.
- Tung, R. L., & Koch, J. L. (1980). School administrators: Sources of stress and ways of coping with it. In C. L. Cooper & J. Marshall (Eds.), White collar and professional stress. New York: Wiley.
- Warr, P. (1987). Work, unemployment, and mental health. Oxford: Clarendon Press.

- Webb, W. (1990). Cognitive behavior therapy: Application for employee assistance counselors. Employee Assistance Quarterly, 5, 55-65.
- Weiss, D. J., & Dawis, R. V., England, G. W., & Lofquist, L. H. (1967). Manual for the Minnesota Satisfaction Questionnaire.
- Weitz, L. J., Abromowitz, S. I., Steger, J. A. Colabria, F. M., Conable, M., & Yarus, G. (1975). Numbers of sessions and client-judged outcome: The more the better? Psychotherapy: Theory, Research, & Practice, 12, 137-340.
- Wells, R. A., & Phelps, P. A. (1990). The brief psychotherapies. In A. S. Bellack & M. Hersen (Eds.), Handbook of the Brief Psychotherapies (pp. 3-24). New York: Plenum Press.
- White, S. L. (1981). The impact of mental health services on medical care utilization: Economic and organizational implications. Hospital and Community Psychiatry, 32, 311-319.
- White, S. L. (1983). Recent trends in occupational mental health: An overview. In S. White (Ed.), New directions for mental health: Vol. 20. Advances in occupational mental health (pp. 3-14). San Francisco: Jossey-Bass.

Wiener, Y., Vardi, Y., & Muczyk, J. (1981).

Antecedents of employees' mental health-The role of career and work satisfaction. Journal of Vocational Behavior, 19, 50-60.

Wolkon, G. H. (1972). Crisis theory, the application for treatment, and dependency. Comprehensive Psychiatry, 13, 459-464.

Appendix A

Today's Date: _____ ID# _____

Name: _____ Visit# _____

Are you currently taking any anti-depressant,
anti-anxiety, or anti-psychotic medicine? _____ If

yes, what kind? _____

Are you currently seeing a counselor/therapist? Yes _____

No _____

The following section gives you a chance to let us know how you feel about the services that you have received through our office. Please feel free to be as honest and as open in your responses as you like, as your responses will not be seen directly by either your therapist or other related persons.

Please rate the following questions by circling the number that best describes how you feel about the services that you have received through this office.

0=Not at all; 1=A little bit; 2=Moderately; 3=Quite a bit
4=Extremely

1. How satisfied are you with the services that you received through our office.....0 1 2 3 4
2. How much would you say that the therapy helped you with you problem/s.....0 1 2 3 4
3. How courteously were you treated by our business office.....0 1 2 3 4
4. Were you satisfied with the way that your therapist handled your situation/problem.....0 1 2 3 4
5. Were you comfortable in talking to your therapist0 1 2 3 4
6. How will would you be to see this therapist again0 1 2 3 4
7. How satisfied were you with the therapy that you received.....0 1 2 3 4
8. Would you recommend your therapist to others0 1 2 3 4
9. How comfortable would you feel in recommending to others the services provided by this office...0 1 2 3 4
10. Overall, how much improvement do you think you have experienced since you began therapy at this office.0 1 2 3 4

Comments regarding our services:_____

Appendix B

Group Means and Standard Deviations for Dependent Measures
at Pre and Post Assessment for Analysis One.

	<u>Pre Assessment</u>	<u>Post Assessment</u>
	Mn (sd)	Mn (sd)
Somatization		
<u>Clients (N=15)</u>	<u>.69 (.81)</u>	<u>.49 (.83)</u>
<u>Students (N=42)</u>	<u>.36 (.44)</u>	<u>.36 (.39)</u>
<u>Employees (N=13)</u>	<u>.15 (.29)</u>	<u>.18 (.22)</u>
Hostility		
<u>Clients</u>	<u>.68 (.63)</u>	<u>.79 (.91)</u>
<u>Students</u>	<u>.68 (.55)</u>	<u>.58 (.51)</u>
<u>Employees</u>	<u>.32 (.30)</u>	<u>.26 (.28)</u>
Depression		
<u>Clients</u>	<u>1.74 (1.11)</u>	<u>1.32 (1.14)</u>
<u>Students</u>	<u>.58 (.56)</u>	<u>.56 (.44)</u>
<u>Employees</u>	<u>.21 (.31)</u>	<u>.19 (.20)</u>
Anxiety		
<u>Clients</u>	<u>1.21 (.95)</u>	<u>.90 (1.06)</u>
<u>Students</u>	<u>.65 (.50)</u>	<u>.62 (.46)</u>
<u>Employees</u>	<u>.42 (.36)</u>	<u>.40 (.44)</u>
Phobic Anx.		
<u>Clients</u>	<u>.63 (.58)</u>	<u>.53 (.62)</u>
<u>Students</u>	<u>.16 (.16)</u>	<u>.22 (.29)</u>
<u>Employees</u>	<u>.12 (.27)</u>	<u>.05 (.09)</u>

Paranoid Ideation

Clients	1.45	(1.18)	1.21	(.95)
Students	.71	(.62)	.67	(.55)
Employees	.68	(.47)	.69	(.51)

Psychoticism

Clients	1.23	(.89)	.95	(.99)
Students	.42	(.45)	.41	(.47)
Employees	.20	(.29)	.11	(.11)

Interpersonal Sensitivity

Clients	1.45	(1.11)	1.12	(.95)
Students	.81	(.61)	.74	(.65)
Employees	.38	(.39)	.27	(.31)

Obsessive-Compulsive

Clients	.856	(.77)	.756	(.82)
Students	.798	(.50)	.984	(.65)
Employees	.410	(.48)	.205	(.31)

GSI

Clients	1.13	(.80)	.90	(.78)
Students	.56	(.35)	.57	(.37)
Employees	.32	(.25)	.28	(.22)

PST

Clients	26.93	(13.85)	24.53	(12.60)
Students	20.00	(9.41)	21.19	(10.39)
Employees	12.84	(9.60)	10.46	(6.53)

PSDIA

<u>Clients</u>	<u>.04</u>	<u>(.01)</u>	<u>.03</u>	<u>(.01)</u>
<u>Students</u>	<u>.03</u>	<u>(.01)</u>	<u>.03</u>	<u>(.01)</u>
<u>Employees</u>	<u>.02</u>	<u>(.004)</u>	<u>.03</u>	<u>(.01)</u>

Tension-anxiety

<u>Clients</u>	<u>10.60</u>	<u>(6.70)</u>	<u>6.13</u>	<u>(6.20)</u>
<u>Students</u>	<u>6.52</u>	<u>(4.70)</u>	<u>5.43</u>	<u>(3.81)</u>
<u>Employees</u>	<u>4.46</u>	<u>(5.17)</u>	<u>4.46</u>	<u>(5.77)</u>

Depression-dejection

<u>Clients</u>	<u>25.80</u>	<u>(15.60)</u>	<u>18.53</u>	<u>(17.45)</u>
<u>Students</u>	<u>8.71</u>	<u>(8.08)</u>	<u>7.61</u>	<u>(7.71)</u>
<u>Employees</u>	<u>3.30</u>	<u>(4.55)</u>	<u>4.15</u>	<u>(4.10)</u>

Anger-hostility

<u>Clients</u>	<u>18.20</u>	<u>(12.14)</u>	<u>11.48</u>	<u>(10.12)</u>
<u>Students</u>	<u>10.21</u>	<u>(9.34)</u>	<u>7.88</u>	<u>(7.08)</u>
<u>Employees</u>	<u>3.84</u>	<u>(3.11)</u>	<u>3.92</u>	<u>(2.93)</u>

Vigor-activity

<u>Clients</u>	<u>12.27</u>	<u>(7.26)</u>	<u>15.80</u>	<u>(6.05)</u>
<u>Students</u>	<u>15.07</u>	<u>(6.92)</u>	<u>14.88</u>	<u>(6.78)</u>
<u>Employees</u>	<u>19.65</u>	<u>(5.04)</u>	<u>19.62</u>	<u>(5.81)</u>

Fatigue-inertia

<u>Clients</u>	<u>9.87</u>	<u>(6.75)</u>	<u>7.13</u>	<u>(6.63)</u>
<u>Students</u>	<u>9.31</u>	<u>(6.06)</u>	<u>8.71</u>	<u>(6.52)</u>
<u>Employees</u>	<u>5.77</u>	<u>(3.75)</u>	<u>5.46</u>	<u>(4.65)</u>

Confusion

<u>Clients</u>	6.33	(4.61)	3.40	(5.82)
<u>Students</u>	3.50	(4.31)	3.31	(4.51)
<u>Employees</u>	-2.07	(1.75)	-2.30	(1.48)

General Job Satisfaction

<u>Clients</u>	69.27	(19.48)	68.67	(14.94)
<u>Students</u>	70.36	(15.91)	70.14	(14.27)
<u>Employees</u>	75.92	(8.85)	72.85	(12.29)

Appendix C

Group Means and Standard Deviations for Combined Client
Group, Student Group, and Employee Control Group on
Dependent Measures at Pre and Follow-up Assessment for
Analysis Two.

	<u>Pre Assessment</u>		<u>Follow-up Assessment</u>	
	Mn	(sd)	Mn	(sd)
Somatization				
<u>Clients</u>	<u>.44</u>	<u>(.68)</u>	<u>.25</u>	<u>(.42)</u>
<u>Students</u>	<u>.31</u>	<u>(.39)</u>	<u>.31</u>	<u>(.35)</u>
<u>Employees</u>	<u>.09</u>	<u>(.15)</u>	<u>.23</u>	<u>(.15)</u>
Hostility				
<u>Clients</u>	<u>1.02</u>	<u>(.99)</u>	<u>.51</u>	<u>(.50)</u>
<u>Students</u>	<u>.66</u>	<u>(.41)</u>	<u>.76</u>	<u>(.65)</u>
<u>Employees</u>	<u>.35</u>	<u>(.31)</u>	<u>.31</u>	<u>(.30)</u>
Depression				
<u>Clients</u>	<u>1.64</u>	<u>(1.28)</u>	<u>1.21</u>	<u>(.90)</u>
<u>Students</u>	<u>.53</u>	<u>(.51)</u>	<u>.48</u>	<u>(.49)</u>
<u>Employee</u>	<u>.18</u>	<u>(.30)</u>	<u>.14</u>	<u>(.22)</u>
Anxiety				
<u>Clients</u>	<u>1.15</u>	<u>(.88)</u>	<u>.76</u>	<u>(.53)</u>
<u>Students</u>	<u>.63</u>	<u>(.49)</u>	<u>.65</u>	<u>(.63)</u>
<u>Employees</u>	<u>.47</u>	<u>(.37)</u>	<u>.50</u>	<u>(.42)</u>

Phobic Anx.

<u>Clients</u>	<u>.40</u>	<u>(.46)</u>	<u>.29</u>	<u>(.30)</u>
<u>Students</u>	<u>.16</u>	<u>(.16)</u>	<u>.19</u>	<u>(.23)</u>
<u>Employees</u>	<u>.13</u>	<u>(.30)</u>	<u>.07</u>	<u>(.16)</u>

Paranoid Ideation

<u>Clients</u>	<u>1.20</u>	<u>(.93)</u>	<u>.66</u>	<u>(.61)</u>
<u>Students</u>	<u>.70</u>	<u>(.57)</u>	<u>.70</u>	<u>(.62)</u>
<u>Employees</u>	<u>.71</u>	<u>(.45)</u>	<u>.71</u>	<u>(.52)</u>

Psychoticism

<u>Clients</u>	<u>.95</u>	<u>(1.01)</u>	<u>.66</u>	<u>(.74)</u>
<u>Students</u>	<u>.38</u>	<u>(.43)</u>	<u>.29</u>	<u>(.35)</u>
<u>Employees</u>	<u>.20</u>	<u>(.32)</u>	<u>.11</u>	<u>(.21)</u>

Interpersonal Sensitivity

<u>Clients</u>	<u>1.09</u>	<u>(1.03)</u>	<u>.75</u>	<u>(.69)</u>
<u>Students</u>	<u>.80</u>	<u>(.61)</u>	<u>.71</u>	<u>(.71)</u>
<u>Employees</u>	<u>.41</u>	<u>(.41)</u>	<u>.34</u>	<u>(.61)</u>

Obsessive Compulsive

<u>Clients</u>	<u>.92</u>	<u>9.76)</u>	<u>.84</u>	<u>(.46)</u>
<u>Students</u>	<u>.82</u>	<u>(.54)</u>	<u>.87</u>	<u>(.81)</u>
<u>Employees</u>	<u>.50</u>	<u>(.50)</u>	<u>.41</u>	<u>(.52)</u>

GSI

<u>Clients</u>	<u>.98</u>	<u>(.83)</u>	<u>.66</u>	<u>(.43)</u>
<u>Students</u>	<u>.54</u>	<u>(.33)</u>	<u>.54</u>	<u>(.43)</u>
<u>Employees</u>	<u>.32</u>	<u>(.25)</u>	<u>.30</u>	<u>(.27)</u>

PST

<u>Clients</u>	<u>23.18</u>	<u>(14.01)</u>	<u>20.46</u>	<u>(12.31)</u>
<u>Students</u>	<u>19.76</u>	<u>(9.04)</u>	<u>19.76</u>	<u>(12.27)</u>
<u>Employees</u>	<u>12.36</u>	<u>(8.82)</u>	<u>10.36</u>	<u>(8.57)</u>

PSDI

<u>Clients</u>	<u>.04</u>	<u>(.01)</u>	<u>.03</u>	<u>(.01)</u>
<u>Students</u>	<u>.03</u>	<u>(.01)</u>	<u>.03</u>	<u>(.01)</u>
<u>Employees</u>	<u>.02</u>	<u>(.00)</u>	<u>.03</u>	<u>(.01)</u>

Tension-Anxiety

<u>Clients</u>	<u>10.27</u>	<u>(6.92)</u>	<u>5.64</u>	<u>(4.11)</u>
<u>Students</u>	<u>6.76</u>	<u>(4.99)</u>	<u>5.85</u>	<u>(4.87)</u>
<u>Employees</u>	<u>5.18</u>	<u>(5.33)</u>	<u>5.27</u>	<u>(7.16)</u>

Depression-dejection

<u>Clients</u>	<u>24.18</u>	<u>(16.99)</u>	<u>15.36</u>	<u>(12.00)</u>
<u>Students</u>	<u>7.61</u>	<u>(7.11)</u>	<u>7.49</u>	<u>(7.71)</u>
<u>Employees</u>	<u>3.55</u>	<u>(4.93)</u>	<u>3.27</u>	<u>(6.15)</u>

Anger-Hostility

<u>Clients</u>	<u>19.27</u>	<u>(12.82)</u>	<u>9.27</u>	<u>(8.88)</u>
<u>Students</u>	<u>9.76</u>	<u>(7.03)</u>	<u>9.55</u>	<u>(8.13)</u>
<u>Employees</u>	<u>3.64</u>	<u>(2.84)</u>	<u>3.00</u>	<u>(3.61)</u>

Vigor-activity

<u>Clients</u>	<u>11.46</u>	<u>(6.19)</u>	<u>13.73</u>	<u>(6.44)</u>
<u>Students</u>	<u>15.73</u>	<u>(6.51)</u>	<u>15.39</u>	<u>(5.52)</u>
<u>Employees</u>	<u>20.64</u>	<u>(4.61)</u>	<u>21.18</u>	<u>(6.21)</u>

Fatigue-inertia

<u>Clients</u>	<u>9.27</u>	<u>(8.12)</u>	<u>6.91</u>	<u>(6.38)</u>
<u>Students</u>	<u>9.36</u>	<u>(6.38)</u>	<u>6.94</u>	<u>(4.68)</u>
<u>Employees</u>	<u>5.73</u>	<u>(4.10)</u>	<u>4.91</u>	<u>(4.09)</u>

Confusion

<u>Clients</u>	<u>7.09</u>	<u>(5.58)</u>	<u>2.73</u>	<u>(4.59)</u>
<u>Students</u>	<u>3.30</u>	<u>(4.20)</u>	<u>3.52</u>	<u>(5.52)</u>
<u>Employees</u>	<u>-1.82</u>	<u>(1.78)</u>	<u>-2.18</u>	<u>(1.33)</u>

General Job Satisfaction

<u>Clients</u>	<u>67.18</u>	<u>(20.51)</u>	<u>71.82</u>	<u>(17.48)</u>
<u>Students</u>	<u>72.36</u>	<u>(13.85)</u>	<u>71.27</u>	<u>(14.44)</u>
<u>Employees</u>	<u>75.46</u>	<u>(9.00)</u>	<u>72.55</u>	<u>(10.60)</u>

Appendix D

Means and Standard Deviations for EAP and Non-EAP Groups at
Pre and Post Assessment.

	Pre Assessment	Post Assessment
	Mn (sd)	Mn (sd)
Somatization		
EAP (N=8)	.88 (.81)	.46 (.92)
Non-Eap (N=7)	.49 (.84)	.53 (.80)
Students (N=42)	.36 (.44)	.36 (.39)
Employees (N=13)	.15 (.29)	.18 (.22)
Hostility		
EAP	.90 (.78)	.68 (.39)
Non-EAP	1.06 (1.07)	.91 (1.32)
Students	.68 (.55)	.58 (.51)
Employees	.32 (.30)	.26 (.28)
Depression		
Eap	1.71 (.92)	1.09 (.50)
Non-EAP	1.79 (1.38)	1.60 (1.60)
Students	.58 (.56)	.56 (.44)
Employees	.21 (.31)	.19 (.20)
Anxiety		
EAP	1.33 (.90)	.88 (1.02)
Non-Eap	1.07 (1.05)	.91 (1.20)
Students	.65 (.50)	.62 (.46)
Employees	.42 (.36)	.40 (.44)

Phobic Anx.

EAP	.75	(.65)	.56	(.65)
Non-EAP	.49	(.49)	.49	(.63)
Students	.16	(.16)	.22	(.29)
Employees	.12	(.27)	.05	(.09)

Paranoid Ideation

EAP	1.80	(1.31)	1.55	(.78)
Non-EAP	1.06	(.96)	.83	(1.00)
Students	.71	(.62)	.67	(.55)
Employees	.68	(.47)	.69	(.51)

Psychoticism

EAP	1.30	(.72)	.90	(.55)
Non-EAP	1.14	(1.11)	1.23	(1.34)
Students	.42	(.45)	.41	(.47)
Employees	.20	(.29)	.11	(.11)

Interpersonal Sensitivity

EAP	1.91	(1.03)	1.44	(.96)
Non-EAP	.93	(1.03)	.75	(.98)
Students	.81	(.61)	.74	(.65)
Employees	.38	(.39)	.27	(.31)

Obsessive-Compulsive

EAP	.88	(.68)	.67	(.49)
Non-EAP	.83	(.93)	.86	(1.14)
Students	.798	(.50)	.984	(.65)

<u>Employees</u>	<u>.410</u>	<u>(.48)</u>	<u>.205</u>	<u>(.31)</u>
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GSI

<u>EAP</u>	<u>1.25</u>	<u>(.70)</u>	<u>.88</u>	<u>(.50)</u>
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<u>Non-EAP</u>	<u>1.00</u>	<u>(.94)</u>	<u>.93</u>	<u>(1.06)</u>
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<u>Students</u>	<u>.56</u>	<u>(.35)</u>	<u>.57</u>	<u>(.37)</u>
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<u>Employees</u>	<u>.32</u>	<u>(.25)</u>	<u>.28</u>	<u>(.22)</u>
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PSDIA

<u>EAP</u>	<u>.04</u>	<u>(.01)</u>	<u>.03</u>	<u>(.01)</u>
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<u>Non-EAP</u>	<u>.04</u>	<u>(.01)</u>	<u>.03</u>	<u>(.02)</u>
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<u>Students</u>	<u>.03</u>	<u>(.01)</u>	<u>.03</u>	<u>(.01)</u>
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<u>Employees</u>	<u>.02</u>	<u>(.004)</u>	<u>.03</u>	<u>(.01)</u>
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Tension-anxiety

<u>EAP</u>	<u>11.38</u>	<u>(4.17)</u>	<u>6.00</u>	<u>(4.75)</u>
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<u>Non-EAP</u>	<u>9.71</u>	<u>(9.10)</u>	<u>6.29</u>	<u>(7.95)</u>
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<u>Students</u>	<u>6.52</u>	<u>(4.70)</u>	<u>5.43</u>	<u>(3.81)</u>
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<u>Employees</u>	<u>4.46</u>	<u>(5.17)</u>	<u>4.46</u>	<u>(5.77)</u>
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Depression-dejection

<u>EAP</u>	<u>26.75</u>	<u>(13.69)</u>	<u>14.62</u>	<u>(10.11)</u>
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<u>Non-EAP</u>	<u>25.86</u>	<u>(18.69)</u>	<u>23.00</u>	<u>(23.40)</u>
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<u>Students</u>	<u>8.71</u>	<u>(8.08)</u>	<u>7.61</u>	<u>(7.71)</u>
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<u>Employees</u>	<u>3.30</u>	<u>(4.55)</u>	<u>4.15</u>	<u>(4.10)</u>
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Anger-hostility

<u>EAP</u>	<u>19.00</u>	<u>(11.50)</u>	<u>10.75</u>	<u>(5.15)</u>
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<u>Non-EAP</u>	<u>17.29</u>	<u>(13.71)</u>	<u>13.14</u>	<u>(14.30)</u>
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<u>Students</u>	<u>10.21</u>	<u>(9.34)</u>	<u>7.88</u>	<u>(7.08)</u>
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<u>Employees</u>	<u>3.84</u>	<u>(3.11)</u>	<u>3.92</u>	<u>(2.93)</u>
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Vigor-activity

<u>EAP</u>	<u>10.75</u>	<u>(5.15)</u>	<u>16.88</u>	<u>(5.96)</u>
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<u>Non-EAP</u>	<u>12.14</u>	<u>(6.99)</u>	<u>14.57</u>	<u>(6.37)</u>
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<u>Students</u>	<u>15.07</u>	<u>(6.92)</u>	<u>14.88</u>	<u>(6.78)</u>
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<u>Employees</u>	<u>19.65</u>	<u>(5.04)</u>	<u>19.62</u>	<u>(5.81)</u>
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Fatigue-inertia

<u>EAP</u>	<u>10.13</u>	<u>(4.26)</u>	<u>6.00</u>	<u>(4.78)</u>
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<u>Non-EAP</u>	<u>9.57</u>	<u>(9.22)</u>	<u>8.43</u>	<u>(8.50)</u>
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<u>Students</u>	<u>9.31</u>	<u>(6.06)</u>	<u>8.71</u>	<u>(6.52)</u>
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<u>Employees</u>	<u>5.77</u>	<u>(3.75)</u>	<u>5.46</u>	<u>(4.65)</u>
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Confusion

<u>EAP</u>	<u>6.25</u>	<u>(3.54)</u>	<u>3.86</u>	<u>(8.07)</u>
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<u>Non-EAP</u>	<u>6.42</u>	<u>(5.91)</u>	<u>3.00</u>	<u>(3.81)</u>
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<u>Students</u>	<u>3.50</u>	<u>(4.31)</u>	<u>3.31</u>	<u>(4.51)</u>
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<u>Employees</u>	<u>-2.07</u>	<u>(1.75)</u>	<u>-2.30</u>	<u>(1.48)</u>
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General Job Satisfaction

<u>EAP</u>	<u>69.13</u>	<u>(23.14)</u>	<u>68.88</u>	<u>(16.40)</u>
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<u>Non-EAP</u>	<u>69.43</u>	<u>(16.15)</u>	<u>68.43</u>	<u>(14.37)</u>
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<u>Students</u>	<u>70.36</u>	<u>(15.91)</u>	<u>70.14</u>	<u>(14.27)</u>
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<u>Employees</u>	<u>75.92</u>	<u>(8.85)</u>	<u>72.85</u>	<u>(12.29)</u>
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Appendix E

Means and Standard Deviations for EAP and Non-EAP Groups at
Pre and Follow-up Assessment. *

	<u>Pre Assessment</u>		<u>Follow-up Assessment</u>	
Somatization	Mn	(sd)	Mn	(sd)
EAP (N=8)	.20	(.33)	.14	(.17)
Non-EAP (N=7)	.86	(.99)	.43	(.68)
Students	.31	(.39)	.31	(.35)
Employees	.09	(.15)	.23	(.15)
Hostility				
EAP	.77	(.77)	.57	(.60)
Non-EAP	1.45	(1.30)	.40	(.28)
Students	.66	(.41)	.76	(.65)
Employees	.35	(.31)	.31	(.30)
Depression				
EAP	1.43	(1.03)	.97	(.79)
Non-EAP	2.50	(1.34)	1.65	(1.05)
Students	.53	(.51)	.48	(.49)
Employee	.18	(.30)	.14	(.22)
Anxiety				
EAP	.93	(.63)	.79	(.46)
Non-EAP	1.54	(1.20)	.71	(.73)
Students	.63	(.49)	.65	(.63)
Employees	.47	(.37)	.50	(.42)

Phobic Anx.

EAP	.29	(.38)	.37	(.36)
Non-EAP	.60	(.57)	.15	(.10)
Students	.16	(.16)	.19	(.23)
Employees	.13	(.30)	.07	(.16)

Paranoid Ideation

EAP	1.03	(.89)	.66	(.74)
Non-EAP	1.50	(1.05)	.65	(.34)
Students	.70	(.57)	.70	(.62)
Employees	.71	(.45)	.71	(.52)

Psychoticism

EAP	.60	(.72)	.46	(.66)
Non-EAP	1.55	(1.27)	1.00	(.83)
Students	.38	(.43)	.29	(.35)
Employees	.20	(.32)	.11	(.21)

Interpersonal Sensitivity

EAP	.96	(1.04)	.71	(.77)
Non-EAP	1.31	(1.14)	.82	(.63)
Students	.80	(.61)	.71	(.71)
Employees	.41	(.41)	.34	(.61)

Obsessive-Compulsive

EAP	.76	(.52)	.83	(.42)
Non-EAP	1.21	(1.11)	.84	(.60)
Students	.82	(.54)	.87	(.81)

<u>Employees</u>	<u>.50</u>	<u>(.50)</u>	<u>.41</u>	<u>(.52)</u>
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GSI

<u>EAP</u>	<u>.74</u>	<u>(.59)</u>	<u>.60</u>	<u>(.43)</u>
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<u>Non-EAP</u>	<u>1.42</u>	<u>(1.09)</u>	<u>.75</u>	<u>(.48)</u>
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<u>Students</u>	<u>.54</u>	<u>(.33)</u>	<u>.54</u>	<u>(.43)</u>
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<u>Employees</u>	<u>.32</u>	<u>(.25)</u>	<u>.30</u>	<u>(.27)</u>
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PST

<u>EAP</u>	<u>19.57</u>	<u>(11.37)</u>	<u>18.86</u>	<u>(11.80)</u>
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<u>Non-EAP</u>	<u>29.50</u>	<u>(17.67)</u>	<u>23.25</u>	<u>(14.50)</u>
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<u>Students</u>	<u>19.76</u>	<u>(9.04)</u>	<u>19.76</u>	<u>(12.27)</u>
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<u>Employees</u>	<u>12.36</u>	<u>(8.82)</u>	<u>10.36</u>	<u>(8.57)</u>
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PSDIA

<u>EAP</u>	<u>.04</u>	<u>(.01)</u>	<u>.03</u>	<u>(.01)</u>
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<u>Non-EAP</u>	<u>.04</u>	<u>(.01)</u>	<u>.03</u>	<u>(.02)</u>
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<u>Students</u>	<u>.03</u>	<u>(.01)</u>	<u>.03</u>	<u>(.01)</u>
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<u>Employees</u>	<u>.02</u>	<u>(.00)</u>	<u>.03</u>	<u>(.01)</u>
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Tension-anxiety

<u>EAP</u>	<u>8.57</u>	<u>(4.82)</u>	<u>6.00</u>	<u>(3.16)</u>
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<u>Non-EAP</u>	<u>13.25</u>	<u>(9.71)</u>	<u>5.00</u>	<u>(5.94)</u>
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<u>Students</u>	<u>6.76</u>	<u>(4.99)</u>	<u>5.85</u>	<u>(4.87)</u>
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<u>Employees</u>	<u>5.18</u>	<u>(5.33)</u>	<u>5.27</u>	<u>(7.16)</u>
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Depression-dejection

<u>EAP</u>	<u>17.86</u>	<u>(13.62)</u>	<u>11.71</u>	<u>(8.32)</u>
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<u>Non-EAP</u>	<u>35.25</u>	<u>(18.30)</u>	<u>21.75</u>	<u>(16.01)</u>
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<u>Students</u>	<u>7.61</u>	<u>(7.11)</u>	<u>7.49</u>	<u>(7.71)</u>
<u>Employees</u>	<u>3.55</u>	<u>(4.93)</u>	<u>3.27</u>	<u>(6.15)</u>

Anger-hostility

<u>EAP</u>	<u>17.14</u>	<u>(11.50)</u>	<u>8.57</u>	<u>(8.72)</u>
<u>Non-EAP</u>	<u>23.00</u>	<u>(15.94)</u>	<u>10.38</u>	<u>(10.38)</u>
<u>Students</u>	<u>9.76</u>	<u>(7.03)</u>	<u>9.55</u>	<u>(8.13)</u>
<u>Employees</u>	<u>3.64</u>	<u>(2.84)</u>	<u>3.00</u>	<u>(3.61)</u>

Vigor-activity

<u>EAP</u>	<u>12.14</u>	<u>(7.43)</u>	<u>12.57</u>	<u>(7.56)</u>
<u>Non-EAP</u>	<u>10.25</u>	<u>(3.75)</u>	<u>15.75</u>	<u>(3.86)</u>
<u>Students</u>	<u>15.73</u>	<u>(6.51)</u>	<u>15.39</u>	<u>(5.52)</u>
<u>Employees</u>	<u>20.64</u>	<u>(4.61)</u>	<u>21.18</u>	<u>(6.21)</u>

Fatigue-inertia

<u>EAP</u>	<u>7.86</u>	<u>(6.20)</u>	<u>6.00</u>	<u>(6.35)</u>
<u>Non-EAP</u>	<u>11.75</u>	<u>(11.44)</u>	<u>8.50</u>	<u>(7.05)</u>
<u>Students</u>	<u>9.36</u>	<u>(6.38)</u>	<u>6.94</u>	<u>(4.68)</u>
<u>Employees</u>	<u>5.73</u>	<u>(4.10)</u>	<u>4.91</u>	<u>(4.09)</u>

Confusion

<u>EAP</u>	<u>6.00</u>	<u>(5.44)</u>	<u>1.43</u>	<u>(4.32)</u>
<u>Non-EAP</u>	<u>9.00</u>	<u>(6.06)</u>	<u>5.00</u>	<u>(4.69)</u>
<u>Students</u>	<u>3.30</u>	<u>(4.20)</u>	<u>3.52</u>	<u>(5.52)</u>
<u>Employees</u>	<u>-1.82</u>	<u>(1.78)</u>	<u>-2.18</u>	<u>(1.33)</u>

General Job Satisfaction

<u>Eap</u>	<u>68.14</u>	<u>(21.94)</u>	<u>73.57</u>	<u>(16.15)</u>
<u>Non-EAP</u>	<u>65.50</u>	<u>(20.83)</u>	<u>68.75</u>	<u>(21.82)</u>
<u>Students</u>	<u>72.36</u>	<u>(13.85)</u>	<u>71.27</u>	<u>(14.44)</u>
<u>Employees</u>	<u>75.46</u>	<u>(9.00)</u>	<u>72.55</u>	<u>(10.60)</u>
