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NOVEMBER 1993

VOL.6, NO.4

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COMMENTARY

Adolescence, Gambling and EAPs

There are several definitions of adolescence. My favorite says that adolescence begins as one night while our loving, cherubic 12- or 13-year-olds are sleeping, God sneaks into their bedrooms, puts a straw into their ears and sucks their brains out. Having two teen-agers, this one fits the ups and downs of the teen years, both for parents and teen-agers. It's a time of conflict too. My sixteen-year-old daughter Janna nailed me last night when she said, "Dad, it seems like all you notice about me are the negatives, the things I don't do very well." She was right (teen-agers often are). What I wanted to communicate to her was, "Honey, I care about what you are doing and I worry about you out there." Worry I do when I recall a 1991 federal study that concluded one of five adolescents has at least one serious health problem, including drug abuse, eating disorders or sexually transmitted diseases. Gun violence now kills more than 4,000 youths ages 15 to 19 annually. One million teen-agers become pregnant each year. It's no wonder a teen-ager's problems can affect a person's productivity in the workplace.

Thanks to the many of you who stopped by to see us in San Francisco at the Behavioral Healthcare Tomorrow show. Some 2,200 EA professionals, managed care companies and treatment and service providers attended. Our booth was one of more than 150 at the show. Look for some trend-setting editorial for our 1994 calendar mixing in the best from the show. Just as the plane landed, I had a chance to change my suitcases, and I was off to the Cape Cod Symposium, which blended warmth, ambiance and top-rated presenters to the 550-plus attendees. This conference also offered excellent editorial opportunities in breakthrough studies on depression, psychopharmacology and AD/HD.

In December, we'll be off to SECAD in Atlanta, the premier drug/alcohol conference in the Southeast sponsored by Charter Medical.

This month we're running a story on gambling in the workplace. I met a man at one of these shows that shared his story with me. Joe (not his real name) was sitting behind a table covered with Xeroxed pages about the ravages of gambling. His gamble-buster information stated, "Seventy percent to 80 percent of the total U.S. population gambles $300 billion a year! There are 12 million adult and 1.5 million teen-age compulsive gamblers in this country." Twice Joe had risen to the top of his own company only to have the success he worked so hard to build slip through his fingers from gambling. He was living proof of the disease...and its recovery potential. He *is* on his way back.

One other sidelight of the BHT and Cape Cod conferences is the sense that both the EA field and the treatment field are strengthening their positions. Both are heartened by the initial Clinton healthcare reforms. EAPs who have joined, integrated their care with or are directing managed care companies are growing—Mobil, Chevron and AT&T, to name three. Treatment centers have adjusted their length of stays and cost packages to be in line with other care providers.

One final note: I just got the word that *EmployeeAssistance* won another award! This time it's the Ozzie for best cover in a trade publication under 50,000.

Chip Drotos

J.Chip Drotos, CEAP
Associate Publisher

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The Workplace Gambler

EAP's Early Assessment Cuts the Expense of Misdiagnosis

For one successful executive, gambling wove a web of deceit, denial and ultimately financial and occupational ruin. Engulfed in fear and a loss of control, he was led from an intervention to recovery through his employee assistance program (EAP). The corporate world is discovering that the compulsion for gambling is a problem prevalent across all races, sexes, ages and levels of employees.

According to the Council on Compulsive Gambling of New Jersey Inc., director Arnold Wexler compiled statistics citing that $305 billion is gambled legally each year in the United States. He suggests that approximately 5 percent of the population—or 10 million to 12 million Americans—are compulsive gamblers.

Similar to any compulsive behavior, whether it is chemical dependency, an eating disorder or sexual addiction, detrimental gambling is characterized by increased and persistent use over time despite negative consequences. Undoubtedly, this behavior will be exemplified through a loss of control, and repeated attempts to stop gambling without success.

Although substance abuse continues to account for a significant loss to organizations through mental health claims, greater attention is now being given to other diagnoses and compulsive behaviors, including gambling. Approximately one in every 20 employees in the workforce has a gambling problem. Unfortunately, many organizations are guilty of minimizing the seriousness of gambling, focusing primarily on substance abuse.

EAP ASSESSMENT. The EAP may encounter the compulsive gambler through numerous avenues. With the gambler masked in denial, a supervisor, friends and/or family members may spot the problem first and call upon the EAP to assist in an intervention. More commonly, however, individuals access the EAP voluntarily, seeking relief from financial or legal difficulties or displaying addictive or compulsive patterns and behaviors not related to gambling. Referral also may result from continued work performance problems. For example, a compulsive gambler's pilfering or stealing from within an organization may lead to a supervisor requiring a last-chance work agreement.

IDENTIFICATION SIGNS. It is crucial that the EAP conduct a thorough and comprehensive diagnostic assessment, regardless of whether EAP clinical involvement will include assessment and referral or short-term counseling. Early and effective intervention identifying compulsive gambling patterns will help reduce the cost and frustration of a misdiagnosis. According to Wexler, whose organization annually fields 22,000 calls for help from problem gamblers, the typical profile of a compulsive gambler in 1992 read:

- predominately male (80 percent);
- average age between 21 and 30;
- a high level of energy;
- an IQ over 120;
- an extremely competitive personality;
- a history of gambling before the age of 14;
- frequent financial risk-taking behaviors;
- an average gambling debt of $34,244; and
- an average annual income of $36,944.

When assessing the existence of a possible gambling disorder, it is important to collect a thorough history of gambling practices, probably through a simple gambling screen that will detail an individual's gambling patterns. Also, one should identify the various forms of gambling that a client has

By Richard F. Paul, MSW, LSW, CEAP

participated in.

Often there is a progression in compulsive gambling from smaller dollar amounts in playing lotteries, bingo and cards to greater dollar amounts involving various sports, betting with "bookies" and casino gambling. In addition, this progression is coupled with increased risk-taking in the client's behavior.

The identification of problem gambling should not be limited to the conventional stereotypes of the back-alley, underground gambling world. Because gambling extends across all socio-economic classes, it may involve varied forms, ranging from track betting to involvement in the stock or commodities markets.

CD PARALLELS. While gambling, compulsive gamblers experience a "high" or euphoric state similar to that obtained from the use of drugs or alcohol. This euphoric state is often of short duration and great effort is devoted to achieving and maintaining it.

"The euphoria associated with compulsive gambling is related to endorphin release. This is characterized by elevated subjective excitement and physiological arousal. Endogenous endorphins, which have been implicated in chemical dependency, produce effects similar to exogenous opioids. Subsequently, gambling can elicit stimulating, tranquilizing or pain-relieving responses, or all three simultaneously. Therefore, withdrawal symptoms associated with the cessation of gambling are related to the accompanying endorphin deficiency" (Wexler & Wexler, 1992).

EAP ASSESSMENT. For the EAP assessing the existence of a gambling disorder, the warning signs may range from blatant to nearly obsolete. In addition to the work-related concerns, there may be subtle lifestyle patterns indicating a possible gambling problem. A compulsive gambler frequently lives life vicariously and may appear to the outside world as "having it all together." In addition, these individuals may attempt to live a life of extravagance by purchasing expensive material items that appear to be beyond their financial means. Ironically, as quickly as they may make such a purchase, they may lose it due to gambling losses, repossession or foreclosure.

Additional warning signs that the EA practitioner should watch for include references to the words "good luck" or "bad luck" when referring to life's aspirations or achievements. Furthermore, the compulsive gambler will frequently make excuses for his or her problems either at work or at home.

One assessment tool EAPs may have easy access to is the *Diagnostic and Statistical Manual of Mental Disorders.* According to the American Psychiatric Association, the diagnostic criteria for pathological gambling is indicated by at least four of the following:

(1) frequent preoccupation with gambling or with obtaining money to gamble;
(2) frequent gambling of larger amounts of money or over a longer period of time than intended;
(3) a need to increase the size or frequency of bets to achieve the desired excitement;
(4) restlessness or irritability if unable to gamble;
(5) repeated loss of money by gambling and returning another day to win back losses;
(6) repeated efforts to reduce or stop gambling;
(7) frequent gambling when expected to meet social or occupational obligations;
(8) sacrifice of some important social, occupational or recreational activity in order to gamble; and
(9) continuation of gambling despite inability to pay mounting debts, or despite other significant social, occupational or legal problems that the person knows to be exacerbated by gambling.

THE GAMBLER'S LIFE. The compulsive gambler's life is characterized by instability, both financial and emotional. This chaos and insecurity from day to day often provides the catalyst for tendencies toward extreme anger and rage followed by periods of depression. The gambler may express feelings of helplessness and hopelessness at the loss of control that he or she is experiencing.

In the later stages of this progressive disorder, gamblers may express suicidal thoughts, or perhaps even act upon them. These shame-based emotions may be accompanied by extreme feelings of guilt, particularly if there has been involvement in illegal activities. To alleviate the negative emotions and feelings, the gambler may turn his compulsive behavior toward other detrimental activities. Many gamblers seek relief or escape from their gambling by overeating, chemical dependency or a sexual addiction. Due to the nature of addictive personalities, one must assess for the risk of a cross-addiction when identifying a gambling problem, as well as throughout the course of recovery. It is estimated that between 19 percent and 33 percent of people attending chemical dependency treatment programs suffer from compulsive gambling (Smith, 1992). When the addictive and compulsive behaviors of a gambler have been identified, the EAP should also rule out any characterological and/or personality disorder contributing to such behavior, such as borderline or antisocial tendencies.

Compulsive gamblers will undoubtedly display textbook examples of denial. Similar to the alcoholic who may hide bottles of alcohol, compulsive gamblers may hide betting slips, lottery tickets, gambling money and other indicators of gambling from their spouse, children and other important persons in their lives. By including a "significant other" in the assessment process, EAPs may discover marital discord or relationship difficulties centered around gambling. In addition, a compulsive gambler may express feelings of guilt about the way in which he or she gambles and the consequences of the gambling.

Perhaps the most crucial areas to assess when identifying a compulsive gambler are the legal and financial consequences of his or her behavior. Severe legal and financial difficulties typify the later stages of a long history of problem gambling. Financial warning signs may include: borrowing on one's checking account, passing bad checks, selling personal and/or family property, cashing in stocks, bonds or other securities and using credit cards excessively. In addition, problem gamblers may have borrowed large sums of money from banks, loan companies, credit unions, friends and/or family members. Moreover, at times of extreme desperation, a gambler may resort to the resources of loan sharks. Ultimately, financial difficulties stemming from gambling may result in filing for bankruptcy. Despite the recent trend in many cities to legalize various forms of gambling, there continues to be a strong

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When paychecks are lost to problem gambling, everyone in the family loses. Help the gamblers in your workplace, before they break the wrong bank.

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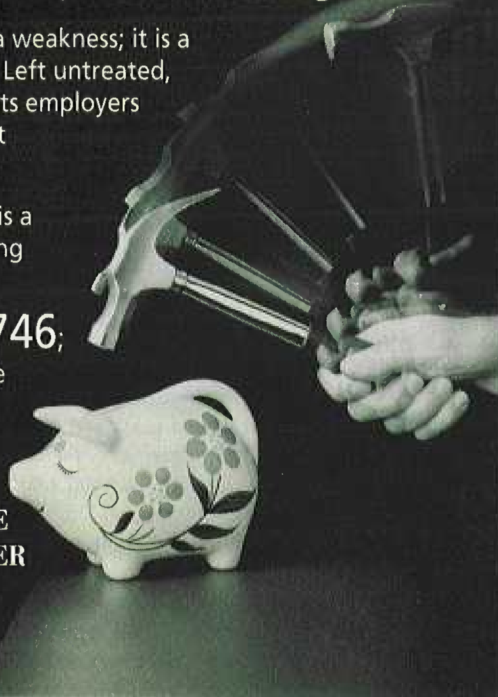

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presence of illegal gambling. Illegal, underground gambling exists primarily as a result of a wide variety of betting options and often a very high betting limit that feeds the compulsive gambler's need to take risks and make the big, break-even score.

EA practitioners' assessments may uncover clients' involvement with illegal sources of gambling. Also, they may uncover clients' legal difficulties resulting from charges of stealing and/or embezzlement to support their compulsion to gamble.

EDUCATING EMPLOYERS. Although compulsive gamblers are not a population frequently identified as problematic by an organization, identification of these employees may expose greater underlying work-performance problems and issues. The EAP can play an invaluable role by educating supervisors and managers of the warning signs of compulsive gambling, if they suspect an employee has such a problem. In addition, by merely providing quality supervisor training and instruction on appropriate referrals, an individual's gambling problem may subsequently surface.

Supervisors should document work-performance problems which may include: frequent and excessive telephone use, extreme mood swings, decreased productivity and the excessive borrowing of money from co-workers. Individuals with a gambling problem may also brag about gambling wins or display depressive symptoms following a significant loss. Furthermore, the gambler may display poor concentration on work, moodiness, irritability and an intense preoccupation with "breaking even." As a gambler's compulsive behavior progresses, he or she may have frequent absences, as well as problems with tardiness or job abandonment.

Through supervisor referrals, an EA practitioner can effectively monitor the employee's behavior and work performance, while coordinating the appropriate resources and treatment for a compulsive gambler. The gambler's denial and fear of being exposed may result in client resistance and anger. These feelings may be heightened when referred by a supervisor. In collaboration with human resources, the EAP can assist an organi-

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Women Gambling On Escape

The term "gambler" has traditionally been associated with the male population. "Gambler" usually conjures up a macho image of a man figuring the odds for the next big game; betting at the blackjack table; or spending hours at the racetrack. The "compulsive gambler" is even more strongly stereotyped as "the man about town."

The truth is that with the proliferation of gaming opportunities and the increased independence of women, the number of female gamblers is clearly on the rise. Moreover, women can be just as vulnerable as men to crossing the line from gambling as recreation to gambling as obsession.

Female problem gamblers generally present a different profile than most of their male counterparts. They are usually dependable and steadfast in their duties, and quiet, not wanting to be singled out. Those treated at Valley Forge Medical Center have been employed in many different positions. The common thread is that they are trusted and valued employees, and thus, often have access to the company's money stream.

Our experience indicates that female gamblers also tend to gamble differently than males. While men are generally after "the big win," women tend to be low rollers. To some extent, this is a function of the kind of gambling available to them. Responsibilities at home and work can place severe limits on the amount of time women have to gamble, so that easy access is important. Local bingo games, video poker machines and lotteries are among the most accessible and popular gambling activities for women. Their gambling takes the form of betting every day with reasonably controlled amounts of money. This activity can remain undetected for years, as money is diverted in small sums from household expenses, children's allowances, "pin money," or petty cash.

Women seldom seek limelight or success through their gambling. What they are seeking, at least temporarily, is a way out of their situations. They gamble in reaction to something intolerable to them. It may be a workaholic, absentee husband; an "empty nest" created by children leaving home; a dear friend moving away; divorce; or the death of a relative or friend.

Gambling is an escape from these and other difficult situations. Ironically, it is the only aspect of their lives where they feel in control. Everywhere else they see themselves as victims, trapped by other people's expectations of them. Rather than shun their obligations (unthinkable to them), they gamble to alleviate the stress of each day.

Maintaining a facade of normalcy at work and at home takes a tremendous toll on all gamblers. Associated emotional problems—loneliness, low self-esteem, depression, feelings of being inadequate, unappreciated or misunderstood—continue to fester while the gambling action gains a greater hold over their lives. This is particularly harmful for women because their gambling tends to be long term. The passage of time, coupled with the burden of finding money and time to gamble, exacerbate these other conditions.

Eventually, though, an incident occurs that brings the female gambler's world crashing down: money is discovered missing at work; household finances are inexplicably depleted; children experience severe problems at school or socially; or relationships fall apart completely. The woman responds by gambling more with drastic consequences for herself and her family.

The challenge for the business community is to be mindful that women can, and do, get caught in this web. Since gambling is so rarely associated with women, it is simply overlooked when unexplained financial difficulties or other related problems begin to surface. On the whole, professional treatment for compulsive gambling is still relatively new, with limited specialized programs or self-help options available nationwide. However, there is an increasing need for such treatment as problem gambling spreads throughout society.

Undoubtedly, EAPs, human resource executives and others in the workplace will encounter more individuals who cannot control their gambling activities. The goal is to be proactive in creating a work environment that promotes awareness of the dangers of compulsive gambling and encourages both men and women to seek help early, before the results devastate everyone involved.

—J. Kenneth Nelson, MD, assistant director of psychiatry and the director of gambling treatment program at Valley Forge Medical Center & Hospital in Norristown, Pa.

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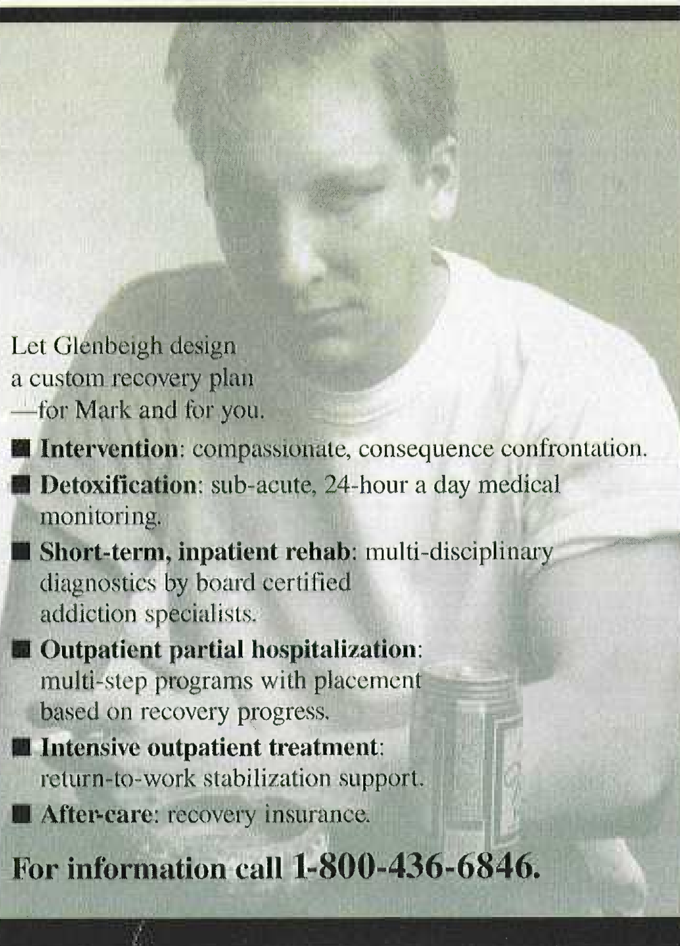

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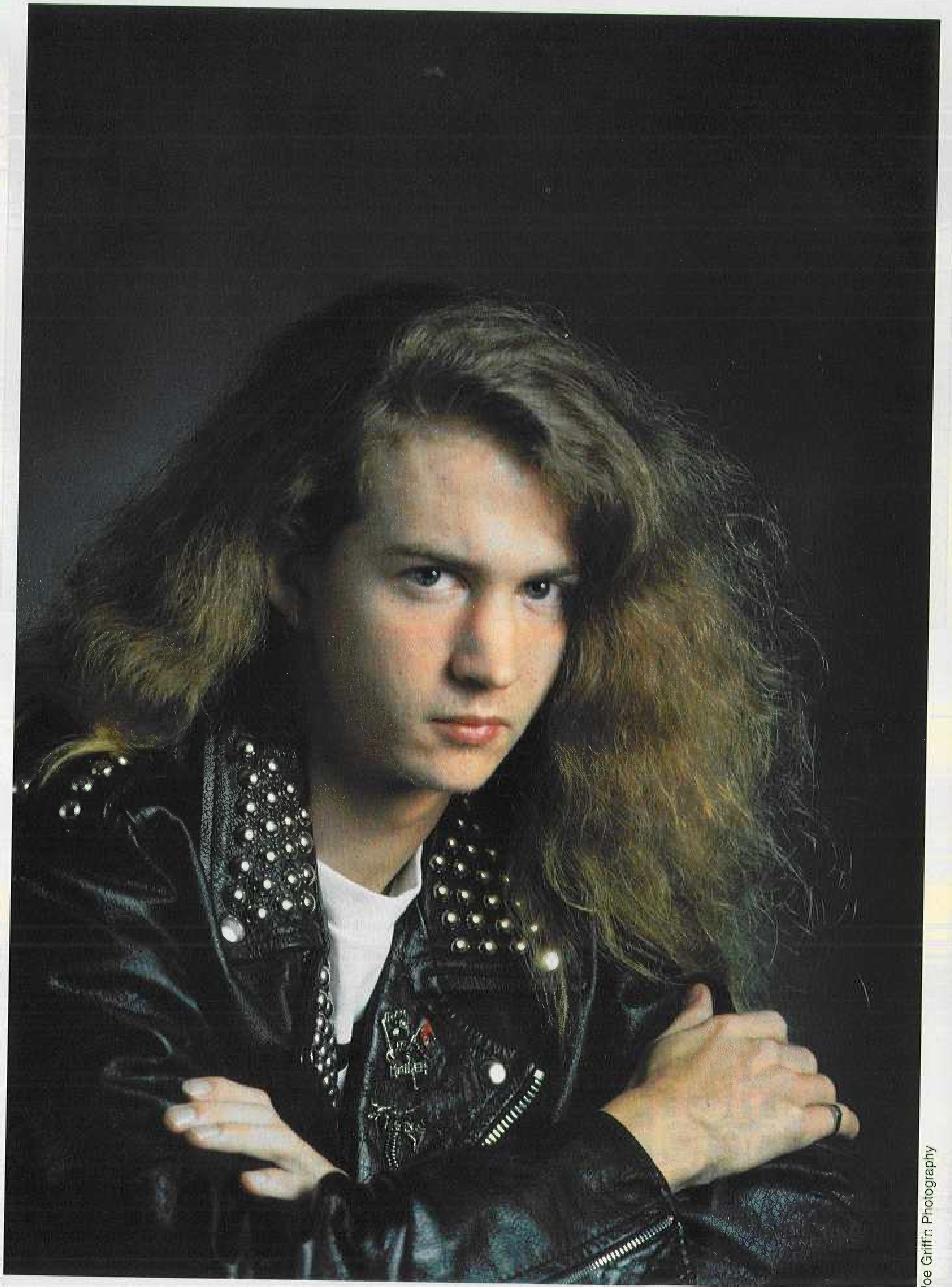

Joe Griffin Photography

Negotiating Reality

Therapy Offers Change Without Coercion

By Gregory L. Malone, MEd.

Working with emotionally disturbed youth can be monumentally difficult; it requires a great deal of patience and skill to help them regain effective control of their lives. Typically, such youth have poor peer relationships; are impulsive; are angry, bitter and resentful toward adults; are oppositional and defiant; are easily distracted; do not tolerate frustration well; and exhibit low self-esteem. Their behavior is self-defeating as they act in ways that are clearly in opposition to their self-interest. These features and their accompanying behaviors—which we commonly call "acting out"—are of special interest to those of us who are charged with trying to alter them.

An understanding of "control theory" and "reality therapy," a method of psychotherapy developed by psychiatrist William Glasser, can give mental health providers an alternative approach to adolescents who do not respond to more traditional treatment modalities. Treatment does not occur just in

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Resource Materials for the Human Services Professional

HIV and the Adolescent

In response to the growing incidence of HIV among adolescents, the New York State Department of Social Services is offering new resource materials for the social services professional who works with this age group.

HIV Infection and the Adolescent provides detailed information on HIV/AIDS, adolescent development, HIV prevention strategies, legal issues, and implications of HIV infection. A bibliography and list of community resources are included in this 119-page manual.

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treatment sessions, it also occurs throughout the day as the staff and clients go about the business of living and interacting in the treatment setting.

Control theory and reality therapy give both the staff and clients a common language and frame of reference as they negotiate their way through the tasks and obstacles of daily living. Because reality therapy is not done *to* someone but *with* someone, it promotes a sense of partnership and mutual respect that is a critical element in teaching clients how to establish and maintain meaningful relationships and how to meet their needs in healthy, satisfying ways.

BASIC NEEDS. Glasser argues that we are driven by our genes to satisfy basic physical and psychological needs. He asserts that all behavior is an attempt to meet these needs. This is easily understood with physical needs. If we were not driven to satisfy our hunger, we would starve. Our physical needs are defined by survival functions that are clearly understandable. It is not so apparent that we are every bit as compelled to meet our psychological needs. They too have a survival function that makes them a commanding force in our lives on a par with our physical needs. If a basic need, either physical or psychological, goes unsatisfied for a period of time, our brain sends signals directing us to meet that need; the longer the need goes unsatisfied, the more impelling the signals.

Glasser identifies four basic psychological needs: power, belonging, freedom, and fun. Counselors should help adolescents understand what their needs are—the greater their understanding, the more likely they are to cooperate as they are encouraged to satisfy their needs in healthy ways.

- **Power:** The need for power can also be described as the need for competence or recognition. We desire acknowledgment; our brain impels us to act in ways that cause us to be recognized by others.
- **Belonging:** This need is often referred to as the need for love. We want to be connected with other people in a significant and meaningful way.
- **Freedom:** The need for freedom describes the genetic drive to want choices and options.
- **Fun:** This need might also be described as pleasure or recreation. All

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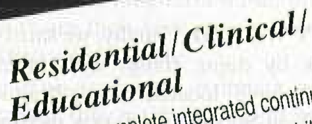

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too often people view fun as expendable. Glasser views it as a basic need. In other words, the need for fun is no more optional than the need for food.

Basic needs often conflict. One physical need may conflict with another, one psychological need may conflict with another; or a physical need may conflict with a psychological need. Both physical and psychological needs must therefore be balanced.

QUALITY WORLD. Usually, we satisfy our needs by doing things with other people. We have, located in our brains, what can best be described as a picture album. In this picture album we store images of activities that fulfill our needs. Our albums contain a vast number of pictures. In it might be a picture of eating a medium-rare steak, playing a guitar with a friend, running a marathon or writing an article on control theory. All of these pictures are of activities we have found to be, or think might be, need-fulfilling. Many of these activities satisfy more than one need. Glasser calls this picture album our quality world.

As we move through a day, we constantly monitor the real world through our sensory system. We compare this information with the pictures in our quality world. If there is a match between our sensory information and our pictures, we receive signals that we experience as happiness, contentment and satisfaction. If there is not a match, we receive error signals. Error signals are as unpleasant as match signals are satisfying. Error signals often generate feelings and thoughts, to one degree or another, of being out of control; they are always experienced as an urge to act. The goal of this behavior is to change the real world in ways that will produce a match between reality and our quality world.

TOTAL BEHAVIOR. The behaviors used to change the real world are composed of four components: physiology, emotion, thinking, and doing (conscious and voluntary activity). Although these components are separate, they are connected; if one component of behavior changes, the others change. Because of the way our brains are structured, the components that affect thinking and doing are the most accessible and controllable.

Control theory now gives us a model

to examine the seemingly irrational behavior of emotionally disturbed youth. When troubled youth receive an error signal, the behaviors they use to change the real world are often heavily weighted with physiological and emotional components. Their faces turn red, their blood pressure rises, their veins stand out and they scream and rage. These are the behaviors they use to change the real world so they will get a match between reality and their pictures. While ineffective in any long-term sense, these behaviors are their best attempts to deal with their error signals.

This leads to a hallmark of troubled youth: they meet their needs in ways that are destructive to themselves or others. Youth who satisfy the need for power by cheating at games severely limit their ability to meet their need for belonging and fun—no one wants to play with them. However, cheating does, in a very real but short-term way, meet a need. Similarly, youths who steal, thus meeting their needs for power and fun, will likely lose their freedom.

The behaviors successful people use to meet one need often enhance their ability to meet other needs. For example, successful people often meet their need for power by performing well at their job, which, through a paycheck, more effectively allows them to meet their physical needs and enjoy more recreational options (both fun and freedom). Our job as youth-workers is to help troubled youth understand their basic needs and to teach them healthy, long-term ways to meet them.

RESPONSIBILITY. Reality therapy is ideally suited for such a task. The goal of reality therapy is to help the youth assume responsibility for meeting his or her needs by using long-term, effective and responsible behaviors. Because people have the most control over their thinking and doing, reality therapy focuses on changing these components.

For reality therapy to be effective, the counselor must establish a significant relationship with the client; in other words, the counselor must become a picture in the youth's quality world. Glasser refers to this as establishing the counseling environment. He believes that teaching a client to effectively control his or her life depends on being involved with that client. Through a

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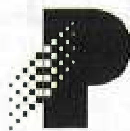

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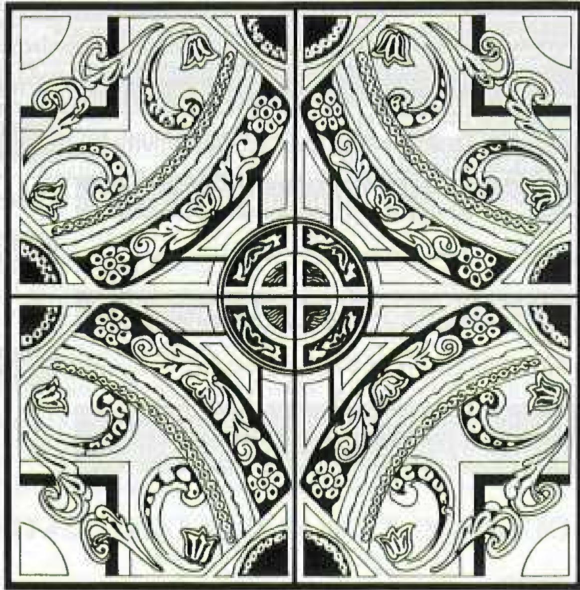

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series of questions, the counselor helps clients identify what they want and what behaviors they are using to get what they want, and then, helps them make a judgment about whether those behaviors are effective in the long run.

Although the counselor listens compassionately to the client's story and feelings, the counselor doesn't want the youth to get stuck in the past or become too focused on feelings. People cannot change the past and they have little control over their feelings. The counselor does believe that if adolescents use more effective behaviors in the present to meet their needs, their feelings will change for the better.

A THERAPY CONVERSATION. The following is a composite of conversations our staff members have had with youth regarding their involvement with poor peer groups.

The counselor has worked with Jamie for three months, knows him and his background well, and has a good relationship with him. Jamie likes his counselor, but does not get along well with other group members; he is aloof and projects an air of contemptuous superiority. The counselor has just delivered mail to the group. Jamie doesn't get a letter, curses, pushes a group member and storms off. The counselor gets Jamie back to the group and begins a counseling session using his knowledge of control theory and reality therapy.

Counselor: What's going on, Jamie?
Jamie: I haven't gotten a letter from my folks in two months. I write them every week. I hate their guts, and I hate this (expletive) place too. You just wait, I'm running away tonight.

This statement gives the counselor critical information. In Jamie's quality world, he is connected to his parents. They love and care for him. They think he is important enough to recognize by writing letters. Jamie's immediate picture was one of receiving a letter from his parents. When Jamie doesn't, his brain sends out an error signal. This signal is painful and experienced as an urge to misbehave. The behaviors Jamie uses to regain some control are to curse, push people, storm off and think about running away. In short, Jamie is using anger as his response to the error signal. Jamie has no control over the initial error signal;

he does, however, have control over the behaviors he uses when he receives the signal.

Counselor: What would be different in your life if you ran away?
Jamie: Man, I know people. Do you think I need my folks or this crappy place? I've got friends who care about me.

Now the counselor is beginning to home in on the needs Jamie is not satisfying. In other words, the counselor is helping Jamie figure out what he wants.

Counselor: Jamie, are these the same friends you were hanging out with before you came here?
Jamie: So what? At least they care about me and don't treat me like dirt.
Counselor: Let me make sure I understand; you want to be connected to people who are important to you and you want these people to care about you. Is that right?
Jamie: Yeah.

The counselor now has an explicit statement from Jamie about what he wants.

Counselor: Okay, lets look at that. You want to be connected with people. When you were home, how did you do that?
Jamie: I hung out with my friends.
Counselor: Right. And when you were with them, what kind of things did you do?
Jamie: We broke into houses and stuff.
Counselor: What happened because you broke into the houses?
Jamie: I got sent to this program.
Counselor: So when you were with them, you felt important and connected when you would do things with your friends that hurt other people and that put your freedom at risk. Is that right?
Jamie: Yeah.
Counselor: And when you didn't get a letter from home, what did you do?
Jamie: I cussed, pushed Billy, and threatened to run away.

The counselor is helping Jamie identify the behaviors he is using to satisfy his needs.

Counselor: So, these things you are doing, are they working? I mean, are they helping you be connected with people in ways that also don't interfere with your ability to be free and make choices?
Jamie: No, they're not working too well.

This is a crucial part of reality therapy. Jamie has placed a value judgment on the behaviors he is using to meet his needs.

Counselor: If we could figure out some ways to be connected to some people who are important to you in ways that also will help you be more free, would you be interested?
Jamie: Yeah.

The counselor now has Jamie's agreement to explore new and healthier ways to meet his needs. Because there is a partnership between Jamie and the counselor, Jamie is much more likely to follow through with the plans he develops with his group and counselor. The plan the counselor and Jamie develop will have three thrusts.

First will be to explore ways to help Jamie get a better relationship with his parents. However, this might not be sufficient; Jamie doesn't have control over what his parents do. While Jamie might want a better relationship with them, they may not want a better relationship with him.

Therefore, the second part of the plan will be to help Jamie develop some satisfying relationships with people in his community.

Finally, remembering that needs must be satisfied on an every-day basis, the third part of the plan will involve helping Jamie develop more satisfying relationships with his group members. The plan will focus on the doing and thinking components of Jamie's behavior.

In conclusion, EAPs should note that emotionally disturbed adolescents are both remarkably vulnerable and remarkably treatable. They are flexible, impressionable, elastic and resilient. While they often bend into bizarre shapes, they are still malleable enough to return to conventional appearance when given opportunities through reality therapy to talk about and discuss their needs, their options and their choices. Underneath their resistance and hostility, they are often anxious for guidance from someone who will help them change without coercing them to do so. If therapy is offered in this spirit, adolescents respond in a most gratifying manner. They become a partner with us in their treatment and therapy. Their behavior, their productivity and their degree of happiness often change markedly for the better in a short period. EA

Malone, MEd, is director of training at Eckerd Family Youth Alternatives Inc., in Clearwater, Fla.

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SECAD-1993 comes to Atlanta December 1-5 to offer treatment professionals and others concerned with addiction diseases the opportunity to earn professional credits and insight into the field.

Since 1975, SECAD has provided professionals with needed information on alcohol and drug abuse. Charter Medical Corporation is sponsoring this year's conference and the American Society of Addiction Medicine will co-sponsor.

For the first time, the Marriott Marquis in Atlanta will host SECAD and the 130 plus exhibits involved. The cost of the four-day conference is $400 and includes all day and evening sessions; all conference materials; admission to the exhibit area; the reception Wednesday evening; lunch Thursday; and breakfast Sunday morning.

SECAD will explore topics, such as sexual addictions, intervention, codependency and eating disorders, in addition to several others. Some of the sessions include: "The Impaired Professional and AA" (Special Problems—Special Groups); "Pharmaceutical Management of the Chemically Dependent Patient"; "The Compulsive Gambler"; "Out of the Darkness: For the Elder Alcoholic and Drug Abuser"; "Addiction Recovery in the '90s"; "Management of a Day Hospital Treatment Process: Case Reports and Outcomes"; "Negative Biopsychosocial Consequences and the Maintenance of Addictive Behaviors"; "The Impact of Unresolved Grief, Abuse and Violence on Recovery"; and "The Dually Diagnosed Woman in Treatment."

Some of the speakers include: Terence Gorski, MA, NCACII; Lynn Hankes, MD; David Mee-Lee, MD; John Wallace, PhD; Father Joseph Martin; C.C. Nuckols, PhD; LeClair Bissell, MD, Brenda Williams, NCACII, CCS; Earnie Larsen, MRE, Claudia Black, MSW, PhD; James Bartling, PharmD; F. Hal Marley, EdD; Merrill Norton, RPh, NCACII; and Michael J. Bouldoff, MD.

Mac Crawford, chairman, president and CEO of Charter Medical Corporation, will deliver the conference welcoming, followed by a presentation titled "Feelings" by Father Joseph Martin, consultant and educator on alcoholism, and president of Father Martin's Ashley at Oakington at Havre de Grace, Md.

Special guest Larry Gatlin, lead singer for Larry Gatlin and the Gatlin Brothers, will speak Friday evening, presenting "Hi, I'm Larry and I'm an Alcoholic."

Professional credit is available for physicians, nurses, counselors, pharmacists, psychologists, social workers and certified EA professionals. Further information is available through the toll free registration number.

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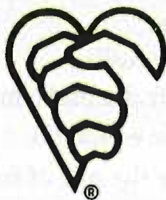

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It's Time for a Summit

By Bradley K. Googins, PhD

When President Clinton announced the first economic summit with much fanfare, I doubt he had any idea he was introducing a new forum for examining issues. Since then, there have been summits on the environment, kids, a second economic summit, a mental health summit, and so on. Like so many good ideas, the rush to copy them trivializes the uniqueness, and we soon become overexposed and plain sick of yet another one.

Having said this, let me now contradict my argument and suggest that it really is the time for a summit of those in the employee assistance field. Over the past three years to five years, there have been so many major developments affecting the broad agenda of workplace substance abuse, that the major players in this field need to come together to examine both the nature of these changes, current trends and future directions, and the impact, negative and positive, that continues to transform this field.

The call for a summit begins with a basic observation. The field of employee assistance in 1993 is barely recognizable compared to the field as it existed as recently as five years ago, in 1988. These intervening five years do not reflect the inevitable changes experienced in any half decade. Instead, they reflect some of the most dramatic changes one might experience once in a lifetime. It is precisely because this is not an ordinary time, reflecting ordinary changes, that a summit is needed to take stock of these changes and to bring out new and fresh thinking on how to respond to the transformations that are occurring, both inside and outside EAPs.

The first thing the proposed summit should consider is the nature of the changes that have taken place. Examine first a major shift in the area of substance abuse. What have you heard recently about the "War on Drugs?" Whatever became of the highly touted "Say no to Drugs" campaign? With the change of administrations in Washington, a dramatic reversal has begun to take place reflecting both the mood of an electorate, which has tired of yet another war in which America is bogged down and not showing much success. The new drug czar has indicated a turnabout from the interdiction-and-supply strategy of the Bush and Reagan years to an emphasis on treatment and curbing demand.

On the "street," events have also shifted from the perception of a widespread epidemic that spurred the War on Drugs, to a "ghettoization" of illegal drugs, primarily within the inner city and lower socioeconomic groups. At the same time, alcohol, the most widespread drug of all, has returned from obscurity to reassume its rightful place as king of the drugs. This is particularly reflected in statistics on use by school-age children and in colleges where widespread, heavy drinking, in place of cocaine and other so called hard drugs, is now of great concern.

In the workplace, another series of events has transformed substance abuse from illegal to legal and from higher rates to lower rates of reported problems. Few protested very loudly in the mid-1980s when the war on drugs turned to a drug-free workplace. The advent of drug testing and screening met with little resistance despite virtually no evidence of need or efficacy. When drug screening programs were adopted, they offered parallel programs with the EAP but with vastly different philosophy and methods of intervention. The mania of the war on drugs, however, muted any opposition. Today, drug testing is limited primarily to pre-employment screening, and given the economy in which there are few new hires to begin with, the result is a relatively inactive campaign.

Perhaps more disturbing are the widespread reports of decreased drug and alcohol cases within the EAP. While there is little acknowledgement of this within the EAP field and denial around this issue is high, what lies at the root of this decrease is not clear. How to confront this development and what strategies are needed is even less clear.

EA PROGRAMS. Any summit will have to contemplate the enormous changes that have swept over the EAP field in just the past several years. At the top of the agenda is managed care which continues to transform and reconfigure EAPs far beyond their simple mission of addressing substance abuse within a work context. Integrated care, utilization review and regulation of utilization review have brought into existence not only a new framework for EAPS, but in essence, a new platform upon which to stand.

EAP core technology, first articulated and adopted only a few years ago, is scarcely referred to these days. What the boundaries, mission and nature of the EAP are, is becoming less clear. Can anyone really show me the rudiments of the EAP profession? The swallowing up of EAP external vendors by increasingly larger national firms points to an uncertain direction and future. Are internal EAP models fast becoming rusty relics of a past age?

There is much to contemplate about the EAP world at this summit, not the least of which is the evolving nature of the EAP and its core. While a case can be made that the events surrounding the transformation of EAPs are either inevitable or for the good of employees, there appears to be a number of downside issues. Of particular importance is why the EAP field is no longer in charge of its future. How we got to this situation and what points of leverage remain should be put squarely on the table at this summit so the EAP field can think, with some reflective certainty, that it is in charge of its own destiny.

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BHT Conference Offers MC, EAP Dialogue

Dr. Michael A. Freeman, president of the Institute of Behavioral Healthcare, opened the conference with a forecast on the national healthcare reform's possible impact on restructuring. The various symposia and workshops brought experts from managed care, providers, EAPs and benefits to examine new models of care, new systems and new partnerships.

Freeman explained that the emphasis on reducing the cost of behavioral healthcare will require new models of care that home in on reducing the overall demand rather than applying managed care strategies after the need has occurred. These models would refocus solutions to problems related to some of the major cost factors: lack of prevention, high-risk health behaviors, regional inequities and terminal illnesses.

The Health Project, a voluntary consortium of business leaders, health insurers, policy experts and government, represented by the Centers for Disease Control, and the Office of Health Promotion and Disease Prevention, presents a plan for proliferation of worksite health promotions.

Freeman and co-speaker Dr. James F. Fries, CEO of Healthtrac Foundation, also stressed overcoming the barriers to cost containment by emphasizing prevention and aftercare. The efficacy of control requires self-help guidelines to re-educate consumers to eliminate learned helplessness, he said.

The workshops provided a forum for discussing the increase in healthcare technology, developments with psychoactive drugs, risk management strategies, EAP-driven managed care and public/private partnerships, among others.

Consensus among speakers seemed to be that the door may be open to EAPs to assume a coordinating role, stretching from front-end prevention to monitoring and follow-up aftercare. There was also a hint that stepping into this role might be vital to the strengthening of EA as a profession.

MH Providers Note Improved UR Relations

The sixth annual survey of members of the National Association of Psychiatric Health Systems (NAPHS) found the relationship between mental healthcare providers, managed mental healthcare and utilization review firms has been steadily improving.

Seventy-eight percent noted improvement in the relationship over the past year, in the *NAPHS 1993 Survey Report on Utilization Management Firms Conducting Psychiatric Review*, which polled 141 NAPHS members. This is an increase from only 36 percent, who noted improvement in 1992.

The improved relations occurred in spite of respondents' observations (94.2 percent) that the use and/or impact of outside UR firms increased.

The number of clinicians preforming the reviews has also increased. With 70.5 percent reporting the outside reviewers "often" or "always" were clinicians. In 1990, 75 percent said "sometimes" or "often" they were non-clinicians.

Those surveyed also reported managed care firms are becoming more responsive to complaints of inconsistent, unknown or unwritten evaluations used in patients' reviews. Similarly, outside firms are exercising more flexible benefits by selecting treatments according to the individuals.

Concerns about the time and resources consumed by outside utilization firms and the affects the firms have on patients' overall care topped the list of areas needing improvement. Gatekeeping and the risk of undertreatment for the patients also concerned survey respondents.

Benefit Managers Share Views Of Health Reform

Employee benefit professionals expressed their fears about the Clinton healthcare plan in a survey taken at the 5th Annual Corporate Benefits Conference on September 20.

More than half of the 95 professionals surveyed think their companies will pay more under the Clinton plan than they are currently, and over 60 percent said if permitted, they would not join a healthcare alliance.

Only 34 percent of the companies represented will be eligible to form their own alliances under the present plan. Currently companies must employ no less than 5,000 people to have this option.

Forty-six percent do not believe the Clinton healthcare reform ideas will control healthcare costs better, according to the survey.

Conflicting opinions surfaced when the survey explored where the primary funding should be found. Shared employer/employee contributions led with 39 percent, followed by savings from other federal programs and profits from sin taxes.

EAPs, Managed Care Explored At Conference

In a step to institutionalize EAP education, the School on Management and Clinical Aspects of EAP Practice will hold its residential program April 24-29.

With the move toward managed healthcare, those working in EA or MMH programs will benefit from the school's emphasis on building networks needed by corporate clients. The conference, sponsored by the University of Maryland, offers a balance of management and counseling courses focused on EAP practice. Tenured and tenure-track professors with EAP and similar management fields will teach the courses.

Dale A. Masi, the program director and University of Maryland professor, is the president of Masi Research Consultants Inc. and has written several articles and books relating to the EAP field.

For the first year, the conference will include a day in Washington, DC, where participants can explore EAPs in reference to public policy through briefings with top public officials.

Cost for the conference is $1,850 and includes living accommodations, meals, recreation facilities and program materials. The Maryland campus provides facilities for faculty presentations and living accommodations.

Registration information for the conference, held at the Maritime Institute Seminar and Conference Center in Baltimore,

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Employee Assistance Lives! Part 1

By Paul M. Roman, PhD

This is definitely a year of crisis and concern for EAP. In this magazine we read of the "disappearance of EA today." Nearly everywhere there is concern that healthcare reform is going to kill the EA field. But most of these doomsayers are wrong, due to a narrow vision of both the workplace and of EA work.

Too often these people are based in metropolitan areas, influenced by workshops for the Fortune 1000 and thinking they are on top of the latest transformations of the American workplace and of EA work. This is often seduction by self-styled gurus of a future that they will gladly shape for a handsome fee.

Indeed, there is a larger world out there, a world poorly represented by the faddish, "hot" management media and consultants' latest buzzwords.

But the doomsayers are getting the floor and getting attention. Their words can become self-fulfilling prophecies, especially as the EA world has become much less of a community and more of a Tower of Babel. Who is listening? And, to what?

So as a true believer, trying to lead a hearty little band that keeps telling me that this string of commentary is right-on, I am going to have to work at being more persistent and obnoxious. EA work is real. It is not dead. It is based on a heritage of strategies that now go back several decades, and it does not need to be recast or restyled in order to survive.

THE WORKPLACE REVOLUTION? One of the biggest irritants of the recent past is the conclusion by several of my colleagues that the workplace has changed dramatically before our very eyes, transformed into some combination of nirvana and hell. Here, on the one hand, supervision has vanished and the rank and file lives, eats and breathes quality. On the other hand, we are told that employers have stopped caring about employees and delight in turnover. I don't know where these places are, but I am sure these features do not describe the places where very many people work.

Certainly global competition has moved to center stage, and many comfortable organizations have found themselves fighting hard for their market share while downsizing rapidly. In such an arena, quality concerns are appropriately central. And once again, many managements are reviving time-honored and time-worn mechanisms to suggest more employee participation. Hard times for many, particularly for those who are not used to hard times, but a major revolution? Hardly.

EA ROLES IN TREATMENT. Quotes from the national media have asserted that in the eyes of workplace managers, the value of EAPs will diminish significantly through healthcare reform because EA staffs will lose their roles in selecting treatment. This is a terribly misguided vision, but its free-falling diffusion throughout the nation, seemingly supported by EA field leadership, is most frightening.

If newcomers and hangers-on who presume to speak for the EA field would only do a few hours of reading! EA work stands alone in two vital roles that have virtually nothing to do with any healthcare reform plan.

Specifically, if EA work is functioning as anything other than a conduit to treatment, it can vitally motivate employees to enter the treatment process. Likewise, EA work should be uniquely equipped at the "other end," namely to perform workplace follow-up.

Thus, EA work makes a huge contribution in cost-effectiveness in its roles of initiating treatment and sustaining recovery. But these words just go past the prophets bound to remake this field into some weird hybrid of direct treatment and benefits management, devoid of any real workplace content.

VALUE-ADDED EA WORK. I have always found it useful to consider the basic functions of EA work in terms of supervisory/line management functions and external care/benefits management functions. Three dimensions in the first category can survive as value-added and cost-effective dimensions of EA work, totally independent of healthcare reform.

Paramount among these is the EA staff's assistance to supervisors who are trying to deal with troubled subordinates. For those who say there is no more supervision in the workplace, let them apply this to work group peers.

We know inside-out that people of the cultural traditions of North America and Western Europe generally do not have readily accessible mechanisms to persuade the troubled amongst them that they need to do something about their problems. There is more than ample documentation that the amateur attempts at help rarely are effective and almost never are efficient.

So the need to provide guidance in how to deal with these troubles remains, and will remain, a central EA function. I have been told repeatedly by experienced EA workers, working as either internal or external providers, that the largest single block of their time is spent providing help to employees (usually supervisors) who don't know what to do about the employees. Value-added? Cost-effective? You better believe it, my workplace colleagues tell me. But don't expect to find testimony to this effect where EA work consists only of reactive counseling and treatment referrals.

DUE PROCESS. Closely linked to the provision of advice and direction to those who don't know what to do with the troubled worker is the paramount need to do it right. While attention is focused on efforts to reduce national healthcare burdens, there is little concern with beginning to curb the social costs and deterioration of

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social order produced by unbridled litigation.

Thus, it is critical for workplaces to deal with troubled employees in a consistent policy-driven manner. Due process means equity and it is a great concept. Use of EA opportunities has been repeatedly shown to be an effective buffer against later questions of harassment and discrimination. Value added? Take a look at employment-related lawsuits in companies with EAPs unconnected to the workplace or without them altogether.

TRAINING AND AWARENESS. The training of supervisors and managers is one facet of EAP work that seems to clearly draw the line between those who can be classified as clinicians and those who see a vital workplace connection in their activity. There are a very large number of EAPs that include no supervisory training component. Were I in charge of EAP standards, I would take steps to "de-certify" such alleged EAPs and make certain that they did not use the EAP label.

The key assumption underlying supervisory/management training is that use of the EAP reduces productivity losses, smoothes organizational functioning and reduces the likelihood of employee turnover. These are major reasons for both management and unions to support the presence of an EAP.

But this point seems lost on those who "know" that EA workers' singular roles are tied to linking employees with the right treatment. Indeed, it seems that many of these commentators are barely aware of what an operative EAP looks like.

To be sure, few have ever talked seriously to managers or union leaders in worksites where EA staff intervene early, seeking solutions to problems that, from a management perspective, are costly to the operation of the workplace. Without this experience, they have never heard workplace testimony about the tremendous value of EA work on everyday operations. Instead they define cost effectiveness only in terms of treatment savings.

Looking back 20 years, it is both saddening and hard to believe that EA work would diffuse to the extent that it has, and yet it would still be necessary to sermonize on the critical importance of supervisory training. Does the word "quality" ring a bell anywhere in the EA field?

RAYS OF HOPE. There is a final point for today, and a heartening one. Just as watching TV can make you sick with too much information about things that don't deserve so much attention, the national media about EA work would have us all wondering if we have some clean, dark clothes to wear to the funeral.

What "makes my day" is a chance to attend a meeting of a local EAPA chapter, as I recently did in Seattle. Here one sees the real life of EA work in action, and far more fundamental knowledge and good sense than seems forthcoming from the national soothsayers. Pay a visit to the trenches. The good action is still there.

Roman is a research professor of sociology and director of the Center for Research on Deviance and Behavioral Health at the University of Georgia.

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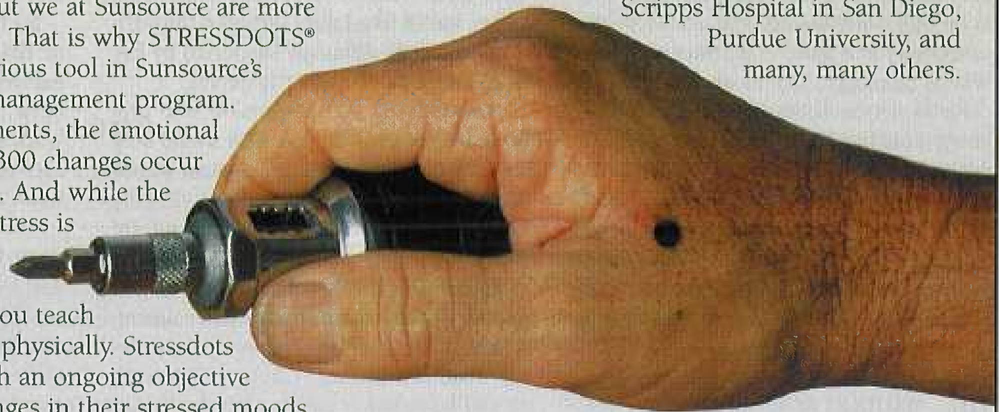

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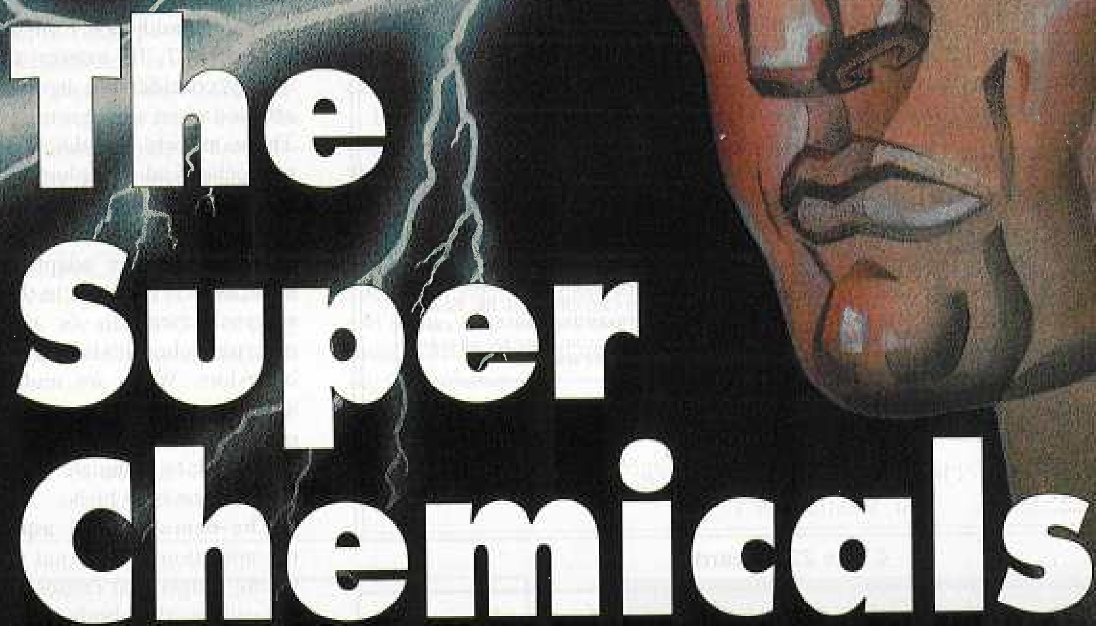

The Super Chemicals

EAPs, Clinicians Confront New Drugs and Components of Addiction

By Joel C. Robertson, PharmD

Most clinicians feel frustrated with the apparent lack of success with many of their clients. Perhaps one of the reasons is the tremendously potent chemicals that are available to these clients. These "super chemicals" have such reinforcing power over the body and mind that the EAP, clinicians and others working with these addicted persons must expand their knowledge to include an understanding of biochemical and neuropharmacological systems.

Although this article is not intended to be an exhaustive review of neuropharmaceuticals or new chemicals on the street, it is intended to lay a foundation for individuals interested in working with the addicted client. To understand the addictive potential of drugs, one must understand a bit about the workings of the brain.

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ADDICTION REVISITED. Based upon our old definition of addiction, a drug that causes tolerance and physical withdrawal will be physically addictive. A drug that creates reinforcement for its use will be psychologically addictive. However, that definition on its own doesn't explain why crack or cocaine are so addicting.

What is addiction from a biochemical perspective? To answer that question briefly, consider five aspects of the body affected when a drug is used consistently. These aspects of addiction include: 1. neurochemical or pharmacological, 2. cellular or enzymatic, 3. neurohormonal, 4. psychological (chemically mediated) and 5. end organ adaptation. Each of these aspects responds to the ingestion of external chemicals or the release of internal chemicals through certain behaviors. When we understand these aspects and how they are affected, we can understand why potent chemicals are so difficult to eliminate and why transfer of addiction is so high.

The neurochemical aspect is simply the addiction to external chemicals (by taking drugs) that causes a direct effect or causes the body to increase or decrease a brain chemical's effect on the brain. Therefore, chemicals that increase excitatory or decrease inhibitory neurochemicals will have stimulant-like properties. Those increasing inhibitory chemicals or decreasing excitatory chemicals will have a depressant-like effect. It is important to note that behavior, such as sexual or eating addictions, can also cause neurochemical alterations.

The cellular aspect is mediated through such enzymes as adenylate cyclase and the micro-enzyme oxidizing system. These enzymes increase or decrease the breakdown or activation of the brain chemicals. For example, if the body is continually pounded with an excess of excitatory chemicals, these enzymes will try to decrease the effect of these chemicals by increasing the speed at which they breakdown or by decreasing the activation of the chemical. This is, in part, where tolerance comes from. It also explains part of the cause of cravings and mood swings. Enzyme adaptation can take months to return to normal, thereby creating physiological voids of the chemicals that are withdrawn.

The neurohormonal aspect is also involved in the production of natural

brain chemicals. For example, if too many excitatory chemicals are ingested, the hypothalamus tells the adrenal gland to decrease production of epinephrine. Once again, this system will cause craving or mood swings because of the decreased or increased production of neurochemicals.

The psychological aspect is mediated through the reward center. Although not an identifiable center, per se, we do know that chemicals are released when something feels pleasurable to the person. These chemicals are related to the dopamine-methionine-endorphin system. That is why for some, stimulants may feel good, while for others, they cause too much anxiety. This reward center is based upon a person's "neurochemical personality" and is stimulated by behaviors or chemicals, thus causing transfer of addiction or recovery through alternative rewards.

For example, an "arousal" person is one who prefers excitatory chemicals. They are prone to addictions such as cocaine, crack, sex, gambling or risk-taking. "Satiation" persons prefer inhibitory chemicals, predisposing them to overeating, cleaning, perfectionism, control, alcohol and depressant addiction.

Finally, we have **the end-organ adaptation aspect**. In general the thyroid, adrenal gland, liver and other organs adapt to prolonged ingestion of chemicals, trying to decrease their effects. By eliminating a drug and not understanding the biochemical effects, we have mood swings and distortions of reality caused by physiological effects.

In essence, these five aspects are not treated with a purely psychodynamic or Twelve Step approach alone. We may be able to stop the neurochemical ingestion and alter rewards, but the physiological issues from the other elements need an additional recovery plan to keep a person from developing uncontrolled urges, mood swings, distortions in their thinking and relapse.

Since our new "super drugs" have such a dramatic effect on a person's physiological and psychological states, we need to treat these biochemical aspects of the person if we want recovery. This doesn't mean we eliminate our Twelve Step programs or psychodynamics, we just augment them. It is going to be increasingly difficult for the client to remain drug free with the newer pharmaceuticals and street drugs, if we don't assess and manage their physiological alterations.

ADDICTIVE DRUGS. Although we can still classify newer drugs into five major categories, the differences within each category will be in potency and addictive potential. Those categories are: 1. stimulants, 2. depressants, 3. narcotics, 4. hallucinogens and 5. mixed or unclassified.

In general, the new drugs, whether produced with the FDA's approval or on the street, are more selective in their action on the brain, causing them to be more powerful. By using more selective pharmaceutics, the dosage can be increased, thus a "high" produced, with a lesser degree of side effects. For

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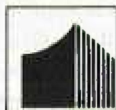

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