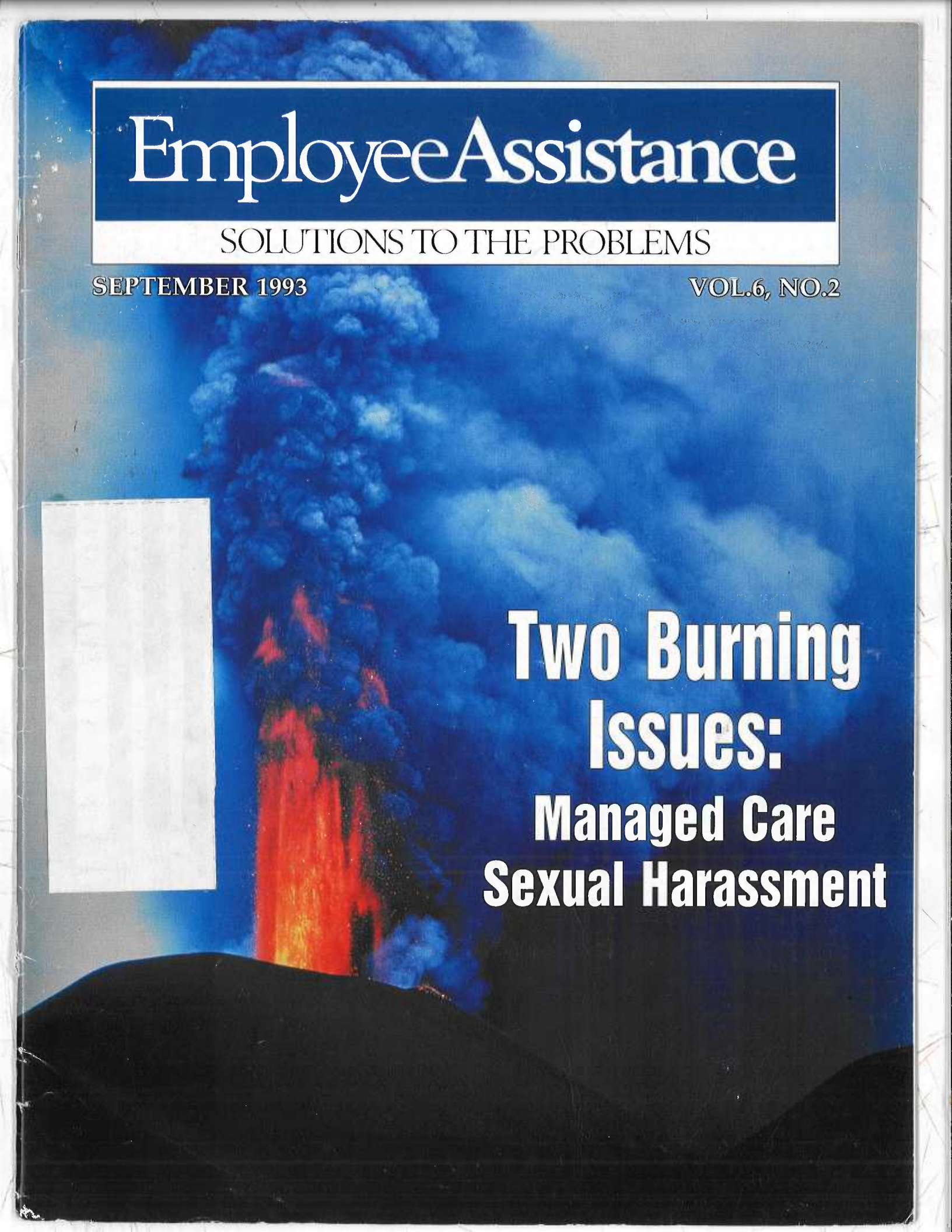


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SEPTEMBER 1993

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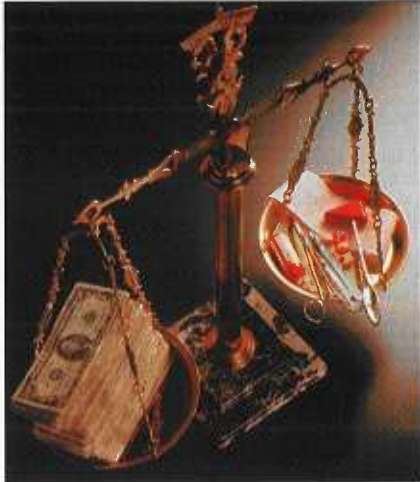
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Employee Assistance

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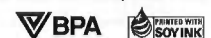
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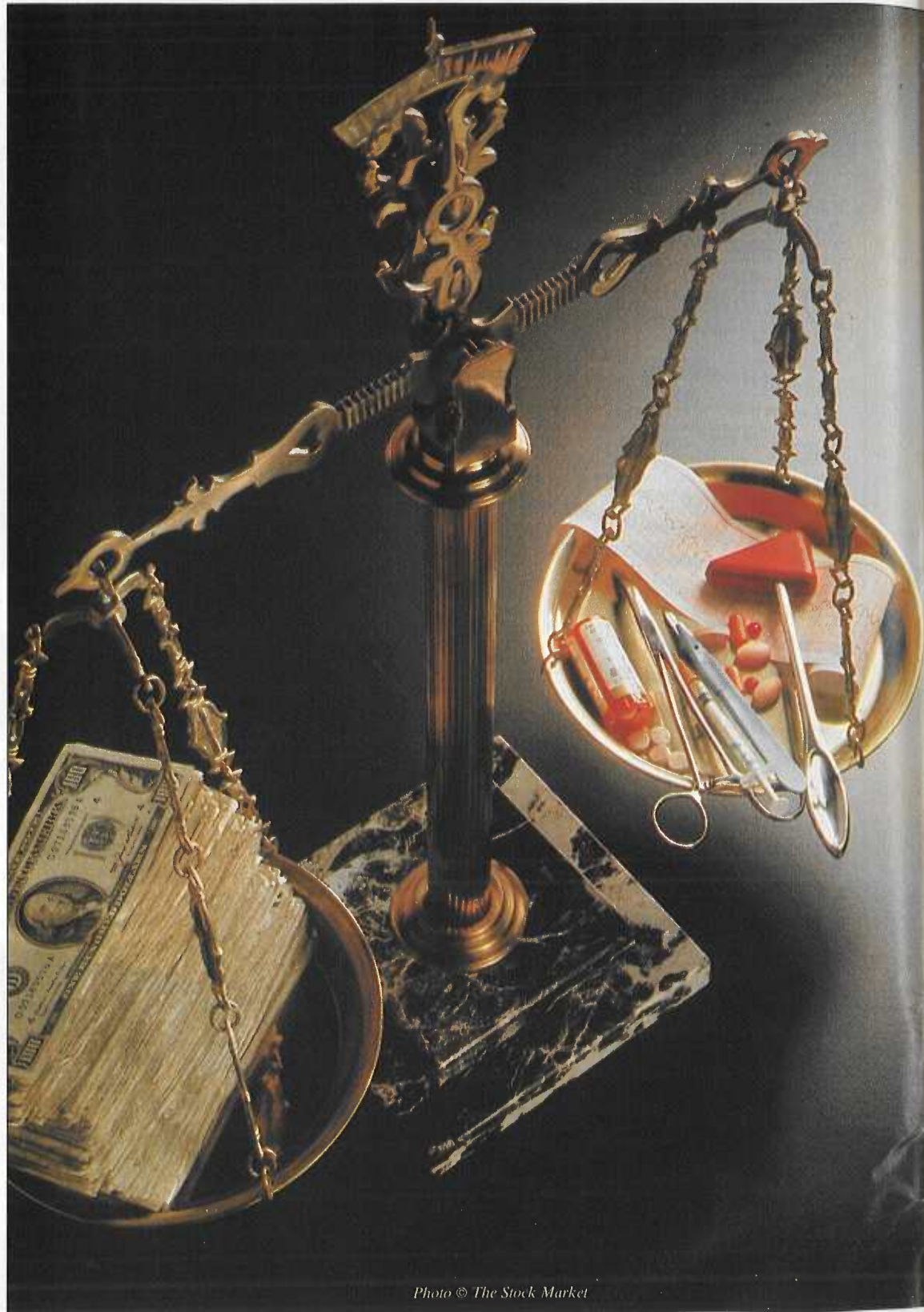
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The Misnomer

*Today's system is
neither management-
focused nor care-
focused, but there is
a way to restore the
balance between
business and quality
outcomes.*



By Lee Wenzel

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Of Managed Care

The very term "managed care" carries with it significant ironies: The concept usually excludes care, and it typically refers to insuring rather than managing.

Managed care products exclude care because they exist instead to provide cure. A chronic condition incapable of cure but requiring nursing home care seldom gets covered by managed care plans. Chronic mental illness is also excluded by more than 85 percent of health maintenance organizations (HMOs).

To explain how managed care is not managed, we will consider several of its forms. Managed care generally refers to at least one of three technologies packaged within a defined benefit plan:

- Capitated risk contracting, such as HMOs offer.
- Preferred provider organizations (PPOs).
- Utilization review.

To get a glimpse of a truly managed care approach, contrast each to methods of modern management. Rather than being a defined benefit plan, such a plan relies upon a defined aggregate contribution.

CAPITATION AND HMOs. A health maintenance organization commits to provide all medically necessary services for a fixed price to an aggregate purchaser. Although the company may seek to manage costs, it definitely assumes risk in this transaction. Consequently, the employer has an insurance contract—not managed care.

A management contract, by contrast, would establish a budget ceiling and earmark any unused funds for services or expenses with the employer. It would also have quantitative performance requirements. These differences are crucial. In most organizations, if a manager fails to spend all of a budget, the manager does not personally keep the difference. If he should go over budget, consequences may follow, but the overage does not come from the manager's personal funds.

Similarly, though HMOs ordinarily assume the financial risk for providing services, they risk little, if any, financially for most consequences of inadequate services. If an employee is ill and away from work 20 days when proper treatment would have meant only five days out, the employer picks up that cost. If an HMO provides chemical dependency treatment to only five workers per 1,000 when the disease affects 86 per 1,000, the lost time at

work, mistakes on the job and other workplace consequences are borne by the employer, not the HMO. If an inebriated pilot causes an expensive accident, the HMO does not pay.

Indeed, since chemically dependent employees generally incur medical costs at about four times the normal rate, the HMO has a financial incentive for them to leave their employer and health plan—even though the same employee might be rehabilitated at significant savings to the employer.

AT THE CORE: PPOs. The PPO is a core technology of managed care and has become more prevalent than the HMO. To use business terminology, the PPO is essentially a staffing function. Hiring quality staff is an important part of management, but only a small part. Other key responsibilities include bringing vision, resources, support and coordination to the process of implementing goals.

Normally, when managers use a preferred vendor relationship, they stay involved in defining what should be purchased and in what quantity. Effective vendors are intimately involved in seeing how buyers use their products and services. Quality purchasing managers are intimately involved in supporting the vendor's accurate, efficient and reliable supply of goods and services. But, for the most part, the impact of the quality revolution in purchasing has not yet come to the purchase of health-care services.

An example will illustrate: Assume an employer wants a preferred provider as a vendor for copying machines and services. Prices are requested and negotiated, but the buyer doesn't look at a copying machine or test it in any way. After choosing the preferred vendor, employees determine purchasing according to policies in place for who needs a copier. Need may hinge upon distance to a copying machine, amount of copies run or average waiting times. The buyer relies heavily upon the vendor to decide who needs a copier and what model they need—subject to confirmation by utilization review (which we will discuss in the next section). After the copier is installed, the invoice is sent to the plan administrator. That person reviews submitted information on whether the copier is necessary and then pays the vendor.

Obviously, a purchasing department would see this as absurd. Purchasing people would want to screen vendors for developing a preferred relationship—and be involved in the

actual purchasing decisions.

Preferred provider relationships, however, often focus too much on the discount and too little on the purchase. Prices are inflated so that a discount can be offered, and the negotiator might take a percentage of that. In terms of prudent purchasing, price is actually less important than assuring that the right people get the right help in the right amount from the most effective vendor.

Too many preferred provider arrangements have given free access to uncontrolled types and amounts of services from providers who happened to be in the network. Then they summarily dismiss a provider at the end of a year because of practice patterns or costs. Such management may be neither good nor fair. Network providers can't be expected to look out for the buyers' interests in the transaction above their own—unless they know they will be evaluated based upon cost of services delivered. They also deserve to know continuously how they are performing against these expectations. A case manager is in a much better position to compare the competing needs of various clients than a particular provider.

UTILIZATION REVIEW. Utilization review is another core technology of managed care. If the PPO parallels the hiring process, utilization review parallels the performance appraisal. Although performance appraisals are an important part of management, they are only a small part. Utilization review is judging whether claims match the terms of the insurance contract. It is contract administration, not contract management. It is surveillance—catching people doing wrong rather than helping them do right. It resembles McGregor's autocratic Theory X management rather than a more participative Theory Y management style.

As a management process, utilization review can be looked at in terms of provider selection, outcome, efficiency and the kind of relationships fostered.

MADE FOR MISMATCHES. In terms of provider selection, utilization review or preferred provider arrangements seldom do anything to help match the customer with the best provider for that situation. This is true despite the fact selection is much more important in behavioral health than in other specialties.

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If one needs an appendix removed, one does not need to choose among 20 doctors. Objective criteria exist for what should be done. If a doctor is competent and geographically accessible, selection from a very limited panel is appropriate—without worrying a great deal about a doctor's bedside manner.

Except for prescribing medications, however, the relationship in behavioral health care is not ancillary. It is the primary medium or tool of therapy.

One way to help make the relationship successful in terms of satisfaction and outcome is to make a good demographic match between therapist and client. Results improve when matching takes into account ethnic background, age, gender, sexual preference and even marital status. Feeling more understood, clients are more likely to risk sharing themselves and their dilemmas quickly and honestly.

Demographics aside, clients benefit tremendously by seeing someone who specializes in their particular situation. Working with adolescents is very different than working with issues of aging. Working with step-families or mixed-race families each have their own dynamics. Some of these specializations are objective and can be matched by objective criteria; some are intuitive and require matching by an assessment person who knows both client and provider.

Providers succeed much sooner when given credibility by a referring source. If after an hour's interview, the assessor demonstrates an understanding of the client and then says she or he knows exactly who can be most useful—because this provider has been very

caring and competent in similar situations—that provider is then more than halfway to success.

When utilization review is involved, however, it is rare to find enough personal knowledge of either client or provider to make a truly credible referral.

Arrangements that combine utilization review and preferred providers typically have limited access to the most effective, appropriate resources. Because the combination of personal and professional interests and capabilities is so crucial to outcome in behavioral health, the referring professional should have access to the full spectrum of diverse resources within a community. The selection should be made at the case level rather than by people putting together a network or buying a network.

PROCEDURES VS. RESULTS. After selection, outcome is the next key aspect of utilization review and the management process. Utilization review exists to assure compliance with the insurance contract, not to assure a successful outcome for the client. The reviewer represents the payor, not the client. The focus is not on whether treatment works, but whether the provider satisfies the criteria of the utilization review organization.

This misplaced focus creates a flawed bureaucratic culture. If the provider does the wrong things but the client improves, the claim could well be denied. The legitimacy of the provider's credentials and diagnosis is paramount, and quality is not the issue. If the provider does the right things and the client's problem remains, the

continued on page 10

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MISNOMER

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reviewer is not responsible for further action.

Utilization review is based more on the report than the actuality. Some therapists have excellent writing skills and can write a good report, but do poor therapy. Some therapists do excellent therapy and write poor reports.

When I was a therapist, I found wide discrepancies in comparing my records and client's notes. I would sometimes wonder if we were at the same session. Themes I thought crucial were omitted entirely. Meanwhile, an incidental remark might make all the difference in the world for the client. Similarly, your summary a week from now of this article might be very different from mine. I have not discovered valid research that correlates the written record for psychotherapy with results or with clients' perceptions of results.

The business success of the provider depends upon using the right words and phrases with the reviewer. To get services approved initially or at a particular point in treatment, providers can turn to databases that have documented what words work best with a given review organization or individual reviewer. But such a sophisticated process of feeding back what the reviewer wants to hear supports business outcomes more than quality outcomes.

HUNG UP ON DEFENSE. Beyond selection and outcome issues, utilization review as a management process must also be examined in terms of efficiency. A bureaucratic process is not efficient when monitoring for compliance rather than working for results. Studies have found professionals spend between 30 percent to 36 percent of their time in documentation. Such excess overhead providers and payors can ill afford. What line manager could survive spending one-third of each day documenting every discussion and meeting.

Even more tragically, the excessive documentation creates a defensive style of intervention. Despite the differences between behavioral health care and the traditional medical paradigm, things must be done according to the book—applying a prescribed solution to a diagnosed condition. Yet the great therapists leading the best seminars and doing the best writing today are highly creative people, typically doing very unorthodox and paradoxical things with exceptional results. UR's review and documentation requirements would stifle such talents.

ADVERSARIAL STRUCTURE. Another great hindrance to the efficiency of the system is that, at the point of service, neither provider nor distressed client have much certainty about what will be paid. This creates ambivalence for each at a time when their energies need to be maximally focused on the primary problem.

After-the-fact resolutions in business relationships are always inefficient and produce poor customer relations. Surprises that appear after a business agreement are not good. The drama of contract disputes in most courtrooms could be more effectively resolved with detailed, precise understandings reached earlier in the process, before commitments had to be made. Finally, from a management perspective, an analysis of utilization review is not complete without probing its relational aspects.

Utilization review is an authoritarian relationship set up to create manipulations. In effect, the reviewer asks, "Can you give me a reason to substantiate your request of x number of service hours or days?" In this adversarial structure, reviewers are evaluated and rewarded based on cost savings much more than client outcomes.

Provider survival, on the other hand, depends upon claims approval. Since reviewers rarely have direct information from the client, they face the distinct disadvantage of having to rely upon the

supplicant. This forces them to maintain a certain distrust of the validity of the data presented. Since most relevant information in behavioral health is heavily circumstantial and not very objective, the review dynamics are even worse than for medicine.

Few managers could afford to deal with employees the way reviewers deal with providers and their representatives. Parents would have very rebellious children, especially adolescents, if they asked questions the way reviewers do and then made after-the-fact denials and withholdings.

Providers are frequently dismayed at the lack of professional credentials among such reviewers. Review organizations develop escalating levels of review so that if required, a doctor can speak to a doctor about a specific claim. This "doc to doc" testing of authority as if it were competence is counterproductive.

Neither professionals nor the managed care specialists hired to protect them and their time enjoy dealing with utilization review. It's no secret that doing utilization review is not a highly satisfying job, either. Both sides tire of this "Captain, may I?" game fairly quickly. Surveys of benefit managers reveal they are less than enthusiastic about the promises of utilization review. Given these facts, why perpetuate such a system? Why not establish a new structure that really is managed and really does focus on care?

TRUE MANAGED CARE. In this model, first of all, benefits are available for care as well as cure. Appropriate ongoing care is not only humane and equitable, but much cheaper on an annual basis than occasional emergency services.

True managed care would follow the principles of good management and good procurement. A purchasing agent or case manager works with consumers and consumers' families to obtain accurate assessments and make effective referrals. In each of these referrals, considerations are given to probable results and to the cost. The case manager is a case manager—not a provider manager. In other words, the primary contact is with the client rather than the provider. The case manager hires the provider to serve the client for a particular situation.

A good manager need not have all the technical knowledge of everyone who works for her. Nor should she encounter many challenges to her authority. Under managed care, the patient does not belong to the provider. The managed care plan hires the provider on behalf of its client. For the provider, the managed care plan is a customer, just as the client is a customer. The provider should be trusted to know how to provide optimum services to the client and should be accountable to the managed care plan for results and for costs. The relationship between case manager and provider should be what any manager would want in terms of a working relationship between herself and the people accountable to her.

The manager is accountable to achieve results within budget. When I took a corporate staff position defined as manager, I was initially surprised no one reported to me. Everyone reported to their respective divisions. I asked a colleague why I was called a manager. He told me it was because I had a budget. Employees who didn't have a budget were called supervisors or lead persons. He also

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informed me my survival depended upon defining appropriate objectives, securing budget funds appropriate to the objectives, and then reaching those objectives with that budget. That is the task of a manager.

A defined benefit plan for an undefinable benefit creates the problems we have been describing. So how to provide health-care benefits without a defined benefit plan? To borrow from the language of pensions: Offer a defined contribution plan. The difference is that the contribution may be defined for each individual and also in aggregate.

The individual defined contribution might be in the form of each employee having \$1,500 available each year for personal and professional development. These funds could be used to purchase psychotherapy, career counseling, courses in an MBA program or an approved personal development workshop. Or a proscribed amount, such as \$400, could be available for counseling—with an assurance of no denials. Rarely is brief, short-term therapy not a good investment for the individual, family or employer when someone has the motivation to pursue such services.

Beyond the individual defined contribution, the employer defines an aggregate contribution. This is usually specified in terms of dollars per employee per year. For example, a budget of \$200 per employee per year for 1,000 employees would be \$200,000. The case management function is responsible to find the people who most need these services, provide accurate assessments, make the most effective referrals when needed and assure the employer the most

value possible is being achieved with these funds. Each case manager participates in this process by having current and accurate information as to priorities and budget status, and by sharing responsibility for prudent purchasing with each consumer.

Such a plan resembles a health maintenance organization except for a few crucial differences.

First, the employer or aggregate buyer defines the specifications and budgets.

Second, the employer keeps the risk. Actually, for a budgeted process there is no risk. The issue becomes one of having a population large enough to achieve predictable costs with the aid of good management. Medical services, in contrast to health-care services, are actuarially predictable and may need to be insured.

Third, a wider range of services can be offered. This is a natural outgrowth of services being determined by value and probable outcome as well as whether financial resources are available. Service levels are determined by value and budget rather than by defined benefits.

Fourth, consumers have access to a wider range of providers because it is the case management function that assures value within cost constraints rather than attempting to achieve value through a restricted panel of providers.

The way to buy services is to form a budget, integrate the referral and payment processes and then manage the budget and purchasing. Hardly revolutionary, except in health care.

Wenzel is a consultant with the Wenzel Group of Eden Prairie, Minn., and a member of the Employee Assistance advisory board.

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EA and Managed Care Face the Future Together

By Sara Bilik, MBA, MEd and Tom Pasco, PhD, CEAP

Health-care reform has driven managed care and employee assistance toward a union that has not been uniformly easy. Some groups have successfully bucked the trend. For others, it has been a forced coupling—often arranged by a corporate benefits department seeking economies of scale. For some, the match has proven natural—evident from the start that the whole is larger than the sum of its parts. For still others, the entry of managed behavioral care has caused management to do away with the EAP altogether.

In this context of an uneasy alliance incompletely achieved, a brief look at the history of both the EAP and managed behavioral health-care movements can help us see the value of each and the benefits of achieving a successful rapprochement between the two.

Depending on your definition, EAPs have been around in some form for more than half a century. Expanding from their origins in the field of industrial alcoholism prevention, EAPs have applied their broad brush and core technology to profoundly influence the course of development in fields as diverse as corporate counseling, organizational training, behavioral health-care treatment delivery, child care and elder care, and workers' compensation and disability funding. Management and unions have recognized EAPs' bottom-line value, and its ability to assist employees and members with their problems. EAP is frequently an important area where union and management jointly oversee operations.

As concrete testimony to EAP success, we know more than 95 percent of

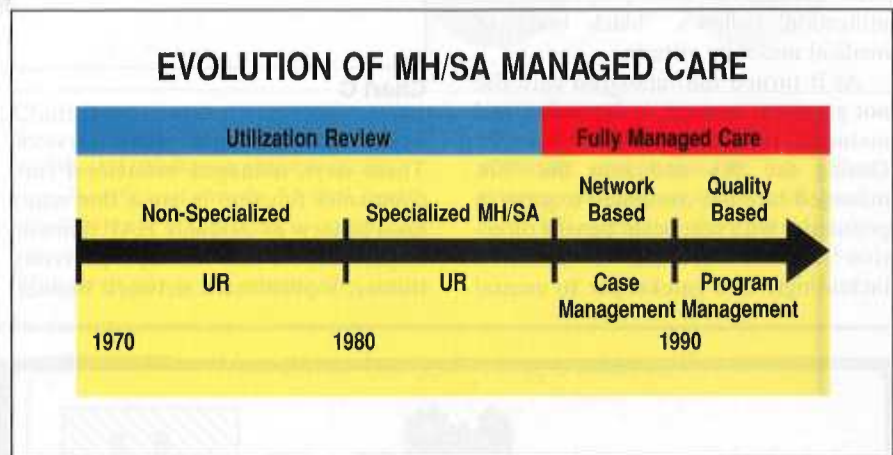


Chart A

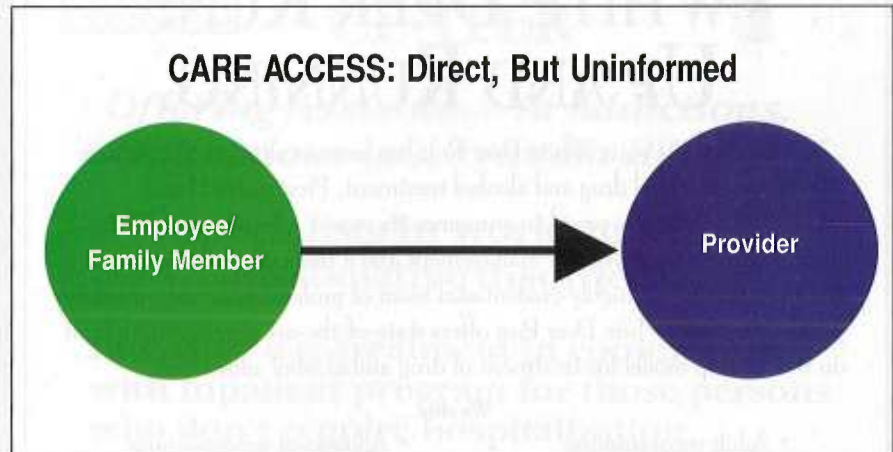


Chart B

all Fortune 500 companies have some form of EAP in place. Some smaller organizations have formed consortium groups nationwide to allow them EAP access as well (precursors to the Jackson Hole's HIPC concept). EAPA's membership swelled to 7,000 in 1993, and international chapters have been founded in the last decade to accomo-

date growing interest and need in Europe, South America and Australia.

Just as EAP roots are in alcoholism prevention—a field that has become a subset of the current EAP domain—the managed behavioral health-care field is an outgrowth of the relatively limited discipline of utilization review.

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Primarily focused on cost-containment—and often only secondarily on triage to appropriate, quality care—behavioral health-care utilization review earned the rapid scorn of many EAP and treatment professionals. Throughout the '80s, EAPs often allied with treatment facilities in hoping managed care would somehow disappear. For many EAPs, the early UR programs got in the way, and slowed what they saw as the critical process of timely care access. EAPs were designed as compassionate, efficient case-finding and referral systems, sometimes putting their mission at cross-purposes with utilization review's "black box" of medical necessity criteria.

As it turned out, managed care did not go away. Instead, it expanded and matured. It also improved clinically. During the '80s and into the '90s, managed care has continued to grow in popularity with corporate benefit directors nationwide, and to function increasingly as a gatekeeper to mental

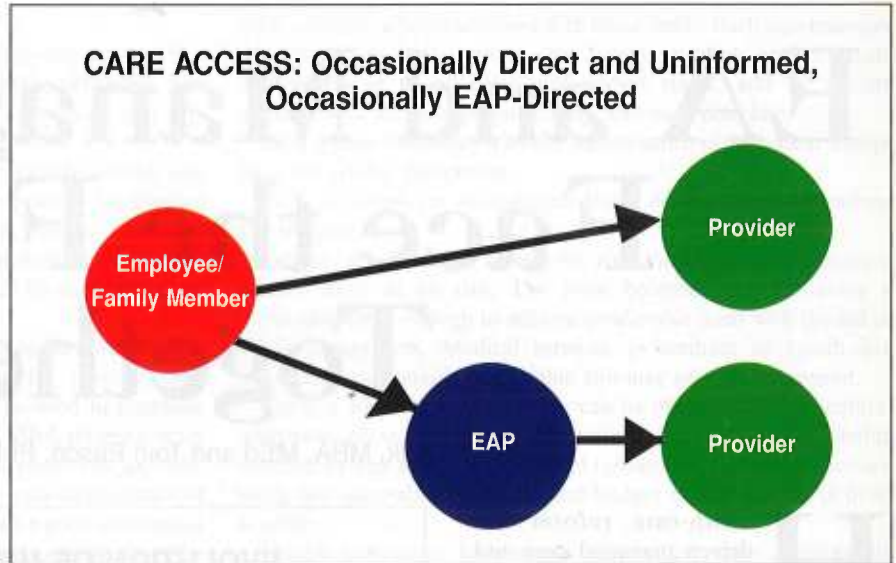



Chart C

health and substance abuse services. These days, managed behavioral care companies function in areas that many used to view as uniquely EAP domain: as gatekeeper, case finder, supervisory trainer, sophisticated network builder,

compassionate case manager and program data analyst, among others.

Although numerous EAPs have made their peace with the better managed care companies, many others still seem stunned by the impact that man-



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aged care's clinical and administrative protocols have had on the treatment field, as well by the blow managed care has landed to some EAPs' valued autonomy.

It is important, however, to review the reasons for managed care's success as objectively as possible. Only then can EAP professionals understand fully what managed care brings to the table for employees, and what EAPs have to offer managed care programs in turn.

Two compelling statistics that benefit consultants share with corporate benefits and medical directors nationwide have become a sort of wake up call to change:

- *Behavioral health care benefit costs.* Unmanaged, mental health and substance abuse benefits typically cost large companies around \$300 to \$500 per employee per year (and more)—which translates to as much as 15 percent of total health-care benefit costs. This occurs despite the fact that generally fewer than 5 percent of a company's employees use the mental

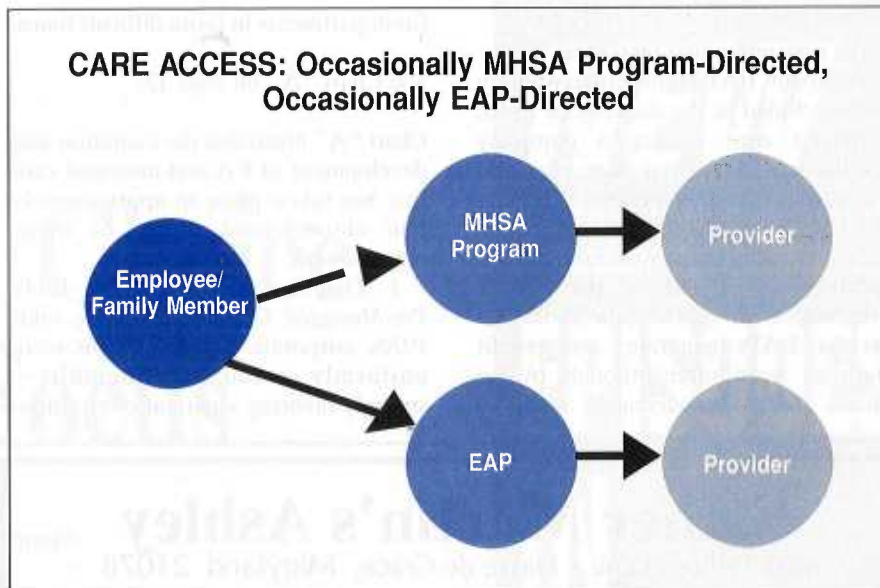


Chart D

health and substance abuse benefit.

- *Benefit cost spirals.* Mental health and substance abuse costs to companies rose during the late '80s an average of 20 percent per year, earning the status

at many companies as the fastest-growing portion of their total health-care bill. During the previous two decades, these costs had averaged only

continued on page 16



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3 to 5 percent annual increases.

Although EAP managers have often been included in the decision of which managed care vendor a company selects, few discussions have occurred about whether managed care was coming. Costs were too high to ignore, and managed care had proven itself on the medical-surgical side of the benefit program. With sparse data about the savings EAPs generate, cost-benefit statistics were often—though by no means always—unpersuasive to bene-

fits departments in those difficult times.

See Chart "A" on page 13.

Chart "A" illustrates the evolution and development of EA and managed care that has taken place in approximately four chronological phases of triage management.

1. *The Medical Model (Pre-EAP/Pre-Managed Care)*. Before the mid-1970s, corporate benefit designs were uniformly standard indemnity—strongly favoring inpatient over outpa-

tient treatment. They often covered outpatient psychiatric or substance abuse care minimally. Sometimes they didn't cover it at all. And they typically folded the psychiatric benefit wholly or partially into the medical-surgical plan. EAPs were rare until the late 1970s—which meant EAP case finding, referral and care management were typically unavailable.

As a result, employees who sought treatment found their way into what was often the wrong system or type of care for their problem. Companies at that time exhibited minimal interest in "the psych benefit," and that unconcern, at least in part, reflected a dollar figure too small to generate much concern. Providers, too, were less sophisticated about "troubled employees" and the corporate environment. Intermediate levels of care (intensive outpatient, partial hospitalization, etc.) were not yet available. Access to care was direct, but uninformed.

See Chart "B" on page 13.

2. *The Advent of EAP*. Chart "B" illustrates the Golden Age of employee assistance—the 1970s and early 1980s. During these growth years, EAPs had substantial impact on American industry and on how both management and labor viewed a troubled employee or family member. A well-designed, widely communicated EAP that had employees' trust in its confidential assistance often experienced annual penetration rates of 2 percent to 10 percent. Employees finally had the help they needed in finding appropriate, quality care.

One of EAPs' most significant contributions to the treatment field came in working with benefit directors to radically restructure benefit designs at companies and unions nationwide. EAPs lobbied strongly—and successfully—during these years to have benefit plans cover inpatient and outpatient psychiatric and substance abuse care. Together, EAP directors, benefit managers, union representatives and senior corporate officers crafted benefit programs that would pay for much-needed behavioral care.

The flip side to this important success came in the form of skyrocketing costs to companies' psychiatric and

continued on page 37

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Change, Choice and Focus

By Jim Francek

Over the last few months, life for me has been moving at an incredible speed. This past winter I decided to go in search of a new structure in which to work. Changing one's work structure, whether undertaken voluntarily or involuntarily, creates a lot of personal turmoil.

As one who has chosen to be a professional change agent, I *should* be good at it. Well, I'm here to tell you that even with a great amount of experience and training, one still experiences change as a roller coaster. As I reflect on my current personal journey, I realize that sharing my flow of consciousness with *EA* readers may prove helpful to some.

First, I think that most of us do not start the process of change without some resistance. Most of us find a great deal of comfort in what is known, in routine and in a sense of security. To consciously choose to change entails a fair amount of energy. It means I need to probably let go of something that I value at some level. We change either because it has been forced as a threat on us by external circumstances or because of an internal realization that there is more opportunity in plowing some new ground.

For the last several years, I have focused most of my work in assisting organizations and individuals to "make change a positive process." A significant finding from this effort is this: When we arrive at a cut point in our life, we often feel a significant sense of loss. Depending on how we have proc-

essed loss in our past, we may experience the grieving process in a variety of ways.

Clearly, when we let go of people, places, routines and relationships that we have valued, we can expect an emotional roller coaster for awhile. Change involves the *breaking up* of a known paradigm.

As I reflect on the different times I have shifted my work structure, I realize that different things were operative. A number of years ago, I was in the active ministry. I loved my work, I loved the people I served, and I feel I did a good job at what I did. However, deep within I desired to have a grounded relationship with another person as well as a family.

I chose to go through a significant shift, and I left a comfortable setting to set out in a new direction. I had no idea how much loss and grieving I would experience. It was significant and took years to heal. The love and support of those around me, joined to a vision of what my life could be, carried me through that time.

As the years of my life have unfolded, I have worked in a number of settings. I can genuinely say that I have enjoyed each one of those work experiences. I have been blessed with stories of challenge and growth. I know that I have an internal process that assists me in working change. I also know from looking back that each change has improved my life.

In 1986, I was working with a large
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Understanding Families Of Adoption

By Paula B. Randant, MSW, LCSW, ACSW, CADC

Adoption is a complicated, lifelong process, not a single event, and families of adoption present unique challenges for EA professionals. All members of the adoption triad—the adopted individual, the adoptive parents and the birth family—share significant themes of grief, loss and identity change. Working with these families requires EA professionals to understand this complexity and to address their own personal values and beliefs. Working in a context of maximum effectiveness and minimum stress also requires a special sensitivity to the pitfalls that often present themselves.

Developing the necessary understanding and sensitivity requires first a clear understanding of two broad categories: the healthy infant adoption and the special needs adoption. Healthy infant adoptions typically involve adoptive parents who have experienced infertility or who have believed at the time of the adoption they had a fertility problem. The adoptive couple tends to be from a mid-range socioeconomic class, and usually looks to form a family resembling their racial and cultural heritage. One or both individuals place a high value on becoming a parent.

With these parents especially, traditional family roles tend to be valued, and becoming a family may be viewed as critical to viewing themselves in a positive light. Adoptive couples tend to have high expectations of themselves and other family members. Infertility has often been the first major impediment to achieving lifelong goals. These couples are generally likable, successful and willing to do whatever is necessary to become a parent.

HEALTHY INFANTS. Couples who adopt healthy infants have usually undergone a great deal of physical and emotional stress to build a family. The fertility-testing techniques are often physically and emotionally intrusive. The process may shake the couple's self-esteem and their belief in their capacity to control their own lives. The adoption process can also prove intrusive—and sometimes assaultive—causing the couple to feel a significant loss of control. The couple usually tolerates intensive study of their marriage, their families of origin and themselves. Their strong desire to parent encourages them to continue through a system that might deter others.

The wife tends to stay home after the adoptive child arrives. Roles become traditional, possibly leading to problem areas, such as rigidity, perfectionism and the inability to acknowledge or accept differences (Kirk, 1964). Problems with adolescent children in the

family may arise with the adolescent's budding sexuality if one or both members of the couple have not grieved the loss of fertility. Control issues are common between adopted children and their adoptive parents. The parent's loss of reproductive control and the child's loss of control of family membership often collide.

The stamp of approval that a couple receives by finishing the process often sets the couple up to believe that they personify "perfect parents" and, therefore, must maintain a standard of perfection. Frequently, these couples believe that because of this special approval, they cannot make mistakes or experience parenting as difficult. The reality of parenting often leaves these parents feeling isolated and unable to get emotional support. The lack of social supports, problems with bonding and attachment, and unrealistic expectations of their own abilities often propel adoptive parents toward disappointments.

SPECIAL NEEDS. With the second general adoption category, special needs, situations vary and often fall into one or more special sub-categories: children placed after the age of two years old, children with handicaps, children who have been physically, emotionally or sexually abused, children who have been neglected or abandoned, and children of color.

Special needs parents are frequently experienced parents (often having several birth children) who wish to parent additional children but do not want to, or cannot, add children to the family through pregnancy and birth. These couples usually see themselves as competent parents able to nurture and problem-solve around parenting issues. They usually place a high value on family life. They tend to follow traditional family roles. The wife acts as primary caretaker, and the husband acts as primary provider.

Adoptive fathers in this category may differ from other fathers in the degree to which they support and participate in parenting. They often actively share discipline, household tasks and nurturing of children. Successful special needs couples see themselves as a team and the rearing of children as a shared responsibility. Problems may arise when the balance between the couple changes, producing stress on one or both of the partners. Developments such as alcohol and drug abuse, changes in the father's job, problems with parental health, personal or professional losses, or unresolved family of origin issues can create family crises.

Families who report feeling successful are usually flexible, open

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to learning and able to take responsibility for their own issues or shortcomings.

Couples who report high levels of dissatisfaction tend to be rigid, perfectionistic and encumbered with unrealistic expectations of the child, themselves and the parent-child relationship.

Parents seldom expect, for example, the level of disturbance an abused or neglected child can exhibit over time. The need to work with school systems and mental health systems to help their child grow and mature into a productive individual also can overwhelm them.

Problems arise, too, when adoptive parents expect loyalty to the new family. Parents who become jealous or competitive around the child's attachment to birth parents, previous foster placements or previous adoptive placements set up conflict and divided loyalties that the child is not capable of mastering to the parents' satisfaction (Boszormenyi-Nagy, 1986).

EA professionals should be aware of a significant, but common, error among therapists: blaming the adoptive parent for the child's pathology. These children enter the family with significant damage and inappropriate behaviors already in place.

Children have an investment in surviving, not in committing to a family. Commitment is a slow process that grows as the child experiences nurturing, discipline and safety in a new family. Children who have experienced several family losses, such as birth parents and foster parents, learn early in life that adults, and particularly parents, cannot be trusted. As is true with anything worthwhile, the attachment between parent and child grows slowly and takes work. Parents need to be the initiators and promoters of a relationship, and they need infinite patience (Jewett, 1978).

Motivation to adopt can also play a key role in family problems. A couple hoping to save a marriage, a husband hoping his "empty nest syndrome" wife will find something to do, individuals hoping to find someone to meet their emotional needs or someone wishing to overcome loneliness will become weary of the constant demands of a special needs child.

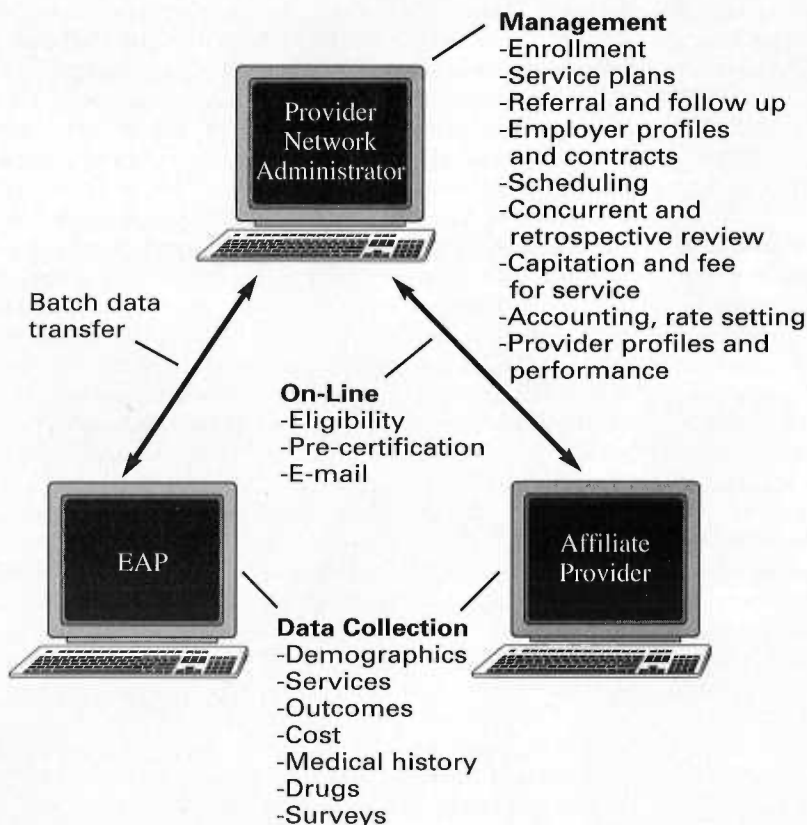
Parenting a child requires emotional and physical energy. Successful parents can use resources to replace their emotional and physical energy and have a life beyond their children. The desire to "save a child" is not enough and not necessary. Children do not wish to be saved. They wish to survive. Many are not grateful for what we

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do as parents. Parenting is a narcissistic endeavor on the part of the parent. The gratification one feels as a parent must come from within. The pleasures of seeing a child grow and mature to be independent and productive must be reward enough. A parent looking for gratification in the present usually feels dissatisfied, cheated and angry at the child for being ungrateful.

TYPES OF ADOPTION. In some cases, successful work with special needs children also requires additional understanding of the circumstances and context that make the case special.

- *Cross-cultural adoption.* The adoption of children of other races brings some inherent problems, such as defining racial identity for the child, racism in society as well as in the family, denial of differences and inability to teach a child to cope with racism (Kirk, 1964). Frequently infertility and desperation have played a part in the parents' motivation to adopt. Problems escalate as the child reaches adolescence, and both parents and child may be unable to like or accept each other. Parents must learn to promote a positive sense of self, and this must include racial identity as well as adoptive family membership.

- *Within-family adoption.* This, the most frequent kind of adoption, occurs when a relative adopts the child. When the family is emotionally healthy, normal adoption questions and issues will arise but often with no pathology. Dysfunctional families, however, will exhibit a full range of problems, often scapegoating the adopted child (Woititz, 1983).

Secrets can be a significant problem in this type of family (Black, 1981). Often everyone knows the secret but the adopted child. The child feels that everyone is tiptoeing around the "elephant in the living room." Some important factors in stabilizing the parent-child relationship include communication about the adoption, openness and honesty about birth parents, and the adoptive parents' reasons for adoption.

Extended families often play a significant part in family problems and may need to be involved in family therapy at some point. Parent education and support groups are also important for these adoptive parents. Issues around parenting and attachment are similar to other adoptions. The only significant differences are the availability of information about the birth family and a blood tie to one of the adoptive parents. Boundary issues between extended family members may be signifi-

cant and should be addressed. Loyalty issues may develop as the child matures. They may stem from the relationship between adoptive parent and birth parent or develop as a function of the child's internalization of his or her adoption. Both possibilities need to be explored.

- *Single-parent adoption.* In this relatively new area of adoption, parents have often chosen not to marry and usually have successful careers but feel the void of not

having a family. They place a high value on family but have little experience parenting. They are often independent and feel lonely. They may hope parenting will fill a void in their lives. Since our current system prefers placement among married couples, these single parents often adopt the children most difficult to place. Emotional, physical, and economic resources can become a major problem.

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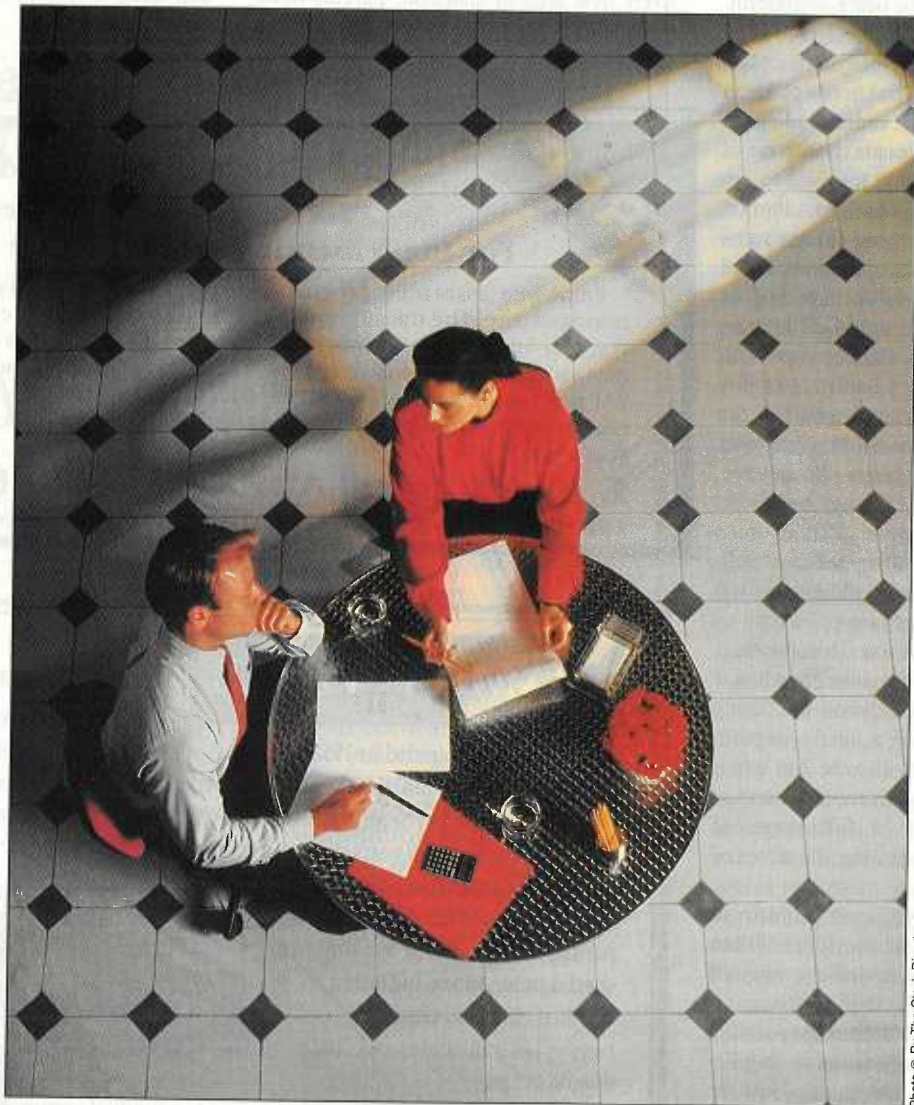


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Boundaries

Demystifying the Gray Areas

By Billie Wright Dziech, PhD, and Michael W. Hawkins

Mention sexual harassment these days and some people will yawn and leave the room while others prepare for verbal combat. Like the national deficit, harassment has been the subject of endless analysis, yet it remains as controversial and confusing as when the problem was first identified.

This is because demands for clear definitions have invited oversimplification and polarization around complicated and occasionally ambiguous behaviors.

Most experts describe sexual harassment as an assertion of power on the part of the perpetrator. Feminists contend it occurs on a continuum that runs the gamut from rude remarks to forced sex and sends messages of disempowerment to females. The opposition argues that distinctions must be made between gauche and inappropriate as opposed to illegal behaviors. Meanwhile EAPs and workers must make their way cautiously through politically and philosophically charged debates when their greatest need is for pragmatic advice about acceptable workplace behaviors.

While some tend to talk in theoretical and legal terms, employees ask very direct, personal questions in training sessions:

- "Is it wrong to hold the door open for a woman?"
- "Is thinking someone is nice-looking sexual harassment?"
- "Will I get in trouble if I compliment a secretary on a new hair style?"
- "Can I be fired for telling an off-color joke?"

Every employee should be educated about organization policies and procedures and about the laws governing sexual harassment. But genuine understanding and behavior modification come only when the problem is placed within individual contexts—only when people begin to monitor and reconcile personal attitudes and actions in accordance with the law and organizational policies.

This cannot happen if sexual harassment is presented as a black-and-white consideration. Open-minded people know that in addition to being a power issue, harassment can also be the result of ignorance and miscommunication.

There are "gray" areas of behavior that people may interpret in a variety of ways, depending upon innumerable cultural factors, as well as gender. Ironically, much employee training, like the media, focuses not on these but on more egregious behaviors that require less explanation.

In 1993, for example, fewer and fewer people assume a supervisor can, with

impunity, demote an employee who refuses sexual advances, but a great many wonder how often a supervisor or co-worker can ask for a date before the invitations constitute sexual harassment. If they are to serve employees and organizations well, EAPs must anticipate and provide leadership in discovering solutions to queries about the gray areas.

One of the most common and difficult areas is that of consensual relationships. Some believe that the only way for an organization to avoid liability is to prohibit fraternization among employees. The difficulty with this approach, of course, is that it is not realistic. As women enter the workforce in greater numbers, expect offices, factories, and stores to become more, not less, crucial to social interaction. This means a significant percentage of co-workers and managers and employees may become sexually involved.

The ramifications are enormous for both individuals and organizations. Some romances will flourish and survive. Others will die natural deaths. The problems arise when one participant uses his or her position to force a relationship on a seemingly consenting employee. A manager insists that an individual engage in sexual activity or become "more friendly," and the person does so to avoid job retaliation. Later the individual recognizes that this was not a genuinely consensual relationship but rather classic *quid pro quo* sexual harassment and files a lawsuit, leaving everyone wondering how the situation could have been avoided.

Even the once innocuous act of inviting someone out for a date is now suspect. Men ask at training sessions, "Is it sexual harassment if I invite a woman in my office to dinner?" In the environment in which we currently find ourselves, the wisdom—and legality—of such a request often rest on the number of times and the tone in which it is made, as well as the romantic status of the individuals involved. Clearly, an enormous difference exists between an eligible bachelor asking an unmarried woman out once or twice and an individual's being badgered for dates.

"What about complimenting a woman on what she is wearing? Will that get me in trouble?" others want to know. The safe course, prescribed by some organizations, is that one should never make a comment about appearance to a woman that he would not also make to a male. But many—women most of all—object to the rigidity of this approach. Much of the research on differences between the gen-

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ders reveals a significant portion of women base their self-esteem on body image and thus appreciate sincere compliments that have no ulterior motives. The difficulty lies in differentiating those who find compliments demeaning from those who are flattered by them.

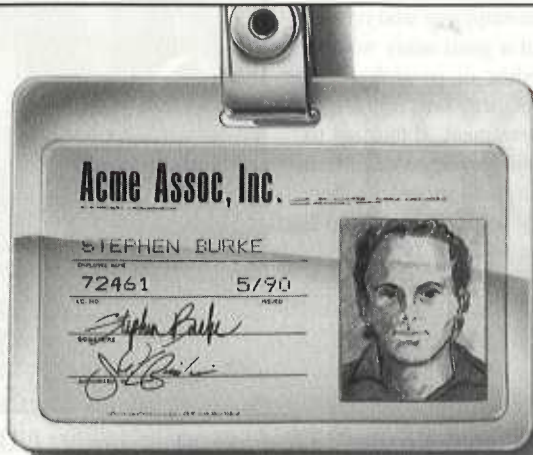
Touch can be another gray area. Obviously, there are parts of the body with which only intimates should make contact, and clearly neck massages and arm stroking do not belong in the office anymore than "innocent" kisses on the cheek. But what about a pat on the hand or a casual arm around the shoulder? Can harassment be curtailed only by requiring employees to become wooden in their interactions?

Inquiries into one's personal life may or may not offend, depending upon the intent and delivery of the questioner and the listener's concept of privacy parameters. It does not take a genius to recognize it is inappropriate to ask people for details about their sex lives. On the other hand, an individual undergoing an acrimonious divorce may appear eager to confide intimate information about the marriage. How does one know what is acceptable in such a conversation?

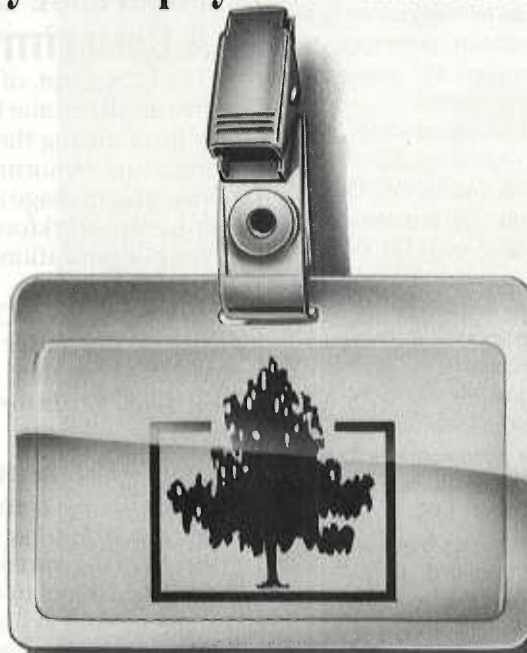
Sexual references and jokes, as well as sexually explicit materials (such as nude calendars) are regarded by some as another gray category. Many males, encouraged by popular culture, assume the typical female shares their taste for erotic pictures and jokes. They are disconcerted when some females are offended by pictures of naked women hanging on walls of factories while others are not. They do not understand why some women tell off-color jokes and others are disgusted by them. Are these simply matters of personal preference, genuinely gray areas, or do other factors govern decisions about erotic materials and language in the workplace?

The ambiguous areas are, after all, the heart and core of the sexual harassment issue, not simply because they arouse so much confusion but also because so much of the "gray" is dealt with in silence. People seek advice from EAPs or go to court when managers proposition them, but very few are willing to complain about jokes or excessive compliments that make them uncomfortable. The result is that "hard core" harassers maintain their power over victims, and those who are simply ignorant and uneducated never improve because the silence discourages change.

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how difficult is its task? The truth is that the gray areas of sexual harassment are not as impossible to deal with as some contend. Trainers must differentiate popular culture from workplace culture and appropriate private behavior from organizational behavior. Then education, communication, and shared responsibility between employees and employers will lessen uncertainty.

Training programs should be expanded to include discussion of gender differences and contemporary popular and work climates.

For example, considerable research demonstrates that from adolescence on, typical males are more responsive to erotic cues than females; they talk, think, and joke more about sex and assume women share their propensities. Once acquainted with research establishing that women's attitudes are governed by very different gender characteristics and socialization patterns, males are better able to understand that female opposition to erotic language and pictures derives from very intrinsic motivations not just disagreeableness.

When men are taught their own direct-

ness is not typical of the average woman and most females are not reared to be assertive in their responses to others, they may be less likely to assume that female silence means acquiescence. Women, too, can learn. They need to be taught to communicate disapproval more effectively and to understand males also are frustrated and confused about appropriate boundaries and behaviors.

The gray areas demand that organizations establish policies based upon painstaking discussion with employees. It is vital for management to seek employee input and to reach agreement about workable procedures to govern consensual relationships and requests for dates. Members of the organization should participate in discussion and role playing that clarify for co-workers their individual attitudes about touch, personal comments, and other facets of male-female interaction. The goal is to encourage understanding of personal boundaries and of the complexity that characterizes organizations that must accommodate conflicting attitudes. Then the reason for policies and laws becomes

more apparent.

In the final analysis, the best response to queries or expressions of frustration about ambiguous behaviors is to rely on the highly personal, which is what motivates most reactions to the sexual harassment issue. In training sessions and in individual counseling, males and females, must be taught that when they are in doubt about how to act, the most crucial standard they can apply is to ask themselves, "Would I want my daughter, my wife, my son, my brother, my husband or my sister subjected to this behavior?"

What that test reveals is that most people are perfectly capable of coping with the gray areas of harassment on their own. In the final analysis, sexual harassment is not simply about policies and procedures, not even about power. Ultimately, it is about people and choices, about recognizing the importance of sensitivity, civility and understanding.

Dziech is a professor of English at the University of Cincinnati. Hawkins is a partner in the labor and employment law department for Dinsmore & Shohl, Attorneys at Law, in Cincinnati.

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Stopping Harassment Before It Erupts

By Linda Houden, CEAP, and Larry Demarest, PhD

Three years after the Clarence Thomas/Anita Hill hearings, sexual harassment remains a hot topic in the public mind. In June, for example, Warner Bros. paid a record \$3.5 million for film rights to Michael Crichton's unpublished novel on the subject.

Despite the heightened public awareness, the root causes of harassment run deep. They are not going to change overnight or in a year or even in a decade. Change will require a variety of tools—among them education, counseling, policy development and enforcement, and legal action.

As EAP providers, we have many roles in these areas, and our roles can help prevent harassment from erupting into a major workplace problem:

- Encouraging client organizations to have clear, well-defined and enforced policies and procedures.
- Balancing the rights and concerns of the individual involved in the complaint with those of the organization itself.
- Counseling the harassed.
- Counseling the harasser.
- Providing effective education and training programs for supervisors and employees.

This article focuses on employee education. Coupled with stricter enforcement of harassment regulations, such education can help shift behaviors that, in turn, will help shift attitudes.

The first step in change is raising awareness through experiential training programs. We emphasize prevention by building respectful relationships in the workplace. We find it essential to use two screening mechanisms before agreeing to provide a sexual harassment seminar to a client organization.

The first is "why now?" Has an incident occurred? If so, where is it in their system? How much information does the rest of the staff



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have? What is the status of the rapport between the alleged harasser and alleged harassed person? Has there been polarization of staff?

If the answer is yes to any of these questions, the EAP should delve further to see if preliminary work needs to be done to debrief individuals or the group before going ahead with an education piece. In effective conflict management, the feelings must be vented first before the facts can follow.

The second mechanism that must be in place is that the organization must have a sexual harassment policy that has been communicated to the employees by top management. At the training session itself, the CEO or person with the highest position must introduce the session by stating that policy and underlining the fact that the organization is committed to providing a harassment-free environment and will

take whatever steps necessary to ensure it. If you don't have information and buy-in on both of these counts, the training could do more harm than good. (We have learned this the hard way.)

After completing these two screening steps, it is also important (as with any training program) to understand what outcomes the organization seeks from this training. Sometimes it is necessary to manage the expectations and let the organization know realistically what the training can and cannot do. External EAPs or trainers can clarify this by stating objectives in the proposal or outline they submit to the organization.

In scheduling, we have experimented with lunch-hour awareness sessions, but we have found them to be rushed, mostly didactic and not as effective as we would like—though probably better than nothing. A two-hour session allows more time for small-group discussion and role playing. Three or four hours can be even more experiential. Ideally, the trainer would conduct a first session of two

to four hours and then schedule follow-through sessions over the next 12 months to reinforce the learning and help with building communication skills.

After collecting the initial information from your client, put yourself in the shoes of that client's employees as you begin to design the training. How do they learn best? What is the corporate culture? How much experience have they had talking about potentially sensitive topics?

EAPs have a distinct advantage here since we usually have our thumbs on the pulse of each organization (or should have), and have valuable information to make the session optimally effective.

For example, in an advertising agency it is important to have professional visuals, stimulating conversation and humor (appropriate, of course) because those are all values held dear in that industry. Let them know you understand the uniqueness of their situation and make sure you actually DO understand that uniqueness by gathering information from executives, human resource people, supervisors and members of the rank and file.

When you understand the culture, your training will have more impact because you can operate on a level of familiarity. It makes real change more likely, and it's worth taking the time to make a few phone calls.

Next, base the design of the training session on the premise that building respectful relationships in the workplace does not involve establishing or enforcing an edict on how to behave, nor should it diminish the capacity for being creative, for showing spontaneity or for having fun.

Employees sometimes tell us, "This sexual harassment thing is taking all the fun out of work" or "We can't say anything to anybody anymore without getting in trouble." Such statements are not true and need to be challenged immediately. Let it be known that teasing is one way that intimacy is built between individuals, but the litmus test for whether it is harassment is whether both parties are participating at an equal level and willingly. If people can only have fun at someone else's expense, how healthy is that for the work group?

We start the sessions out using this

framework and have had positive results. People tend to be receptive when they know they are getting guidelines for acceptable, respectful behavior and a chance to sharpen their awareness of their own comfort level and those of their co-workers. Such an approach is far more effective than leaving the impression that they are having rights taken away.

After asking the key "why now?" screening questions, creating manageable expectations for training outcomes and laying the foundational concept that healthy workplaces let employees do their best work, we design a format for delivery. To get the greatest impact, we include as much active experiential learning as possible—such as role plays and small group discussions. Our skeleton outline follows.

Introduction

1. Opening statement of commitment and review of policy by CEO.
2. Introduction and completion of boundary instrument where participants assess their own comfort level in a variety of

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situations.

Legal Information

3. Recent statistics.
4. Impact of harassment on organizations and individuals.
5. Causes of harassment—historical and cultural.
6. Legal definition, examples and liabilities.

Healthy Relationships

7. Boundaries—a discussion of instruments completed at the beginning of the program.
8. Effective communication techniques.
9. Evaluation and closing.

We always start with a cartoon to help relax people. Sexual harassment is a loaded, volatile topic. The more open your audience is, the more learning will occur. Humor helps.

Next, we have the group fill out a self-assessment instrument called "Are You Comfortable?" This provides a way to increase individual and group awareness of personal comfort levels around different situations. We let them know there are no

wrong answers (since each of us have different comfort levels) and that we'll come back to it later.

We then go on to the legal aspects of sexual harassment. This piece points out that the increase in the number of cases and the consequences of unacceptable behavior. Most law firms that do sexual harassment training focus on this portion and the fear associated with large monetary loss. Although fear is a not-to-be-underestimated motivator of behavioral change, it seems more appropriate for EAPs to paint a realistic picture of what's happening, then build the foundations for change.

Current statistics are compelling—particularly when you use those from your own locale. In Minnesota, complaints have increased by 61 percent since the Thomas hearings, according to the Department of Human Rights. Nationally, the EEOC reports a 150 percent increase in inquiries and a 23 percent increase in claims filed since October 1991. Get stats from your city's affirmative action department, the civil rights commission or your state's Department of Human Rights.

The impact of sexual harassment must not be diminished. The effects include:


- Negative public image for the organization and individuals.
- Negative impact on morale.
- Lost revenue because of lowered productivity, absenteeism, workers' comp claims, legal fees and judgments.
- Psychological effects on alleged victims, perpetrators and staff.

The causes of harassment are also important to cover because they give a framework for why things that weren't considered harassment 15 years ago are now. The three main causes include:

- Changing social norms and the cultural lag that accompanies those changes.
- Lack of good communication skills—intent vs. impact.
- Abuse of power.

We then go over state and federal regulations. Use what is appropriate for your state. Though we are not lawyers, (and we emphasize this), employees need to understand the two kinds of harassment:

- *quid pro quo*—a request for a sexual favor in exchange for an employment



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• *hostile environment*—a person's ability or opportunity to do the job is diminished because of a hostile or intimidating environment.

Included in this portion are the liabilities that organizations and individuals carry if involved in a sexual harassment claim. Most often, for example, employer liabilities can extend to supervisors, co-workers, third parties (vendors, clients, etc.), and non-participants (such as an employee who didn't get promoted because someone having an intimate relationship with a supervisor was promoted instead).

We cite specific examples of settled cases in our area for each of the above, thereby putting some muscle into the seriousness of this. It has a greater impact when the participants hear about the judgment against the discount store they shop at or the school they went to or their own city government.

A good exercise to use here is small-group discussion of case studies. One idea we got from The Employer's Association in Minneapolis is to get actual legal cases that

have already been decided. The small groups determine whether sexual harassment exists, what kind it is (*quid pro quo* or hostile environment), who is liable and how much the judgment should be. After they come back to the large group to report their findings, they can see how they fared compared to the court system.

After definitions and liabilities, it is important to identify the behaviors that may be considered harassment. The most effective way I've seen this accomplished is through a live theatrical performance. It hits the participants at a gut level without asking them to disclose personally. In Minneapolis, we have many great resources. The Theatre for Corporate and Community Education, The Illusion Theatre, Mixed Blood Theatre and amateur actors who do a professional job with Jewish Family and Children Services all have developed effective presentations concerning sexual harassment. Most of these troupes travel. Check your own community for theatrical resources. They can provide compelling awareness raising.

Another option for identification of

behaviors is to have small-group discussions. The groups can both identify behaviors and come up with their own working definitions of sexual harassment. The value here is that it has more impact when they develop these ideas themselves.

At this point, we shift from the legal focus to the interpersonal focus. We return to the "Are You Comfortable?" instrument and break into small groups for discussion. This has turned out to be a powerful part of the workshop, despite its seeming simplicity. We have found that most people in our sessions have never let their co-workers know how they feel about off-color jokes or the use of expletives or provocative pictures. Participants find it illuminating to discover differences they hadn't suspected.

After the small groups come back to the large group, we look for trends in comfort levels. It doesn't take long to discover that we are often influenced by our gender, our age, our race and our upbringing. The most important piece that the participants consistently get out of this exercise is the fact

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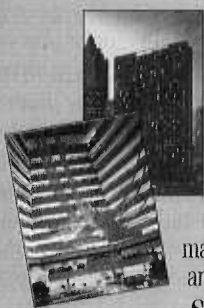
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that everyone has different comfort levels and that being respectful of these differences helps to ensure a healthy work environment.

From this point, we go into effective communication skills. Use any of your already developed programs with emphasis on assertive communication. An interesting small-group discussion is to have people identify situations where they have used different styles of communication (assertive, aggressive, passive, passive/aggressive), why they used that style and what results they got.

This is also a great spot for role plays using assertive communication. Give the group case studies where they can play the roles of both harasser and harassed. The teachable moment often comes when people play the role opposite from their dominant style. We sometimes use films or videos to show examples of the different styles of communication because it's an easy way to stimulate discussion. Just remember to always bring it back to the participants personally for the greatest impact.

In conclusion, we reinforce the use of assertive communication to set limits (both written and verbal), then reiterate the organization's policy and procedure—the mechanism they can use to resolve the problem, including the names of the persons to report to. We encourage them to use the EAP as a confidential resource to help build assertive communication skills and let them know we are available to work with alleged harassers as well. We have experienced an increase in perpetrators coming in on their own as they come to understand that their intent may have a different impact that is no longer acceptable.

A written evaluation is always done, and it is from these comments that we continue improvement of the training. The evaluations consistently reinforce how much the participants appreciate having a male and female presenter to lend the discussions gender balance.

The more training we do, the more it becomes clear that employees want a safe, professional environment to discuss and debate the complex and sensitive issue of sexual harassment. It is through these dialogues that understanding, tolerance and respect are built.

Houden is executive vice president for Dor and Associates, an external EAP provider in Minneapolis. Demarest is an organizational development consultant for Dor and Associates.