

CHAPTER 7

THE ROLE OF EAP IN THE WORKPLACE

7.1 INTRODUCTION

This study investigates the role of EAP in relation to infected and affected women in the workplace. It is therefore important to outline the historical emergence of EAP, both internationally and locally. This chapter looks at the state of EAPs and key roles of workplace counselling.

7.2 EMPLOYEE ASSISTANCE PROGRAMME (EAP)

7.2.1 Definition

EAP is defined by the EAP Association of South Africa (2005:6) as a work site-based programme, designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns, but not limited to health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal concerns which may adversely affect employee job performance. Employee Assistance Programmes has been used as part of the business strategy to enhance employee functioning, loyalty, and performance in organisations around the world.

7.2.2 The Concept of EAP

Beidel, and Brennan (2006:36) refer to EAP practice as an approach with core technology dealing with:

- Identification of employees' behavioural problems on the basis of their job performance. The emphasis is on delineating job stressors.
- Provision of consultation with supervisors, managers, and shop stewards in assisting them with training regarding EAP utilisation and accessibility.
- Appropriate use of constructive confrontation.
- Development of linkages with external other community resources.

- The centrality of employees' alcohol problem as the focus of programme

In addition to change in the conceptualisation of EAP core technology, managing the HIV and AIDS scourge will be necessary within the framework of EAP. There has been a change in focus from earlier EAPs internationally. Van Den Bergh (2000:2) seeks to offer insight and pragmatic information on evolving themes for EAPs, which highlight the impact of changing workforce demography as it influences the need for workplace sponsored services which will assist caregivers and older workers. Secondly, the development of intervention skills broader than generic assessment and referral, to help organisations manage crisis, change and evolution.

De Jong and Miller (1995) and Saleeby (1997) encourage the use of concepts for a strength-based employee assistance intervention as empowerment, suspension of disbelief, dialogue and collaboration, membership, resilience healing and wellness and synergy. Strength employee assistance intervention can therefore mean finding opportunities of strengths in the clients. The opportunities may be formulated from the assumption that every environment is full of resources, trauma, illness and struggles that may be a resource of challenge, opportunity, and change. Every individual has strengths and clients are best served when they are experiencing the abovementioned challenges.

In addition, to keep up with the efforts in managing the HIV and AIDS scourge, it is the researcher's opinion that HIV and AIDS present with specific challenges that may require specific focus interventions in the workplace. For that reason the researcher proposes the addition of development of a comprehensive HIV and AIDS programme to be considered as one of the EAP's core technologies. This suggestion does not overlook the fact that core technologies include already interventions on health and welfare in a broader term, but the suggestion seek to enhance the technologies of EAPs and acknowledges the uniqueness of HIV and AIDS challenges.

7.3 HISTORICAL PERSPECTIVE OF EAP

An EAP is easily seen to be the descendant of a long life of programmes combining concerns for production and compassion. There are many reasons why companies adopt an EAP; some believe that helping employees solve their problems is good for workers as well as for the company, some use EAPs to avoid unionisation and retain control of the workforce.

An EAP is a work-based counselling programme that needs to be implemented strategically in order to impact on the life of employees. Involving key important people such as the Chief Executive Officer (CEO), the Chief Operating Officer (COO), and Unions is important to the success of an EAP.

7.3.1 International Perspective

The EAPs practiced internationally today, have their roots in the earlier Occupational Alcoholism Programme (OAP) model of 1940, established in the United States of America. These programmes were started during World War II. It was launched by the Kemper Group (USA) in 1962. Drinking was interfering with job performance, which in turn impacted productivity and ultimately economic efficiency. These OAPs saved companies money because of increased production and ultimately skilled workers were rehabilitated. The approach adopted was constructive confrontation, meaning supervisors were encouraged to confront employees with evidence of their unsatisfactory job performance, coach them on job improvement, encourage them to use employee assistance programmes and explain the consequences of continued poor performance. The assumption therefore was that the approach could be effective for other human problems, thus the establishment of EAPs.

In some countries, EAPs and occupational social work are seen to be one and the same discipline, due to the overlapping tasks. Some countries that have a strong background of occupational social work are still reluctant to introduce an EAP, or due to their culture do not accept EAPs. Such are France, Germany, Greece, Israel, Italy, Spain,

Switzerland, the Czech Republic, Korea, Norway, the Philippines, Portugal and Sweden. In other countries, the EAP concept is steadily growing and gaining momentum such as in Belgium, Ireland, India, Denmark, Jamaica, Mexico, Taiwan and the Netherlands (Masi, 2000).

Generally, EAPs are established in many countries and have started similarly as in the USA as a chemical dependency programme. Important to note is that in Brazil and India there is a strong cultural relevance and acceptance and Masi (2000) warns that one must not evaluate such services negatively. She noted that EAP in Brazil is more ‘Brazilianized’; similarly in South Africa, there is call for a more ‘Africanised’ EAP, Du Plessis in (Maiden, 2001:112). The emphasis is that business needs to parallel their culture with the socio-political changes. Countries that have seen the benefit of EAPs significantly include those with strong substance abuse incidents such as Puerto Rico, Bermuda, Russia, Jamaica and Trinidad and Tobago. In Singapore, EAPs is seen as a tool for enhancing both the individual and the workplace collectively to achieve their utmost potential. EAPs are seen as mechanisms for overcoming barriers that impact on personal and corporate success.

Interestingly, some of the South American and other countries that have implemented EAPs, have done so due to the existing USA companies in their countries. This raises a question whether they would have done so if they were no USA based companies. Johnson and Johnson, Levi Strauss, and other motor companies are examples of this phenomenon. Motorola in Japan has an interesting way of providing counselling to employees. They don’t call it an EAP, but the psychologist is reimbursed whenever an employee has consulted. This could be similar to the Netherlands style, which tends to rely on existing EAP vendors. According to an EAP consultant at the 2007 EAP International Conference held in San Diego, California in October 2007, he found it common that in Bermuda there are no internal EAPs due to the fact that companies tend to have only a few employees as a result most of the EAP services are offered by consultants and through external models.

The countries that have strong EAPs include the USA, Canada, New Zealand, United Kingdom, Australia and South Africa. In these countries the EAP external models seem to be more popular. It is noted that currently in the United Kingdom, EAPs provide services to between 5% and 6% of the workforce, covering 1 285 000 employees (Berridge *et al.*, 1997). Today in the USA large corporations without an EAP, is the exception. From 1970 when the OAP was formed, to 1990, EAPs have progressed very positively, expanding emphasis on work-family balance, cultural diversity, and health promotion programmes. In addition, EAP staff members became expert consultants in critical incidence debriefing and the prevention of violence in the workplace, which was seen as effective during 11 September 2001, as reported by Maiden in a 2003 presentation, during a visit to the University of Pretoria in South Africa.

Sweden, even though the emphasis is not on EAPs, has identified the importance of HIV and AIDS education through the occupation social work programme. In Greece, Masi (2000) notes that there is a strong history of family norms, and interestingly, AIDS is viewed as a threat to the integrity of the Greek family and viewed as an outsider's problem. There is a strong proactive attempt at AIDS prevention, similarly in Jamaica the high prevalence of AIDS has necessitated an EAP that deals with the HIV and AIDS pandemic and substance abuse in a proactive way. In South Africa, employees are beginning to fall ill as a result of the HIV virus. Companies are expected to assess their responsibility towards their employees, home-based care, and education interventions.

7.3.2 South African Perspective

South Africa, like many other developing countries and the international world, is not unique with regard to problems in the workplace. Thus the concept and practice of EAPs are seen as vital in addressing workplace problems. EAPs were introduced in South Africa in the 1980s (Padiachy, 1996:44). Some of the first companies to introduce EAPs were the Chamber of Mines, Iron and Steel Corporation, which is now known as ArcelorMittal, Electricity Supply Commission, Alpha Limited, Everite (Fibre Cement Division), South African Breweries, Sabax and the Council for Scientific and Industrial Research. According to Du Plessis (1990: 246), there is no accurate information on

exactly how many EAPs there are in South Africa, however she cites Terblanche's study done in 1988 that 64 companies in an audit of companies with EAP in South Africa reported having an EAP. Currently, the implementation of EAPs is on the increase in South Africa. In 1995/96 a survey by Harper (1996) of the top hundred companies revealed that 42% companies had EAPs in the workplace. The study looked at the prevalence, model design, and services rendered. In 2005 it was estimated that about 65% of the top hundred companies surveyed have EAPs, ranging from internal to external models. In the 1980s, the preferred model was an in-house or coordinator model. There is a growing trend to outsourcing and combination / mixed models. In the 1980s there were only four recognised national service providers with a number of excellent regional players. Today, there are a higher number of service providers with even international recognised partners.

Due to the South African political history, counselling services are mostly run by NGOs and the emphasis on primary mental health services is high. Some companies still feel strong to involve primary mental health coordinators in dealing with problems experienced by employees, such as trauma debriefing and depression. One would therefore still find that employers would use service providers such as the Family and Marriage Society of South Africa (FAMSA), Lifeline, and The South African National Council for Alcohol and Drug Abuse (SANCA) for specialised services. SANCA has encouraged the development of counselling services for alcohol dependent employees by emphasising and publicising most importantly the hidden costs of alcohol abuse to organisations and that alcoholism is a treatable condition, Du Plessis in (Maiden, 2001:101).

EAPs in South Africa have been established for a variety of reasons, ranging from seeking alternative ways to manage poor performance to giving expression to the concept of internal responsibility and preventative approaches to crisis intervention (Du Plessis, 1990: 35). Due to the South African political history, an EAP often plays a role in encouraging trends, such as moving from an authoritarian culture to a more

participative one, from an exclusive to an inclusive style, from secrecy to transparency, from withholding to empowering, and a culture of ownership and belonging.

EAPs in South Africa are not only engaged in clinical or curative interventions, but have developed creative preventative programmes to address employee needs. The following are some of the programmes that various EAPs have introduced in companies in South Africa (Maiden, 1992:4):

- A development of a Visiting Wives Programme for miners by Anglo American Gold and Uranium Division's (West Rand Region), after it was found that miners were ill at home. This stemmed from a family-focused need and could be seen as a supportive approach type programme.
- The Chamber of Mines offers a wide range of EAP services to the mining industry. The services offered include assessment, diagnosis, and treatment, with emphasis on the core technology and incidence debriefing. Most South African companies offer similar kind of programmes, either through internal model or external models.
- The Electric Supply Commission of South Africa (ESKOM). ESKOM was one of the companies with a comprehensive HIV and AIDS programme in the early 1990s. Maiden's (1992: 2-7) observation was that the ESKOM programme tended to focus on education for all employees from rural and remote areas, including Zimbabwe, Mozambique and Botswana. This programme could be seen as a preventative approach type programme.

A study by Liebenberg (1990:21) makes two observations:

- That EAPs in South Africa have unique third world characteristics in that some of the facets are still complicated by issues such as malpractice liability, insurance, and clinical accountability.
- The second observation is that traditional patterns of EAPs in South Africa tend to focus mainly on early identification, and on treatment as a reactive rather than a proactive response. The strength of EAP in SA is that EAPs are empowered to identify problems earlier due to the problem identification skills that are inherent in

their social work background. Early problem identification precipitates good prognosis and a well-defined treatment plan.

These observations are in contrast with Maiden's observation that South African EAPs tend to be rather advanced and have developed rapidly and have become sophisticated in a short period (Maiden, 1992:2). Du Plessis (1990:35) adds that EAPs in South Africa are growing at an unprecedented rate, using both micro and macro perspective approaches. Harper (1999:12) reports that EAPs in South Africa evolved from internal social responsibility role changing social and legislative conditions within the workplace to being integral part of the business. Some of the changed issues include, among others, managing diversity, effective HIV and AIDS management, and managing transformation and affirmative action.

Many EAPs in South Africa are involved in bio-psychosocial health prevention and lifestyle disease management, in spite of the above observation in the study done by Terblanche (1992:27) where it significantly notes that EAPs in South Africa have just taken off, but are still not utilised to their fullest potential. The study suggests that EAPs in South Africa lack operational specifics, such as comprehensive training for managers, union representation, development of a sophisticated record keeping system that enhances confidentiality and staffing of the EAP by personnel with appropriate experience. It is the researcher's observation that it is becoming common practice in South Africa that EAPs, in addition to offering counselling are focusing on training and coaching of managers and employees in various workplace aspects. The training includes basic EAP referral, dealing with alcoholism and HIV and AIDS in the workplace, and life skills training.

A study done by Padiachy in 1996 made an observation that EAPs in South Africa were still applied predominately in blue-collar environments. Padiachy's study looked at the Standard Bank of South Africa Limited as a white-collar environment and the results were that Standard Bank has come to terms with the challenges of business and society and recognised that the establishment of an Employee Wellbeing Programme was a business imperative. (Padiachy, 1996:4).

Top problem categories in South African EAPs, as reported by Masi (2000: 134), include marital problems, depression, anxiety and suicide, financial problems, bereavement, gambling, hostility, domestic violence and rape, post-traumatic stress - related to violent crime, substance abuse and interpersonal workplace conflict.

There appears to be an emergence to broaden EAP in South Africa to include both employee psychosocial needs and organizational needs. The DPSA strategy document (2007:30) categorises the programmes into three:

- Employee Assistance Programme (EAP)
- Wellness Programmes (EWP)
- Work Life Programmes (WLP).

All three programmes even though they are defined differently it would seem that according to DPSA the focus is on service offerings that covers the traditional areas which addresses the entire spectrum of psycho-social stressors in the workplace in order to enhance individual and organisational wellness and ultimately productivity.

With the establishment of EAPs in South Africa, which then gave rise to formulation of EAP standards in 1996, it is hoped that EAP principles and ethics will be adhered to. The standards include the definition of EAP, core activities, and guidelines on evaluations.

7.4 REASONS FOR IMPLEMENTING EAP

There are two major reasons for EAP in the workplace. Firstly, the identification of social problems at work stemming from issues such as violence, strikes, high turnovers, high costs of recruitment, low productivity, the need to motivate workers towards greater productivity, counselling for personal, psychological or alcohol-related problems. Secondly, and the most important reason, is the employers' positive regard for employees. This could therefore be seen as the employers' social responsibility. If the

view is that employees experience problems at one point or the other in their lives, it will be therefore important to establish an EAP to address those problems so as to minimise problems and maximise profit. Sometimes these efforts are just more than internal initiatives but do enhance the company's image on an external basis.

Some companies see EAPs as integrating management concerns for productivity with humanitarian values, a management tool that reinforces the management principles, policies and procedures. A good EAP, established with union buy-in, reinforces the supervisor's responsibilities and create forums for employee debates. Dickman, Emener and Hutchinson (1985) emphasise that labour involvement is important to secure employee participation in any programme. The union's primary objective in the workplace is to look after the interests of employees. The union often has a strong background of social policy on a national level and ensures that the Human Resources Department implements key policies such as the Employment Equity Act, where the focus is on non-discrimination and equity.

The important reason for an EAP is to provide timely, professional help for employees whose personal problems are interfering with their work performance; such problems may not be limited to marital, HIV and AIDS, transport problems, day care problems, mental health, and work-related problems such as absenteeism, accidents, and conflicts in the workplace. Van Den Bergh (2000:2) suggests that EAPs in the 21st century should focus on human intervention strengths, rather than pathologies with emphasis on new paradigm words such as strengths, resiliencies, hardiness, empowerment and solution-focused approaches. Not many managers and union officials alike enjoy disciplinary processes. EAP offers an alternative to a misunderstanding of workplace processes and an EAP remains a better option to a disciplinary process.

7.5 THE TROUBLED EMPLOYEE

The term troubled employee will be used in this research as defined by 'those individuals whose personal problems such as HIV and AIDS; alcohol and drug addiction; marital difficulties; emotional distress preoccupy them to the extent that is on either own, or supervisors judgments, work performance is disrupted'. The term troubled employee is often used interchangeably with problem employees. Bruce (1990) defines a problem employee as an employee whose behaviour in the workplace causes reduced productivity and lowered morale for self, colleagues, or supervisors. An employee can be troubled by personal problems as major as death of a spouse or an HIV and AIDS infected family member. It is important that unless those troubles spill over into the workplace as behaviour that lessens effectiveness, that the employee will not be considered a problem employee.

The effect of one problem employee or troubled employee can change organisational goals. Problem behaviour of one employee will have a ripple effect that can destroy the productivity of every employee in a work unit. Employees do not often leave their troubles at home. The problems stay with them, haunt them and sometimes reduce work performance. Troubled employees are described by Bruce (1990) as the most difficult cases, as one must continuously deal with difficult and diverse challenges that often require control that most EAP practitioners have no expertise in. He further cites family problems as the major concern for escalating conflicts between work and family life; stating that 44% of the work force is female, and that 60% of those women have children under the age of six. In addition, some of the personal problems, which may be caused by employee deficiencies, include developmental issues, alcohol drug, emotional, financial, health care, legal, mental and physical issues. It has become common practise to define troubled employees not only as those with personal problems, but include those with several work-related problems such as discrimination, skill deficiencies, management style, sexual harassment, expatriate re-entry, job condition, job structure and role conflict.

With the call for more integrated EAPs, a need analysis of the company will guide where most of the programmes are needed. This will require cost benefit and workplace impact studies on various employee problems. The costs of mental health illness can add up to major costs annually, if not managed. Mental illness definition can be understood from a mental health perspective. Mental health is a term used to describe either a level of cognitive or emotional well-being. From the perspective of the discipline of positive psychology, mental health may include an individual's ability to enjoy life and maintain a balance between life activities and efforts to achieve psychological resilience (About.com, 2006).

The World Health Organisation (2001) argues that there is no 'official' definition of mental health. Cultural differences, subjective assessments, and competing professional theories all affect how 'mental health' is defined. This background therefore suggests that how an organisation is going to calculate the cost of mental illness on their workforce will primarily be influenced by their definition and their organisational culture. Therefore mental illness can be described as a state of the mind, thoughts, mood, or behaviour that causes distress which can result in a reduced ability to function psychologically, socially, occupationally, or interpersonally.

The methodology to calculate the costs of mental illness can therefore be formulated along the lines of subdividing the cost that results from a reduction of productive activity among the mentally ill; the cost of treating the mentally ill; the cost of illegal and other undesirable behaviour that can be attributed to the effects of mental illness; and the measurable and visible psychological loss indicators such as; fear, frustration, and despair which are often as a result of idleness and rejection.

Occupational mental health however is associated solely with the psychiatrically ill worker, whose symptoms interfere with his effective functioning on the job. In a broader sense, occupational mental health is concerned with thought, feeling, and behaviour - both healthy and unhealthy - as it occurs in the workplace, organisation, or as it relates

to the performance in a job. In a larger context, the mental health field deals with factors in the work environment, which supports mentally healthy behaviour as well as those that may be involved in triggering the development of symptoms of emotional disturbance.

Today we have begun to realise that a person cannot ignore either his concern with social, financial, and spiritual obligations or his very personal likes, dislikes, attitudes and temperamental traits when he comes through the office door or factory gates. EAP, for some companies is a component of Occupational health and Safety. The goal of occupational health or mental health in industry is therefore to promote and maintain the highest degree of physical, mental, and social well-being of all employees. The employee can be a bit fearful, a bit forgetful, a bit suspicious, a bit compulsive, irritable, and angry, and still be very much normal. When confronted by stress and strain in the form of worries, whether they precipitate in the home or at work, there may be an exaggeration of these particular traits. In a research involving the top 100 companies in South Africa, Harper (1999:4) identified that of the 42 companies who have EAP services, 45% were located in the Occupational Health. This according to Matlhape (2003: 32) tends to give EAP a health and health promotion focus to the exclusion of other broader organisational development issues affecting employees.

7.6 MODELS OF EAP

Whatever the reason for an EAP, the benefits are evident for both economic and humanitarian reasons. From the employee point of view the benefits may be summarised as cost effectiveness, i.e. reduction of health care cost and improvement of social functioning and self-esteem (Kurzman & Akabas, 1993:27).

On the other hand, from the company's point of view the benefits are:

- An EAP provides a mechanism that reinforces basic management practices.
- An EAP enhances corporate image.

- Measurable cost savings: this may be evident in measurable variables as reduced absenteeism, improved error judgment, and less late-coming.
- Minimises appeals, grievances, and arbitrations - especially when there is an improved relationship between union and management.

It is with these benefits in mind that a company considers a model that will address core issues and bear these benefits. Every model will distinguish clear functions for both the employer and the employees. The EAP model is the structure that the company uses to plan, design, and implement programmes to address the needs of the troubled employee. As a result, a need assessment and programme plan will assist in determining which model to use. The programme plan should be flexible enough to allow appropriate changes, which will yield to an intended goal and prove to be useful and valuable to the organization. (Warley, 2004:8).

There has been a rapid growth in the number of EAPs. This study will focus and narrow the models to only two as defined by Bruce (1990) as internal and external models. Organisational employees staff internal models, while personnel who are employed by an organisation that sells EAP services operate external programmes. The internal models are employers and union monitored while external models may be hot-line, consortium or contractor-driven. Union programmes may be totally union-operated and maintained. A union member may volunteer for the programme. Highlights of this model may be self-development activities, crisis intervention and peer confrontational.

The internal model (**Appendix 11**) is the one that is designed, implemented, and managed by the company's personnel. In this model, the employees either refer themselves or are referred and the counselling takes place onsite. The office is accessible and the cost for travelling and loss of time is minimal. The role of the counsellor is to perform case monitoring, aftercare, and job re-entry of employees and assist management in the planning of organisational functions. It is widely observed that confidentiality and anonymity are the two principal disadvantages of the internal programme (Bruce, 1990).

External models (**Appendix 12**) are models where many functions are provided by external agencies with various EAP specialists. There is a contract between the outside agency and the company. The advantage of this model could be that employees may feel comfortable to discuss their problem with someone who is not part of their company and feel their confidentiality is guaranteed. The external models often include hot-line services. There are currently a few major EAP service providers in South Africa, namely ICAS, Ndawo, The Careways Group, Leaders Culture Innovators and Agility. According to Sithole (2002:159), the external model is the most common model in South Africa and it seems to be yielding successful results to a successful EAP.

Both external and internal models may provide services for employee dependants. Assessment skills for practitioners include assessing dependent care as an underlying problem, even if the employee's presenting problem does not include care giving responsibilities. Given that EAPs offer structured limited sessions to most employees, the practitioner's knowledge of community resources, health care systems and community educational support services assist in addressing some of the complex issues related to dependant care. According to Hoffman (2002:29), a survey of EAP counsellors in New York found that less than one quarter of respondents had ever attended a seminar or training regarding dependent care. The recommendation therefore is that EAPs must provide their counsellors with comprehensive training that addresses practical skills building opportunities in identifying dependent care. Some of the dependent care issues may include care for people with HIV and AIDS and other life threatening diseases, parenting and child care, physical and mental health and issues relating to death and dying. The involvement of an EAP in dependent care may help in minimising the impact of dependant care stressors on employees.

Dr Volpe (CEO Leadership and Culture), one of the experts consulted in this study, believes that more has to be done to diversify the services offered through EAPs. She emphasised that given diversity in various countries, an EAP's core technology may no longer be applicable in its totality in the running of a day-to-day EAP. As such, she indicated that creativity is required to change employees' behaviour. This approach, she

said, it is not only one-on-one counselling, but could include diversity training, change leadership and identification of cultural strengths.

7.7 SUCCESS OF THE EAP

Whether the company chooses an internal or external model, the EAP needs to be well implemented. To yield a positive and successful EAP, Dickman *et al.*, (1985) advise that the company should consider a policy guideline, which recognises that problems are part of life for every employee. The company's policy should be informed by the core ingredients of a successful EAP, which are:

- Accessibility
- Training for managers and supervisors
- Management orientation
- Insurance coverage
- Broad service components, which covers all various employee problems
- Professional leadership
- Programme evaluation and follow-up
- Confidentiality and anonymity.

This researcher therefore concludes that when an EAP has been successfully implemented, the following will be indicators of some of the management benefits:

Popularity of the programme: When employees understand the referral procedures and believe in the confidentiality of the programme, they are likely to use the programme. The popularity may be promoted through intervention techniques, referral procedures, review, and alignment of policies and procedures.

Mobilisation role: When union and management work together cooperatively under the auspices of an effective EAP to help troubled employees, work morale tends to increase and apathy diminishes while there is a significant high turnover and low absenteeism. An effective EAP mobilises all stakeholders for high utilization.

Satisfactory feedback: It is important to allow employees who utilise EAP to give continuous feedback regarding service offered. When more challenged employees are helped, feedback by employees indicate timely assistance and positive wellness.

Enhanced productivity: EAPs are designed to reach intended goal of its existence in any organization. The goal of EAP is to restore employees to a more functional state after any personal or work related challenge.

Resilience building: The role of EAP is to give employee alternative option to problem resolution and offer skills that contribute to employee resilience, personal growth and empowerment.

7.8 SUMMARY

Motivations for providing human services in the workplace are related to cost savings, increased productivity and humanitarian reasons. EAPs emphasise the kind of programmes that offer a holistic approach focusing on physical, mental, and emotional wellness. Evidently, as seen in this chapter, there is little information and scientific research about EAP in South Africa. There are still conflicting debates about its development and effectiveness. It is however important to note that there is academic interest in the subject and enthusiasm among authors that EAPs in South Africa are here to stay.

There is a clear difference in the historical development of EAPs in the USA and EAPs in South Africa. The scope of EAPs in the USA focuses on broad interventions, while in South Africa the focus seems to be on individual interventions. The focus in the USA in the past was on alcohol programmes and in South Africa it looks like the focus will be on HIV and AIDS. As evidently noted, organisations have already in the 1990s been implementing HIV and AIDS programme. This means that HIV and AIDS had been identified as a threat to the business and prioritised as an integral part of the EAP programme. The next chapter takes a look at HIV and AIDS in the workplace as a responsibility of EAP.

CHAPTER 8

THE ROLE OF EAP IN ADDRESSING ISSUES OF HIV AND AIDS INFECTED AND AFFECTED WOMEN IN THE WORKPLACE

8.1 INTRODUCTION

Drawing on the interrelationship between personal problems and job performance, the thrust of EAP lies in broadened EAP services; including problems that affect, or have the potential to impact negatively on an employee's job performance. An intervention that can reduce the stress, associated with high job strain, has the potential for immediate benefits. EAP clientele will include among others, risk populations, e.g. single parents, substance abusers, mentally ill workers, and persons with HIV and AIDS and family members of each of these groups.

8.2 HIV AND AIDS PROGRAMME

In South Africa, EAP practitioners have begun to assume a major role in the area of HIV and AIDS. A recent survey conducted by Markinor across 130 small, medium and large JSE Securities Exchange listed companies in South Africa, reveals that 59% of the companies are not aware of the HIV and AIDS prevalence within their workplace (*Succeed/Essential...*, 2004:5). The results indicated that only 62% of participating companies provided counselling for those infected in the workplace. One company's response to HIV and AIDS was evidently seen within the restructuring process whereby the wellness programme was designated as responsible for HIV and AIDS management (Steven, 2004:10). EAPs are involved in managing HIV and AIDS programmes, including designing and implementation of the programmes.

Three important aspects are training, education, and counselling of those infected and affected. In the area of HIV and AIDS risk prevention, Purcell, Degroff, and Wolitski (1998: 282) mirror this sentiment, suggesting that the first task of social workers (EAP practitioners in this case) is to assess risk behaviour. Valid assessment of high risk sexual behaviour related to HIV is important, because this information is used to

determine who receives education services and EAP interventions. It is suggested that individuals do not accurately self-report their sexual practices, especially behaviour related to HIV and Sexually Transmitted Infections (STIs). Under-reporting of high risk behaviour and over-reporting of protected sex have been found to occur more frequently in face-to-face interviews than in more anonymous conditions (Scandell *et al.*, 2003: 120). This could explain the EAP statistic reports presented at various local EAP conferences and during benchmarking sessions among various SA corporates. However, according to Du Plessis in (Maiden, 2001:115), statistics shared by EAP practitioners in a meeting held in Johannesburg in 1995, health issues such as HIV and AIDS and Sexually Transmitted Infections were on the increase. This means the EAP forums are platforms to discuss best practice and confidential statistics that are not otherwise discussed in the companies' published newsletters.

EAP and occupational social work use some of the frameworks and skills borrowed from psychiatry. With the impact of HIV and AIDS in the workplace, the treatment of employees in the environment with focus on casework is helpful. In addressing HIV and AIDS, practitioners face death and dying on an ongoing basis. In psychiatric management, the treatment of HIV and AIDS is treated and understood in causality with other mental health problems such as depression, grief responses, irrational guilt, diminished self-esteem and at times pronounced suicidal thoughts. This management requires psychological debriefing according to Lewis (2004:10). In most cases the symptoms are related to conscious and unconscious conflicts about how the disease was acquired. One of the common psychiatric interventions for patients with psychiatric disorders is the ability to create a structure for the patient. The importance of limit setting appropriate to the patient's current capacities, decrease unreasonable preoccupations, and reducing self-destructive behaviour can refocus the patient. Similarly, HIV and AIDS can first present in the form of cognitive or emotional symptoms, thus the need to follow structured counselling may be necessary. Warley (2004:8) encourages adoption of a pre-treatment model that uses quantitative and qualitative data collection methods: The model, which the researcher believes, is important in counselling of people living with HIV and AIDS includes the following theoretical frameworks:

- **Psychodynamic questions:** the technique that makes enquiry about the impacts of the client's past history as it affects the present and the hidden fears and anxieties.
- **Cognitive-behavioural queries:** the focus here is on the thoughts about self, others and the future.
- **Life model questions:** the enquiry is about phase of life, interpersonal processes and environmental barriers.
- **Solution- focused queries:** the focus here is about assessing the strengths and motivation of the client.
- **Psycho-education:** this process is important in particular to all clients facing life-threatening illness. The focus is understanding and acceptance of the illness.

It is not uncommon to find some AIDS patients remaining unreasonably hopeful about recovery, despite the presence of their fatal illness. In cases where denial in some patients has become so extreme that it interferes with the patient receiving medical care, it is recommended to confront the patient and treatment be instituted. The psychological problems caused by AIDS are psychosocial stressors particular to death and dying. These include ostracism by family, friends, and lack of a supportive social network. As more people are infected daily, the need for counselling by trained mental health professionals is growing. Most therapists can offer psychotherapy to treat grief, anxiety, depression, alienation, and avoidance behaviour. Although self-help groups and support groups are available, some individuals may have unique problems concerning confidentiality and anonymity preventing them to participate.

Persons who are HIV negative - but who are at risk for HIV infection - are often psychologically distressed, despite their HIV negative status. This may include individuals whose recent behaviour (intravenous drug use or unsafe sex) has placed them at risk of HIV infection. The distress, which is often acute, may be related to fear of pending test results. Stress may also result from the fact that the person must now alter their future behaviour to avoid infection. Providing counselling reduces the psychological problems and helps to prevent the spread of the disease.

8.3 HIV AND AIDS COUNSELLING IN THE CONTEXT OF EAP

Counselling is widely used as a strategy in health care and in the workplace (Summersfield & Oudtshoorn, 1995: 55). Many people offer AIDS counselling, such as telephone counselling and / or face-to-face counselling. AIDS counselling has some very particular characteristics, but also shares many familiar resemblances with other forms of counselling. According to Burnard (1992), counselling people with AIDS involves counselling in three categories, namely: educational issues, advice, and psychological issues.

Nurses are one group that find themselves in the counselling role for HIV and AIDS patients. Klonoff and Ewers (1990) in Burnard (1992:11), administered a questionnaire to the nursing staff of a teaching hospital in the USA to determine sources of stress in caring for AIDS patients, to determine perceived sources of stress in being an AIDS patient and to investigate attitudes towards other various illnesses. This study revealed a number of factors related to increased stress, including: general concerns about the care of these patients; specific concerns in crisis situations; and concerns regarding the personal / social implications of caring for these individuals.

Another study in New Zealand by Will (1990) quoted by Burnard (1992: 14), was carried out to examine the nurses' attitudes to a wide range of matters relating to the management of patients and persons with AIDS. Prevention of HIV infection showed a strong support for public health measures and showed that most nurses believe AIDS patients should not be treated differently than other disease sufferers. The nurses' attitudes were that treating AIDS patients is not different from treating other patients.

Given this background regarding the attitude of nurses found in various studies, it is evident that nurses need to have education about HIV and AIDS, modes of transmission and become acutely aware of the vocabulary in the field. Advice is a form of counselling. Having AIDS is not an automatic indicator of a person's knowledge about it. Information about AIDS does not always change people's behaviour. Burnard (1992) emphasises

that counsellors should explore their own attitudes about beliefs related to AIDS before assuming the role of advisors.

Many writers on counselling have advocated a client-centred approach. This counselling style that advocates that the counsellor remains in the background while the client takes the lead in clarifying the problem and perceptions about the problem (Burnard, 1992:12). Counselling of HIV and AIDS patients may involve advice, confrontation, prescriptive mode and education, cathartic, catalytic and supportive approaches.

There are various psychosocial problems in AIDS counselling. An example of a psychosocial problem includes the client's own perception of himself / herself as a person with AIDS. In addition to the fact that the person has AIDS, they bring to the counselling sessions cultural beliefs, fears, anxieties, attitudes and mental health problems. After all these factors have been explored, issues of meaning, purpose, and dying may emerge.

AIDS counselling cannot be professionalised, particularly within the context of the medical and health professions. The aim of AIDS counselling is to encourage the person with AIDS to live as fully and as independently as possible. The emotional aspect of the person in AIDS counselling is important. HIV and AIDS people have a wide range of emotions, ranging from fear, guilt, anger, apprehension to worries about the likelihood of infecting others and future relationships. Burnard (1992:69) identifies the following emotions that are associated with the experience of having AIDS: shock, relief, anger, guilt, decreased self-esteem, loss of identity, loss of a sense of security, loss of personal control. Many people, including lay counsellors, religious leaders, and community volunteers who have been trained to work with HIV and AIDS people, can conduct AIDS counselling.

George, Green and McGreaner (1989) identifies the following counselling skills as important in counselling people living with HIV and AIDS:



- **Minimising Uncertainty**

The emphasis here is on the fact that HIV positive people have the right to know about their physical health. A therapist who becomes vague and evasive does not help people with life threatening diseases, but rather increases their mistrust and lack of confidence in the service offered. It is important that counsellors remain sensitive and confrontational.

- **Understanding And Correcting Misconceptions**

When a person is informed about his / her HIV positive status, checking misconceptions and clarifying myths set a good foundation for education. It is also important at this stage to reassure the person about confidentiality. Given the stigmatisation that accompanies HIV and AIDS, the emphasis on confidentiality is necessary.

- **Examining Personal Resources**

Examining personal information and who in the family needs to know about the HIV diagnosis and who does not, is important. Enquiring about housing, employment and finance will help prevent stress at a later stage. If work is an important part of the person's life, it may be important to discourage the person not to leave their work immediately. The person should be encouraged to consider options of limiting working hours. This will also largely depend on the kind of reasonable accommodating attitudes and support in the workplace.

- **Death And Dying**

Clients should not be forced to talk about the death or dying process. Gentle, tactful and sensitive enquiries are enough to ensure that the person understands the significance of the prognosis and who can answer questions pertaining to the disease. Death and dying should only be discussed when the client is ready. At the stage of death and dying, it may be important to discuss practical matters, such as

the will, children custody if necessary, the estate, etc. It may be advisable to link the client with community resources if any assistance falls outside the counsellor's area of expertise.

- **Developing A Sense Of Purpose**

Developing a sense of purpose aims to maximise the client's quality of life in a realistic way. Encourage the client to maintain realistic ambitions and alternative sense of purpose. The client with HIV and AIDS may feel that life is already over. It is important not to deny the difficulties the clients have, the feelings they are experiencing, as this may lead to alienation and isolation.

- **Choice And Dignity**

Most clients respond with realistic hope when their dignity is restored during counselling. HIV and AIDS can leave clients with a sense of dependency and unrealistic perceptions that they are not dignified. It may be important to encourage the client to exercise their choices in instances when it is necessary, particularly with regard to cultural and religious matters.

- **Setting Boundaries**

People with HIV and AIDS need to know whom they can rely on in cases of crises. This knowledge gives them a sense of security and privacy to their issues. Trust in the counsellor provides a sense of privacy. Refraining from over-involvement, over-helping and encouraging independence can only help the client's sense of boundaries and limits.

8.4 SKILLS FOR COUNSELLORS HELPING PEOPLE AFFECTED BY HIV AND AIDS

The following skills have been compiled by the researcher from various research reports over the years of experienced and are continuously tested and used by the researcher when counselling employees living with HIV and AIDS.

8.4.1 Ability to overcome Health Worries

It is important to educate caregivers about People living with HIV and AIDS (PWA) and the disease itself to avoid misconceptions. It may be difficult to care for a PWA when experiencing nagging fears about one's own health. The caregiver needs to be reassured about what is possible and what is not.

8.4.2 Role Reversal

In the case of role reversal, the caregiver needs to be taught how to cope with the changes, such as taking more charge, be more assertive and take responsibilities for more practical matters if this was the role of the PWA. In the case of couples, the roles may fluctuate and it is important that open communication regarding who may survive the other do happen. Children may also be involved in these communications and planning.

8.4.3 Dealing With Betrayal

In the case of couples, issues about who infected who may be raised. Allowing the client to ventilate and own their feelings may be essential. Verbal expression of feelings is often enough to ease the deep sense of hurt, pain and blame. It is important to remain neutral and not to take sides, as this will not help the client to move on. Listening and reflective feelings will alleviate anger and blaming.

8.4.4 Handling Sexuality Issues

Couples may not know how to deal with their sexual needs initially. Education on sexual matters, i.e. how to create enjoyment and the importance of safer sex is essential. It normalises their sexual needs and empowers them to take responsibility. Counsellors should always recognise the couple's need for intimacy and help them to realise it through safer methods.

8.4.5 Adjustment to Multiple Issues

Multiple issues may include loss of income, grieving in advance of the death of the PWA, accommodation and some family fun activities. This may often become a reality to the caregiver when the PWA's health starts to decline. As with other serious illnesses, such as cancer, heart disease or stroke, HIV can be accompanied by depression, an illness that affects mind, mood and behaviour. Depression undermines people's ability to deal with the problems of everyday life. It will be a mistake to assume that prolonged or intense depression is natural. It is reported that one in three persons with HIV may suffer from depression (*Dbsaalliance.org...*, 2005). When assessing the mental status of a PWA, it is important to look for symptoms of depression as identified by the American Psychiatric Association (1987).

8.4.5.1 Affective Symptoms

Affective symptoms are symptoms of mood and mental status. The following signs steps should guide the counsellor in identifying the patient's mood symptoms:

- Ask about moods, especially over the past few weeks.
- Enquire about changes in enjoyable activities. Things often seem pleasurable. It may be important to ask how this aspect has been during the last two weeks.
- Enquire about a loss of libido; distinguish fear and loss of interest.
- Enquire about irritable moods and emotional instability. Usually the depressed person would report being more easily upset than usual.

8.4.5.2 Cognitive Changes

Depressed people see themselves usually as worthless and unlovable this may result in a loss of self-esteem. They look at themselves in a negative way and highlight their shortcomings. Sometimes they tend to be neglectful regarding their appearance. It is important to enquire how they feel about themselves. Typical related symptoms are:

- Feeling of failure;
- Loss of hope; the future often looks bleak in their minds and eyes;

- Difficulties in concentrating;
- Forgetfulness.

8.4.5.3 Somatic Symptoms

Somatic symptoms are symptoms that are experienced by the patient as real, even if there is no medical confirmation or a diagnosis of sort.

- Look for changes in sleep patterns.
- Assess eating disturbances and food appreciation.
- There may be multiple physical complaints, e.g. headaches, joint pains, and / or stomach problems.

8.4.5.4 Behavioural Symptoms

When people are infected, everything seems like too much effort to do. People with depression may feel less energetic than usual. They would often do less than they used to do.

8.4.5.5 Suicidal Tendencies

Many people who are depressed contemplate suicide at one point or another. The dangerous time for suicidal people is usually the time when they just come out of a depression. Green (1989: 4) identify the following steps to take in consideration when counselling people with depression:

- **Putting things in perspective**

It helps to clarify depression symptoms to the client, reassure them that depression does not last forever and help them to focus on the future. Reassure them that depression is treatable.

- **Sorting out problems**

Assess what is causing the depression and help the client to sort out the problem. Once this is sorted out the client may feel better.

- **Increasing activity**

Helping the client to focus on activities that bring pleasure may defocus attention on the problems at hand. This may also help the person to find new activities that help to focus more on future plans.

- **Identifying inaccurate thoughts**

Challenging the client's inaccurate thoughts may empower them to take responsibility for their emotions and life. This skill could be applied by asking the client to write down their views and thoughts.

- **Working with the family**

This is one of the most important aspects when counselling depressed people. The family's understanding, support, and encouragement help the depressed person in the process of a speedy recovery. Should the depressed client not improve after family intervention, psychiatric intervention should be considered.

8.5 SPIRITUAL COPING MECHANISM FOR WOMEN WITH HIV AND AIDS

There have been various changes in the world of work to make the workplace a friendlier place for employees and to enhance job performance. Evidently, in the late 1990s, workplaces became faith-friendly, incorporating policies that respected all religions through leave policies accommodation. Studies indicate that this in turn encourages workplaces to allow employees to live their lives openly and bring the value of their spiritual identities, their souls and their faith to the workplace, making it for them a great place to work at (Miller, 2005:13).

Research on other life-threatening illnesses has indicated that individuals often turn to religion and spirituality to cope (Dein & Stygall, 1997, Demi, Moneyham, Sowell & Cohen 1997). It can be assumed that spiritual awareness contributes to lower levels of psychosocial distress as it provides a sense of meaning in the face of threat to existence. On the other hand, it is reported that an individual, battling with a life-

threatening illness, use religious coping in complex and variable ways, making it difficult to identify the mechanisms by which it operates (Smith & Hill, 1993).

Pargament (1997) suggests that prayer allows expression of anger and disappointment, emotions that are common among HIV positive women, particularly upon knowing their status. On the other hand it is suggested that prayer assists one in repairing damaged relationships, letting go of the past, achieving a sense of closure and provides hope of an ultimate victory (Carson *et al.*, 1990). There is however a view that some clinicians see spirituality as detrimental to emotional functioning and believe that it fosters passivity, dependency and denial (Jenkins & Pargament, 1995:131). Studies indicate that HIV is associated with greater religiosity and spirituality among HIV positive and HIV negative partners of men with AIDS (Folkman, Chesney, Cooke, Boccillari, & Collette 1994:746). Qualitative research regarding spirituality is needed to give conclusive evidence of the role it plays as a coping mechanism of those with life-threatening illnesses in general. The use of spirituality-based coping has been found to be prevalent among women. Studies have consistently indicated a greater use of spiritually-based coping activities among samples of women than in samples of gay men (Demi *et al.*, 1997:173) and (Potts, 1996:16). Faith can be a source of solace and nurture and healing in difficult times, such as when one has just been diagnosed with HIV.

When the usual human coping resources are ineffective or are threatened, as in the case of a life threatening disease such as HIV and AIDS, spirituality may be an available resource. Drawing from the perspective of Pargament (1997), spirituality may help individuals conserve meaning and transform their sense of significance through integration of the stressor into existing definition of self, thus providing a greater sense of control and aiding in psychological adjustment.

In a study by Simoni, Martone and Kerwin, (2002:137) that aimed at examining spirituality and its correlation to spiritually-based coping among women with HIV the researcher found that spirituality and spiritually-based coping mechanisms may lead to better well-being. Furthermore, the study concluded that women who feel better

psychologically are more optimistic and appreciative regarding spirituality in their lives. The study however found that there was a high level of depressive symptomatology, which suggested counsellors should pay more attention to suicidal ideation in the group.

The best way forward regarding spiritual counselling would be for a workplace to develop policies that help create faith-friendly cultures in the workplace. Employees need to be given permission to bring their whole being to work. According to Miller (2005:15), companies that allow this perspective in the workplace are likely to avoid major accidents and become better places to work

Even at a professional level, faith and work are leadership issues and can make such difference in the executive coaching and mentoring (Miller, 2005:14). Increasingly, leadership training and seminars tend to emphasise inherent spiritual values such as respect for individuals, care, sharing and improved relationships. Some religious beliefs play an important role in encouraging greater tolerance of, and respect for employees. McAninch (2006:16) highlights that understanding spirituality is essential in addressing any traumatic event, including dealing with HIV and AIDS, particularly because every incidence has social, political, and spiritual impacts. He encourages EAP professionals to be comfortable talking about the spiritual dimension, as it can be a major factor in the recovery of workers.

8.6 PSYCHOSOCIAL IMPACT OF HIV AND AIDS ON COUNSELLORS

There is a perception that health workers are able to cope with all related health matters. However, studies indicate that coping in the work environment is difficult for nurses because of lack of support from employers and most of the health workers do not have access to any form of official support such as counselling for work-related stress. A study in Uganda among health workers showed the same results indicating inadequate counselling and lack of facilities and equipment (Mungherera, Van der Straten, Hall, Faigeles, Fowler & Mandel, 1997; Hall, 2004:111). Bateman (2001: 3) reported that since 1999, the Health Professions Council of South Africa has had an increase in cases of alleged impaired doctors.

Bateman describes “impaired”, as a mental or physical condition, or abuse of substance, which affects the competence, attitude, judgment, or performance of a health professional. It can be assumed that the impairment may be related to lack of support, which then ultimately leads to stress in the workplace. A study by Hall (2004:113) in South Africa found that confidentiality of a patients’ HIV status posed challenges to health professionals in their work. Evidently in Hall’s study, the stigma attached to HIV and AIDS in communities led to an influx of very ill patients. Nurses then found themselves taking care of terminally ill patients, who were becoming increasingly taxing as dying patients generally need supplementary support.

A study by Aiken and Sloane (1997a) in Hall (2004:111) found that the organisational form of the unit and hospital in which AIDS care is provided has a significant impact on the emotional exhaustion experienced by nurses. HIV work is extremely intense and difficult. Counsellors and EAP practitioners are constantly exposed to people who are in an intense emotional state. To protect themselves from becoming overburdened and incapacitated, counsellors develop a variety of ways to cope. One mechanism is to create and maintain an emotional and cognitive thinking process that gives the counsellor a sense of invulnerability; seeing the client as different from himself or herself enables the counsellor to work with the client. It is noted that some counsellors would then skip all the emotional counselling and concentrate on the medical and educational aspects of the disease and ending up lecturing rather than listening to the client (Fowley, Rosenthal, & Levine, 1990:286).

Nurses, like EAP professionals, found themselves having an additional load of counselling added to their daily work routine due to the HIV and AIDS challenge. Hall (2004:110), in a study about the challenges HIV and AIDS poses to nurses in the work environment, found that the secrecy surrounding the disease reduces nurses’ productivity, confronts them with ethical issues and hinders them from curbing the spread of HIV and AIDS. O’ Grady (2004:205) agrees that the lack of disclosure of HIV is the compounding difficulty in managing HIV and AIDS. Similarly, EAP practitioners

face ethical dilemmas about high sick leave rates of employees with HIV and AIDS and assisting managers to manage productivity and create reasonable accommodating environments for sick employees. In a survey of NGO managers in South Africa in 2002, several senior managers reported difficulties to cope with managing employees with long-term illness (James & Mullins, 2003:4).

Psychosocial support has been evidently documented to be one of the most effective tools of assisting HIV and AIDS patients in gaining access to antiretroviral treatment. In South–East Asia and in many other countries, there is considerable evidence of the psychological benefits of self-help clubs for HIV infected and affected people (UNAIDS, 2002:158).

Research suggests that EAPs should be moving towards integrating resources. Kramer and Ricket (2006:23) stress that by incorporating resources, EAPs can both validate health and productivity services while also providing a strong growth product on EAPs. Kramer and Ricket (2006:24) suggest the following components to be included in the integrated programme offering:

- Tracking and administration of employee absences.
- A toll-free “Life Enhancement Line”.
- A health risk assessment.
- Employee group interventions.
- Organisational effectiveness interventions.
- Employee interventions.
- Return on investment analyses.

8.7 SUMMARY

HIV and AIDS counselling present difficulties for most EAP practitioners, due to the fact that it is a new field of counselling. The ethical dilemma of confidentiality and workplace management of HIV and AIDS is a continuous problem for most practitioners. It is therefore very important that EAP practitioners be abreast of new changes and education on HIV and AIDS as they remain in the forefront of the management of the pandemic. Employees need comprehensive care regarding HIV and AIDS management, as well as understanding and creation of reasonable accommodating environments for employment opportunities. EAP practitioners are the best advocates to assist employees. However, there is limited information on HIV and AIDS counselling by EAP practitioners, which necessitates future research and studies in this area. In addition, spirituality and spiritually- based coping should be explored as part of a strategy of identifying and bolstering cultural strengths, particularly in relation to HIV and AIDS.