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Effect of Leadership Style on Work Climate and Program Completion in Domiciliary Addiction Programs

Patricia L. Johnson
East Tennessee State University

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Johnson, Patricia Lee, Ed.D.

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U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

Effect of Leadership Style on Work Climate and Program Completion in Domiciliary Addiction Programs

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A Dissertation

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In Partial Fulfillment

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Doctorate of Education

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by

Patricia L. Johnson

December 1994

APPROVAL

This is to certify that the Graduate Committee of

PATRICIA L. JOHNSON

met on the

7th day of November, 1994.

The committee read and examined her thesis, supervised her defense of it in an oral examination, and decided to recommend that her study be submitted to the Graduate Council and the Associate Vice-President for Research and Dean of the Graduate School, in partial fulfillment of the requirements for the degree of Doctorate of Education in Leadership and Policy Analysis.

W Hal Knight
Chairman, Graduate Committee

Signed on behalf of
the Graduate Council

Associate Vice-President for Research
and Dean, School for Graduate Studies

ABSTRACT

EFFECT OF LEADERSHIP STYLE ON WORK CLIMATE AND PROGRAM COMPLETION IN DOMICILIARY ADDICTION PROGRAMS

by

Patricia L. Johnson

Addiction leads to homelessness, AIDS, other health problems, crimes, financial burdens, family conflict and many social and psychological problems, Relapse rates remain very high in addiction programs and employees are frustrated by the poor response of clients to treatment and to the bureaucratic style of management often found in hospitals and clinics. Relapse rates are due to stress factors, respondent conditioning processes, and lack of focus on techniques of relapse prevention. One approach to overcoming the morale problem could be a more participatory style of management to improve the work climate. This study was completed in response to the lack of previous research in this area.

Employees in 11 Veterans Affairs Domiciliary Addiction Programs completed the Work Environment Scale developed by Moos to measure stress in the work environment. The leadership behavior of the coordinators was measured with Yukl's Managerial Practices Survey to determine levels of skills of participative management. Rates of program completion and program demographic data were also obtained.

Seventy-three (72.3%) sets of responses were used in the analysis of data from eleven programs. The rate of program completion ranged from 62.5% to 85%. The MPS mean for each program ranged from 117.25 to 246.00. A one-way analysis of variance indicated that programs with higher scores on the MPS had higher program completion rates (F=32.86, p=.003). The five programs with mean scores above 205 on the MPS and the six programs with mean scores below 184 were compared with their scores on the WES subscales. The following dimensions were statistically significant:

involvement, comfort, autonomy, and supervisor support. There was no statistically significant difference in the subscales of innovation, clarity, task orientation and peer cohesion. The programs with lower scores on the MPS had higher scores on the subscales of work pressure and control. The analysis produced an F=11.54 (p=.01) for work pressure and F=25.10 (p=.007) for control.

Results of this study supported the importance of using a participative management style to improve work climate and increase program effectiveness. Recommendations for further studies focused on organizational development and job redesign in health care to tap the unrealized potential of human resources. Future studies could be focused on successful reintegration of clients within the community since recovery is a social process.

INSTITUTIONAL REVIEW BOARD APPROVAL

This is to certify that the following study has been filed and approved by the Institutional Review Board of East Tennessee State University.

Title of Grant or Project Effect of Leadership Style on Work Climate and Program Completion in Domiciliary Addiction Programs

Principal Investigator Patricia L. Johnson

Department Leadership and Policy Analysis

Date Submitted June 12, 1993

Institutional Review Board, Chairman David N. Wallace MD

DEDICATION

Dedicated to

my father, Dixon Shipe Fain,

who viewed education as a means

to help others.

ACKNOWLEDGEMENTS

I wish to express my gratitude to Dr. W. Hal Knight, my advisor and and chair, for his patience and inspiration during this learning process. I admire his skill in research and realize that his meticulous reading did much to enhance this manuscript. My appreciation is also directed to the other members of my committee: Dr. Robert McElrath, Dr. Robert Spangler, Dr. Marie Hill, and retired members Dr. Floyd Edwards and Dr. J. Howard Bowers for their cooperation and guidance.

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Finally, I wish to recognize my mother, Ms. Violet Fain, and my best friend, Robert W. Coffman, for their encouragement, optimism and constant support. My son, Charles M. Johnson, helped me to keep the proper perspective and to maintain a sense of humor.

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Chapter 1

Introduction

The Department of Veterans Affairs (V.A.) has recently expanded its substance abuse treatment services to include programs for dual diagnosis clients with both alcohol and drug addiction and psychiatric problems (i.e., Bipolar Disorder, Schizophrenia, and Depression), extended care programs, and services designed to improve continuity of care and community re-entry. Veterans are one of the largest segments of our nation's chemical dependency population. In 1990, the V.A. was operating 180 inpatient (including domiciliary) and 98 outpatient programs with addiction counselors at 12 other free-standing medical clinics. These new programs were still needed to meet increasing demands. These veterans are primarily male (98-99%), caucasian (66%), black (27%), and other races (7%), forty years old or older (55%), and only 31% were married. Many (37%) had a history of polysubstance abuse and 14% had more than one admission during the year (Peterson, Swindle, Moos, Finney & Suchinsky, 1992).

To expand these services, Congress appropriated 60 million dollars in 1980 with anticipated annual increases of 15 million dollars per year through 1993. Proposals to utilize these expansion funds were based on needs assessments conducted by treatment staff rather than policy implementation. Treatment providers indicate that more severe cocaine and heroine addictions, Anti-immune Deficiency Syndrome (AIDS) cases, homelessness cases, and chronic

mental illness cases are increasing among V.A. patients. Brief inpatient programs (28-30 days) may be sufficient for detoxification but provide too little time for psychological and vocational rehabilitation for these severely impaired clients. The shorter programs may have been developed for reimbursement purposes, rather than for desired clinical effects (Berg & Dubin, 1990). Gallup (1989) reported that competition for budgetary dollars is intense and health and cost control measures are targeting substance abuse benefits for reductions even though the public ranks the drug problem above national security and economic concerns as the country's most serious current issue.

Statement of the Problem

Relapse rates remain very high in addiction programs and the morale of personnel employed in this field is often low. Employees are frustrated by the poor response of clients to treatment and to the bureaucratic style of management often found in hospitals and clinics. This style of management results in high control, increased work pressure, low morale, decreased cohesion, and reduced support (Hoy & Miskel, 1991). One approach to overcoming the morale problem is a more participatory style of management which can lead to improved work climate. An improvement in the work climate may also affect relapse rates. There is no research available on the impact which participatory management may have on the effectiveness of addiction programs.

Significance of the Study

This study may reveal whether a participative management style can improve the work climate and empower employees to obtain results. According to Beck & Hillmar (1986) democratic leadership does fundamentally change what constitutes the team effort. Truly effective leadership begins to emerge when team members become leaders themselves. A directive leadership style can create a climate that guarantees risk-aversion, low morale and indecision. It is all too easy for the leadership role to include the belief that judgment is more sound at the leader's level. Beginning with the team leader, effective leadership requires a constant suppression of the individual ego on behalf of all team members.

It is hoped that this study of leadership styles used in chemical dependency programs will show that increased employee participation can increase worker commitment and support changes to stimulate improvement in the relapse rates among its clients.

Limitations

The population was confined to the thirteen VAMC Domiciliary Addiction Programs. The programs are located in Bath, New York; Hampton, Virginia; Martinsburg, West Virginia; Cincinnati, Ohio; Dayton, Ohio; Leavenworth, Kansas; Lyons, New Jersey; Milwaukee, Wisconsin; Bay Pines, Florida; Bonham, Texas; Los Angeles, California; White City, Oregon and Mountain

Home, Tennessee. The Domiciliary programs are extended care facilities, but the length of treatment can vary from a few months to a year. Some of these programs are primary care settings and others are aftercare programs for clients who have completed a detoxification and four week treatment unit at a hospital (See Appendix A for an example). The clients have diagnoses of alcohol addiction, drug addiction, polysubstance abuse, addictions with psychiatric disorders (dual diagnosis), and various medical complications. Clients with multiple impairments have a range of special needs related to behavior management, suicidal potential, medication and treatment compliance, socialization, and employability. Many homeless veterans have basic needs for shelter, food, clothing, and medical care that may precede their interest in rehabilitative counseling and support group attendance. Dual diagnosis patients are considered a higher risk for relapse and noncompliance and require more counseling and frequent monitoring. The majority of the clients will be male with their ages varying from the twenties to the sixties. The programs to be studied have already been established and vary in size and patient characteristics, but are more similar than private and state addiction programs.

Assumptions

The following assumptions are considered relative to this study:

1) Chemical dependency programs have a high rate of relapse since addiction is not easily arrested.

2) It is important to gather data about the effectiveness of chemical dependency programs to improve their quality.

3) Democratic leadership increases employee participation and enhances organizational effectiveness.

4) Involvement in decision making improves morale and increases employee motivation.

5) The leaders of VA Domiciliary chemical dependency programs will be able to assess their leadership styles.

6) The instruments will be completed by the employees identified to participate in this study.

7) Program completion rates will be included in the statistics for the chemical dependency programs.

Hypotheses

Based upon a review of the relevant literature and research currently available on chemical dependency, addiction programs and participative management, the following hypotheses were developed.

H1: Programs with participative management styles will have higher program completion than programs with directive management styles. The leadership behavior of the coordinators will be measured with the Managerial Practices Survey developed by Yukl (1981).

H2: Programs with participative management styles will have higher scores

than programs with directive management styles on the following dimensions of work climate: involvement, peer cohesion, supervisor, support, autonomy, task orientation, clarity, innovation, and physical comfort. The work climate will be measured by the Work Environment Scale developed by Moos (1981, 1986).

H3: Programs with participative management styles will have lower scores than programs with directive management styles on the following dimensions of work climate: work pressure and control.

Definition of Terms

Domiciliary - For the purpose of this study, the domiciliary is a place of residency in the Veterans Affairs Medical Center for veterans of all age groups. The length of residency can vary from a few months to several years. The average length of stay in an addiction aftercare program in the domiciliary is six months (Peterson, et al., 1992).

Addiction - A person who has an addiction will habitually or compulsively take a drug due to a psychological and/or physical dependence on that drug regardless of the consequences. These drugs can be narcotics, alcohol, cocaine, heroine, marijuana, tranquilizers, amphetamines, hallucinogens, or any other legal or illegal drug (Faupel, 1991).

Relapse - A client who relapses begins to use the drug again. The actual relapse process indicates a change in attitude and emotional response that may occur weeks and months before the actual use of the drug occurs (Ludwig, 1988).

Leadership Style - The democratic leadership style is a participative approach with group as well as leader involvement. The laissez faire leadership style is a leader approach that grants freedom to employees without direction. The leader with an autocratic style prefers centralized decision-making and retention of power (Knezevich, 1984).

Work Climate - The work climate is the social climate of the work milieu which includes the relationship dimensions, personal growth dimensions, and system maintenance and change dimensions (Moos, 1986).

Milieu Therapy - A therapeutic procedure in which the total social environment becomes influential in the treatment process. It is often accompanied by self-government patients in an inpatient setting.

Assertion Training - A therapeutic procedure in which an individual is taught to express personal rights and feelings, usually by means of specific instructions, examples, practice, feedback, and reward.

Co-dependency - A reactive stance in relation to the dominance of another where the other person's feelings are considered more important than your own.

Incentive therapy - Domiciliary members are paid to transport charts, push wheelchair hospital patients to appointments in the hospital, file records, and other details.

Contract Work Therapy - Domiciliary members are paid by outside businesses through a contract with the Veterans Affairs Medical Center Domiciliary to do work. Some of these appointments are similar to assembly line factory work.

Recidivism - Patients relapse and return to the use of their drug of choice.

Overview of the Study

Chapter I includes the introduction, the statement of the problem, the significance of the study, assumptions, hypotheses, limitations, definition of terms, and an overview of the study.

Chapter II contains a review of relevant literature and research.

Chapter III is a description of the methods and procedures to be used in the study.

Chapter IV provides information on the data collection, descriptions of the programs and coordinators, and findings for hypotheses.

Chapter V suggests conclusions of the study and recommendations for further research.

Chapter 2

Review of Relevant Literature

Introduction

This chapter is divided into three major sections. First, the dynamics, effects, demographics, attitudes, diagnostic instruments, and predictors of outcome are presented to provide an understanding of the disease concept of addiction. Data is then provided about effectiveness of chemical dependency programs, their structure, and predictors of client functioning. Four major therapeutic approaches are discussed with research on various strategies and activities that can guide the addict in behavior modification. Studies on relapse and current relapse prevention models provide an appreciation for the difficulties encountered in treatment. The second section introduces a history and current research on participative management with a comparison of participative and directive management. The benefits and dilemmas of this style of leadership are identified with evidence of how employee participation can empower workers and increase effectiveness in organizations through teamwork. The last section defines climate and culture, its levels, and describes how to change the culture through humanistic approaches to improve the social environment of work settings.

Alcoholism

Alcohol is the most abused drug in the United States, costing society well over one hundred billion dollars in lost productivity and employment, excess mortality, health care costs, and property loss and crime. The research evaluating the effects of programs and policies designed to reduce the incidence of alcohol problems supports the efficacy of these policies: raising the minimum legal drinking age to 21, increasing alcohol taxes and increasing the enforcement of drinking-driving laws (Harwood, Proditano, Kristiansen, & Collins, 1984).

Active alcoholism is not easily arrested. It has a dynamic of its own and the social, interpersonal, and psychological consequences of continued abusive drinking are so devastating that a downward spiral is almost ensured. Even with proper diagnosis, premature and unempathic confrontations of the addiction may drive the client away before any progress has been made. The treatment goal with the overwhelming majority of addicts and their therapists is complete abstinence. Many alcoholics have never been normal social drinkers and very few are able to move from problem drinking to normal social drinking (Levin, 1987).

Stigmatizing attitudes about alcoholism may be sources of the defense mechanisms alcoholics employ since their self-esteem is threatened by the

belief that they are morally weak. This problem can be dealt with by treating the alcoholic and reducing the stigma by changing attitudes through education. Caetano (1987) conducted 484 interviews and found that the majority of the respondents accepted alcoholism as an illness. Accepting the disease concept does not necessarily predict that people will hold humanitarian views of alcoholism. Ames (1985) speaks of a medical-moral dilemma in that both views may exist in a parallel or an overlapping way in one individual.

Television and radio can be used as mediums for education to influence broad audience perceptions about the norms surrounding the use of alcohol. Television is a potentially important source for observational learning as well as defining and reinforcing cultural values and norms (Gerbner, Gross, Morgan, & Signorielli, 1986). Observing a model can increase the likelihood of a behavior even when no overt consequences are observed. Identification with or a desire to attain valued characteristics associated with models also may play a role (Wallack, Grube, Madden, & Breed, 1990).

Older veterans are likely to come to treatment facilities from the same referral sources as other age groups. A report of an outpatient program for the elderly substance abusers in a VAMC (Kofoed, Tolson, Atkinson, Turner & Toth, 1984) shows the largest group of referrals to be from the legal system (57%) and about equal referrals from the health care system (19%) or self and

family (17%). A case has been made for gender differences in referral, with elderly alcoholic men more likely to be referred by the legal system and referral of elderly alcoholic women more likely to come from medical or personal sources. When they appear in hospitals and clinics, elderly alcoholics present nonspecific or more subtle signs than do younger alcohol abusers. These signs may include self-neglect, falls and injuries, confusion, depression, and malnutrition (Atkinson, 1984).

Some screening tools and useful instruments in detecting the presence of alcohol abuse and dependence are the Michigan Alcoholism Screening Test (MAST) (Selzer, 1971) and the Alcohol Dependence Scale (ADS) (Skinner & Horn, 1984). The widely used MAST self-report items tap various problems associated with alcohol use, including its medical, interpersonal, and legal consequences. The ADS is designed to measure elements of the alcohol dependence syndrome and includes impaired control over alcohol use, salience of drink-seeking behavior, tolerance, withdrawal symptoms and a compulsive drinking style. The MAST assesses the degree of problems and the ADS yields a quantitative index of the severity of alcohol dependence.

A number of studies on alcoholism have proposed subtypes of the disease based on patient demographics, course variables, and psychometric measures. The majority of the psychometric studies have used the Minnesota Multiphasic

Personality (MMPI) and the Eysenck Personality Inventory (EPI) to characterize alcoholic clients. There are multiple alcoholic subtypes and alcoholism is most often associated with peak elevations on the Depression, Psychopathic Deviate and Psychasthenia scales of the MMPI and high scores on EPI neuroticism (Conley, 1981; Alterman, 1988).

Etal-Lawrence, Slade, & Dewey (1986) followed fifty successful controlled drinkers, 45 abstainers, and 44 relapsers for one year to determine predictors of outcome type. The results showed that outcome is influenced by previous contact with AA; past behavioral expectations and periods of abstinence; subjects cognitions; as well as having the freedom of a choice of goals for recovery. Unconditional acceptance of controlled drinking procedures as part of treatment is limited to experimental studies or atypical local agencies (Robertson & Heather, 1982). Factors influencing outcome are interactive.

Chemical Dependency Programs

It is important to gather data about the effectiveness of chemical dependency programs even though the course of the average alcoholic is cyclic. Exposing a patient to a treatment and discovering that he is functioning better a year later does not prove that the intervention caused the outcome. As many as 20 percent or more of all alcoholics might develop abstinence without

treatment or attendance in self-help groups (Schuckit, Schwel, & Gold, 1986; Nordstrom & Berglund, 1986).

Rosenberg (1983) obtained retrospective data from a sample of patients in a VA Alcohol Treatment Program. Psychosocial measures indicated that the relapsers experienced more negative life events during the previous year, whereas the nonrelapsers experienced more positive events. Indices of social support showed that the relapsers had lower levels of family and friend support, emotional support, and perceived support from their overall network. Patients who are homeless, whose home situations are violatile and disruptive, or who suffer from significant social instability often require the type of organized therapeutic environment offered by residential aftercare i.e., halfway houses, or domiciliaries. This is frequently preferable to a long term hospital inpatient stay, since most residential programs encourage early resocialization (Knott, 1986).

Drug use may serve as a form of self-medication for coping with the depressive effect caused by interpersonal conflict or loss of a support system. Kosten, Rounsaville, and Kleher (1983) used a longitudinal design over a six month period in a sample of 123 patients in a multimodal opiate treatment program. Negative life events, measured retrospectively at the follow-up measurement, were related to depression and to greater illicit drug use during the follow-up period. Drug use, poor occupational functioning, and

psychological symptoms were most strongly related to interpersonal conflict.

Sannibale (1989) discovered that the best pretreatment predictors of client functioning (the degree of problem drinking) were measures of alcohol-related problems i.e. accidents, jails, hangovers, and deterioration. Program-related variables account for a slightly greater proportion of the explained variance in treatment outcome compared to client-related variables. In some studies the recovery rates have varied directly with the amount of treatment, length of stay and level of participation in the program activities (Pritchard, 1990). While many treatment programs have some type of aftercare program, this component has not traditionally been a central part of treatment and continues to be the weakest link of the treatment process for most chemical dependency programs (Miller & Hester, 1986; Faupel, 1991). Many true addictions are chronic conditions that require a very long period of intensive treatment, with relapses to be expected at intervals. Recovery from chemical dependency requires more than maintaining abstinence. It requires global changes in life-style and attitude, i.e., learning how to have fun without drugs, learning how to reduce stress without drugs, and establishing a reliable peer support network. If attitude change is to be maintained, repetition of group rituals and the group support that they engender must be sustained (Bennett & Woolf,1991).

Most programs are highly structured and incorporate experiences with self-

help groups, i.e., anonymous groups and peer support groups. The therapy group is the generally acknowledged therapy of choice for substance abusers and should match their level of progress. The therapy groups use role playing and discussion to express feelings and ideas which can provide insight into maladaptive behavior. The greatest potential drawback of groups is their tendency to not supply sufficient emotional support especially in the early meetings before group cohesion forms. Individual counseling should be used in conjunction with groups to enable members to cope with stressors (Bennett & Woolf, 1991).

Many treatment programs subscribe to the interdisciplinary team concept which may include nurses, physician, counselors, social worker, family therapists, psychologists, dieticians or other health care workers. Each member of the team interviews and assesses the patient and her/his family to establish goals and objectives for the treatment plan. The team convenes frequently and shares their assessment. The team concept is crucial in breaking through the patient's distorted sense of reality. The patient and his family will view the problems very differently and each need therapy and education. The various disciplines which comprise the team each holds their own unique perspective which enhances the treatment approach. A unified team will reduce the opportunity for the patient and family to deny, manipulate, and avoid the issues

of recovery (Bluhm, 1987).

A multimodal, comprehensive program coordinates the medical, psychologic, social, spiritual, and vocational components necessary plus a one-to-one relationship with a case worker or counselor. Most programs are highly structured and incorporate experiences with self-help groups, i.e., anonymous groups and peer support groups. Other important components are education about the physiological consequences, antabuse therapy, stress reduction techniques (meditation, biofeedback), and expression of creative instincts through art or poetry therapy. Acupuncture has also been used to treat oppoid addicts to produce sedation and relaxation and to decrease relapses for crack addicts. Crises intervention is used as a means not only of resolving the immediate crises but also of helping the client learn how to deal with crises generally to build his self-esteem and problem solving abilities (Brill, 1981).

Therapeutic Approaches

Four major approaches to individual and group therapy for substance abusers are: psychodynamic, cognitive-dynamic, behavioral, and humanistic. Three cognitive approaches are reality therapy; rational-emotive therapy (RET); and transactional analysis (TA). The client is encouraged to use logic to make

choices to avoid negative consequences and effect positive changes in an irrational and self-destructive belief system. TA focuses on changing communication games that cause poor life adjustment. Humor, role-playing, and self-analysis are encouraged to develop insight. Behavioral approaches include assertiveness training, covert sensitization, and relaxation therapy to reduce the anxiety that may trigger relapses. Humanistic approaches include Rogerian therapy, Gestalt therapy, and Logotherapy. Empathy and genuineness are utilized to guide the client in expression of feelings and discovering a new purpose in life (Neubuerger, Hasha, Matarazzo, Schmitz, & Pratt, 1981; O'Leary & Wilson, 1987; Persons, 1989; Sobell & Sobell, 1984; Ellis, 1985).

A safe climate must occur for a therapy group to develop cohesiveness and to function well. The facilitator should have two essential qualities to establish this safe climate: acceptance and commitment. Acceptance can be displayed in many ways, but the leader must believe in the miracle and hope of recovery internalized through experiences and previous work with recovering clients. A facilitator who has no fear of the disease and is comfortable with the anger, fears, hurts, and emotions of the clients will transmit acceptance to the group. Some examples of commitment are follow through, modeling responsibility and being there as a support mechanism. The therapist needs to evaluate when genuine assistance is needed as a part of a treatment plan or when it is time

for the client to do what they can do for themselves (Yalom, 1975).

Many clinicians (Palmer, 1980; Finney & Moos, 1986; Donovan, 1988; Abroms, 1983) advocate an eclectic approach to avoid using one model to understand the very diverse clients. Assessment is emphasized and a therapy plan is then formulated based on those theories and techniques that appear to "fit" the client's problem and the therapist's style. The eclectic therapist keeps abreast of research and new skills so the basis for practice becomes stronger as the education and experience increase.

Conjoint family therapy is used to help the non-drinking spouse stop controlling the alcoholic and to be more self-directed. This action can induce the alcoholic to "hit bottom" and to achieve abstinence. The therapists then assist the whole family to come closer together again because abstinence leaves a void in the family system until new patterns of functioning can be established. Therapists need a firm understanding of personal and family dynamics, the symbiotic relationships and interactions resulting from the victimization and scapegoating of the user, and the hidden agendas in the family. Therapists need objectivity, endless patience, and a rational perspective to avoid becoming judgmental, punitive, and moralistic (Brown, 1988; Stanton & Todd, 1982; Brolsma, 1986).

Marital dysfunction is a prominent and highly probable feature in the life functioning of an alcoholic. The association of stable family functioning with recovery has been supported by empirical evidence. Research also supports the utility of conjoint involvement of the spouses of alcoholics in the treatment process. McCrady, Noel, Abrams, Stout, Nelson, and Hay (1986) demonstrated better marital satisfaction after treatment for behavioral marital therapy when compared to treatment with minimal spouse involvement. Bowers and Al-Redha's (1990) study indicated significant improvement for clients and their partners in conjoint therapy on measures of marital adjustment, relationship ratings, and ratings of work functionings with greater reduction in alcohol consumption.

The helping process usually consists of talking: the client voices thoughts, relates past and present feelings, and charts future action. The therapist asks questions to gain content, clarifies and summarizes, and responds as the client plans strategies, sets goals, and assesses progress. Bibliotherapy is assignment of readings to increase knowledge and understanding. Self-help books can be loaned to clients to provide insight and assure them that other people have similar concerns (Hutchins & Cole, 1991).

The strategy of role playing is useful in helping groups (Hackney & Carmier, 1988). Role reversal may involve one client with the helper, with an empty

chair, or with another member of a helping group. Behavior rehearsal involves a client trying out a new set of behaviors that the client would like to perform. The client can practice and review a new behavior until it becomes comfortable or at least achievable. Sometimes the practice is videotaped so that the client can view the new role if this does not seem too threatening. Other members of the group can offer support and constructive feedback.

Siegel (1987) suggests the use of confrontation in addiction therapy to give correct information and make the client aware of discrepancies in their thoughts, feelings, and actions. Open, honest identification of the client's self-defeating patterns or manipulations can be positive when done in a nonjudgmental and caring manner. The therapist shares how inappropriate behaviors produce negative consequences in interpersonal relationships. Confrontation must be well timed when the client is ready for it and when there is a good working relationship between the therapist and the client. Discovering incongruencies in the client's behavior alerts the therapist to unresolved or potential problems.

Three activity therapy modalities: music, occupational and recreational therapy can offer valuable input to the addiction program. Activity therapists can treat the whole person rather than the addiction. Music therapy services may promote group cohesion, assist individuals to express their feelings and

emotions, and allow for individual values clarification. Occupational therapy can improve self-esteem and promote healthy self-image, improve specific problem-solving skills, and facilitate increased frustration tolerance. Recreation therapy can promote a healthy leisure lifestyle, assist in the development of interpersonal truce, improve specific communication skills, and promote group cohesion. Each individual can transfer the total program and new skills to real life situations (James & Townsley, 1989).

Reintegration into the community is often difficult for the street addict because they have to adjust to the common routines that most of us take for granted. Treatment efforts have been directed toward relinquishing those social ties that facilitated drug availability. Important predictors of post-treatment success are legitimate employment and family support. Aftercare programs are more effective if they establish apprenticeship programs with local employers and employment agencies to provide an opportunity for the addicts to develop positive work habits and attitudes. Clients need to learn interview techniques, how to budget their pay, and vocational skills. They need to be helped to use community resources more effectively. Job and career fairs, church functions, and community activities can prepare the addict to function in mainstream culture if incorporated throughout the treatment process (Faupel, 1991).

Relapse Prevention

While a conversion experience may be the start of recovery for many alcoholics, those who continue to enjoy sobriety tend to discover a basic set of coping techniques and a change of life style. Alcoholics have had a progressive narrowing of their focus and behavioral repertoire around drinking. They need a general reorientation of habits and interests as far away from alcohol as possible. When alcohol is psychologically unavailable and the recovering person has learned thought substitution and distraction, craving is less of a problem (Ludwig, 1988).

Respondent conditioning processes in part underlie the desire for alcohol and thus contribute to relapse. The presence of interoceptive cues, i.e. negative mood states alone is sufficient to elicit craving in some clients. Reactivity to cues may be substantially reduced by relaxation methods, discussions of environmental triggers, and deconditioning (Litt, Cooney, Kadden & Gaupp, 1990). Explanation helps to relieve some of the patient's excessive guilt and counterproductive feelings of uniqueness and shame. The importance of taking responsibility for one's own behavior and especially for developing alternative action plans must also be emphasized. Treatment should be individualized.

Studies of relapse have shown that stress factors are of considerable

importance for relapse episodes (Curry & Marlatt, 1985; Glasgon, Klesges, Mizes & Pechacek, 1985). Negative life events, perceived stress, and stress related patterns of substance use have all been shown to be predisposing factors for relapse to substance use. There is also evidence that predictors of relapse are temporally linked. Relapses that occur shortly after cessation seem to be attributable more to physical withdrawal symptoms, whereas relapses occurring at later stages (one month or more postcessation) seem predominantly linked to emotional distress (Rosenberg, 1983).

Relapse rates in addiction treatment continue to remain unacceptably high in part because there has been no focus on techniques of relapse prevention. This has led to feelings of frustration, pessimism, and hopelessness. Marlatt and Gordon (1985) have developed a cognitive behavioral model employing the self-efficacy theory to prevent relapse. Burling, Reilly, Moltzen, and Ziff (1989) report that patients who have confidence about their ability to cope with events are more likely to utilize coping responses and are less likely to relapse with this type of treatment. They are taught how to identify external triggers and to deal with negative emotional states, cognitive distortions and self-defeating thinking patterns through educational and skill-training procedures, relapse rehearsal, relaxation training, self-monitoring techniques, avoidance strategies and impulse control techniques.

The goal of Marlatt and Gordon's (1985) relapse prevention model is to teach clients to rely on behavioral self-management skills and to slip without defining themselves as failures. A sense of perceived control is enjoyed until a high risk situation occurs with negative emotional states. An assessment is conducted of high risk situations that includes strategies of self-monitoring, examination of fantasies, and description of past relapses. Program approach emphasizes the difference between what the person is and what the person does in order to free the client from guilt and defensiveness. The clients need to increase their choice concerning their behavior, to develop coping skills and self-control capacities, and to develop self-confidence, mastery, and self-efficacy (Botvin, 1986; Engs & Fors, 1988).

Case management is an essential part of mental health service delivery systems throughout the nation to prevent relapse. The aftercare case manager has the duty of patient service coordinator and advocate. The client and case manager meet weekly to evaluate and discuss cravings and triggers for relapse, coping techniques, adherences to the aftercare plan, and any other conflicts or questions the client may have. The case manager assists the client to utilize resources and to build a support network. Much of the case manager's time with the client is focused on skill building and creative problem solving (Franklin, Solovitz, Mason, Clemons, & Miller, 1987).

Relapse prevention is also based on social learning theory. Bandura (1977) states that social learning theory relies on four processes in the learning of a behavior: attentional, retentional, motor reproduction, and motivation. An addict's motivation is very important in sobriety maintenance. Other constructs of the theory include the importance of the environment as both a determinant and a reinforcer of behavior. Reinforcement can also be accomplished through self and vicarious reinforcement. Vicarious reinforcement proposes that clients engage in the behavior due to the satisfaction of seeing others rewarded. The way an individual views or interprets events influences their behavior (Spiegler, 1983). The behavior will be learned if the individual has the self-efficacy or expectation that they have the ability to cope and that the outcome will be positive (Rotter, 1984).

Participative vs. Directive Management

A number of empirically oriented organizational theorists have challenged the traditional notion that participation deters rather than enhances organizational effectiveness. Lewin (1951) and Coch and French (1948) indicated how participation satisfies social needs; Maslow (1954), Schein (1965), and McGregor, G.M. (1960) suggested that participation satisfies growth needs as well. Research carried out in industry, voluntary organizations, and

schools alike demonstrated that the satisfaction of organizational members increases when they can influence decision making.

The sharing of information is a key factor in genuine participation and is critical to sharing power. Often managers ask for employees' attitudes and opinions in great detail, but once they have the data, nothing is done with it. Employees tell management what it does not want to hear, so management ignores the finding. Most employees are concerned about decisions that directly affect their own jobs. A key requirement for effective democratic management is that those in power view the diffusion of power as sharing, rather than surrender. If leaders believe there is a limited amount of authority that has to be guarded at all costs, then they will view increased participation as a threat (Simmons & Maves, 1985).

Organizational effectiveness means more than satisfied people; it also means improvement in the quality of decisions and increased likelihood of implementation as well. Maier (1970) provided evidence that people who feel the support of a group are more willing to take risks in pursuit of creative solutions. Decision-making procedures that allow more people to risk sharing their good ideas can yield decisions that are worth implementing. Organizational development consultants can help clients explore the kinds of decisions made in organizations, pin-pointing those that must be of high quality and that require

high acceptance for implementation, and calling attention to situations in which participative decision making is especially important.

Four sets of arguments have traditionally been advanced in support of employee participation or involvement in organizational decision making. One of these is that employees have a right to a voice in decisions that affect their livelihoods and personal health. Autocratic approaches to management ignore basic human needs, such as autonomy, respect, and a sense of achievement. They are also inconsistent with the democratic principle that authority is derived from the consent of the governed (Nightingale, 1982).

Another argument is that involvement in decision making improves morale and job satisfaction and reduces burnout because it gives employees more sense of control over their work lives, enhances their sense of the importance of their efforts, and reduces their sense of isolation. It also contributes to morale and satisfaction because employees are more likely to accept less than ideal policies or conditions over which they have had some influence. It does so indirectly by providing employees with opportunities to secure changes in conditions that have negative effects on their morale and satisfaction (Stogdill, 1974).

Involvement enhances employee motivation, organizational commitment, and acceptance of change. Involvement gives employees more opportunities to

satisfy their personal needs for control, accomplishment, meaningfulness, and collegiality in the course of satisfying the needs of the organization.

Involvement brings individual and organizational goals into alignment with each other, provides employees with a sense of ownership over new policies or initiatives, and increases their trust in the employer. Involvement increases consensus on goals and priorities and breaks the narrow perception employees may have when isolated. Seeing the broader picture and understanding their role in the greater scheme of things will influence classroom decisions (Conley, Schmidle, & Shedd, 1988). Involvement also increases employee's understanding of decisions and increases the feedback they receive as they first make or influence decisions, implement, and monitor them (Locke & Latham, 1984).

Involvement enhances cooperation and reduces conflict and stress by reducing the causes of conflict and in part by enhancing employees' confidence in the process by which managerial decisions are made. Involvement also provides employees with a legitimate cooperative alternative for voicing problems and expressing dissatisfaction. Lack of opportunities to participate in decision making is a factor in many teachers' decisions to leave the profession. Strong evidence indicates that the benefits of involvement and teamwork seem to depend upon a variety of contextual and intervening factors (Bacharach &

Bamberger, 1990; Conway, 1984).

Gardner (1981) warned, "one of the clearest dangers in modern society is that men and women will lose the experience of participating in meaningful decisions concerning their own life and work, and that they will become cogs in the machine because they feel like cogs in the machine" (p. 59). Participation is not only beneficial to individuals, but also productive for organizations. Innovative organizations implement many changes through participation. Participatory organizations eventually respond faster. Participation can enhance the quality of decisions by improving the flow of information for joint decision making (Baloff & Doherty, 1989).

Participation does have its dilemmas. Participation does not produce contented employees automatically, and there is no simple formula to make it meaningful and significant. Kanter (1984) identified several areas of dilemmas: beginning involvement, participation in what issues, the structures of participation, developing teamwork, and evaluation. If participation relies on volunteers, it may not be representative. If participation is mandated, this action might be perceived as coercive. Employees would rather be involved in local issues that affect them and their jobs. There is a need for visible results or involvement will be viewed as a waste of valuable time. Maintaining continuity can be difficult and requires structure and delegation. Even when

teams remain constant, they still need renewal activities to avoid problems. Too much team spirit can be damaging, particularly if that feeling isolates team members from the rest of the staff (Goens & Clover, 1991). Involvement is not a panacea that will solve all organizational problems but there is usually an increase in the satisfaction of people if they realize that participation, as a process, can mobilize more resources in resolving issues (Sergiovanni & Moore, 1989).

Since one of the most significant obstacles to participatory decision making is the size of a large organization, Katz and Kahn (1966) suggested solutions to the problem of size. Most large hospitals can profitably experiment with decentralized decision making in substructures. Job enlargement is often possible within existing structures so that therapists can take on some of the functions of coordinators and vice versa. Team responsibility for a set of tasks can ensure greater psychological involvement of individual staff members. The key idea in managing a big hospital is to conceive of it as composed of groups working on specific tasks and linked together by members of more than one group.

Because the participative approach to decision making has some disadvantages, a number of theorists have argued that the correct approach is to choose the decision-making style that best fits the situation (Vroom & Yetton,

1973). The key elements in deciding which decision-making style to use are the degree to which acceptance of the decision is important, the degree to which general knowledge and information about the decision are spread throughout the organization, the degree to which the work force is motivated to make a good decision, and the degree to which quick decision making is important.

Just as there are times when participation is inappropriate, people participating can feel negative consequences for doing so. Baloff and Doherty (1989) list the negatives for participation which relate to peers, management, and their roles. Negative peer pressure appears when participation is seen as collaboration with management against the interest of the employees. This situation can result in sanctions against those who get involved. If management attempts to coerce, influence and retaliate, the result is employee resentment. In these circumstances, overt actions against an employee can occur, such as the assignment to undesirable duties or withholding desirable roles. Employees may also have difficulty adapting at the end of a highly motivating participative project, particularly if they must return to routine or rigidly structured activities. The duration and intensity of involvement are key factors, as well as the changed perceptions of the participants.

Initial experiments with participative management are some pioneering work

in the area of job enrichment done at American Telephone and Telegraph and other companies. Job enrichment gives individuals a whole product or service to do and holds them accountable for it. Most theories of job enrichment stress that unless jobs are both horizontally and vertically enriched there will be little positive impact on motivation and satisfaction. Horizontal expansion refers to assigning additional steps in the production process to an individual. Vertical expansion gives individuals responsibility for control tasks that require decision making i.e. scheduling work, determining work methods, and judging quality. Typically, job enrichment programs are installed in only a small part of an organization and focus only on changing the content of the job itself. Employees get a broader perspective on the work and can often do it better so job enrichment has a greater impact on quality than on productivity (Hackman & Oldman, 1980).

Managers commonly fear that if employees participate in developing policies concerning hours of work, benefits, and other human resource issues, that they will be too lenient or generous. In fact, research shows that when employees are involved in developing these policies, they often set higher standards than would be set by senior management (Lawler, 1981). If employees are involved, they understand the importance of these policies and are more committed to seeing that the policies will help the organization be effective.

Several authors have emphasized that organizations need more leadership from their managers and less behavior that is control oriented (Burns, 1978; Bennis & Nanus, 1985; Bennis, 1989; Kotter, 1990). Leadership can be a substitute for the traditional practices and controls that exist in hierarchical bureaucratic organizations. Bennis and Nanus (1985) talk about leaders managing through communication and developing trust. A slightly different perspective is offered by Kotter (1990). He writes about leadership as establishing direction for the organization aligning people with the organization's interest, and inspiring behavior.

Even in a high-involvement organization, it is unlikely that all decisions can be made in a highly participative manner. In some cases, time is short so the decision needs to be made by an individual, without widespread involvement. This does not mean it has to be made by the manager. Sometimes, other employees have more information and knowledge than managers, so they should make the decision. We are now in a society in which authority derives from expertise more than from positions (Bennis & Nanus, 1985). Younger managers have fewer needs for dominance and increased concern about due process and employee rights (Ewing, 1983). The working population has changed with significant entry of minorities, women, and the baby boom generation who want a stronger influence on how they do their work and are

more entitlements oriented.

Participative involvement with a focus on quality care through competence, innovation, and pride is a characteristic of the highly successful Magnet Hospitals. These hospitals have been particularly successful in attracting and retaining professional staff and have reputations as being good places to work. Commitment gives a sense of purpose and meaning and is the source of vitality in the workplace. Alienation exists when workers are unable to obtain any control. When managers invite employees to participate and to share power, it provides them with a chance for self-direction, satisfaction, a sense of ownership, and a productive orientation. If opportunities are created for involvement, employees may feel their contributions are valued (Brief & Tomlinson, 1987; Hall, 1980; Kramer, 1990).

Influence is reciprocal in effective organizations. It is not necessarily true that if some people become more influential others must become less so. Members of all hierarchical levels can gain in power and influence as the power and influence of their subordinates increase. March and Simon (1958) theorized that expanding the influence of lower echelons not only increases the power of those members but also allows management to participate more fully. According to Likert (1967) who described a similar phenomenon in his link-pen model for organizations, more influence is given to subordinates by

communicatively linking all organizational levels. Researching the relationship between organizational power and effectiveness, Tannebaum (1968) found it suitable for more influence to be exercised at every hierarchical level in what he called polyarchic organizations.

The democratic leadership style is a participative approach with group as well as leader involvement in key policies and decision determination. Authority is shared and the leader is objective as the members work in concert as a social unit. The other leadership styles listed by Knezevich (1984) are autocratic, laissez faire, and a variant of these basic three styles called manipulative leadership. There is a decided preference for centralized decision-making in the autocratic style with a reluctance to share power with others. The leader with the laissez faire leadership style grants complete freedom of action without direction. Support services and advice are provided when requested by the group.

The autocratic style is frequently used by leaders in large, complex organizations with the classic bureaucratic structure. Weber (1970), developed this type of administrative framework to make these large organizations both rational, efficient, and professional. Rational control was based on the presence of several characteristics: rules and regulations, expertise, a hierarchical structure, and record keeping (Daft, 1989).

Bureaucracy is now associated with negative characteristics such as narrow mindedness, duplication of effort, and nonsensical rules. In addition, it is perceived to stifle spontaneity, freedom, and the self-actualization of employees. The power in bureaucracies is a concern because of concentrated influence in the hands of a few leaders. In times of rapid change and in a complex environment, bureaucracies fall short because they are designed to deal with routine tasks in a stable environment. Although the functional structure itself carries with it a certain amount of ill fame, it offers clearly defined authority, strong discipline, and a setting that breeds technical competence. The inflexibility of the hierarchy can be a virtue in certain situations and is quite appropriate for some project situations (Dinsmore, 1984, Goens & Clover, 1991).

In many ways most large organizations unintentionally encourage employees to choose to maintain what they have, to be cautious and dependent. A patriarchal contract consists of four elements: submission to authority, denial of self-expression, sacrifice for future regards, and a belief that these approaches are just. Since the patriarchal contract gives emphasis to control and authority, new employees soon shift their focus from doing meaningful work to ambitions for upward mobility and behavior that is strategic, indirect and manipulative. Self-interest, a patriarchal contract, and the

manipulative strategies feed and reinforce each other in a manner that nurtures a dependent mentality. Subordinates take comfort in the fact that it is not their fault when things go wrong and pay for this with feelings of helplessness (Block, 1991; Dinsmore, 1984).

Leaders in these organizations have a hard time finding out what is really happening due to isolation. Employees are reluctant to communicate bad news to those who control their future. The top managers are as controlled by their subordinates as they control them. The expectations people have of their leaders are unreal and constraining which makes genuine human interaction very difficult. The higher a leader is in the levels of the organization, the more cautious they may become because they are more focused on what they have to lose than what they are trying to create. The greatest frustration for many employees is that they can see no clear path to contributing something of true value (Daft, 1989; Block, 1991).

Harris (1985) believes that the driving force that is changing the nature of work is new technology. The same force is altering relationships among workers and eliminating levels of management. Even trade unions formed to protect workers from exploitation have grown affluent, bureaucratic, inefficient, and sometimes corrupt. Management has become more responsive by providing for many of workers' needs and developing a more creative work

environment. Masuda (1981) is optimistic about such technological developments and their impact on work. He believes that employees will have more free time for learning and personal development, more autonomy, more participation and communication, increased research and development, and an entrepreneurial spirit.

Perhaps the most critical aspect of the psychosocial work environment is control over the work process. Employees who report high job autonomy experience less emotional exhaustion and alienation (Hall, 1989). Stress is a major occupational hazard for all people who are engaged in human services such as the delivery of health care (Baglioni, Cooper, & Hingley, 1990). There is a positive correlation between low levels of staff distress and high levels of support from a supervisor (Mahl, Denny, Mote, & Coldwater, 1982). Work settings in which staff are supported by co-workers tend to make demanding patient care less threatening for individual workers (Stone, 1984). The theme of colleague support was echoed by Moos and Schaefer (1987), who suggested that employees who view their work environment as supportive and innovative develop a greater sense of personal accomplishment.

In order to determine staff perceptions of their work, it is essential to use a measure which can take account of the multidimensional nature of the work and the work environment. The Work Environment Scale (WES) appeared to do

this using the social climate perspective (Moos & Schaefer, 1987). Variations in the work climate associated with work discretion and work-related social support have been found to be associated with morale (Parker, 1982).

Empowerment

Empowerment is an antidote to the malaise of bureaucracy. To empower means to release the energy and creativity in employees and to challenge them to autonomy and full responsibility. It requires an attitude shift on the part of employees from feelings of helplessness to a realization of the importance of initiative and that nothing happens unless they make it happen. A leader who empowers gives subordinates goals, direction, support, validation and lets them know their efforts are important (Koestenbaum, 1991).

Leaders who can empower others are spirited leaders who love the business, the people with whom they work, and the product. They are able to imbue others with this excitement and believe deeply in the special value of their work. The single most important aspect of spirited leadership may be the combination of a sense of mission and a fierce tenacity (Callan & Trusty, 1987). Peters and Waterman (1982) concluded in their research that great corporations were due to spirited leadership and cultures that had incorporated the values and practices of these leaders. The authors confessed that they

began their research with a bias against leadership since they believed that successful companies had a unique set of characteristics that set them apart.

The leader who utilizes a Theory Z perspective similar to spirited leadership attempts to develop trusting and harmonious relationships among the staff members. They use this solid relationship to constructively confront problems that present barriers to the realization of organizational goals. They exercise a considerable amount of personal power and involvement in the initial stages of goal-setting or problem solving and then find ways to delegate authority and disperse decision-making. The leaders know their staff well enough so that when important problems arise, or new opportunities present themselves, they know who will have the strengths that will be most effective in that particular situation. They involve their employees in making decisions while insuring that the trust will not be deflected away from central priorities (Ouchi, 1981).

People will work hardest and longest to accomplish the goals to which they have freely committed themselves. When the only inducement to effort in support of a cause is money, only significant and regular increases in money will keep people at their tasks. More and more organizations are seeking leaders with Jingshen, the Mandarin work for spirit and vivacity, and are actively enlisting the participation of their employees in the decision-making processes of the company. Each time a manager solves a problem that a subordinate

could solve, perhaps with greater effort, he denies the subordinate an opportunity to be reinforced through intrinsic job satisfaction. The best way to avoid action that denies reinforcement to others is to take positive steps to design the system of reinforcement (Harabin, 1971; Hayes, 1986).

Dedication and commitment has to be nurtured by the leader who has no more important concern than helping all of the employees feel that they are important in the accomplishment of the organization's goals. Everyone has to find a personal reason for doing the task. Management has to be a catalyst. As soon as leadership begins to be serious about quality and to place it at the top of the significance list, everyone else will get involved. Organizations miss the chance to be spectacular by limited the dimensions within which they operate (Crosby, 1986).

If the work ethic has been in decline, it may be because those who are leaders have been poor examples. Words and examples should coalesce; there should be consistency between words and behavior. Setting forth a list of commandments will not convince anyone that management is serious about integrity. Almost everything that goes on in an organization is known by most employees. Leaders often just do not realize what they can cause if they permit the impression to exist that there is room for dishonesty. Fuses are lit all over the place. The most pervasive and damaging of all crimes against

organizations concerns the theft of productive time by employees who arrive late and take long lunch hours. An auspicious start toward overcoming employee malaise is to screen employees in terms of their work attitudes. Company rewards must relate to and be consistent with the kinds of employee performance that demonstrate commitment and effectiveness (Pritchard, 1990; McConkey, 1983; Drucker, 1985).

The quality of fostering organizational learning by example may be one of the most important functions of leadership. Burns (1978) points out that "the most marked characteristic of self-actualizers as potential leaders goes beyond Maslow's self-actualization; it is their capacity to learn from others and the environment - the capacity to be taught" (p. 117). If the leader is seen as an effective learner from the environment, others will emulate that model. The leader and the organization nurture each other.

Management has been described as getting work done through others. It therefore follows that delegation is a facet of every manager's job. One of the main reasons for delegation is that it is a way a manager can decide his priorities and concentrate on the work of greatest importance since time is limited. In many cases the delegated work can be performed more competently by the subordinate and utilize their talents. The skills of delegation include effective planning, clarity, and periodic feedback. The manager needs to be

accountable and monitor progress (Rees, 1984).

Frederick W. Taylor discovered that work could be managed and made more productive. Before this, the only way to get more output was to work harder and longer. Taylor saw that the way to get more output was to work smarter. Productivity was the responsibility of the manager and the result of the application of the human capital resource of knowledge. Human resource theorists later argued that the central task of managers was to build organization and management systems that produce harmony between the needs of the individual and the needs of the organization. Maslow's influential hierarchy of motivation suggests that, as people satisfy lower-lower needs for food and physical safety, they move to higher-level needs for self-esteem and self-actualization. Traditional managers often treat employees like children, satisfying only their lower-level needs (Drucker, 1980; Bolman & Deal, 1991).

The problem with many organizations, and especially the ones that are failing, is that they tend to be overmanaged and underled. They may excel in the ability to handle the daily routine, yet never question whether the routine should be done at all. There is a profound difference between management and leadership, and both are important. A manager coordinates and utilizes the technical, financial, physical, and human resources presented by the system. A leader releases and channels his own and followers' energies to achieve

common goals. The difference may be summarized as activities of judgement and vision; efficiency versus effectiveness (Bennis & Nanus, 1985; Hannaway, 1989).

Effective Leadership with Participative Management

Argyris's (1962) research showed that leaders' effectiveness was often impaired because they were overcontrolling, excessively competitive, uncomfortable with feelings, and closed to ideas other than their own. He emphasized the importance of interpersonal competence as a basic managerial skill. When situations are demanding and challenging and managers doubt their interpersonal skills, they often revert to self-protection. They avoid dealing with the issue, deal with it indirectly, or attack the other person. The result is escalating games of camouflage and deception.

If a leader exploits employees, they will eventually lose them. The main reason managers tend to focus on the technical rather than the human side of the work is not because it is more crucial, but because it is easier to do. Human interactions are complicated and never very precise in their effects, but they matter more than any other aspect of the work. Out of the five hundred bankrupt projects DeMarco and Lister (1987) studied, there was not a single technical issue to explain the failure. Most managers are willing to concede the

idea that they have got more people worries than technical worries. They seldom manage that way.

One of the most important tasks of the modern manager is to integrate the contributions of the employees with both adaptive and innovative styles. The adaptor accepts the generally recognized theories, policies, and customary viewpoints when confronting a problem. This adaptive constraint is reflected in almost all of the classic analyses of bureaucracies. The innovator who reconstructs the original problem invariably has a problem of communication. Since it can be difficult to explain, a solution dependent on innovative thought often gets a skeptical reception. This resistance tends to be reinforced by the fact that there are nearly always adapters who have alternative solutions that may be seen as just as resourceful and knowledgeable and have the reputation as being sound. Managers need to develop competence in such areas as conceptual flexibility and managing interaction to build teams of people with complementary styles. This involves multi-dimensional thinking competencies and managing group process competencies. It includes building alliances to achieve managed change which is optimally responsive to the strategic environment (Struefert & Swezey, 1986; Boyatzis, 1982).

It is clear that innovative ideas multiply in a favorable climate. A high degree of flexibility and informality is needed to generate opportunities for

serendipitous encounters and discoveries. The leader needs to consolidate the lessons learned through innovation and then to apply and refine them. Innovation requires a way of thinking that focuses on anticipating the future to exceed the expectations of the client. Success comes naturally if you like what you are doing because you are dedicated to learning about it and feel that it is important (Garfield, 1992).

Barnard (1948) identified five active qualities of leaders, listing them in what he considered their order of importance: vitality and endurance, decisiveness, persuasiveness, responsibility, and intellectual capacity. Barnard intentionally relegated intelligence to last place. He emphasized that "intellectual competency is not a substitute for the other essential qualities of leadership". The sheer energy required to meet the demands of an executive's job seem to justify Barnard's decision to place vitality and endurance at the top of his list. Since Barnard compiled his list, the executive's job has become infinitely more complex and demanding.

In his Pulitzer Prize winning book, Burns (1978) identified two basic types of leaders: transactional and transforming. He described the transactional leader as "behaving essentially in an exchange mode; jobs are exchanged for votes, or reward is exchanged for motives in followers" (p. 4). The result of transforming leadership is a "relationship of mutual stimulation and elevation

that converts followers into leaders and may convert leaders into moral agents" (p. 4). A further important result is organization renewal.

McClelland's (1961) studies have shown that the person with high need for achievement tends to show initiative in researching the environment and searching for new opportunities. This factor may be related to luck or good fortune, since those who explore many places will naturally expose themselves to more situations, including situations of opportunity. Kanter's (1983) study of opportunity within a large, hierarchical organization stresses the importance of exposure and high visibility through movement within the organization. Mobility increases opportunity.

The successful leader has a good perception of reality. The ability to acquire information continuously and select what is relevant is an essential skill that confers knowledge and power. The leader should rely heavily upon information networks to seek bad news as well as good news. Perception requires an understanding and a respect for the subjective as well as the objective view. This is obtained by making rounds in the organization and conversing with employees and customers. Effective executives encourage information flow from the bottom to the top of the organizational levels and share their vision with others (Hannaway, 1989).

An open-door policy and good communication can create a synthesis of

viewpoints. Communication should increase exponentially as any company's size and complexity increase; but that almost never happens. The effective managers recognize and avoid the disruption caused by surprise and miscommunication. They spend many hours writing, speaking, and visiting their employees to get the essential messages across. They avoid the executive perks that create distance and strive to become more visible and accessible (Tushman & Moore, 1988; Clifford & Cavanagh, 1985).

Self-recognition is also important for leaders to become aware of the needs and forces that drive them. Having learned to accept the person within themselves, they develop increased empathy with others. By directing the force of their intense drive for mastery and their need for control, they subordinate their ego needs to the organization's needs. These leaders learn to respect their own limits and acknowledge their mistakes and failures. They have the capacity to mobilize the organization without weakening it in the process (Kaplan, 1991).

Gilmore (1988) wrote that leaders also need to be aware that several types of anxiety seem to be particularly conspicuous in hierarchical relationships: anxiety about aggression, control, and punishment. Leaders often fear being too tough, fantasizing that they might destroy someone or provoke someone to retaliate. The task is to join with the organization and create the capacity to

lead it, not to ensure that no one is hurt. Leaders can be in such a state of crises management that they do not have time for their staff. Leaders' difficulties at building effective teams, given the complexities of an entrenched civil service system, may allow them to view their dilemma as a personal attack by subordinates.

For a successful transformation to be achieved in the organization, three things have to happen: the leader creates a new and compelling vision, the vision must be articulated and intention is translated into reality. The vision has to be articulated clearly and frequently in a variety of ways, from policy statements to revising recruiting aims and methods, training that is explicitly geared to modify behavior in support of new values, and adapting shared symbols that signal and reinforce the new vision. It involves not only organizational mission, structure, and human resource systems but also the political and cultural forces that drive the system. The cultural values can be changed to a winners feeling by taking risks, tolerating dissent, accepting creative tension, and encouraging employee participation.

Leadership is the effective meeting of the situation, whatever the situation is. Lippitt (1982) determined that this effective meeting comes through confrontation, search, and coping. They take the initiative, do not just react to a situation, and face up to issues and problems. They do not copy others, but

instead search for data and feedback that will enable them to make sound decisions. A problem-solving approach is used, knowing disagreements can be eliminated if they are brought out in an atmosphere of experimentation, flexibility, and adaptability to change. This approach is based on trust relationships that have been established with the other members of the group or organization. Rogers (1983) maintains that genuineness, acceptance, and empathetic understanding are the dynamic factors in a trusting relationship.

Teamwork

The secret of an effective organization is to keep a diverse group of personalities working together constructively toward a common goal. Formalization is necessary but with it inevitably come politics, internal competition, and red tape which are degenerative diseases which must be controlled (Clifford & Cavanagh, 1985). Team-building designs can be used that are sensitive to members' degree of psychological burnout. Individual applications of team-building designs seem to be increasingly popular and appear to have positive effects. Simultaneous applications of a common team-building design to large numbers of work units in the same organization have fared less well. As the number of teams increases, so will variant conditions appear to which the usual confrontational designs adapt poorly (Golembiewski,

1990).

The importance of employee participation as teams and the power of the informal system in the workplace was uncovered by Mayo. He is called the founder of the human relations movement in the United States. At the Hawthorne works of the Western Electric Company in Chicago, Mayo studied the effects of work area lighting on productivity. They found that the informal system exists today as a part of organizational culture, but the issues and teams today are more complex than those studied by Mayo (Pugh & Hickson, 1989).

Lewin (1951) focused attention on group dynamics and helped us to understand what people can do to increase the effectiveness of teams. In his theory of force field analysis, a team is an open social system with a series of forces applied to it from two sides. If the forces are equal, the team will remain in a state of equilibrium and will not change. The balance point will change if the forces change and result in "unfreezing". The next step, "moving", involves the establishment of new norms, values, and behaviors. The final step, "refreezing", results in a new point of equilibrium where supports exist for the new behavior. This theory is still used today as a technique for improving team effectiveness.

McGregor's, G. M. (1960) study on the development of managers in

industry led to the publication of a book on motivation and theory X and Y. He also presented a list of the characteristics of effective and ineffective management teams that groups can use to evaluate their own operations. Likert (1967) studied managers with the best performance records and found that the least effective managers were job centered while the most effective were employee centered. Likert summarized his findings into four systems of management. System 4, the most effective approach, produced high productivity and greater employee involvement. The work of Blake, Mouton & Topper (1981) is also important because it links management style and team effectiveness in a concept called the managerial grid. The grid is used to improve overall team effectiveness as well as the individual effectiveness of each team member.

Herzberg's (1966) motivation theory is another management philosophy that is a foundation for participation and employee involvement. In developing and promoting this theory, Herzberg stressed that growth and individual development were derived from the content of the job itself. Factors that contributed to the fulfillment of the job were the opportunity for new learning, direct communication between management and employees, regular feedback, and personal accountability. Achievement, recognition, and responsibility were primary motivators for people at work. Herzberg also examined hygiene

factors, such as working conditions, policy, and relationships that made individuals dissatisfied with their jobs, but did not necessarily motivate them.

Other contributions have been helpful in understanding teamwork and team players. Walton (1969) provided a helpful distinction between types of conflict that may arise among team members. Role analysis techniques and role negotiations are techniques designed to deal with substantive and emotional conflict. Substantive conflict involves disagreements about roles, procedures, and policies and can be dealt with by discussion and negotiation. Emotional conflict arises from feelings of loss, fear, and mistrust. Dyer (1987) offers a variety of techniques for managers and consultants who facilitate team building events.

Participative management and team building require a group climate of openness with a norm of airing problems and matters of concern. The advantages of a more open approach are: inner frustration is avoided, closer personal relationships are established, valid feedback is given, problems are clarified, morale is increased, and the stultifying side effects of bureaucracy are lessened. There are also potential hazards in group openness: the individual is more vulnerable; unsureness is exposed and can be interpreted as weakness; and difficult problems are brought into the open (Francis & Young, 1979).

The effectiveness of a team is a function of clarity about its purpose. High

performance teams have both a clear understanding of the goal to be achieved and a sense of mission. Successful leaders are the most results oriented individuals in the world and have an agenda, an unparalled concern with outcome. They challenge their members and create a sense of urgency because they are doing something that clearly makes a difference to them. Politics and personal agenda seem to be the greatest threats to goal clarity and, consequently, to effective teamwork (Sullivan, 1988).

The three basic structures of teams are problem-resolution teams, creative teams, and tactical teams. Four design features that seem to characterize effectively functioning teams are: clear roles and accountabilities; effective communication providing feedback; and an emphasis on fact-based judgments. When strong technical skills are combined with a desire to contribute and an ability to be collaborative, the observable outcome is an elevated sense of confidence among members that enables a team to be self-correcting. A serious threat to the success of a team is the conflict between individual and team goals. There needs to be team spirit, a commonality of purpose, intense emotional bonding and identification, a sense of unity, and energy (Larson & LaFasto 1989).

Team-building succeeds under four conditions: interdependence, risk-taking, joint decision to participate, and equal influence. Team members need to

periodically step back and observe what they are doing that helps or hinders progress. The team-building meeting is one way people learn how to develop trust. Each team member needs to feel free to speak openly on important matters. The simplest team-building technique is the "go-around" where all participants have a chance to say how they see it and what they would do. Leaders can facilitate this task by openly sharing their own dilemmas and willingness to hear people (Russell & Evans, 1992).

Studies of cross-cultural values and behavior reflect the individualistic rather than collectivistic orientation (Gudykunst & Ting-Toomey, 1988). There is practical significance associated with learning about team effectiveness in work areas. As problems become more complex, the solutions will increasingly require the input and coordinated action from several people. Leaders need to learn how to set aside individual agendas and to collaborate within a structure that integrates and focuses, rather than diffuses. Leaders need to determine how to foster the trust and the sharing of information that will lead to the best decisions.

When there is teamwork, there is interdependence and collective responsibility. There is less competitiveness and more focus on and commitment to the mission of the organization. Resources are combined to achieve these results by using power cooperatively with others, having a

positive attitude, accepting differences in people and using these differences productively. When interdependence does not exist, people do not talk to each other; they blame, compete, conflict, avoid, resist, and underutilize each other as resources. Conflicts are usually role conflicts that come about because working relationships are not clear and people are not expressing their needs to each other (Beck & Hillman, 1986).

Parker, G. M. (1991) reported that more and more companies are experiencing the benefits of teamwork as a management strategy for reducing costs, improving quality, and increasing output. As the number of people decreases while the volume of work and the standards remain the same, organizations will need people who do quality work the first time, pitch in to help others out, quickly create a cooperative atmosphere, and challenge others to do the best job possible. This cooperative atmosphere is also a powerful tool for reducing racism. Experiments with interracial learning teams have led to a reduction in prejudice among students in the United States, Israel, and Canada (Coleman, 1989).

The work force is changing dramatically with important implications for teamwork. It will be more diverse in terms of age, sex, education, cultural background, disabilities, and values. This diversity demands one of the important skills of a team player, the ability to work with people who are

different. Many formerly fragmented tasks are being converted into jobs requiring multiple skills. Computer networks integrating diverse functions also require employees who can work as a team (Pennar & Mandel, 1989).

External support and recognition seems to be more an effect of team success than a cause of it. When the support is not there, there are problems. The problems frequently involve the loss of morale, the erosion of confidence, increased feelings of helplessness and futility, and a decreased belief in the teams' goal. When teams win, success is attributed to factors within the team itself; when teams fail, performance is attributed to factors outside the team i.e. lack of support. Top management must demonstrate its commitment and establish a reward system that recognizes team effort and values people's input (Galagar, 1986).

Cohen (1982) observed that triumphs of teamwork are most frequently documented in sports where performance objectives of both team and individual performance occurs. A climate of trust allows team members to stay problem-focused since alliances and personal agenda do not take precedence over the team goal. Trust promotes more efficient communication and coordination and promotes a more efficient use of time and energy. Trust improves the quality of collaborative outcomes because with it, decisions are more in tune with what is actually happening. Problems are not hidden and people are willing to take

risks. Trust leads to compensating. Even teams with something less than ideal talents could compensate for shortcomings by recognizing a latent weakness and deciding to do something about it.

Team management is not a panacea for all management ills. Littlejohn (1982) wrote that it is a common sense approach of letting people improve their performance by improving the process they use. Employees become better problem solvers due to better communication and mutual team support. Creativity and innovation permeate the team interaction. Teams increase cooperation and reflect greater coordination. Ultimately, productivity is significantly increased through the team's synergism. A collective strength is formed that is superior to the sum of individual strengths, enabling the individual within a team to grow and produce.

The collective strength is based on group dynamics principles designed to influence positive team behavior. Lewis (1985) suggested the leader should encourage every team member to become involved but refrain from dominating. He/She should work to obtain synergy and enable team members to satisfy their personal and team goals. Each member's value should be emphasized, strengths maximized, and weaknesses of each minimized. It is important to remain alert and open to new ideas but establish high standards and expectations and reward team members. An advice-seeking attitude should be

created. Resistance can be faced by verbalizing it but blaming should be avoided. Leaders should emphasize honesty, reassure nervous team members and encourage them to explore their feelings.

The capacity to deal with interpersonal problems is a good test of team climate. Effective interpersonal problem solving is a combination of both confrontation and care for individual viewpoints. The skills of listening are particularly helpful. Although games underlie many of the interactions between people, effective teams place a value on authentic relationships and try to purge games from the currency of interactions (Ryan & Oestreich, 1991).

Training for team members should model effective communication through direct participation and supportive behavior to increase enthusiasm for the process. Buzz groups allow participants to move around and talk in smaller groups. This provides a comfortable forum for members who may hesitate to speak in front of the entire group (Reardon, 1987). Role playing is helpful in exploring various aspects of a problem or case study. Using a variety of presentation formats increases interest and group involvement in the learning experience i.e. flip charts, slides, films, and videotapes (Wood, Phillips & Pedersen, 1986).

Team members are encouraged to use unity terms such as "we" and "our" in team building activities. The team that takes time to integrate new members

into the group and talk about the loss of other members is a stronger, more integrated unit. The team may also have its own special name that gives it an identity and represents the members' goals and values. Teams should be encouraged to develop their own rituals and ceremonies such as celebrating the birthday of a team member to create its own history based on shared experiences. The facilitator should model unity and cooperation to provide a solid and consistent support system (Kreps, 1986).

Quality circles are used to increase workers' commitment, increase job satisfaction, and resolve problems that concern the quality of production, quantity of output, safety, and other matters. Members are trained in a method of tracking information through devices such as parieto diagrams, cause-and-effect diagrams, graphs, histograms, and scatterdiagrams (Lawler & Mohrman, 1985). Quality circles originated in Japan in the early 1960s and were first introduced in the United States in 1970 by Lockheed Aircraft. The success of the Lockheed program encouraged other American companies to adopt the participative process. There are an estimated one million quality circles in Japan with over ten million members (Main, 1986).

Training in statistical analysis and display of information facilitates the groups' work in the initial intelligence phase. In the design phase members construct alternative ways of solving an identified problem. The real value of

quality circles are to be found in this phase since the members are those closest to the work. The third phase, choice, is less patterned. Variability among quality circles exists in how choices are made. The final phase is review and is facilitated by regular meetings and standardized methods of tracking and displaying performance information (Richards, 1984; Elvine, 1985).

Brainstorming is one of the most effective and frequently used tools of teams in action for quality improvement. This creative model involves production of ideas to identify potential projects for the groups and to isolate elements for problem analysis. Round-robin brainstorming is often useful to ensure more equal participation. The group should strive for a large quantity of ideas to maximize the effectiveness of the process. Next, the ideas must be examined critically and narrowed through a discussion, ranking, and voting process. Team members should feel free to explain their ideas or ask for clarification so that the group has a good understanding of all ideas generated (Keiser, 1986; Daniels & Spiker, 1987).

Measuring the results of employee involvement activities can provide feedback for teams to support changes and stimulate improvement. Objective data for rating team activities are sometimes hard to obtain and, because of the qualitative nature, subjectivement measurement is equally necessary. These intangible results can be measured through employee displays of increased job

satisfaction and quality consciousness, improved morale and communications, and increased interest in and attendance at team meetings. Other methods are to conduct attitude surveys and monitor recognition from outside sources as customer complaints and customer perception surveys. Articles and presentations about the participation process that are accepted for publication also provide recognition. Measures that fall into the tangible, but indirect category are absenteeism, turnover, safety, and grievances (Field, 1985; Aubrey & Felkins, 1988).

Organizational Climate and Culture

Joyce and Slocum (1984) defined climate as the shared perception of "the way things are around here" (p.721). McGregor's (1960) view of climate was that leaders create the climate in which subordinates work by what they do, how they do it, how competent they are, and their ability to make things happen through their influence in the organization. More precisely, climate is shared perceptions of organizational policies, practices, and procedures, both formal and informal. Climate can most accurately be understood as a manifestation of culture. Culture exists at a higher level of abstraction, but both climate and culture are learned, largely through the socialization process and through symbolic interaction among group members.

The levels of culture are artifacts, values, and basic assumptions. The most

visible level of the culture is the artifact or constructed physical and social environment. At this level one can look at physical space, the technological output of the group, its written and spoken language, artistic productions, and the overt behavior of its members. All cultural learning ultimately reflects someone's original values or sense of what should be. If the solution works, and the group has a shared perception of that success, the value gradually becomes a belief and, ultimately, an assumption (Schein, 1985).

Ouchi (1981) believes that values may serve the moral function of guiding members of the group in how to deal with certain key situations. If those values are not based on prior cultural learning, they will be seen only as adopted values which predict what people will say but may not be what they will actually do. If these values are congruent with the underlying assumptions, they can bring the group together, serving as a source of identity and core mission (Peters & Waterman, 1982).

Organizations also have activities that are social forms of the primary values and beliefs of the culture. Celebrations, games, picnics, and family outings require communication, willingness to participate, and common purpose. They matter because they tend to evoke feelings of enjoyment, meaningfulness, and fellowship while formal organizations may result in frustration. Special ceremonies such as award ceremonies convey the importance of desired

values to employees. Just as negative stories inform members about activities to avoid, organizational taboos convey boundaries concerning acceptable behavior (Shrivastava, 1985; Jones, Moore, & Snyder, 1988).

Organizations tend to have role models who personify the cultural value system and define the organization's concept of success in a tangible way. Although such heroes are frequently part of upper management, they may be identified throughout the organization. The key is that these individuals represent what the company stands for and reinforce the values of the culture by illustrating that success is attainable and by motivating employees (Buono & Bowditch, 1985).

Leaders often have only an intuitive grasp of their organization's culture and recognize it only when they have transgressed its bounds. Severe conflicts or adverse relationships ensue and they frequently find themselves dealing with culture in an atmosphere of crisis management, not seasoned reflection and consensual change. With a full understanding of culture, leaders can articulate decisions in a way that will speak to the needs of various constituencies and marshall their support. An awareness of culture will also enable leaders to recognize those actions and shared goals most likely to succeed and how they can best be implemented (Chaffee & Tierney, 1988).

A negative and pessimistic view of human nature tends to be associated

with a management style dominated by values of command and control. This style is found in companies characterized by top-down communications, authoritarian supervision, inflexible work rules, and adversary labor-management relations. Companies with values supportive of worker commitment tend to reflect a more positive and optimistic view of human nature, the management style in these firms is characterized by two-way communication, participative decision-making, flexible work rules and teams, and cooperation. Both management styles probably exist in most large corporations although the emphasis will vary (Davis, 1984; Tomasko, 1987).

Deal and Kennedy (1982) formulated four corporate culture types based on two main dimensions: the degree of risk and the speed of feedback characteristic of the organization. In organizations where daily decisions involve major stakes and fast results, a macho culture dominates. Insurance and utility companies, characterized by low risks and slow feedback, develop process cultures in which the ability to manage details is the key to success. Bet-your-company cultures tend to evolve in high risks, slow-feedback organizations where success is dependent on attention to detail and the ability to cope with uncertainty for long periods of time. Sales companies whose success depends on an action orientation and a highly motivated staff have relatively low risks and quick feedback.

Allen (1985) describes a four phase program for changing cultures: analysis of culture and norms, leadership training and workshops, modification of the culture with feedback, evaluation and further modification. The leader needs to focus on both the individual and the culture, involve people, have an integrated plan, have a results orientation, and encourage freedom and sustained effort. The barriers that can interfere with the success of the change process are blame placing, crash programs, learned helplessness, and promises that cannot be kept.

Culture change is more difficult than other types of organizational change in that it challenges ingrained habits of thought. What is being confronted is not only behavior, but intellect and feelings. Knowing a culture is the key to changing it. Efforts to change often end abruptly when decisions are not supported by continuous purposeful action. Resistance to culture change can be eased if those affected understand why a change in values is needed. Planning involves using the formal and informal networks of communicators and selecting those who are the most willing and capable to function as the spokespersons of change (Martin & Siehl, 1983).

Summary

The research on the topics of chemical dependency and participative management is expansive and varied.

The review of the literature led the researcher to the following postulates:

1. Alcohol is the most abused drug in the United States and is not easily arrested. The stigma may be reduced by changing attitudes through education (Ames, 1985; Caetano, 1987).
2. Alcoholism can be detected with the MAST and ADS instruments as screening tools (Selzer, 1971, Skinner & Horn, 1984) and subtypes determined by the MMPI and the EPI instruments (Alterman, 1988).
3. Factors influencing outcome of treatment for chemical dependency are interactive (Robertson & Heather, 1982).
4. The course of alcoholism is cyclic and recovery rates vary with the amount of treatment, length of stay and level of participation in a program (Pritchard, 1990).
5. Data on effective chemical dependency programs indicates that they are highly structured, have a multidisciplinary team approach, encourage AA or self-help groups, education, and an aftercare program (Brill, 1981; Bluhm, 1987; Bennett & Woolf, 1991).
6. The most frequently used therapeutic approaches to chemical dependency are psychodynamic, cognitive-dynamic, behavioral, humanistic, or an electic approach (Ellis, 1985).
7. Specific techniques included in these approaches that are helpful are

conjoint family therapy, individual counseling with confrontation, role-playing, activity therapies, and vocational rehabilitation (Siegel, 1987, Faupel, 1991).

8. Relapse rates continue to be high and are due to stress factors, respondent conditioning processes, and lack of focus on techniques of relapse prevention (Litt, Kadden & Gaupp, 1990).
9. Program approaches which reduce relapse are Marlatt and Gordon's (1980) model, case management, and behavioral modification with reinforcement (Rotter, 1984).
10. Participative management satisfies growth needs of employees; increases communication; improves morale and job satisfaction; enhances motivation, commitment and acceptance of change; enhances cooperation and reduces conflict and stress; and increases productivity in organizations through improved quality of decisions and increased likelihood of implementation (Nightingale, 1982; Conway, 1984).
11. The obstacles to participative management are the type of involvement and structures, size of the organization, negative peer pressure, and control oriented leadership in bureaucracies (Dinsmore, 1984, Baloff & Doherty, 1989).
12. The Work Environment Scale has been useful in measuring the social

climate (Parkes, 1982, Moos & Schaefer, 1987).

13. Empowerment can motivate employees to become more creative, committed, self-actualized, and efficient (Ouchi, 1981, Peters & Waterman; Koestenbaum, 1991 & Hannaway, 1989).
14. Authors who have contributed to the knowledge of effective leadership are Barnard (1948), Burns (1978), McClelland (1961), Kanter (1983), and Rogers (1983). Humanistic leadership can increase trust, reduce fear, and transform the organization.
15. Teamwork can reduce costs and improve quality and succeeds with interdependence, risk-taking, joint decision to participate and equal influence (Parker, 1991, Russell & Evans, 1992).
16. Some activities that promote team-building are quality circles and brainstorming (Main, 1986).
17. Organizations can be changed to successful ones only through an awareness of their culture and the barriers that can interfere with the change process (Allen, 1985, Tomasks, 1987).

Chapter 3

Methodology

Introduction

The purpose of this study was to analyze the relationship between managerial behavior, social environment of work settings, and their effect on rates of program completion. The objective of this study was as follows: (1) to obtain a measurement of managerial behavior as perceived by the managers and their subordinates; (2) to obtain a measurement of ten dimensions of the work environment of each addiction program as perceived by subordinates; (3) to obtain the rates of program completion for each addiction program; (4) to determine the relationship between managerial behavior and each dimension of the work environment; (5) to determine the relationship between managerial behavior and rates of program completion; and (6) to determine the relationship between the work environment and rates of program completion.

Population

The target population was comprised of the program coordinators employed in the 13 Veterans Affairs Domiciliary Addiction Programs and their subordinates. The programs and the number of subordinates were as follows:

Bath, New York (8); Hampton, Virginia (10); Martinsburg, West Virginia (5); Cincinnati, Ohio (7); Dayton, Ohio (4); Leavenworth, Kansas (6); Lyons, New Jersey (6); Milwaukee, Wisconsin(7); Bay Pines, Florida (8); Bonham, Texas (5); Los Angeles, California (10); White City, Oregon (6); and Mountain Home, Tennessee (6). The names of the coordinators and the addresses of the programs were obtained from the Department of Veterans Affairs Domiciliary-Based Substance Abuse Programs Directory and can be found in Appendix B. The 13 coordinators were distributed by gender as follows: 9 males (69.2%) and 4 females (30.8%).

Instrumentation

Two instruments were used in collecting data: the Work Environment Scale and Managerial Practices Survey. The Work Environment Scale (Appendix C), developed by Moos (1981, 1986) blends personal perspectives and work outcomes in a measure of stress in the work environment. It is composed of 90 true/false items that assess three broad aspects of the environment: relationship dimensions; personal growth or goal orientation dimensions; and systems maintenance and change dimensions. The relationship dimensions (involvement, peer cohesion, supervisor support) assess the extent to which employees are concerned about and committed to their jobs; the extent to which employees are friendly to and supportive to one another; and the extent

to which management is supportive of employees and encourages employees to be supportive of one another. The personal growth, or goal orientation dimensions (autonomy, task orientation, work pressure), measure the extent to which employees are encouraged to be self-sufficient and to make their own decisions; the degree of emphasis on good planning, efficiency, and getting the job done; and the degree to which the press of work and time urgency dominate the job milieu. The system maintenance and change dimensions (clarity, control, innovation, physical comfort) evaluate the extent to which employees know what to expect in their daily routines and how explicitly rules and policies are communicated; the extent to which management uses rules and pressures to keep employees under control; the degree of emphasis on variety, change, and new approaches; and the extent to which the physical surroundings contribute to a pleasant work environment (Moos, 1986).

The WES has three forms, a REAL form which measures perceptions of existing work environments, an IDEAL form which measures ideas and conceptions of the work environment and an EXPECTATIONS form in which subjects' anticipations and expectation of a new work milieu are measured. The REAL form (Form R) will be used in this research project since it measures perceptions of existing environments and is suitable for group use. This form takes approximately 20 minutes to complete.

Items for the scale were developed from information gathered in structured interviews with employees in different work settings, as well as adapted from other social climate scales (Moos, 1974, 1981). Concurrent validity is indicated by a study in which findings on WES subscales were consistent with information obtained from independent open-ended interviews (Lusk, Diserens, Cormier, Geranmayeh, & Neves, 1983). Normative data for the WES have been collected for 1,400 employees in general work settings and 1,600 employees in health care settings. For the individual subscales, Cronbach's alpha ranges from 0.69 to 0.86. Intercorrelations (r=0.25) between subscales conducted for a sample of 1,045 employees in general and health care work groups indicate that the subscales measure distinct though somewhat related aspects of the work environment. The subscales can therefore be analyzed and described independently (Moos, 1986).

Since the WES requires a descriptive judgement of what the respondent encounters, it does not measure morale or work satisfaction, which require affective judgements (Payne, Fineman, & Wall 1976). It does, however, address those dimensions of the work environment which contribute to them (Moos & Schaefer, 1987). Its use helps to answer the question of whether and in what dimensions employees who are working in different organizations with varying leadership styles regard their environment differently.

The leadership behavior of the coordinators was measured with the Managerial Practices Survey (MPS), originally developed by Yukl (1982) with 115 items grouped into 23 scales (Appendix D). The MPS was revised in 1986 and 1988. The 1988 version has 110 items grouped into 11 major scales plus 3 supplementary scales. The wording of items was modified to make them suitable for use by peers as well as subordinates and suitable for describing the behavior of managers at all levels, including executives. Not only was factor analysis used in identifying behavior categories and selecting questionnaire scales, but judges were also used to sort behavior into categories and these were tested by using them to code behavior descriptions from diaries and critical incidents. A comparison with earlier research resolved some inconsistencies and helped to develop a behavior taxonomy that integrated earlier major ones.

The fourteen managerial practices surveyed were informing, consulting, delegating, planning and organizing, problem solving, clarifying roles and objectives, monitoring operations and environment, inspiring, recognizing, rewarding, supporting, mentoring, managing conflict and team building, and networking. The supplementary scales (Delegating, Rewarding, Mentoring) were used only by subordinates. Each item in the 1986 and 1988 versions of the MPS has the following six response choices: 1 - Never, Not at All; 2 -

Seldom, To a Limited Extent; 3 - Sometimes, To a Moderate Extent; 4 - Usually, To a Great Extent; NA - Not Applicable; and ? - Don't Know.

Tests for the content validity of the scales in the MPS were carried out in 1984, 1985, 1986, and 1988 with MBA students serving as judges. Coding accuracy was measured in terms of percentage of judges who accurately coded the items, averaged across the items in a scale. The percentages ranged from 72 to 96 indicating that coding accuracy was relatively high for all the scales. Relevance was tested in three studies by asking managers to rate the importance of each defining behavior in a category. Each of the behaviors was viewed by 73% to 96% of the managers as very important or essential for effective performance. Internal consistency was computed separately from three samples of subordinates and ranged from 0.80 to 0.93. The stability was tested in three studies by administering the questionnaire to the same sample of subordinates on two different occasions and correlating each scale score on the first administration with the corresponding scale score on the second administration. The results ranged from 0.61 to 0.94. The F-tests for interrater reliability were significant at the 0.01 level for each of the scales. There is also supporting evidence on the capacity of the scales to discriminate contrasting groups. In six different studies on criterion-related validity, the correlations were higher than is typical for behavior description questionnaires when used with a

criterion of leader effectiveness that is independent of the behavior descriptions. The MPS has had a favorable reaction by managers who report that the categories are relevant and meaningful (Yukl, Wall, & Lepinger, 1990).

All Veterans Affairs Domiciliary Substance Abuse Programs are required to keep records of program completion but not of actual relapse rates. This data was analyzed in this study and was obtained from each of the program coordinators in the Program Demographics Form (Appendix E).

Research Design

The design of this study was descriptive using survey methodology. The purpose of this design was to describe relationships between variables. Scores for the WES were obtained by summing items for each subscale for individuals and converting to standard scores using the stated conversion values for health care work settings. The scores for health workers were standardized for each subscale. Analysis of variance was used to analyze the data. Scores for the MPS were also obtained by summing items for each subscale and analyzed using analysis of variance. This analysis determined whether the mean scores on the factors differed significantly from each other and whether the various factors interacted significantly with each other. The test also determined whether sample variances differed significantly from each other.

Data Collection and Procedures

Approval was obtained from the Institutional Review Board of East Tennessee State University and the Veterans Affairs Research Committee at each medical center to conduct research on employees (Appendix F). Permission was also obtained to use the Work Environment Scale and the Managerial Practices Survey from the developers of these instruments (Personal communication, September 17, 1993).

After permission to conduct the study and use the instruments was obtained, packets containing the two instruments were mailed with a cover letter and a postage paid returned envelope to the 13 individuals identified as program coordinators (Appendix G). Three weeks after the initial mailing, a follow-up letter, along with another set of instruments, was mailed to the non-respondents (Appendix H). Responses to the instruments were scored according to their respective designs.

Chapter 4

Analysis of Data

Introduction

The purpose of this study was to analyze the relationship between managerial behavior, social environment of work setting, and their effects on program completion in domiciliary addiction programs. Program demographic data was also collected and examined relating to the length of the program, title, function, level of authority, and time in position of the coordinator; program characteristics such as classes, group therapy, activities, patient government, disciplinary measures, rewards, certificates, and forms of recognition; and percentage of patients with various types of addiction, polysubstance abuse, and dual diagnosis.

Managerial behavior was determined through administration of the Managerial Practices Survey (MPS) developed by Yukl (1982). The MPS yields a score of fourteen scales of 0-24 with 0 being the lowest in managerial skills and 24 being the highest in the skills needed for participative management. Perception of stress in the work environment was measured through the administration of the Work Environment Scale (WES) developed by Moos (1981). This scale scores between 0-9 on three relationship dimensions, three personal growth dimensions, and four system maintenance dimensions.

Data Collection

The administration of the surveys to the 13 domiciliary addiction program coordinators identified in the population resulted in responses from 6 programs with data from 41 subordinates and 6 coordinators (46.5%). A second request mailed to the 7 remaining program coordinators resulted in an additional 32 sets of responses from 5 programs (31.7%). A total of 79 (78.2%) sets of responses were received. Of those 79, six sets of responses were determined to be unusable due to one or more of the following reasons: (1) incomplete Managerial Practices Survey, or (2) incomplete Work Environment Scale. Telephone calls were made to eight respondents to receive accurate data on the program demographic survey items dealing with program characteristics and patient census.

The total number of respondents completing both the MPS and the WES was: Program 1 (8), Program 2 (4), Program 3 (6), Program 4 (8), Program 5 (6), Program 6 (8), Program 7 (7), Program 8 (6), Program 9 (8), Program 10 (5), and Program 11 (7). The programs were numbered randomly since several coordinators did not wish their programs to be identified. One coordinator did not participate in this project because he felt the survey to be too intrusive. Another coordinator did not participate because all the clients in that program

had a dual diagnosis of addiction and Post Traumatic Stress Disorder.

The remainder of this chapter is devoted to presenting characteristics of the coordinators and programs and analysis of the data. First, the results of the program demographics are presented. Last, the chapter concludes with findings relevant to the three proposed hypotheses.

Descriptions of the Programs and Coordinators

Seventy-three (72.3%) sets of responses were used in the analysis of the data. The length of the eleven programs, ranged from twenty-one days to nine months (M=6 months). The rate of program completion ranged from 62.5% to 85% (M=73.6%). The three female and eight male coordinator's ages ranged from thirty-five to fifty-four (M=45). The time that each coordinator had been in the leadership role in the program ranged from one year to nine years (M=3). The average percentage of addicted patients in each program was: alcohol addiction only (25.2%), cocaine addiction only (15%), heroine addiction only (2%), benzodiazepine addiction only (0.5%), and polysubstance abuse (57.3%). The average percentage of patients with a dual diagnosis of addiction and a psychiatric problem was 35%. The number of beds in these programs ranged from 25 to 119. The coordinators had been selected from various medical disciplines such as psychology, nursing, social work, counseling, and vocational rehabilitation. Job titles were chief (3), coordinator (7) and domiciliary

coordinator (1) and they were primarily accountable to the chief of staff or chief of the domiciliary.

The classes in these programs included orientation, relapse prevention, stress management, assertiveness training, psychomedical education, interpersonal skill training, art, spirituality, consumer management, coping skill training, aspects of antabuse therapy, nutrition, vocational rehabilitation, AIDS prevention, and time management. Some of the groups that were conducted were supportive group therapy, aftercare, relaxation therapy, Post Traumatic Stress Disorder therapy, conjoint family therapy, contract group, treatment planning, and peer support groups. The disciplinary measures vary from withholding passes or special privileges to discharge for noncompliance and for positive urine and blood drug screens. These disciplinary decisions were made in some programs by staff and in some by committees composed of both staff and patient representatives. Recognition was given with performance awards to both individuals and groups, informed praise, plaques, medallions, and certificates.

Findings for Hypotheses

The central question of the study concerned the nature and extent of the relationship between the management style of the coordinator and the program completion role. Null hypothesis I stated that there is no significant relationship

between management style and program completion rate. Data for the MPS was analyzed by obtaining the total score for each subject by adding their scores on each subscale and then determining the mean score for each program. The MPS mean for each program ranged from 117.25 to 246.00. The program completion rates ranged from 62.5% to 85%. Five programs had mean scores above 205 for the skills needed for participative management and six programs had mean scores below 184 which indicated that the coordinators of these programs may have had more directive styles of management. The standard deviations ranged from 13.40 for Program 5 to 53.97 for Program 9 with six programs ranging from 33.17 to 33.45 (see Table 1).

Completion rates of programs with participative management scores on the MPS above 205 were compared to those with lower scores (below 184) using a one-way analysis of variance. Programs with high scores had a mean of 80.40 (SD=3.65). Those with low scores had a mean of 67.92 (SD=3.56). The analysis produced an $F=32.86$ ($p=.003$). The Null hypotheses was rejected. These results indicated that programs with higher scores on the MPS had higher program completion rates.

Table 1

Total MPS Score Average by Programs

Program	Number of Respondents	Total MPS Mean	Total MPS Std Dev	Program Completion
1	8	159.00	33.17	72%
2	4	117.25	35.17	70%
3	6	205.00	38.30	85%
4	8	216.88	34.60	80%
5	6	246.00	13.40	82%
6	8	184.00	50.70	62.5%
7	7	221.14	28.91	75%
8	6	143.83	38.76	65%
9	8	149.00	53.97	70%
10	5	207.20	27.74	80%
11	7	176.29	34.69	68%

Null hypothesis 2 stated that there is no significant relationship between high and low scores on the MPS management styles and the following dimensions of work climate: involvement, peer cohesion, supervisor support,

autonomy, task orientation, clarity, innovation, and physical comfort. Subordinates in each program were asked to rate the coordinators on each dimension of the Work Environment Scale. Data was analyzed by obtaining the means on each subscale on the WES for each program. The overall WES mean for each program was then obtained across all subscales and ranged from 3.98 to 7.13. The means for the scores on the MPS for each program previously obtained were also used in this analysis.

An analysis of variance was used to compare each program MPS mean score with each mean score on the subscale of the WES. The scores on the subscale of involvement for the WES had a mean of 7.12 (SD=1.05) for those five programs with high scores on the MPS. The six programs with lower scores on the MPS had a mean of 5.25 (SD=1.39). The analysis produced an $F=6.14$ ($p=.04$). The null hypothesis was rejected (see Table 2). Programs with higher scores on the MPS also had significantly higher scores on the involvement subscale of the WES.

Table 2

Measures of Central Tendency and Variability for Dimensions of the Work Environment Scale

Dimension	Participative		Directive		F Value	P
	Mean	SD	Mean	SD		
Involvement	7.12	1.05	5.25	1.39	6.14	.04
Comfort	6.16	.97	5.06	.57	5.46	.04
Innovation	4.41	1.39	3.56	1.09	1.30	.06
Clarity	6.61	.75	5.62	.79	4.46	.06
Task Orientation	6.25	.80	6.71	.88	.77	.40
Autonomy	6.22	.65	4.62	1.01	9.21	.01
Support	5.80	.97	4.18	.71	10.15	.01
Peer Cohesion	6.16	1.33	4.65	1.52	2.98	.12
Work Pressure	3.67	1.70	6.32	.82	11.54	.01
Control	4.93	.94	6.97	.33	25.10	.0007

An analysis of variance of the scores on the subscale of physical comfort on the WES had a mean of 6.16 (SD=.97) for the five programs with high scores on the MPS. The six programs with scores below 184 on the MPS had a mean of 5.06 (SD=.57). The analysis produced an F=5.46 (p=.04). The null

hypothesis was rejected (see Table 2). Programs with higher scores on the MPS also had significantly higher scores in the physical comfort subscale of the WES.

An analysis of variance of the score on the subscale of innovation on the WES had a mean of 4.41 (SD=1.39) for the programs with high scores on the MPS. The programs with scores below 184 on the MPS had a mean of 3.56 (SD=1.09). The analysis produced an F=1.30 (p=.06). The null hypothesis was retained (see Table 2). There was no significant difference on the innovation subscale between high and low MPS programs.

An analysis of variance for the scores on the subscale of task orientation for the WES had a mean of 6.25 (SD=.80) for the programs with high scores on the MPS. The programs with scores below 184 on the MPS had a mean of 6.71 (SD=.88). The analysis produced an F=.77 (p=.40). The null hypothesis was retained (see Table 2). There was no significant difference on the task orientation subscales between high and low MPS programs.

An analysis of variance for the scores on the subscale of autonomy for the WES revealed a mean of 6.22 (SD=.65) for the programs with high scores on the MPS. The programs with scores below 184 on the MPS had a mean of 4.62 (SD=1.01). The analysis produced an F=9.21 (p=.01). The null hypothesis was rejected (see Table 2). Programs with higher scores on the

MPS also had significantly higher scores on the autonomy subscale of the WES.

An analysis of variance for the scores on the subscale of supervisor support on the WES had a mean of 5.80 (SD=.97) for the programs with high scores on the MPS. The programs with scores below 184 on the MPS had a mean of 4.18 (SD=.71). The analysis produced an F=10.15 (p=.01). The null hypothesis was rejected (see Table 2). Programs with higher scores on the MPS also had significantly higher scores on the supervisor support subscale of the WES.

An analysis of variance for the scores on the subscale of peer cohesion on the WES had a mean of 6.16 (SD=1.33) for the programs with high scores on the MPS. The programs with scores below 184 on the MPS had a mean of 4.65 (SD=1.52). The analysis produced an F=2.98 (p=.12). The null hypothesis was retained (see Table 2). There was no significant difference on the peer cohesion subscale between high and low MPS programs.

An analysis of variance for the scores on the subscale of clarity on the WES had a mean of 6.61 (SD=.75) for the programs with high scores on the MPS. The programs with scores below 184 on the MPS had a mean of 5.62 (SD=.79). The analysis produced an F=4.46 (p=.06). The null hypothesis was rejected. There was no significant difference on the clarity subscale between

high and low MPS programs.

Null hypothesis 3 stated that there will be no significant difference in scores between participative and directive management styles on the following dimensions of work pressure and control. Data was analyzed by obtaining the means on the subscale of work pressure and control of the Work Environment Scale for each program work pressure ranged from 1.00 to 9.62 and control ranged from 4.00 to 7.33.

An analysis of variance for the scores on the subscale of work pressure on the WES had a mean of 3.67 (SD=1.70) for the programs with high scores on the MPS. The programs with scores below 184 on the MPS had a mean of 6.32 (SD=.82). The analysis produced an F=11.54 (p=.01). The null hypothesis was rejected. Work pressure was significantly higher in programs with low MPS scores.

An analysis of variance for the scores on the subscales of control on the WES had a mean of 4.93 (SD=.94) for the programs with high scores on the MPS. The programs with scores below 184 on the MPS had a mean of 6.97 (SD=.33). The analysis produced an F=25.10 (p=.007). The null hypothesis was rejected. Control was significantly higher in programs with low MPS scores.

Summary of the Findings

Findings Related to Research Question 1

The five programs with mean scores above 205 on the MPS were programs 3, 4, 5, 7, and 10 which indicated the coordinators of those programs had a participative style of management. The remaining six programs with mean scores below 184 on the MPS were programs 1, 2, 6, 8, 9, and 11 which indicated that the coordinators of these programs had a more directive style of management. When the completion rates of these programs were compared, the results indicated that programs with participative management styles had significantly higher program completion rates.

Findings Related to Research Question 2

The mean scores on the MPS of the five programs with a participative style of management and the six programs with a directive style were compared with their scores on the subscales of the WES. The following dimensions were statistically significant: involvement, comfort, autonomy and supervisor support. There was no significant difference in the subscales of innovation, clarity, task orientation and peer cohesion.

Findings Related to Research Question 3

The mean score on the MPS of the five programs with a participative style of management and the six programs with a directive style of management

were also compared with their scores on the WES subscales of work pressure and control. A significant difference was found in the scores in both of these dimensions.

Chapter 5

Summary, Conclusions, and Recommendations

Introduction

Three research questions were proposed and examined in this study. Findings related to research question 1 indicated a significant relationship between the two variables of the programs' scores on the MPS and their relapse rates. Programs with scores above 205 had significantly lowered relapse rates. Findings related to research question 2 indicated statistically significant differences between scores of programs with participative styles and programs with directive management styles on the following subscales of the WES: involvement, comfort, autonomy and supervisor support. The programs with higher scores on the MPS had higher scores on these subscales. The programs with participative management styles also had higher scores on the subscales of innovation, clarity, and peer cohesion but these were not statistically significant. Programs with low scores on the MPS had higher scores on the subscale of task orientation but these were not statistically significant. The statistical analysis related to research question 3 also revealed a significant difference in the WES subscales of work pressure and control. The programs with directive management had higher scores. Conclusions drawn from the major findings related to these questions will be presented in

this chapter along with recommendations for further research on participative leadership and addiction treatment.

Summary

Addiction has devastating effects on society and on the individuals with this disease and their families and friends. Relapse rates are high since relapse is a symptom of this illness and the course of the addict is cyclic. Addiction affects all age groups and socioecomonic and cultural levels and results in stigmatizing attitudes since many still believe it is a moral weakness. Referrals for treatment are from the legal system, health care system, families and self-referrals. Assessment for alcoholism has improved with screening instruments and therapeutic approaches have been based on psychodynamic, cognitive-dynamic, behavioral, humanistic, electic and relapse prevention models. Treatment has also expanded to include conjoint family therapy, A.A. and N.A. involvement, education and bibliotherapy, activity therapy, vocational rehabilitation, case management, aftercare programs, and halfway houses to assist in gradual reintegration into the community.

Research has been conducted evaluating treatment programs using confrontational approaches, i.e., Synanon, and therapeutic communities such as the Delancey Street movement in San Francisco which is self-supported and

boasts a success rate close to 90% in reforming addicts (Stein, 1990). No studies have been found on the effects of leadership styles on the employees in these programs or effects on relapse rates of the clients.

Participative management can satisfy the social and growth needs of employees and increase their morale when they are involved in the decision making process and can share information (Schein, 1985; Simmons & Maves, 1985). Participative management can increase organizational effectiveness by improving the quality of decisions through job enrichment and increasing the likelihood of implementation, since involvement enhances employee motivation, organizational commitment, pride, and acceptance of change (Maier, 1970; Hackman & Oldman, 1980). Involvement can satisfy needs for control, accomplishment, meaningfulness, increase consensus on goals and priorities, enhance cooperation and reduce conflict and stress, and increase trust and feedback from employees (Locke & Latham, 1984; Conley, Schmidle & Shedd, 1988; Bacharach, 1981). Participation can improve the flow of information, enhance innovation, and mobilize resources to resolve issues (Baloff & Doherty, 1989; Sergiovanni & Moore, 1989).

Participation has more significant results if there is a need for visible results, a focus on issues that affect employees, decentralization in large organizations, continuity is maintained with structure and delegation, and if the team is not

isolated from the rest of the staff (Goens & Clover, 1991). This democratic leadership style is more difficult to maintain in a large, complex organization with the bureaucratic structure where the autocratic style is used more frequently (Dinsmore, 1984). Managers can act as a catalyst and empower their employees to release their energy and creativity by utilizing a Theory 2 perspective (Ouchi, 1981). Tranformational leadership can result in organizational renewal through teamwork, quality circles, group dynamics and culture change (Allen, 1985).

The design of this study was descriptive using survey methodology. Instruments selected for use were the Work Environment Scale by Moos (1981); the Managerial Practices Survey by Yukl (1990); and a demographic survey. The population was comprised of the 13 program coordinators employed in the Veterans Affairs Domiciliary Addiction Programs and their 88 subordinates.

A total of 73 sets of usable responses and 11 demographic questionnaires from the coordinators was attained (72.3%). Variable examined were managerial practices; relapse rates of the programs; and the following ten dimensions of the work environment: involvement, peer cohesion, supervisor support, autonomy, task orientation, clarity, innovation, physical comfort, work pressure, and control.

Data derived from these surveys were analyzed using the one-way analysis of variance to determine the extent of the relationship between the managerial practices and relapse rates of the programs and each dimension of the work environment. The level of significance was set at alpha = .05.

Conclusions

1. Results of this study supported the importance of using a participative management style to increase program effectiveness since the ultimate goal of an addiction program is to decrease the relapse rates of the clients. Other intervening variables that could have influenced this result could have been the education and experience of the employees; the motivation, knowledge, and insight of the clients, and the types of addiction. Three programs with higher relapse rates had a higher percentage of patients with cocaine addiction although the highest percentage in all programs was polysubstance abuse. The designs of the eleven programs were very similar since each program had some didactic groups or educational classes, individual counseling, group therapy, vocational rehabilitation or work therapy, recreation, exercise, patient government, disciplinary measures, treatment planning, and some form of certificates, rewards, or recognition.

2. Involvement is the extent to which employees are concerned about and

committed to their jobs, and is included in the relationship dimension of the Work Environment Scale. Hall (1980) wrote that participation creates a potential for commitment but does not insure it. Commitment is a common bond which holds people together through a sense of purpose. The results of this study supported these ideas. Coordinators with participative management styles did have employees who felt more commitment to their work.

Peer cohesion is the extent to which employees are friendly and supportive of one another and is a subscale of the relationship dimension of the WES (Moos, 1981). Fawzy, Wellisch, Pasnau, and Leibowitz (1983) in a study on prevention of nursing burnout, found high scores on the WES subscales of peer cohesion, involvement, task orientation, and work pressure among oncology nurses and high peer cohesion among nurses in obstetrics. No significant relationship existed, in this study, between high scores on participative management styles on the MPS and high scores on the WES subscale of peer cohesion as one might expect. The intervening variables could have been personality differences, the work milieu, their work roles, and a high percentage of personnel who were involved directly in patient care. Moos (1986) reported that working in health care settings is thought to be more stressful on staff involved in patient care as physicians, psychologists, social workers, and nurses who view their environments more negatively. They tend to have lower scores

on peer cohesion, supervision support, autonomy, task orientation, and clarity subscales.

Supervisor support is also a subscale on the relationship dimension of the WES and is defined by Moos (1981) as the extent to which management is supportive of employees and encourages employees to be supportive of one another. This support can affect the health of employees. Kobasa and Puccetti (1983) examined the connections between stressful life events, personal hardiness, supervisor support, and family cohesion and expressiveness among executive businessmen. High support from supervisors was related to less physical illness among men who experienced more stressful events.

Leaders who focus on higher quality services and quality assurance programs may exert a positive influence on staff morale by making the work more meaningful and purposeful. Sinclair and Frandel (1982) compared two outpatient treatment programs, one with a quality assurance program and one as a control. Clinicians in the experimental group reported an increase in supervisor support and a decrease in control.

This study showed a significant relationship between programs with high scores on the MPS and high scores on the subscale of supervisor support of the WES. Lusk, Diserens, Cormier, Geranmayeh, and Neves (1983) in research on planned organizational change also found that dental students who

were organized into smaller groups with participatory planning meetings had higher scores on the WES subscales of involvement, peer cohesion, and supervisor support.

This study showed a significant relationship between high scores on the MPS and high scores on the subscale of autonomy. Moos (1981) defined autonomy as the extent to which employees are encouraged to be self-sufficient and to make their own decisions. Leadership that does not constrain behavior can increase employees' sense of autonomy and freedom to help them realize their potential. Jackson (1983) also found that participation had a positive impact on perceived influence with high scores on the WES autonomy subscale and job satisfaction, and helped to reduce role conflict and ambiguity. Involvement in decision making may lessen role strains and enhance valued individual and organizational outcomes.

A study by Hunnicutt and MacMillan (1983) of over 800 community mental health center employees found that personnel who rated their work environment as higher in task orientation, involvement, supervisor support, autonomy, and clarity tended to feel they were accomplishing more and reported less emotional exhaustion and depersonalization. This study found no significant relationship between high scores on participative management and high scores on the subscale of task orientation of the WES. Morale among employees is lower in

work settings in which the job is chaotic or poorly planned. Task orientation is defined by Moos (1981) as the degree of emphasis on good planning, efficiency, and getting the job done. The team meetings may have focused more on promoting better work relationships and less on defining goals and good planning.

No significant relationship was found to exist between the high scores on the MPS in this study and the high scores on the subscale of clarity. Clarity was defined by Moos (1981) as the extent to which employees know what to expect in their daily routine and how explicitly rules and policies are communicated. Communication may have been poor and policies may have become confusing. Clarity is a critical factor in delegation of tasks. Time and care need to be taken in defining an employee's job, especially when the employee has just started the job. The use of discretion by subordinates must be tolerated within reasonable limits. If a subordinate is always expected to perform in exactly the same way as his boss, then the work concerned is prescribed content, not discretionary content. Random or periodic feedback is often sought by employees. Often misunderstandings, poor job performances, and damaged personal relations are created when communications between the leader and group members are superficial facades where real feelings are concealed due to a lack of trust (Rees, 1984).

Innovation is defined by Moos (1981) as the degree of emphasis on variety, change, and new approaches. No significant relationship was found to exist in this study between the high scores on the MPS and high scores on the WES subscale of innovation. Change is slow in bureaucracies and often met with much resistance to change. Bennis and Nanus (1985) wrote that leaders can overcome resistance to change by creating visions of the future that evoke confidence in and mastery of new skills and practices. Roberts (1985) researched personality factors, aspects of the work environment, and demographic and job experience variables to determine their relationship to an employee's receptiveness to new technology. Employees were more accepting of change if they perceived their work milieu as more involving, cohesive, and task oriented.

Comfort is a subscale in the system maintenance dimension of the WES. Moos (1981) defined it as the extent to which the physical surroundings contribute to a pleasant work environment. A significant relationship was found between high scores on the MPS and high scores on the subscale of comfort in this study. Intervening variables could have been lighting, temperature, plants, pictures, and how new and modern the facilities were where the programs were located. You would not expect management style to greatly affect the comfort of physical surroundings but it could increase employee morale and job

satisfaction.

3. A significant relationship was found to exist between high scores on the MPS and low scores on the subscale of work pressure. Low scores on the MPS were associated with high scores on the W.E.S. subscale of work pressure in this study one might expect. Work pressure was defined by Moos (1981) as the degree to which the press of work and time urgency dominate the job milieu. Health care groups have been found to have higher scores on work pressure and control than general work groups. Employees generally want high emphasis on all of the subscales except for a moderate emphasis on control and little work pressure. High levels of work pressure and control have been found to increase absenteeism, accidents, low morale, high rates of burnout, illnesses, and depersonalization.

There was also a significant relationship between high scores on the MPS and low scores on the WES subscales of control as you would expect. Control was defined by Moos (1981) as the extent to which management uses rules and pressures to keep employees under control. Low scores in this study on the MPS were associated with very high scores on control. Wetzel (1978) found that women with depression perceived their work environment as less supportive and encouraging of self-sufficiency and as more controlling.

Recommendations

Based on the conclusions cited in this chapter, the following recommendations are made for further research on the concepts of participative management, perceptions of work environments, and addiction treatment.

1. Schools, workplace, family, mass media, and law enforcement play a role in shaping addiction-related attitudes, norms, and behaviors associated with addiction-related problems. More research is needed to examine these effects as these institutions undergo changes.

2. Primary prevention programs might be more effective if their primary objective were to change social perceptions and values. The task of research could be to develop and evaluate interventions that influence social norms that could lead to changes in public policy affecting physical and economic availability.

3. The course of recovery in addiction is often stalled or ultimately halted entirely by the threat of defensive challenge. Research can focus on developing and evaluating programs that challenge these defenses after the client has developed rapport with the therapists. Since new insights are often preceded by a brief return to familiar defenses, retreat would be viewed as a part of the normal growth process. Clients find it difficult to step out of the frame that has provided a limited sense of safety, a feeling of belonging and a

sense of self.

4. Recovery from addiction implies changes in life style and is a social process. Studies should be focused on successful reintegration within the community or resocialization. Preparing the addict for life in the outside world means minimizing the aura of institutionalization by establishing strong bonds with host communities, i.e., church functions, job and career fairs, and neighborhood functions and needs to be incorporated throughout the treatment process.

5. The higher cost of residential treatment for addiction in contrast to less expensive community-based approaches calls into consideration whether residential care is more effective than outpatient treatment. More research needs to be done using random assignment or matching to determine the advantages of nonresidential settings, length of treatment programs, the type of interventions that are helpful in polysubstance addiction, and electic approaches combined with participative management to involve the client even more in his treatment plan. It is helpful to present several alternatives for treatment to a client to provide the opportunity to shape the plan of care.

6. The Form R (Real) and Form I (Ideal) of the Work Environment Scale can both be used in evaluating and promoting improvement in addiction programs. They can be administered simultaneously to staff members to

identify areas in which change is needed and the extent of employee dissatisfaction. The Form R could be given again to evaluate the impact of interventions.

7. Other areas of health care such as nursing homes, hospitals, home health care, hospices, and community mental health centers need to do more research on the effects of participative management. It could be possible to increase creativity and efficiency in employees and to improve the quality of patient care through flexible roles, reciprocal interdependence, and coordination by means of lateral relationships and mutual feedback.

8. Participation in decision making can be a valuable training tool. Employees in health care settings could be scheduled for workshops on team management and research to determine the effects of participative management and counseling on levels of absenteeism and turnover in burn units and oncology wards which traditionally have higher rates of burnout.

9. The WES has been translated into Dutch, French, German, Hebrew, Japanese, Portuguese, Spanish and Vietnamese. More research is needed in cross-cultural applicability.

10. Managers should tap the unrealized potential present in their human resources. Organizational development and job redesign research is needed in health care. The employees could be requested to assess their own hospital

culture, to decide on ways in which the culture is lacking, and to take actions to produce a climate-improvement program. Patients also need to be surveyed before and after the changes are instituted.

11. Research is needed that focuses on the shifts of power and changes in hospital administrator's management style with the new health care system. Organizations that share knowledge with their employees can generate the ongoing innovation that is the source of success in modern health care.

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APPENDICES

APPENDIX A

Veterans Administration Addiction Aftercare Program

Aftercare programs have been established in many Veteran Affairs Medical Center Domiciliaries to provide follow-up services, continuity of care, and community reentry for many veterans with addiction problems. Some programs provide extensive vocational training, marriage and family counseling, educational rehabilitation, and consultation/liaison services. Others have extended aftercare programs that have a cognitive-behavioral therapeutic orientation and use principles of rational-emotive therapy and relapse prevention.

The Mountain Home, extended aftercare program was developed four years ago with enhancement funds to replace the Alcohol Treatment Program, the primary mode of addiction therapy in the domiciliary. The twenty-eight day Addiction Treatment Unit (A.T.U.) was continued at the hospital and a fourteen day relapse program was added for clients who had relapsed but had recently completed a treatment program. Relapsed clients, particularly those who are addicted to cocaine, require a longer period than four weeks for rehabilitation and many are homeless. They need a place to live where they can stabilize and continue their aftercare group therapy and individual counseling. Cocaine addicts often require a minimum of six months in a halfway house or aftercare

addicts often require a minimum of six months in a halfway house or aftercare program (Persons, 1989).

The Addiction Rehabilitation Program (ARP) was developed on the principles of participative management and democratic leadership stressing the critical role that teams play in getting work accomplished and in solving problems. Each team member has an equal vote on each client that is admitted and each policy that is instituted. The leader encourages each group member to participate actively in discussion, problem solving, and decision making. Consensus is sought with power-equalization. The leader's goal is to remain easily approachable to both employees and clients so an open-door policy has been instituted. The approach is multidisciplinary because health problems are defined in complex and multifaceted terms and the skills of many disciplines are needed to deliver comprehensive care (Ridgely, 1991).

Every treatment program needs to have operational goals, which imply how program success is to be measured (Courtwright, 1990). The goals for ARP are diverse: substantially reduce the use of drugs, reduce the use of legal psychoactive drugs, reduce or end violent and acquisitive crimes (robberies), substantially reduce specific educational or vocational deficits, improve health, increase fulfillment of family roles, AIDS risk reduction, restore or initiate legitimate employment, reduce the size and profitability of the drug market, and

reduce the number of infants born with drug dependence symptoms. Goals vary as do individual problems from client to client.

The coordinator of ARP was selected by the Chief of Domiciliary and Chief of Psychiatry who are the administrators of their departments. All other team members were selected by the Chief of Domiciliary and the ARP Coordinator, with input from the Assistant Coordinator. The team consisted of the coordinator (therapist), two addiction therapists, a rehabilitation counseling therapist (assistant coordinator), two technicians, a psychologist, a nurse, a physician, and a Domiciliary Assistant to be in charge of the housekeeping duties, section incentive therapy, and section duties.

After a client completes a four week program at any VAMC treatment unit, the therapist schedules the client for screening by the ARP treatment team. Each team member gets an equal vote on the selection after the interview is completed. The selection is based on the client's previous progress and sobriety contract he developed in the hospital program. After admission each client is interviewed and given an orientation of the treatment and rules by the nurse, physician, social worker, psychologist, and a therapist. Each client is assigned to a primary therapist with open-door counseling sessions to seek advice whenever a problem occurs. The program is based on the principles of Alcoholics Anonymous (AA) that the members will admit they are powerless

over alcohol or drugs, turn their lives over to the care of God as they understand Him, make a moral inventory of their wrongs, make direct amends, and try to help others. Each client is encouraged to attend either AA or Narcotics Anonymous (NA) meetings, work the AA steps, and obtain sponsors.

The decision to establish an AA focused program was influenced by Costello's (1982) report of the Rand Corporation's extensive treatment evaluation. Information was obtained on 85% of 922 men who had received treatment in an alcoholism unit. They were followed for over four years. The researchers found that alcoholics who regularly attended AA had a higher rate of long-term abstinence than all the other groups. About half were abstinent after four years. However, only 14% of the patients were regularly attending A.A. at the end of four years.

The decision to establish an AA focused program was also based on Brown's (1985) suggestions for developing successful treatment programs. He believed that the success of the comprehensive treatment model rests on several key factors. Therapists must be able to merge theory and practice they have been taught with knowledge based on their experience working with addicts. Clear understanding about the developmental nature and the stages of recovery is required to provide individually tailored diagnosis and treatment planning according to the progression of the addiction. A single psychotherapy

treatment, theory, and practice will not work. The therapist defined to one school may have considerable difficulty recognizing and responding to the changing needs or environment of the client. The therapist needs the ability to use a variety of therapeutic tools and strategies.

Therapists also need exposure to AA's steps and traditions and education on the purposes and benefits of peer support groups. Attendance at AA can reduce fears and may reveal prejudice the trainee holds toward the addict that can interfere with treatment. Based on their experience in counseling addicts, Estes and Heinemann (1986) believe it is not necessary to be an addict to work with addicts. They contend it is useful to have had a personal experience with loss of control and to understand, at depth, the reality of loss of control and the difficulties in altering behavioral and thinking patterns.

Antabuse therapy is encouraged for those who request it and are compliant with the recommended dosage of 250 mgm daily. It is not mandatory for all clients. Antabuse (Disulfiram) is a useful adjunct in the treatment of alcoholism and is a deterrent drug that has been used since 1948. It blocks the conversion of acetaldehyde to 5 to 10 times normal levels. The acetaldehyde is toxic and produces the following effects: nausea, vomiting, sweating, heart palpitations, headaches, flushing of the skin, and hyperventilation. The reaction typically occurs within 10 to 20 minutes after ingestion of alcohol and lasts 30 to

60 minutes. The severity of the reaction is proportional to the dosage of antabuse and the amount of ethanol ingested. The patient should be aware of risks and side effects and instructed to avoid alcohol-containing substances of any type (e.g., cough syrups and mouthwashes). Many patients find antabuse to be insurance against relapse in the initial 3 to 6 months of recovering as they develop ties with AA and gain support from counseling (Littrell, 1991; Frances & Miller, 1991).

Each therapist and co-leader conduct a didactic group each week for all clients in the first four weeks of the ARP program. The leader presents educational material and lectures for thirty minutes. All presentations are followed by group discussions to share ideas and experiences. One group focuses on the medical consequences of alcohol, drug, and nicotine abuse. Each member views a film and is assigned a drug to research the medical complications and present to the group. Clients are also requested to share any complications that they have personally experienced.

Another group assignment is to complete the family diagram to formulate a framework for assessing variability in adaptation, pattern and response within individuals and between individuals. In its simplest form, the diagram is a large circle representing the family as a whole, with smaller circles placed inside or outside the large family circle to designate the relationship of family members to each other and to alcohol. This provides a base for understanding the roles, alliances, and degree of denial operating within the family as well as

accessibility of various family members to the world outside. It is a framework for assessment and as such, its uses and interpretations are broad (Bronn, 1988). Clients often do not consider or recognize the impact of ethnicity, religion or class on themselves and their functioning. The therapist should consider the resources available to foster mobility. Each family has explanations, values, and rituals. The practice or lack of practice of tradition may have been a family issue (Yalom, 1975).

A group session focuses on co-dependency and how it relates to addiction. Clients are given handouts to read about the roles of the dysfunctional family and are assigned the task of discovering which roles they played in their own family. The roles are the hero, lost child, scapegoat, mascot, enabler, and victim. Feedback is encouraged from the other members in discussions on how they reacted in the same roles or ways in which they have played other roles. Topics of discussion are the guilt and shame that addicts feel and the manipulative behavior they develop to obtain their drug of choice. (Johnson & Johnson, 1982).

This group is followed by a session on self-esteem and how losses and past failures can reduce faith in oneself. The leader presents instruction on the components of self-esteem and how poor self-esteem can contribute to psychological problems and addiction. The leader then models assertiveness in a situation one of the members has listed as a problem and requests group participation with role-playing by volunteers (Rose, 1990). Clients are praised

for their efforts to give positive reinforcement. Experimental psychologists view addiction as escape behavior related to negative reinforcement.

Other groups are focused on instruction in nutrition, vocational rehabilitation, budget planning, leisure time, feelings, spirituality, AIDS, grief issues, sexuality, relationships, post traumatic stress disorder, dual diagnosis and powerlessness. Clients are also encouraged to participate in the Unit Government with officers elected from the client population. These officers are consulted on changes in rules and policies and report grievances by the members.

After the first twenty-eight days of the program, each client is assigned to a one hour aftercare group session for the remainder of the program. In each group there are eight to ten members in weekly sessions that last one hour. The feedback between these co-leaders is both supportive and challenging as the clients are encouraged to focus on the dynamics of relapse and their own personal programs of recovery they have formulated in the ATU program's contract groups. Each client discusses the conditions and mental states that have led to past relapses. Since the recidivism rate of chemical dependency is very high and variable, many have had both successful and unsuccessful coping attempts. Feedback is encouraged from the group members on ways to cope with loneliness, frustration, anger, grief, depression, confusion, impulsive behavior, and feelings of guilt and shame. Relapse may often be easily detected by other members while the client may be unaware of the changes in

his attitude. The client's defensiveness may have increased so that problems are viewed as being caused by other people or the system (Elder, 1990).

All group sessions have both a leader and co-leader. Co-leadership offers a number of special benefits both to the group leaders and to the group members. Leaders gain from the opportunity to have peer support during the group and to have easy access to backup coverage for holidays and vacations. In addition, the prospect of sharing the experience makes it even more pleasurable. Leaders also benefit, in terms of their own growth as therapists, by having an opportunity to watch another therapist work. The sharing of responsibility and the decreased sense of burden, and the ability to give constructive feedback to one another, help leaders to stay on top of the dynamics of the group (Cooper, 1987; Elder, 1990; Vannicelli, 1992).

Clients can choose to obtain employment and/or attend school after they have completed the first four weeks of the program and still live in the domiciliary. Most clients are working in the community or in the hospital in Incentive Therapy or Compensated Work Therapy programs. Many members are attending East Tennessee State University obtaining college degrees or enrolled in the Upward Bound Program to prepare for college. Job instability and unemployment are very real and pressing problems to alcoholics. Vocational rehabilitation programs, especially those with specialized services for alcoholics, can offer evaluation of individual needs, personal adjustment, prevocational and vocational training, coordination and integration of

is the specific problem of the client who lacks job skills and job opportunities. Career development represents one of the major areas in which a substantive change in self-esteem can be effected if the client can experience some measure of success with each endeavor (Knott, 1986).

If a member has a chronic illness or medical complications that are disabling, he/she is evaluated for placement in the general medical care unit. All members are encouraged to attend their groups regularly and to be productive and involved in AA, NA, Vietnam Veterans Group, or any supportive self-help group. A client can request a regular discharge at any time since the program is voluntary but is given an irregular discharge if he relapses. He/she is then referred to the detoxification and relapse program at the hospital for more intensive therapy.

APPENDIX B

Department of Veterans Affairs

Domiciliary-Based Substance Abuse Programs

Region I

Chemical Dependency Program
Bath, VAMC, Bath, NY 14810
Pat Stevens, Chief

Drug Abuse Program
Hampton, VAMC
100 Emancipation Road
Hampton, VA 23667
Wendy Harvey, Coordinator

Substance Abuse Treatment Program
Martinsburg, VAMC
Martinsburg, WV 25401
Michael D. McCarty, Ph.D., Dom Coordinator

Region 2

Substance Abuse Domiciliary Program
3200 Vine Street
Cincinnati, OH 45220
Mike Toner, M.S., Coordinator

Polysubstance Abuse Rehab Program
4100 West Third Street
Dayton VAMC
Dayton, OH 45428
Carol Blanford, R.N., Coordinator

Substance Abuse Unit
Dwight D. Eisenhower VAMC
4101 South 4th Street Trafficway
Leavenworth, KS 66048
Gary Dunn, Ph.D., Coordinator

Domiciliary Substance Abuse Program
Lyons VAMC
Valley Road
Lyons, NY 07939
Peter Kawonczyk, Chief

Posttraumatic Stress Disorder Substance Abuse Program
and Sobriety Living Unit
Clement J. Jablocki VAMC
5000 West National Avenue
Milwaukee, WI 53295
Dee Ramsel, Ph.D., Coordinator

Region 3

Substance Abuse Treatment Program
Bay Pines VAMC
Bay Pines, FL 33504
James Robyak, Ph.D., Chief

Domiciliary Substance Abuse Program
Bonham VAMC
9th and Lipscomb Streets
Bonham, TX 75418
Decca Hodge, Coordinator

Addiction Rehabilitation Program
Mountain Home VAMC
Mountain Home, TN 37684
Jim Forgey, Coordinator

Region 4

Dom Substance Abuse Program
West Los Angeles VAMC
Wilshire & Sawtelle Boulevards
Los Angeles, CA 90073
Wayne W. Rueckl, MSW, Coordinator

Alcohol Drug Treatment Program
White City VA Domiciliary
White City, OR 97501
Charles Holmgren, Ph.D., Chief

APPENDIX C

APPENDIX D

APPENDIX E

PROGRAM DEMOGRAPHICS

Program Title_____ Length of Program _____

Number of Beds_____ Average Patient Census _____

Rate of Program Completion _____

Name of Coordinator _____ Age_____ Sex ____

Job Title_____ Time in Position _____

Function _____

Level of Authority _____

Program Characteristics:

A. Classes _____

B. Group Therapy _____

C. Activities _____

D. Patient Government _____

E. Disciplinary Measures _____

F. Rewards, Certificates, Recognition _____

Percentage of Current Patient with:

A. Alcohol Addiction Only _____

B. Cocaine Addiction Only _____

C. Heroine Addiction Only _____

D. Benzodiazepine Addiction Only _____

E. Polysubstance Abuse _____

F. Dual Diagnosis _____

APPENDIX F

Department of Veterans Affairs

Memorandum

Date: September 17, 1993

From: Chairman, Research & Development Committee (151)

Subj: Approval of Research Project

To: Patricia Johnson, MSN (18B)

REF: "Effect of Leadership Style on Work Climate and Program Completion in Domiciliary Addiction" VA #0001.

1. On August 18, 1993 the Research & Development Committee reviewed and approved the above-named project pending some revision. This is to inform you that you have satisfied the contingencies and may initiate the project.

2. We wish you well with your research endeavors.

Linda Quade
for THOMAS A. TURNER, D. Ph.

APPENDIX G

September 16, 1993

Dr. John Doe
Chief, Substance Abuse Program
Veteran Affairs Medical Center Domiciliary
100 Main Street
Anyplace, USA 00000

Dear Dr. Doe,

Since relapse rates are high among clients with addiction problems, there is a need for more research on how to decrease these rates and improve the work climate and morale among employees in substance abuse programs. As a doctoral candidate at East Tennessee State University, I would appreciate your participation in disseration research on the effect of leadership style on work climate and program completion in Veteran Affairs domiciliary addiction programs. You are one of thirteen coordinators requested to participate.

Enclosed you will find copies of the Work Environment Scale, Managerial Practices Survey, and one copy of a program demographic survey. Could you please give one copy of the WES and MPS to each clinical staff member to complete and staple for return in the enclosed envelope? Permission has been obtained to use the instruments. Could you please complete the program demographic study?

You and your employees may be assured of complete confidentiality. Names are not necessary on the instruments and the programs will be numbered for identification in the report. Each instrument can be completed in fifteen to twenty minutes. I have obtained permission from the VA research committee which permits me to conduct surveys in all of the programs.

I will gladly mail you the results of the study upon request.

Sincerely,

Patricia L. Johnson
Doctoral Candidate

APPENDIX H

October 8, 1993

Dr. John Doe
Chief, Substance Abuse Program
Veteran Affairs Medical Center Domiciliary
100 Main Street
Anyplace, USA 00000

Dear Dr. Doe:

Dissertation research is being conducted entitled "Effect of Leadership Style on Work Climate and Program Completion" in thirteen Veteran Affairs Domiciliary Addiction Programs. On September 16, 1993, copies of two surveys and a program demographics form were mailed to you requesting your participation in my doctoral dissertation research.

Dr. Doe, my response rate is encouraging, but your input is needed. If you have already completed and returned them, please accept my gratitude. I would appreciate your response by November 1, 1993.

You may be assured of complete confidentiality. At your request, I will gladly mail to you the results of the study.

I welcome any questions you might have. Please write or call (615) 926-xxxx, Extension xxxx.

Thank you for your participation and support.

Sincerely,

Patricia L. Johnson
Doctoral Candidate

VITA
Patricia Lee Fain Johnson

Personal Data:
Date of Birth: September 1, 1941
Marital Status: Widowed

Education:
Diploma in Nursing
Martin Memorial School of Nursing; Mt. Airy, NC; 1964

B.S. in Psychology
East Tennessee State University; 1984

B.S.N. in Nursing
East Tennessee State University; 1985

M.Ed. in Supervision and Administration
East Tennessee State University; 1987

M.S.N. in Mental Health Nursing
University of Tennessee - Knoxville; 1990

Professional Experience:
Clinic Nurse and Therapist
Veterans Affairs Medical Center
Mountain Home, TN, 1975 - present

Staff Nurse
Walton County Hospital
Defuniak Springs, FL, 1974-1975

Cardiac Nurse
Veterans Affairs Medical Center
Dublin, GA, 1971-1974

Supervisor/Emergency Room
Vereen Memorial Hospital
Moultrie, GA, 1970-1971

Pulmonary Nurse
Veterans Affairs Medical Center
St.Petersburg, FL, 1969-1970

Medical Nurse
Veterans Affairs Medical Center
Mountain Home, TN, 1968-1969

Psychiatric Coordinator
Veterans Affairs Medical Center
Perry Point, MD, 1967-1968

Industrial Nurse
Walalua Agricultrual Company
Oahu, HI, 1966-1967

Night Supervisor
Leeward Oahu Hospital
Oahu, HI 1964-1966

Honors and Awards:

Outstanding Psychology Student
East Tennessee State University, 1984

Psy Chi Honorary Society, 1984

Phi Kappa Phi Honorary Society, 1984

Sigma Theta Tau Honorary Society, 1985

Gerontology Nurse Specialist, 1985

Phi Delta Kappa Honorary Society, 1988

Who's Who in American Nurses, 1990