Series 3: Positive Psychology

ABSTRACT: *In the following Series of articles, you will learn: [1] the 24 character strengths identified by Seligman and Peterson that act as a system of values to guide Positive Psychology; [2] how Positive Psychologists have begun recognizing that "the best things in life" can be found in meaningful work; [3] the features of a positive institution, such as a workplace; [4] that the finding of physical trauma does not necessarily preclude meaningful work; [5] how Positive Psychology and comprehensive disability management programs are aligned; and [6] about the biopsychosocial approach to understanding disease and illness and their effects on job productivity.*

Positive Psychology: A Primer (and Challenge)

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Introduction:

Martin E. P. Seligman, Ph.D., the past-president of the American Psychological Association is largely credited with founding the Positive Psychology movement. Offering a radical departure from behavioral sciences that focus on "dis-ease," members of the positive psychological research community seek to find specific ways to improve the lives, communities, and social institutions, including school and the workplace. In essence, Positive Psychology is the study of human behaviors that lead to the "pursuit of happiness" and the "good life."

Seligman and other positive psychologists study the nature of constructs such as flow, that is, how people can become so engaged in work or play that all else seems to disappear. Flow is said to be a key to creative productivity and problem solving. Positive psychologists are studying hope, optimism, gratitude, resilience, and a myriad of other human phenomena that have the potential to change how we think, feel, and behave generally in our lives, including the workplace.

Within the framework of Positive Psychology, Dr. Seligman and Christopher Peterson, Ph.D., have identified 24 character strengths found in any particular individual. Divided among the six virtues of wisdom and knowledge, courage, humanity, justice, temperance, and transcendence, these character strengths act as a system of values to guide the new psychology. Below, we present a summary of each of the six virtues, with specific highlights from the book Character Strengths and Virtues, the Handbook and Classification, authored by Seligman and Peterson.

Wisdom and Knowledge:

Character Strengths: Creativity, Curiosity, Open-Mindedness, Love of Learning, Perspective

This virtue includes positive traits that relate to the utilization of acquired information, and the authors define it as "knowledge hard fought for, and then used for good." The strengths falling under this virtue are considered cognitive in nature. The authors note that there is evidence that "making more life changes, particularly during the thirties life transition, appears to have a positive affect on the development of wisdom." However, they also acknowledge that wisdom and knowledge mean more than just the number of books read: "Perhaps it has something to do with living through hardship, emerging a better person…." In any case, acquirement of these strengths takes time.

Courage:

Character Strengths: Bravery, Persistence, Integrity, Vitality

According to the authors, courage is the will to accomplish goals even in the face of adversity, be it an internal or external factor. Strengths included in this virtue are considered corrective as they "counteract some difficulty…some temptation…or some motivation that needs to be checked or rechanneled." They even commented that courage is not limited to an external act of bravery; rather, inner acts, emotions, and decisions can be deemed courageous. They point to Cicero's definition of courage as one they chose to model: "Courage is the deliberate facing of dangers and bearing of toils."

Humanity:

Character Strengths: Love, Kindness, Social Intelligence

Considered to be positive traits found in caring relationships, character strengths of humanity reflect altruistic or "prosocial" behavior. People with these strengths will show kindness even when it will not be returned, and they do more than what is only fair. Most relationships in this virtue are interpersonal by nature, which is why love falls under this category. The difference between strengths of humanity and those of justice is that the former thrives on "one-to-one" relationships. The latter, strengths of justice, thrives on a "one-to-many" type of relationship.

Justice:

Character Strengths: Citizenship, Fairness, Leadership

Justice is that which makes life fair. The authors comment it is the notion of equity. Citizenship contains the values of social responsibility, loyalty, and teamwork. As noted above, strengths of justice are strengths among many, not just between individuals.

Temperance:

Character Strengths: Forgiveness and Mercy, Humility and Modesty, Prudence, Self-Regulation

This strength is that which protects us from excess. While the initial thought may be overindulgence in eating or drinking, excess can also refer to the concepts of hatred, short-term pleasure, and arrogance. Strengths of temperance do not cause the indulgence to end, but it tempers the activity from reaching an excessive point. The authors point out that courage is not included in these strengths because, unlike courage, these strengths lead individuals toward behaving in positive ways regardless of temptation. In conclusion, they remark that temperance is "a form of self-denial that is ultimately generous to the self or others – prudence and humility are prime examples."

Transcendence:

Character Strengths: Appreciation of Beauty and Excellence, Gratitude, Hope, Humor, Spirituality

As the connection to something higher, it is important to note that "what is transcendent does need to be sacred but does not need to be divine." Each character strength gives individuals the ability to connect with the larger universe, which can inspire awe and hope. For example, the authors claim, "Appreciation of beauty is a strength that connects someone directly to excellence."

Conclusion:

Seligman and Peterson believe that "coherent resemblance" of these High Six virtues can be found across cultures. In their words, "The higher-order meaning behind a particular core virtue will line up better with its cross-cultural counterpart than it will with any other core virtue…."

Positive Psychology endeavors to elucidate the human factors, including virtues and character strengths, that lead to the "good life." In this set of CEU articles, we assert that people with occupationally significant impairments, mental and/or physical, still have the right and capacity to pursue such a life. This is consistent with the CRCC *Code of Professional Ethics* for Rehabilitation Counselors, which states (A.1.c.),

Rehabilitation counselors work with clients to consider employment consistent with the overall abilities, functional capabilities and limitations, general temperament, interest and aptitude patterns, social skills, education, general qualifications, transferable skills, and placement of clients in available positions that are consistent with the interest, culture, and the welfare of clients and/or employers.

We begin this series of papers with what Seligman and Peterson define as six virtues and 24 character strengths with cross-cultural value. We argue that vocational counselors and disability management program directors could enrich their work and enhance their services to others by integrating positive psychology concepts in their approaches with clients and employees. After all, everyone has the right to pursue and experience happiness.

The CDMS *Code of Professional Conduct* requires professional growth and development for disability management specialists (RPC 1.21.b):

Certificants will also be aware of their own professional growth and development needs and seek continuing education, training, supervision, and consultation for themselves.

Case managers are also required to complete continuing education to maintain their certification. The CCMC *Code of Professional Ethics* (S2) states:

Case Management competence is the professional responsibility of the Board-Certified Case Manager, and is defined by educational preparation, ongoing professional development, and related work experience.

Professional development provides disability management specialists with the opportunity to learn more about and implement Positive Psychology into their work.

We offer this summary of strengths and virtues not with any specific career change or vocational rehabilitation applications in mind. We simply invite the reader to consider the constructs presented and challenge rehabilitation personnel to greater participation among those helping professionals investigating various aspects of Positive Psychology.

References:

Peterson, C., & Seligman, M. E. (2004). Character Strengths and Virtues: A Handbook and Classification. New York: Oxford University Press.

Disability Management Parallels Positive Psychology in Work Organizations

Jasen Walker, Ed.D., and Fred Heffner, Ed.D.

Background:

All work organizations encounter problems with lost time secondary to employee injury or illness. To some degree, all companies operationalize disability management, which is broadly defined as the organizational prevention of and reaction to lost time associated with employee injury or illness. Proactive Disability Management Programs (DMPs) have become viable and practical human resource management strategies that follow positive psychological principles.

DMPs became human capital strategies after a series of economic studies in the 1990s showed that disability costs in the workplace averaged 8% of company payrolls and that some organizations were spending as much as 31% of payroll on various consequences of employee disability. Now, after two decades of development, DMPs target human factors in the workplace and are designed on psychological principles that govern human behavior. For example, underlying assumptions of proactive disability management are that (1) work is a central theme in the lives of individual employees; (2) following the onset of injury or illness, employees want to continue working; and (3) if reasonably accommodated, they can and will return to work. DMPs are thus human capital strategies following psychological laws of human behavior. DMPs have economic consequences in work organizations.

People acquire disabilities through aging and a multitude of mishaps, diseases, and afflictions, and as with most human problems, disability has been historically viewed through the lens of a medical-disease model. Since World War II, vocational rehabilitation has tended to follow a similar model, one that has paralleled the evolution of psychology, a science largely devoted to healing mental illness rather than enhancing and enriching life skills. Since the days of Sigmund Freud, when the famed psychoanalyst asserted: “I found little that is good about human beings on the whole. In my experience most of them are trash,” psychology and the human behavioral sciences in general have not looked seriously at the positive side of human beings, until recently.

Over the last decade, Positive Psychology has captured the attention of social scientists from around the world. Empirical studies have shown that the “good life” can be found in thriving communities that focus on positive affect, good citizenship, responsibility, altruism, gratitude, moderation, tolerance, and the work ethic. Positive psychologists have begun recognizing that “the best things in life” can be found in meaningful work. Moreover, meaningful and “healthy” work can be experienced by workers with health impairments as well as employees without impairments in organizations that are committed to positive psychological principles.

The Science of Positive Psychology and Disability Management:

In 1998, Martin E. P. Seligman, Ph.D., the renowned University of Pennsylvania psychologist, urged the American Psychological Association (APA) to refocus its mission from exclusively defining and treating mental illness to also finding and advocating pathways to mental health and emotional well being. The APA followed the lead of at least one other profession: Organizational Disability Management. That is, since the mid-1980s, DMPs have evolved from simply allowing the injured worker to collect disability payments (at worst) or litigating the compensable injury claim until resolution (at best) to “light-duty” programs. Now, DMPs implement “proactive” prevention and early intervention processes of refined job selection, employee health maintenance, injury prevention, and transition to meaningful work as quickly as possible following the onset of lost time.

The traditional, now antiquated, medical-disease model of workplace disability (in which only physicians made return-to-work decisions) was comparable to the mental illness/treatment approach applied in the pre-positive stage of psychology, during which psychiatrists and psychologists diagnosed and treated only people with mental illness. Seligman was encouraging his colleagues to focus on character, virtue, optimism, and various other acts in life that prevent and reduce human strife. Psychologists were discovering that among life’s virtues was meaningful work!

Disability managers had already realized that safety programs, wellness programs, employee assistance programs, leadership effectiveness, conflict resolution strategies, and good old common sense in the workplace reduced the number and severity of disability claims. Research from the University of Michigan showed that enlightened employers applying "an integrated continuum of intervention" measurably reduced disability expenditures. Prior to "positive psychology," it had already become clear to disability management specialists and organizational leaders that most employees experience the "good life" in part through rewarding work and that injured employees respond better to return-to-work efforts if they perceive themselves as valued and respected members of the organization prior to any injurious incident or illness. As a consequence, disability costs were reduced.

DMPs continue to recognize that if an injury or illness were to occur, the organization and not the physician alone can assist the impaired employee with a meaningful transition to work, one executed with purposeful dialogue, reasonable accommodation, and an "integrated continuum" of intervention. What is more, DMPs in the context of viable human resource and human capital paradigms have begun to demonstrate that absence prevention and productivity maintenance are realized through effective employee well being and safety programs. These realizations have led to the proactive (preventive) approach of disability management used in well-managed companies today.

Positive Psychology has begun transforming the world of psychological assessment and treatment by amending the disease model and establishing an empirical basis for what constitutes "the good life." State-of-the-art disability management has unearthed the understanding that "the good work life" is a function of sound hiring practices, worker safety, employee wellness, effective interpersonal communication, conflict resolution, broadbrush employee assistance, transformational leadership,and the application of positive human resources before and after worker injury or illness. Like Positive Psychology, disability management no longer relies exclusively upon the medical paradigm of disease and sets forth a collaborative model of prevention, early intervention, job accommodation, and return to work.

Sound Hiring Practices:

Sound hiring practices are fundamentally important to disability prevention and management and may indeed be more important than safety programs. In reality, only conscientious individuals concerned with the welfare of others (a personal characteristic that can be assessed through careful screening and selection) will become the team players essential to keeping themselves and others safe and well in the workplace. Moreover, conscientious individuals are so **whether or not they have a history of medical impairment.** The notion that a person with a disability is a higher risk for injury in the workplace has long been dismissed as myth. Hiring individuals with disabilities who can be appropriately assigned (with accommodation if needed) is a sound human resource management policy. According to The CDMS *Code of Professional Conduct*, disability management specialists must also (RPC 1.13.a.1):

demonstrate respect for clients with diverse populations regardless of age, color, culture, disability, ethnicity, gender, gender identity, race, national origin, religion/spirituality, sexual orientation, marital status/partnership, language preference, or socioeconomic status.

The CCMC *Code of Professional Conduct* describes unprofessional behavior that would affect ethical responsibilities as including if a case manager *engages in conduct involving discrimination against a client because of race, ethnicity, religion, age, gender, sexual orientation, national origin, marital status, or disability/handicap* (S20-c).

The DuPont corporation has been surveying its workforce, dating back to at least 1973, in respect to the effectiveness of employees with disabilities as opposed to employees without. The results have consistently shown that employees with disabilities rated average or better in job performance, and in some years even surpassed their non-disabled co-workers in job performance.

The significance of these and similar studies demonstrates that **transition to work following occupational injury or illness makes good management sense.** Pennsylvania employers who do not have sound hiring and transition-to-work policies may be failing from the very beginning to establish proactive disability management.

The Importance of the "Essential Functions":

The Americans with Disabilities Act and Americans with Disabilities Act with the Amendments Act of 2008 (ADA/ADAAA) provided a landmark concept to private sector employers: the "essential functions" of a job. The ADA/ADAAA clarified what constitutes a job. That is, the Job Description must specify the essential functions of that job, and only the essential functions of the job. If a person can do the essential functions of a job, the employer cannot deny the job on the basis of an individual's inability to do something outside of those functions. In short, the ADA/ADAAA made the existence of a valid Job Description prima facie evidence in case of a legal dispute involving discrimination.

That reality led to the need to do verifiable job analyses producing essential function job descriptions. To pass muster, a Job Description is a list of the specific physical and mental activities of a job. The specificity is achieved by observational and physical measurements of non-exertional and exertional activities. Examples of activities include but are not limited to:

- how many hours of standing in measured steps (hours) are required for the job,
- how many pounds of lifting in an 8-hour shift are required, and
- what are the specific repetitions required of the job and how many repetitions per hour.

The Job Description (the outcome) is based solely on the results of the job analysis (the process). The Job Description may no longer be a creative narrative, usually ending with something like, "And other duties as assigned by the supervisor."

Another aspect of these disability management concerns is the ADA/ADAAA issue of "job accommodation." The ADA/ADAAA specifically states that if an individual can do what is required in the Job Description, "with or without accommodation**," then that person's application for that job cannot be denied.**

Hiring the right person for a job is important to the employer, and hiring the right person must be based on a pre-existing Job Description that in turn is based on a pre-existing job analysis. Returning to work those injured at work with the use of a pre-accident Job Description and job modification is sound human resource management.

It is important to note that the ADA, which was enacted in 1990, was recently amended by Congress to Americans with Disabilities Act with the Amendments Act of 2008 (ADAAA). The basis of the 2008 amendments is to strengthen the definition of disability in the original Act, **thereby reinforcing the intent of Congress to support the rights of qualified individuals with disabilities to find meaningful employment in the workplace.**

Worker Safety:

Planning for employee safety in the workplace is a major responsibility for every work organization. Injured employees can be a significant cost factor, and prudent employers do everything they can to minimize injury and lost time. There is no longer variance among business leaders regarding the value of Safety Programs.

If Safety Programs were 100 percent effective, people would not be injured at work and there would be no lost time secondary to occupational accidents. In fact, Safety Programs are not 100 percent effective, but the data are clear that a safe workplace and a safety-conscious workforce are without doubt the most cost-effective disability prevention and management objectives an organization can pursue.

Organizations with effective safety committees are in the best position to smoothly integrate workers with disabilities if they are truly motivated to do so. Success with workplace Safety Programs is generally the result of the organization infusing its culture with workplace safety practices and procedures.

Employee Wellness:

Employers have become aware that it is to their financial benefit to plan and conduct Wellness Programs. As a corollary to a safety initiative, and as an integral component of a comprehensive disability management program, Wellness Programs are prevention methodologies that communicate commitment to a workforce. Issues such as exercise, smoking cessation, obesity, regular physical checkups, drug use, and nutrition are more than feel-good concepts. Paying attention to wellness issues carries significant paybacks for employers in terms of reducing absenteeism and limiting the costs of health benefit programs.

Effective Interpersonal Communication:

Lost time from work is too often precipitated by a buildup of tensions between supervisors and subordinates. Interpersonal communication is the key ingredient in establishing cooperative relationships that are vital to workplace productivity. Thomas Gordon began a national movement in leadership effectiveness by promoting the skills of active listening to help employees solve problems. Gordon was fond of saying, "being the leader doesn't make you one." He recognized that job productivity is most often realized when both the supervisor and the supervisees are getting their needs met. Human beings in the workplace are big challenges for most of us. Instructing front-line supervisors how to effectively communicate interpersonally and maintain good relationships with those they lead not only maximizes productivity, but it improves corporate cultures and prevents the workplace stressors and tension buildups that often lead to carelessness, accidents, and injuries.

Conflict Resolution:

In any workplace, conflicts between employees or between employees and their supervisors are inevitable. Conflict is a part of life, but when it goes unmanaged and unresolved, it can be destructive. Well-managed companies recognize that unresolved workplace conflicts can be very expensive. According to Daniel Dana, Ph.D., a pioneer in a conflict resolution method known asManagerial Mediation, unmanaged conflict is the largest reducible cost in organizations today. It is also the least recognized cost.

Organizational managers can readily take proactive measures to deal with conflict when its existence is recognized. Since specific conflict resolution methods (and even training materials) are available, prudent management can easily adopt methods to teach these skills to their supervisors and managers. Workers' compensation claims can be, and frequently are, the result of unresolved conflict.

Employee Assistance Programs:

Employee Assistance Programs (EAPs) represent one of the oldest interventions that good management put into place to increase positive worker relations and productivity. In brief, EAPs begin with the identification of a troubled worker and a planned attempt to assist the employee in ameliorating the personal problem because it affects the employee's productivity. Historically, if an employee had a substance abuse problem, for example, the EAP provided specialized counseling to intervene and assist the employee and his or her family in controlling the condition. According to the U.S. Department of Labor, the vast majority of drug users are employed, and when they arrive for work, they don't leave their problems at the door. But, today's EAPs are generally more and more "broad-brush," providing assistance to workers with various psychosocial problems that may be manifesting themselves at work and interfering with workplace relationships and productivity.

Within companies employing a relatively large number of workers, the EAP may begin with an intervention from an in-house staff member, but as with all disability management concepts, front-line supervisors and co-workers are encouraged to assist in making appropriate referrals. In smaller companies, the appropriate referral may be to an external resource. Disability management is, in fact, most effective when it becomes part of the organizational culture. To achieve this level of integration, all effective disability management programs are initiated through transformational leadership.

Transformational Leadership:

While the term transformational leadership may seem somewhat overdrawn, it can be defined in specific terms (concepts). These concepts are what companies should expect of their top leaders. Transformational leadership occurs when one or more persons engage with others in such a way that leaders and followers raise

one another to higher levels of motivation, action, and morality, according to James MacGregor Burns, the noted presidential biographer who coined the term. Companies that recognize the value of a proactive disability management program generally do so because their leaders are transformational. That is, they are leaders who are able to recognize opportunities, inspire action, transform outcomes, and facilitate change in those around them.

At minimum, "transformational" leadership includes the following. The leader:

- encourages initiative;
- delegates responsibilities;
- generates ideas and encourages others to generate ideas;
- shares ideas;
- takes calculated risks;
- ensures that all employees have documented goals;
- initiates mentoring and coaching programs; and
- values, trusts, and respects all those who work for the company.

Peak leadership performance may very well be a prerequisite to more fully controlling the financial and human costs associated with workplace accident and injury. However, more often than not, the initiation of a well-designed Disability Management Program is but another manifestation of transformational leadership as described above.

Positive Human Resources:

In companies that are large enough to have Human Resource (HR) programs, the basic methodologies of Disability Management already exist in positive human capital strategies. These HR strategies (i.e., health and wellness programs, employee assistance programs, and effective recruitment and selection) may represent "silos" or independent programs rather than components of an integrated Prevention and Management System. The synergy (e.g., the whole is greater than the sum of its parts) of these HR programs is a necessary step in creating proactive, integrated prevention and management of disability in the workplace.

A significant correction in professional psychological thought now offers organizations further evidence that proactive, multidimensional, and integrated positive human resource programs are the building blocks of an efficacious Disability Management System. In the past, clinical psychology usually identified human dysfunction and considered ways of treating it. Clinical psychology has spent too much time with late interventions and treatments and too little time preventing illness and promoting strategies for optimal experiences. In 1998 the APA abruptly challenged this historical trend. Through the transformational leadership of Seligman and others, the APA changed its course and focused on identifying the "positive" human virtues and characteristics that lead to the "good life," including peak human performance, organizational productivity, job satisfaction, and thriving. Positive Psychology focuses on both the theory and methodology of identifying, promoting, and teaching ways in which individuals, schools, workplaces, and communities can identify and experience the best in themselves through optimism, resilience, gratitude, team effort, and devotion.

Proactive disability management represents what is currently among the "best practices" in organizations because it serves to leave no one behind while it promotes organizational health and productivity. As stated in the CRCC *Code of Professional Ethics* for Rehabilitation Counselors (A.1.a),

The primary responsibility of rehabilitation counselors is to respect the dignity and to promote the welfare of clients. Clients are defined as individuals with, or directly affected by a disability, functional limitation(s), or medical condition and who receive services from rehabilitation counselors. At times, rehabilitation counseling services may be provided to individuals other than those with a disability. In all instances, the primary obligation of rehabilitation counselors is to promote the welfare of their clients.

Proactive disability management is a function of positive psychological constructs that reflect what is best about human beings when they elevate themselves by devoting time and energy to improve themselves and the lives of others around them.

Steps toward Transforming a Workers' Compensation "Light Duty" Program into a State-of-the-Art Disability Management System

1. Turn your safety committee into a Disability Prevention and Management Committee and include human resource, medical (Case Management), and legal personnel.
2. Improve hiring practices by using essential function job descriptions and pre-employment testing related to essential job functions.
3. Train line supervisors (leaders) how to communicate – interpersonally – more effectively.
4. Teach managers how to mediate employee disputes and resolve work conflicts.
5. Provide transition-to-work and job accommodation programs.
6. Integrate EAP and Wellness Programs into the safety committee as it morphs into a Disability Prevention and Management program.
7. Help leadership become "transformational" by providing information and selling leadership on the merits of Disability Prevention and Management.
8. Be Positive and Optimistic. Have fun and be devoted!

Gratitude for the Disability Manager

Jasen Walker, Ed.D., and Fred Heffner, Ed.D.

"Man need only divert his attention from searching for the solution to external questions and pose the one, true inner question of how he should lead his life, and all the external questions will be resolved in the best possible way." ***Leo Tolstoy***

"Gratitude is the best attitude." ***Roberto Assagioli***

Introduction

Disability Management, the proactive organizational system of preventing and reducing costly effects of workplace disability, is tough work. Those employees assuming the role and responsibilities of Disability Manager (DM) are "middle managers" attempting to create and maintain coordination and collaboration among those organizational members with disparate and competing interests. The DM must somehow justify (usually to upper level financial officers) the time and expense of a company-wide human capital strategy (i.e., keeping people healthy, at work, and productive.) At the same time, the DM must convince the employee population (sometimes unionized) that paying employees to stay home and collect workers' compensation, short-term, and long-term benefits is in no one's best interest. Ken Mitchell, a pioneer in the disability management program movement, has referred to these dynamics as the "politics of disability" in the workplace.

Empirical evidence has shown that the twin strategies of trying to prevent injuries in the first place and working to minimize their disabling effects through disability management interventions in the second place are highly effective. In the summary of a critical and defining study, Successful Employer Strategies for Preventing and Managing Disability, Rochelle V. Habeck states:

"Employer policies and practices can reduce the incidence and improve the outcomes of work disability, especially when the policies and practices are a conscious and coordinated part of the company's overall goal."

However, the evidence that disability management works may not be enough to convince business leaders. Ultimately, an organizational commitment to implement strategies for preventing and managing disability likely depends on an informed DM's character strengths and leadership capabilities.

The DM must not only possess knowledge of risk management, medical/health programs, human resources, and industrial/labor relations but also manifest character strengths and virtues that convince organizational leaders to foster a company-wide commitment to proactively prevent and manage disability in the workplace. The DM must be capable of convincing key members of the work organization that they can both "do the right thing" and profit enormously from doing so. Too often in the world of business, in which profit rules, doing what is "right" is viewed as suspect if not contemptuous. Along with being armed with evidence that companies can profit from preventing injuries and minimizing their disabling effects, the DM must possess the creativity, open-mindedness, persistence, courage, social intelligence, and leadership to sell, implement, and maintain human resource strategies that keep people healthy and happy while at work. This is consistent with the CRCC *Code of Professional Ethics* for Rehabilitation Counselors (C.1.a):

Rehabilitation counselors remain aware of actions taken by their own and cooperating agencies on behalf of clients and act as advocates for clients who cannot advocate for themselves to ensure effective service delivery," and C.1.f: "Rehabilitation counselors are aware that disability benefit systems affect the quality of life of clients. They provide accurate and timely information or appropriate resources and referrals for these benefits.

Positive psychology focuses on positive emotion and positive traits, particularly human strengths and virtues. Positive psychology, however, also concerns itself with positive institutions, such as workplaces that are democratic, inclusive, and conducive to facilitating other positive experiences, including flow and gratitude. Among the strengths that a DM must possess most is the capacity to experience and express gratitude.

Gratitude

Gratitude is a timeless concept that has fascinated philosophers, religious leaders, and authors of self-help literature but also a subject that has received little sustained attention from the scientific community. Gratitude is derived from the Latin gratia, meaning grace, graciousness, or gratefulness. According to Emmons and Shelton (2005), gratitude psychologically is felt as a sense of wonder, thankfulness, and appreciation for life. Gratitude has been empirically linked with other positive emotions including contentment, happiness, pride, and hope.

In reviewing gratitude as concept in the history of ideas, Harpham (2004) references The Wealth of Nations by Adam Smith, the 18th century Scottish economist, considered by many as the father of modern economics. According to Harpham, Smith recognized that it was "…not benevolence or love of our fellow human beings that brings food to our table," but self-interest. Smith apparently believed that self-interest was a more steady passion than benevolence because the unintended consequences of self-interest could be calculated and projected into the future. Although Smith felt that self-interest played a central role in economic theory of commercial society, Harpham goes to length to explain that Smith also wrote The Theory of Moral Sentiments in which he recognized the importance of gratitude in the maintenance of a successful commercial society. Harpham wrote: "According to Smith, gratitude is the passion or sentiment that prompts us to reward others for the good they have done us."

Gratitude in modern life generally follows what Erickson (1963) termed identity, the primary developmental task of late adolescence and young adulthood. Gratitude, according to Erickson, manifests itself through generativity, the adults concerned for a commitment to promoting the well-being of the next generation through parenting, teaching, mentoring, and leading. As Tolstoy and Assagioli undoubtedly recognized, the development and expression of gratitude in the modern world generally challenges most of us.

Gratitude is offered here as a fundamental and essential attitude for DMs to nurture in themselves and others. By cultivating gratitude in themselves, DMs will hopefully model a critical set of behaviors that they want to find in others who might ultimately support the proactive, humanistic strategies necessary to prevent and ameliorate the consequences of injury and/or illness that are antecedent to workplace disability.

Shelton (2000) has portrayed gratitude as a key ingredient that makes up a daily moral inventory that individuals can use to foster moral growth. Shelton posits that developing a healthy moral life involves, first of all, self-awareness that one is a moral being. Second, by engaging in a daily moral inventory with a genuine intention to foster personal moral development, one is more likely to experience positive emotions associated with gratitude, such as humility and empathy. Third, searching for reasons to be grateful in daily experiences that otherwise evoke nongrateful thoughts and feelings "stretches" the character beyond the egocentric habitual ways of interpreting day-to-day life from a "take it for granted" perspective.

Naikan, a form of personal moral development, was developed by Yoshimoto Ishin (1916-1988), a devout Buddhist of the Jodo Shinshu sect in Japan. Naikan reflection is based on three questions, queries one poses to oneself daily:

- What have I received from...?
- What have I given to…?
- What troubles and difficulties have I caused...?

Asked of oneself daily, Naikan questions can provide an opportunity to gain perspective, reevaluate one's priorities, and experience gratitude, humility, and appreciation.

Emmons and Shelton (2005) inform us that Miller (1995) offers a simple, four-step behavioral-cognitive approach for learning gratitude: (a) identify nongrateful thoughts, (b) formulate gratitude-supporting thoughts, then (c) substitute the gratitude-supporting thoughts for the nongrateful thoughts, and (d) translate the inner feeling into outward action.

Rehabilitation professionals often develop a sense of thankfulness when they realize through working with their clients that they have a particular level of health and well-being. Moreover, rehabilitation professionals are often humbled by the courage their clients demonstrate. Finally, rehabilitation professionals are fortunate enough to experience the gratitude that clients can express when they feel they have truly been helped.

Most DMs have been professionally trained in rehabilitation as evidenced by the Certification for Disability Management Specialists (CDMS). It seems that because most DMs have experience in the altruistic-nurturing rehabilitation profession, a career path frequently encountering situations that potentially foster giving and/or receiving expressions of gratitude, DMs will recognize the importance of maintaining an attitude of gratitude. That attitude will likely be essential in helping an organization develop, implement, and maintain proactive strategies for DM.

Why gratitude for the Disability Manager?

DMs often have experience in rehabilitation of people injured through trauma or disabling disease. Through that experience, DMs have come to appreciate the value of good health and independence. People experiencing trauma often pass through stages of recovery. Initially, they are victims. With time and support, they become survivors. Ultimately, rehabilitation professionals want to facilitate an injured person's recovery to the point that the survivor is once again a contributing citizen, most often through meaningful employment.

Through their experiences with people who have experienced trauma and recovery, rehabilitation professionals acting as DMs maintain a sense of gratitude for both the gift of personal health and power of individual spirit. Witnessing others overcome what is perceived as tragedy is uplifting. Nothing can make us more grateful than knowing another human being who has broken through physical, psychological, and social barriers with resilience. If only vicariously, DMs generally have had personal and professional experience with awesome human resilience, and for that, they are grateful.

DMs are familiar with our society's history of discrimination against and exclusion of people with physical and/or mental impairments. Per The CDMS *Code of Professional Conduct*, DMs are to (RPC 1.13.a.1):

demonstrate respect for clients with diverse populations regardless of age, color, culture, disability, ethnicity, gender, gender identity, race, national origin, religion/spirituality, sexual orientation, marital status/partnership, language preference, or socioeconomic status.

Case managers are also held to ethical responsibilities through their ceritifying body, CCMC. According to the CCMC *Code of Professional Conduct* (S20-c), a case manager is unprofessional if he/she *engages in conduct involving discrimination against a client because of race, ethnicity, religion, age, gender, sexual orientation, national origin, marital status, or disability/handicap*.

The language evolution of describing particular Americans as crippled, handicapped, disabled, or challenged has given the DM an appreciation for the struggles of individuals who have received minority status. DMs can be grateful that they are responsible for bringing this evolution of both language and behavior to the workplace.

DMs are likewise aware of this country's remarkable legislative efforts to include and mainstream its citizens with disabilities. Although most would want more progress, to be grateful for the moral insight and courage of local and national leaders who have advocated for removal of barriers and greater inclusion can only ground the DM in a rich tradition of human rights. DMs can be grateful that they are given the responsibility of extending this bold civil rights tradition from the public sector into the private, sometimes sacrosanct, structures of work organizations.

Moreover, DMs are educators. They are enhancing the new workplace in America, one that is realizing its gifts of diversity and employment of talent in whomever they may be found. DMs can be grateful that they have the opportunity to expand the awareness and change the behaviors of their co-workers, much as civil rights advocates have changed the American public.

DMs are by tradition rehabilitation professionals. Rehabilitation in America has not lived up to its potential primarily because it has functioned as a professional antechamber to society, a profession that has tended to provide services to others outside the mainstream. DMs can now more expansively employ vocational assessment, job reengineering and accommodation, transition to work, and other paradigms that have been the fruit of the rehabilitation profession's labor. DMs can also help organizations integrate the various human resources that proactive companies attempt to make available to their employees. Integration of existing human resources and human capital strategies is often the result of the DM's awareness that any of us are only "temporarily able," and without various forms of assistance, many of us might be less productive or even unemployed.

And perhaps the awareness that all of us are only temporarily able provides the DM with the basis for experiencing and hopefully expressing gratitude. Among all of the organization's "middle managers," it is the DM who through professional training and experience can recognize that the benefit of well-designed and integrated disability management may someday be extended to him or her. That is, through his or her training and professional experience, the DM is anchored by the realization that he or she could potentially require the type of assistance available in an organization's Disability Management Program.

To experience gratitude, DMs need only to reflect on the potential of making workplaces more compatible with the diversity of the country in which we live. The challenge is ours, and the opportunity deserving of thankfulness.

DMs can consider Tolstoy's advice and answer their internal questions regarding the professional lives they lead and the external questions including to whom and for what we might be grateful are more easily answered. For the DM, among all organizational managers, "Gratitude is the best attitude."

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Positive Outcomes Following Physical Disability

Jasen Walker, Ed.D., and Fred Heffner, Ed.D.

As remarkable as it may seem, research has shown that "individuals who incur a physical disability may do more than 'survive' their condition; their resilience and clarity of purpose may result in greater resolve for pursuing personal goals" (Snyder 1998). Those same individuals often attain "spiritual awareness and psychological adjustment that surpasses their previous level of adaptation" (Wright 1983).

Resilience after Loss of a Limb

The Landmine Survivors Network (LSN), a Washington, D.C., based agency created by and for survivors of landmine trauma, assists victims "to recover from trauma, reclaim their lives, and fulfill their human rights." This group, along with a coalition of agencies focused on the same issue, was a co-recipient of the 1997 Nobel Peace Prize and with its partners was responsible for the 1997 Mine Ban Treaty. The Network provides workshops on disability laws and human rights around the world.

In 2004 LSN conducted a study "to determine factors that contribute to an individual's recovery." The study "indicated that the survivor's acceptance of limb loss and their state of psychological recovery were greatly influenced by the **individual's resilience characteristics**[bolding added], social support, medical care, economic situation and societal attitudes toward people with disabilities."

Among other facts, the study found that "personality dispositions, such as hardiness, may allow an individual to develop adaptive coping behaviors in response to traumatic stressors, thereby mitigating the development of Post-Traumatic Stress Disorder (PTSD)." Further, people who recovered psychologically from an accident "developed new coping strategies and ways of thinking that allowed them to address their new role in society, in their family, and in their work." Those who did better in the survival process described a conscious effort "to change their way of thinking to cope with their injuries and cited their own determination, perseverance, and positive thinking as important to their recovery."

The LSN study provides crucial guidance to rehabilitation professionals involved with those injured in workplace accidents. The critical findings of the study show that while there are essential contributing factors to recovery from trauma, such as the level of medical care, societal acceptance, family supports, and the economics of the case, a significant aspect in the final analysis is the ability and determination of the injured individual to cope with the situation. In essence, resilience is defined in the study as "determination, perseverance, and positive thinking."

Recognizing that some individuals responding to traumatic injury do better than others, rehabilitation professionals need to understand why that is and should do all they can to encourage these essential traits. While we may not be able to teach all individuals to be resilient, we can certainly devise strategies to encourage it.

Resilience in the Workplace

In the workplace, there is a need to consider resilience from two different perspectives:

1. Hiring employees who are resilient or at least training them to be proactively resilient to meet and surmount challenges as they arise

and,

2. Working with employees who are dysfunctional in respect to returning to productivity post-trauma but who exhibit little or no willingness to do so.

The seminal work in promoting proactive resilience was done by Mary A. Steinhardt, Ed.D., of the University of Texas (Austin) in a project she developed for, and carried out with, Motorola. The results of that study are titled "Transforming Stress into Resilience," and they are published in the Journal for Quality and Participation, among other sources. The premise of Steinhardt's work is that employers are looking for employees who know how to take initiative without waiting to being told to do so and that in fact, this characteristic can be inculcated. This approach starts with the reality that stressful conditions are inevitable but employees can be encouraged to react positively to them and overcome them.

Ideally, employers will seek to hire applicants who test positive for resilience. (For assessment tools on resilience, search the web for "resilience assessments.") Also, employers might consider the questionnaires on the Positive Psychology web site, especially the "Attributional Style Questionnaire." It is important to note that resilience is generally considered as going beyond coping or adapting to actually becoming stronger as the result of besting the stressful occurrence.

The second perspective on resilience in the workplace is a much more prevalent situation and much more difficult to address: how to incorporate the need to be resilient in a Disability Management Program (DMP) for the purpose of assisting employees to return to work **after** an injury or illness.

Disability management services are defined by The CDMS *Code of Professional Conduct* as:

The prevention and minimization of the human and economic impact of illness and disability for the employee/employer to optimize the quality of care, productivity, organizational health, and regulatory compliance. The goal of disability management is to provide necessary services, using appropriate resources in order to promote the ill or injured individual's maximum recovery and function. Disability management services include the following activities: case management; disability assessment and evaluation; return-to-work intervention; labor market analysis; career exploration and counseling; and reporting (plan development and report preparation).

Case management is defined by the CCMC *Code of Professional Conduct* as:

…a professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the "Triple Aim," of improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

The reality is that most employers do not have operational DMPs, and few of those who do actually conduct prevention training at the level of sophistication of the Motorola program. Still, dysfunctional or disability-prone employees also need assistance to recognize and overcome stressful situations at work.

Most frequently, employees who lack resilience manifest that deficit after they have been injured (at work or outside of work). They may be extremely reluctant to return to work after the trauma. Ground-breaking work addressing the specific issues of disability proneness and injured worker helplessness has been done by Jasen Walker, Ed.D., President of CEC Associates, Inc., in Valley Forge, Pennsylvania. Dr. Walker's work has led to his recommendations on shaping cost-effective DMPs. Dr. Walker develops and tests evolving concepts of effective disability management in which injured worker helplessness and disability proneness are addressed and prevented. These methods have been reported in The New Worker, the longest running newsletter of its kind, as well as in numerous articles in the relevant professional literature.

Dr. Walker's work focuses on after-the-fact situations, for example, scenarios in which workers have not learned to be resilient and for various other reasons are having significant difficulty returning to work. Unlike the beneficiaries of Steinhardt's pre-stress and stress-avoidance skills, employees who are exhibiting stress following trauma and demonstrating an unwillingness to return to work require an entirely different set of interventions than those used in prevention training.

Preparing to Combat Injured Worker Helplessness

To succeed with employees who are reluctant to return to work, rehabilitation professionals need to consider and apply a range of strategies. There are a number of causes for injured worker helplessness. Obviously, one problem is that the impaired employee has low or no resilience to overcome the negatives. Some of these negative thoughts or beliefs include:

- being unable to accept the value of the return-to-work opportunity (the worker undervalues the positives of working),
- enlarging the challenge to return to work (distorting/magnifying the negatives of the return),
- having a low frustration threshold,
- fearing disapproval or criticism, and
- believing that he or she has no personal control or influence over outcomes.

To understand injured worker helplessness and disability proneness, rehabilitation professionals have to take into consideration critical concepts such as Explanatory (Attributional) Style, Locus of Control, and Maslow's Hierarchy of Needs.

The first challenge to the rehabilitation professional is to understand the employee in terms of his or her Explanatory Style. This term is used in psychology to signify how people explain causality to themselves and others; that is, how and why things happen. Psychologists have shown that some people, pessimists, tend to blame themselves for negative events and believe that the negatives will persist. Other people, optimists, tend to blame negative outcomes in their lives on the behavior of others and believe that these negatives are only temporary. Moreover, pessimists typically think that bad outcomes represent what generally happens to them across events, and optimists believe that bad outcomes are specific to the situation.

Locus of Control is a fundamental principle in Attribution Theory (a basis for Explanatory Style) and is the psychological construct through which individuals place responsibility, choice, and control of events in their lives. There are two ways to ascribe control: internal and external. Individuals with internal control tend to attribute the outcomes of events in their lives as being under their own control, whereas individuals with external control attribute the outcomes of events to external circumstances.

It is essential for rehabilitation professionals to have these cognitive-behavioral constructs in mind when working with injured employees resisting return to work. There are test instruments available for both Explanatory Style and Locus of Control. The "Attributional Style Questionnaire" (ASQ) is used to determine Explanatory Style and optimism; the "Rotter I-E Scale" is commonly used to determine an individual's Locus of Control orientation. (At least one version of a Rotter Scale is available free on the internet: www.Ballarat.edu.au).

Another paradigm professionals may wish to consider when working to strengthen an individual's resilience is Maslow's "Hierarchy of Needs." The subtitle of the Hierarchy is "A Theory of Human Motivation." What is involved here, then, is how to understand the "motivation" that resists return to productivity and independence through work.

At its simplest, the Hierarchy consists of five levels of "needs." The highest level is "Self-Actualization." Being resilient may presume that the individual has achieved a sustainable level of both self-esteem and regard for others. Maslow's levels are illustrated as a pyramid with the most basic need on the bottom and the most developed level at the apex:

1. Self-Actualization
2. Esteem
3. Social
4. Safety
5. Physiological

It is highly unlikely that an individual who does not derive self-esteem from work and a concomitant desire to succeed occupationally will have the resilience to overcome the challenge of disabling impairment. The most important method of understanding at which level the injured employee is operating is through a well-conducted

assessment by an experienced rehabilitation counselor or psychologist. According to the CRCC *Code of Professional Ethics* for Rehabilitation Counselors (G.4.b),

Rehabilitation counselors are responsible for the appropriate applications, scoring, interpretations, and use of assessment instruments relevant to the needs of clients, whether they score and interpret such assessments themselves or use technology or other services. Generally new instruments are used within one year of publication, unless rehabilitation counselors document a valid reason why the normative data from previous versions are more applicable to clients.

In Maslow's theory, achieving any one level is dependent upon having realized the sequenced lower levels. If the goal of the rehabilitation counselor is to assist the client to achieve greater self-esteem through a return to work, the counselor will be well served to understand at which Maslow level the client was generally functioning before the injury. Then, the optimal task is to identify the impediments for a return to work based on "need" and address specific ways to overcome those impediments.

Transition to Work: The Framework Needed to Work with Employees Resisting a Return to Work

The dominant conclusion of the LSN study was that those who do better in "the survival process" describe a conscious effort "to change their way of thinking to cope with their injuries." They also specifically reference "their own determination, perseverance, and positive thinking as important to their recovery."

In vocational rehabilitation, the traditional method of dealing with injured employees was either to outsource them (find a job for them with another employer) or, at best, to provide them with "light duty" assignments. Light duty often meant returning the employee to the company but providing meaningless chores for them to do. No effort was made to rehabilitate the worker while attempting to maintain their level of self-esteem. In some cases, of course, the injury could be eventually resolved through medical rehabilitation, including physical therapy and work hardening. However, in cases where the resistance was the worker's learned helplessness or another psychological factor as opposed to a physical one, the solution was simply some light-duty activity or radically different outplacement.

When DMPs began to replace light duty with a "Transition-to-Work" approach, new opportunities presented themselves to introduce resilience-building activities. Whereas "light-duty" assignments typically demean workers, a Transition-to-Work maximizes post-injury potential, reduces the incidence of helplessness, and facilitates resilience.

Transition-to-Work (TTW) is an **incremental** process designed to involve the worker with appropriately sequenced activities to strengthen both the physical and psychological needs of the injured worker. Materials to guide the process have been developed and are available from CEC Associates, among other sources.

The key to mitigating injured worker helplessness is to place recovering employees in a TTW program so that the rehabilitation counselor has the time to assess the nature of the resistance and apply remedial concepts. All this occurs while the employee is being productively engaged in meaningful work, albeit in incremental steps.

Can Resilience be Taught?

Although all employers instruct employees in learning job-related skills, most employers do not perceive themselves as teachers. They insist that the public schools (and even colleges) are responsible for teaching, and most feel that the schools are not doing a good job of it.

In life, and perhaps especially in work, there is no more fundamental skill than resilience. People who can overcome adversity will fare better in life than those who cannot. In the workplace, employees are constantly being challenged to overcome some adversity: a supervisor's reprimand, disparagement by a colleague, frustration in learning a new skill, failure to meet a quota, etc. The irreducible fact is that resilient employees will carry greater benefits for the employer than those who are not.

The question becomes one of how employers can address this issue for their benefit and profit. The starting point for employers who recognize the benefits of resilience and choose to address the issue is to make every individual employee aware of the benefits of resilience and what the specific features of possessing it are. Employees should be given a brief list of factors that distinguish the resilient from the less resilient. That list will include, at minimum:

Resilient people:

- view the world in optimistic and hopeful ways;
- have self-esteem and feel appreciated by the people that are significant to them;
- are able to, and do, set goals and expectations for themselves;
- manifest self-discipline;
- take responsibility for their actions;
- can solve problems and make decisions; and
- view mistakes, hardships, and obstacles as challenges to confront and overcome.

Employers who choose to do so can, over time and on an on-going basis, introduce motivators. For example:

- reinforcing responsibility can be achieved by requiring, or at minimum encouraging a specific, measurable contribution by the employee;
- offering encouragement and positive feedback;
- challenging individuals to solve a specific problem;
- discussing a mistake frankly and with understanding; and
- requiring individuals to set and document measurable objectives.

Some Ways to Build Resilience in Those Who Are Not Resilient:

Stressful events happen to everybody. We cannot change that reality. But we can change how we respond to adverse events. We can change an adverse reality by changing the focus of our thinking from the past (the event has already occurred and there is nothing we can do about it) to the present (what can we do about it now?) to the future (how can I manage or prevent the same type of occurrence?).

Employers can present the basics of resilience and confidence-building by helping their employees to think through the following concepts:

- People who seem to do better than most on rising above adversity have goals for what they want to achieve in their lives. If you have a goal (or goals), remind yourself of what they are. If you have goals, bring them to the forefront and rededicate yourself to achieving them. If you don't have goals, now is the perfect time to set some.
- Be decisive about what you do going forward. If your first need is to set goals, identify some professional help that can assist you to set goals and then write them down.
- Teach yourself to be positive about yourself. In the world of psychology, there is something new happening. Psychologists are now fostering something they call "Positive Psychology." They think that rather than teach doctors and psychologists how to address and correct problems, they should teach individuals how to avoid problems by being positive.
- Try to improve your personal life. What can you do to improve your living conditions? Join a group in your neighborhood. This not only gives you something to do but, more importantly, will get you in touch with new friends.
- It is good to rely on others, but you need to give equal time to relying on yourself, too.
- Step up and volunteer to do something. Do what? Plan, be positive, learn new skills, and manage your feelings.

The key to adjustment following the onset of a disabling health condition is directly related to the Locus of Control orientation the individual brings to the situation. Those with some measure of internal Locus of Control report less distress than those with expectations of external assistance. Further, disabled individuals who have

mastered and possess problem-solving skills have positive attitudes about resolving their own problems and are at once “more assertive, more psychosocially mobile, more accepting of their disability, and less depressed than their counterparts who lack these skills” (Elliott, 1999).

The strands of research here have been specifically culled to serve our premise that an impairment, however severe, does not necessarily equate to a work disability. Nonetheless, this research is a valid basis from which to extrapolate some lessons for disability management in the workplace.

There was a time in vocational rehabilitation when an impairment meant excuse from further work or, at best, an assignment to “light duty.” During these formative years of DMPs, medical doctors determined whether a worker was “disabled” and could therefore continue on lost time disability benefits for the rest of his or her life. Now, in quality DMPs, trained Vocational Disability/Evaluation professionals in collaboration with the employer and employee determine the degree to which the employee is disabled with or without accommodation.

With the advent of Positive Psychology, researchers have examined the literature for outcomes associated with physical disability to determine if, in fact, physical trauma essentially always translates to negative results. The finding that physical trauma does not necessarily preclude meaningful work is an important message for those creating and operating DMPs in the workplace. When Disability Managers learn to recognize the state of mind and motivation of the impaired worker, they will be more prepared to facilitate recovery during an adjustment period and aptly apply transition-to-work methodology to the case.

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Positive Psychology as an Emerging Construct in Disability Management

Jasen Walker, Ed.D., and Fred Heffner, Ed.D.

Transformational Leadership:

Just as the development of Positive Psychology requires visionary leadership (which has manifested itself especially in the contributions of Martin E. P. Seligman, Ph.D., and his colleagues), the evolution of how injured workers are treated in the workplace also requires visionary leadership. In the early stages of "managing" the injured worker, the employer encouraged the lost-time employee to remain on workers' compensation (WC) and, in effect, leave the company. When employees took to the idea of not having to work again by staying on WC, the employer, in these early efforts, sought out third party providers to find an alternative employment outside the company. These so-called rehabilitation services were simply the employer or insurance carrier's effort to resolve claims, usually by following the mandates of a particular workers' compensation jurisdiction.

In the article "Functions and Knowledge Domains for Disability Management Practice: A Delphi Study," the authors state, "…traditional rehabilitation services often fail to develop active, equal, and valued partnerships with employees in implementing the rehabilitation process" (Currier, Chan, Berven, Habeck, & Taylor, 2001). Incidentally, one of the authors of that article, Rochelle V. Habeck, a disability management consultant who once taught at Michigan State University, conducted research on and wrote about the significant difference between traditional "Rehabilitation" and "Disability Management." Habeck found that where the leadership representing employers had been progressive, i.e., "transformative," and where companies had fewer labor-management conflicts, there were fewer disability claims.

In Positive Psychology, the proactive approach to assisting human beings is based on strengthening assets and preventing as opposed to treating illness or dysfunction. Beyond that, Positive Psychology seeks to not only study positive emotion and identify positive personality traits (i.e., character traits and virtues) but also help build positive institutions, including strong families and viable workplaces. As opposed to the failed traditional rehabilitation services referenced by Currier et al., Disability Management sought to develop and apply methods of prevention and early intervention as basic elements to keep the employee population safe and well and, if necessary, assist impaired employees in navigating effectively through the quagmire of the disability-claims process, the medical treatment process, and the emotionally-charged personal (family) process to occupational recovery. Disability Management Programs (DMP) became integrated not only in terms of benefits but also in terms of human capital strategies for keeping people productive. State-of-the-art DMPs now advocate for prevention and early intervention through integrating Accident Prevention and Safety Programs, Wellness Initiatives, Employee Assistance Programs, Leadership Effectiveness Training, Conflict Resolution, and Mediation Training as well as applying similarly positive resources before and after lost time resulting from employee injury or illness.

According to The CDMS *Code of Professional Conduct*, disability management services are defined as:

The prevention and minimization of the human and economic impact of illness and disability for the employee/employer to optimize the quality of care, productivity, organizational health, and regulatory compliance. The goal of diability management is to provide necessary services, using appropriate resources in order to promote the ill or injured individual's maximum recovery and function. Disaiblity management services include the following activities; case management; disability assessment and evaluation; return-to-work intervention; labor market analysis; career exploration and counseling; and reporting (plan development and report preparation).

DMs will find that they will need to work together with other professionals, including case managers, to provide services to clients. According to the CCMC *Professional Code of Conduct*, case managers are provided with a definition of inter-disciplinary as:

Collaboration occurs among different disciplines that address inter-connected aspects of the client's defined health problem or needs. The members of the team bring their own theories and frameworks to bear on the problem and connections are sought among the disciplines to improve client outcomes.

Transformational leaders embrace concepts central to positive psychological thinking and organizational well-being. Company heads and disability managers now recognize that individual employees do not stumble onto happiness, well being and productivity. They actively seek it out in work environments that enable not lost time and occupational disability but opportunities to experience work-life balance, positive emotion, and flow.

Work-Life Balance:

Originally, employers recognized no connection between the employee's workplace responsibilities and anything else in the employee's life. As work intensified in terms of its competitive nature and skilled people became more "valuable," employers were urged to balance their expectations of their employees for loyalty and dedication with the recognition that taking external pressures (especially family pressure) into consideration and designing accommodations for that reality significantly improved worklife effectiveness and productivity. The Family and Medical Leave Act was promulgated, in part, on the notion that one's personal life had to have some degree of balance with job commitments.

Losing interest and even burnout are directly attributable to increased workplace and familial stress, and work frustrations are real for blue-collar workers as well as management-level employees. In fact, the stress is heightened as both workplace and family pressures combine. Stress-derived injuries and subsequent disability claims continue to rise, and the workplace is often identified as the crucible for the onset of stress related disorders.

Well-designed and integrated DMPs have allowed employers to assist employees in better managing life's pressures. The gamut of strategies developed in state-of-the-art DMPs, such as effective Employee Assistance Programs, the use of flexible hours, job modifications, job sharing, engaging employees in the decision-making processes that most affect them, and transition-to-work methods are now part of the human resource strategies mix in most well-managed companies.

Emotional Contagion in Groups:

Emotional contagion has been shown to play a significant role in work-group dynamics. A better understanding of the conditions and concepts of emotional contagion can lead to greater insight into and understanding of employees' workplace behavior. Recently, the concept of emotional contagion has taken a role in the formation of effective DMPs.

Emotional contagion in groups was first researched by Sigal G. Barsade of the Yale School of Management in 2001. The concept can be defined as "a process in which a person or group influences the emotions or behavior of another person or group through the conscious or unconscious induction of emotion states and behavioral attitudes" (Schoenewolf 1990).

The results of Barsade's research confirms that people do not live on emotional islands but rather as group members experience moods at work. These moods ripple out and, in the process, influence not only other group members' emotions but their group dynamics and individual cognitions, attitudes, and behaviors (e.g., interpersonal conflict) as well. Thus, emotional contagion, through its direct and indirect influence on employee and work team emotions, judgments, and behaviors, can lead to subtle but significant ripple effects in groups and organizations. Whereas positive emotional contagion can enhance productivity, negative emotional contagion can reduce it.

Negative moods are highly infectious, and as a result, employers are learning under the prodding of DMP innovators to teach recognition and protection skills. Perhaps the most important skill to help contain contagion is teaching employees to achieve and maintain independence from "group think." Awareness is certainly a start, but the key is active prevention and early intervention.

Leadership Effectiveness Training, Managerial Mediation, and Conflict Resolution Skills development programs intend to go beyond awareness alone. Unresolved conflict has been shown to be one of the most costly issues in the workplace. A classic management study determined that 25% of the typical manager's time is spent responding to conflict. That figure rises to 30% for first line supervisors. As noted, Habeck's research has shown that management-labor strife leads to increased WC losses. It has been estimated that a quarter of the management salary budget represents no small investment in shielding productive work from the destructive effects of conflict. Leadership Effectiveness Training includes skill development in interpersonal communication, conflict resolution, and problem solving. Transformational leaders invested in proactive disability management do not fear conflict but know how to prevent and effectively manage it.

Flow:

If employers could choose one attribute they would want in their employees, it would certainly be motivation. Individuals who are highly motivated (and happy) generally experience satisfaction at work through an optimal mental state called "flow," which was introduced to the world by a positive psychologist, Mihaly Csikszentmihalyi, Director of the Quality of Life Center at Claremont Graduate University in California. Flow is a single construct that distinguishes a regularly productive employee from one who is not as productive.

Csikszentmihalyi recognized that a person who is fully engaged (immersed) in what he or she is doing is energized by it. This total immersion in the activity (e.g., the work process) reveals that one can experience high levels of satisfaction in challenging tasks that match skills.

With Csikszentmihalyi's assistance, Disability Management professionals, supported by transformational leadership, can induce flow experiences. Csikszentmihalyi identifies these experiences as:

- Having clear goals.
- Concentrating and focusing.
- Having a distorted sense of time.
- Receiving and analyzing feedback.
- Balancing ability level and challenge.
- Sensing control over the activity.
- Finding the activity rewarding.
- Being absorbed in the activity.

The Csikszentmihalyi concept of the value of flow is much broader than just a work process. One can be deeply immersed in play or other leisure activities as well. However, employers are constantly searching for ways to make their employees more productive, and flow was tailor-made for the workplace.

Job Modification/Job Accommodation:

In a well-established, proactive transition-to-work program, job modification, job accommodation, and job sharing can facilitate an injured employee's return to work. Job modification is the process of subtracting from, or adding to, a job description or transitional work role while maintaining its essential functions. "Essential Functions" is a primary concept of the Americans with Disabilities Act.

Job modification might include eliminating unessential lifting, changing hours, relocating a job within a particular work environment, or changing the job/transitional assignment in a manner that results in both employer satisfaction and employee success. Transition-to-work programming, in general, is an effort to create a win-win outcome following lost-time injury or illness. Jobs can be modified in terms of their physical demands, time allocation, environmental requirements, supervision, and in countless other ways that are a function of employer-employee joint (creative) problem-solving. By creating transition-to-work assignments and modifying jobs, employers maintain a pathway for employees to return by rehabilitating themselves while at work. Transition-to-work programs have replaced the self-limited paradigm of "light duty."

Job accommodation is a specific method advanced by the collaborative effort between employer and employee to modify work or to accommodate the needs of an impaired employee so that the essential functions of the job

may be carried out to the mutual satisfaction of both the employer and employee. Job accommodation is not a new concept, but in 1990, the Americans with Disabilities Act advanced the practice of "reasonable accommodation" by making it mandatory that qualified individuals with disabilities be given the opportunity to begin or maintain work with reasonable accommodation.

Rehabilitation counselors are called by the CRCC *Code of Professional Ethics* for Rehabilitation Counselors to (C.1.b):

provide clients with appropriate information to facilitate their self-advocacy actions whenever possible. They work with clients to help them understand their rights and responsibilities, speak for themselves, make decisions, and contribute to society. When appropriate and with the consent of clients, rehabilitation counselors act as advocates on behalf of clients at the local, regional, and/or national levels.

Given this aspect of the professional code of ethics, rehabilitation counselors should encourage job accommodation for clients.

The U.S. Department of Labor comments, "The process for making such accommodations is no different in principle than implementing workplace procedures designed to build productive work environments. As with all such procedures, open lines of communication and clearly defined steps help to facilitate the process and achieve positive outcomes for both employers and employees." An excellent resource for job accommodations and assisting in the employment of individuals with disabilities is the Job Accommodation Network.

Conclusions

Disability managers and transformational leaders have the good fortune of Positive Psychology research, which parallels DMP development and empirically supports the commonsense conclusion that human beings have specific pathways to well being, happiness, and productivity. These pathways are available to employers and employees in proactive work organizations that integrate not only insurance programs but human capital strategies to keep people at work, safe, engaged, creative, and too satisfied to become or remain disability claimants.

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The Origins of Occupational Disability, a Formulation of Disability Management, and the Need for Good Public Policy

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Background

It is a fact in the world of work that some employers are sensitive to the need to plan and conduct Disability Management Programs (DMPs), while other employers are either not aware of the benefits of such programming or have chosen not to implement one. This article is written for both of these entities.

The Certification of Disability Management Specialists Commission (CDMS) defines "Disability management services" in The CDMS *Code of Professional Conduct*:

The prevention and minimization of the human and economic impact of illness and disability for the employee/employer to optimize the quality of care, productivity, organizational health, and regulatory compliance. The goal of disability management is to provide necessary services, using appropriate resources in order to promote the ill or injured individual's maximum recovery and function. Disability management services include the following activities: case management; disability assessment and evaluation; return-to-work intervention; labor market analysis; career exploration and counseling; and reporting (plan development and report preparation).

Disability management specialists may have to work in conjunction with case managers who provide care coordination to clients. Coordination is the process of organizing, securing, integrating, modifying and documenting the resources necessary to accomplish goals within a case management plan. The CCMC *Code of Professional Conduct* states care coordination is the:

…deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

For those employers who already do sponsor DMPs, even exemplary programs, there is at least one highly significant innovation in the occupational disability realm that will, in most cases, be new information. That innovation is the application of Adverse Childhood Experiences (ACE) findings to disability management in the workplace.

To those employers who have not yet come to understand how valuable a quality DMP can be for the bottom line and the valuation of skilled and loyal employees, this article should serve as a blueprint for developing one.

The article is divided into three sections:

I. Introduction to the Biopsychosocial Model of Illness/Injury and Its Effect on Productivity in the Workplace
II. The "Psychosocial Constructs"
III. What We Think Needs to be Done and How to Do It

I. Introduction to the Biopsychosocial Model of Illness/Injury and Its Effects on Productivity in the Workplace

Historically, there have been two approaches to understanding disease and illness and their effects on job productivity: the biomedical approach and the biopsychosocial approach. The biomedical model posits that every disease process can be explained in medical terms. Therefore, if the symptoms are simply biomedical, the employer's response is medical treatment and the application of the Family and Medical Leave Act, the Americans with Disabilities Act with the Amendments Act of 2008 (ADAAA), an appropriate company-

sponsored short-term/long-term disability program, or a jurisdictional workers' compensation program. Regardless, the biomedical outcome is generally lost time.

However, Engel, a research professor at the University of Rochester, discredited the usefulness of the biomedical model in an article published in *Science* (1977). He put forth the idea that a combination of biological, psychological, and social factors play a dominant role in how humans function in the context of disease/illness, and that these factors are more significant than biomedical issues alone in terms of disease/illness consequences, including workplace disability.

The biopsychosocial explanation is steadily becoming, or has become, the basic model used by enlightened employers in terms of their DMPs. The key concept in this approach is that healthcare professionals diagnose the disease and designate the degree of impairment and associated levels of functionality, but the employer, along with the employee, determines whether or not the employee is disabled from performing the essential functions of an existing job in the work organization.

The Commission on Rehabilitation Counselor Certification, in its *Code of Professional Ethics* for Rehabilitation Counselors, notes that in serving the welfare of those who are injured and seeking rehabilitation – in this case, an injured employee – it is important that the individual remain a crucial decision-maker in his or her own rehabilitation. Code A.1.d. states:

Rehabilitation counselors respect the rights of clients to make decisions on their own behalf. On decisions that may limit or diminish the autonomy of clients, decision-making on behalf of clients is taken only after careful deliberation. Rehabilitation counselors advocate for the resumption of responsibility by clients as quickly as possible.

In other words, physicians have the education, training, and experience to identify a disorder or disease and describe what, if any, impairment follows. Only the employer, or an employer in the process of hiring a new employee, can determine whether or not the given impairment and its functional consequences disable the employee or job candidate from performing the essential functions of a well-defined job. Walker (1993) distinguishes between medical impairment and vocational disability in the context of a well-constructed DMP.

At Corporate Education and Consultation (CEC) Associates, Inc., we have been privileged to gather the medical and social histories and assess the psychodynamics of thousands of individuals who have experienced trauma said to affect their physical and/or mental capacities to work. These vocational-disability assessments have consistently shown that the biopsychosocial constructs of disease and disability have far more descriptive power and ecological validity than what is conveyed by the biomedical principle alone, and because they do, biopsychosocial frameworks should hold more value to the employer trying to prevent and manage occupational disability and associated lost time.

It is important that employers understand the significant difference between relying solely on the biomedical model of disease and disability versus taking the more informed approach of considering how **biological, psychological, and social factors influence mental and/or physical trauma and ultimately result in occupational disability and productivity disruption.** We assert that it is crucial that *all three* of these factors are considered in the organizational decisions leading to the re-employment of workers who have lost time secondary to injury and/or illness.

Once this basic concept of the primacy of the biopsychosocial model is accepted by employers, other contemporary constructs and theories begin to play a significant role in the development and maintenance of a quality DMP. The DMP is the effective integration of human resource strategies intended to prevent occupationally significant impairment, reduce lost time, and increase productivity. Specific biopsychosocial constructs (selected here) include:

- Adverse Childhood Experiences (Anda, Felitti, et al., 2004)
- Work Dysfunctions (Lowman, 1993)
- Disability without Disease (Behan & Hirschfeld, 1966)
- The Disability Process (Weinstein, 1978)

- Disability Proneness (Walker, 1990)
- Learned Helplessness (Seligman, 1992)
- Injured Worker Helplessness (Walker, 1992)
- Positive Psychology (Peterson & Seligman, 2004)

This article defines these and other relevant constructs in an attempt to specify the various human problems that precipitate occupational disability and, also, to provide an outline for disability management rationale, delineating methods and tools that employers can immediately consider for implementation. We stress the importance of guidance from choosing the *biopsychosocial* model of disability over the *biomedical* paradigm.

Finally, we call for cooperation among private sector business leaders and public policy makers in reducing the psychosocial antecedents and economic consequences of vocational disability and decreased job productivity. Some observers with different disciplines would implicate poor diet and nutrition or the existence of labor unions as the potential cause for this nation's problems with work productivity and economic success. We neither deceive ourselves by pretending to know all the ills and cures of workplace productivity, nor do we suggest that occupational disability is a major reason for our nation's economic struggles. We respectfully offer what we believe is an improved way of perceiving, preventing, and managing occupational disability. This article focuses on these matters and what employers and public policy makers might do to prevent and manage lost time resulting from individual developmental issues, injury, and illness. We argue that employers would be wise to bring together their human resources to prevent and manage lost time and productivity, while at the same time, leaders in the private and public sectors must endeavor to combine their efforts to eliminate the causes of biological, psychological, and social disorders that ultimately manifest as occupational disability.

Lost Time Issues in the Workplace:

American employers have a collective responsibility to pay heed to public policy and to share in the shaping of it. At the same time, it is important for employers to start with a full understanding of where and how absenteeism issues in the workplace start. That is, to be effective in the public advocacy process and to change the quality of the work experience, employers will need to recognize the root causes of occupational dysfunctions and disabilities (i.e., injuries and absenteeism) in their companies.

The overriding reality in terms of absenteeism in the workplace is that essentially all injuries and illnesses derive from some form of aberration on the part of the employee *or* as a result of counterproductive employer-employee interaction.

We adopt and endorse the biopsychosocial descriptor because we believe that many of the causes of disability before and after the onset of medical impairment have psychological and social origins, and we do not advocate complete separation from the biological influences that sustain disability. Relevant biopsychosocial constructs are listed above. In Part II, we will endeavor to list and define the specific constructs that will be of value in understanding the origins of and potential remedies to occupational disability and other issues affecting workplace performance. Those constructs that will be of value in understanding the origins of occupational disability include:

- ACE Scores
- Work Dysfunction
- Disability without Disease
- The Disability Process
- Disability Proneness
- Injured Worker Helplessness
- Anger, Conflict, and Emotional Contagion
- The Effects of Depression and Substance Abuse

In addition, we reference what we believe are potential remedies to acquired occupational disability. They are:

- Positive Psychology
- Resilience Work for the U.S. Army (Seligman)

- Work and Flow (Wrzesniewski and Csikszentmihalyi)
- Private Sector Effects on Social and Public Policy
- Sanctuary Model (Bloom, 2001)
- Transition-to-Work Programs

II. The "Psychosocial Constructs"

Following a seminal study, and reporting under the aegis of the Centers for Disease Control and Prevention (CDC), Anda, *et al*., wrote an article titled "Childhood Abuse, Household Dysfunction, and Indicators of Impaired Adult Worker Performance" (2004). Significant quotations from the report include the following:

Because child abuse and household dysfunction are common and have long-term effects that are highly disruptive to workers' health and well-being, these adverse childhood experiences merit serious attention from the **business community, labor leaders, the everyday practitioners of medicine, and government agencies**.

Traditionally, maintaining a healthy and productive workforce has centered on job training, technologic improvement in production, and medical treatment for occupational injury or illness. Instead, however, our data indicate the need to adopt the World Health Organization (WHO) definition of health. To do so would necessitate a paradigm shift, in which the disease-oriented biomedical approach is **replaced by a biopsychosocial approach in which child abuse and household dysfunction are understood in terms of their long-term effects on worker health and well-being** [emphases added]. (Anda, Felitti, et al., 2004, p. 35)

To give a meaningful perspective to these serious declarations, it will be useful to revisit the basic constructs of occupational disability. We set the stage by reviewing these biopsychosocial constructs that seem to predict or describe occupational disability. This conceptual review will lead to an analysis of how organizations can better manage and even prevent workplace disability. Both public and private entities, even in these austere economic times, must collaborate to financially support prevention and early intervention through psychoeducational and social programs if we are to recover and maintain economic prosperity through work productivity.

1. Adverse Childhood Experiences (ACE) Scores:

The acronym ACE stands for Adverse Childhood Experiences. ACE as a phenomenon in adult medical conditions and work behaviors constitutes a relatively new framework, which affords us a potentially useful perspective to more fully understand occupational dysfunction and disability proneness.

The key findings were first reported by Anda and Felitti, *et al*. (Anda is with the National Center for Chronic Disease Prevention and Health Promotion, a sub-group of the CDC, and Felitti is with Kaiser Permanente). In their paper, Anda and Felitti make the critically significant assertion that "Job performance can be affected by personal factors other than knowledge and skills." Of course, employers in general have had considerable experience with the relationship between employees' personal issues and job performance, but this research sheds light on the origins of that relationship and may finally give both employers and public policy makers some rationale for privately supporting a social system that includes primary prevention strategies.

Adverse Childhood Experiences are defined as pertaining to (and deriving from) "eight phenomena experienced by respondents during their first 18 years of life." These experiences are said to be:

1. Emotional Abuse
2. Physical Abuse
3. Sexual Abuse
4. Battered Mother
5. Household Substance Abuse
6. Mental Illness in Household
7. Parental Separation or Divorce
8. Incarcerated Household Member

To "assess the cumulative effect of adverse childhood experiences," Anda and his colleagues "calculated for each respondent a score ranging from 0 to 8 (the ACE score), which represented the total number of [these] categories to which the respondent had been exposed." The number of exposures is said to be the "ACE Score." To have been physically abused and to have had mental illness in the family, for example, would generate an ACE score of 2.

The paper is even more specific in terms of "Worker Performance." It lists "three indicators of impaired worker performance" as:

1. Job problems
2. Financial problems
3. Absenteeism

Respondents in the CDC/Kaiser Permanente (CDC/KP) research were identified as having impaired worker performance if they answered "yes" to any of the following questions:

1. Are you currently having serious problems with your job?
2. Are you currently having serious problems with your finances?

The study drew the following conclusions:

1. The long-term effects of adverse childhood experiences on the workforce impose major human and economic costs that are preventable.
2. These costs merit attention from the business community in conjunction with specialists in occupational medicine and public health.

The important conclusion of ACE research is that "employers [and the relevant public health entities] have both the need and the opportunity to work together against the long-term effects of childhood abuse and household dysfunction." The article presents the fact that, "Exposure to such adverse circumstances is likely to **lead to massive financial expenditures for health care as well as to economic losses attributable to poor work performance**" [emphasis added].

The article concludes:

If even a small fraction of the economic and human resources currently spent on these conventional approaches was used to identify and address the root origins of these problems in the workforce, we could reasonably expect to find more effective ways to improve worker health, well-being, and performance. (Anda, et al., 2004, p. 37)

We believe that the ACE research establishes a foundation for better understanding the theories of disability proneness, disability without disease, work dysfunction, and the disability process as it often unfolds in the workplace. Before taking a look at corporate strategies that can prevent and interrupt the disability process, we briefly review these concepts and other occupational disability phenomena below, beginning with work dysfunction.

2. Work Dysfunction (Lowman):

Lowman's 1993 book, *Counseling and Psychotherapy of Work Dysfunctions,* is an early look at individual problems in the workplace from a psychodynamic perspective. Lowman recognized that "work is a natural part of living, and the issues it raises are important parts of character." Lowman itemized work dysfunction as including:

- over-commitment and burnout
- under-commitment and fear of success and failure
- work-related anxiety and depression

- personality disorders in the workplace

Although these aspects of work dysfunction are almost too broad to be useful in terms of workplace planning, they do serve as a starting point for many of the psychological issues that manifest in the workplace.

Lowman defined work dysfunction as a psychological condition in which there exists a significant impairment in the capacity to work caused by either the personal characteristics of the employee or by an interaction between those characteristics and the working conditions. Organizations vary in the extent that they create or ameliorate stress. Jobs can be poorly designed. Supervisors can be ogres or behave very aggressively in an attempt to meet their own needs. Co-workers can be petty, vindictive, and antagonistic. Work conditions, particularly those characterized by high levels of responsibility with limited opportunities for control, can have demonstrable effects on an individual employee's health and well-being.

On the other hand, dysfunctional workers themselves may not be aware of, or accept responsibility for, the extent to which their own shortcomings and personal characteristics contribute to problems on the job. Work dysfunction is often a precursor to what Walker (1990) termed "disability proneness," which will be reviewed below. Well-planned and implemented DMPs within companies can be instrumental in identifying work dysfunction and in assisting those individuals so identified with specifically designed strategies.

3. Disability without Disease (Behan and Hirschfeld):

Behan and Hirschfeld (1966), occupational medicine professionals, analyzed the disabilities and lost time of employees in the automobile manufacturing business in Detroit,Michigan. Behan and Hirschfeld started by examining employee accidents. They found that most often, the disability did not match up to the severity of the accident. They were puzzled about the relationships between the accident and the outcome. How did one lead to the other?

In contrast to their predecessors, Behan and Hirschfeld attempted to answer this question by first looking at **events preceding** the accident and then at the larger human and social context in which the accident occurred. They then searched for ways to understand the problem of chronicity through the assumption that a life of disability or invalidism, with its constricted activity and reduced autonomy, would be chosen and maintained by the employee only if it resolved some extremely powerful and disturbing conflicts within the individual.

These researchers concluded that particular employees, under certain stressful conditions, could manifest "**disability without disease**." From hundreds of case studies, these physicians concluded that unacceptable disability **required** an accident, or explanatory event, in order to be acceptable, even though the occupational dysfunction (disability) began well before the identification of an injury (disease).

Behan and Hirschfeld went on to demonstrate that many of the most perplexing and resistant examples of chronic disability in the wake of industrial injuries were actually the late stages in a sequence they termed "the accident process." The four key features of this process were thought to be:

a. Tension and stress: In almost every instance, the accident is preceded by the development (not necessarily in the working area of the patient's life) of tension and stress, leading to feelings of inadequacy and depression. These unwelcome dysphoric states are often associated with a powerful sense of being insufficiently appreciated, having too much demanded or expected of one, and/or disappointments and frustrations about promotion, security, advancement, and competence.

b. Dependency denial: Essential to the initiation of the accident process is a personality configuration that makes the patient unusually sensitive to perceptions of increased expectations and of reduced support and approval. This personality configuration also makes it very difficult for the patient to acknowledge or to directly and explicitly ask for help for the tension-depression state he/she is experiencing. The personality styles of these people (mostly men in the Behan-Hirschfeld series) have prominent dependent and passive qualities, along with an inability to accept or acknowledge such dependent wishes or passive strivings – a complex

commonly found in the working blue-collar population of our industrial centers and which is still (but of recent date less strenuously) widely considered to be normal or even ideal for American men in general.

c. The injury: The coupling of increasing subjective distress with an attitude that makes it difficult to ask for help sets the stage for the next phase of the accident process: the occurrence of an injury that transforms the employee into someone whose distress and impaired performance can be understood by him and others as the result of an externally generated event, something that "could happen to anyone," understandable to all, and generally compatible with an image of tough self-sufficiency. In brief, the accident transforms an "unacceptable disability," equated with weakness and failure, into an "acceptable disability," neither dishonorable nor shameful. None of this requires us to assume that the accident happens because of the need for an acceptable disability; but, of course, the concept of the accident-prone person is an old and recurrent one and would seem to have one of its bases here.

d. Disability as a way of life: The remainder of the accident process has to do with the crystallization and stabilization of disability as a way of life, energized by the patient's ongoing personality characteristics, by the rapid accumulation of reinforcing social and financial responses to the initial disability, and sometimes, unfortunately, by the consequences of diagnostic and therapeutic interventions of physicians and health-care agencies.

4. The Disability Process (Weinstein):

At CEC Associates, Inc., our concern has been with the contributions of social agencies and social systems (including medicine) to the stabilization phase of the accident (and lost time) process. We found considerable relevancy and value in the work of Weinstein (1978) in what he called "The Disability Process." From Weinstein's work, we realized that the initiating event could be a non-industrial illness rather than a work-related accident, and that led us to publish papers of our own, extending Behan and Hirschfeld's concepts.

First, we came to realize that **work disability is commonly the end result of a complex process** rather than the direct consequence of a discrete accident or illness. This realization helped us to predict and to appreciate the tenacity with which some disabilities may actually be sought out and maintained over time. Whenever self-esteem is elevated, change is difficult and unlikely; when it is low, change is actively sought by the patient and can be facilitated by others.

Second, our contemporary cultural valuations of depression and anxiety as being unworthy, shameful, and unacceptable – valuations that often seem to actually initiate the disability process – appear to be changing. To the extent that we can further soften the cultural polarization of some kinds of suffering as honorable and other kinds as unacceptable, we will reduce the energy that makes the disability process operate.

Third, in view of their prominence as ingredients of the disability process, we could re-examine some of the social and programmatic reinforcements and supports for ongoing disability; we can slow the crystallization and stabilization phases of the disability process by promoting public policies that reduce the reinforcement of disability by monetary and other rewards. Finally, we can re-examine our own activities as rehabilitation professionals to see whether our diagnostic efforts, treatment intervention, participation in the establishment of awards, and even our covert messages about hopelessness or the rightness of the patient's "claim" against society, contribute to the disability process.

The task of inducing changes in cultural values and societal patterns is enormous, but the disability process is, after all, only a statement of what our society believes to be good and what it holds to be bad about people and their behavior. In the final analysis, the disability process is not likely to change unless the values that energize it are themselves changed.

Retrospectively, we have learned from our experiences of evaluating injured and ill workers, for the purposes of either forensic disability assessment or occupational rehabilitation, that an employee's personal difficulties, coupled with a troubled life situation, can produce an "unacceptable disability." An unacceptable disability may be defined as a vocational maladjustment (or dysfunction), with or without lost time, that is difficult to explain from a biomedical perspective alone and is nearly always tension-producing for both the employer and

employee. Unacceptable disability often reveals itself in an employee's lack of productivity, increased unhappiness, interpersonal conflicts manifested in the workplace, and/or absenteeism.

When **unacceptable** disability is followed by an accident or diagnosable illness, the so-called "explanatory event" (e.g., a work-related slip-and-fall accident), unacceptable disability can be transformed into an **acceptable disability for the employee**. With resultant lost work time sanctioned by various benefits systems (including healthcare) and paid for by the employer, the pre-accident occupational maladjustment is no longer the focus of concern. Instead, the accident or explanatory event, not necessarily the beginning of, but the tangible evidence of disability, serves to justify lost time and absenteeism.

For many years, Behan and Hirschfeld, as well as others including Weinstein, proposed that unresolved anger, particularly among men who struggled with verbally expressing their frustrations, was an identifiable precursor to the so-called explanatory event(s) that made lost time following occupational injury or disease tangible and acceptable. Four decades after the Behan/Hirschfeld proposal, Vinson and his research colleagues (2006) **found that higher levels of anger increase the risk of injury, especially among men.**

Our experiences have led us to believe that ignored or poorly managed anger, frustration, resentment, and/or unrecognized depression in the individual employee, and resultant interpersonal conflict, often sabotage work/business productivity. These human experiences frequently manifest as a *disability proneness* that actually "seeks" an accident or injury to justify and explain inevitable lost time, or what most professionals think of as vocational disability.

It has become evident in our thousands of case histories that disability proneness is a significant dynamic during the antecedents of lost work time. Employee disability proneness not only reduces organizational productivity, but also drives disability costs. More importantly, we have come to believe that disability proneness can be recognized by well-oriented front-line supervisors, co-workers, employee assistance personnel, and occupational health professionals in companies committed to proactive disability management.

In addition, disability proneness can be a target of human capital strategies and workplace interventions, such as employee assistance and managerial mediation programs in a comprehensive, integrated DMP. In pursuit of this conclusion, we begin by looking at corporate/workplace strategies that can prevent and interrupt the dynamics of disability proneness and its consequences of lost time and productivity.

5. Injured Worker Helplessness:

After years of research, Seligman, a psychologist at the University of Pennsylvania, discovered that when an individual believes he or she has no control over life's events, he/she is likely to demonstrate helplessness, to give up, and to experience depression. Learned helplessness may become chronic and refractory (hard/impossible to manage) depending on what Seligman terms is the individual's "attributional style." Attributional style is how one has learned to perceive and explain life events.

Building on the Seligman model, in 1992, we described in detail the debilitating effects of **injured worker helplessness** and the importance of work organizations endeavoring to keep injured employees productive and in control of their work and personal lives, as opposed to separating them through the so-called benefits system, e.g., workers' compensation. We have shown that "benefits" programs designed to aid injured or sick employees actually engender helplessness (or laziness) in them. Productive, meaningful work is more therapeutic and empowering than the receipt of disability benefits while the individual remains idle and lost in the health care system.

As an aside, since formulating his theory of Learned Helplessness, Seligman has realized the more beneficial aspects of focusing on learning optimism. Human capital workplace strategies and proactive DMP administrators would be wise to adopt Seligman's concepts of Positive Psychology (reviewed below) for application in their DMPs.

It becomes very evident that work organizations, workplace relationships, and injury compensation programs can create situations that set the stage for an employee to learn helplessness. Moreover, for particular

individuals who tend to believe that personal control and job outcomes are beyond them (an attributional style), the lost time system becomes fertile ground for "injured worker helplessness." Depending on the workplace dynamics and the individual's attributional style, the employee can learn helplessness that will, in turn, make him or her more vulnerable to permanent disability and unending lost time. Once the lost time process begins, the workers' compensation or other disability systems only add fuel to the process of learning helplessness.

Not incidentally, research has also shown that "non-contingent reward" or benefits programs can produce a phenomenon known as "learned laziness" (Walker, 1992). Together, lost time systems that engender a loss of control and reward money noncontingently are gateways for learned helplessness and laziness.

The lesson here – keep people productive in meaningful jobs in which they perceive control over outcomes! Do not create punitive "light duty" assignments that only add to individuals' perceptions of no control. Resist releasing them into the lost time system that engenders helplessness, and avoid making them recipients of "benefits" when they can indeed remain productive in alternative employment.

6. Anger in the Workplace, Workplace Conflict, and Emotional Contagion:

Anger in the workplace is a problem, and there is evidence that workplace anger is common. Nearly 25% of respondents to a 1996 Gallup survey said they were "generally at least somewhat angry at work." Anger is a strong emotion that is often misdirected. Workplace anger is commonplace enough that we sometimes conceive of the significantly frustrated employee as potentially "going postal." According to the National Institute for Occupational Safety and Health (NIOSH), the Bureau of Justice Statistics reported that an average of 1.7 million people were victims of violent crimes while working or on duty in the United States each year from 1993 through 1999. An estimated 1.3 million (75%) of these incidents were simple assaults, while an additional 19% were aggravated assaults.

While estimating over 111,000 violent incidents annually, NIOSH introduced a 1993 study showing that workplace violence costs $4.2 billion each year. Although anger does not always result in workplace violence, it serves as a form of control over others, or it lingers as a personal preoccupation, causing employees to be tense and at risk for accident and injury. Furthermore, workplace bullying, a form of chronic anger, is a significant problem that has led to proposals for federal legislation to prevent it.

After analyzing data from more than 2,500 injured patients, Vinson found that anger was significantly associated with increased injury risk among men and women combined. Of course, it is difficult for the purpose of research to define anger, but it is evident in retrospective analyses that employee tension build-up and anger are frequently antecedents to, if not causes of, workplace injury.

People do not always get along in the workplace, and workplace conflict is inevitable. And, while it is costly, it is also reducible. According to Dana, a management consultant, over 65% of performance problems result from strained relationships between employees – not from deficits in the individual employee's skills or motivation. Value differences, racial and gender prejudices, personal needs and emotional issues, perspective, role conflicts, and power struggles are but a few of the reasons that interpersonal conflict is common in the workplace and why these issues become a major focus of attention for managers. Most organizations spend little time training people how to communicate, cooperate, and solve interpersonal conflict. Yet, a classic study found in the *Academy of Management Journal* (1966) determined that 25% of the typical manager's time is spent responding to conflict; that figure rises to 30% for first-line supervisors.

Ignoring interpersonal conflict at work has even greater consequences. Some results of unresolved conflict in the workplace are injury and accidents, lost productivity, increased client complaints, absenteeism, sabotage, increased use of sick leave, and "presenteeism." Presenteeism, as opposed to absenteeism, is the phenomenon of lost productivity of employees who have a high intent to turnover but who do not leave the organization. This situation is sometimes referred to as "retired on the job."

A highly effective process for dealing with anger and conflict in the workplace is called "**Managerial Mediation**." Every workplace has some moments of contention between and among employees and/or employees and their supervisors. In the world at large, these moments are addressed with some form of conflict

resolution. In the world of work, the methodology is a separate and unique process called Managerial Mediation; that is, managers are taught the unique and specific methods needed to resolve conflicts in the workforce. Employers who do not avail themselves of opportunities to train their supervisors in Managerial Mediation skills are avoiding opportunities to save money and improve the quality of work life for all employees.

Emotional contagion is another significant factor in terms of workplace dynamics. Awareness of the concept of "emotional contagion" goes back to at least the early 1990s. It has been defined as signifying *the tendency to express and feel emotions similar to, and influenced by, those of others*. In human development, emotional contagion is frequently looked at as a cause of dysfunctional dynamics in families, especially affecting children.

Emotional contagion can, of course, be a critical factor in the workplace. To understand employee behavior in the workplace, employers need to be aware of the phenomenon and take measures to counteract it. While the most prevalent situation is that of the interaction between and among employees, the contagion is also cited as a condition sometimes present in the employee-customer relationship.

Barsade is considered the most knowledgeable researcher on this phenomenon. In Barsade's paper, "The Ripple Effect: Emotional Contagion and Its Influence on Group Behavior," he wrote:

The results of this research confirm that people do not live on emotional islands, but, rather, that group members experience moods at work, these moods ripple out and, in the process, influence not only other group members' emotions but their group dynamics and individual cognitions, attitudes, and behaviors as well. Thus, emotional contagion, through its direct and indirect influence on employees' and work teams' emotions, judgments, and behaviors, can lead to subtle but important ripple effects in groups and organizations. (Barsade, 2002, p. 670)

Barsade concludes, "Emotional contagion has been shown here to play a significant role in **work-group** dynamics. A better understanding of the conditions and concepts of emotional contagion can lead to greater insight into and understanding of employees' workplace behavior."

7. The Effects of Depression and Substance Abuse:

Depression: Another very common human experience, often described as "anger turned inward," that can be linked to workplace dysfunction and disability proneness is depression. According to the National Institute of Mental Health, "in any given 1-year period, 9.5% of the population, or about 20.9 million American adults, suffer from a depressive illness." The economic cost of depression is estimated to be in the tens of billions of dollars. Left untreated, depression is as costly to the U.S. economy as heart disease or AIDS, costing over $43.7 billion in absenteeism from work with over 200 million days lost from work each year. Depression has also been shown to directly contribute to lost productivity, while at the same time, increasing treatment costs. Depression ranks among the top three workplace problems for employee assistance professionals, following only family crises and stress.

The Behan and Hirschfeld formulations of more than 40 years ago (1966) and Weinstein's subsequent construct (1978) hold true today: the build-up stage of the disability process, before an explanatory event (such as a workplace accident), which can be observed as increased depression, increased irritability, increased blaming, and decreased productivity, becomes the seed for "unacceptable disability." Employee depression need not go unrecognized and untreated. Competent and sensitive supervisors, leaders of health and wellness programs, and active employee assistance intervention can interrupt the disability process precipitated by depression.

Substance Abuse: The vast majority of drug users are employed. Unfortunately, when they come to work, they do not leave their substance abuse and related problems at the workplace door. According to a national survey from the Substance Abuse and Mental Health Services Administration, of the 20.2 million illicit drug users aged 18 or older in 2010, 31.3 million (65.9%) were employed either full or part time.

Research from the Occupational Safety and Health Administration indicates that between 10% and 20% of the nation's workers who die on the job test positive for alcohol or other drugs. In fact, industries with the highest rates of drug use are the same as those at a high risk for occupational injury, such as construction, mining, and

manufacturing. The National Institute on Drug Abuse has estimated that employed drug-abusers cost their employers about twice as much in medical and workers' compensation claims as their drug-free coworkers.

The term "self-medicate" can be defined as the process by which some individuals may abuse substances while attempting to relieve other problems such as depression, anxiety, pain, sleeplessness, or other symptoms of illness. Therefore, substance abuse can be a symptom of an underlying problem, and individuals experiencing job stress (from promotion, demotion, failure, reduced seniority or status, or other changes) and/or family tension may be inclined to self-medicate.

Employees self-medicate with prescribed medications, illicit drugs, and/or alcohol. Substance abuse is an international problem, and it most certainly finds its way into the workplace. Historically, Occupational Assistant Programs (OAPs) have focused on substance abuse, and with their development, OAPs have evolved into more comprehensive Employee Assistance Programs (EAPs) with "broader brush" concerns and targets, including family stressors.

At this point, the problem identification process leads to potential solutions. Workplace disability having its origins in the biopsychosocial dynamics of human development and adult behaviors requires new remedies as we accept a broader definition of workplace disability than the traditional biomedical model affords us.

III. What We Think Needs to be Done and How to Do It

Positive Psychology (Seligman and Peterson):

"Positive Psychology" is a recently developed (1998) branch of psychology that shifts the focus from the traditional functions of identifying disease and treating dysfunction to a concerted effort to teach positive approaches to life. Positive Psychology is posited as a complement, not a replacement, of traditional psychology. It is defined in some quarters as a proactive process to make normal life more fulfilling and not simply a process to treat mental illness. The original developers of Positive Psychology are two university professors, Seligman and Peterson.

The primary development tool of Positive Psychology is a set of 24 "character strengths" that Seligman and Peterson said are found (or should be found) in mentally healthy individuals. To measure the presence or absence of these important values, they devised *Character Strengths and Virtues: A Handbook and Classification*. The classification is divided into six virtues, each with subsets of specific strengths:

1. Wisdom and Knowledge: Creativity, Curiosity, Open-Mindedness, Love of Learning, and Perspective
2. Courage: Bravery, Persistence, Integrity, and Vitality
3. Humanity: Love, Kindness, and Social Intelligence
4. Justice: Citizenship, Fairness, and Leadership
5. Temperance: Forgiveness and Mercy, Humility and Modesty, Prudence, and Self-Regulation
6. Transcendence: Appreciation of Beauty and Excellence, Gratitude, Hope, Humor, and Spirituality
7. These composite "strengths" are sometimes referred to as "Values in Action."

Positive Psychology endeavors to elucidate the human factors (including virtues and character strengths) that lead to the "good life." In its work with employers developing and evaluating DMPs, CEC Associates has written that individuals with occupationally significant impairments, mental and/or physical, still have the right to pursue such a life. Company leaders, human resource managers, and DMP directors can significantly enrich their organizations and enhance their human capital strategies by integrating positive psychology concepts into their methods of human resource development and disability management.

Resilience and Seligman's Work for the U.S. Army:

Members of CEC Associates have spoken to the importance of "resilience" as a crucial trait in employee success. The questions are:

- Can mental toughness be taught?

- Can individuals learn how to be more resilient?

The answers to these questions may be found in a study that the U.S. Army has initiated under the leadership of Dr. Seligman, who tested cadets at West Point. The preliminary work at West Point was centered on the self-rated "24 Character Strengths" survey created by Seligman and Peterson. The results of the West Point test showed that those cadets who scored highest on such traits as bravery, optimism, persistence, enthusiasm, fairness, and honesty were more likely to stay in the West Point program than those who scored lower on these strengths. Positive Psychology is seen by the Army as being of great value in helping the healthy majority of soldiers to:

- learn to achieve greater satisfaction
- adapt more effectively to novel and challenging situations
- develop the sense of existential meaning that appears to be linked to soldier adaptation

While CEC Associates is not aware of any comparable study of the value of resilience in the workplace, the study of the U.S. Army is encouraging and suggests that what worked in the rigors of cadet training can also work in the demands of the workplace. (At least one major American employer has developed an application process for new hires that tries to determine whether or not an individual displays the desirable characteristic of resilience.)

Positive Psychology is a rich source of methods and material that will benefit employers who are determined to improve the quality of their workforce while at the same time improving the quality of life of their valued employees.

Work and Flow (Wrzesniewski and Csikszentmihalyi):

Employees who see their employment as "work," simply a job and nothing more, have not benefited from the formulations and conclusions that Wrzesniewski and Csikszentmihalyi have provided us.

Wrzesniewski developed the concept that all employment falls into one of three categories **from the worker's perspective.** That is, they see themselves having a:

- Job: the individual is primarily concerned with the financial reward of work, or a
- Career: the individual is focused on advancing within the occupational structure, or a
- Calling: the individual works not for financial gain or career advancement but for the sense of fulfillment that work brings.

Csikszentmihalyi developed the concept that when a "task" is totally engrossing, the individual is experiencing "flow." Csikszentmihalyi carefully enumerated the personal experiences that are present when flow is achieved and the individual "acts from a deep but effortless involvement that removes everyday concerns."

These studies have value to management because many workers fail to achieve the desired levels that can lead to quality work and creativity. Employees who resist returning to work after an injury may perceive their employment merely as a "job," and these same employees are not likely to ever experience the satisfaction of "flow," or at least not in their work.

Workplace leaders who recognize the disadvantages of just having a job and never achieving flow have resources available to them if they choose to apply them. Wrzesniewski states:

My work addresses the possibility of finding positive meaning in work through a variety of paths: the work itself, its perceived contribution to the greater good, interactions and relationships with others on the job, and the ability to challenge oneself, to name a few.

Csikszentmihalyi asserts:

In too many instances, employees who see their work as only a job have never been given the opportunity to find a suitable/preferable career through career assessment and counseling. By the same token, employers also frequently see a given job as merely a job, and they are not interested in creating a more stimulating and rewarding work environment. If the employer is not invested in improving the quality of worklife for its employees, it simply will not happen.

What Employers Can Do:

We argue here that employers need to manage their human resources with proactive strategies designed to prevent and lessen the effects of occupationally significant injury or illness. At the same time, employers and employer groups have a responsibility to take an interest in **public policy** affecting education and social service delivery systems and, further, to take initiatives to effectively change that public policy for the benefit of the workplace, as well as society at large. In this regard, all educated citizens have a responsibility, and employers have an increased responsibility to help create healthy environments in which the future workforce will inevitably develop.

The challenge is that we, as a democracy, need to improve the quality of our workforce, and leading the charge for that change must be this nation's employers. We need to do everything we can to develop better prepared and more literate adults throughout the nation, and employers are directly accountable creating an organizational culture that promotes growth and learning. This is not socialism; this is good public policy being supported, facilitated, and applied by private sector leadership.

Public policy that recognizes and targets the origins of ACE and other biopsychosocial causes of vocational disability and failed productivity is simply good economic policy. All American employees and employers in this increasingly competitive global economy would benefit from ways of reducing the biological, psychological, and social causes of family disintegration, child abuse, educational underachievement, poor vocational preparedness, and occupational dysfunction in the prospective and current employee populations.

The U.S. Bureau of Labor Statistics reported as of October 7, 2011, that between September 2010 and September 2011:

- the number of employed Americans with a bachelor's degree or higher grew by 448,000
- the number of employed Americans with only a high school diploma decreased by 772,000

The reality for employers is that the competition for skilled, educated employees makes it harder to find and hire workers with the particular skill-sets needed. At the same time, employers need to do what they can to prevent good employees from leaving the company.

It is also important to note that the issue is not just finding and keeping educated and job-ready employees; it is also important for producers (employers) to have a population sufficiently well educated and affluent to buy the product or service the employer is hoping to sell them. This is not to mention having a society/culture that is amenable to the good life in which the employer and all employees want to live.

The priorities of public policies that need to be addressed include:

- equality in public education
- environmental (climatological and social) threats to our future
- political processes that are cooperative rather than antagonistic
- continuing recognition of how important prevention and early intervention programs are in the long-term health of our citizenry and the commitment to fund these programs.

The imperative to change educational futures is not only for the sake of the children, but also for all present and future members of our society. In the meantime, we must continue efforts to prevent the antecedents of occupational disability and to proactively manage it when it occurs.

The Minimum Requirements of Dealing Effectively with Impaired Worker Performance

The long-term effects of ACE on the workforce impose major human and economic costs on employers that are preventable. When asked in the CDC/KP study how many days of work they had missed in the past 30 days because of poor physical health, stress, or feelings of depression, those reporting having missed two or more days were characterized as having a problem with absenteeism. Regardless the reason for not wanting to return to work after an illness or injury, it must be attended to with state-of-the-art DMP methods.

Particular employees in specific circumstances can be prone to develop disabling disease or injury, that is, infirmity that results in lost time or measurable reduction in productivity. Disability proneness exists in every work population. As summarized in Part II of this article, the ACE research, as well as the theories of Behan, Hirschfeld, Weinstein, etc., all expound upon the biopsychosocial factors that engender disability proneness in the workplace. We advocate that in the context of good public health care policy, human capital strategies in quality DMPs can reduce the effects of disability proneness by being comprehensive, well integrated, and proactive.

Based on anecdotes in the literature and our own observations at CEC Associates in more than 5,000 injury cases, we introduced the concept of "disability proneness" in 1990 and spoke to potential organizational remedies in 2007. Here, we propose corporate methods and strategies on how disability proneness might be proactively managed by the work organization that wishes to reduce absenteeism, curb disability costs, maintain morale, and increase general productivity.

What corporate strategies can prevent and interrupt the biopsychosocial dynamics of disability proneness and the disability process? There are a number of human capital strategies to deal with disability proneness that have been deemed essential to exemplary and truly integrated DMPs. To be "truly integrated," these strategies must not become corporate silos operating independently in a bureaucratic fashion. Most of these programs can be effectively operated by a disability management team, led perhaps by a human resource professional, and integrated not only with each other, but into the very fabric of the workplace.

1. Communication Skills Training. It is necessary for all supervisory and front-line management personnel to learn effective communication skills. Whether a supervisor is attempting to teach a concept or intervening in a dispute, how well that supervisor interpersonally communicates is key to continuing productivity and morale. The most vital element in effective management and supervision – communication – must be learned. Unfortunately, most of us are "taught" communication styles from our first supervisors – our parents – and more often than not, these are ineffective in the workplace.

In *The Assertive Manager,* Zuker (1989) writes, "Communication is the cornerstone of business. Managers use many different channels to communicate with others, and [they] spend between 50% and 90% of their day in communication of one-kind or another. Communication is a set of skills you learn."

Most communication between front-line supervisors and subordinates is verbal. Listening and sending messages are more complex than we realize. Listening is an art that takes some of us many years to learn. When another's behavior is unacceptable to us, the messages that we send them to change their behavior can be destructive rather than constructive to the relationship. Of course, no one wants to be told that their behavior is unacceptable. Learning to listen is tough and learning to confront appropriately is probably even more difficult. Instead of acquiring and consciously *learning* listening and confrontation skills, most of us who engage in interpersonal communication at work follow our idiosyncratic styles of relating to others, and whether we want to admit it or not, we probably communicate like our parents communicated with us.

2. Employee Assistance/Safety and Wellness Programs. The EAP is a basic process designed to assist management in identifying and resolving an individual worker's problem that interferes with work. EAPs are most effective when they can identify and address problems before they manifest themselves. Effective EAPs provide "24/7" access (including telephone access). The functions of an effective EAP in chronological order are supervisory training, assessment, consultation, referral, and crises management. The stages of how these functions develop are: awareness of the problem, predicting consequences, identifying causes, and applying corrective resources. The more effective EAPs are "broad brush" and recognize that personal problems that interfere with work behaviors are highly variable and not limited to substance abuse alone.

Since prevention and early intervention are the objectives, EAPs must be constructed with the philosophy that supervisors are on the front line. Supervisors must receive specialized training in how to recognize potential problems and when, where, and how to refer the worker to the EAP component for services. Training supervisors in smaller companies is as important as training them in larger companies: the difference is in the referral source. Referral sources for small companies are frequently community-based resources. Safety/Wellness and EAP coordinators are responsible for designing the supervisor training, initiating it, and conducting follow-up training in regularly scheduled intervals.

In fact, because many of the causative factors in EAP cases are family-related (including domestic violence), model EAP services are available to family members as well. That is, the family may be a cause of the problem and will have to be treated along with the employee. In all cases, the familial unit will be affected by the employee's dysfunction and will have to be brought into the referral/treatment process to optimize outcomes.

The objectives for Safety/Wellness programs and EAPs for employers include:

- Fostering improved health outcomes for employees and their families
- Promoting an optimum quality of life for the employee and his or her family
- Increasing workplace productivity

The specific services of the EAP include:

- Professional assessment of issues related to mental health, substance abuse, the workplace environment, and other challenges to major life activities of the employee or family members
- Immediate, personal counseling (for employees and family members)
- Referral to either treatment or support services
- Implementation of pre- and post-stress management assistance
- Application of return-to-work strategies including vocational assessment with Transition-to-Work (TTW) methods

For mid- to large-sized companies, the essential correctives to injury proneness are aggressive and continuing safety and wellness programs. (For smaller companies, understanding the basics of what these formal programs include is the minimum, essential ingredient.) Ergonomics, smoking cessation, relaxation/meditation methods, stress management techniques, nutrition classes, and other such prevention strategies are made a regular part of the operational process. In Pennsylvania, for example, employers receive a 5% discount on their workers' compensation premiums if they implement safety programs. If work organizations maintained the philosophy that all accidents could be prevented, and successfully acted on that philosophy, significantly fewer employees would be injured.

The overriding interest for employers in operating Safety/Wellness programs and EAPs is to put prevention and early intervention policies in place. While the value of the services that flow from such policies may, on first blush, appear to benefit the employee most, the greater value accrues to the employer.

3. Managerial Mediation Training. Since anger plays such a significant role in workplace injuries, the single most productive preventative is managerial mediation. As discussed earlier, strife in the workplace is between co-workers or between an employee and his/her supervisor. This condition is a commonplace event; Managerial Mediation Training will assist supervisors in dealing with it.

The specialized methods and materials for mediation in the workplace are those that were developed in conflicts outside of this environment. There are now mediation (conflict resolution) services available through most court systems; they are available for counselors specializing in marital/divorce conflicts; and mediation methods are even used in nation-to-nation conflicts: President Carter (Nobel Peace Prize recipient in 2002) brought in mediation specialists when he worked on the Middle East conflict.

Workplace supervisors are trained in the specialized methods of mediation and are required to apply the methods to those conflict situations that, if left unaddressed, would likely escalate. The process is designed to bring "mutual acceptance" to the disputants in the conflict. Given that over 65% of work performance problems

result from strained relations between employees, unmanaged employee conflict is arguably the largest reducible cost in organizations today.

Federal legislation, notably the Family Medical Leave Act and the ADAAA, requires disputants, under the direction of the Equal Employment Opportunity Commission and the Department of Justice, to engage in mediation before they will sanction litigation.

4. The Sanctuary Model. Thus far, there appears to be no model that specifically suggests a methodology to cope with ACE scores in the workplace. However, one research article that does address "trauma" in the workplace, which presumably could cover the trauma experienced by individuals with an ACE score, is the work of Bloom, a Drexel University professor and board certified psychiatrist.

Bloom has done extensive work on "the impact of trauma on individuals, families, organizations, and cultures." She is on the staff of Drexel's Center for Nonviolence and Social Justice, a component of Drexel's School of Public Health. The Center focuses on trauma as a public health issue and provides a "program of healing." The basis for this work is developed in Bloom's research, *Sanctuary: a Trauma Informed Method*. The work postulates a process for creating an organizational culture by which healing from psychological and social traumatic experiences can be addressed.

In an article written for the New York Business Group on Health in 2001, titled "Creating Sanctuary in the Workplace" (www.publichealth.drexel.edu), Dr. Bloom lays out the process. Sections of the program include the following:

- The signs of traumatic stress.
- What does trauma do to a person?
- The most critical psychologically destructive aspect of trauma.
- Who will have the most difficulty feeling normal again?
- Why is it so important to pay attention to all this and not just expect that people should "pull themselves together"?
- What protects against long-term impact? (Resilience factors)
- What are "acute stress disorder" and "posttraumatic stress disorder?"
- With so many traumatized people in the workplace, how will our businesses continue to function?
- Does everyone need therapy?
- How can we promote a workplace environment that promotes recovery and healing?
- What is a "trauma-sensitive workplace culture?"

The significance of Bloom's work, as sketchily outlined here, is that it provides a basis for developing methods and materials for effective Disability Prevention and Management in the workplace. If an ACE score may be considered to be a subset of Bloom's "trauma," that is, if the ideas she sets forth for trauma also apply to individuals with ACE scores, then those ideas could provide a structure on which DMPs can be modeled.

Although Bloom's research and writing do specify, at times, a workplace context, her interest is larger than just the workplace. We, at CEC, however, are focused on what employers can do to mitigate dysfunction and disability in the workplace.

5. Transition-to-Work Programs. The primary premise of workplace disability management is that all injured or ill workers must be encouraged to return to appropriate employment as soon as possible. When the job demands substantially exceed the employee's capacity, modified duty, as guided by an in-place TTW program, is essential. We strongly discourage the use of so-called light duty programs that are generally meaningless and, therefore, sometimes punitive. Vocational assessment as an integral aspect of transition to work and selective internal job placement should be used to replace the traditional outsourcing programs often sponsored by workers' compensation insurance carriers.

Private Sector Responsibility in Affecting Social and Public Policy

After outlining the various dynamics of occupational dysfunction and vocational disability and current workplace strategies to prevent injury, illness and lost time, we call for a collaborative effort among scientists, educators, and private sector leaders to influence politicians and public policy makers to reduce the causes of Adverse Childhood Experiences and other biopsychosocial factors that lead to occupational disability. With evidence that one out of 50 children is homeless and that 35.8% of all childhood fatalities are linked directly to neglect, we need to come to terms with the fact that our society is failing to protect its human resources and future workforce.

We recognize that there is a substantial portion of the population that believes in the importance of keeping government, particularly the federal government, out of citizens' lives. Indeed, it may be posited that one of the byproducts of a truly democratic society is the personal choice adults have to create the circumstances for adverse childhood experiences. After all, a free and democratic society allows for a range of personal choices and behaviors, including those that may be irresponsible and aberrant enough to damage youth. But in a truly Democratic society, children should have sufficient protection and ample opportunity to become healthy adults capable of enjoying "life, liberty and the pursuit of happiness." Good public policy recognizes the importance of protecting and educating children just as it has embraced the value of worker health and safety.

Helping to create environments in which families develop healthy children, schools enrich students, and employers maintain skilled employees will require much more dedication, creativity, commitment, and capital expenditure than it takes to change a dietary pyramid into a food plate.

But from our vantage point, the work needs to be done.

Only when we fully recognize that our country's well-being depends on healthy human capital will we approach the guarantees of a free and democratic society, one that can once again prosper in a global economy. Therefore, employer groups, such as manufacturing associations and chambers of commerce, along with educators and health care professionals, would be wise to collaborate and influence public policy makers to ameliorate the effects of poverty, poor education, chemical dependency, unintended parenthood, and child abuse in order to prevent the antecedents to these socially and occupationally destructive biopsychosocial dynamics.

It should be made perfectly clear that the notion that ACE and other factors cause disability proneness should not be misused by employers as a rationale for conducting employee "witch hunts." Employers do not need another reason to discriminate. Suffice it to say that many individuals with ACE and other risk factors for disability are not necessarily susceptible to work dysfunction, poor productivity, and lost time. Resilience can be learned if not inherited. Other employees who have not had psychosocial developmental misfortunes can fail in the workplace for a variety of reasons. What we need is a society that prevents ACE whenever possible. For employers to view a worker's history of personal adversity and developmental turbulence as a reason to discriminate against him or her constitutes a terrible injustice that is completely contrary to the practice of good human resource management and antithetical to disability management.

Summary

The purposes of this paper are to describe the various human situations and workplace dynamics that can lead to occupational dysfunctions and disability proneness, to address the basic elements and methods of an integrated and effective DMP, and to call for a more united effort among social/healthcare professionals and employers to influence and shape public policy. We begin by asserting that the biological, psychological, and social dynamics in people's lives are predictive of health or dysfunction, and that consideration of the biomedical factors alone is insufficient when attempting to reduce the incidence of vocational disability and lost time secondary to injury and/or illness. We recognize the contribution of the ACE research in this regard.

We emphasize the importance of *creating* effective disability management, not so much through benefit integration, but through collaboration of effective human resource strategies and empowerment programs. In this paper, we examine the genesis of work dysfunction and posit strategies to prevent causes of disability proneness and ameliorate, if not eliminate, the vocational "disability process," one that begins prior to lost time, injury, or illness, and evidently, in some cases, with Adverse Childhood Experiences. It is hoped that an understanding of disability proneness and a greater appreciation of how truly integrated disability management

can prevent and interrupt the process of becoming disabled will assist human resource professionals in designing, implementing, evaluating, and ultimately upgrading DMPs.

We propose that work organizations, preferably under the supervision of a human resources administrator, organize and integrate the various personnel programs that can collectively combat the antecedents and potential causes of disability proneness. By assisting employees at risk with the right services in a timely fashion, disability can be prevented. Integration of disability management is as much an effective combination of employee help programs as it is an integration of benefits programs and insurance plans. With an emphasis on prevention of the antecedents to workplace disability rather than benefit payment for lost time, integrated DMPs can reduce costs by having a significant effect on keeping members of a work organization healthy and productive.

Finally, it is imperative that educators, social scientists, employers, and politicians unite and collaborate to reduce the antecedents and consequences of ACE and other destructive developmental dynamics in our citizenry that biologically, psychologically, and socially result in occupational dysfunction and work disability.

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Useful web sites:

National Institute for Occupational Safety and Health. www.cdc.gov/injury.
National Institute of Mental Health. http://www.nimh.nih.gov/health/publications/depression-listing.shtml
"Fact sheet: alcohol and other drugs in the workplace." National Council on Alcoholism and Drug Dependence. http://www.ncadd.org/facts/workplac.html
National Health Information Center. www.health.gov/nhic.
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