Organizational Programming:
The Challenge to Consumer Research

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Abstract

Business organizations are assuming practices formerly restricted to medical institutions in the management of intractable problems. This article explores organizational programming in terms of formal control and indigenous regulation of such problems in the workplace. Consumer behavior in relation to organizational programming is discussed, and suggestions for improving service delivery are made.

Introduction

Within the last decade we have witnessed an acceleration of what Illich (1976) has referred to as the medicalization of life, and what has been termed more specifically the medicalization of deviance (Szaz 1975; Conrad and Schneider 1980). Such intractable problems as drug abuse and alcoholism have, as a result of the confluence of a number of sociopolitical forces, been assigned to the domain of medicine (Room 1978). The treatment of a complex psychosocial issue such as alcoholism as a disease, as conceptualized by Western biomedical science, has some interesting implications for consumer researchers interested in organizational behavior.

Consumers make numerous adjustments to the social environment of the workplace. Drinking is one behavior pattern commonly pursued. However, this pattern often becomes a coping strategy, and occasionally results in maladaptive consequences. Drinking patterns may disrupt the social order of the workplace. The threat of disruption is regularly countered, and the relationship of the consumer to the work organization is realigned in several ways.

In an effort to preserve the social order of the workplace, business corporations have assumed some of the practices formerly restricted to medical institutions in the management of such intractable problems as alcoholism.[1] These practices may include diagnosis, referral and treatment. Frequently, these practices are part of a formally instituted and corporately administered comprehensive package known generically as an employee assistance program. It is the nature and positioning of such a service program that is of interest to consumer researchers.

The field of organizational programming provides the consumer researcher with an opportunity to study the multileveled interplay of decision making, attitude, and delivery system attributes in the management of a medico-behavioral problem. The results of such a study promise to facilitate strategic planning for diagnosis, referral and treatment of consumers defined as "troubled employees", and reduce the impairment of corporate consumers employing "troubled" workers. Consequently, this article addresses the perspective of both individual and corporate consumer involved in organizational programming.

Based on intensive field research conducted in several corporations with formally instituted employee assistance programs, some observations on issues of focal interest to consumer behavior are offered in this article.[2] The relationship of formal programming to informal, indigenous mechanisms of control is explored. Barriers to program adoption, as well as factors influencing the decisions of consumers to accept or circumvent the services of formal programming are considered. After presenting suggestions for improving service delivery, additional avenues of investigation for consumer researchers interested in organizational programming are proposed.

THE DUAL PERCEPTION OF PROGRAMMING

The implementation of programming within a particular corporation can be instructively examined as a process of intramural marketing involving a hierarchy of consumers. The initial consumers are the corporate officials who decide that formal programming is indicated. Intermediate consumers are generally drawn from the ranks of Medical, Personnel and Industrial Relations departments, depending upon which governing image of the "troubled employee" is corporately sanctioned.[3] Penultimate consumers are the line supervisors, who must execute program directives "in the trenches." The ultimate consumer, of course, is the individual employee. Depending upon the consumer's perspective, which is conditioned both by status in the consumption hierarchy and by the history of labor relations within the corporation, organizational programming may be viewed as a therapeutic enterprise or as a vehicle of social control.

This dual perception of organizational programming arises in several ways. First, the conflict between human welfare and human capital orientations to workplace behavior impedes efforts at directed intervention.[4] Dysfunctional reactions are assumed to be epiphenomenal to systems of production; often, impaired workers who cannot be exploited are terminated.[5] Secondly, depending upon his orientation, a supervisor may apply program policy selectively. Whether this inconsistent implementation

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[1] This regulation is not limited to pathological syndromes. Increasingly, corporations are implementing "wellness" programming, which is ostensibly benign and preventative in nature. Such programming also has a latent social control function. See Floyd (1982) in this regard.

[2] Field research was conducted over an eighteen month period. Participant observation, interviews and survey research were employed.

[3] Schramm, Mandell and Archer (1979) identify several categories of organizational flow in their study of programming.

[4] See Schramm (1980) for an elaboration of this view.

[5] See Trice, Hunt and Beyer (1977), Beyer, Trice and Hunt (1980), Schramm, et al. (1978) and Sherry (1982) in this regard.

is benign or despotic, it produces mistrust. Finally, the presence of a union or of an adversarial relationship between labor and management can create conflicting perceptions of organizational programming.

BARRIERS TO IMPLEMENTATION[6]

At each of the levels of the consumption hierarchy, resistance to implementing a program may be encountered. This resistance persists largely as a result of ineffective (or nonexistent) marketing of the program to the various stata of consumers. A brief outlining of some of the barriers to implementation may suggest appropriate corrective measures.

At the corporate level, the resistance to formal programming is ideological and financial. Disorders leading to impaired job performance are frequently stigmatizing. Consequently, it is often feared that formal diagnosis would result in a stigmatized corporate identity, both through association and implicit culpability. Where stigma is not at issue, the calculation of cost and benefits related to program implementation certainly is. Some corporate officials do not regard programming as a sound investment.

At the intermediate level of consumption, corporate departmental resistance may be attributed to the sociopolitical dynamics of hegemony, and to differentially perceived spheres of influence. Decentralization of authority may also produce resistance. Formal programming is frequently viewed at this level as an encroachment on someone elses' "turf."[7]

At the level of the line supervisor,[8] a myriad of difficulties may be encountered. Selective application of program policy is perhaps the most serious impediment to implementation. Depending upon his orientation, a supervisor may act out of ignorance of formal policy protocol, out of compassion for a subordinate (which may inadvertently exacerbate the problem), or out of deliberate calculation to exploit or terminate an impaired subordinate.[9] Frequently, the supervisor views organizational programming as a usurpation of some of his most cherished skills.

The barriers encountered at the level of the ultimate consumer, the individual worker, are both ideological and pragmatic. In our society, the roles of "jobholder" and "alcoholic" are often perceived as mutually exclusive. Dysfunction can be effectively denied as long as one is employed. Perhaps greater than the threat of stigmatization is that of economic sanction. Acceptance of organizational programming entails termination if therapy fails to improve job performance. Once diagnosed as impaired, the worker exposes himself to manipulation by superiors at any time his behavior is construed as suspect.

INFRASTRUCTURAL REGULATION OF PROBLEM DRINKING: CIRCUMVENTION OF ORGANIZATIONAL PROGRAMMING

The number of alcoholic workers identified in the workplace and pursuing some form of therapy is often greater than that indicated by figures generated by formal programming efforts. Roman (personal communication) has postulated the existence of "indigenous forces" of alcoholism prevention, noting that most drinking is functional in its consequences. This concept can be extended to treatment. Problem drinking is frequently regulated without formal or "official" intervention.

In response to such factors as perceived inadequacies in formal programming, imputations of ulterior motives to selective implementation, and fear of socioeconomic stigmatization, it is not uncommon for infrastructural regulatory mechanisms to control problem drinking in the workplace. Alcoholic employees typically circumvent formal programming in several ways. Impaired job performance may be corrected without directly addressing the issue of problem drinking. An employee may institute a regimen of abstinence or controlled drinking on his own initiative, with no assistance from any quarter. Finally, self-referral, either to a local treatment agency, or to a shop or community AA network, is a viable alternative. Both managers and union committeemen regularly serve a brokerage function by assisting a troubled employee in affiliating with such an informal self-help network.[10]

CONTAINMENT SYSTEM FUNCTIONS

In many corporations, it is most accurate to describe the management of the consequences of alcoholic drinking in terms of a comprehensive containment system, of which formal programming and informal processing are distinct conduits. The formal and informal mechanisms complement each other, and cannot be understood independently of each other.

Formal programming fulfills a number of functions. It serves a humanitarian purpose. It serves as a legal safeguard and as a visible symbol of corporate commitment to occupational health and safety. It serves both to prevent and recoup loss to production. It helps minimize insurance payments attendant on complications of and sequelae to alcoholism. It also minimizes the cost of formal grievance procedures. It is a good public relations vehicle on a community- and industry-wide scale. Formal organizational programming permits a manager to delegate responsibility falling beyond his technical range of expertise, which results in enhanced productivity. It even permits the enterprising and manipulative worker to exploit the system and to receive an *ad hoc* vacation. Finally, it serves as an important vehicle of social control, by reinforcing the notion of just cause in the termination of a problem employee. By legitimizing a label perceived to be stigmatizing, formal programming can double as a coercive ideology, compelling conformity with organizational goals.

While informal regulation of problem drinking exhibits similar functions, several others are apparent. The informal mechanism saves the corporation much money in terms of direct service provision, both for intramural processing and extramural treatment. It subjects the legitimate alcoholic employee to affective leverage technically beyond the scope of impaired job

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[6] See Sherry (1982) and Roman (1982) for additional impediments to implementation.

[7] See Roman (1981) for additional insight into these dynamics.

[8] See Googins and Kurtz (1979), and Kurtz, Googins and Williams. (1980a, 1980b) for additional insight.

[9] See Sherry (1983) for a detailed account.

[10] Collusion between labor and management to divert an employee from the formal program and into an informal network does occur. Often this creates an obligation for the employee to reciprocate, and opens him up to the possibility of being exploited.

performance criteria to which managers are ostensibly restricted.[11]

Informal regulation protects job security and minimizes the threat to occupational mobility. It also militates against stigmatization. It protects the local union from potential law suits by disgruntled, terminated rank and file members. In shielding a problem drinking worker from formal recognition, the fear of losing a relatively reliable employee to the disciplinary procedure in the event of relapse is minimized. Unfortunately, the potential for exploiting such an employee is also preserved. Finally, an employee may be diagnosed and referred informally as a direct result of ignorance on the part of significant actors of the existence of a formal program. Unlike many formal programs, the informal mechanism is often most effective in facilitating the job reintegration and social rearticulation of the troubled employee.

SUGGESTIONS FOR IMPROVING SERVICE DELIVERY

While a thorough epidemiologic approach to managing problem drinking would have to address the pathogenic factors of the workplace and their social context, such treatment is clearly beyond the scope of this article.[12] However, it is reasonable to propose several suggestions for improving the delivery of specific services to troubled employees within a corporation. Of primary importance is the integration of formal programming and indigenous regulation to identify and refer a greater number of consumers at risk. Rather than operating independently of or at cross purposes with the other, each mode of regulation needs to share resources. Some specific steps might facilitate this merger.

First, an expansion from narrowly focused, problem-specific programming to a "broad brush" assistance program is indicated. Such a shift would provide for comprehensive service delivery, facilitate destigmatization, and pave the way for a more holistic "wellness" programming in successive periods of growth. Expanding program scope demands an increase in program budget and staff. This increase could be shouldered cooperatively, with labor and management jointly underwriting salaries for human service workers. The provision of manpower by unions and a corporate redefinition of "lost time" to "counseling time" reimbursible by the company would facilitate cooperation. Intramural personnel in continuous contact with employees, who have access to informal intramural networks, could be trained as paraprofessional adjunct service providers. This would increase system redundancy and facilitate popular bonding to the program. Efforts to expand coverage by third party carriers need to be escalated.

Secondly, the disaffiliation of program personnel from perceptions of vested interest is essential. The creation of an autonomous unit with accountability solely to the insurance office would be conducive to role distance. Decentralized office space is indicated, with the provision of "satellite offices" in various corporate facilities and regularly scheduled office hours by program staff being very desirable. Designation of a conference room as a counseling site, drop-in center or self-help group meeting room would further increase shop floor visibility of the program.

Thirdly, a consensus on the nature of organizational programming to be implemented must be achieved. Will managers and workers participate jointly in the same program, or will a two-track referral pattern be observed? "Joint" programming might be more properly conceived as "cooperative" in those areas where the interests of labor and management coincide.[13] At this juncture, intramural marketing becomes a key factor. A unified orientation must be forged. Regular joint training of supervisory and nonmanagement personnel in criteria for referral to the assistance program is indicated. Regular education seminars concerning emotional problems, stress management, referral procedures and program dynamics could be incorporated into the work schedule. Investigation, evaluation and improvement of community treatment resources may be jointly undertaken, and mediated by employee assistance program personnel.

Finally, cooperation with, if not co-optation of, existing diagnostic and referral networks within a corporation would be a priority objective of an employee assistance program. Facilitation of job reintegration through structured aftercare regimens, provision of intramural self-help group meetings, reassignment to new duties or redesign of the job itself is essential. The need for follow-up in terms of therapeutic support is universally recognized. Prevention and early intervention (to say nothing of cost-benefit justification for program funding) would be well served by the conscientious collection of quantitative data covering demographics of program participation and impact on job performance evaluation criteria.

DIRECTIONS FOR FUTURE RESEARCH

The evaluation of organizational programming is in its infancy, and published studies report equivocal findings. Many program directors are reluctant to undertake program evaluation (Williams and Tramontana 1977). Variable definitions of "success" further complicate the issue. A paucity of quantitative data on demographics of program usage and impaired performance exists. Few case studies of organizational programming beyond intramural statistical profiles have been produced.[14] Improved data collection must be given high priority, if program impact is to be adequately assessed. Edwards (1975) has suggested that we measure what is happening, how much is happening, and how much is happening compared to doing something else.

The validity of survey and questionnaire-based studies continues to be problematic, not only in the area of frequency/prevalence estimation, but more fundamentally in the presentation of an accurate description of the system in question (Trice and Roman

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[11] Formal employee assistance programs generally require that clinical diagnosis of symptoms be reserved for health care professionals.

[12] Since the interplay of alienation and flow in a consumer's life is experienced intensely at work, the reinvestment of his life with meaning could well be reinforced at work. A sociotechnical systems approach to job design (Trist 1973) coupled with a methodical regimen of social systems therapy (Pattison 1977) could be implemented by corporate officials and mental health care professionals to this very end.

[13] "Joint programming" denotes equal participation in the planning, implementation, maintenance and actual usage of a program by labor and management. A two-track system creates role distance between labor and management, with essentially separate programming taking place.

[14] See Sherry (1983) for a detailed account of the state of organizational programming research.

1978). A need exists for unstructured, open-ended research instruments to understand differential accommodation (Schramm, Mandell and Archer 1978) of troubled employees to the realities of the workplace. Survey data must be complemented with ethnographic data in the interest of interpretative accuracy.

Consumer researchers are particularly suited to this enterprise. Facility with both quantitative and qualitative methodologies is essential in collecting as much of this sensitive data as possible. Further, the status of many consumer researchers as faculty members of colleges of Business Administration affords them access to kinds of corporate cooperation typically unavailable to other scholars. Finally, this status lends credibility to the consumer researcher as a change agent. Insights gained from research can be used to improve organizational programming efficacy.

CONCLUSION

Effective organizational programming benefits the entire community. The rewards for labor and management are apparent. Apparent also are the gains for the individual consumer and his family. Social service organizations are similarly served. Rearticulation of a productive, recovering person with the web of social institutions potentially enhances the overall quality of life in the community. Through the efforts of consumer researchers, a variety of local resources can be mobilized to improve organizational programming.

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