Spring 2011

A Conceptual Model for Employer Training to Manage Employee Counter-Productive Behaviors

Naomi Spickard Rock
Old Dominion University

A CONCEPTUAL MODEL FOR EMPLOYER TRAINING TO MANAGE EMPLOYEE COUNTER-PRODUCTIVE BEHAVIORS

Naomi Spickard Rock

B.S. May 1977, Radford University
M.A. May 1999, Lynchburg College

A Dissertation Submitted to the Faculty of
Old Dominion University in Partial Fulfillment of the
Requirements of the Degree of

DOCTOR OF PHILOSOPHY

OCCUPATIONAL AND TECHNICAL STUDIES

OLD DOMINION UNIVERSITY

May 2011

Approved by:

Dr. John Ritz (Director)

Dr. George Haber (Member)

Dr. Suzan Thompson (Member)

ABSTRACT

A CONCEPTUAL MODEL FOR EMPLOYER TRAINING TO MANAGE EMPLOYEE COUNTER-PRODUCTIVE BEHAVIORS

Naomi Spickard Rock
Old Dominion University, 2011
Director: Dr. John M. Ritz

The purpose of this study was to develop a model for employer training to manage employees who possess counter-productive behaviors. With the increasing encouragement for employers to hire without discriminating, the number of individuals with disabilities in the workforce will rise. There is limited training in universities and businesses to teach how to deal with difficult individuals.

Qualitative research in the form of focus groups was conducted. The following research objectives were developed: 1) Identify components of counter-productive behaviors that need to be managed in the workplace. 2) Develop behavioral management strategies that need be learned by employers. 3) Integrate the findings of counter-productive behaviors with behavior management strategies into a model that can be used to instruct employers in the management of counter-productive behaviors of employees.

From the research, a conceptual model was developed using the andragogical model of Knowles, Holton and Swanson (1998). In planning the framework for the training, the instructional design of Morrison, Ross and Kemp (2007) was used. Two levels of training for a company were developed for: 1) top management and 2) middle management and front line supervisors.

Objectives for top management were to obtain: 1) knowledge of profitability of training, 2) knowledge about laws mandating hiring, 3) knowledge about laws mandating

accommodation and 4) approval for the training of middle management and front line supervisors.

Objectives for middle management and front line supervisor training were: 1) identify counter-productive behaviors, 2) obtain knowledge of possible causes of counter-productive behaviors, 3) obtain knowledge of possible accommodations and modifications and 4) evaluate understanding and willingness to implement strategies in the workplace.

Five employee counter-productive behaviors of absenteeism, difficulty concentrating, inappropriate social skills, impulsivity and negativity were reported. Additional counter-productive behaviors of anger outbursts, anxiety, communication, irritability, over activity, shifts in mood, excessive talking and lack of awareness of non-verbal social cues were suggested.

The most frequent accommodations were flexible breaks and scheduling. Other strategies reported were creating task lists, modifying workspace, relocating worker to a different workspace, use of ear phones to block out noise and use of a mentor. It was also determined that employees do not request accommodations or modifications for fear of retribution on the job. This model provides a guide for detailed training to meet the objectives of top management, middle management and front line supervisors of a company.

DEDICATION

This dissertation is dedicated to my loving husband, Michael, my daughter, Jennifer and my son, Darren. Without their support and encouragement, I would have never completed this undertaking. Michael, thank you for thirty-three plus years of understanding my desire to attend school and the support of reaching my ultimate goal. I love you for the many things you did and your willingness to do your own projects while I completed mine. Jennifer, thanks for the friendly competition to see which one of us could obtain the title of "doctor" first. Even though I won, I encourage you to keep your eye on your goal; you still have many years ahead of you. Darren, thank you for your willingness to fend for yourself while I was completing work. Also, for your honesty in telling me when I needed to take a break and focus on the family. Through your actions, I know you have inherited my love of learning. Set your goals high and reach them.

I also dedicate this to the many students with disabilities that I have worked with through the years. I hope that in some way this conceptual model will be successful in helping you obtain and maintain employment and reach your goals in life.

Naomi Spickard Rock

ACKNOWLEDGEMENTS

The act of obtaining knowledge and producing ideas does not happen for an individual without assistance and encouragement. I would like to offer a heartfelt thank you to my dissertation chair, Dr. John Ritz. His wisdom and guidance was imperative in completing the dissertation and obtaining a doctoral degree. At the end of the admissions interview for the Occupational and Technical Studies program, Dr. Ritz stated that the college would not let me quit; he kept that promise.

I also thank Dr. George Haber and Dr. Suzan Thompson for their willingness to serve on the dissertation committee and for their guidance and direction. Their understanding and appreciation of my topic and desire to assist individuals with disabilities was encouragement for me to push forward.

To my family, co-workers and friends, I give a huge thank you for the support and encouragement. Your varied responses of offering words of encouragement to lovingly telling me I was crazy helped me reach a long-time goal. Thanks to all of you! The goal could not have been reached without you!

TABLE OF CONTENTS

Page

APPENDIXES

LIST OF TABLES

Table Page

LIST OF FIGURES

CHAPTER I
INTRODUCTION

The workplace is a conglomerate of different personalities, abilities and beliefs among employers and employees. Society has unspoken rules of behavior for all individuals in the world. Well-known etiquette guide, Post said, "Many courtesies are as old as time" (1992, p. 75). She detailed topics such as having conversations, thoughtfulness, borrowing items, along with personal hygiene as appropriate behaviors at the workplace and many others. Post also said that general courtesies and rules for appropriate behavior are expected in the workplace. Businesses with a large number of employees in the United States generally have written conduct codes and policies for employees. What some individuals do not recognize is unspoken rules are as important as written ones. Post warned, "A positive attitude will get you much further than complaints and rebelliousness" (1992, p. 222).

Personality of individuals contributes to their conduct in the workplace and to their productiveness within the confines of written and unspoken rules of conduct. Grandey, Tam and Brauburger (2002) stated people have two distinct personality traits that reflect their outlook on life. One is *positive affectivity* that allows an individual to have a positive view of life and cope well with difficulties. The other is *negative affectivity.* This personality trait causes an individual to view life in a more negative fashion and not possess effective coping skills. Negative affectivity causes an individual to be more emotionally vulnerable and have difficulty following the unspoken rules. One's personality also contributes to analyzing, predicting and determining the roles and actions of others in the work place (Furnham, 1992; Luchman & Haynes, 2009; Bowling

& Eschleman, 2010). Individuals with a negative affectivity will most likely react to co-workers and supervisors in a more negative fashion.

In addition to personality traits, diagnosed medical conditions may affect job performance. Some of these conditions are attention deficit hyperactivity disorder (Carroll & Ponterotto, 1998; Barkley, 2002; Nadeau, 2005; Patton, 2009) autism spectrum disorder (Hurlbutt & Chalmers, 2002; Bernery, 2004; Grandin, 2006; Barnhill, 2007), post-traumatic stress disorder (American Heroes at Work, n.d.; Haisch & Meyers, 2004; Smith, Schnun, & Rosenheck, 2005; Resnick & Rosenheck, 2008), mood disorders which include major depressive disorder, dysthymic disorder (chronic mild depression) and bipolar disorder (Bowden, 2005; SHRM, 2005; Kidd, Boyd, Bieling, Pike, & Kazarian-Keith, 2008; Lauber & Bowen, 2010). The number and types of definitions of disabilities are so great it is difficult to relate the findings for all in research (Hagglund & Heinemann, 2002).

The United States has instituted many laws that govern the employment of individuals with medically documented disabilities. These laws have a major impact on both the employer and the employee. Hagglund and Heinemann (2002) summarized major public policies they believe have the strongest implications to society. The authors identified and explained the Americans with Disabilities Act (ADA) of 1990 (United States Department of Labor, 1992), Individuals with Disabilities Education Act (IDEA) (1997), and the Rehabilitation Act of 1973 (United States Department of Labor, 1973), as well as others. Hagglund and Heinemann also identified areas in need of further research. One of these areas was the need to determine the "individual, agency, and service

variable that affect performance, as well as potential interactions between these variables" (2002, p. 167).

In order for employees to be productive, it is important employers understand how personality differences and emotional and mental disabilities can affect job performance of individuals. It is also important for the employer to understand how one individual's counter-productive behaviors can affect other employees. It is imperative employers have experience or a training tool to address employees' counter-productive behaviors created by personality traits and medical conditions (Furnham, 1992; Krupa, 2007). Hagglund and Heinemann (2002) indicated most employers prefer employees disclose their disabilities; however, these same employers have little to no knowledge of how to offer accommodations or assistance to the employee.

Statement of Problem

The purpose of this study was to develop a model for employer training to manage employees who possess counter-productive behaviors.

Research Objectives

To guide this study, the following research objectives were developed:

RO_1: Identify components of counter-productive behaviors that need to be managed in the workplace.

RO_2: Develop behavioral management strategies that need to be learned by employers.

RO_3: Integrate the findings of counter-productive behaviors with behavior management strategies into a model that can be used to instruct employers in the management of counter-productive behaviors of employees.

Background and Significance

The 2006 American Community Survey conducted by the United States Census Bureau (2007) reported for the entire United States population over the age of five years, 6.8% have one type of disability and 8.3% have two or more types of disabilities. In the population between the ages of 16 and 64, only 28.4% of all individuals identified with a mental disability have some type of employment.

Jans, Stoddard and Kraus (2004) compiled information from federal agencies to provide statistics regarding individuals with mental disorders and disabilities caused by the disorders. The authors noted there is incomplete and sometimes contradictory information concerning the prevalence of individuals with mental disorders. Before the year 2003, only one study had collected information by interviewing individuals using a diagnostic tool. This study was conducted from 1980 to 1985. The President's New Freedom Commission on Mental Health (2003) reported data obtained from the National Co-morbidity Survey performed in 1990. This survey determined a prevalence rate over time for youth with mental disorders using a validated tool; it continues to provide data, but is limited to a specific population of individuals being followed over a specific period of time.

Jans, Stoddard and Kraus (2004) compiled data that showed mental disorders affect approximately one fifth of the population of the United States in a given year. The prevalence of mental disorders in working-age adults (18-54 years) is 21.0%. The employment rate for these individuals ranged from 48% to 73%. Educational attainment was the best predictor of employment for these individuals; the higher levels of education were most likely to maintain employment.

The National Institute of Mental Health (2010) regularly compiles statistics regarding mental disorders in the United States. The data indicated mental disorders are the leading cause of disability in the United States. Of the individuals who are diagnosed with one mental disorder, 45% will meet criteria for a second disorder as well.

Mood Disorders have the greatest numbers of individuals diagnosed. Mood disorders include major depressive disorder, dysthymic disorder and bipolar disorder. Approximately 9.5% or 20.9 million American adults have a mood disorder. The median age for the onset is 30. Major depressive disorder affects about 14.8 million or 6.7% of the population of 18 years old with the median age of onset being 32. Dysthymic disorder affects about 3.3 million adults or 1.5%. Bipolar Disorder impacts approximately 5.7 million adults or 2.6% with the median age of onset being 25 (NIMH, 2010).

Post-Traumatic Stress Disorder (PTSD) involves approximately 7.7 million adults or 3.5% of the population in a given year. PTSD can develop at any age, but due to the high percentage of veterans developing the disorder, the median age is 23. Attention Deficit Hyperactivity Disorder affects approximately 4.1% of the adult population between the ages of 18 and 44 in a given year. The disorder typically is diagnosed around the age of seven, but the disorder can persist into adulthood (NIMH, 2010).

Autism Spectrum Disorder is a disorder that is growing in prevalence among children. The rate of diagnosis in children is one in one-hundred. The prevalence among adults is difficult to determine and controversial due to changes in diagnostic criteria and methods of identifying the disorder. Autism is considered a life-long disorder; therefore the children diagnosed will become adults in the workforce (NIMH, 2010).

The employment systems in the United States do not appear adequate or equipped to address the needs of individuals with mental disorders (Jans, Stoddard, & Kraus, 2004; Goldberg, Killeen, & O'Day, 2005). The authors advised more research is needed to determine what services are needed to assist individuals with mental disabilities in the workplace as well as the effectiveness of the services. Hagglund and Heinemann (2002) reported individuals with mental disabilities receive fewer accommodations and support at the workplace as compared to persons with physical disabilities. These authors stated there was a lack of training about mental disabilities for employers.

In describing Affective Events Theory, the authors Grandey, Tam and Bauburger (2002) described how the work environment influences certain events which in turn create attitudes and behaviors of employees. These attitudes and behaviors may be immediate or develop over time. Furham (1992) also examined both positive and negative affectivity as they relate to the attitudes, stress and social functioning. Additionally, Fiske and Taylor (1999) reported emotional reactions at the workplace may be caused by the work environment. The authors described the emotions shown by individuals as being brief, intense and disruptive to the work environment. Grandey (2002) concluded understanding an employee's emotional reactions is valuable for the workplace and recommended further research in this area.

Emotional reactions by individuals can take place in all types of settings. Bernstein (2002) identified medical disabilities of individuals that cause emotional reactions in all phases of life. He stated although different individuals have the same medical diagnosis; their emotional reactions could be very different. The author explained the disabilities of panic disorder, depressions, mood disorder and anger control

could all be displayed as fear, sadness and anger. He reported experts in the field do not have definite answers or treatments for mental and emotional disabilities. Most of society's information about mental disabilities comes from values, beliefs and prejudices as well as science.

Employers most likely have preconceived ideas about mental disabilities and difficult counter-productive behavior traits. Many employers are ignorant about disabilities and have an aversion to taking the risk of hiring individuals with disabilities (Hastings, 2010). An implemented training model such as one developed by Merrill (2008) would assist employers in successfully managing individuals with these traits, by providing supervisory staff information and strategies. Merrill's instructional systems design model was based on the United States Navy's approach to training and offered guidance in training-the-trainers that would be beneficial in developing a program to train supervisors. Dench (2005) developed a model entitled "Multi-Element Behavioural *(sic)* Support: A Short Cycle." It was a competency-based training tool used to design and implement behavioral supports for individuals with challenging behaviors. Both of these models provide useful information and training. A model that would target counter-productive behaviors in the workplace with strategies for managing them would be extremely helpful to employers.

Furnham (1992) conducted research concerning what type of traits were likely to have the most number of accidents at the work place, high absentee rate and other difficulties on the job. Furnham reported the research was very limited in these areas, but personality traits can assist in identifying difficult behaviors from individuals in the workplace and many businesses were seeking outside consultants to identify personality

traits as well as assist in the management of employees. This study will provide a training model that can assist employers in managing employees with counter-productive work behaviors. The training model will be developed with identified limitations and assumptions being considered.

Limitations

The following limitations of the study were identified:

- It was limited to workplace behaviors.
- It was limited to a small sample of individuals in an urban area who showed expressive traits in the workplace that were identified by social service workers, mental health workers and individuals exhibiting the behaviors.
- It was limited to the most prevalent mental disorders as identified by the National Institute of Mental Health.
- The model targeted specific behavioral differences of medically diagnosed conditions: attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), mood disorders and post-traumatic stress disorder.
- It was limited to businesses that had a Human Resources Department.

Assumptions

The following assumptions of the study were determined:

- Employers being trained had sufficient knowledge and background in social science of how individuals relate to and respond to their

surroundings to understand the material being presented and questions being asked regarding workplace counter-productive behaviors.

- The managers interviewed had knowledge of the needs of the direct supervisors in managing employee behaviors.
- The targeted behaviors needed to be managed in the workplace.
- Counter-productive behaviors of various mental disabilities could be managed with the same strategy.

Procedures

Qualitative measures were used to obtain information regarding the necessary components of the training model. Focus group interviews were conducted to determine the most prevalent counter-productive behaviors in the workplace, employers' views of the behaviors and managing them and employee needs of assistance with the behaviors in the workplace. The groups contained six to seven people with similar backgrounds. The interviews were conducted a total of two hours with open-ended questions being asked by the researcher to guide the discussion (Patton, 2002; Creswell, 2009). The first focus group was conducted with seven individuals diagnosed with specific disabilities; some of the individuals were gainfully employed and others were currently seeking employment. A second focus group was conducted with professionals who assisted individuals with disabilities through counseling and support. The group consisted of one licensed psychologist, one licensed clinical social worker, one licensed medical social worker and four vocational counselors, two with bachelor's degrees and two with master's degrees. To determine the needs of businesses, a third focus group was conducted with three human resource managers, one human resource consultant and two directors of medical

programs. Detailed questions were asked about the needs of the employer in learning to manage the counter-productive personality traits of employees. The results of the groups were correlated with the literature to determine the necessary components of a training model.

Definition of Terms

The following are definitions of terms as related to the study:

Attention Deficit Hyperactivity Disorder: "Persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development" (Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR*), 2000, p. 85).

Autism Spectrum Disorders: "The presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual" (DSM-IV-TR, 2000, p. 70). The disabilities result in a broad range of impairments in social skills, communication and restricted patterns of interest. Difficulties in motor, sensory and integrative functions can result in significant inability to function in society (Tani, Newton, & Kaur, 2006).

Bi-polar Disorder: "Characterized by an occurrence of one or more Manic or Mixed Episodes, usually accompanied by Major Depressive Episodes" (DSM-IV-TR, 2000, p. 345).

Counterproductive Work Behaviors: Behaviors in the workplace "which include any actions that employees engage in that harm their organization or organization members"

(Bowling & Eschleman, 2010). Specific behaviors include withdrawal such as absenteeism, lateness and lack of socialization (Gruys & Sackett, 2003).

Dysthymic Disorder: "Characterized by at least two years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet criteria for a Major Depressive Episode" (DSM-IV-TR, 2000, p. 345).

Major Depressive Disorder: "Characterized by one or more Major Depressive Episodes (i.e., at least two weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression)" (DSM-IV-TR, 2000, p. 345).

Mood Disorders: "Disorders that have a disturbance in mood as the predominant feature" (DSM-IV-TR, 2000, p. 345).

Post-traumatic Stress Disorder: "The development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (DSM-IV-TR, 2000, p. 463).

Summary and Overview

The federal government has enacted laws and policies to encourage the employment of individuals with disabilities; this included medically diagnosed mental disabilities (The President's New Commission on Mental Health, 2003). The individuals with these disabilities most likely possess behaviors that are challenging and at times counter-productive in the workplace. Employers need the knowledge to understand these

behavior traits, possible causes of the traits and strategies for managing them effectively. In order to develop a training model to assist employers, qualitative research was conducted. The results were compiled to determine the counter-productive behaviors of employees and the needs of the employers to be able to manage them effectively.

The content of this study is divided into five chapters. Chapter I provides an introduction as well as background and significance of the study. Chapter II contains a review of the literature regarding counter-productive personality traits and behaviors, research regarding the needs of employers, information on training models and implementation. Chapter III details the methods and procedures of gathering and evaluating the qualitative data. Chapter IV presents the findings. Chapter V details the summary, conclusion and recommendations of the study. A model for the best approach to train employers is recommended.

CHAPTER II
REVIEW OF THE LITERATURE

In order to conduct a literature review for this study, the researcher utilized the library, Internet, journals and government research to obtain writings relating to the study. Research was conducted on the topics of mental and emotional disabilities of adults that could cause a person to have counter-productive behaviors in the workplace. Literature was reviewed regarding how these traits affect the employer and the employee in the workplace. A review of literature was conducted to determine how adults learn and the most appropriate teaching methods to be used in teaching adults.

The first section of this chapter provides information on the historical foundations and changes of employment. The second section reports on the federal laws pertaining to individuals with disabilities. The next section describes medical diagnoses individuals can have that create counter-productive behaviors. The following section reports employment statistics regarding individuals with disabilities and advantages and concerns of hiring these individuals. Next is a discussion of the role of human resources management in working with the employer and the employee with disabilities in the workplace. The subsequent section discusses adult learning and methods used to train and teach adults. The next section provides information regarding a conceptual model and its benefits as a training tool. The final section is a summary of the chapter.

Historical Foundations of Employment

The idea of one human being training another human being to work, learn a task and then train another individual has been around since the beginning of human life. As needs changed from working for survival, to working for trade, then working for economic purposes, training also changed and evolved. Humans have always had to work

for economic purposes, but the ways of training and the attitudes about workers have undergone many changes. Humans have always been a valued resource for trade and businesses; however, the recognition of that value took many twists and turns along the way. Humans are now recognized as a valued resource for businesses and organizations (ASTD, 2003; Werner & DeSimone, 2009).

The American Society for Training and Development (ASTD, 2003) reported the most competitive resource available today is a high-knowledge, multi-skilled workforce. The economy has shifted from mass production to "service industries that emphasized innovation, speed, cross-functionality and strong customer relations" (p. 6). This shift generated a need for workers who have the ability to "communicate effectively, access and apply knowledge, synthesize information, solve problems, adapt to fast-moving work environments and work across the organization in teams" (p. 6). This has produced a new focus for employers on the concept of human capital. The human capital challenge is using innovative approaches for recruitment, retention, training and employee relations.

Federal Law Pertaining to Employment of Individuals with Disabilities

Laws enacted by the Federal government protect the rights of individuals with disabilities in the workplace. Section 504 of the Rehabilitation Act of 1973 (United States Department of Labor, 1973), protects qualified individuals from discrimination in the workplace of any employer receiving financial assistance from the government. Individuals with disabilities are defined as "persons with a physical or mental impairment which substantially limits one or more major life activities" (U.S. Department of Health and Human Services, 2006, p. 1). The law requires the employer to provide reasonable accommodations unless such provision would cause an undue hardship.

The Americans with Disabilities Act of 1990 (United States Department of Justice, 2009) is another Federal law. Title I of this Act prohibits employers with fifteen or more employees from discriminating against qualified individuals with disabilities in all areas of employment. An individual is classified with a disability if it can be verified that one or more major life activities are significantly limited and if there is a substantiated record of the impairment. Employers are required to make reasonable accommodations including modifying work schedule, reassignment to another available position and providing modifications to the tasks. The law through the Internal Revenue Code offers tax incentives for business that hire individuals with disabilities (United States Equal Opportunity Commission, 2008).

The Workforce Investment Act (WIA) of 1998 provides federal job training funds for adults, dislocated workers and youth. The regulation mandates the coordination of federal job training programs, adult education programs, literacy programs, welfare-to-work programs, vocational education and vocational rehabilitation to provide workforce development to employers and workers. The goal of WIA is to provide the services through an accessible, one-stop career center system (AFL-CIO, 2010).

The United States Congress is actively pursuing avenues to increase the education and employment of women, minority groups and the disabled. On September 25, 2008, the Senate and House of Representatives passed an amendment to the Americans with Disabilities Act (ADA). This act stated:

> In enacting the ADA, Congress recognized that physical and mental disabilities in no way diminish a person's right to fully participate in all aspects of society, but that people with physical or mental disabilities are frequently precluded from

> doing so because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers. (United States Equal Opportunity Commission, n.d., p. 3)

The idea of making all Americans employable is very strong and continues to gain momentum (Kennedy& Harris, 2005). The difficulty with the law is many employers are finding they do not have the resources and trained staff available to deal with all of the diversity in employees. A conceptual model for training employers to manage employees with diverse behavior traits would be beneficial to businesses in meeting the requirements of the laws.

Medical Diagnosis and Counter-Productive Behaviors

Personality traits and characteristics are unique to every individual; therefore, counter-productive behaviors in the workplace vary with each individual (SHRM, 2006). Many medical conditions are not physically obvious, but are characterized by inappropriate conduct, emotional displays and inappropriate social interactions. These conditions create counter-productive behaviors in the workplace making employment difficult for the individuals. Adult attention deficit hyperactivity disorder, autism spectrum disorder, mood disorders and post-traumatic stress disorder are discussed in this section.

Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) was once considered a childhood disorder, but has gained increasing attention as an adult disorder (McGough & Barkley, 2004; Nair & Moss, 2009; Moncrieff & Timimi, 2010). Critics of adult ADHD questioned the validity of the diagnosis based on the lack of a diagnosis in the DSM-IV-

TR, the inability of professionals to reach a consensus on a diagnosis and the evidence of adults diagnosed with ADHD having co-morbid diagnoses (McGough & Barkley, 2004; Moncrieff & Timimi, 2010). Moncreiff and Timimi (2010) expounded their belief that the increasing interest in adult ADHD is due to a lucrative market for drug sales.

Proponents of adult ADHD described it as one of the most common psychiatric disorders of adults. The authors asserted the disorder creates an economic burden on society (Nair & Moss, 2009; Carroll & Ponterotto, 1998). Approximately 5% of school-age children are diagnosed with ADHD; an estimated 50% of them will still have the disorder in adulthood (Barkley, 2002; Bernfort, Nordfeldt & Persson, 2008; Patton, 2009). Adults with ADHD must deal with pressures and responsibilities of life; therefore, relationships, employment and everyday tasks affect the individual with ADHD both positively and negatively. Three major symptoms of adult ADHD are impulsivity, hyperactivity and distractibility (Carroll & Ponterotto, 1998; Patton, 2009; Adult ADHD, 2010; Manos, 2010). According to Murphy (2005), ADHD is treatable but it cannot be cured.

Impulsivity is a condition of the adult having difficulty controlling immediate reactions to situations (Patton, 2009; Adult ADHD, 2010; Manos, 2010). Patton (2009) identified impulsivity as being "manifested in behaviors such as the inability to delay gratification, not thinking through the consequences of actions, disregarding the feelings, thoughts and actions of others and an unwillingness to stand in lines" (p. 329). The adult with ADHD will often say the first thought that enters the mind without consideration of the appropriateness or possibility of offending others. Hyperactivity is described as the individual being restless, having trouble sitting still and having a desire to constantly be

doing some task. The positive side of this trait is the adult with ADHD will often do more work than the average person because of the need to do something until they are physically exhausted. Distractibility is the inability of the individual to keep focused on a specific task, difficulty concentrating on a conversation and being easily bored (Patton, 2009; Adult ADHD, 2010; Manos, 2010). Outward signs of hyperactivity might be restlessness, tapping of objects, interrupting and easily upset over simple requests. The inward feelings could be described as nervousness and anxiety (Patton, 2009).

Adults with ADHD have difficulty with organization and may not meet appointments or deadlines. They may struggle to maintain traditional employment and work better in a flexible setting with flexible hours. The individual with ADHD may be extremely creative, be very quick minded and intelligent. They can be very successful when they are passionate about a task or interest because they will dedicate much time and energy to the project (Carroll & Ponterotto, 1998; Patton, 2009; Adult ADHD, 2010).

Signs and symptoms of ADHD in adults are most evident in the workplace (Nadeau, 2005). In recent research of 7,000 individuals, 3.5% were diagnosed with ADHD. These adults could have a negative impact on the economy due to their work behaviors. These individuals are counter-productive in the workplace due to their need to take time off from the work environment. Adults with ADHD work approximately 22 fewer days per year than those without the condition. The individual with ADHD finds it difficult to concentrate on work due to work related problems, stressful home life and difficulties with relationships in and out of the workplace (Adult ADHD, 2010).

ADHD is more prevalent in developing countries (Nutt, Fone, Asherson, Bramble, Hill, Matthews, Morris, Santosh, Sonuga-Barke, Taylor, Weiss, & Young, 2007; Adult ADHD, 2010). The rationale for this prevalence is that the workforce moves from agricultural and manual tasks to sedentary and cognitive employment, the number of adults with ADHD seems to increase (Adult ADHD, 2010). Another thought is less developed countries do not have the medical knowledge or facilities to diagnose and treat (Nutt et al., 2007). The modern society will need to develop a plan to accommodate these individuals in the workplace. The individual with ADHD can be an asset to the community if given accommodations to meet the needs of their symptoms of the condition (Nutt et al., 2007; Adult ADHD, 2010)

A research study conducted with employees in a large manufacturing firm to assess adult ADHD and work performance reported a prevalence of 1.9% of the respondents met the medical criteria for ADHD. A 4-5% reduction in work performance was noted with 2.0% relative-odds of workplace accidents or injuries. Human capital value of lost work performance totaled $4336 per year for each individual targeted. The conclusion was adult ADHD is a significant impairment to workers and creates lost capital for employers. A viable study from the employer's perspective would be trials to evaluate whether accommodations in the workplace would be advantageous (Kessler, Lane, Stang, & VanBrunt, 2009).

Autism Spectrum Disorder

Autism spectrum disorder (ASD) is a medical condition characterized by marked difficulty in social interaction, restricted interest or patterns of behavior,

difficulty with everyday use of language and difficulty with motor planning (DSM-IV, 2000). These symptoms make it difficult for individuals with the diagnosis to obtain and maintain employment and they create counter-productive behaviors in the workplace. Employers typically look for individuals who are team players in the workplace. Individuals with ASD do not have this skill nor are they able to communicate abilities and skills; therefore, obtaining and maintaining employment is inhibited (Hurlbutt & Chalmers, 2002; Bernery, 2004; Grandin, 2006; Barnhill, 2007).

Approximately one to one and a half million people in the United States have autism spectrum disorder. It is the most rapidly growing diagnosis in the world. There are approximately 24,000 new diagnoses each year (Cimera & Cowan, 2009; Autism at Work, 2010). An estimated 50-75% of adults diagnosed with ASD are unemployed. If these individuals do not obtain employment, it will create an economic drain on the federal government and society (Cimera & Cowan, 2009; Hendricks, 2010).

There are limited resources for individuals with autism and their families, especially in the area of socialization and employment (Schaller & Yang, 2005; Graetz, 2010). Rehabilitation services are available through the federal government; however many individuals are denied services due to the severity of the disability. The individuals with ASD who are given services receive the most expansive of any disability; however the individuals who receive the support are successful in employment (Schaller & Yang, 2005; Lawer, Brusilovskiy, Salzer & Mandell, 2009). Private organizations are available to assess and train individuals

with ASD for an active role in the labor market. A management model would enable companies to hire and manage individuals with ASD and increase awareness of society regarding the positive contributions individuals with ASD can make within the community (Specialist People Foundation, n.d.).

Cimera and Cowan (2009) determined that vocational rehabilitation organizations serve 41.1% of adults with autism. The primary goal in the United States culture is for most individuals to obtain employment in order to support themselves and pursue their interests. In addition, there are economic advantages to the government and society for employment of these individuals (Lawer et al., 2009; Hendricks, 2010). The population of individuals who do not become employed after receiving services from vocational rehabilitation will rely on family, friends or the government for support (Cimera & Cowan, 2009). Employers who hire individuals with ASD determine the employee to be trustworthy, reliable, have low absenteeism, demonstrate strengths of attention to detail and intense focus resulting in increased work output. The individual with ASD often enjoys tasks not wanted by other employees due to the social isolation or repetitive nature of the task. Further research on this subject is needed to assist both employers and employees (Petty, 1997; Hendricks, 2010; Specialist People Foundation, n.d.).

Adults with ASD have many barriers to obtaining employment, the first being the interview process. Willey (1999), an individual with ASD, reported job interviews were a challenge due to lack of skills in non-verbal communication, literal interpretation of language and the need to state the obvious and express truthful opinions. Once a position was obtained, the author reported she was

usually over qualified and only held the position for several months. The author reported success in obtaining and maintaining employment once she advised the employer of her ASD and consequently obtained accommodations and assistance in the workplace.

Other individuals with ASD report similar difficulties with employment (Willey, 1999; Graetz, 2010; Lawrence, Alleckson, & Bjorklund, 2010; Billstedt, Gillberg, & Gillberg, 2011). The communication difficulties of the individual with ASD create difficulty in understanding reciprocal conversation and create difficulty in providing feedback on work projects. These individuals are obsessed with their own ideas and are not often willing to listen to others. Individuals with ASD do not understand personal space and their encroachments in the area of others are viewed as sexual harassment. They do not initiate conversation or ask about others thoughts and feelings; they do not read body language or understand jokes. This results in complaints from co-workers and supervisors such that the individual with ASD may lose the employment (Hurlbutt & Chalmers, 2002, 2004; Berney, 2004; Barnhill, 2007; Foden, 2008). Individuals with ASD are also blatantly truthful and do not understand emotions. They will often say what they are thinking regarding a problem in the workplace without regard to the thoughts and feelings of the employer or co-workers. This creates embarrassment for employers and supervisors, often resulting in termination of work for the individual with ASD (Grandin, 2006; Hume, Loftin, & Lantz, 2009; Lawrence, Alleckson, & Bjorklund, 2010).

Individuals with ASD also have many skills and abilities needed in the

workplace. An individual, interviewed by Tachibana (2009), stated his career success was because of his ASD diagnosis. The ASD provided the ability to remain focused on the task at hand making him extremely accurate with manual data entry tasks. The same individual reported difficulty with employment requiring multi-tasking and social skills.

Mood Disorders

Mood disorders are defined as "disorders that have a disturbance in mood as the predominant feature" (DSM-IV-TR, 2000, p. 345). There are several types of mood disorders; however this study focuses on the most prevalent mood disorders identified by the National Institute of Mental Health. These disorders are bipolar disorder, dysthymic disorder and major depressive disorder (NIMH, 2007; Hollan & Ponniah, 2010).

Bi-Polar Disorder

Bi-polar disorder, according to National Institute of Mental Health (n.d.), is "a brain disorder that causes unusual shifts in mood, energy, activity levels and the ability to carry out day-to-day tasks" (p. 1). NIMH reported bi-polar symptoms in individuals result in disruption of relationships, poor job performance or loss of job and the inability to cope with everyday life situations. Medications and therapy can assist with the symptoms of bi-polar disorder and individuals can lead productive lives.

Over 10 million people in America reportedly have the diagnosis of bi-polar disorder and the prevalence between men and women are equal. Bi-polar disorder is a chronic and life-long condition that affects children through adulthood. It is

characterized by recurring episodes of mania and depression (National Alliance on Mental Illness, 2010; Gilbert, Olino, Houck, Fagiolini, Kupfer, & Frank, 2009; Simon, Ludman, Unutzer, & Operskalski, 2008). NAMI detailed the symptoms of mania as:

> Either an elated, happy mood or an irritable angry, unpleasant mood; increased physical and mental activity and energy; racing thoughts and flight of ideas; increased talking, more rapid speech than normal; ambitious, often grandiose plans; risk taking; impulsive activity such as spending sprees, sexual indiscretion, and alcohol abuse; and decreased sleep without experiencing fatigue. (p. 1)

NAMI reported symptoms of the depression phase as:

> Loss of energy; prolonged sadness; decreased activity and energy; restlessness and irritability; inability to concentrate or make decisions; increased feelings of worry and anxiety; less interest or participation in, and less enjoyment of activities normally enjoyed; thoughts of suicide; change in appetite (either eating more or eating less); and changes in sleep patterns (either sleeping more or sleeping less). (p. 1)

NAMI (2010) reported these conditions could occur at the same time or cycle rapidly. The episodes can occur without any obvious cause or reason.

Bipolar disorder creates a high cost to society due to reduced productivity, work loss and unemployment of individuals diagnosed with the disorder. The estimated cost per year to society ranges into the billions of dollars. The unemployment rate for individuals with the diagnosis is 60% and approximately

88% of those employed have difficulties in the workplace. The most common employment difficulty for individuals with bipolar disorder is absenteeism. Other work difficulties include immediate verbal memory, anxiety, somatic complaints and poor work performance. There is a positive correlation between individuals with bipolar disorder managing the symptoms and having gainful employment (Bowden, 2005; Bush, Drake, Xie, McHugo, & Haslett, 2009; Simon et al., 2009).

Dysthymic Disorder

Dysthymic disorder is "Characterized by at least two years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet criteria for a Major Depressive Episode (DSM-IV-TR, 2000, p. 376). It is often referred to as "depression" -- less severe in its symptoms than other mood disorders. However, the difficulty for individuals is the longevity of the disorder (NIMH, 2007; Strine, Mokdad, Balluz, Gonzalez, Crider, Berry, & Kroenke, 2008).

Depression is often described as having the emotions of feeling sad, unhappy, down in the dumps or miserable. All individuals have these feelings at some point during a lifetime, but the emotions come and go due to circumstances in life. The symptoms may seem mild, but over time may become severe (Klein, Schwartz, Rose, & Leader, 2000; Young, Klap, Shoai, & Wells, 2008; Strine et al., 2008; National Library of Medicine, 2010). It creates a reduced quality of life and social functioning and can contribute to or cause worsening of chronic diseases. Depression is a major cause of illness and death in the United States (Center for Disease Control, 2009). Depression is considered to be a leading cause of disability worldwide (Krupa, 2007; Young et al., 2008).

In 2006, the Center for Disease Control (CDC) conducted a Behavioral Risk Factor Surveillance System to measure depression and anxiety in thirty-five states and three territories. The results of the survey reported 15.1% of the individuals taking the survey stated they currently had depression. Those who reported a lifetime diagnosis of depression was 12.4%. The CDC reported females were more likely to be diagnosed with depression than males with the percentages being 20.2% to 8.2%. The United States Census Bureau (2000) noted 10.2% of all families in the nation reported at least one family member having a mental disability.

The symptoms of depression create difficulty for individuals in all aspects of life. Some symptoms include inability to enjoy activities with others, fatigue and lack of energy, feelings of hopelessness and helplessness and consistently low or irritable mood (Coyne & Marcus, 2006; McKenzie, Clarke, Franzcp, Forbes, Sim, Fafom, & Ffom, 2010; National Library of Medicine, 2010). Other noted symptoms are lack of interest or enjoyment in solitary activities, feelings of worthlessness, a loss of pleasure in usual activities and recurring thought of death or suicide (Coyne & Marcus, 2006; McKenzie et al., 2010). Additional characteristics are pessimism, self-hate and inappropriate guilt (McKenzie et al., 2010). The National Library of Medicine (2010) included discouragement or despondency, trouble sleeping or excessive sleeping, a dramatic change in appetite, often with weight gain or loss, extreme difficulty concentrating and slowed or agitated physical movements.

The symptoms of depression an individual develops may cause difficulties

in the workplace. Often there is a slowdown in work performance; tasks which were once pleasurable may hold less interest and the individual may become overly critical of his or her own work (Gresenz, Pacula, & Wells, 1999; SHRM, 2005; Sturm, Adler, McLaughlin, Rogers, Chang, Lapitsky, & Lerner, 2006). Individuals experiencing depression may be able to manage continued employment because of familiarity with work tasks, work flexibility, informal arrangements with coworkers and support of family and friends (Krupa, 2007).

Major Depressive Disorder

Major depressive disorder is "characterized by one or more Major Depressive Episodes (i.e., at least two weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression)" (DSM-IV-TR, 2000, p. 369). The disorder is a combination of symptoms that interferes with an individual's ability to sleep, work, eat and enjoy activities. Major depression is disabling during the occurrence. An individual may only experience major depression once in a lifetime or it may reoccur throughout a lifetime.

An incidence of a high level stress event can cause the first event of a major depression episode. Life stressors tend to make the condition worse and more difficult for the depression to subside. The depression events make it difficult if not impossible for an individual to work or be a part of a family or community without strong supports (Adler et al., 2006; Griffin, Greiner, Stansfeld, & Marmot, 2007; National Library of Medicine, 2010).

Post-Traumatic Stress Disorder

National Institutes of Health (NIH, 2007) defines post-traumatic stress disorder (PTSD) as:

> An anxiety disorder that some people develop after seeing or living through an event that caused or threatened serious harm or death. Symptoms include flashbacks, bad dreams, emotional numbness, intense guilt or worry, angry outburst, feeling 'on edge' and avoiding thoughts and situation that are reminders of the trauma. (p. 1)

Miller (1994) described additional symptoms of jumping at the slightest provocation, feeling estranged from other people and viewing the world as a hostile place. The author noted individuals with PTSD tend to lose capacity for emotions such as tenderness, intimacy and passion. The individuals exhibit difficulty in controlling irritation and anger while developing guilt, remorse and self-dislike. Impulsive behaviors such as suddenly quitting a job, taking a trip, moving or altering lifestyles dramatically often occur.

Individuals who experience combat, terrorist attacks, natural disaster, serious accidents, assault or abuse and major emotional losses are at risk of developing post-traumatic stress disorder (PTSD). Approximately 3.5% of American adults age 18 and over will have PTSD in any given year. It is believed with the mass trauma events of the terrorist attack of the World Trade Centers in September 2001 and the natural disasters of Hurricane Katrina the incidences of PTSD in America will increase (NIH, 2007).

The United States Office of Veterans Affairs National Center for PTSD

(2010) reported the prevalence of PTSD changes over time, people and places. Most periods reported for PTSD are usually one year. However, the lifetime prevalence of PTSD among adult Americans is estimated to be 6.8%, with the lifetime prevalence for men being 3.6% and women 5.2%. American's Heroes at Work (n.d.) reported approximately 8% of the American population will develop PTSD during their lifetime. Approximately 30% of Vietnam War veterans experience PTSD and approximately 20% of service members deployed to Afghanistan or Iraq will have symptoms of PTSD or depression. Richardson, Frueh and Acierno (2010) concluded that PTSD in combat veterans had a range of 2% to 17% with a lifetime prevalence of 6% to 31%. Adults in the community with PTSD were noted to be 5% to 6% with a lifetime prevalence of 7.8%.

PTSD is not limited to adults; it greatly impacts children and teens that will eventually be in the workforce. More than 40% of the population of children and teens has endured at least one traumatic event resulting in 15% of girls and 6% of boys developing PTSD. Statistics reveal up to 100% of children who have seen a parent killed or endured sexual assault or abuse tends to develop PTSD. Babies born to mothers who have PTSD are more likely to have at least one chemical change in their body predisposing them to PTSD later in life (Edwards & Stoppler, n.d.). Children of veterans with PTSD have higher levels of behavioral and emotional problems creating difficulty for them in society. Adverse experiences in childhood contribute significantly to "adverse adult outcomes, including depression, PTSD, substance abuse, poor medical health, and low occupational attainment" (Marmar, 2009, p. 496).

PTSD can have a significant impact on the economy. In 2005, the cost of veterans receiving disability for PTSD was $4.3 billion; this is a 149% increase over the cost in 2000 (Edwards & Stoppler, n.d.). Gainful employment is an important aspect of recovery for individuals with PTSD. Employment creates a way for individuals to fully participate in society and thus have a higher satisfaction in life. Successful employment allows the individual with PTSD to build self-esteem, experience success and provide financially for self and family which facilitates healing and recovery (American Heroes at Work, n.d.). The individual with PTSD will face difficulties in the work place that may interfere with productivity and success. Individuals with PTSD may experience memory deficits, have difficulty concentrating, be disorganized, have poor sleep patterns, be hyper vigilant, have exaggerated startle responses, may try to avoid experiences that cause memory of the trauma, be detached from others, have restricted affect and have loss of interests or participation in activities (Haisch & Meyers, 2004; American Heroes at Work, n.d). The author reported employers must make reasonable accommodations and supports to assist the individual with PTSD in meeting the necessary standards for job performance.

Personality and the Workforce

Understanding personality is imperative to those who teach or manage people in the workplace. In order to be effective in guiding others, one must know how people relate to themselves and others, how they develop goals and ambitions for life, how they develop and manage codes of conduct and how they deal with difficulties in life. Teachers and managers must know and understand performance is not only determined

by intelligence, but by a full range of personal functioning (Fontana, 2000). Eysenck, Arnold and Meili (1975) developed a widely used definition of personality:

> Personality is the relatively stable organization of a person's motivational dispositions, arising from the interaction between biological drives and the social and physical environment. The term . . . usually refers chiefly to the affective-cognitive traits, sentiments, attitudes, complexes and unconscious mechanisms, interests and ideals, which determine man's characteristic or distinctive behaviour *(sic)* and thought. (p. 779)

This definition maintains personality to be stable and unchanging from day to day, it is formed by interactions between environment and biological forces and every person has a unique and distinctive personality.

According to Fontana (2000), personality is not something purposefully created by an individual. An individual is not fully to blame for traits of being awkward, difficult, passive, aggressive, withdrawn, overly excited or any other traits. However, an individual can learn about him/herself and take steps to change and grow. This is not an easy task, but a possible one.

An important part of personality is emotional intelligence. Goleman (1995) described this as having the ability to recognize and manage one's own feeling, and to be able to recognize, empathize and respond to the feeling of others. Fontana (2000) advised these traits are necessary to be a good teacher and manager. More specifically, a teacher or manager needs to be able to see and understand verbal and non-verbal emotional signals and be able to communicate his/her own feelings. Managers who have employees

with counter-productive behaviors can assist them in changing and developing new skills. This will only be accomplished with training and knowledge.

Personality difficulties can surface when a person has constructs that are too rigid, too inadequate to help in making predictions, too easy to change or too impervious to change. In the work environment, according to state based theory, a person will perform better with expectations that are consistent and easily predictable (Fontana, 2000).

The Society for Human Resource Management (SHRM) (2006) acknowledged there are times when an employer must deal with employee problem behaviors. The Society used the term "difficult employee" to identify individuals with "undesirable personality traits or those who conduct themselves in a manner that is disrespectful and unprofessional to managers, co-workers or customers" (p. 1). It is noted these individuals are able to perform the basic job functions, but their attitude and behavior is a detriment to the co-workers and organization. SHRM advised these difficulties must be addressed and resolved quickly.

Duggan (2007) explained there is a need to develop a workforce of employers who have a greater awareness of individuals with personality differences and disorders. Beyond the basic awareness, training is required at high levels in business systems to encourage support of individuals with personality difficulties. This training will assist the individuals, businesses and the community.

Employment Statistics, Advantages and Concerns

The Bureau of Labor Statistics (2009) reported the unemployment rate in May 2010 for people with a disability to be 14.7% compared to the percentage of non-disabled

individuals at 9.1%. Only 19.1% of the disabled population was employed as opposed to the non-disabled population at 63.7%. The types of disability were not identified. Hastings (2009) suggested many employers are missing out on being able to hire individuals with talent because they do not look at individuals with disabilities.

In a Technical Report created for Office of Disability Employment Policy (ODEPP), Domzal, Houtenville and Sharma (2008) surveyed employers to determine the number who employed individuals with physical and mental disabilities; the disability type was not reported. The results indicated among companies in the United States, only 19.1% reported hiring people with disabilities and 13.6% of the companies actually recruiting. The larger corporations showed a higher percentage than smaller businesses. The cost of employing people with disabilities and the belief workers with disabilities lack skills and experience were the reasons most often given by small businesses for not hiring these individuals. The uncertainty of how to take disciplinary action was cited as the most often reason by large businesses.

Hastings (2009) interviewed individuals with disabilities regarding the need and desire for employment. One individual stated he did not know of a group of Americans who wanted to pay taxes except for the unemployed individuals with disabilities. Another stated if an organization hired one individual with a disability, that person would help others and soon the organization would be comfortable and more likely to hire others. The author advised one person with a disability could make a difference to employers. The United States Department of Labor, Office of Disability Employment Policy (ODEP) (2008), conveyed that an employer who hires one individual with a disability is much more likely to hire other people with disabilities.

In considering the United States labor force data, hiring individuals with disabilities is an important topic. Toossi (2002) noted the labor force of the United States has experienced major changes in size, composition and character. Decades of the future will experience changes in the same areas but with decreasing numbers. The annual growth rate of the labor force was 1.6% between 1950 and 2000. The projected labor force between 2000 and 2050 is 0.6%; there is almost no projected growth for employment. The employees available will be more diverse than in the past. More research is needed to compare the projected labor force and with the projected increase in the prevalence of ASD, PTSD and other disabilities.

Human Resources Management

Human resources training has changed over the centuries from skills being taught in the home, to skills being taught in the workplace. The value of human beings in the workplace has come full circle from being a valued part of a family, to not being valued and thought of as a machine, to being valued and counted as an investment in the workplace. The field of Human Resources Training has a great impact on the training and respect given to individuals in the workplace. The field changes as the work environment changes, but it is seen throughout the world as an important investment for economic growth and development (ASTD, 2003).

Historically, human resources (HR) professionals have managed physical disability and health issues and the Employee Assistance Program (EAP) has managed mental health issues. However, HR professionals have always had specific responsibilities for managing mental health and disability issues. These are:

- Creating safe return-to-work policies that comply with the

standards of the Americans with Disabilities Act.

- Resolving employee behaviors that affect the work environment as well as events in the workplace related to mental illness.
- Developing employee management practices that reduce attrition by addressing stress in the workplace. (O'Connor, 2000)

Disability management has presented HR professionals with the opportunity to explore work environment factors that affect absence and disability costs of mental health conditions. Risk management is a new focus; it examines how employee mental health and behaviors affect productivity, attrition and employee management costs. Because the costs involved are rising and behaviors are unmanaged, employers are no longer avoiding mental health issues because they are uncomfortable. HR is able to provide a return on investment of employees by creating a workplace that is more sensitive to risk, wellness and costs. HR professionals have the opportunity to affect the fast-growing cost of mental health by developing strategies for the next generation of disabilities (O'Connor, 2000; Patton, 2009).

The difficulty for HR professionals is the lack of disclosure by employees of mental health disabilities. The employee is not required to disclose the disability and many HR professionals only want to know what is necessary. This thought process does not give the needed information to assist the employee. In turn, it creates an adverse relationship between the employer and employee and the employee becomes viewed as a burden rather than a fully developed resource. In addition, the employer receives legitimate complaints from other employees about the behaviors of co-workers with disabilities creating discourse among all parties (Sanders, 2005).

The approach of not disclosing is significantly different from the current trend toward cultural diversity. All individuals are encouraged to learn about differences in experiences of all races and ethnicities that impact job performance. Rarely are HR professionals urged to learn about the implications of mental and emotional disabilities and strategies to assist them in the workplace. The majority of employees with these disabilities deserve to be coached to better job performance and assistance in managing their behaviors (Sanders, 2005).

One area considered by employers was the possibility of using human resources departments of educational systems to train employers and supervisors in the area of dealing with employees. Smiley and Wenzel (2006) conducted a research study to determine if Human Resources Management (HRM) in a school division could be utilized to train teachers as opposed to the direct supervisor of the school conducting the training. The authors firmly stated that using HRM is a way to ensure an entire school system moves forward in educational reform. They stated the use of HRM allowed the teachers to feel respected, in control and have the needed "fit" for the teaching position. The authors suggested before this technique could be used, administrators from the state level down would need to revise their way of looking at teacher hiring, training, recertification and development. The authors suggested since the use of HRM in the education system was successful it would be equally successful in the business world.

In January 2001, the United States General Accounting Office determined human capital management was a high-risk area that needed immediate attention. Later in the year, President Bush placed this issue as a priority. With those events, American Society for Training and Development and Congress joined forces to determine the needs of

Human Resources Development and plans for the future. From their research, legislation was passed to establish Chief Human Capital Officer (CHCO) positions in 24 federal agencies. Responsibilities and goals were written and clearly stated for these positions. This law will enable employers to properly train and manage their workforce. Research is proposed to determine an employer's return on investment (ROI) from training and development programs. The demands on business in the 21st century require innovative approaches in recruitment, retention, training, employee relations, developing and using employee knowledge and skill and maintaining data on the results. These data will provide statistics on ROI in human capital (ASTD, 2003).

Congress and legislators continue to be a part of HRD. The 111th Congress of the United States passed stimulus legislation called the American Recovery and Reinvestment Act of 2009. The money from this bill is targeted to be invested into new technologies, infrastructure projects and health care, assist unemployed workers and invest in training for the workplace. Money will be allocated for partnerships between business and colleges to train workers for specific employment (ASTD, 2009).

Adult Learning

In teaching adults in the work place to deal with counter-productive behaviors, a model giving guidance and direction would be imperative. Adult learning is a topic that has been researched and explained, but it will likely gain increased attention in future years (Merriman, Caffarella, & Baumgartner, 2007). Harteis and Gruber (2008) reported there is no type of regulation for educators in the field of adult education. They advised there are no set standards, curriculum or methodology for teaching adults. They noted most adult educators have developed strategies over time and have learned

subconsciously how to teach adults. It takes approximately ten years for an educator to develop expertise.

According to Merriman, Caffarella and Baumgartner (2007), adult education is a growing field, but adults learn according to what the emphasis is in society at any given time. They stressed that in the United States the trends are based on changes in demographics, globalization and technology. They proposed individuals need to shape education instead of education shaping individuals. D'Amico (2011) noted it is critical for education systems to understand the unique needs of adult learners when designing programs.

Generally, adult learners have definite ideas about how and what they learn. Many adults prefer learning that is given in a developmentally appropriate manner and pace. They want information that flows without gaps or disconnections. They want to learn at their own pace and will in spite of the instructor. Many adults direct their own learning, they make time for it, determine what they need and find the opportunities. Most adults prefer self-directed learning (Fogarty & Pete, 2004; Heimlich & Horr, 2010; D'Amico, 2011).

There are many theories and models of education, but two well-known ones are pedagogy and andragogy. Malcolm Knowles is well known in the field of education as the father of andragogy. Knowles (1989) declared pedagogy has been the foundation of education since the Middle Ages. This model dictates the learner is dependent and relies on the teacher for information. The only duty of the student is to be submissive and complete the directions of the teacher. Pedagogy assumes the motive to learn comes from external pressures.

In contrast, Knowles (1995) declared the andragogical model is learner centered. It assumes the learner is self-directed, ready to learn, has life experiences to draw from and share and is motivated to learn for any number of reasons. Knowles stated adults can be ready to learn from any change in life and the learning experience should be centered on the situation. Knowles stressed the pedagogical and andragogical methods are parallel, not opposing (1995). There are many situations in which the learner needs to be guided at first, but in time, the learner should be allowed to be self-directed (Knowles, 1995; Ponton, Derrick, & Carr, 2005; Heimlich & Horr, 2010).

There are three primary opportunities for adult learning: formal settings, non-formal settings and informal self-directed. In whatever setting learning takes place, there needs to be acknowledgement that experiences aide in learning. Learning in groups, called organizational learning, can be a meaningful way to learn, solve problems and develop new ways of doing things (Ponton, Derrick, & Carr, 2005; Merriman, Caffarella, & Baumgartner, 2007; Harteis & Gruber 2008).

Self directed learning is one of the most researched topics of adult learning (Jarvis, 2004; Ponton, Derrick, & Carr, 2005; Merriman, Caffarella, & Baumgartner, 2007; Heimlich & Horr, 2010). Many models have been developed and marketed. Three types of models have been extensively researched. These are: linear, which holds that the learner moves through a process of steps to reach a goal; interactive, which holds learning takes place when two or more factors such as opportunities, personality, cognitive process and the context of learning interacts to cause learning; and instructional, which holds a teacher assists a student in becoming self-directed in learning (Merriman, Caffarella, & Baumgartner, 2007).

Self-directed learning is important for adults. Jarvis (2004) reported, "Teaching is dependent upon the learners being present, either actually or virtually, but not that they learn" (p. 43). The author stated adults would self-direct their learning when working on projects and neither a teacher nor institution is needed for the project to be completed. This is still considered education because it was intended and planned. Teaching is a human process and teachers are the best tools available to help learners learn and reach their full potential.

In thinking about the teacher as a tool, Vella (2002) proposed adult learning is the most effective when dialogue is used. She explained, "*Dia* means 'between,' *logos* means 'word.' Hence, *dia* + *logue* = 'the word between us" (p. 3). She added if adults are not encouraged to offer thoughts and suggestions, they will disassociate themselves and learning will stop. Vella also mentioned that learning should be full of energy for the adult learner.

For the teacher to have appropriate dialogue with students, Wojeck (2007) explained the educator must encourage the learner to tell stories about previous experiences as a learner. The way a student perceives himself/herself and the experiences he/she has had will affect future learning. If the student is what Wojeck called a "wounded learner," meaning he/she had a difficult time with learning in the past, the student will make statements that he/she cannot learn, will not be able to do a task or will not be good at a task. It is the responsibility of the educator to find out what thoughts the learner has in terms of being willing to learn. The educator should then create a sense of excitement and positive image of the task. The teacher is the best tool and role model for a "wounded learner." Using pedagogy, the teacher would inform the student that he/she

could learn and would supply the information to be learned. As the student provided evidence of learning the material, the teacher would praise. Using andragogy, the teacher would encourage the student to reflect on his/her strengths, relate information to life experiences and find a need and desire to learn.

A relatively new idea in the field of education is whether intuition is important for the adult educator. Harteis and Gruber (2008) proposed intuition is a crucial part of teaching adults. In their writing, the authors gave evidence of how educators learn and share information. They also stated that mere knowledge does not give an educator the ability to answer questions or guide in the areas that do not have textbook answers. Intuition occurs as knowing-how-to-act, sudden-inspiration and gut-feeling. These factors assist in making decisions and acting beyond rules, set criteria, and many times without prior attention. The authors conducted a qualitative study through interviews and determined that expertise had little bearing on an individual with intuition; it appeared to be more of an innate quality. Research regarding intuition and the part is has in adult decisions making, cognitive processing and learning has been targeted over the past few years (Zelman, 2002; Raab & Laborde, 2009; Kuhnle & Sinclair, 2010; Wright, 2010).

Conceptual Model

A conceptual model is a hypothetical description of a phenomena being investigated. The description can be unspoken, assumed or explicit (Jarvelin & Wilson, 2003). According to Engelbart (1962) developing a conceptual model means identifying essential components that need to be studied, the relationships of the components identified, how changes in the components or their relationship affect their functioning and potential goals and methods of the research. Jarvelin and Wilson (2003) reported

conceptual models are more fundamental and broader than scientific theories; the models provide the tools needed to formulate a hypothesis or theory. A conceptual model provides a working strategy and major concepts and the relationship to each other. The conceptual model of research must always be constructed. There is no template or design developed for a conceptual model.

Engelbart (1962) noted the rise in human population and gross product was growing at a rapid rate and with this came complex problems in all areas of life. The author stressed the need for enhancement of a human's ability to approach the problems, gain comprehension of the problems and to find solutions to the problems. Engelbart advised that ability meant "a mixture of more rapid comprehension, better comprehension, the possibility of gaining a useful degree of comprehension in a situation that previously was too complex, speedier solutions, better solutions, and the possibility of finding solutions to problems that before seem insoluble" (p. 1). This can be accomplished through a conceptual model. In conducting qualitative research with employers and individuals with counter-productive workplace behaviors, a conceptual model can be developed to assist both the employer and the employee.

In 1997, Garrison reported little information had been discussed about the learning process in self-directed learning. Since that time research on self-directed learning has evolved into an important concept (Vella, 2002: Jarvis, 2004; Ponton, Derrick, & Carr, 2005; Merriman, Caffarella, & Baumgartner, 2007; Heimlich & Horr, 2010). Garrison developed a model that is multidimensional and interactive (Figure 1). The model has three interconnected constructs: self-management (task control), self-monitoring (cognitive responsibility) and motivation (entering task). The author proposed

individuals could not achieve ultimate learning and progress without understanding and being involved in these three areas.

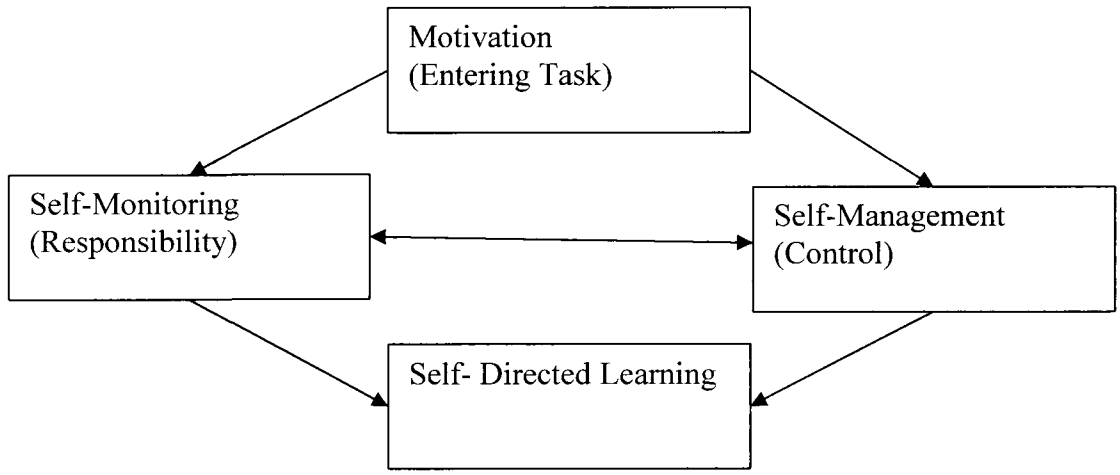

Figure 1. A multi-dimensional interactive model depicting three interconnected constructs for self-directed learning. Obtained from Garrison (1997).

The first dimension of self-management involves identifying the social surroundings in which learners are interacting and recognizing whether it is an informal or formal setting. Garrison (1997) stated, "Educational self-management concerns the use of learning materials within a context where there is opportunity for sustained communication" (p. 23). This dimension creates a responsibility for the learner to understand the environment.

The second and third dimensions of self-monitoring and self-management are on the same level with and represent the cognitive areas of self-directed learning. Self-monitoring is the ability to think critically about learning and reflect on what is already known and constructs meaning of what is being learned. Self-management is the control the learner uses to make progress in learning and to process the information in a usable form. The fourth dimension is motivation. This dimension focuses on what influences the

learner to take part in learning. It also focuses on what keeps the learner participating in learning. Although Garrison does not identify his model as andragogy; it follows the basic ideas of andragogy.

In reviewing the works on andragogy, Knowles (1984) published his conclusions regarding the models. Two of the conclusions were:

1. The andragogical model is a system of elements that can be adopted or adapted in whole or in part. It is not an ideology that must be applied totally and without modification. An essential feature of andragogy is flexibility.
2. The appropriate staring point and strategies for applying the andragogical model depend on the situation. (p. 418)

Knowles (1995) added a second part to the andragogical model called the andragogical process design. This part of the model creates the basis for the adult learning experience. The eight steps of the process are:

1. Providing information to the learner and preparing them for learning.
2. Building an atmosphere conducive to learning.
3. The leader and learners mutually plan the learning process.
4. Assisting learners to determine their own learning needs.
5. Assisting learners in setting their own learning objectives.
6. Assisting learners in developing their own learning plan.
7. Assisting learners in completing their plan.
8. Assisting learners in evaluating their learning outcomes. (p.149)

Knowles, Holton and Swanson (1998) published an enhanced conceptual framework of the andragogy model which they identified as andragogy in practice model. The model was developed to offer a more systematic framework for multiple domains of adult learning. The practice model has three dimensions consisting of goals and purposes for learning, individual and situational differences and core adult learning principles. This model stated that learning is a multifaceted activity and is interdependent on many aspects of life.

The adult learning model of andragogy has a central role in human resources development (Swanson & Holton, 2001). The andragogical model was introduced in 1968 and has continued to refine and develop the model. Knowles, Holton and Swanson (1998) reported six core principles of the andragogical model. The principles are:

1. Adults need to know the necessity of learning something.
2. The self-concept of an adult influences self-directed learning.
3. Adults use previous experiences as a basis for learning.
4. Adults will be ready to learn when there is a need to cope or learn a task.
5. Learning for adults is life centered and needed to reach competency levels and full potential.
6. Motivation for adults to learn is intrinsic as opposed to extrinsic. (p. 4)

The flexibility of the andragogical practice model and the interaction of the three dimensions make it a valuable tool for guiding the development of a conceptual model to assist employers in managing counter-productive traits of employees in the workplace.

Instructional Design

Instructional design is a systematic design process based on what is known about learning theories, information technology, systematic analysis, educational research and management methods. It is an approach that considers instruction from the perspective of the leaner as opposed to instruction from the perspective of the content. Instructional design begins by identifying the performance problem; it does not assume instruction to be the solution to all problems identified (Morrison, Ross, & Kemp, 2007; Gibbons, 2010; Higbee, Schultz, & Goff, 2010; Hung, Smith, Harris, & Lockard, 2010; Vasser, 2010).

Instructional design concentrates on variables that influence learning outcomes. Some of these variables are:

- What level of readiness do individual students need for accomplishing the objectives?
- What instructional strategies are most appropriate in terms of objectives and learner characteristics?
- What technology or other resources are most suitable?
- What support is needed for successful learning?
- How is achievement of the objectives measured?
- What revisions are necessary if a tryout of the program does not match expectations? (Morrison et al., 2007, p. 6)

Four basic elements create the framework for systematic instructional planning and are found in a majority of instructional design models. These elements are learners,

objectives, methods and evaluation. Morrison et al. (2007) reported the elements can be represented by answers to questions:

- For whom is the program developed? (characteristics of learners or trainees)
- What do you want the learners or trainees to learn or demonstrate? (objectives)
- How is the subject content or skill best learned? (instructional strategies)
- How do you determine the extent to which learning is achieved? (evaluation procedures). (p. 14)

These authors presented a diagram (Figure 2) of a typical linear design model that is rigid in the approach with little flexibility. They identified components that need to be included with the four basic elements of an instructional design model to make it complete and humanistic. The authors described nine elements that must be reviewed and addressed before the design is complete. Although the steps are given in an order, there is no specific sequence needed to complete the steps. It is advantageous to review all steps throughout the process (Morrison et al., 2007).

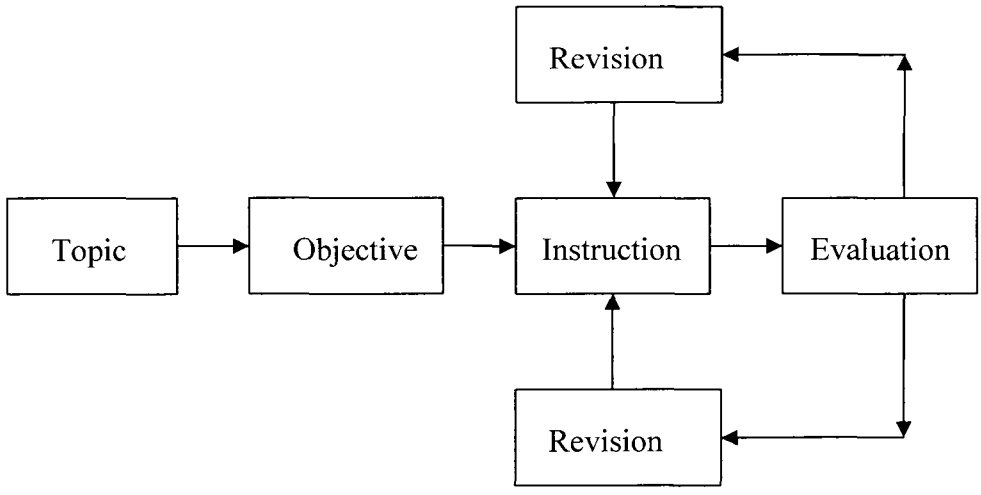

Figure 2. Example of a linear design model that is rigid and allows for little to no flexibility. Obtained from Morrison, G., Ross, S., & Kemp, J., 2007, p. 21.

The first element includes instructional problems, ones that need to be solved. If the problems involve instruction, then the designer continues in the process. The second step is to identify the learner characteristics. This includes defining the targeted audience and collecting pertinent information about them. This might include the background knowledge, assumptions and work experience of the targeted audience.

The third element is that of task analysis. The authors stressed that it is the most important component of the process. It is used to determine what knowledge and procedures are needed to be included in the instruction. The fourth element is instructional objectives. The objectives provide the plan for the instructional design and are used as a way to check for quality and content.

Content sequencing is the fifth element. The design of the instruction must be in a logical sequence to assist the learner in understanding and processing the information. Instructional strategies are the next element and are considered the creative portion of the design. This element involves determining the manner in which the material will be presented to assist the learner in referencing it to their background knowledge for ease of learning. The strategies range from simple to complex.

The seventh element in the model is designing the message. This element is combined with the instructional strategies to assure the words communicated, graphics designed and text written are all relevant to the material. The message draws the material together.

Development of the instruction is the eighth element. The element takes all parts of the previous elements and combines them into instructional materials such as printed material, audio or video presentations, visual and other mechanisms of presentation.

Evaluation instruments are the ninth element. These are used to determine if the objectives have been mastered by the audience. The evaluation methods can be simple or complex.

In addition to the nine elements, there are accompanying processes that are ongoing throughout the development of the instructional design. Two of the processes are planning and project management which are required to determine the scope, schedule and budget needed for the project. The next is support services that may include services ranging from graphic designer to scriptwriters. The size and complexity of the project will determine what support services, if any, are needed. Formative evaluation and revision are two of the processes. These are ongoing processes to ensure the project meets the objectives and all elements of the project are appropriate. Implementation is a process that needs to be planned as the project is being developed to assist in the efficiency of the project presentation.

A summative evaluation is an important part of the instructional design project. It allows feedback to be gathered at the end of the project as well as weeks later to determine if the design was successful in meeting the objectives of the project. This type of evaluation also allows the cost effectiveness and long term benefits of the project to be determined.

An additional type of evaluation is confirmation evaluation. This process allows the instructional designer to determine if a course of instruction has benefits for use over time. This eliminates the use of an instructional program that is out-dated or no longer useful in a particular setting.

The instruction design model developed by Morrison, Ross and Kemp (2007) will be used as a guide for the researcher to develop a training model for employers. This model will assist employers and supervisors in learning about employee counter-productive work behaviors and ways to manage them in the workplace.

Summary

This review of literature reported the historical foundation of employment, how workplace demographics have changed through the years and the projected changes over the next decades. The Federal government has enacted laws to prohibit the discrimination against individuals in the workplace who are affected by physical, emotional and mental disabilities. The medical diagnoses reviewed in the literature included autism spectrum disorder, post-traumatic stress disorder, bi-polar disorder, adult attention deficit hyperactivity disorder and clinical depression. Issues of various personality information and traits were also discussed.

Employment statistics, advantages and concerns of hiring individuals with medical diagnoses that create counter-productive behaviors in the workplace were reviewed. There has been a steady increase in the number of individuals with emotional and mental medical conditions that cause counter-productive behaviors in the workplace. The projection is the percentages of these diagnoses will continue to increase. This along with a decrease in population creates a need for employers to understand the individuals' with counter-productive behaviors and offer accommodations and modification.

Human resources management was found to have a great impact on the training and respect given to individuals in the workplace. The Federal government passed legislation to encourage businesses to properly train and manage the workforce. In order

to train the workforce, consideration should be given to the best method to use in order for the adults to learn.

The majority of work in the field of adult learning is using the model of andragogy. There are many theories and models for adult learning, but they include the assumption adults have their own ideas about learning, want to control what they learn, will learn at their own pace and want to have a say in the learning process. All of these ideas have been built on the work of Knowles (1995) and his predecessors.

A conceptual model giving employers the needed information about disabilities and ways to manage the counter-productive behaviors would be beneficial for all. Before a model can be created, research must be completed identifying essential components that need to be studied, the relationships of the components identified how changes in the components or their relationship affect their functioning and potential goals and methods of the research. The andragogy practice model would be a valuable tool in guiding the creation of a training model to assist employers in managing employees' counter-productive behaviors in the workplace.

In creating a conceptual model for training employers to manage employee counter-productive behaviors in the workplace, an instructional design model is an imperative tool. The design model created by Morrison et al. (2007) will be used to guide the creation of the model by the researcher.

Chapter III will provide specific methodology for obtaining data for this study. The intended methods and procedures, population, instrumentation, data collection and data analysis will be reported.

CHAPTER III
METHODS AND PROCEDURES

The purpose of this study was to develop a model for employer training to manage employees who possess counter-productive behaviors. With growing encouragement by law and society for employers to hire individuals without discriminating, the number of individuals with disabilities in the workforce will increase. Many of the disabilities are of a mental and emotional nature; therefore, the accommodations for these individuals are not as apparent as with physical disabilities. There is limited training in universities and businesses to teach how to deal with difficult individuals. This study was conducted in the year 2010 – 2011 within the Roanoke Valley in Virginia.

In order to obtain research data, qualitative measures in the form of interviewing focus groups were used (Creswell, 2009). To guide this study, the following research objectives were developed:

RO_1: Identify components of counter-productive behaviors that need to be managed in the workplace.

RO_2: Develop behavioral management strategies that need to be learned by employers.

RO_3: Integrate the findings of counter-productive behaviors with behavior management strategies into a model that can be used to instruct employers in the management of counter-productive behaviors of employees.

This chapter describes the methods and procedures for completing the research. The first section describes the population involved in the study, the characteristics and position in the workplace. The next section describes the instrumentation used to obtain

the data. The third section describes the method and details of data collection. Next, the type of data analysis is explained. The final section is the summary of the chapter.

Population

The population for this study consisted of employees and employers who have difficulty in the work place due to counter-productive behaviors of the employees. The information regarding these individuals was obtained from one licensed psychologist, one licensed clinical social worker, one licensed medical social worker, four degreed vocational counselors, three human resource managers, one human resource consultant, two directors of medical programs and seven individuals with employment related counter-productive behaviors. The focus was on individuals with counter-productive behaviors who had been medically diagnosed with conditions such as autism spectrum disorder, bi-polar disorder, post-traumatic stress disorder, adult attention deficit hyperactive disorder and clinical depression. Gender and age were not considered as a factor in this study due to the concentration and emphasis on behaviors.

Instrumentation Design

The method of data collection was the use of interviews in the form of three focus groups. The researcher is the key instrument in this type of data collection; the researcher does not depend on material developed by others (Creswell, 2009). The first focus group consisted of seven individuals who each have been diagnosed with at least one of the targeted medical conditions of this study. The topics of the first focus group included difficulties the individuals had in the workplace that created counter-productive behaviors, how the employer could assist the individual and what accommodations or

modifications could be made to the job in order to decrease the counter-productive activities.

Employment support for individuals with autism spectrum disorder can be divided into five major themes of job placement, supervisors and co-workers, on-the-job training, work place modifications and long-term support (Hendricks, 2009). Similar employment support has been shown to be needed for individuals with bi-polar disorder, adult attention deficit hyperactivity disorder and depression (Adult ADHD, 2010; Bowden, 2005; Jans et al., 2008). Within the area of job placement, individuals with the targeted medical diagnosis need to have employment that matches their intellectual and educational background, social skills and abilities (American Heroes at Work, n.d.; Krupa, 2007). It is important for supervisors and co-workers to have knowledge about the disability of the individual and job supports available. This would not be possible if the individual determines not to disclose the disability. On-the job training affords the opportunity to learn specific skills in the work environment removing the stress of making changes when transitioning from a training site to the work place. On the job-training also provides the opportunities to determine needed work place modifications; some of these modifications may include organization, time management, increased concentration, co-worker interactions and other factors that might create counter-productive behaviors. Long term support through the use of a mentor or job coach would assist the employee with a disability to have support during any work changes or situation that develops and creates difficulty on the job (O'Connor, 2000; SHRM, 2010).

Questions used to stimulate dialogue and obtain data were developed from the literature review reported previously in this paper and are based upon the goals for this study. They are as follows:

- Please describe your current employment and how you obtained the position.
- What type of training did you receive for your current position?
- Please identify and describe any behavior you have that results in counter-productive behaviors in the work place.
- Please describe accommodations or modifications in the workplace that would assist you in managing the counter-productive behaviors.
- Please describe the knowledge you believe your employer and co-workers have regarding the counter-productive behaviors and the willingness of the employer to assist you in your job.
- What are your suggested strategies for employers to better deal with your condition?

See Appendix A for a copy of the Focus Group I questions.

The second focus group consisted of two mental health counselors, two psychologists, two rehabilitation counselors and two medical social workers. Gender and age were not considered as criteria for the study; the expertise of the participant was the focus. The topics of the second focus group were the most prevalent counter-productive traits, the difficulties experienced by the individuals with these traits in obtaining and maintaining employment and modifications and accommodations that would be valuable to the employee with counter-productive behaviors.

The Occupational Outlook Handbook created by the United States Bureau of Labor Statistics (2010) identified different types of counselors and their job responsibilities. Mental health counselors work with individuals and families to promote mental health. They are trained in therapeutic techniques to address issues of emotional and mental illnesses and often provide assistance with job and career concerns. Rehabilitation counselors focus on assisting individuals with disabilities make career decisions, job searches and job training. They provide education and training to employers, families and communities as needed to assist the individual with a disability. Medical social workers provide psychosocial support to individuals and families to assist them in coping and planning when a lifelong medical diagnosis is given to a person. Clinical and counseling psychologists assess, diagnose and treat individuals with mental and emotional illnesses.

The review of the literature reported previously in this paper identifies the employment areas of concern that the counselors target with their patients. The review of the literature and research goals were the basis for the questions asked of the group. The questions were:

- Please identify and describe any behavior exhibited by your clients that result in counter-productive behaviors in the workplace.
- Please tell if these clients have disclosed whether they have an identified medical diagnosis and if so, the name of the diagnosis.
- Please describe your client's perspective of strategies used in the workplace in managing the counter-productive behaviors.
- Elaborate on whether or not the strategies used were effective and why.

- What type of training would be beneficial to employers in learning how to manage employees with counter-productive behaviors?
- What has been your experience with employers regarding the willingness to make accommodations and modifications for employees with counter-productive behaviors due to a medical diagnosis?
- What are strategies for accommodating these behaviors?

See Appendix B for a copy of the Focus Group II questions.

The third focus group consisted of three human resources personnel and three business managers. The credentials and training of the individuals were the criteria for participation; gender and age was not considered. The topics of the third focus group included counter-productive behaviors in the workplace, strategies for dealing with the behaviors, approximate cost of managing the employees, the legal demands for the employer to hire and strive to maintain the individuals in the workplace and needed training for employers to manage the individual with counter-productive behaviors.

The Office of Disability Employment Policy (2008) conducted a survey of small, medium and large size employers to determine their perspectives on employing individuals with disabilities. Questions were asked regarding the challenges of hiring people with disabilities. The top ranked challenge was noted to be not finding qualified people with disabilities to hire. The second challenge was noted as whether the individual with a disability could perform the type of work to be done. The third and fourth challenges were not knowing the cost of making accommodations and then the actual cost of the accommodations. The lack of knowledge or information regarding disabilities

was listed as the fifth challenge. The seventh, eighth and ninth challenges were concerns about attitudes of supervisors, co-workers and discomfort of all involved.

The ODEP (2008) survey asked about strategies that would be helpful in hiring people with disabilities. The top five responses of all companies regardless of size were employer tax credits, disability awareness training, visible top management commitment, mentoring and assistive technology. The survey asked if the companies were aware of state and federal assistance programs offered to employers of individuals with disabilities. For all companies surveyed with five or more employees, 7.45% reported being aware of the Job Accommodation Network, 8.0% were aware of the Employer Assistance and Resource Network and 25% were aware of One-Stop Career Centers.

Questions used to stimulate dialogue and obtain data were developed from the literature review of this study and were based upon the research goals. They were:

- Does your business currently employ individuals with disabilities? If yes, please describe the types of disabilities.
- What concerns does your company have regarding the hiring of individuals with disabilities which are not physical in nature?
- Please identify and describe any behavior exhibited by employees that results in counter-productive behaviors in the workplace.
- Please tell if these employees with the behaviors have disclosed whether they have an identified medical diagnosis and if so, the name of the diagnosis.
- Please describe strategies used in the workplace in managing the counter-productive behaviors.

- Elaborate on whether or not the strategies used were effective and why.
- What type of training does your business offer to managers and supervisors in dealing with employees with counter-productive behaviors?
- What has been discussed at your business regarding the willingness of employers to make accommodations and modifications for employees with counter-productive behaviors due to a medical diagnosis?
- Is your company aware of agencies that offer support to companies that hire individuals with disabilities? If yes, has your company used the agency?

See Appendix C for a copy of the Focus Group III questions.

Data Collection

To gather the necessary data concerning counter-productive behaviors in the workplace, this study incorporated the use of qualitative measures in the form of interviews consisting of three focus groups with six to eight individuals in each group (Creswell, 2009). A focus group gives the ability to interview a small group of individuals on a specific topic (Patton, 2002). It consists of six to eight individuals with knowledge regarding a particular subject. A focus group is useful in obtaining historical information and allows the researcher control of the questioning (Creswell, 2009). This type of research provided data about experiences, feelings, opinions and activities of individuals with counter-productive behaviors, their co-workers and supervisors that could not be obtained without open-ended questions and observations. The focus groups provide information only, not solve problems. Information regarding consistent shared views and different views can be quickly determined (Patton, 2002).

At the beginning of the study, the researcher assured the participants of the confidentiality and professionalism of the study. The participants were asked to complete a consent form to participate in the focus group (Appendix D). During each of the events, the sessions were digitally audio-recorded for later review, the researcher wrote notes regarding responses, non-verbal facial emotions, activities and the setting observed to assure validity. Immediately after each focus group was completed, the researcher reviewed the notes to clarify any abbreviated words, shorthand and writings. It was also reviewed for accuracy of times and details. The digital audio-recording was transcribed in order to analyze the information received; no other technology devices were used.

The first focus group consisted of seven individuals over the age of eighteen, who had been identified to have counter-productive behaviors in the workplace. Psychologists, counselors and vocational case managers identified the individuals by their knowledge of the participant's behaviors in the workplace; gender was not considered due to the focus of this study on identifying behaviors. The potential participants provided written permission for their identifying information to be given to the researcher. The researcher contacted the individuals, explained the research and requested the individuals' participation. Information regarding the date and time of the focus group was supplied at that time. A letter was sent to each individual to confirm participation, the date and the time (Appendix E). A local facility conference room was the meeting place and lunch was provided for the participants.

The second focus group was conducted at the same local facility conference room and lunch was provided. The participants were mental health counselors, psychologists, vocational rehabilitation counselors and various social service professionals. Each of the

participants worked with individuals who exhibited counter-productive behaviors in the workplace. The questions developed through the literature review were asked to the appropriate groups.

The third focus group was conducted at the same local facility conference room and lunch was provided. The participants were human resources professionals and managers or supervisors of various businesses. The professionals had similar positions within the workforce as related to the employees and their supervision.

Data Analysis

The researcher used a holistic account of the problem under study by obtaining multiple perspectives and factors involved in the problem. Then a visual model of the information was developed finding central themes (Creswell, 2009).

In order to analyze the data, notes from each focus group were transcribed and arranged into different sets of data by their content. The transcribed notes were then read multiple times to obtain a general idea of the content, tone and usability of the information. Next, the researcher began a detailed analysis using a coding process to sort and label the data. The traditional coding process of allowing the codes to emerge was used (Creswell, 2009).

The researcher created a diagram identifying recurring themes within each event. The themes were identified by the number and frequency of similar information being discussed in the three focus groups. The researcher created a diagram of the themes and then information from the events was listed in the diagram. Pertinent information that was not part of a theme was recorded in the diagram.

Using this approach, the researcher identified general themes and specific data to develop a model for employer interventions needed to assist employees with counter-productive behaviors in the workplace. Specific components of counter-productive behaviors were identified from all focus groups. Behavioral management strategies needed to assist the employee with the counter-productive behaviors were identified. The information was correlated to obtain the most significant and most frequent themes cited in all three groups. Literature was reviewed to determine recommended accommodations and modifications in the workplace for each medical diagnosis targeted in the study.

Using this information, the researcher created a conceptual model focusing on the major themes of the three groups into a visual diagram. The literature was used to strengthen the strategies needed in the model to aid workers with disabilities and their supervisors. The andragogical model of adult learning was integrated into the conceptual model to provide employers information on how to manage employees with counter-productive behaviors in the workplace. The instructional design model of Morrison et al. (2007) was used as a guide to create an instructional model to enable others to use the research for training purposes.

Summary

This chapter has provided information about the specific methodology for obtaining research for this study. A grounded theory approach was used and qualitative measures were employed. The population of the study included employers and employees with knowledge and experience with counter-productive behaviors in the work place.

The instrumentation was used with three focus groups. The first focus group included employees and potential employees identified with counter-productive

behaviors in the workplace. The second focus group consisted of counselors, psychologist and vocational rehabilitation counselors who work with individuals with the counter-productive behaviors. The third focus group consisted of employers or representatives of employers with knowledge regarding employees with counter-productive behaviors.

During the focus groups, the researcher asked open-ended questions relating to counter-productive behaviors in the workplace in order to obtain the thoughts, feelings, opinions and experiences of the participants. The researcher took notes of the focus groups sessions and the conversations were digitally recorded for future review by the researcher.

To analyze the data, the researcher transcribed the notes and recorded conversations, reviewed them thoroughly and coded them into themes. A diagram was created of the themes to determine the number and frequency in each focus group. The themes were organized into specific components of counter-productive behaviors and behavioral management strategies needed to assist the employee with the counter-productive behaviors. This information was correlated and the researcher developed a model for employer interventions needed to assist employees with counter-productive behaviors in the workplace.

Chapter IV will provide the data from the research, the information obtained, the information correlated and will present the conceptual model for training employers to manage the counter-productive behaviors of employees in the workplace. Detailed information will be provided regarding the purpose of each group, the participants of

each group, the focus of the discussions and information obtained. A correlation of the findings will be determined and presented.

CHAPTER IV
FINDINGS

The purpose of this study was to develop a model for employer training to manage employees who possess counter-productive behaviors. Qualitative research in the form of focus groups was conducted to obtain information to develop a conceptual model for training. To guide this study, the following research objectives were developed:

RO_1: Identify components of counter-productive behaviors that need to be managed in the workplace.

RO_2: Develop behavioral management strategies that need to be learned by employers.

RO_3: Integrate the findings of counter-productive behaviors with behavior management strategies into a model that can be used to instruct employers in the management of counter-productive behaviors of employees.

This chapter presents the findings of the focus group research. It describes the information obtained from each group and then describes the correlations and themes obtained from the research.

Participants

The population of the study included employers and employees with knowledge and experience with counter-productive behaviors in the work place. The instrumentation used was three focus groups. The first focus group included employees and potential employees identified as having counter-productive behaviors in the workplace. The second focus group consisted of counselors, psychologists and vocational rehabilitation

counselors who work with individuals with the counter-productive behaviors. The third focus group consisted of employers or representatives of employers with knowledge regarding employees with counter-productive behaviors.

Focus Group I
Individuals with Disabilities and Counter-Productive Behaviors

The participants for this focus group were solicited through referrals from counselors, psychologists, medical personnel and contacts made by the researcher. Each participant was contacted by telephone. The research study was explained in detail and information regarding the date and time of the group was given. A confirmation letter was mailed to each participant (Appendix E) and a reminder telephone call was made the day before the event was scheduled. The participants were provided lunch before the focus group meeting as an incentive and show of appreciation for the participation. Each participant signed an informed consent document before the formal group meeting began (Appendix D).

The topics of the first focus group included difficulties the individuals had in the workplace that created counter-productive behaviors, how the employer could assist the individual and what accommodations or modifications could be made to the job in order to decrease the counter-productive activities. Open-ended questions were asked during the focus groups to ensure responses from all participants (Appendix A). The group was facilitated by the researcher and was digitally recorded in order to assure accuracy with transcribing and analyzing the data. The participants were assured the recording would be destroyed upon successful completion of the study.

Demographics

The requirement for participation in the group was individuals who each have been diagnosed with at least one of the targeted medical conditions of this study. All seven participants had dual diagnoses giving a total of fourteen diagnoses; two autism, three bipolar, one post traumatic stress disorder (PTSD), four major depressive disorder and four attention deficit hyperactivity disorder (ADHD).

Of the seven participants, five were gainfully employed, one was a full-time student and one was seeking employment. Five of the participants had high school diplomas, one was currently enrolled in college and one had a post-graduate professional degree. All participants searched for and obtained employment on their own without the assistance of an agency. See Table 1.

Table 1

Demographics of Individuals with Disabilities

Disabilities	Education	Employment
Autism/Bi-polar	High School	Retail
Bi-polar/Depression	Post Graduate	Private Medical
Bi-polar/PTSD	High School	Ex-military/Retail
Major Depression/ADHD	High School	Manufacturing
Depression/ADHD	High School	Unemployed
Autism/ADHD	High School	Retail
Major Depression/ADHD	High School	Student

Training

The participants were asked about employment training received for their current job; the discussion progressed into including information regarding previous jobs. The

replies varied from no training to six months of training. The participants working in retail obtained the least amount of training and the manufacturing received the most. One participant shared, "The current job I have hired me and put me to work with no training. I am working with different people to learn the job." The participant who worked in manufacturing added, "My previous job gave six months on the job training, my current job gave three months. The training was done on the job in the shop and I had to take a test at the end to make sure I knew what I was doing." Another participant said he has two college degrees and is expected to know his job; however he stated that employers forget they each have their own way of doing things. He declared, "Because I have degrees, I am expected to know the work. Each company has their own computer system and their ways of doing things; if I don't follow the rules, I won't have a job. It would be nice if management took the time to explain the intricacies of their company." Another participant reported, "I worked as a bank teller and got two days training before being expected to do it myself. I was fired after a week and still do not know why. The best jobs for me were waiting tables. I was put with another server and taught by doing." Another participant explained, "Training was adequate. I did not understand them until someone working there showed me how to do the job. The one-on-one training worked the best. If you tell me how to do something, I may or may not be able to do it, but if you show me, I will definitely be able to do it." See Table 2 for responses regarding training.

Counter-Productive Behaviors

The participants were asked to identify and describe any behaviors they have which results in counter-productive behaviors in the work place. One participant stated impulsivity creates a lot of difficulty in the workplace. The participant stated, 'I would

Table 2

Training

Behavior	Number
Manufacturing company had intensive training.	1
Retail, restaurants and labor jobs had on the job training.	6
All participants wanted more one-on-one training.	7

get upset over something that happened and just walk out. I would just react and whatever came to my head, I would do. Before I started in medication management and counseling, I had thirty-seven jobs in seven years." Another participant described attendance was a big issue. He shared, "I would get so overwhelmed in a day that I just had to get out of there and say I wasn't going back the next day; I needed some time to get out of the head space where I was and regroup." Another participant explained, "I just wouldn't go to work or I would be late. It is hard for me to be organized without a routine. I could not get it together to go to work." One participant added he needed sameness and a schedule and it would help to have the same schedule every week. He expounded, "It is hard trying to work varied days. I need to know what days I am working and what days I have off every week. When a store gave me set hours, I was much more successful." Another participant elaborated that, "Virginia is a right to work state and an employer can fire for any reason they wants. There is no required breaks and lunch. At my previous job, I would work twelve hours a day because there was no one to relieve me. That type of exhaustion and responsibility creates stress, which in turn causes lapses in judgment. I would say things to people that I should not and end up getting

fired." Another participant shared, "I like working for a small group. Laying brick I had one boss, we all helped each other and I didn't have to deal with people. I worked for six years with no difficulty." One participant reported that he stays at the same work station all day doing a repetitive job. He explained, "Sometimes I just need a break. I stand doing my job and when things are rough in my personal life, I spend all day rehashing them in my mind and getting more depressed. I need to take a break and try to clear my head, but I am not allowed to except at set times." See Table 3.

Table 3

Identified Counter-Productive Behaviors

Behavior	Number
Impulsivity	7
Poor attendance	7
Reacting to being overwhelmed/walking off the job	7
Poor attendance/being late to work	6
Difficulty concentrating	5
Lapse in judgment due to exhaustion	4
Refusing to do tasks that seemed futile	3

Accommodations and Modifications

The participants were asked to describe accommodations or modification in the workplace that would assist in managing their counter-productive behaviors. One participant answered, "I do not need any special help on the job; there are just times when I need to have an extended break or a short break that is not scheduled. I just have to clear my head." Another participant revealed, "If a set schedule is considered an

accommodation, then I need it. I have to have things the same each week or I get overwhelmed and confused." One participant complained that he has disclosed his disability and asked for accommodations and modifications, but his supervisors were always reluctant. He reflected, "After working at (retail store) for a while, my supervisors will finally let me wear sunglasses to defuse the florescent lights and I can wear head phones if I am stocking shelves. I had to keep asking before they finally gave in." Two participants stated they had never considered asking for accommodations and modifications. One expressed, "If I ask for special help on the job, then I would have to tell why I need it. I am afraid if anyone knows I am bi-polar I will be fired. If I tell my boss, he is going to think I am a serial killer and he will find a reason to fire me. He will say it is because I am not doing my job correctly, but it will be because I am bi-polar and he is afraid." See Table 4.

Table 4

Needed Accommodations and Modifications

Accommodations and Modification	Number
Unscheduled breaks	7
Consistent work schedule	7
Participants have not requested accommodations for fear of retribution	6
Sunglasses for fluorescent lightening	2
Earphones for noise	2

Employer Knowledge and Willingness to Assist

The participants were asked to describe the knowledge they believe the employer and co-workers have regarding counter-productive behaviors and the willingness of the

employer to assist them in their job. One participant conveyed, "I have disclosed my disability, what I need and why I need it. They don't seem to understand the way I think. I have told them if they want me to do something then tell me why it is needed, if they do not, I will wander around and find other stuff to do. Some jobs are a total exercise in futility and the employer still wants them done." One participant disclosed, "I would like the supervisors to have more compassion. It would be nice for them to see employees as human beings. At one time I was going through a really rough time. I was drinking and was at the bottom in my depression. No one cared or tried to help me. They ended up finding a made up reason to fire me." Another asserted "My manger was young and inexperienced; if he noticed I was having difficulty with depression he never showed it or mentioned it. After I was fired, I learned he was checking behind me and my work, looking for a reason to fire me. The only good thing about that situation is that I sought medical help and counseling." Another expressed, "I was in the military and my supervisor seemed to enjoy seeing how far he could push me until I blew. I may have been in the military, but he recognized a problem and played me with it. That is just wrong." Another participant shared, "When I was moving from job to job, I didn't realize I had a disability and why I could not control my behaviors like I wanted. Since I have begun medication and counseling my job history has been good." Another elaborated, "The biggest thing about any disability is having someone to notice and care. Thankfully my [spouse] pushed and made the phone calls to get me help. I couldn't recognize my own problems; it took someone else to make me look at myself and my life." Another commented, "There is a whole stigma on mental illness, I will not disclose during an interview because I am afraid they will not hire me because they will think I am a trouble

maker. I want them to understand my illness in case I have trouble on the job, but I do not want to tell them." One participant summarized, "I had a job interview and thought I did well. I told the truth as to why I was out of work and my diagnoses. I did not get hired because employers want a perfect employee. Next time I will use other excuses such as an elderly mother and being needed at home for my children, which are both somewhat true, in case the employer checked and it is more acceptable." See Table 5.

Table 5

Participant Belief of Employer's Knowledge of Disabilities

Belief of Employer's Knowledge	Number
Disclosed disability to the employer who in turn did not understand it or appear to want to learn.	1
Do not believe their employer knows about their disability; the employer has not approached them to offer extra assistance.	6

Suggested Strategies for Employers

The participants were asked to suggest strategies for employers to better deal with their disability and counter-productive behaviors. The first respondent replied, "That we are human and have needs, please pay attention to them and help if you see something different or strange. Please keep an open mind and do not over react to situations." Another participant answered, "I would like for employers to have information about disabilities so they can recognize it and not just think I am being difficult. If they recognize it, they can ask me and maybe make some change to their management style to assist me." One participant revealed, "I need my employer to know that I know what I need to do, but sometimes I just can't do it. I need someone to understand me." Another

emphasized, "I would really like for the employers to know about disabilities and not seem completely at a loss or surprised if they hear that I have a disability. I am still a person." Another expressed, "I know there are laws to protect people with disabilities, but I really wish there were a place on the application to mark if I have a disability. Hopefully they would get the information they need about me ahead of time. I feel as if I am hiding something from them, but I do not feel comfortable with the possible reactions if they found out. I would love for an employer to say to me they notice I am having a difficult time and ask about it." Another participant offered, "It seems to me it all boils down to the employer asking one question, 'What can I do to help you?' I finally got a supervisor who asked that question, cared and got me the help I needed." See Table 6.

Table 6

Needed Strategies of Employers to Assist Employees

Strategy	Number
Employers need to learn about disabilities and be able to recognize the symptoms.	6
Supervisors need to remember employees are human beings and sometimes have needs.	6
Employers need to be understanding.	6
Employers need to be willing to offer help if needed.	6

Focus Group II
Support Workers for Employees with Counter-Productive Behaviors

The participants for this focus group were solicited by the researcher through telephone calls to local organizations and referrals made by other support workers. Each participant was contacted by telephone. The research study was explained in detail and

information regarding the date and time of the group was given. A confirmation letter was mailed to each participant (Appendix E) and a reminder email (Appendix F) was sent a week before the scheduled event. The participants were provided lunch before the focus group meeting as an incentive and show of appreciation for the participation. Each participant signed an informed consent document before the formal group meeting began (Appendix D).

The topics of the second focus group included: difficulties the clients of the support workers had in the workplace that created counter-productive behaviors; if the clients disclosed their medical diagnosis; the client's perspective of strategies that are used in the workplace to manage counter-productive behaviors and whether or not they were effective; types of training that would be beneficial for employers in managing the clients and the support workers experience with employers regarding accommodations and modifications in the work place. Open-ended questions were asked during the focus groups to ensure responses from all participants (Appendix B). The group was facilitated by the researcher and was digitally recorded in order to assure accuracy with transcribing and analyzing the data. The participants were assured the recording would be destroyed upon successful completion of the study.

Demographics

This focus group was comprised of experienced and degreed social service providers. The education levels were one licensed medical social worker, one licensed clinical psychologist, one licensed clinical social worker, two master's level vocational counselors and two bachelor's level vocational counselors. The requirement was that

each participant was a manager in their agency or in private practice; gender and age was not considered as a factor. See Table 7.

Table 7

Demographics for Support Workers Group

Professional Title	Number
Licensed Clinical Psychologist	1
Licensed Clinical Social Worker	1
Licensed Medical Social Worker	1
Bachelor's Level Vocational Counselor	2
Master's Level Vocational Counselor	2

Client Counter-Productive Behaviors

The focus group was asked to identify and describe any behaviors exhibited by their client that result in counter-productive behaviors in the workplace. The first respondent stated, "Since this group is made up of service workers, anyone we deal with regarding employment has most likely been unsuccessful many times and has decided to obtain help from an agency." Another participant shared, "Many of my clients can perform the work tasks well, it is the soft skills or lack of social skills that creates the problems in the workplace. These are more difficult for the employer to control." A participant expressed, "The ability to deal with the demands of the job schedule creates a high absentee rate for my clients. If they need a break, they just take the day off." Another participant expounded, "My clients with physical disabilities do not have the same difficulties in the workplace as those with mental illness. The physical disability is easier to identify and target on the job. The mental disability can have an entire range of

symptoms that come and go at any given time." Another participant responded, "Most of my clients with emotional and mental disabilities have difficulty working in a team, they become anxious, then the impulsivity takes over and they say the first thing that comes to their mind. This causes many people to lose their jobs." See Table 8.

Table 8

Noted Client Counter-Productive Behaviors

Behavior	Number
Inappropriate Social Skills	7
High Absenteeism	7
Impulsivity	7
Short attention span/needing flexible schedule	5

Disclosing the Diagnosis

The participants were asked if their clients have disclosed their identified medical diagnosis and the name of the diagnosis. The first respondent stated, "I work with a multitude of clients with physical and mental disorders. In considering the mental and emotional disorders, I work with autism spectrum, anxiety disorders, bi-polar, mental retardations, depression, and Asperger's." Another participant added that he works with the same population and also with tourettes and severe ADHD. A third person agreed and added PTSD as the primary diagnosis of her support position. Each of the participants verbally agreed they work with individuals with the same disabilities.

In answer to the question of disclosure, the first person responded, "The answer to the question is no. Individuals learn early they are singled out and are different if they have any disability or do something different. They have been bullied and picked on all

of their life. They have thousands and thousands of instances where they have been bereted because of their disability. The notion that they need to share their disability in order to get accommodations they need is not something they can understand or believe would be beneficial to them. It is a high threat to them and creates a lot of anxiety. They believe the employer will determine the individual is not motivated or not capable and then will stop working with them."

The second respondent added, "I have seen the entire spectrum of the thought process from people who do not want anyone to know to those who want to share everything in order to get attention and something special. An example of one particular client is a male with PTSD who did well on his job. However, the stress of PTSD created high blood pressure and the employee was not allowed to work until the blood pressure returned to normal. This of course created a Catch-22 situation. He was not willing to disclose what was actually creating the blood pressure difficulty. He was mandated to take time off and so he finally disclosed. The employer would not work with him to change positions or work part-time. This experience made my client distrustful of all employers." Another participant proposed, "I would imagine it is employer fear and their own anxiety about liability, productivity and issues with co-workers. It is very much a parallel process where each side is experiencing the same kinds of issues, but not for the same reasons."

The second respondent continued, "We run into the issues of the employer not wanting to put forth the effort. They believe the employee is faking or there is a lack of understanding and they believe people try to get out of work. I have a couple of people that I tried to convince if I could help them with accommodations they would be less

likely to be fired. They will come to me for several months, but never let me be proactive for them."

"I find with prolonged chronic illness it is a learning experience. Our programs are designed to be there over time, so if a client says they do not want to disclose we will do what is needed for them. After several job changes, disappointments and maturity, the individual learns they need the assistance and guidance of vocational counselors," concluded a participant. Another described, "Any individual I work with that has both a physical and emotional disability, will also blame all difficulties on the physical and not disclose the emotional. Sometimes they do not want to own the emotional disability."

Client's Perspective of Strategies in the Workplace and Their Effectiveness

The group was asked to describe their client's perspective of strategies used in the workplace in managing counter-productive behaviors. "I believe all individuals appreciate the accommodations given and the strategies work well, the difficulty is getting to the place where the client will request them," explained a participant. The group as a whole agreed and contributed information regarding the most often needed and used strategies. The most important was determined to be flexible breaks for movement. This helps the individuals have a chance to decompress, move and revitalize in order to continue working. Flexible scheduling was the next most important. The group determined there are no rules for flexible scheduling; it all depends on the client which is sometimes difficult for the employer. Some may need to work shorter days; others may need to work longer days in order to have an extra day off.

One participant noted, "There are natural progressions to accommodations. The first is the accommodations the employer has to provide which is scheduling, work area,

etc. The next is the one that the employee is responsible for, but needs permission to do such as use head phones, make a task list, etc. All of these things are a shared responsibility between the worker and the employer." The consensus of the group was rarely do accommodations and modifications not work to control counter-productive behaviors. See Table 9.

Table 9

Support Workers Noted Effective Accommodations and Modifications

Effective Accommodations and Modifications	Number
Flexible Breaks	7
Flexible Scheduling	7

Beneficial Training for Employers

The group was asked to describe what type of training would be beneficial to employers in learning how to manage employees with counter-productive behaviors. The first response given was, "Employers are ignorant in the true sense of the word. They are not incredibly resistant, but they are scared of the American with Disabilities Act (ADA). They are afraid of legal action and loss of profit." A second person reported, "Employer inflexibility is really a problem. We work really hard to provide the education and close the gap, but the employer has to be willing to put their foot out and step over the gap." Another stated, "The sad part is about one out of every ten employees has a disability, so every employer has already hired someone with a disability, it just has not been disclosed." Another response was, "Employers need education about disabilities. If a client does disclose, many times the employer has no idea what the disability is and what needs to be done by the employer."

Support Workers Experience with Employer

The group was asked to report their experience with employers regarding the willingness to make accommodations and modifications for employees with counter-productive behaviors due to a medical diagnosis. A participant replied, "My experience is that employers do not have the knowledge to know what is needed and what is required by law. The main thing I find is the 'imaginary grandfather clause" that employers think they fall into because of how long they have been in business and how long ago their building was built."

"Many times the employers do not want someone coming in telling them they must change or must do certain things to assist an employee. My agency needs to go in and try to understand the employer and what they need before we can get the individual with a disability to be successful in that work environment," stated a participant.

Another stated, "My experience is more helping employers and educating them about ADA. The employer often says if he makes the job easier for one worker than for another one, it is not fair. A lot of education is needed to help them learn it is not difficult and most jobs can be reorganized to look fair to all."

"I tried to find partnerships to place my clients with PTSD in jobs. I met with a hiring manager of a major retailer in the valley. His first response to me was, 'They're okay aren't they, they aren't going to come in here and go postal (into a rage)?' I spent a lot of time on education during that meeting and he agreed to participate in the program," explained a participant.

One participant offered, "There is always going to be a gap in the employment field unless the company has a good human resources (HR) department that knows the

laws and strives to be the best they can be in their field. The small business owner and small store owner does not have the knowledge or many times does not have the desire to assist employees." Another stated, "In our area there are only a few companies large enough to have good HR departments. The very large companies have HR departments out of the area and tend to have no knowledge about the local needs of this area."

In describing a process the statement was made that, "You have to go past the front line HR people to find the people who have the authority to change things to help the person with the disability. It is a multi-tiered process. You have to convince the individuals responsible for approving changes, the persons responsible for implementing the change and the front line supervisor who works with the employee. The process is not simple." See Table 10.

Table 10

Support Worker Perspective of Needed Employer Education

Needed Employer Education	Number
Characteristics, signs and symptoms of a person with emotional or mental disabilities.	7
How to approach an employee who is exhibiting counter-productive behaviors.	7
Profits may increase with understanding and flexibility in working with some employees.	7
One in ten individuals has a disability; they have employees with disabilities.	4
The truth about the American with Disabilities Act.	3

Strategies for Accommodating Counter-Productive Behaviors

The participants were asked to provide examples of strategies for accommodating individuals with the disorders targeted in the group session. The themes of responses were: use of planners and organizers, consistent work team, acknowledge transitions, give prompts, give visual cues, flexible scheduling, multi-sensory cues, alarm clocks, simple low tech strategies, time to regroup and most importantly time.

It was stated, "What people need to realize is all disabilities are a spectrum. Blindness is portrayed as you are either blind or you are not; you need a regular menu or Braille. There is no in-between. When in actuality the majority of people diagnosed as blind have some sight. Blindness is a spectrum. All disabilities have a spectrum."
A final thought was given that, "We are not talking about curing anyone. We are talking about accepting differences and appreciating them. When that happens, there will be success."

Focus Group III
Employers of Individuals with Counter-Productive Behaviors

The participants for this focus group were solicited by the researcher through telephone calls to local businesses and referrals made by business personnel. Each participant was contacted by telephone. The research study was explained in detail and information regarding the date and time of the group was given. A confirmation letter was mailed to each participant (Appendix E) and a reminder email (Appendix F) was sent a week before the scheduled event. The participants were provided lunch before the focus group meeting as an incentive to attend and as a show of appreciation for the participation. Each participant signed an informed consent document before the formal group meeting began (Appendix D).

The topics of the third focus group included whether or not the business hired individuals with disabilities and if so what type, what concerns the company has regarding the hiring of individuals with mental and emotional disabilities, counter-productive behaviors exhibited by employees, whether or not any employee has disclosed a medical disability that is not physical strategies used in the workplace to manage counter-productive behaviors and whether they were effective, type of training offered to managers and supervisors regarding dealing with counter-productive behaviors, willingness of the employer to make accommodations and modifications and if the company has used agencies to hire individuals with disabilities. Open-ended questions were asked during the focus groups to ensure responses from all participants (Appendix C). The group was facilitated by the researcher and was digitally recorded in order to assure accuracy with transcribing and analyzing the data. The participants were assured the recording would be destroyed upon successful completion of the study.

Demographics

The participants of this focus group were either professionals experienced and trained in the field of human resources or direct managers of employees within a specific department of a corporation. All participants had a minimum education level of bachelor's degree and all were experienced in their fields. See Table 11 for a summary.

Table 11

Demographics of Employer Group

Professional Title	Number	Company Size Employee Number
Human Resources Manager	3	Range 200-500
Human Resources Consultant	1	None
Director of a Business Unit	2	12,100

Employing Individuals with Disabilities
Employee Disclosure of Disabilities

The group was asked to provide information regarding whether or not their business hired individuals with disabilities and if so, what types. The first respondent stated, "I know we definitely do have associates with physical disabilities and emotional disabilities that very often affect their behaviors in the workplace. Some employees do not disclose, but their behaviors indicate an emotional or mental disability. Usually when a behavior needs to be coached or written up, the employee will then disclose." The second respondent stated, "We have found that only the physical disabilities are disclosed, it is rare if an emotional or mental disabilities is reported; however the behaviors quickly show themselves." One person stated that military personnel have disclosed their diagnosis of PTSD. One participant stated an individual he interviewed disclosed he had raging Attention Deficit Hyperactivity Disorder, but has been in therapy once a week to develop strategies to control the disability. The participant advised he hired the individual; it has been easier to work with the employee and develop strategies without trying to side-step the issues. Another participant reported, "Our manufacturing company hires many individuals with physical impairments and emotional issues. The difficulty we have is training the front line supervisors to deal with the employee difficult behaviors."

It was stated that disclosure would help the employer find the best place for the employee to work, the opportunity to be proactive and place the employee in the best possible work setting. Disclosure would keep an individual from being set up to fail from the beginning.

Concerns of Hiring Employees with Non-Physical Disabilities

The group was asked what concerns their business has in hiring individuals with disabilities which are not physical in nature. The group consensus was businesses, by law, are not allowed to inquire about any illness or disability of an applicant. During the application process, the human resources department attempts to find the best fit for the job. Any concerns about counter-productive behaviors do not surface until after the employee has started work.

Counter-Productive Behaviors

The group was asked to describe any behaviors exhibited by employees that results in counter-productive behaviors in the workplace. The first respondent outlined a list of the most difficult behaviors from employees. They were: poor attendance, lack of team work, lack of organization, confrontation and aggressiveness toward others. Two other participants agreed that absenteeism was the first behavior to call attention to the fact an employee may have a problem. The remaining three participants noted they begin to observe the employee cannot get along with others, complains about others and uses deflection to take attention from him/her. In discussing the attendance issue, the group agreed when attendance is the issue; it starts gradually. First the employee is tardy, then tardy several times a week, progressing to missing work a day to several times throughout the month. The attendance changes long before the behaviors develop. It was agreed that when the employee behavior changes it generally starts as negativity to anything that happens, the employee complains about other employees, asks to move work stations, needs to have drama and co-workers begin to make complaints. This creates a loss of productivity and wasted time on the job. See Table 12.

Table 12

Most Frequent Counter-Productive Behaviors

Behavior	Number
Absenteeism	6
Lack of Team Work	6
Lack of Cooperation	6
Negativity	6

Strategies Used with Counter-Productive Behaviors

The focus group was asked to describe strategies used in the workplace to manage counter-productive behaviors. "Identifying the root cause in order to determine what the employee needs is the first obstacle on the job," explained the first respondent, "This comes down to training the frontline supervisor to notice there is a problem." Another asserted, "We can mold breaks as needed, but the job must be done. I have tried to regimentalize the employees who need schedules. I have made checklists to be completed in certain amounts of time. This keeps them focused with a beginning and an end." Another participant stated, "We do not mind changing employees work locations, being more explicit on directions and making sure the individual understands the job." Someone else reported, "We have given employees alternate work schedules especially for those who do not do well with mornings. We have also changed work spaces around to accommodate people." One participant stated, "Our business is very limited because we are an assembly system. If a person leaves to take a break the entire process shuts down. Extended breaks and alternate work schedules are not possible. We can move people on the line, let them wear headphones, but nothing that leaves a gap in the line."

One participant shared his business department has changed the interview process in order to determine the fit and potential of a prospective employee. The interviewee must shadow and work with another employee for eight hours on the potential job. This gives the interviewee firsthand knowledge of job expectations and it also offers insight into the potential employee's strengths and weaknesses. See Table 13.

Table 13

Strategies Used by Employers to Control Counter-Productive Behaviors

Strategy	Number
Try to determine the root of the problem	6
Flexible breaks	4
Flexible schedules	2
Modifying workspaces	2
Relocating employee to a different work area	2
Job shadowing interviews	1
Task lists	1

Training Offered to Managers and Supervisors
Willingness of Employers to Make Accommodations and Modifications

The focus group was asked to describe training offered to managers and supervisors in dealing with employees with counter-productive behaviors. The group was asked to expound on the willingness of employers to make accommodations and modifications for employees.

The first response given was, "We try annually to give a supervisory refresher course on how to manage associate behaviors, when to refer to the Employee Assistance

Program (EAP) and to review the basics. We as a company are starved for resources; we do not have the materials or professionals needed to offer the desired training." A second response given was, "I think that the managers I work with do not have a concept of the whole therapy of a functioning person with a disability. It is not something we are typically looking for. We have to have big red flags waved in front of us before we even get into that thought pattern." He continued, "The fact that people are working in a business with possible disabilities is unknown and not introduced to managers. Even adults with ADHD in the workplace are not recognized by the managers. Our business does not have a good bridge between the individual units and the EAP. The frontline manager does not get training on how to look beyond a specific behavior."

Another participant stated he has had plenty of training in how to manage behaviors on the job, but has not received training to look for underlying issues. He advised his company teaches how to make referrals to the EAP. One participant shared his business trains front line supervisors to look for obvious drug and alcohol related issues; emotional and behavioral issues are not generally considered for EAP services by frontline supervisors. Three other participants noted they have peers who are afraid to ask questions of an employee as to whether there is something behind the inappropriate behaviors. The front line managers are afraid to probe and will only deal with the behavior at hand. Another agreed and added that the front line supervisors tend to distance themselves from behaviors; they do not want to deal with emotional or mental disabilities for fear that the employee will become confrontational and aggressive. Another participant agreed and added, "My front line managers are well trained, the difficulty is they do not want to deal with emotions, they only want to manage the job."

Another added, "We deal with generational differences with the older sector wanting the younger folks to suck it up and do their job without being coddled."

Another stated that in experiences with several different types of companies, the difficulty was always with training the managers how to deal with both physical and emotional disabilities. The participant advised behaviors will continue and escalate without the frontline supervisors being trained in recognizing a problem and making a plan to address the problem. The front line supervisors are the most important people; they are usually not "touchy feely" and not trained to notice subtle behavioral changes.

In discussing the willingness of employers and managers to make the necessary accommodations for an employee, one participant advised, "Our business has policies and procedures to make sure an employee obtains what is needed to be successful on the job and follow all laws. The difficulty comes when the front line manager or supervisor does not follow through with the plan." Another replied, "If one person gets by with inappropriate behavior, it spreads like wildfire. People see others doing it and will then try. We must be careful with what we allow."

"Being an HR manager, I have supervisors coming to me asking for assistance and wanting me to be the one to probe deeper. It is good for HR personnel to have a good relationship with the front line supervisors to get advice and deal with the issues," shared a participant. Another proposed, "The small companies without human resources departments do not have the resources to manage or redirect behaviors. If an employee exhibits multiple inappropriate behaviors or aggression, they are dismissed." Another shared, "My [spouse] works for a very large company with facilities in multiple locations. There is no local HR department or anyone to support the frontline supervisors.

The employees are given a 1-800 number to call to get help. The supervisor can email corporate and hope they get a response within a week. These companies have no support systems."

In summarizing, the participants agreed that the most significant barriers an individual with emotional and mental disabilities might have for being employed is the willingness of the employee to disclose the disability and then the willingness of the employer to offer the accommodations needed. One participant summarized, "It would be nice to have a training manual to give information on how to train the front line supervisors on how to recognize what is a true emotional or mental disability and what are just bad behaviors." See Table 14 for a summary of these items.

Table 14

Training Offered to Supervisors and Managers

Training	Number
Annual training on how to manage difficult behaviors.	4
Annual training on how to refer employee to Employee Assistance Program.	4
No training on the importance of offering accommodations in order to assist the employee and the company.	5
No training on how to recognize the obvious signs of disabilities such as ADHD, depressions, inappropriate social skills.	6
No training on how to look for underlying causes of inappropriate behaviors.	6

Results of the Three Focus Groups

In order to analyze the data, notes from each focus group were transcribed and arranged into different sets of data by their content. The transcribed notes were then read multiple times to obtain a general idea of the content, tone and usability of the information. The researcher identified general themes and specific data to develop a model for employer interventions needed to assist employees with counter-productive behaviors in the workplace. Specific components of counter-productive behaviors were identified from all focus groups.

In identifying counter-productive behaviors in the workplace all three groups identified the following behaviors: high absenteeism, inappropriate social skills, difficulty concentrating and negativity. Two of the three groups added impulsivity as a problem. In identifying strategies used by employers to control counter-productive behaviors, flexible breaks and scheduling were reported by all three groups. Two of the groups reported that employees do not request strategies to assist them for fear of retribution. In identifying needed education for employers, all three groups reported the following: employers need to understand emotional and mental disabilities and how to recognize them, employers need to know how to approach a person exhibiting counter-productive behaviors in a non-threatening manner and employers need to know the benefits to the company of providing accommodations and modifications to employees.

The Job Accommodation Network (2008) published information regarding accommodations and compliance information for employers who hire employees with all types of disabilities. This information provides facts of the definition, symptoms and accommodations ideas for many physical, emotional and mental disabilities. A review of

this material was completed and a comparison of the symptoms of the disabilities targeted in this study was completed. Table 15 shows the main symptoms and the disability associated with the symptom. It should be noted that the symptoms are not obvious or present all of the time; some individuals may not exhibit all of the symptoms. An understanding of these symptoms would assist employers in identifying possible causes of employee counter-productive behaviors.

Table 15

Symptoms of Mental and Emotional Disabilities

Symptoms	Disabilities				
	ADHD	Autism	Bi-polar	Depression	PTSD
Anger Outbursts		*			*
Anxiety		*	*	*	*
Difficulty Communicating	*	*			*
Impulsivity	*		*		
Irritability			*		*
Lack of Focus	*	*	*	*	*
Lack of Social Skills		*	*		
Over Active	*		*		
Shifts in Mood	*	*	*	*	*
Startle Response				*	*
Talking Excessively	*	*	*		
Unaware of Social Cues	*	*			

Summary

The purpose of this study was to develop a model for employer training to manage employees who possess counter-productive behaviors. The population for this study was employees and employers who have difficulty in the work place due to counter-productive behaviors of the employees. The method of data collection was

qualitative methods of using the researcher as the key instrument of collecting data. The data collections type was an interview in the form of three focus groups (Creswell, 2009). The researcher conducted the focus groups face-to-face.

The first focus group consisted of seven individuals who each have been diagnosed with at least one of the targeted medical conditions of this study. The topics of the first focus group included difficulties the individuals had in the workplace that created counter-productive behaviors, how the employer could assist the individual and what accommodations or modifications could be made to the job in order to decrease the counter-productive activities.

The second focus group consisted of two mental health counselors, two psychologist, two rehabilitation counselors and two medical social workers. The topics of the second focus group were the most prevalent counter-productive traits, the difficulties experienced by the individuals with these traits in obtaining and maintaining employment and modifications and accommodations that would be valuable to the employee with counter-productive behaviors.

The third focus group consisted of three human resources personnel and three business managers. The topics of the third focus group included counter-productive behaviors in the workplace, strategies for dealing with the behaviors, approximate cost of managing the employees, the legal demands for the employer to hire and strive to maintain the individuals in the workplace and needed training for employers to manage the individual with counter-productive behaviors.

The findings of each of the focus groups were reported in this chapter. Chapter V will provide a summary and correlation of the information obtained from all three focus

groups. An analysis will be reported of common findings and data regarding the research questions of the study. A conceptual model for training employers to manage employee counter-productive behaviors will be provided.

CHAPTER V
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter provides an overview of the research project. It is divided into three sections of Summary, Conclusions and Recommendations. The Summary will report the problem statement, research objectives, significance of the study, limitations of the study, population, instrumentation and data collection. The Conclusions will provide answers to the research objectives, give details of the data collection and the findings of the study. The Recommendations will give practical suggestions for implementing the findings and will suggest additional research studies that need to be conducted due to the findings of this study.

Summary

The purpose of this study was to develop a model for employer training to manage employees who possess counter-productive behaviors. In order to determine the needs of the employers and employees, qualitative research in the form of focus groups was conducted to obtain information. The information obtained from the focus groups was correlated and analyzed in order to develop a conceptual model for employer training to manage employee counter-productive behaviors in the workplace.

Three research objectives were used to guide the study. The research objectives were: 1) identify components of counter-productive behaviors that need to be managed in the workplace, 2) develop behavioral management strategies that need to be learned by employers and 3) integrate the findings of counter-productive behaviors with behavior management strategies into a model that can be used to instruct employers in the management of counter-productive behaviors of employees.

The 2006 American Community Survey conducted by the United States Census Bureau (2007) reported for the entire United States population over the age of five years, 6.8% have one type of disability and 8.3% have two or more types of disabilities. In the population between the ages of 16 and 64, 28.4% of all individuals identified with a mental disability have some type of employment. The information compiled by Jans, Stoddard and Kraus (2004) reported that mental disorders affect approximately one fifth of the population of the United States in a given year.

The National Institute of Mental Health (2010) reported statistics regarding mental disorders in the United States. The statistics indicated mental disorders were the leading cause of disability. Of the individuals who were diagnosed with one mental disorder, 45% were predicted to meet criteria for a second disorder as well. Mood Disorders had the greatest numbers of individuals diagnosed. Mood disorders included major depressive disorder, dysthymic disorder and bipolar disorder. Approximately 9.5% or 20.9 million American adults were reported to have a mood disorder. Post-Traumatic Stress Disorder affected approximately 7.7 million adults or 3.5% of the population in a given year. Attention Deficit Hyperactivity Disorder was noted to affect approximately 4.1% of the adult population between the ages of 18 and 44 in a given year. Autism Spectrum Disorder was reported as a disorder that is growing in prevalence among children. The rate of diagnosis in children was given as one in one-hundred. Autism was reported as being considered a life-long disorder; therefore the children diagnosed will become adults in the workforce.

The employment systems in the United States were described as not to appear adequate or equipped to address the needs of individuals with mental disorders (Jans,

Stoddard & Kraus, 2004). Hagglund and Heinemann (2002) indicated individuals with mental disabilities received less accommodations and support at the workplace as compared to persons with physical disabilities. These authors stated there was a lack of training about mental disabilities for employers.

Employers most likely had preconceived ideas about mental disabilities and difficult counter-productive behavior traits. Many employers were ignorant about disabilities and had an aversion to taking the risk of hiring individuals with disabilities (Hastings, 2010). An implemented training model would assist employers in successfully managing individuals with these traits, by teaching supervisory staff information and strategies Merrill (2008).

The following limitations of the study were identified: 1) it was limited to workplace behaviors, 2) it was limited to a small sample of individuals in an urban area who showed expressive traits in the workplace that were identified by social service workers, mental health workers and individuals exhibiting the behaviors, 3) it was limited to the most prevalent mental disorders as identified by the National Institute of Mental Health, 4) the model targeted specific behavior differences of medically diagnosed conditions: attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), bi-polar disorder, mood disorders, and post-traumatic stress disorder and 5) it was limited to businesses that had a Human Resources Department.

Qualitative measures were used to obtain information regarding the necessary components of the training model. Focus group interviews were conducted to determine the most prevalent counter-productive behaviors in the workplace, employers' views of the behaviors and managing them and employee needs to assist them with the behaviors

in the workplace. The groups contained six to seven people with similar backgrounds. Each focus group session was conducted a total of two hours with open-ended questions being asked by the researcher to guide the discussion (Patton, 2002). The first focus group was conducted with seven individuals diagnosed with specific disabilities; some of the individuals were gainfully employed and others were seeking employment. All seven participants had dual diagnoses giving a total of fourteen diagnoses: two autism, three bipolar, one post traumatic stress disorder (PTSD), four major depressive disorders and four attention deficit hyperactivity disorder (ADHD). A second focus group was conducted with professionals who assisted individuals with disabilities in the areas of counseling and support. The group consisted of one licensed psychologists, one licensed clinical social worker, one licensed medical social worker and four vocational counselors, two with bachelor degrees and two with master's degrees. To determine the needs of businesses, a third focus group was conducted with three human resources managers, one human resources consultant and two directors of medical programs. Detailed questions were asked about the needs of the employer in learning to manage the counter-productive personality traits of employees. The results of the groups were correlated with the literature to determine the necessary components of a training model. Each focus group discussion was guided by the researcher using a pre-determined set of questions.

The focus group of individuals with disabilities was asked the following: 1) Please describe your current employment and how you obtained the position, 2) What type of training did you receive for your current position? 3) Please identify and describe any behavior you have that results in counter-productive behaviors in the work place. 4) Please describe accommodations or modifications in the workplace that would assist you

in managing the counter-productive behaviors. 5) Please describe the knowledge you believe your employer and co-workers have regarding the counter-productive behaviors and the willingness of the employer to assist you in your job. 6) What are your suggested strategies for employers to better deal with your condition?

The focus group of professionals who offer support to individuals with disabilities was asked the following: 1) Please identify and describe any behavior exhibited by your clients that results in counter-productive behaviors in the workplace. 2) Please tell if these clients have disclosed whether they have an identified medical diagnosis and if so, the name of the diagnosis. 3) Please describe your client's perspective of strategies used in the workplace in managing the counter-productive behaviors. 4) Elaborate on whether or not the strategies used were effective and why. 5) What type of training would be beneficial to employers in learning how to manage employees with counter-productive behaviors? 6) What has been your experience with employers regarding the willingness to make accommodations and modifications for employees with counter-productive behaviors due to a medical diagnosis? 7) What are strategies for accommodating these behaviors?

The focus group of human resources personnel and supervisors was asked the following: 1) Does your business currently employ individuals with disabilities? If yes, please describe the types of disabilities. 2) What concerns does your company have regarding the hiring of individuals with disabilities which are not physical in nature? 3) Please identify and describe any behavior exhibited by employees that results in counter-productive behaviors in the workplace. 4) Please tell if these employees with the behaviors have disclosed whether they have an identified medical diagnosis and if so, the

name of the diagnosis. 5) Please describe strategies used in the workplace in managing the counter-productive behaviors. 6) Elaborate on whether or not the strategies used were effective and why. 7) What type of training does your business offer to managers and supervisors in dealing with employees with counter-productive behaviors? 8) What has been discussed at your business regarding the willingness of employers to make accommodations and modifications for employees with counter-productive behaviors due to a medical diagnosis?

The dialogue of each focus group was digitally recorded then manually transcribed in order to review the information, analyze it for similarities and compare and correlate the data from all three focus groups. The transcribed notes were read multiple times to obtain a general idea of the content, tone and usability of the information. The researcher identified general themes and specific data to develop a model for employer interventions needed to assist employees with counter-productive behaviors in the workplace.

Conclusions

In order to develop a conceptual model to train employers to manage employee counter-productive behaviors, focus groups were held to obtain the data and information. The focus groups were guided by three research objectives.

RO_1 was, "Identify components of counter-productive behaviors that need to be managed in the workplace." All three focus groups reported the same five counter-productive traits of absenteeism, difficulty concentrating, inappropriate social skills and negativity. Two of the three groups reported impulsivity as a concern. The literature review conducted at the beginning of the research revealed additional counter-productive

behaviors of anger outbursts, anxiety, communication, irritability, over activity, shifts in mood, excessive talking and lack of awareness of non-verbal social cues (American Heroes at Work, n.d.; Barnhill, 2007; Berney, 2004; Foden, 2008; Hurlbutt & Chalmers, 2002; Hurlbutt & Chambers, 2004; NAMI, 2010).

RO_2 was, "Develop behavioral management strategies that need to be learned by employers." All three focus groups described the first step in developing management strategies is for the employer to understand that most counter-productive behaviors have a cause. The cause may be due to an emotional or mental disability or it may be due to a personal difficulty in the employee's life. All three focus groups identified three main areas of knowledge needed by employers. The first was employers need to understand emotional and mental disabilities and how to recognize them. The second was employers need to know how to approach a person exhibiting counter-productive behaviors in a non-threatening manner. The third was employers need to know the benefits to the company achieved by offering modifications and accommodations to the employee.

The focus group of professionals who support individuals with disabilities stressed the need for employers to understand that statistics show one in ten individuals have a disability; therefore every employer has employees with disabilities that have not been disclosed. This group also reported employers need education regarding the American with Disabilities Act and the employer's responsibility to these individuals.

The focus group of human resources personnel and supervisors urged the need for training materials and training opportunities for their companies. The group agreed that the front line supervisors were the people who manage the counter-productive behaviors. These individuals are the least likely to have training and often do not want to deal with

behaviors; they only want to focus on the job. The literature supports the information obtained from the focus groups. The literature concluded employment systems in the United States do not appear adequate or equipped to address the needs of individuals with mental disorders. It was explained there is a lack of training about mental disabilities for employers (Jans, Stoddard & Kraus, 2004; Hagglund & Heinemann, 2002).

RO_3 was, "Integrate the findings of counter-productive behaviors with behavior management strategies into a model that can be used to instruct employers in the management of counter-productive behaviors of employees." According to Engelbart (1962) developing a conceptual model means identifying essential components that need to be studied, the relationships of the components identified and how changes in the components or their relationship affect their functioning.

The research provided data regarding the knowledge and education employers and supervisors need to effectively manage employees. The human resources and supervisors' focus group reported there are several levels of management in companies and each level must recognize the need for the training. The first level is top management which is responsible for the overall well being of the company and makes the decisions regarding budget. The next level is middle management that carries out tasks and supervises the front line supervisors; human resources is typically in the middle management. The next level is the front line supervisors who manage the everyday workings of the company and the workforce personnel. These supervisors have day-to-day contact with employees and are the first to manage counter-productive behaviors. The core of the company is the employees who produce the goods and services of the company. Figure 3 shows the layers of a typical company. The outer group has very little

contact with the inner groups. Middle management is the line of communication from top management to front line supervisors, front line supervisors are the line of communication from the workforce personnel to the middle management. The Human Resources Department in middle management can be reached by the workforce personnel when needed.

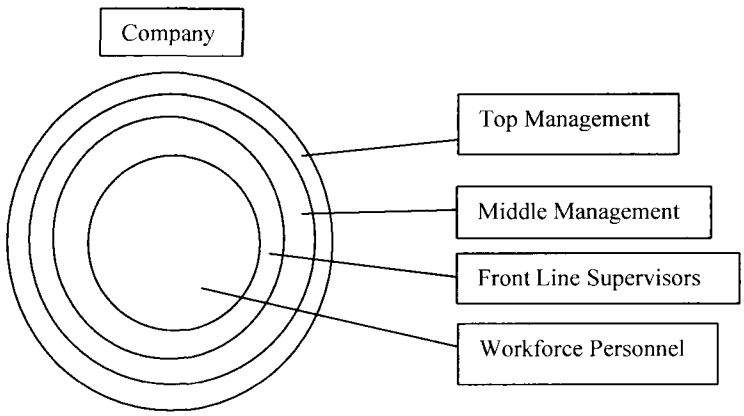

Figure 3. Most typical layers of management and employees of a company.

The difficulty in this company design is the lack of communication among the different levels. The top management develops the goals, strategies and production expectations for the company; however the top management team has little contact with front line supervisors and workforce personnel to know what is needed to meet the expectations. The middle management has direct contact with top management and front line supervisors, but has limited contact to know the needs of the workforce personnel to get the job accomplished. The front line supervisors are the main source of day to day contact with workforce personnel; they see what is needed for employees to meet the goals of the top management.

The front line supervisors have minimal authority to change work stations, schedules, breaks or make other accommodations that may be needed by an employee with emotional or mental disabilities. The front line supervisor must be willing to seek assistance from middle management in order to make accommodations. If the front line supervisor does not understand the needs of the employee, it is likely no help will be given which may result in counter-productive behaviors by the employee.

This research proposes a conceptual model for training employers to manage employee counter-productive behaviors and has two levels of training for a company. The first level is for top management and the second is for middle management and front line supervisors. Top management must acknowledge the need and benefits of the training for middle management and front line supervisors and approve the plan. Middle management and front line supervisors must acknowledge the need for assistance and be willing to learn.

This conceptual model is designed to use the core principles of the andragogical model of Knowles, Holton and Swanson (1998) in the presentation of the information. For adults to be invested in learning they must have a clear goal and purpose to engage in the process. Six core principles must be met for adults to be willing to engage in learning. Adults must know the necessity of learning something. They must have a self-concept that will allow self-directed learning. Adults use previous experiences as a basis for learning; therefore they must have background knowledge in the area of training. Adults will be ready to learn if there is a need to know how to cope or learn a new task. Adults learn what is centered on their lives and will only reach competency levels if the material presented pertains to them. Adult learning is intrinsically motivated; extrinsic motivation

is of little value. In addition, individual and situational differences of adults influences what each learns of the material presented.

In planning the specific framework for the training, the instructional design of Morrison, Ross and Kemp (2007) was incorporated into the model. A program developed to be offered as a single program for all businesses would not be productive for utilization in training employers to manage employees with counter-productive behaviors. In order for the training to meet the needs of the employer, the level of readiness of the middle management and front line supervisory staff must be determined.

In order to plan a valuable training session for a company, a survey should be distributed to top management, middle management and front line supervisors to obtain an assessment of their level of understanding of counter-productive behaviors and readiness to learn. The survey should query the knowledge each person has regarding emotional and mental disabilities, how to recognize counter-productive behaviors as a possible symptom of a disability, how counter-productive behaviors are managed and what training would be helpful to learn more about disabilities and the symptoms. The survey should be anonymous, but coded to determine the management group to which it was distributed. The responses of the surveys should be compiled, compared and analyzed for the areas of needed training in managing employee counter-productive behaviors. The training needs to meet the employers where they are in the process and not assume what the trainer has developed is what is needed.

The objectives of the company should be identified and made the objectives of the training. The type of instructional delivery and strategies should be developed specifically for the group targeted. The needs of the company and the needs of the

employee with counter-productive behaviors may vary from one business to another. There may be similarities, but all individuals from top management to workforce labor determine the true successes and needs of the company. Each company will be different.

Objectives for the training should be developed from this research and then tailored to meet the needs of an individual company through the use of the survey results. Objectives for top management determined by this study were: 1) obtain knowledge of profitability of training, 2) obtain knowledge about laws mandating hiring, 3) obtain knowledge about laws mandating accommodations and 4) obtain approval for the training of middle management and front line supervisors.

This study revealed objectives for middle management and front line supervisor training. These objectives were: 1) identify counter-productive behaviors, 2) obtain knowledge of possible causes of counter-productive behaviors, 3) obtain knowledge of possible accommodations and modifications and 4) evaluate understanding and willingness to implement strategies in the workplace. These objectives should be used as a basic foundation for the training with specific information obtained from the survey added.

Instructional strategies must be developed in order to meet the objectives of both groups. Using andragogical principles, instructional strategies for training were developed and should be used as a guide. Additional strategies should be added after the results of the survey have been determined. The instructional strategies were: 1) present information in multiple modalities, 2) present goals of training and encourage individuals to develop personal goals for the training, 3) encourage exploration of the necessity of learning, 4) encourage self-reflection to determine prior knowledge and beliefs, 5) allow

for previous experiences to be explored and integrated into the training and 6) draw from individual and situational influences to encourage learning.

In order to meet the objective of obtaining knowledge of the profitability of training, top management will need to know the necessity of learning this information. Facts and figures showing that humans are recognized as a valued resource for business and the most competitive resource available is a high-knowledge, multi-skilled workforce should be presented. The fact that innovative approaches for recruitment, retention, training and employee relations is imperative for the company to meet annual goals should be emphasized (ASTD, 2003). Training is a vital part of human capital.

When targeting the objective of obtaining knowledge about laws mandating hiring, those laws should be presented and explained. One fact is that the United States Congress is actively pursuing avenues to increase the education and employment of women, minority groups and the disabled (USEOC, n.d.). Section 504 of the Rehabilitation Act of 1973 protects qualified individuals from discrimination in the workplace. Top management must acknowledge that the law requires an employer to make reasonable accommodations including modifying work schedules, reassignments to another available position and providing modifications to work tasks for all individuals with a disability who requires the provisions (Americans with Disabilities Act, 1990).

The fourth objective of obtaining approval for additional training should be targeted during the summary discussion of the training. The previous three objectives target the need of additional training.

After training of top management is completed, an evaluation should occur to determine if the objectives were met, if the content was appropriate and the reactions to the presentation. The training should then be revised as needed.

The training for middle management and front line supervisors should be developed as soon as approval from top management is given. The first objective to be targeted is to identify employee counter-productive behaviors. This study determined the most frequent counter-productive behaviors were high absenteeism, inappropriate social skills, difficulty concentrating, negativity and impulsivity. In conjunction with the learning the facts, the employees should be encouraged to assess their personal responses and beliefs about these behaviors.

The second objective is to obtain knowledge of possible causes of counter-productive behaviors. This study determined that there are two possible causes. One is personal stressors in life of a family illness or crisis, financial hardship or other short term incidents. The behaviors from personal stressors are generally resolved quickly. The second cause of counter-productive behaviors is emotional or mental disabilities of the employee. The most prevalent of these are attention deficit hyperactivity disorder, autism spectrum disorder, mood disorders including bi-polar and depression and post traumatic stress syndrome. These mental health disabilities have similar symptoms and many of them share the same symptoms. The most prevalent symptoms are anger outbursts, anxiety, difficulty communicating, impulsivity, irritability, lack of focus, lack of social skills, over activity, shifts in mood, startle response, talking excessively and unawareness of social cues. Table 16 shows a comparison of the disability and the symptoms.

Table 16

Similarities of Mental Health Disorder Symptoms

Symptoms	Disabilities				
	ADHD	Autism	Bi-polar	Depression	PTSD
Anger Outbursts		*			*
Anxiety		*	*	*	*
Difficulty Communicating	*	*			*
Impulsivity	*		*		
Irritability			*		*
Lack of Focus	*	*	*	*	*
Lack of Social Skills		*	*		
Over Active	*		*		
Shifts in Mood	*	*	*	*	*
Startle Response				*	*
Talking Excessively	*	*	*		
Unaware of Social Cues	*	*			

The next objective for middle management and front line supervisors is to obtain knowledge of possible accommodations and modifications for employees with counter-productive behaviors. The most frequent accommodations noted in this study were flexible breaks and flexible scheduling. Other strategies reported to be useful were creating task lists, modifying workspace, relocating worker to a different workspace, use of ear phones to block out noise and use of a mentor. It was also determined that employees do not request accommodations or modifications for fear of retribution on the job. During the presentation of the modifications and accommodations, discussion and reflection should occur as to the advantages and disadvantages of each strategy.

The last objective determined from this study was to evaluate the understanding and willingness to implement the strategies in the workplace. Although this is listed last,

contemplation of this concept should be encouraged during the entire training. A summary and conclusion would be developed during this time.

In order for training of employers to manage employees with counter-productive behaviors traits to be successful, the training must target the core principals of andragogical learning. Each level of the training must refer to how adults learn and what they need to ensure the material being presented is being accepted and will be utilized. This model provides the necessity of learning the information, encourages the learning to apply previous experiences, encourages the learner to examiner personal beliefs and provides opportunity to assimilate the information into life outside of work. Figure 4 provides a visual model of the training.

A broad syllabus should be developed for use in the training. Appendix G provides a sample syllabus. The syllabus would target the data obtained from the research yet be flexible in order to add information obtained from the survey. A comprehensive curriculum should be developed in order to obtain facts, data and strategies to be presented in the training.

Recommendations

Recommendations for implementing the conceptual model and for further research related to this study have been recognized. When the model is implemented, reliability and validity studies should be completed utilizing professionals and individuals similar to the ones who took part in this study. Edits and revisions should be made as determined by the studies. Broad syllabi for the proposed training should be developed and planned in a manner that would allow it to be changed in order to target individual needs of different companies.

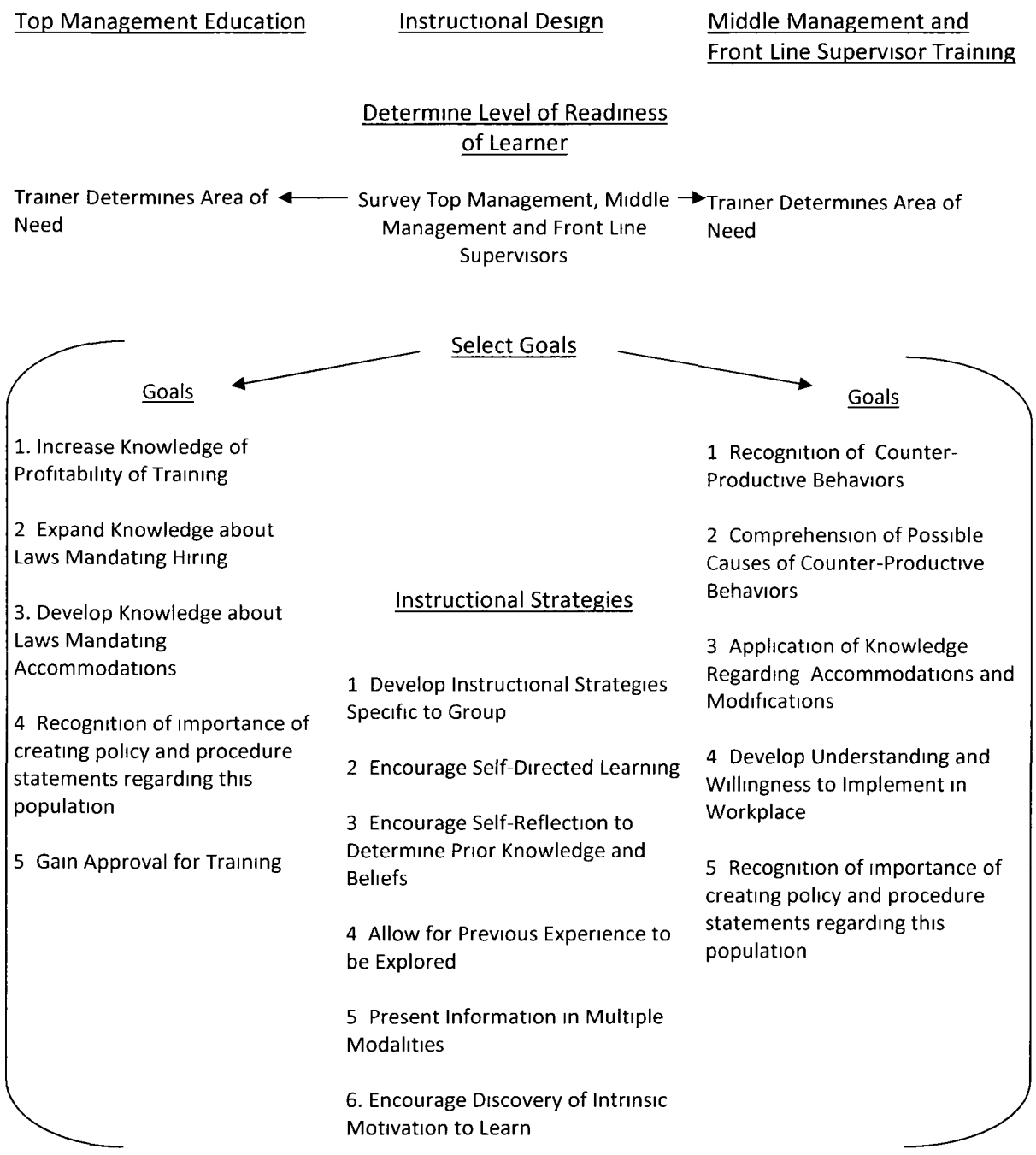

Figure 4. Conceptual model for training employers to manage employee counter-productive behaviors. Designed using Knowles et al., 1998 and Morrison et al., 2007

Future research is indicated from this study. For this study, information regarding the training of top management needed was obtained from middle management and literature. Top management individuals should be surveyed or interviewed to obtain information regarding their knowledge of employee counter-productive behaviors and how it affects the workplace. The research would provide information as to additional training top management requires in order for them to understand employees in the company. The training would also provide knowledge to encourage additional support training for middle management and front line supervisors.

Additional research using this study in a larger geographic area should be conducted to determine the needs of businesses in more populated and rural areas. Comparisons of the three should be completed to determine if a state or national model for training employers to manage employees with counter-productive behaviors is warranted. Another study would research the needs of small businesses and individual proprietorships regarding their ideas of hiring individuals with disabilities and their willingness to offer accommodations and modifications.

Another study should determine the level of training offered by employers to new employees and correlate the length of employment in the company to the level of training offered in the beginning. This study determined employees received one to two days of training before being expected to do the job alone. Individuals with mental health disabilities reported a very short length of employment in these companies. An additional study would be to evaluate whether individuals who worked a short amount of time before leaving the company presented with the counter-productive behaviors related to emotional and mental disabilities.

This study did not include information regarding gender and age of individuals with counter-productive behaviors. In order to determine whether or not these variables are indicators of counter-productive behaviors, a study should be conducted. The study should analyze differences of behaviors in males and females and across ages of each. The findings should be stratified in order to make appropriate recommendations.

In order to evaluate for researcher bias, a study should be conducted using the method of investigator triangulation. This process would require several individuals to conduct the focus groups and then compare findings for similarities and differences. The study in this paper used data triangulation obtained from one researcher.

After training from this conceptual model has been implemented in several companies, a follow-up study should be completed to determine the effectiveness of the training. The study should focus on the usefulness of the training in reducing employee counter-productive behaviors. It should also focus on continued needs of the front line supervisors and employees with mental or emotional disabilities.

REFERENCES

Adler, D., McLaughlin, T., Rogers, W., Chang, H., Lapitsky, L. & Lerner, D. (2006). Job performance deficits due to depression. *American Journal of Psychiatry, 163*, 1569-1576.

Adult ADHD: Attention Deficit Hyperactivity Disorder in Adults. (2010). *Adult ADHD: A misunderstood potential*. Retrieved from http://www.adultadhd.net/.

AFL-CIO Working for Americans Institute. (2010). *The workforce development act*. Retrieved from http://www.workingforamerica.org/documents/workforce.htm.

American Heroes at Work. (n.d.). *Frequently asked questions about post-traumatic stress disorder (PTSD) and employment*. Retrieved from http://www.americasheroesatwork.gov/forEmployers/factsheets/FAQPTSD/.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Text Revision*. Washington, DC: American Psychiatric Association.

American Society for Training and Development. (2003). *The human capital challenge: A white paper by the ASTD public policy council*. Retrieved from http://www.astd.org/NR/rdonlyres/94B67899-27AD-4826-9B8C-EA3A2D486E66/12999/HCWPcolor.pdf.

American Society for Training and Development. (2009). *Policy brief*. Retrieved from http://www.astd2009.org/government.

Autism at Work. (2010). *Thinking in numbers: Who is most likely to employ those with autism.* Retrieved from http://autismatwork.org/?page_id=45.

Barklley, R. A. (2002). Major life activity and health outcomes associated with attention-deficit/hyperactivity disorder. *Journal of Clinical Psychiatry, 63*(12), 10-15.

Barnhill, G. (2007). Outcomes in adults with Asperger syndrome. *Focus on autism and other developmental disabilities, 22*(2), 116-126.

Bernfort, L., Nordfeldt, S. & Persson, J. (2008). ADHD from a socio-economic perspective. *Foundation Acta Pediatrica, 97,* 239-245.

Berney, T. (2004). Asperger syndrome from childhood into adulthood. *Advances in Psychiatric Treatment, 10*, 341-351.

Bernstein, A. J. (2002). *How to deal with emotionally explosive people.* New York, NY: McGraw-Hill.

Billstedt, E., Gillberg, C. & Gillberg, C. (2010). Aspects of the quality of life in adults diagnosed with autism in childhood: A population based study. *Sage Publications and The National Autistic Society, 15*(11), 7-20.

Bowden, C.L. (2005). Bipolar disorder and work loss. *The American Journal of Managed Care, 11*(3), 591-594.

Bowling, N.A. & Eschleman, K.J. (2010). Employee personality as a moderator of the relationships between work stressors and counterproductive work behavior. *Journal of Occupational Health Psychology, 15*(1), 91-103.

Bureau of Labor Statistics United States Department of Labor. (2010). *News release: The employment situation May 2010.* Retrieved from http://www.bls.gov/ news. Release/pdf/empsit.pdf.

Bush, P., Drake, R., Xie, H., McHugo, G., & Haslett, W. (2009). The long-term impact of employment on mental health service use and costs for persons with severe mental illness. *Psychiatric Services, 60*, 1024-1031.

Carroll, C.G. & Ponterotto, J. G. (1998). Employment counseling for adults with attention-deficit/hyperactivity disorder: Issues without answers. *Journal of Employment Counseling, 35*, 79-95.

Center for Disease Control. (2009). *Anxiety and depression.* Retrieved from http://www.cdc.gov/features/dsBRFSSDepressionAnxiety/.

Cimera, R. & Cowan, R. (2009). The cost of services and employment outcomes achieved by adults with autism in the United States. *Sage Publications and National Autistic Society, 13*(3), 285-302.

Coyne, J. & Marcus, S. (2006). Health disparities in care for depression possibly obscured by the clinical significance criterion. *American Journal of Psychiatry, 163*(9), 1577-1579.

Creswell, J.W. (2008). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (4th ed.). Thousand Oaks, CA: Sage Publishing, Inc.

D'Amico, D. (2011). Providing worker education and building the labor movement: The Joseph S. Murphy Institute of City University of New York. *Adult Learn, 22*(1), 12-17.

Dench, C. (2005). A model for training staff in positive behavior (sic) support. *Learning Disability Review, 10*(2), 24-30.

Domzal, C., Houtenville, A. & Sharma, R. (2008). *Survey of Employer Perspectives on the Employment of People with Disabilities: Technical Report.* (Prepared under

contract to the Office of Disability and Employment Policy, U.S. Department of Labor). McLean, VA: CESSI.

Duggan, M. (2007). A capable workforce: Progress and problems. *Mental Health Review Journal, 12*(4), 23-28.

Edwards, R. & Stropper, M. (n.d.). Posttraumatic stress disorder: Causes, symptoms, treatment and diagnosis. Retrieved from http://www.medicinenet. com/post traumatic_ stress_disorder/article.htm.

Engelbart, D. C. (1962). Augmenting human intellect: A conceptual framework. SRI Summary Report AFOSR, 3223. Retrieved from http://www.doujgengelbart.org/ pubs/augment-3906.html.

Eysenck, H. J., Arnold, W. J. & Meili, R. (1975). *Encyclopedia of psychology (Vol. 2).* London, England: Fontana Collins.

Fiske, S. T. & Taylor, S.E. (1991). *Social cognition* (2nd ed.). New York, NY: McGraw-Hill.

Foden, T. (2008). Adult employment: Strangers in a strange land. *IAN Community*. Retrieved from http://www.iancommunity.org/cs/articles/strange_land.

Fogarty, R.J. & Pete, B.M. (2004). *Social Cognition*. New York, NY: McGraw-Hill.

Fontana, D. (2000). *Personality in the workplace*. London, England: MacMillan Press, Ltd.

Furnham, A. (1992). *The role of individual differences in the workplace*. New York, NY: Routledge.

Garrison, D.R. (1997). Self-directed learning: Toward a comprehensive model. *Adult Education Quarterly, 48*(1), 18-33.

Gibbons, A. (2010). An alternative view of the instructional design process: A response to Smith and Boling. *Educational Technology, 50*(4), 16-26.

Gilbert, A.M., Olino, T.m., Houck, P., Fagiolini, A., Kupfer, D.J. & Frank, E. (2009). Self-reported cognitive problems predict employment trajectory in patients with bipolar disorder. *Journal of Affective Disorders, 124*, 324-328.

Goldberg, S., Killeen, M. & O'Day. (2005). The disclosure conundrum: How people with psychiatric disabilities navigate employment. *Psychology Public Policy and Law, (11)*3, 463-500.

Goleman, D. (1995). *Emotional intelligence*. New York, NY: Bantam.

Gradus, J. L. (2010). *Epidemiology of PTSD.* United States Department of Veterans Affairs, National Center for PTSD. Retrieved from http://www.ptsd.va.gov/professional/pages/epidemiological-facts-ptsd.asp.

Graetz, J. (2010). Autism grows up: Opportunities for adults with autism. *Disability and Society, 25*(11), 33-47.

Grandey, A. A., Tam, A. P. & Brauburger, A. L. (2002). Affective states and traits in the workplace: Diary and survey data from young workers. *Motivation and Emotion, 26*(1), 31-55.

Grandin, T. (2006). Making the transition from the world of school into the world of work. *Autism Research Institute*. Retrieved from http://www.autism.com/individuals/transition/htm.

Griffin, J., Greiner, B., Stansfeld, S. & Marmot, M. (2007). The effect of self-reported and observed job conditions on depression and anxiety symptoms: A comparison

of theoretical models. *Journal of Occupational Health Psychology, 12*(4), 334-349.

Hagglund, K. & Heinemann, A. (2002). *Handbook of applied disability and rehabilitation research.* New York, NY: Springer Publications.

Haisch, D. & Meyers, L. (2004). MMPI-2 assessed posttraumatic stress disorder related to job stress, coping, and personality in police agencies. *Stress and Health, 20*, 223-229.

Harteis, C. & Gruber, H. (2008). How important is intuition in the field of teaching? *Studies in the Education of Adults, 30*(2), 96-104.

Hastings, R. (2010). Can hiring one employee with a disability make a difference? *Society of Human Resource Management.* Retrieved from http://www.shrm.org/hrdisciplines/Diversity/Articles?pages?CanHiringOne Employee.aspx.

Hastings, R. (2010). Has the Americans with disabilities act made a difference? *Society of Human Resource Management*. Retrieved from http://www.shrm.org/hrdisciplines/Diversity/Articles/Pages/HastheADAMadeaDifference.aspx.

Heimlich, J. & Horr. (2010). Adult learning in free-choice, environmental settings: What makes it different? *New Direction for Adult and Continuing Education, 127*, 57-66.

Hendricks, D. (2010). Employment and adults with autism spectrum disorders: Challenges and strategies for success. *Journal of Vocational Rehabilitation, 32*, 125-134.

Higbee, J., Schultz, J. & Goff, E. (2010). Pedagogy of inclusion: integrated Multicultural instructional design. *Journal of College Reading and Learning, 41*(1), 49-66.

Hollon, S. & Ponniah, K. (2010). A review of empirically supported psychological therapies for mood disorders in adults. *Depression and Anxiety, 27,* 891-932.

Hung, W., Smith, T., Harris, M. & Lockard, J. (2007). Development research of a teachers' educational performance support system: The practices of design, development and evaluation. *Education Technology Research Development. (58)*1, 61-80.

Hume, K., Loftin, R. & Lantz, J. (2009). Increasing independence in autism spectrum disorders: A review of three focused interventions. *Journal of Autism Developmental Disorders, 39*, 1329-1338.

Hurlbutt, K. & Chalmers, L. (2002). Adults with autism speak out: Perceptions of their life experiences. *Focus on Autism and Other Developmental Disabilities*, *17*(2), 103-111.

Hurlbutt, K., & Chalmers, L. (2004). Employment and adults with Asperger syndrome. *Focus on Autism and Other Developmental Disabilities, 19*(4), 215-222.

Individuals with Disabilities Act Amendments of 1997. H. R. 5, 105th Cong. (1997).

Jans, L., Stoddard, S. & Krane, L. (2004). *Chartbook on mental health and disability in the United States; An InfoUse report.* Retrieved from http://www.infouse.com/ disabilitydata/mentalhealth/intro.php.

Jarvelin, K. & Wilson, T.D. (2003). On conceptual models for information seeking and retrieval research. *InformationResearch*, *9*(1). Retrieved from http://informationr.net /ir/ 9-1/paper163.html.

Jarvis, P. (2004). *Adult education and lifelong learning*. New York, NY: RoutledgeFalmer.

Job Accommodations Network. (2008). *Accommodation and compliance series: Employees with post traumatic stress disorder (PTSD).* Retrieved from http://askjan. Org/media/ptsd.html.

Kaplan, S., Bradley, J.C., Luchman, J. N. & Haynes, D. (2009). On the role of positive and negative affectivity in job performance: A meta-analytic investigation. *Journal of Applied Psychology 94*(1), 162-176.

Kennedy, R. & Harris, N.K. (2005). Employing persons with severe disabilities: much work remains to be done. *Journal of Employment Counseling, 9*(1), 1-17.

Kessler, R.C., Lane, M., Stang, P.E. & Van Brunt, D. L. (2008). The prevalence and workplace costs of adult attention deficit hyperactivity disorder in a large manufacturing firm. *Psychological Medicine, 39*(01). Retrieved from http://bps-research-digest.blogspot.com/2009/01/adult-adhd-leads-to-more-accidents and.html.

Kidd, S., Boyd, G., Bieling, P., Pike, S. & Kazarian-Keith, D., (2010). Effect of a vocationally-focused brief cognitive behavioural intervention on employment-related outcomes for individuals with mood and anxiety disorders. *Cognitive Behaviour Therapy (37)*4, 247-251.

Klein, D.N., Schwartz, J.E., Rose, S. & Leader, J.B., (2000). Five-year course and outcome of dysthymic disorder: a prospective, naturalistic follow-up study. *American Journal of Psychiatry, 157*, 931–939.

Knowles, M.S. (1989). *The making of an adult educator: An autobiographical journey.* San Francisco, CA: Jossey-Bass, Inc.

Knowles, M.S. (1995). *Designs for adult learning: Practical resources, exercises, and course outlines from the father of adult learning.* Alexandria, VA: American Society for Training and Development.

Knowles, M.S., Holton, E.F. & Swanson, R.A. (1998). *The adult learner: The definitive classic in adult education and human resource development.* Houston, TX: Gulf Publishing Company.

Krupa, T. (2007). Intervention to improve employment outcomes for workers who experience mental illness. *The Canadian Journal of Psychiatry, 52*(6), 339-345.

Kuhnle, C. & Sinclair, M. (2011). Decision mode as an antecedent of flow, motivational interference and regret. *Learning and Individual Differences, 21*, 239-243.

Lawer, L., Brusilovskiy, E., Salzer, M. & Mandell, D. (2009). Use of vocational rehabilitative services among adults with autism. *Journal of Autism Developmental Disorders, 39*, 487-494.

Lawrence, D.H., Alleckson, D.A. & Bjorklund, P. (2010). Beyond the roadblocks: Transitioning to adulthood with Asperger's disorder. *Archives of Psychiatric Nursing, 24*(4), 227-238.

Manos, M.J. (2010). Nuances of assessment and treatment of adhd in adults: A guide of psychologist. *Professional Psychology Research and Practice, 41*(6), 511-517.

Marmar, C. (2009). Mental health impact of Afghanistan and Iraq deployment: Meeting the challenge of a new generation of veterans. *Depression and Anxiety, 17*, 493-497.

McGough, J. & Barkley, R.A. (2004). Diagnostic controversies in adult attention deficit hyperactivity disorder. *American Journal of Psychiatry, 161*(11), 1948-1056.

McKenzie, D., Clarke, D., Franzcp, Forbes, A., Sim, M., Fafom & Ffom. (2010). Pessimism, worthlessness, anhedonia and thoughts of death identity DSM-IV major depression in hospitalized, medically ill patients. *Psychosomatics, (51)*4, 302-311.

MedicineNet.com. (2010). *Attention Deficit Hyperactivity disorder: ADHD in adults.* Retrieved from http://www.medicinenet.com/adhd_in_adults/article.htm.

Merriam, S.B., Caffarella, R. & Baumgartner, L. (2007). *Learning in adulthood: A comprehensive guide*. San Francisco, CA: Jossey-Bass Publishers.

Merrill, S. (2008, June). Training the trainer: Strengthen learning by getting the most out of your newfound presenters. *Training + Development*, *12*(1), 28-31.

Meyer, R. & Deitsch S. (1996). *The clinician's handbook: Integrated diagnostics, assessment, and intervention in adult and adolescent psychopathology.* Boston, MA: Simon and Schuster Company.

Miller, L. (1994). Civilian post-traumatic stress disorder: Clinical syndromes and psychotherapeutic strategies. *Psychotherapy*, *31*(4), 665-664.

Moncrieff, J. & Timimi, S. (2010). Is ADHD a valid diagnosis in adults? No. *British Medical Journal, 340*, 547-551.

Morrison, G., Ross, S. & Kemp, J. (2007). *Designing Effective Instruction.* Hoboken, NJ: John Wiley & Sons, Inc.

Nadeau, K.G. (2005). Career choices and workplace challenges for individuals with ADHD. *Journal of Clinical Psychology (JCLP)/In Session, 61*, 549-563.

Nair, R. & Moss, S. (2009). Management of attention-deficit hyperactivity disorder in adults: focus on methlphenidate hydrochloride. *Neuropsychiatric Disorders Treatment, 5*, 421-432.

National Alliance on Mental Illness. (2010). *Bipolar Disorder*. Retrieved from http://www.nami.org/PrinterTemplate.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23037.

National Institutes of Health. (2007). *Fact sheet: Post-traumatic stress disorder*. Retrieved from http://www.nih.gov/about/researchresultsforthepublic/PTSD.pdf.

National Institutes of Health. (2009). *What is post-traumatic stress disorder or PTSD?* Retrieved from http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd/what-is-post-traumatic-stress-disorder-or-ptsd.shtml.

National Institute of Mental Health. (n.d.). *Bipolar disorder*. Retrieved from http://www.nimh.nih.gov/health/publications/bipolar-disorder/complete-index.shtml.

National Institute of Mental Health. (2010). *The numbers count; mental disorders in America*. Retrieved from http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.

National Library of Medicine. (2010). *Medline: Depression*. Retrieved from http://www.Nlm.nih.gov/medlineplus/ency/article/003213.htm.

NeuroPsychiatry. (2001). *ADHD in adults: Definition and diagnosis*. Retrieved from http://www.neuropsychiatryreviews.com/feb01/npr_feb01_adhd.html.

Nutt, D., Fone, K., Asherson, P. Bramble, D., Hill, P., Matthews, K., Morris, K., Santosh, P., Sonuga-Barke, P., Taylor, E., Weiss, M. & Young, S. (2007). Evidence-based

guidelines for management of attention-deficit/hyperactivity disorder in adolescents in transition to adult services and in adults: recommendations from the British Association for Psychopharmacology. *Journal of Psychopharmacology, 21*(1), 10-41.

O'Connor, T. (2000). *Managing the mental wellness of your employees: SHRM white paper*. Retrieved from http://www.shrm.org/Research/Articles/Articles/Pages/CMS-000177.aspx.

Patton, E. (2009). When diagnosis does not always mean disability: The challenge of employees with attention deficit hyperactivity disorder (ADHD). *Journal of Workplace Behavioral Health, 24*, 326-343.

Patton, M.Q. (2002). *Qualitative Research & Evaluation Methods*. Thousand Oaks, CA: Sage Publications, Inc.

Petty, D. (1997). Employer attitudes and satisfaction with supported employment. *Focus on Autism and Other Developmental Disabilities, 12*(1), 35-47.

Ponton, M., Derrick, M. G. & Carr, P. (2005). The relationship between resourcefulness and persistence in adult autonomous learning. *Adult Education Quarterly, 55*(2), 116-126.

Post, E. (1992). *Emily Post: Etiquette* (15th Ed.). New York, NY: Harper Collins.

Rabb, M. & Laborde, S. (2011). When to blink and when to think: Preference for intuitive decisions results in faster and better tactical choices. *Research Quarterly for Exercise and Sport, 82*(1), 89-98.

Richardson, L., Frueh, C. & Acierno, R. (2010). Prevalence estimates of combat-related post-traumatic stress disorder. *Australian and New Zealand Journal Of Psychiatry, 44,* 4-19.

Sanders, B. (2005). *Understanding psychiatric disabilities*. Retrieved from SHRM website: http://www.shrm.org/Research/Articles/Articles/Pages/ CMS_ 0149 13. Aspx.

Schaller, J. & Yang, N. (2005). Competitive employment for people with autism: Correlates of successful closure in competitive and supported employment. *Rehabilitative Counseling Bulletin, 49*(1), 4-16.

Simon, G.E., Ludman, J., Unutzer, J., Operskalski, B.H. & Bauer, M.S. (2008). Severity of mood symptoms and work productivity in people treated for bipolar disorder. *Bipolar Disorder, 10,* 718-725.

Smylie, M.A. & Wenzel, S.A. (2006). *Promoting instructional improvement: A strategic human resource management perspective*. Chicago, IL: Consortium on Chicago School Research.

Society of Human Resource Management. (2006). *Counseling: What approach should be taken when dealing with an employee who is a good performer with a poor attitude?* Retrieved from http://www.shrm.rot/TemplatesTools/hrqa/Pages/ CMS_018973.aspx.

Specialist People Foundation. (n.d). *About*. Retrieved from http://www.specialistpeople. Com/about/.

Strine, T., Mokdad, A., Balluz, l., Gonzalez, O., Crider, R., Berry, J. & Kroenke, K. (2008). Depression and anxiety in the United States: Findings from the 2006

behavioral risk factor surveillance system. *Psychiatric Services, 59*(12), 1383-1390.

Sturm, R., Gresenz, C., Pacujla, R. & Wells, K. (1999). Labor force participation by persons with mental illness. *Psychiatric Services, 50*, (11), 1402-1412.

Swanson, R. & Holton, III, E. (2001). *Foundations of human resource development*. San Francisco, CA: Berrett-Koehler Publishers, Inc.

Tachibana, C. (2009). Autism seen as asset, not liability, in some jobs: A new movement helps hone unique traits of disorder into valuable skills. *MSNBS.com*. Retrieved from http://msnbc.msn.com/id/34047713/ns/health-mental_health.

Tani, P., Newton, N. & Kaur, A., (2006). Clinical neurological abnormalities in young adults with Asperger syndrome. *Psychiatry and Clinical Neurosciences, 60*, 253-255.

The Presidents' New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, executive summary.* Publication No. (SMAO-3831).

Toossi, M. (2002, May). A century of change: The U.S. labor force, 1950-2050. *Monthly Labor Review*, 15-28.

United States Census Bureau. (2000). *Disabilities and American families 2000: Census 2000 special reports.* Retrieved from http://www.census.gov/prod/2005pubs/censr-23.pdf.

United States Census Bureau. (2007). *American FactFinder; 2006 American Community Survey*. Retrieved from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=.

United States Department of Health and Human Services. (2006). *Fact sheet: Your rights under Section 504 of the Rehabilitation Act*. Retrieved from http://www.hhs.gov /ocr/civilrights/resources/factsheets/504.pdf.

United States Department of Justice. (2009). *Americans with Disabilities Act of 1990, As Amended.* Retrieved from http://www.ada.gov/pubs/adastatute08.htm#top.

United States Department of Labor. (1973) *Section 504, Rehabilitation Act of 1973*. Retrieved from http://www.dol.gov/oasam/regs/statutes/sec504.htm.

United States Department of Labor Bureau of Labor Statistics. (2010). *Occupational outlook handbook, 2010-2011 edition: Counselors*. Retrieved from http://www.bls.gov/oco/ocos067.htm.

Unites States Department of Labor Office of Disability Employment Policy, America's Heroes at Work. (n.d.). *Post-traumatic stress disorder (PTSD) & employment.* Retrieved from http://www.americasheroesatwork.gov.

United States Department of Labor Office of Disability Employment Policy. (2008). *Survey of Employer Perspectives on the employment of people with disabilities: Technical report*. Retrieved from www.dol.gov/odep/documents/survey_report_ jan_09.doc.

United States Equal Opportunity Commission. (n.d.). *ADA Amendments Act of 2008.* Retrieved from http://www.eeoc.gov/laws/statutes/adaaa.cfm.

United States Equal Opportunity Commission. (2008). *Facts about the Americans with Disabilities Act*. Retrieved from http://www.eeoc.gov/facts/fs-ada.html.

United States Office of Disability Employment Policy. (1992). *The Americans with Disability Act Public Law No.101-336*. Washington, D.C.: United States Department of Labor, Office of Disability Employment Policy.

United States National Institute of Medicine. (2010). *Medline Plus: Depression.* Retrieved from http://www.nlm.nih.gov/medlineplus/ency/article/003213.htm.

Vasser, N. (2010). Instructional design process and traditional colleges. *Online Journal of Distance Learning Administration, 13*(4), 1.

Vella, J. (2002*). Learning to listen, learning to teach: The power of dialogues in educating adults*. San Francisco, CA: Jossey-Bass Publications.

Werner J. M. & DeSimone, R. L. (2009). Introduction to human resource development. *South-Western Cengage Learning*, Retrieved May 28, 2009 from Sage database.

Willey, L.H. (1999). *Pretending to be normal.* London, England: Jessica Kingsley Publishers.

Wojecki, A. (2007). What's identity got to do with it, anyway? Constructing adult learner identities in the workplace. *Studies in the Education of Adults, 19*(1), 168-182.

Workforce Investment Act of 1998. P.L. 105-220, 105th Cong. (1998).

Wright, J.C. (2010). On intuitional stability: The clear, the strong and the paradigmatic. *Cognition, 115,* 491-503.

Young, A. S., Klap, R., Shoai, R. & Wells, K. B. (2008). Persistent depression and anxiety in the United States: Prevalence and quality of care. *Psychiatric Services, 59*(12), 1383-1391.

Zelman, A. W. (2002). Nurturing intuition through group learning. *New Directions for Adult and Continuing Education, 54,* 33-41.

APPENDIX A
QUESTIONS FOR INDIVIDUALS WITH COUNTER-PRODUCTIVE BEHAVIORS

Focus Group I

I. Introduction and Purpose (15 minutes)

A. "I want to thank each of you for taking time to participate in this focus group to assist with my research. As I stated when we spoke on the telephone, I am a doctoral student at Old Dominion University and my field of interest is counter-productive behaviors in the workplace. This research concerns barriers to employment for individuals, particularly ones diagnosed with Autism Spectrum Disorder, bi-polar disorder, post-traumatic stress disorder and Adult Attention Deficit Hyperactivity Disorder who exhibit counter-productive behaviors in the workplace. Our group session will be confidential. I will take notes during the interview and it will be digitally recorded. The recording will be destroyed at the end of the project. Your name or identifying information will not be shared in the writings or discussions of the interview. I encourage each of you to maintain the confidentiality of what is said in this session. I hope that you will also gain knowledge and insight during the session. Do you have any questions?"

B. "In order to facilitate the meeting and have a positive outcome, I have developed several guidelines for the session:

1. Please respect the confidentiality of each participant by not quoting or attributing comments to anyone outside of the group.
2. For the session to be valuable, everyone must participate.

3. Discussion and disagreement are encouraged; there are no right or wrong answers and no need to reach a consensus.
4. Only one person should speak at a time; there should be no side conversations.
5. Only group results will be reported; no individual or agency names will be identified. Any questions?"

C. Please introduce yourself to the group by giving your name. If you are comfortable with disclosing any diagnosis you have that may contribute to counter-productive behaviors in the workplace, please provide that information.

II. Topic Discussion (90 minutes total)

1. Please describe your current employment and how you obtained the position.
2. What type of training did you receive for your current position?
3. Please identify and describe any behavior you have that results in counter-productive behaviors in the work place.
4. Please describe accommodations or modifications in the workplace that would assist you in managing the counter-productive behaviors.
5. Please describe the knowledge you believe your employer and co-workers have regarding the counter-productive behaviors and the willingness of the employer to assist you in your job.
6. What are your suggested strategies for employers to better deal with your condition?

III. Wrap Up (10 – 15 minutes)

"I appreciate your participation in this focus group. I hope that each of you gained more insight into the barriers of employment for individuals with counter-productive behaviors. I will provide copies of the report from this segment of my research to each of you. If you have any questions or comments about the session today, please feel free to talk with me."

APPENDIX B
QUESTIONS FOR SUPPORT WORKERS FOR EMPLOYEES WITH COUNTER-PRODUCTIVE BEHAVIORS

Focus Group II

I. Introduction and Purpose (15 minutes)

A. "I want to thank each of you for taking time to participate in this focus group to assist with my research. As I stated when we spoke on the telephone, I am a doctoral student at Old Dominion University and my field of interest is counter-productive behaviors in the workplace. This research concerns barriers to employment for individuals, particularly ones diagnosed with Autism Spectrum Disorder, bi-polar disorder, post-traumatic stress disorder and Adult Attention Deficit Hyperactivity Disorder who exhibit counter-productive behaviors in the workplace. Our group session will be confidential. I will take notes during the interview and the session will be digitally recorded. The recording will be destroyed at the end of the project. Your name or identifying information will not be shared in the writings or discussions of the interview. I encourage each of you to maintain the confidentiality of what is said in this session. I hope that you will also gain knowledge and insight during the session. Do you have any questions?"

B. "In order to facilitate the meeting and have a positive outcome, I have developed several guidelines for the session:

1. Please respect the confidentiality of each participant by not quoting or attributing comments to anyone outside of the group.
2. For the session to be valuable, everyone must participate.

3. Discussion and disagreement are encouraged; there are no right or wrong answers and no need to reach a consensus.
4. Only one person should speak at a time; there should be no side conversations.
5. Only group results will be reported; no individual or agency names will be identified. Any questions?"

C. Please introduce yourself to the group by giving your name, the business you represent and your title.

II. Topic Discussion (90 minutes total)

1. Please identify and describe any behavior exhibited by your clients that result in counter-productive behaviors in the workplace.
2. Please tell if these clients have disclosed whether they have an identified medical diagnosis and if so, the name of the diagnosis.
3. Please describe your clients' perspective of strategies used in the workplace in managing the counter-productive behaviors.
4. Elaborate on whether or not the strategies used were effective and why.
5. What type of training would be beneficial to employers in learning how to manage employees with counter-productive behaviors?
6. What has been your experience with employers regarding the willingness to make accommodations and modifications for employees with counter-productive behaviors due to a medical diagnosis?

7. What are strategies for accommodating these behaviors?

III. Wrap Up (10 – 15 minutes)

"I appreciate your participation in this focus group. I hope that each of you gained some new information regarding the barriers of employment for individuals with counter-productive behaviors. I will provide copies of the report from this segment of my research to each of you. If you have any questions or comments about the session today, please feel free to talk with me."

APPENDIX C
QUESTIONS FOR EMPLOYERS OF EMPLOYEES WITH COUNTER-PRODUCTIVE BEHAVIORS

Focus Group III

I. Introduction and Purpose (15 minutes)

A. "I want to thank each of you for taking time to participate in this focus group to assist with my research. As I stated when we spoke on the telephone, I am a doctoral student at Old Dominion University and my field of interest is counter-productive behaviors in the workplace. This research concerns barriers to employment for individuals, particularly ones diagnosed with Autism Spectrum Disorder, bi-polar disorder, post-traumatic stress disorder and Adult Attention Deficit Hyperactivity Disorder who exhibit counter-productive behaviors in the workplace. Our group session will be confidential. I will take notes during the interview and it will be digitally recorded. The recording will be destroyed at the end of the project. Your name or identifying information will not be shared in the writings or discussions of the interview. I encourage each of you to maintain the confidentiality of what is said in this session. I hope that you will also gain knowledge and insight during the session. Do you have any questions?"

B. "In order to facilitate the meeting and have a positive outcome, I have developed several guidelines for the session:

1. Please respect the confidentiality of each participant by not quoting or attributing comments to anyone outside of the group.
2. For the session to be valuable, everyone must participate.

3. Discussion and disagreement are encouraged; there are no right or wrong answers and no need to reach a consensus.
4. Only one person should speak at a time; there should be no side conversations.
5. Only group results will be reported; no individual or agency names will be identified. Any questions?"

C. Please introduce yourself to the group by giving your name, the business you represent and your title.

II. Topic Discussion (90 minutes total)

1. Does your business currently employ individuals with disabilities? If yes, please describe the types of disabilities.
2. What concerns does your company have regarding the hiring of individuals with disabilities which are not physical in nature?
3. Please identify and describe any behavior exhibited by employees that results in counter-productive behaviors in the workplace.
4. Please tell if these employees with the behaviors have disclosed whether they have an identified medical diagnosis and if so, the name of the diagnosis.
5. Please describe strategies used in the workplace in managing the counter-productive behaviors.
6. Elaborate on whether or not the strategies used were effective and why.

7. What type of training does your business offer to managers and supervisors in dealing with employees with counter-productive behaviors?
8. What has been discussed at your business regarding the willingness of employers to make accommodations and modifications for employees with counter-productive behaviors due to a medical diagnosis?

III. Wrap Up (10 – 15 minutes)

"I appreciate your participation in this focus group. I hope that each of you gained more insight into the barriers of employment for individuals with counter-productive behaviors. I will provide copies of the report from this segment of my research to each of you. If you have any questions or comments about the session today, please feel free to talk with me."

APPENDIX D
INFORMED CONSENT DOCUMENT

I, _____ agree to be a participant in a focus group for the research study "A Conceptual Model for Employer Training to Manage Counter-Productive Employee Behaviors." I understand the research is a study being completed by Naomi Rock, Ph.D. Candidate in Education, to fulfill the requirements of the STEM Education and Professional Studies Department at Old Dominion University. I understand that Dr. John Ritz is the professor and Responsible Principal Investigator of the study. I may contact him at 757-683-5226 with questions or concerns regarding the study.

I have been informed that all personal information provided by me will be held in the strictest confidence and identifying information will be safely secured until the study is complete and then it will be destroyed. I have been advised that if at any time during the study I am uncomfortable with a question, I may willingly choose to not answer. If at any time I become uncomfortable with the events of the focus group, I understand I may choose to leave with no resistance from the researcher.

I understand that information I provide, other than personal information, will be used in the study to collect data regarding needs of employers and employees in the work place. I have been advised there is no monetary reimbursement for participation in the study. I have been informed of the necessity of keeping all identifying information about other participants in the group confidential. I will not share their information with anyone outside of the focus group and I understand they have been advised not to share my information. I understand that the researcher, Responsible Principal Investigator and Old Dominion University will not be responsible for any actions of the focus group participants. I voluntarily agree to be a participant in the focus group.

_____ _____

Name Date

_____ _____

Researcher Date

APPENDIX E
LETTER TO FOCUS GROUP PARTICIPANTS

Naomi S. Rock
XXXXXX
Blue Ridge, VA 24064
540-977-XXXX (home)
540-224-XXXX (office)
540-309-XXXX (cell)

(Name of Participant)
(Address)

(Date)

Dear (Name):

I would like to thank you for agreeing to be a participant in a focus group as part of my dissertation research. As we discussed on the telephone, I am a doctoral student at Old Dominion University and my interest area is in counter-productive behaviors of employees in the workplace.

The goal of the focus group is to obtain information regarding the major types of counter-productive behaviors in the workplace and management strategies needed to assist with the behaviors. The focus group will provide information from your perspective regarding the behaviors and needs of the employee and employer.

The focus group will be held on XX-XXX at XX-XX. The group will meet at (location name and address).

Please contact me if you have any questions or if a conflict develops and you will not be able to attend. I look forward to participating with you in the focus group and obtaining valuable information.

Sincerely,

Naomi S. Rock, M.Ed.

APPENDIX F
EMAIL TO FOCUS GROUP PARTICIPANTS

Thank you again for agreeing to be a participant in my dissertation study. This is a reminder that the meeting will be held at 11:30a.m. on XXXX. The meeting will be held in the conference room at XXXX.

Please call if you have questions or if you will not be able to attend the group meeting.

Thank you again,

Naomi S. Rock
540-XXX-XXXX

APPENDIX G
SYLLABUS FOR TOP MANAGEMENT AND FRONT LINE SUPERVISORS OBJECTIVE 1

Course Description

This course will provide participants and opportunity to identify employee counter-productive behaviors in the workplace. Participants will examine how the behaviors affect the workplace and work production. Participants will also examine his/her personal responses and beliefs about behaviors.

Course Objective

The participant will identify counter-productive behaviors in the workplace and will assess his/her responses and beliefs about the behaviors.

Resources

Resources for the class will be provided by the instruction. Reading from peer reviewed journals will be provided and discussed.

Activities

Using multi-modalities of instruction, participants will take part in interactive activities to reach the following goals:

1. Explore the need to information about counter-productive behaviors.
2. Identify counter-productive behaviors in the company, from research and literature.
3. Assess personal reactions to counter-productive behaviors and how that affects.
4. Explore previous experiences with counter-productive behaviors.
5. Identify benefits of obtaining knowledge regarding possible causes of counter-productive behaviors

Wrap-up Activities

Participants will be led to review what was learned during the session, how it can be used in the workplace and subjects that need further training.

Evaluation

Participants will be asked to complete an evaluation of the training session.

VITA

Naomi Spickard Rock
Old Dominion University
Darden College of Education
Norfolk, VA 23529

Education

Ph.D. in Education, Old Dominion University, May 2011

M.S. in Special Education, Lynchburg College, May 1999

B.S. in Social Work, Radford University, May 1977

Licensure and Certification

Virginia Department of Education, Teaching License in Special Education and Sociology

Autism Diagnostic Observation Schedule, Certification to Administer

Professional Experience

Education Consultant, Child Development Clinic, Virginia Department of Health, Roanoke, VA, 2003-present

Special Education Teacher, 1994-2003, Substitute and At-Risk Teacher, 1982-1994, Botetourt County Public Schools, VA

Administrative Assistant, Bowers Building, Roanoke, VA, 1982-1991

Children's Protective Service Worker, West Virginia Department of Social Services, Kanawha County, WV, 1980-1981

Instructor/Counselor, Goodwill Industries of America, Charleston, WV, 1978-1980

Counselor, Children's Help and Involvement for Progress, Inc., Radford, VA 1977-1978

Publication

Rock, N. S. (2009). Adult learning in the workplace. *Journal for Workforce Education, (1)*2, 21-26.

Professional Memberships

Iota Lambda Sigma Honor Society
American Society for Training and Development
Association for Career and Technical Education