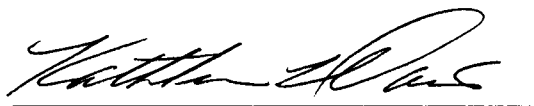


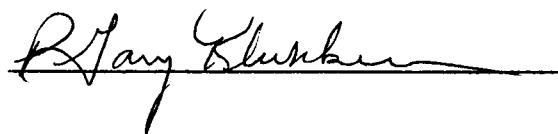
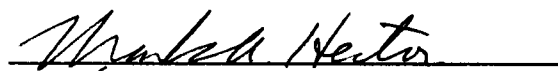
To the Graduate Council:

I am submitting herewith a dissertation written by Scott Elton Anderson entitled "The Effect of Coping Skills Training on the Self-efficacy Expectations of Alcohol Abusers." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Education.



Kathleen L. Davis,
Major Professor

We have read this dissertation
and recommend its acceptance:



Accepted for the Council:



Vice Provost
and Dean of the Graduate
School

THE EFFECT OF COPING SKILLS TRAINING
ON THE SELF-EFFICACY EXPECTATIONS
OF ALCOHOL ABUSERS

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Scott Elton Anderson

August 1988

ACKNOWLEDGMENTS

In the course of my dissertation research, a number of people have been of great help to me. I would like to thank Dr. Kathleen Davis, my committee chairperson, for her support, consultation, and critical reading of several drafts of this document. Appreciation is also extended to the other members of my graduate committee, Dr. Mark Hector, Dr. Kenneth Newton, and Dr. Gary Klukken, for their interest and assistance.

I am also grateful to the many individuals who contributed their services and skills, oftentimes at considerable personal inconvenience, to make completion of this study possible. This includes the raters of the ASB, Deb Heinzl, Ed Reitz, and Lorene Heuvalman; the group leaders, Dawn Bluhm, Paula Danilovics, and Margaret O'Leary; the data collection coordinators, Greg McCabe and Jay Keeney; and Dr. Alan Sodetz, who provided the lecture portion of the training program. I would also like to thank the clients and staff of both treatment centers for their willingness to support and participate in this study.

Finally, I want to extend a special thank you to my friends and colleagues who have offered their support and encouragement throughout the course of my graduate

training. I am especially grateful to my wife, Karen, whose love and understanding have helped me through the times when I didn't think I would finish. I have also benefited from the love and support of my children, Sarah and Cheri, whose presence has made the completion of this document more meaningful and has helped me keep balance and perspective in my life. I would also like to thank my parents and parents-in-law who have believed in me and patiently supported me through many years of training. I am especially indebted to my father who taught me the value of hard work and perseverance in accomplishing life's tasks.

ABSTRACT

This study investigated the utility of a coping skills training program for increasing the self-efficacy expectations, coping skills, and self esteem of alcohol abusers. Fifty two clients at two residential substance abuse treatment centers served as subjects and were randomly assigned to either the treatment or control group. The coping skills training program utilized instruction, modeling, and behavior rehearsal to teach skills for dealing with negative emotional states, interpersonal conflict, and social pressure to drink. Subjects in the control group participated in lecture and discussion about the disease concept of alcoholism and the effects of alcoholism on the family. Each subject was administered the Situational Confidence Questionnaire (SCQ), the Rosenberg Self Esteem Scale (RSE), and the Adaptive Skills Battery (ASB) upon entering residential treatment, immediately following the experimental interventions, and again one week later. Multivariate analysis of variance was used to analyze the data. The results indicated that (a) there were not significant group differences between subjects in the coping skills training program and subjects in the lecture/discussion group on overall self-efficacy or self esteem, (b) there were significant differences between the two groups on the

negative emotions/frustrations subscale of the SCQ and on level of coping skill, '(c) there was a low but significant correlation between the SCQ and the ASB and between the SCQ and the RSE, and (d) both groups demonstrated significant improvement on all three dependent measures across time. These findings were discussed in relation to Bandura's (1977) self-efficacy theory and its application to an alcoholic population. Implications of the results for future research are also discussed.

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CHAPTER I

INTRODUCTION

Statement of Purpose

This study investigates the utility of a coping skills training program for increasing the self-efficacy expectations of substance abusers. The training program utilizes modeling and behavior rehearsal techniques to teach alcohol abusers specific coping skills for dealing with high-risk situations that have been identified as leading to relapse (Marlatt, 1978; Marlatt, 1985c; Marlatt & Gordon, 1980). The acquisition of coping skills is thought to alter self-efficacy expectations which affect the ability of individuals to adequately perform coping behaviors in high-risk situations. The impact of the training program on self esteem and level of coping skill will also be measured.

Introduction to the Study

The theoretical base for the proposed study is formed within the general framework of social learning theory, especially as it has been applied to the field of addictions. Some studies (Donovan & O'Leary, 1979;

Gottlieb, 1983; Leventhal & Cleary, 1980; Neff & Husaini, 1982; Pearlin & Radabough, 1976) indicate that substance usage is at least partially a response to stress. In addition, relapse often occurs in conjunction with stressful situations.

Marlatt and his colleagues (Marlatt, 1978; Marlatt, 1985c; Marlatt & Gordon, 1980) have conducted a series of studies in which they have attempted to identify those situations in which alcoholics are most likely to take a drink. On the basis of this research two major categories have been delineated, intrapersonal situations and interpersonal situations.

Self-efficacy expectations affect how individuals respond in various situations. The concept of self-efficacy was first proposed by Bandura (1977) as a means of explaining psychological change. He states that "self-efficacy is concerned with judgments about how well one can organize and execute courses of action required to deal with prospective situations that contain many ambiguous, unpredictable, and often stressful, elements" (Bandura, 1981, pp. 200-201). According to this theory, one may achieve behavior change by altering the level and strength of an individual's self-efficacy; in turn, Bandura has proposed that efficacy expectations determine whether or not a particular coping behavior will be initiated, how much effort will be expended, and how long

the behavior will be maintained. Four sources of information are thought to impact self-efficacy expectations: physiological state, verbal persuasion, vicarious information, and performance accomplishments. The latter two appear to have the greatest impact (Bandura, Adams, Hardy, & Howells, 1980; Bandura, Blanchard, & Ritter, 1969).

The training program employed in this investigation is similar to that used in other social skills training programs (Curran & Monti, 1982; Goldsmith & McFall, 1975; Ivey & Authier, 1978; Kazdin, 1974; Pentz, 1985) and will include several of the components identified by Bandura as impacting self-efficacy expectations. Other investigators (Chaney, O'Leary, & Marlatt, 1978; Donovan & Chaney, 1985; Eriksen, Bjornstad, & Gotestam, 1986; Hawkins, Catalano, & Wells, 1986; Lin, Bon, Dickinson, & Blume, 1982; Van Hasselt, Hersen, & Millionses, 1978; Watson & Maisto, 1983) have reported positive results from teaching social/coping skills to addicted persons. This investigation employs a unique treatment program which draws on cognitive behavioral techniques to teach addicted persons a set of skills for dealing with potentially high-risk situations for relapse. Social learning theory provides the rationale for the activities which are included in the training program.

Review of Literature

Theoretical explanations and research related to the development and treatment of addictions will be reviewed. Special attention will be given to research which examines the use of alcohol in response to stressful situations, the role of self-efficacy expectations, and the utility of coping skills training, as these concepts apply most directly to a social learning approach to addictions.

Approaches to Addiction

In recent years there appears to have been an emerging paradigm shift in the addictions field which "involves a movement away from understanding addiction primarily as a biologically based disorder (addiction as disease) toward a model that construes addictive behavior as an habitual maladaptive means of coping with stress" (Marlatt, 1985a, p. 367). In contrasting these two perspectives, Marlatt points out that the disease model emphasizes uncontrollable, endogenous biological processes as being the basis of addiction. Upon exposure to the drug, these processes take over and the individual soon develops a physical dependency characterized by tolerance to the effects of the drug and withdrawal upon cessation of drug use. Consequently, the addicted individual is seen as a victim of forces beyond his/her control who

cannot change the habitual use of the drug without external intervention.

The alternative perspective, labelled by Alexander and Hadaway (1982) as an "adaptive orientation," views the individual as actively engaged in the process of change. The organism is seen as capable of choosing to change its addictive behavior when more effective alternatives become available. This orientation does not ignore the significance of biological and drug factors in addiction but focuses on the interaction of psychological and physiological factors along with the role of the individual as a purposive organism who uses drugs as a means of coping with stress. Key to this approach is the assumption that the individual is capable of change and that psychological and learning factors play a central role in the change process (Marlatt, 1985a). The above formulation appears to have important implications for improving the therapeutic strategies used in the treatment of alcoholism and substance abuse.

As pointed out by Marlatt (1985b), disorders such as excessive drinking, smoking, overeating, or substance abuse can be conceptualized as overlearned habit patterns. He states that this category of addictive behaviors can include any compulsive habit pattern in which the individual seeks a state of immediate gratification. It is of further note that this initially pleasurable

experience, (e.g., a "high", tension reduction, or relief from withdrawal symptoms) is often followed by delayed negative consequences, such as disease, financial problems, or social disapproval. Addictive behaviors are seen as maladaptive to the extent that they lead to such delayed negative consequences. Additionally when these behaviors are performed in relationship to stressful or unpleasant situations, they represent maladaptive coping mechanisms. Thus, a broad range of addictive behaviors can be conceptualized as conforming to recognized principles of learning.

"Since addictive behavior problems are assumed to be acquired on the basis of learning maladaptive behavior patterns, there is general agreement among proponents of this model that common factors are involved in the acquisition and maintenance of these behaviors" (Marlatt, 1985b, p. 18). From this perspective, research which examines the efficacy of a particular treatment approach for one addictive disorder also has bearing on the treatment of other addictions.

Role of Stress in Addictive Behaviors

Wills and Shiffman (1985) postulate that substances are used as a coping mechanism in order to decrease negative affect and increase positive affect. There is some evidence that both alcohol use (Abrams, 1983) and

cigarette smoking (Leventhal & Cleary, 1980) serve the function of directly reducing stress. Positive affect is enhanced through the provision of physically pleasurable sensations and feelings of relaxation (Wills & Shiffman, 1985).

Factor-analytic studies (Gottlieb, 1983; Leventhal & Avis, 1976; McKennel & Thomas, 1967) have categorized the reasons people smoke into two areas. One is comprised of elements indicating that smoking is used to reduce anxiety and tension while the other is comprised of elements indicating that smoking is used for stimulation, sociability, or increased pleasure. Furthermore, it appears that the same individuals smoke for both reasons, depending on their originating affect and the situation. There is some evidence that individuals are able to self-regulate their physiological response to a given drug in order to produce either arousing or tranquilizing effects consistent with their present state of arousal (Wills & Shiffman, 1985).

Other researchers have found that positive expectations may increase the probability of drinking in stressful situations (Battistich & Zucker, 1980; Donovan & O'Leary, 1979; Marlatt, 1976; Rohsenow, 1983; Zarantonello, 1986). Farber, Khavari, and Douglass (1980) found that "escape" drinkers tended to be higher consumers of alcohol and that identified alcoholics tended to be

escape drinkers. Marlatt and Gordon (1980), in their retrospective study of relapsed drinkers, found that while the majority of relapse situations were related to stress or frustration, a number of relapses occurred in essentially positive social situations.

Partly in an effort to determine which situations might be especially stressful for persons with a drinking problem, several authors have attempted to delineate those situations which are likely to precipitate relapse in alcoholics. Litman, Eiser, Rawson, and Oppenheim (1977) identified negative mood states, environmental settings which had previously been associated with drinking, social-interpersonal anxiety, and decreased cognitive vigilance as high-risk situations. Another group of researchers (Cummings, Gordon, & Marlatt, 1980; Marlatt, 1978; Marlatt, 1985c; Marlatt & Gordon, 1980) found that certain emotional and situational factors seem to be especially likely to lead to relapse. In Marlatt and Gordon's (1980) study the three categories of situations which most frequently led to relapse were negative emotional states (38%), interpersonal conflict (18%), and social pressure to drink (18%). Annis and Davis (1987b) reported similar results, stating that the subjects in their study identified negative emotional states (39%), interpersonal conflict (17%), and social pressure to drink

(12%) as being their highest-ranked risk situations for drinking.

Using a representative sample of males and females, Timmer, Veroff, and Colten (1985) explored the links between life stress, feelings of helplessness, and the use of alcohol or drugs to cope. They focused specifically on personal and situational factors which affected subjects' responses to questions regarding the use of alcohol and drugs as a means of coping with feelings of stress. Their findings indicated that persons who felt more overwhelmed by life circumstances were more likely to use alcohol and drugs to cope with stress. The authors interpret this finding as support for Marlatt's (1979) hypothesis that a person's sense of personal efficacy is critical in determining whether he/she will cope with stress by turning to substance use. They state that their results "convey(s) the sense that alcohol or drug use for coping is a response of learned helplessness resulting from the feeling that the individual does not have control over the environment and that efforts made to change are essentially futile" (Timmer et al., 1985, p. 187). Other studies (Neff & Husaini, 1982; Pearlin & Radabough, 1976) have also found a relationship between stress and heavy alcohol use. However, the latter study found this effect primarily in individuals who rated themselves low in self-efficacy.

Self-efficacy Theory

According to Bandura (1977), two apparently divergent trends within the field of psychology work together to effect behavioral change. The first movement explains behavior in terms of cognitive processes which mediate change via the processing of direct, vicarious, and symbolic sources of information. The second holds that it is performance-based procedures which have proven themselves to be the most powerful means of effecting change. Bandura has attempted to reconcile these two positions by postulating that cognitive processes do indeed mediate change, but they are impacted most forcefully by mastery experiences arising from performance accomplishments. In other words, cognitive and behavioral processes act upon one another to effect psychological change. A change in cognition is likely to impact behavior and visa versa. Bandura has labelled these intervening cognitive processes as self-efficacy expectations.

In simple terms, efficacy expectations represent the subjective estimate that one has the ability to cope with a threatening situation by executing the behaviors required to produce the desired outcome. Efficacy expectations are distinguished from outcome expectations, which are defined as the person's belief that a particular

behavior will lead to a certain outcome. To the extent that a person's efficacy expectations of dealing with a particular high-risk situation are increased, the individual will be able to initiate and maintain alternative coping strategies in previously threatening situations.

According to Bandura (1977), mastery performance accomplishments in which the individual successfully engages in the feared activity produce the most significant changes in self-efficacy ratings, and research with phobic individuals seems to support this contention (Bandura, Adams, & Beyer, 1977; Bandura, Adams, Hardy, & Howells, 1980). This is thought to be due to the individual's self-observation of his/her improved performance and the perceived development of coping skills adequate for dealing with future difficult situations (Goldfried & Robins, 1982). Vicarious learning and verbal persuasion are thought to impact self-efficacy expectations to a lesser degree. Physiological state impacts self-efficacy in that many people experience decreased levels of performance under conditions of high arousal. Therefore, in anxiety-provoking situations they may not use the skills they possess to adequately meet the particular challenge.

According to Goldfried and Robins (1982), much of the initial work in the area of self-efficacy theory was done

with phobic individuals, but subsequent research has attempted to apply self-efficacy theory to issues such as achievement behavior (Brown & Inouye, 1978), assertiveness (Kazdin, 1979), smoking cessation (Condiotte & Lichtenstein, 1981), and physical stamina (Weinberg, Gould, & Jackson, 1979). Furthermore, many of the treatment methods (e.g., participant modeling, response prevention, and relaxation) used in addressing these problems seem very applicable to the treatment of addictive disorders.

Studies by Condiotte and Lichtenstein (1981), DiClemente (1981), and McIntyre, Lichtenstein, and Mermelstein (1983) support the relationship between self-efficacy expectations and relapse for smokers. Condiotte and Lichtenstein (1981) discovered that self-efficacy expectations at the end of treatment predicted abstinence from smoking over a three month follow-up period. At a five month follow-up, DiClemente (1981) found abstinent subjects to have reported significantly higher self-efficacy scores than did the relapsed subjects. Furthermore, a moderate correspondence was found between situations in which subjects rated themselves as having low self-efficacy expectations and situations in which they later relapsed. McIntyre et al. (1983) found that while pre-treatment self-efficacy ratings were unrelated to continued abstinence from

smoking, post-treatment ratings were significantly correlated with smoking status at all follow-up checks (i.e., 2, 3, and 6 months) except one year. At one year, smoking status was not related to self-efficacy ratings at either pre or post-treatment.

In their study of 145 female alcoholics, Rist and Watzl (1983) extended the exploration of the predictive utility of self-efficacy ratings into the field of alcoholism. The subjects provided self-efficacy ratings of their ability to resist drinking in various situations involving social pressure to drink. The subjects' level of general assertiveness in nondrinking situations was also assessed. These ratings of self-efficacy and general assertiveness were obtained both prior to and following a social skills training program which was included in a 3 month inpatient treatment program. At a 3 month follow-up, the authors found relapsed subjects to have judged themselves significantly lower in self-efficacy at pretreatment than subjects who did not later relapse. Ratings of general assertiveness were not predictive of outcome.

Further support for the idea that self-efficacy expectations are predictive of successful alcoholism treatment comes from the work of Litman and her colleagues (Litman, 1980, 1986; Litman et al., 1977). These investigators engaged in a series of studies which

explored (a) situations perceived to be dangerous for the individual, (b) coping strategies utilized in these situations, (c) the individual's perception of the effectiveness of these coping strategies, and (d) the individual's perception of their alcohol dependence. From the results of these studies, Litman (1986) concluded that the more effective abstainers believed they possessed more effective coping skills than did the relapsed subjects. They also identified fewer dangerous situations than did the less effective abstainers. Litman does not formally integrate the concept of self-efficacy into her model, but the importance of self-perception, especially as it relates to one's ability to cope with high-risk situations, is certainly emphasized.

According to self-efficacy theory, persons entering a high risk situation for alcoholic relapse begin a cognitive appraisal process which culminates in the formation of an efficacy judgement which in turn mediates actual drinking behavior (Annis & Davis, 1987a). This appraisal process consists of both a determination of whether the situation has previously been dealt with by excessive drinking and an assessment of the individual's current coping resources. In situations where coping resources are judged to be inadequate and in which drinking has been the dominant coping response in the past, the individual is likely to drink again (Marlatt,

1985a). From this point of view, treatment strategies which strengthen self-efficacy expectations through the development of alternative coping strategies in high-risk situations have the greatest likelihood of preventing relapse.

In a recent study, Annis and Davis (1987b) developed a treatment program based on the principles of self-efficacy theory. The focus of this treatment program was on having the client perform homework assignments in situations identified by the clients as high-risk. After performing a microanalysis of the client's past drinking behavior and current self-efficacy expectations in respect to high risk situations for relapse, the therapists constructed an individual hierarchy of drinking risk situations for each client. The 41 clients in this study then participated in eight outpatient counselling sessions over a three month period. Performance tasks were individualized and were designed to improve client self-efficacy. The authors reported significant improvement in self-efficacy at six month follow-up. They also reported dramatic decreases in drinking behaviors and marked improvement in physical health, cognitive and affective functioning, interpersonal relationships, vocation, and finances. Of particular interest is their finding that for the 10 clients who reported a heavy drinking episode (i.e., 5 or more drinks), self-efficacy

ratings at intake were predictive of the situation in which the relapse occurred in 60% of the cases.

A number of authors (Donovan & Chaney, 1985; Donovan & O'Leary, 1979; Rollnick & Heather, 1982; Wilson, 1978) have postulated that self-efficacy expectations about one's ability to perform adequately in high-risk situations may be a critical factor in determining treatment success. These authors have noted that many treatment programs rely heavily on individual and/or group insight-oriented therapies as primary intervention tools. They suggest, as does Bandura (1977), that these verbally mediated approaches, based on "verbal persuasion," are relatively ineffective in engendering a sense of self-efficacy. Rollnick and Heather (1982) believe that while these approaches may increase willpower or motivation to stay abstinent they do not provide the client with adequate skills to cope with high-risk situations for relapse and do not adequately enhance self-efficacy expectations. Therefore, it seems both necessary and appropriate to determine those therapeutic techniques which foster a sense of self-efficacy in addicted persons.

Coping Skills

Bandura (1977) has hypothesized that performance-based techniques have the greatest likelihood of positively

impacting self-efficacy expectations. These techniques are frequently utilized within programs which focus on social skills training as a therapeutic intervention. Social skills training has been defined as "a general therapy approach aimed at increasing performance competence in critical life situations" (Goldsmith & McFall, 1975, p. 51). As such, it falls within the framework of response-acquisition approaches to treatment. These approaches emphasize the educational aspects of treatment and focus on the learning of new skills as opposed to the elimination of existing maladaptive behaviors (Curran, 1985).

Theoretical support for social skills training comes from a variety of sources. As pointed out by Curran (1985), many neo-Freudians (Adler, 1935; Horney, 1939; Sullivan, 1953) stressed the role of interpersonal competence in psychological functioning. Subsequently, the work of social-learning theorists such as Bandura (1977) and Mischel (1973) has added to the theoretical foundation for social skills training.

Social skills training has been used as a treatment intervention in a wide variety of disorders with some degree of success (Curran & Monti, 1982). Among the populations to which social skills training has been applied are unassertive college students (Kazdin, 1974; McFall & Marston, 1970), couples with marital

difficulties (Fensterheim, 1972), psychiatric patients (Goldsmith & McFall, 1975; Hersen & Bellack, 1976), and sexual offenders (Abel, Blanchard, & Becker, 1974).

Curran (1985) has summarized the effectiveness of social skills training with these populations, and has attempted to explain the inconclusive results. He states that there is often an initial increase in social effectiveness after social skills training which is followed by some degree of regression at follow-up assessment. Curran also points out that interpretation of results is often difficult due to confounding from conjunctive treatment programs. He makes the observation that in studies where the ultimate goal of treatment is a change in some disordered behavior (e.g., alcohol abuse) there are often no concomitant changes in the targeted behavior despite an increase in social competency. Curran concludes by stating that studies of social skills therapy are often not well thought out or researched.

The relationship between social skills training, self-efficacy, and substance abuse has recently been explored by Pentz (1985). Citing a number of studies targeted at the reduction of smoking behaviors, Pentz (1985) points out that programs aimed at increasing the social competence of adolescents are effective in preventing the use of tobacco. As a result of her own investigation, Pentz (1985) found that self-efficacy and

social skills influenced one another in a manner consistent with Bandura's model of self-efficacy theory. Initial levels of self-efficacy appeared to mediate changes in social skills as well as influencing the impact of these skills on drug use. However, history of prior drug use and the inclusion of external drug influences (e.g., social sanctions for drug use) resulted in better prediction of drug use than social competence alone.

Pentz (1985) defines social competence training as the set of techniques used to improve self-efficacy and social skills. The most commonly employed techniques include modeling, rehearsal, feedback with social reinforcement, and extended practice. These techniques are intended to increase both self-efficacy expectations and social skills. Without high expectations of self-efficacy, attempts at performing a particular behavior are likely to be tentative and sporadic. This leads to ineffective performance. On the other hand, a high level of self-efficacy alone is not likely to produce satisfactory results if the person's behavioral attempts are inadequate due to a lack of practice. The results of a study by Pentz and Huba (1984) confirmed a relationship between social competence and drug use prevention.

There is some evidence that many alcoholic individuals can be characterized as having social skills deficits (Chaney, O'Leary, & Marlatt, 1978; O'Leary,

O'Leary, & Donovan, 1976). Miller and Eisler (1977) found that alcoholics had difficulty in expressing negative feelings. Chaney et al. (1978) also found that an inability to deal adequately with negative mood states, express feelings such as anger and resentment, and handle peer pressure within high-risk situations were related to alcoholics' post-treatment relapse. Cronkite and Moos (1980) reported a higher rate of abstinence among alcoholic patients who possess more effective general coping skills. Chelune and Parker (1981) point out that poor problem solving skills and a limited range of coping behaviors may lead to a resumption of drinking in stressful situations.

Further support for the notion that alcoholics and drug addicts experience a variety of skills deficits comes from the work of Miller and Eisler (1977). In their comparison of alcoholic and nonalcoholic psychiatric patients on self-report and behavioral measures of assertiveness, Miller and Eisler (1977) found that both groups were equally non-assertive on a behavioral role-playing test in situations which required saying "no" or expressing negative feelings to another person. Of additional interest is their finding that there was a negative correlation between scores on behavioral measures of these situations requiring negative assertion and alcohol consumption. Based on their review of the

literature which examined the psychosocial development and social skill acquisition of alcoholics, O'Leary et al. (1976) came to the conclusion that alcoholics seem to lack appropriate interpersonal coping behaviors and that relapse is often related to a deficit in skills for coping with interpersonal stress. They also found support for the idea that prealcoholic teenagers are less socially skilled than either light-drinkers or non-drinkers within their age group. O'Leary et al. (1976) concluded that therapeutic interventions designed to increase the alcoholic's repertoire of social skills should prove helpful in providing alternative responses to drinking in stressful situations.

Catalano, Hawkins, and Hall (1984) report that drug abusers within residential drug treatment centers evidence a deficit in social and coping skills. Likewise, other investigators have commented on the lack of social skills with various populations of drug abusers (Cheek, Tomarchio, Standen, & Albahary, 1973; Lindblad, 1977). Drug addicts are generally characterized as possessing low self esteem and as lacking the skills necessary for effective social performance (Kraft, 1968). Studies investigating the effectiveness of social skills training with alcoholics and drug addicts (Eriksen et al., 1986; Hawkins et al., 1986; Lin et al., 1982) have generally demonstrated positive results. However, these procedures

have often been used as either a component of a broad spectrum treatment program or alone in case study or single subject experimental designs (Van Hasselt et al., 1978). Therefore, it is difficult to make firm conclusions about the effectiveness of coping skills training with alcoholics.

Self Esteem

Although related, the concepts of self-efficacy and self esteem represent different phenomena (Bandura, 1984). Whereas self esteem pertains to one's evaluation of self-worth, self-efficacy refers to one's evaluation of specific capabilities in specific situations (Strecher, DeVellis, Becker, & Rosenstock, 1986). Bandura (1984) points out that individuals may consider themselves to be highly efficacious at an activity from which they derive no self-pride (e.g., taking out the garbage) or regard themselves as very inefficacious at a task but suffer no loss of self-worth (e.g., unskilled at playing horseshoes). However, he also points out that people often pursue and develop self-efficacy in activities which give them a sense of self-worth so that the two concepts become intertwined.

A number of authors have explored the relationship between alcoholism and self esteem (Brown, 1980; Charalampous, Ford, & Skinner, 1976; Connor, 1962;

Vanderpool, 1969; Williams, 1965). Generally these studies support the concept that alcoholics or alcohol abusers have poor self esteem and that self esteem is likely to improve with abstinence from alcohol. However, there is a dirth of research pertaining directly to the issue of the relationship between self-efficacy and self esteem within this population.

There is some evidence that alcoholics differ from nonalcoholic drinkers both in their overall level of self esteem and their level of self esteem after drinking. In a comparison of alcoholics and social drinkers, Brown (1980) found alcoholics to be more anxious, depressed, and possessing lower self esteem than social drinkers. Similarly, Charalampous et al. (1976) found that alcoholics scored significantly lower than nonalcoholics on the Rosenberg Scale of Self Esteem. In her comparison of alcoholics with outpatients at a community mental health center, Smith (1987) found a tendency for the alcoholic population to have lower self esteem scores. However, this relationship proved statistically nonsignificant. Using the Adjective Check List and Tennessee Self Concept Scale, Vanderpool (1969) found that alcoholics possess a generally poor self concept. Furthermore, it was discovered that the more the alcoholic drinks the more the self concept deteriorates along the following dimensions: self esteem, self-confidence, and

self-acceptance; adequacy; social worth; and tolerance to stress and strain (Vanderpool, 1969). In contrast, there is some evidence that drinking to subintoxication levels leads to an improvement in the self concept of social drinkers (Williams, 1965). On the other hand, Williams (1965) also found that problem drinking in his population of college students was positively associated with being self critical and negatively associated with being self-accepting.

Further evidence of the generally low self esteem of alcohol abusers is provided by Connor (1962) who discovered that alcoholics' self-descriptions revealed a lack of organization and integration of self. In addition, alcoholics' generally low self-evaluations were characterized by a lack of emphasis on adjectives such as capable and responsible. Nocks and Bradley (1969) found their alcoholic population showed a trend toward lowered self esteem as the duration of the drinking problem increased.

Beckman and Bardsley (1986) found that men were likely to drop out of treatment if they were depressed, possessed low self-esteem, and had low personal efficacy concerning alcohol use. In his one year follow-up study, Cernovsky (1983) found that abstinence from alcohol following treatment was positively associated with freedom in expression of feelings and self esteem. Rooney and

Volpe (1984) found an increase in the self esteem ratings of alcoholic women during the first thirty days of treatment.

As indicated in the above review, the relationship between self esteem and alcoholism has received some attention by researchers. However, the relationship between self-efficacy, self esteem, and coping skills remains virtually unstudied. It is hoped that the current study will shed some light on this issue and will guide future research and treatment strategies.

Rationale for the Study

Facilitating the long-term effects of treatment interventions is perhaps the greatest challenge facing professionals in the field of substance abuse today. Bandura (1977) has predicted that the strength of self-efficacy expectations is at least partially responsible for the maintenance of therapeutic change, and research in areas other than the addictions has supported the notion that self-efficacy expectations are an important variable underlying successful psychological treatment (Bandura, 1982; O'Leary, 1985). Recently, writers within the field of addictions have suggested that research needs to be conducted to determine the role of self-efficacy expectations in the recovery of substance abusers (Marlatt & Gordon, 1980; Rollnick & Heather, 1982;

Wilson, 1978). Subsequently, researchers working with addicted populations have begun to gather evidence that self-efficacy expectations are related to treatment success (Condiotte & Lichtenstein, 1981; DiClemente, 1981). However, the role of self-efficacy expectations in recovery from an addiction to alcohol and the specific methods for increasing these expectations have just begun to be explored (Annis & Davis, 1987b).

Furthermore, a growing body of literature seems to be pointing toward the reconceptualization of addictive behavior within a social-learning framework in which addictions are viewed at least partially as being a maladaptive means of coping with stress (Marlatt, 1985a). In this light, methods of improving substance abusers' ability to cope with stressful situations have received increasing attention. Initial research findings seem to support the utility of teaching coping skills as a means of preventing relapse (Chaney et al., 1978). This study will attempt to integrate these two trends within the field of alcohol addiction in order to improve treatment methods.

Current treatment strategies are often based on untested theoretical structures which may or may not be effective in assisting the recovery of addicted persons. Several recent authors (Rollnick & Heather, 1982; Wilson, 1978) have questioned the validity of the current

treatment approaches to alcoholism and emphasized the need to take a more scientific approach in the evaluation of alcohol treatment programs. Although some progress has been made in this regard, many of our present-day techniques remain untested. Wilson (1978) has argued that some of the most popular approaches to treating alcoholism (e.g., disease approaches) actually tend to minimize the alcoholic's self-efficacy expectations for coping with alcohol. Similarly, Rollnick and Heather (1982) point out that verbally mediated approaches such as insight-oriented therapies, including both group and individual modalities, fail to adequately equip clients with either the skills or self-efficacy expectations for dealing with high-risk situations for relapse. The present study attempts to apply a treatment strategy based on Bandura's (1977) self-efficacy theory to the treatment of alcohol abusers.

Numerous studies (Bandura et al., 1977; Kazdin, 1979; Weinberg et al., 1979) have demonstrated the usefulness of self-efficacy theory for guiding the development of treatment strategies with other populations. It is hoped that the results of this study will have implications for the development of treatment strategies useful for increasing the self-efficacy expectations of persons addicted to alcohol. This may impact the currently high relapse rates for this population.

Hypotheses

According to Bandura's theory, self-efficacy can be increased through the observation of models and the rehearsal of effective coping behaviors. Persons exposed to these treatment strategies are thought to develop a greater sense of self-efficacy than persons not exposed to these training methods. Similarly, it is expected that there will be a corresponding increase in both coping skills and self esteem for persons in the treatment group. Therefore, the following hypotheses are proposed:

Hypothesis I. Prior to their participation in the study, there will be no differences on the measures of self-efficacy expectations, self-esteem and coping skills between those alcoholics in the skills training program and those who are in the lecture/discussion program.

Hypothesis II. Immediately following the treatments, alcoholics in the skills training program will exhibit a greater increase in self-efficacy expectations as measured by the Situational Confidence Questionnaire (SCQ) than those in the lecture/discussion program.

Hypothesis III. One week after the treatments, alcoholics who participated in the skills training program will have higher self-efficacy expectations relative to pretest scores on the SCQ than those who participated in the lecture/discussion program.

Hypothesis IV. Immediately following the treatments, alcoholics in the skills training program will exhibit a greater increase in level of coping skills as measured by the Adaptive Skills Battery (ASB) than alcoholics in the lecture/discussion program.

Hypothesis V. One week after the treatments, alcoholics who participated in the skills training program will exhibit a higher level of coping skills relative to pretest levels on the ASB than alcoholics in the lecture/discussion program.

Hypothesis VI. Immediately following the treatments, alcoholics in the skills training program will exhibit a greater increase in self esteem as measured by the Rosenberg Self Esteem Scale (RSE) than alcoholics in the lecture/discussion group.

Hypothesis VII. One week after the treatments, alcoholics who participated in the skills training program will have higher self esteem relative to pretest scores on the RSE than alcoholics in the lecture/discussion group.

Hypothesis VIII. There will be a relationship between alcoholics' level of self efficacy expectations as measured by the SCQ and level of coping skills as measured by the ASB.

Hypothesis IX. There will be a relationship between alcoholics' level of self-efficacy expectations as

measured by the SCQ and level of self esteem as measured by the RSE.

Assumptions

The above hypotheses are predicated on certain assumptions: (a) self-efficacy expectations are accurately measured by the Situational Confidence Questionnaire; (b) self esteem is accurately measured by the Rosenberg Self Esteem Scale; and (c) coping skills are accurately measured by the Adaptive Skills Battery. In addition, it is assumed that the two different treatment centers will not differentially impact the participants in the study. Because the usual treatment programs include some of the same elements contained within the experimental intervention, it is assumed that the format and concentrated nature of the experimental intervention will be powerful enough to significantly impact the group participants beyond the effect of the usual treatment programs.

CHAPTER II

METHOD

Sample

Fifty-two persons, 39 males and 13 females, participated in this study. Each subject had been diagnosed as having an alcohol problem according to the criteria set forth in the Diagnostic and Statistical Manual for Mental Disorders, Third Edition (American Psychiatric Association, 1980). Persons receiving a diagnosis of either alcohol abuse or alcohol dependence were included in the study. Both classifications indicate an alcohol problem which requires treatment, and a diagnosis of alcohol abuse is often changed to alcohol dependence as more information becomes available to the clinical staff. Some subjects also had other substance abuse diagnoses. The subjects were admitted to one of two free-standing substance abuse treatment facilities located in the Midwest between October, 1987 and March, 1988. All of the subjects were 18 years of age or older. The average age of the subjects was 28. Forty-seven subjects were Caucasian, and four were Black; one subject was Hispanic.

Sample size was determined using a priori power analysis (Cohen, 1977). According to Cohen (1977), three factors impact the probability of detecting a treatment effect: (a) sample size; (b) the alpha level or significance criterion; and (c) effect size, which is the magnitude of the impact of the independent variable on the dependent variable. This study incorporated an experimental design which allowed for some control over extraneous variables; therefore, a relatively large effect size of .40 was chosen. A smaller effect size would have increased the likelihood of detecting very small effects of the experimental treatment but such small effects would be of little practical value in an applied setting. Using Cohen's (1977) sample size tables for the analysis of variance, with the recommended convention of .80 for power, .05 for alpha level, and .40 for effect size, it was determined that 26 subjects would be needed in each group. Therefore, 52 subjects were needed for the study.

Procedures

The group facilitators for the study were Master's level addiction therapists with over two year's experience in the field of substance abuse. A total of three group leaders participated in the study, but only two of the leaders participated in the study during a given experimental period. Originally, it was planned that only

two individuals would be required to lead the various groups; however, due to personal problems one of the group leaders was unable to participate during the entire course of the study. This necessitated the addition of a third therapist to lead a group during the final two intervention periods. Each of the therapists led both the experimental and control groups at various times in order to control for the effect of the leader's personality on the treatments. Each group leader spent some time reviewing the materials and tapes to be used in the two groups. They also discussed their planned presentation with the other group facilitators prior to leading the groups in order to standardize the information presented to the subjects.

All of the subjects who participated in this study were currently participating in residential treatment at one of two free-standing substance abuse treatment programs. Each of these programs operates on a standard 28-day inpatient treatment model which includes a variety of treatment activities such as individual and group counseling, alcohol education, skills training, and AA attendance. Upon successful detoxification and admission into the residential treatment program, each client was provided with a copy of the consent form (see Appendix A) and was asked if he/she would be willing to participate in the study. Only one subject indicated that he would not

be willing to participate in the study at this point. Following their agreement to participate in the study, the subjects were asked to complete the Situational Confidence Questionnaire, the Rosenberg Self Esteem Scale, and the Adaptive Skills Battery (see Appendix A). The questionnaires were read to subjects who were not able to read and understand the questions without assistance. The subjects then began the usual residential treatment program until the date of the experimental manipulation. On this date, the subjects were randomly assigned to either the coping skills training group or the lecture/discussion group.

Approximately once every five weeks a day was designated as the experimental period. On this day the clients currently involved in residential treatment were randomly assigned to one of the two groups, and the interventions were implemented. The experiment was conducted only once every five weeks in order to allow sufficient client turnover within the residential treatment centers, because both participating residential treatment centers operated on a 28 day model.

The experimental, coping skills training, and control, lecture/discussion, groups met at the same time in different rooms in order to eliminate the possibility of the members of the two groups communicating with each

other during the experimental period. Both groups were conducted during a four hour block of time.

Immediately following participation in one of the two groups, the subjects were asked to again complete the Situational Confidence Questionnaire and the Rosenberg Self Esteem Scale. Again, a reader was provided when needed. They were then asked to complete the Adaptive Skills Battery as soon as possible, usually within 24 hours. The subjects then continued with the usual residential treatment program as provided by the treatment centers.

One week following the experimental manipulation every participant was again asked to complete the three instruments. A short telephone interview was conducted approximately one month after the subjects' discharge from residential treatment.

The subjects in the experimental group and control group all followed the previously described procedures. The two groups differed with respect to the content of the material. The difference in content necessarily influenced the manner in which the material was presented. The specific content is described later in the treatment conditions section. The manner in which the specific content was presented to each group is described below.

Experimental Group

. The group began with the group leader introducing herself and describing the treatment program. The group participants were then asked to generate a list of situations which had led to their drinking in the past. Following a discussion of the role of situational factors in drinking, the videotaped introduction of the training program was viewed by the participants (see Appendix D for transcripts of videotapes). The group facilitator then reviewed the content and format of the training program, answered questions, and provided clarification as necessary. The group participants were asked to generate a personal list of situations which they thought might be problematic in the future or which had been associated with drinking in the past. They were then asked to group the situations on these lists into each of the three categories targeted in the training program, (i.e., negative emotional states, interpersonal conflict, and social pressure to drink). The subjects later used the situations on the lists during the behavior rehearsal portions of the training program.

The second segment of the coping skills training program began with the group participants viewing a videotaped lecture on negative emotional states. The group leader then reviewed the main points and skills presented in the videotaped lecture and provided the group

members with an opportunity to ask for further explanation and clarification. Videotaped vignettes were then viewed by the group participants (see Appendix C for procedures used to develop vignettes). The tape was stopped after each vignette to allow the group members to critique the model's use of the desired coping skills. The group leader facilitated these discussions and provided clarification as needed.

The next step involved a demonstration in which the group leader presented a personal situation in which she had experienced a negative emotional state. The group was asked to identify the activating event, irrational beliefs, and emotional consequences inherent in the situation. The group then worked to help the group leader use reality testing in order to "reframe" the situation and generate alternative beliefs. Finally, the group helped the facilitator to develop an action plan for dealing with the negative emotional state.

The group participants then divided into pairs and helped each other use the same process that had been previously demonstrated with the group leader. This step was intended as an opportunity for the group members to rehearse coping skills in situations which had previously caused them to experience negative emotional states.

The third segment began with the group participants viewing the videotaped lecture on dealing with

interpersonal conflict. Again, the group leader reviewed the main points presented and provided the group participants with an opportunity to ask for clarification or further explanation.

The group participants then viewed four videotaped vignettes which demonstrated the coping skills used in dealing with interpersonal conflict. Again, the tape was stopped after each vignette for discussion of the desired coping skills.

The group participants were then provided with an opportunity to rehearse their coping skills in interpersonal situations which they had identified as problematic. In preparation for doing this, the group was divided into triads, and it was explained that one member of the triad would attempt to utilize his/her assertiveness skills while the second member acted as an antagonist and the third member of the triad observed. The participants were instructed to make the situations as realistic as possible, and the observers were instructed to give their partners feedback as to their use of the desired skills. Each member of the triad was given an opportunity to be in each role, and it was emphasized that the practice sessions were to continue until the person in the primary role successfully utilized effective coping skills. The group facilitator "floated" among the groups providing assistance and feedback as necessary.

The fourth segment, like the others, began with the group participants viewing the videotaped lecture. This segment focused on dealing with social pressure to drink. Following a discussion of the videotaped lecture, the group participants viewed the videotaped vignettes in which models demonstrated coping skills for dealing with social pressure to drink. As with the previous segments, the tape was stopped after each situation, and the model's use of the desired skills was critiqued.

The group members were divided into groups and were asked to practice the coping skills in situations which they had previously identified as causing them difficulties in responding to social pressure to drink. They were again instructed to continue practicing the skills until they became effective in their use.

The training program concluded with the group facilitator processing the experience. She focused on the participants' subjective experience of using the coping skills presented in the program.

Control Group

This group began with the group leader introducing herself and describing the program in which the group members were about to participate. The group leader then presented a lecture on the disease concept of alcoholism. After facilitating discussion on this topic, the leader

showed the videotape described in the treatment section. The group members discussed their reactions to the film. Using a lecture format, the group leader then provided information about the alcoholic family system. She also facilitated discussion about families' reactions to an alcoholic family member prior to showing the second videotape. The general format consisted of the group leader presenting some information to the participants and then facilitating discussion of the information. The group participants were encouraged to discuss their reactions to the material after each section was presented.

Treatment Conditions

Experimental Condition

The training program was developed to teach coping skills for dealing with situations which might ordinarily precipitate drinking. The coping skills training program focused on three problem areas: (a) dealing with negative emotional states, (b) dealing with interpersonal conflict, and (c) dealing with social pressure to drink. These categories have been identified in previous research as particularly high-risk for persons addicted to alcohol (Annis & Davis, 1987a; Marlatt, 1985c; Marlatt & Gordon, 1980). The training format of the four hour intervention included instruction, modeling, and behavior rehearsal

with feedback. The format was very similar to the training procedures generally used in competency training programs (Curran, 1985; Curran & Monti, 1982; Ivey & Authier, 1978).

The instructional and modeling components of the program were presented through videotaped lectures and role plays. In the instructional component, the lecturer first described the type of problematic situation which might lead to drinking behavior and then presented various coping strategies for effectively dealing with that type of situation. These lectures were videotaped prior to the implementation of the study. Videotaped vignettes in which actors attempted to effectively deal with problematic situations were used to demonstrate the targeted coping skills. Generally the videotaped models demonstrated constructive coping strategies, although in three of the vignettes ineffective coping skills were demonstrated prior to the presentation of the more effective skills for comparative purposes. As with the lectures, the vignettes were videotaped prior to the implementation of the study (see Appendix C for the procedures used to develop the vignettes).

The behavior rehearsal with feedback portion of the treatment program was provided in vivo, as the group participants attempted to utilize the targeted coping

skills in personal situations that were role played with the other group members.

The instructional portion, lectures, of this program were presented by a counseling psychologist with approximately six years of experience in the field of substance abuse. The role played vignettes were a combination of situations developed specifically for this study and situations previously developed for teaching coping skills. The participants in these role plays were either actors or recovering alcoholics who were coached in the appropriate use of the desired techniques. A transcript of the videotaped lectures and role played vignettes is in Appendix D.

The videotaped introduction consisted of the lecturer identifying himself and describing the treatment program. He identified the three categories of situations which would be the focus of the program and described each briefly. The lecturer also described the activities which the participants would be asked to engage in during the course of the treatment program (i.e., discussion, observation, role play, and feedback).

The second segment of the coping skills training program focused on dealing with negative emotional states. The lecturer focused on three broad categories of negative emotions: anger, fear, and sadness. Following a description of these three emotions, Rational Emotive

Theory (Ellis, 1974) was presented as an explanation of emotional states and their precipitants. According to this theory, emotional states result from one's cognitions and interpretations of events rather than being a consequence of the events themselves. In addition, the concept of reality testing was presented to provide the group participants with some of the skills necessary for challenging their irrational beliefs. Reality testing involves asking oneself the following questions about a potentially upsetting situation: (a) What is my belief about this situation? (b) What data is there to support my belief? (c) Is there any other way to interpret the data? and (d) How do other people see this situation? The presentation concluded with an emphasis on the necessity of taking action to change unpleasant emotional states.

Four vignettes were used in this segment. Each of these vignettes presented an individual in a negative emotional state. In three of the vignettes a production technique was used in which the audio portion of the tape was dubbed over the video portion making it appear as if the viewer were listening to the actor's thoughts. In the remaining vignette the actor actually talked to herself to allow the listener to follow her thought processes.

The third segment of the coping skills training program focused on dealing with interpersonal conflict.

Assertiveness training (Wolpe & Lazarus, 1969) was chosen as the primary coping skill for this segment due to its demonstrated effectiveness in improving the social skills of a wide range of clients (Curran & Monti, 1982; Kelley, 1982). A videotaped lecture which distinguished among assertive, aggressive, and passive-aggressive behaviors was developed. Each of these three types of behavior was defined and was presented as alternative means of dealing with interpersonal conflict. After this presentation, the following skills for dealing effectively with interpersonal conflict were presented: (a) listening, (b) using effective nonverbal behaviors, (c) making "I" statements, (d) asking questions in a nonthreatening manner, and (e) discussing the behavior not the person.

Three vignettes were used in this segment, one of which demonstrated two types of commonly used ineffective responses (i.e., passivity and aggressiveness) and the more desirable assertive response to the same conflictual situation. The other two vignettes included examples of aggressive responses and more effective assertive responses in two different conflictual situations.

The fourth segment of the training program focused on dealing with social pressure to drink, that is, dealing with pressure from drinking friends and acquaintances. The lecturer pointed out that the skills taught in the previous training segments were also applicable to

situations involving social pressure to drink. The importance of challenging irrational beliefs and dealing with one's fears about what others might think of the person who no longer drinks was discussed. In addition, the following guidelines were presented for assertively dealing with pressure from others to drink: (a) use appropriate nonverbal behavior, (b) make a statement of appreciation, (c) make a statement of the problem, and (d) request a different behavior. Three vignettes followed the lecture and demonstrated how one might deal effectively with social pressure to drink.

After each of the second, third, and fourth segments of the training program, the group participants engaged in behavior rehearsal of the skills presented in that particular segment. The content of the behavior rehearsal varied according to the type of situation identified by a given individual as being problematic for himself/herself.

Control Condition

The control group also met for four hours. They listened to a lecture and participated in a discussion about the disease concept of alcoholism and the effects of alcoholism on the family. Two commercially produced videotapes were utilized in this experimental condition. One focused on the disease concept; the other focused on the generational nature of alcoholism.

Topics included in a brief introduction to the disease concept were (a) evidence that some people have a genetic predisposition to alcoholism, (b) the definition and nature of a disease, (c) the concept of cross-addiction, and (d) the effects of alcoholism on the family. Following this introduction, the film Disease Concept was shown.

Disease Concept focused on alcoholism as a disease. The film's lecturer first defined a disease as anything that interferes with the ability of a person to function normally. He then provided a more exact definition which described alcoholism as a disease characterized by a preoccupation with alcohol, by a loss of control over the amounts consumed, and by its progressive nature. The progressiveness of the disease and the idea that it is incurable were especially emphasized.

This film described alcoholics as people who are controlled by alcohol. The lecturer then talked about the causes of alcoholism, including the genetic factor. He presented evidence that tetrahydroisoquinoline (THIQ) plays an important part in determining who will become alcoholic. The film concludes with encouraging the alcoholic to take responsibility for his/her recovery even though he/she is not responsible for getting the disease.

The group members were asked to process reactions to the film and review some of the information contained

within the film. An emphasis was placed on the need for abstinence from all mood-altering substances. The role of THIQ was also stressed in relation to the addictive nature of alcohol for some persons. The group then spent some time processing their own feelings about being alcoholic in light of the information which had just been presented.

The group then turned its focus to the effects of alcoholism on the family. Family rules within the alcoholic family were discussed, and the alcoholic family was contrasted with the "healthy" family system. Rules such as don't talk, don't trust, don't feel were presented as being common in alcoholic families. The group members were asked for examples from their own experiences of how these rules might have been communicated. It was pointed out that in healthy family systems, family members take turns "being in the middle," (i.e., getting support and attention from the other family members). In the alcoholic family system, the alcoholic is always "in the middle." The alcoholic family was presented as a very closed system as opposed to the much more open system of a healthy family.

The discussion of family roles was followed by a presentation about the roles that various family members typically play within the alcoholic family (i.e., dependent, codependent, hero, scapegoat, lost child, mascot). Each of these roles was described along with the

function that each role serves within the alcoholic family. The group members were asked for examples throughout the presentation.

The participants then watched the videotape My Father's Son. This film was a dramatic portrayal of a 16 year old boy who was the son of an alcoholic. The young man attempts to lead a normal life despite the chaos of an alcoholic family. The film attempted to make children of alcoholics aware of their higher susceptibility to chemical dependence. The group concluded after discussing their reactions to this film.

Dependent Variables

Situational Confidence Questionnaire

The Situational Confidence Questionnaire (SCQ) is a self-report instrument designed to assess self-efficacy expectations in regard to one's ability to cope effectively with alcohol (Annis & Graham, in press). Subjects are asked to imagine themselves in a particular situation and rate themselves on a six-point scale, ranging from 0--not at all confident to 100--very confident (see Appendix A). The level of confidence indicated reflects how confident people are that they will be able to resist drinking heavily in the specific situation. The drinking situations included in this instrument are based on the eight-category classification

system derived from the work of Marlatt and Gordon (1980). These eight categories can be more generally divided into two major classes: intrapersonal situations and interpersonal situations.

The SCQ originally consisted of 100 items (Annis, 1982b) which paralleled the 100 drinking situations included in the Inventory of Drinking Situations (IDS; Annis, 1982a). Some items for the SCQ and IDS were taken from other questionnaires; some were developed from interviews with clinicians, former alcoholics, and alcoholic clients. Some items for the two questionnaires were based upon the recommendations of experienced clinicians and the results of preliminary testing with alcoholics entering an inpatient employee assistance program (Annis, 1982a). Further analysis led to the development of shorter, 42 items, forms of both the IDS and the SCQ (Annis, Graham, & Davis, 1987). Subsequent analysis has resulted in a 39 item version of the SCQ (Annis & Graham, in press).

The subjects in this study were administered the original SCQ, consisting of 100 items. However, the statistical analyses have been performed on the 39 items that comprise the latest revision of the instrument. The revised version of the SCQ was not available at the time the data was originally collected.

Annis and Graham (in press) have performed both exploratory and confirmatory factor analyses to determine the internal structure of the scale. First it was determined that the SCQ consisted of a multifactorial structure. Secondly, confirmatory factor analysis was conducted to determine the goodness of fit of the factors within the SCQ with three different hypothetical models. As a result of the first confirmatory analysis, three items were dropped from the instrument, leaving 39 items. A second confirmatory analysis resulted in a reformulation of the original eight categories. The resulting eight subscales were as follows: unpleasant emotions/frustrations, physical discomfort, pleasant emotions, testing personal control, urges/temptations, social problems at work, social tension, and positive social situations. A final confirmatory analysis was conducted which suggested the new model was marginally better than the previous model which consisted of eight slightly different subscales.

The second-order factor structure of the SCQ was also examined, and four different models were tested. A three-factor model consisting of positive situations, negative situations, and urges/testing best accounted for the correlations among the eight first-order factors (see Table B-1 for factor structure of SCQ-39).

Construct and criterion-related validity of the SCQ-39 have also been investigated. To investigate the construct validity, subscale scores were correlated with measures of alcohol consumption and social context of drinking. Although the correlations tended to be low, they were significant in the predicated direction. On three measures of alcohol consumption, the higher the level of drinking reported, the lower the level of self-efficacy. SCQ correlations with total quantity of alcohol consumed in the year prior to treatment intake ranged from $-.13$ to $-.23$ on the eight subscales. SCQ correlations with typical frequency of drinking days ranged from $-.12$ to $-.19$, and SCQ correlations with typical daily quantity consumed on drinking days ranged from $.04$ to $.20$.

Furthermore, Solomon and Annis (cited in Annis & Graham, in press) administered the SCQ, the Outcome Expectancy Scale (OES; Solomon & Annis, 1984), the Drinking Locus of Control Scale (DRIE; Donovan & O'Leary, 1978), the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and the Hopelessness Scale (HS; Beck, Weissman, Lester, & Trexler, 1974) to a group of 100 male alcoholics entering treatment. They found the relationship of the SCQ with these other instruments to be in the predicted directions based on Bandura's (1977) self-efficacy theory. Self-efficacy and

outcome expectancies were found to be relatively independent. The SCQ showed a significant but low correlation with both the OES score reflecting a client's perception of expected positive consequences once their drinking is under control ($r = .24$) and the OES score reflecting a client's perception of the negative consequences expected once their drinking is under control ($r = .21$). The authors found a moderate negative correlation ($r = -.45$) between the SCQ and the DRIE. Persons who indicated low levels of self-efficacy in their ability to resist the urge to drink tended to report that their drinking was attributable to external rather than internal causes. Correlations between the SCQ and BDI indicated that individuals who report low levels of drinking-related self-efficacy tend to report a greater degree of depression ($r = -.52$). People who reported low self-efficacy also had a tendency to see the future as more hopeless than individuals with high self-efficacy expectations as measured by the SCQ and the HS respectively ($r = -.37$).

Miller, Ross, Emerson, and Todt (as cited in Annis & Graham, in press) provide evidence that the SCQ could significantly discriminate between clients admitted recently to a treatment program and those who had been abstinent for a year. The abstinent clients had significantly higher scores on seven of the eight Marlatt

subscales. The authors report that 92% of the long-term abstainers and 65% of the new clients were correctly classified by a stepwise discriminant analysis which yielded a linear combination of the following three subscales: Unpleasant Emotions, Testing Personal Control, and Social Pressure to Drink. In addition, Solomon and Annis (as cited in Annis & Graham, in press) found that SCQ scores at the beginning of treatment were predictive of post-treatment average daily consumption for clients who drank following discharge. They report that for clients who drank during follow-up the SCQ score at intake accounted for 16% of the outcome variance in post-treatment average daily consumption.

Reliability data on the SCQ indicates that individuals respond consistently to the items within each subscale; internal reliability (Cronbach alpha) of each subscale ranges from .81 to .97. The reliability (Cronbach alpha) of the overall average score is .98, and the correlations between the individual items of the subscales and the total score for that subscale are moderate to high, ranging from .59 to .91.

Rosenberg Self Esteem Scale

Subjects were also administered the Rosenberg Self Esteem scale (RSE; Rosenberg, 1979) upon completion of detoxification at the treatment facility. This instrument

was chosen because of its reasonably strong psychometric properties, ease of administration, and brevity (Wylie, 1974). The RSE measures global self esteem. Subjects indicate whether they strongly agree, agree, disagree, or strongly disagree with a series of items which describe how a person might feel about himself/herself (see Appendix A). According to Rosenberg (1979), high self esteem, as measured by the RSE, indicates that the individual feels that he/she is a person of worth; however, these individuals do not necessarily consider themselves superior to others. Rosenberg (1979) states that low self esteem implies self-dissatisfaction and self-rejection as opposed to self-acceptance.

The RSE is a 10-item Guttman scale with reported Coefficients of Reproducibility of .90 (Giacquinta, 1975) and .92 (Rosenberg, 1979) and a Coefficient of Scalability of .72 (Rosenberg, 1979). Wylie (1974) stated that the reported Coefficients of Reproducibility seem to indicate adequate internal reliability, especially for such a short scale. Test-retest reliability after two weeks with college students is $r = .85$ to $.88$ (as cited in Rosenberg, 1979). Weiss (1978) reported coefficient alpha reliability of .75.

The construct validity of the scale has been examined via studies which have examined its relationship with depressive affect, anxiety, and peer-group reputation. A

very strong and consistent relationship was found between the RSE and a Guttman scale of depressive affect (Rosenberg, 1965). Only 4% of individuals with the highest self esteem scores on the RSE rated themselves as highly depressed; whereas, 80% of those with the lowest self esteem scores rated themselves as highly depressed. There was a very strong and consistent relationship between these two scales ($r = .30$). A strong relationship was also found between the RSE and psychophysiological indicators of anxiety (Rosenberg, 1965). Only 19% of those with the highest self esteem scores on the RSE reported a large number of these psychophysiological symptoms of anxiety while 69% of those with the lowest self esteem reported a large number of these symptoms ($r = .48$). Rosenberg (1965) also found that in his sample of high school seniors, those individuals with high self esteem were more likely to be selected as a leader by their peers, more likely to be involved in extracurricular activities, and more likely to be a club officer. A review of other related studies can be found in Wylie (1974).

In addition, studies by Silber and Tippet (1965) and Tippet and Silber (1965) have examined the convergent and discriminant validity of this instrument with confirmatory results. The convergent validity values between the RSE and self esteem measured by the Kelly Repertory Test, the

Heath Self-Image Questionnaire, and interviewer's ratings of self esteem were .67, .83, and .56 respectively.

Adaptive Skills Battery

The third assessment device used in this study was the Adaptive Skills Battery (ASB; Jones & Lanyon, 1981). This is a brief verbal role-playing measure of coping skills which are considered important for the maintenance of sobriety. It consists of 30 items representing potential relapse situations. The items are administered by cassette tape to insure standardization of administration. Subjects' responses are recorded separately on another cassette recorder and are subsequently scored using a three-point competency rating scale developed by the authors. A competent response, earning two points, is defined as one which maximizes positive gain and minimizes negative outcome in a particular problem situation (see Appendix B for examples). Examples of competent, intermediate, and incompetent responses have been agreed upon by independent judges. The ASB was developed according to the steps recommended by Goldfried and D'Zurilla (1969) in their discussion of methods for assessing competence. The first step involves generating problematic situations. Initially 70 situations that might prove problematic for alcoholics were described, and the difficulty and

potential frequency of each situation was then rated by 24 alcoholics. Next, the 46 items with the highest ratings were retained, and descriptions of these situations were recorded on cassette tapes and played individually to 5 alcoholics and 5 nonalcoholics. These ten subjects were asked to describe their typical responses to these situations, and their responses were recorded and scored. As a result, 16 items which failed to generate varied responses or which appeared to be repetitive were eliminated, leaving the 30 items in the ASB (Jones & Lanyon, 1981). In examining the validity of the ASB, Jones and Lanyon (1981) used an individual, behaviorally oriented, structured interview to assess treatment outcome. Trained raters rated each subject's interview on a scale of 1 to 5, ranging from totally abstinent after treatment to largely uncontrolled drinking after treatment. The correlation between the ASB scores and treatment outcome scores was highly significant ($r = -.52$).

Three raters were trained to score subject responses on the ASB. These raters were first given a copy of the scoring guidelines provided by the authors and were provided with three sample tapes to rate independently. After scoring the tapes, the raters met with the experimenter to compare ratings and discuss the rationale behind their scoring of individual responses. Particular

attention was given to discrepant responses in order to determine if different "rules" were being used by the different raters. Responses which received discrepant ratings were played for the group. Reference to the scoring guidelines (see Appendix B) and discussion among the raters resolved any differences, and through this process the raters established a consistent interpretation of the guidelines. The raters were then given three more tapes to rate independently. After doing this, the raters again met with the experimenter and discussed any discrepant responses. The raters appeared to be scoring responses consistently at this point. Cronbach alpha reliability coefficients for the three pairs of raters were as follows: rater one and rater two (.98), rater one and rater three (.98), rater two and rater three (.99).

For the study itself, each audiotaped ASB was rated by two trained raters. These two scores were then averaged to provide a single score for each administration of the instrument. A total of 156 tapes were rated by the raters, three tapes for each of the 52 subjects. Each tape was rated twice; therefore, each of the three raters scored a total of 104 tapes.

Design and Data Analysis

A randomized groups, pretest-posttest design was used in this study to examine the effects of the coping skills

training program on the following variables: (a) self-efficacy, as measured by the Situational Confidence Questionnaire, (b) self esteem, as measured by the Rosenberg Self Esteem Inventory, and (c) coping skills, as measured by the Adaptive Skills Battery.

The multivariate analysis of variance (MANOVA) method for repeated measures analysis was chosen for this study. O'Brien and Kaiser (1985) point out that univariate analysis, using a mixed-model approach, traditionally has been viewed as the preferred method of repeated measures analysis. While agreeing that "if all of its distributional assumptions are met, the mixed-model approach is the most powerful method for repeated measures analysis" (O'Brien & Kaiser, 1985, p. 316-317), the authors state that the assumptions on which this analysis are based are often violated. In particular, the assumption of sphericity among the repeated measures is unlikely in designs with more than two repeated measurements. O'Brien and Kaiser (1985) explain that compound symmetry, one form of sphericity, requires that the repeated measurements not only have equal population variances but also exhibit equal correlations between the pairs of measurements. In repeated measures designs, it is unlikely that the correlations between the measurements at the various administration times are equivalent. In the current study, this would mean that the variances of

the measurements at pre, post, and follow - up would have to be equal, and the correlations between measurements at pre and post, post and follow - up, and pre and follow - up would have to be equal. This appears highly unlikely, since the subjects are expected to demonstrate some degree of change across time. In conclusion, O'Brien and Kaiser (1985) state that "the researcher who uses a mixed-model approach to analyze data that violate sphericity is testing these hypotheses using a Type I error rate that exceeds the state alpha-level of the tests" (p. 317). Others also support this conclusion (e.g., Hearne, Clark, & Hatch, 1985). Separate MANOVA's were run on each dependent measure.

Subject's length of time in treatment prior to the experimental period was examined to insure that the two groups were equivalent on this factor. It was assumed that the usual residential treatment program would have some impact on participants' responses to the dependent measures.

CHAPTER III

RESULTS

The multivariate analysis of variance (MANOVA) method for repeated measures was used to analyze the data. Individual MANOVA's were conducted on each dependent variable. The dependent variables were self-efficacy expectations, coping skills, and self esteem as measured by the Situational Confidence Questionnaire (SCQ), Adaptive Skills Battery (ASB), and Rosenberg Self Esteem Inventory (RSE) respectively. Pillai's λ was chosen as the test statistic for this study due to its robustness against violations of assumptions that underlie the approximate F test (Olson, 1976).

As indicated in Table I, t tests were conducted on each of the pretest dependent measures in order to determine if any significant differences existed between the skills training (i.e., treatment) group and the lecture/discussion (i.e., control) group prior to the intervention. There were no significant pretreatment differences between the two groups on the SCQ ($t = -.74$, $df = 50$, $p = .462$), the ASB ($t = -1.07$, $df = 50$, $p = .291$), or the RSE ($t = .28$, $df = 50$, $p = .783$). Thus, the first

TABLE I

t Tests for Pretest Scores on the Situational
Confidence Questionnaire, Adaptive
Skills Battery, and Rosenberg
Self Esteem Inventory

Dependent Measure	Treatment Group		Control Group		<u>t</u>
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	
SCQ	56.31	23.44	61.77	29.35	-.74
ASB	31.69	10.25	34.52	8.82	-1.07
RSE	3.42	1.90	3.27	2.11	.28

hypothesis that prior to their participation in the study there would be no differences between the two groups on the measures of self-efficacy expectations, self esteem, and coping skills was not rejected. Furthermore, a t test was executed in order to determine if the two groups were equal in terms of the number of days in treatment prior to the intervention. This test revealed no significant difference between the two groups (t= .37, df= 50, p= .713). Therefore, length of time in treatment prior to the intervention was not included as a factor in subsequent analyses. The mean length of time in treatment prior to the intervention was 10.9 days for the treatment group and 10.1 days for the control group.

Hypothesis two predicted that alcoholics in the skills training group would exhibit a greater increase in self-efficacy expectations than those in the lecture/discussion group, and hypothesis three predicted that these differences would be maintained at a one week follow up. The MANOVA analyzing the SCQ data did not reveal any significant between group differences, $F(2, 49) = 1.20, p > .05$, indicating that the treatment group did not show significantly greater improvement at posttest and follow up than did the control group. Thus, hypotheses two and three were rejected.

The experimental intervention was designed to address three categories of high-risk situations in particular (i.e., negative emotional states, interpersonal conflict, and social pressure to drink). Therefore, separate analyses were also conducted on each of the eight SCQ subscales in order to determine if the subscales representing those categories which had been specifically targeted showed significant improvement when examined apart from the other subscales. The MANOVA for SCQ Subscale 1, Unpleasant Emotions/Frustrations, revealed significant differences between the two groups, $F(2, 49) = 3.73, p < .05$. No significant differences were found between the two groups on any of the other SCQ subscales (see Table E - I for SCQ subscale means). As a follow-up to the Subscale 1 MANOVA, univariate analyses of variance

(ANOVA's) were executed to determine if the between groups differences occurred due to posttest versus pretest differences or due to follow up versus pretest differences (see Table E - II). Pretest scores were used as the comparative scores for both posttest and follow up because no significant increases were expected from posttest to followup for either group. The ANOVA for post versus pre scores revealed a significant between groups difference, $F(1,50) = 6.94, p < .012$. The ANOVA for follow up versus pre scores did not reveal significant between groups differences, $F(1,50) = 3.48, p > .05$.

Hypothesis four predicted that alcoholics in the skills training group would exhibit a greater increase in level of coping skills than alcoholics in the lecture/discussion group, and hypothesis five predicted that these differences would be maintained one week after the treatments. The ASB requires trained raters to assess level of coping skill. In order to confirm the reliability of the ASB ratings Cronbach alpha correlation coefficients were obtained between each pair of raters. These correlations indicated a high degree of interrater reliability for the three pairs of raters (i.e., .97, .93, .97).

The MANOVA, comparing the two groups on level of coping skill, revealed a significant between groups difference, $F(2,49) = 4.05, p < .05$. As a follow-up to

the MANOVA, ANOVA's were carried out to determine if the between groups differences on level of coping skill, as measured by the ASB, occurred at posttest or follow up. As indicated in Table II, the two ANOVA's indicated that there was a significant effect for post versus pre scores, $F(1,50) = 7.93$, $p < .008$, as well as for follow up versus pre scores, $F(1,50) = 4.76$, $p < .05$. Thus, hypothesis four and hypothesis five were not rejected.

TABLE II

Analyses of Variance for Post Versus Pre
and Follow up Versus Pre Scores
on the ASB

Source	<u>df</u>	<u>SS</u>	<u>MS</u>	<u>F</u>
Post vs Pre				
Group Differences	1	705.24	705.24	7.93**
Error	50	4447.62	88.95	
Follow up vs Pre				
Group Differences vs Pre	1	514.08	514.08	4.76*
Error	50	5400.86	108.02	

* $p < .05$

** $p < .01$

Hypothesis six predicted that alcoholics in the skills training group would exhibit a greater increase in self esteem than alcoholics in the lecture/discussion group, and hypothesis seven predicted that these differences would be maintained at a one week follow up. A low score on the RSE indicates high self esteem. The RSE MANOVA did not reveal significant between groups differences, $F(2, 49) = 1.54, p > .05$. Therefore, hypotheses six and seven were rejected.

Examination of the mean scores for each dependent measure at each time of measurement indicated that both groups demonstrated significant improvement on all three measures over time (see Table III). Mean difference scores for each of the dependent measures can be found in Table IV.

Hypothesis eight predicted that there would be a positive relationship between self-efficacy expectations and coping skills level. Hypothesis nine predicted that there would be an inverse relationship between self-efficacy expectations and self esteem, as measured by the SCQ and RSE respectively. The inverse nature of this relationship is due to the fact that a low score on the RSE reflects high self esteem while a high score on the SCQ reflects high self-efficacy. Average scores were computed by using each subjects' pretest, posttest, and follow up scores on each of the three dependent measures.

TABLE III

Means and Standard Deviations on the Situational
Confidence Questionnaire, Adaptive Skills
Battery, and Rosenberg Self
Esteem Inventory

	Time					
	Pre		Post		Follow up	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Skills Training Group						
SCQ	56.31	23.44	73.23	19.01	78.46	19.79
ASB	31.69	9.57	44.54	7.44	44.96	7.07
RSE	3.42	1.90	2.50	1.65	2.04	1.48
Lecture/Discussion Group						
SCQ	61.77	29.35	70.64	20.79	76.40	16.11
ASB	34.52	8.82	40.00	7.34	41.50	7.58
RSE	3.27	2.11	2.69	1.78	1.54	1.77

TABLE IV

Mean Difference Scores and Standard Deviations
for the Situational Confidence Questionnaire,
Adaptive Skills Battery, and Rosenberg
Self Esteem Inventory

	Post versus Pre		Follow up versus Pre	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Skills Training Group				
SCQ	16.92	15.84	22.14	21.31
ASB	12.85	10.89	13.27	11.67
RSE	- .92	1.79	- 1.38	1.83
Lecture/Discussion Group				
SCQ	8.87	22.10	14.63	26.93
ASB	5.48	7.69	6.98	8.93
RSE	- .58	1.33	- 1.73	2.07

Pearson product moment correlation coefficients were computed in order to describe the relationship between each of the three pairs of measures. As indicated in Table V, the correlation between the SCQ and the ASB was low but significant, $r = .31$, $p < .05$, as was the correlation between the SCQ and RSE, $r = -.35$, $p < .05$. Thus, hypothesis eight and hypothesis nine were not rejected.

TABLE V
Correlations Between Dependent Measures

Dependent Measure	ASB	RSE	SCQ
ASB	1.00	-.014	.31*
RSE		1.00	-.35*
SCQ			1.00

* $p < .05$

CHAPTER IV

DISCUSSION

General Limitations

There are several limitations of this study which prevent it from providing definitive information on the effects of coping skills training on self-efficacy expectations. A primary issue is that the subjects in both the coping skills training program and the lecture/discussion group were also participating in residential substance abuse treatment at the time of the study. These residential treatment programs contained some of the same elements included in both the skills training program and the lecture/discussion program. Therefore, it was possible for individuals in the lecture/discussion group to receive some form of skills training either prior to or after the experimental intervention. The fact that both groups experienced significant improvement over time on all three dependent measures tends to support the proposition that the established residential treatment programs at the two facilities participating in this study had some impact on coping skills, self esteem, and self-efficacy

expectations. Although the experimental intervention was a four hour intensive experience, it may not have been powerful enough to completely overcome the effects of the other treatment interventions to which all subjects were exposed. Also of issue is the fact that the control condition was not purely an attention-placebo type group. The participants in the control group received concentrated information on the disease concept of alcoholism and family roles within an alcoholic family. This type of information is usually included within most alcoholism treatment programs.

A second limitation of the study may lie in the difficulty associated with controlling for social desirability effects. DiClemente (1986) points out that the SCQ, along with the other available measures of self-efficacy, is susceptible to distortion and faking. In their sample of 424 clients admitted to alcoholism treatment centers Annis and Davis (in press) found that all subscales on the SCQ were negatively skewed, indicating that responses tended to be toward the high (100%) end of the continuum. This supports the idea that alcoholics entering a treatment facility may be overconfident in regard to their ability to abstain from alcohol in a wide range of situations. Wylie (1974) states that nothing definitive can be said about the effect of social desirability on responses to the RSE,

but given the content of the items it is likely that there is some social desirability effect. Although the subjects in the study were informed that their responses to the instruments would be confidential, they may have desired to present themselves in a positive light. This is consistent with the fact that alcoholics generally have a very strong denial system which enables them to minimize the effects of their drinking on both themselves and other people.

In addition, Bandura (1977) has emphasized the importance of mastery performance accomplishments, i.e., successfully engaging in the feared activity, for altering self-efficacy expectations. The behavior rehearsal segment of the intervention utilized in this study depended upon role played situations to provide the participants with the opportunity to successfully engage in the desired coping activities. Annis and Davis (1987b) developed a treatment program in which clients were given homework assignments to perform the desired coping behaviors in actual situations. Marlatt (1985c), in particular, has advocated for the use of in situ procedures. It is possible that the experience of engaging in coping behaviors in the actual situation would have had a greater impact on self-efficacy expectations than did the method used in this study.

Both the SCQ and the ASB were developed specifically for use with an alcoholic population. However, test-retest reliability data is not reported for these instruments which calls for caution in the interpretation of the results of the study. There is an increased possibility that a null hypothesis will be falsely accepted when unreliable instruments are used as dependent variables. The ASB is a relatively untested instrument, and there is very little psychometric information available. The psychometric properties of the SCQ have been much more thoroughly examined, but this instrument is still in the developmental stages.

Another factor of note is the population from which the subject pool for this study was drawn. Both treatment centers receive significant state funding in order to provide services to indigent clients. This fact is reflected in the participants' income level. Demographic data indicates that 92.2% of the subjects in the current study earned under \$10,000 per year; 73% earned under \$5,000 per year. The subjects in this study do not represent a cross section of the general population, which makes it difficult to generalize the results to other socioeconomic groups.

Implications

In spite of the above-mentioned limitations, there are several important implications that can be drawn from the results of this study. The finding that the experimental intervention had a significant impact on coping skills beyond the effect of the usual residential treatment program has implications for the design of future treatment interventions. The combined use of lecture, videotaped models, and behavior rehearsal in a condensed format was evidently quite effective. This finding is consistent with that of other authors (Curran & Monti, 1982; Ivey & Authier, 1978), working with different populations. This finding is also consistent with the results of Rist and Watzl's (1983) study. These researchers developed a four hour behavioral program involving modeling and role play to prepare patients for situations in which alcohol might be offered. The subjects reported experiencing a decline in their degree of discomfort when refusing a drink. Chaney et al. (1978) also found that a training program which teaches active, problem-solving coping strategies can reduce the likelihood that life stressors will lead to relapse.

Many substance abuse treatment programs continue to rely quite heavily on Alcoholics Anonymous (AA) meetings, lecture, and information related to alcohol and its

effects on the body as opposed to providing clients with the opportunity to practice skills necessary for coping with high-risk situations for relapse. It is doubtful that level of coping skills alone determines the likelihood of an individual relapsing. However, it is certainly arguable that given the motivation to resist drinking in a difficult situation individuals with adequate skills for dealing with that situation are less likely to drink than individuals without those skills. This idea is supported by the findings of Moos, Finney, and Chan (1981). These authors indicate that recovering alcoholics are much more likely to use cognitive and behavioral strategies to cope with difficult situations than are relapsed alcoholics, who are much more likely to use avoidance coping strategies. The skills taught in the current study include some of the same elements (e.g., taking positive action or talking with a friend) as the positive coping strategies discussed by Moos et al. (1981).

Studies by a number of authors indicate that individuals who relapse tend to do so when experiencing some type of stress whether it be depression, frustration, anger, or pressure from other people (Annis & Davis, 1987b; Marlatt & Gordon, 1980; Timmer et al., 1985). However, the relationship between level of coping skill for dealing with stressful situations and relapse has not been clearly determined. Eriksen et al. (1986) provide

some evidence that subjects in their social skills training group drank less alcohol, had more sober days, and a longer average period of abstinence than did a control group. Chaney et al. (1978) report similarly positive results.

A one month follow-up interview (see Appendix A) was attempted in this study; however, no definitive conclusions could be reached due to the difficulties encountered in locating the subjects. Twenty two subjects were contacted, eleven from each group, and twenty reported that they had remained abstinent since treatment. Both subjects who reported relapsing were in the skills training group. One obtained one week follow up scores of 46.50, 96.63, and 1 on the ASB, SCQ, and RSE respectively. The other obtained follow up scores of 56.0, 84.25, and 5 on these same instruments. It should also be noted that both individuals reported that their relapses were short-lived and that they were currently abstinent. Based on data from all subjects contacted, a strong support group, either family, friends, a counseling group, or AA, was the most frequently cited factor in continued abstinence.

A number of authors (Annis & Davis, 1987b; Cummings, Gordon, & Marlatt, 1980; Marlatt & Gordon, 1980) have identified negative emotional states as often leading to relapse in alcoholic clients. The finding that the skills

training program significantly affected the subjects' responses on the Unpleasant Emotions/Frustrations subscale of the SCQ has implications for other treatment programs. It appears that subjects benefit from specific skills training in that area. This in turn may reduce the risk of relapse.

A number of factors may have contributed to the finding that the Unpleasant Emotions/Frustrations subscale of the SCQ was the only subscale on which there were significant differences between the two groups. First, this was a unique aspect of the training program. Whereas both residential treatment centers provide assertiveness training which includes similar skills to those taught in the coping skills training group, neither treatment center provides skills training for dealing with negative emotional states. Secondly, this was both the first and the longest component of the skills training program. This meant that the subjects received this information when they were the least likely to be fatigued. Thirdly, the skills training approach for dealing with unpleasant emotions provided the subjects with specific guidelines which may have increased their sense of control over situations likely to elicit negative emotional states. In addition, the subjects in the experimental group probably received some support and positive reinforcement from the other group members for using the procedures outlined in

the program. This process may have increased their expectations that they could deal effectively with negative emotional states.

Individual and group counseling, along with lectures which include information about cognitive-behavioral strategies are often relied upon in many alcoholism treatment centers to assist clients in dealing with unpleasant emotions. It may be useful to include more focused skills training for dealing with specific negative emotional states.

There were no differences between the two groups at follow up. The combined effects of the usual residential treatment programs, including counseling for personal problems and other skills training, may have assisted all of the subjects in feeling more in control of their emotions and better able to deal with emotionally arousing situations. In addition, there may have been some transfer of information from the experimental group subjects to the control group subjects due to their contact in the other residential treatment groups.

Due to the previously discussed limitations of the study, especially the confounding variable of the other forms of treatment that both groups were receiving during the study, it is difficult to state with certainty whether skills training alone would impact self-efficacy expectations to a greater degree than a lecture/discussion

on the disease concept of alcoholism. Evidence from studies with other populations (Bandura et al., 1980; Goldfried & Robins, 1982) indicates that skills training using strategies such as lecture, modeling, and behavior rehearsal is effective in increasing self-efficacy expectations. There is no clear evidence in the literature that lecture/discussion on the disease concept of alcoholism is likely to do the same.

Future Research

This study represents an attempt to investigate the applicability of Bandura's (1977) self-efficacy theory to an alcoholic population within a field setting. In retrospect, the design of this study may not have allowed for enough control over extraneous variables. As has been pointed out by Gelso (1979), while the results of field research are more easily generalized, it is also much more difficult to control for extraneous variables. Wilson (1981) delineates four levels of research, ranging from basic laboratory research to clinical practice. This study would be placed at the third level of research which he has identified as controlled clinical research with a patient population. This third level of research logically follows analogue treatment research which attempts to identify the effective ingredients of therapeutic change under more controlled conditions than

are possible in a field setting. Future researchers should consider examining the effects of coping skills training on the self-efficacy expectations of substance abusers under more controlled conditions.

One of the difficulties associated with research in a field setting with a clinical population is obtaining an adequate control group which does not receive any form of treatment. As has been pointed out by Lin et al. (1982), experimenters in clinical settings must often sacrifice scientific rigor due to ethical concerns. Many of the limitations of this study are related to this issue of control over extraneous variables. The one-shot four hour intervention used in the current study was designed to control for such threats to experimental validity as history (Campbell & Stanley, 1966) and contact between the subjects in the two groups during the experimental period. However, it is quite possible that a longer intervention over a period of several days or weeks would have had a greater impact on the subjects. In addition, some measure of the social desirability factor would also be helpful in determining its influence on client responses to the questionnaires.

Although much research has been done on Bandura's self-efficacy theory, there has been very little research which investigates its utility with an alcoholic population. This remains a potentially rewarding area.

The question of whether a client's sense of self-efficacy can be strengthened by teaching new coping skills remains unanswered although there is some evidence from both the current study and from the work of Annis and Davis (1987b) that this is possible. It seems clear that strategies which improve clients' coping skills and increase their personal control are likely to reduce the risk of relapse (Clifford, 1983). However, it also appears that many other variables (i.e., motivation level, socioeconomic group, employment, marital status) are also likely to impact an individual's likelihood of relapsing. An important direction for future research is to determine which variables have the greatest impact on recovery from alcoholism.

There is some evidence from the current study that there is a relationship between self-efficacy expectations and both coping skills and self esteem. Future research should explore the nature and extent of these relationships further. The relationship between cognitive and behavioral variables in general is an important one for psychologists. It seems especially important in understanding a problem as complex as alcoholism.

Bandura (1984) has pointed out that self-efficacy differs from self esteem. However, alcoholism impacts almost every area of a person's life and often has a very negative impact on an individual's overall feelings of

self worth (Charalampous et al., 1976). Therefore, it may be that an increase in one's self-efficacy expectations for dealing with this problem will have a more general effect on overall self esteem.

The relationship between self-efficacy expectations and relapse remains relatively unexplored. Research in the area of smoking behavior indicates that self-efficacy increases with successful treatment, and subjects who are able to quit smoking at the end of treatment have significantly greater self-efficacy than subjects who have not been able to quit (DiClemente, 1986). Longitudinal research which examines these variables over several months or years would be especially helpful both in the area of alcoholism and in relationship to other addictive behaviors.

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LIST OF REFERENCES

- Abel, G. G., Blanchard, E. B., & Becker, J. V. (1974). Psychological treatment of rapists. Archives of General Psychiatry, 30, 467-475.
- Abrams, D. B. (1983). Psychological assessment of alcohol and stress interactions: Bridging the gap between laboratory and treatment outcome research. In L. A. Pohorecky & J. Brick (Eds.), Stress and alcohol use. New York: Elsevier.
- Adler, A. (1935). Individual psychotherapy. In C. Murcheson (Ed.), Psychologies of 1930. Worcester, MA: Clark University Press.
- Alexander, B. K., & Hadaway, P. F. (1982). Opiate addiction: The case for adaptive orientation. Psychological Bulletin, 92, 367-381.
- American Psychiatric Association (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, D C: Author.
- Annis, H. M. (1982a). Inventory of drinking situations. Toronto: Addiction Research Foundation of Ontario.
- Annis, H. M. (1982b). Situational confidence questionnaire. Toronto: Addiction Research Foundation of Ontario.
- Annis, H. M., & Davis, C. S. (1987a). Assessment of expectancies in alcohol dependent clients. In A. Marlatt and D. Donovan (Eds.), Assessment of addictive behaviors. New York: Guilford Press.
- Annis, H. M., & Davis, C. S. (1987b). Self-efficacy and the prevention of alcoholic relapse: Initial findings from a treatment trial. In T. B. Baker and D. Cannon (Eds.), Addictive disorders: Psychological research on assessment and treatment. New York: Praeger Publishing Company.
- Annis, H. M., & Graham, J. M. (in press). Situational confidence questionnaire (SCQ): User's guide. Toronto: Addiction Research Foundation of Ontario.
- Annis, H. M., Graham, J. M., & Davis, C. S. (1987). Inventory of drinking situations (IDS): User's guide. Toronto: Addiction Research Foundation of Ontario.

- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavior change. Psychological Review, 84, 191-215.
- Bandura, A. (1982). Self-efficacy mechanism in human agency. American Psychologist, 37, 122-147.
- Bandura, A. (1984). Recycling misconceptions of perceived self-efficacy. Cognitive Therapy and Research, 8, 231-255.
- Bandura, A., Adams, N. E., & Beyer, J. (1977). Cognitive processes mediating behavioral change. Journal of Personality and Social Psychology, 35, 125-139.
- Bandura, A., Adams, N. E., Hardy, A. B., & Howells, G. N. (1980). Tests of the generality of self-efficacy theory. Cognitive Therapy and Research, 4, 39-66.
- Bandura, A., Blanchard, E. B., & Ritter, B. (1969). Relative efficacy of desensitization and modeling approaches for inducing behavioral, affective, and attitudinal changes. Journal of Personality and Social Psychology, 13, 173-198.
- Battistich, V. A. & Zucker, R. A. (1980). A multivariate social-psychological approach to the prediction of psychoactive drug use in young adults. International Journal of Addictions, 15, 569-583.
- Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. General Psychiatry, 6, 561-571.
- Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The hopelessness scale. Journal of Consulting and Clinical Psychology, 42, 861-865.
- Beckman, L., & Bardsley, P. (1986). Individual characteristics, gender differences, and drop-out from alcoholism treatment. Alcohol and Alcoholism: International Journal of the Medical Council on Alcoholism, 21, 213-224.
- Brown, I., Jr., & Inouye, D. K. (1978). Learned through modeling: The role of perceived similarity in competence. Journal of Personality and Social Psychology, 36, 900-908.

- Brown, R. A. (1980). Personality measure in gamma and delta alcoholics: A brief note. Journal of Clinical Psychology, 36(1), 345-346.
- Campbell, D. T., & Stanley, J. C. (1966). Experimental and quasi-experimental designs for research. Chicago: Rand McNally.
- Catalano, R. F., Hawkins, J. D., & Hall, J. (1984, February). Preventing relapse among former substance abusers. Paper presented at the annual meeting of the International Network of Social Network Analysts, Phoenix, Arizona.
- Cernovsky, Z. (1983). Dimensions of self-actualization and posttreatment alcohol use in fully and in partly recovered alcoholics. Journal of Clinical Psychology, 39, 628-632.
- Chaney, E. F., O'Leary, M. R., & Marlatt, G. A. (1978). Skill training with alcoholics. Journal of Consulting and Clinical Psychology, 46, 1092-1104.
- Charalampous, K. D., Ford, B. C., & Skinner, F. (1976). Self esteem in alcoholics and non-alcoholics. Journal of Studies on Alcohol, 37, 990-994.
- Cheek, F. E., Tomarchio, T., Standen, J., & Albahary, R. S. (1973). Methadone plus: A behavior modification training program in self-control for addicts on methadone maintenance. International Journal of the Addictions, 8, 969-996.
- Chelune, G. J., & Parker, J. B. (1981). Neuropsychological deficits associated with chronic alcohol abuse. Clinical Psychology Review, 1, 181-195.
- Clifford, J. S. (1983). Self-efficacy counseling and the maintenance of sobriety. The Personnel and Guidance Journal,
- Cohen, J. (1977). Statistical power analysis for the behavioral sciences. New York: Academic Press.
- Condiotte, M. M., & Lichtenstein, E. (1981). Self-efficacy and relapse in smoking cessation programs. Journal of Consulting and Clinical Psychology, 49, 648-658.

- Connor, R. G. (1962). The self concepts of alcoholics. In D. J. Pittman & C. R. Snyder (Eds.), Society, culture, and drinking patterns (pp. 455-467). New York: Wiley.
- Cronkite, R. C., & Moos, R. H. (1980). Determinants of the posttreatment functioning of alcoholic patients: A conceptual framework. Journal of Consulting and Clinical Psychology, 48, 305-316.
- Cummings, C., Gordon, J., & Marlatt, G. A. (1980). Relapse: Strategies of prevention and prediction. In W. R. Miller (Ed.), The addictive behaviors. Oxford, U. K.: Pergamon Press.
- Curran, J. P. (1985). Social skills therapy: A model and a treatment. In R. M. Turner & L. M. Ascher (Eds.), Evaluating behavior therapy outcome. New York: Springer Publishing Company.
- Curran, J., & Monti, P. (Eds.), (1982). Social skills training. New York: Guilford.
- DiClemente, C. C. (1981). Self-efficacy and smoking cessation maintenance. Cognitive Research and Therapy, 5, 175-187.
- DiClemente, C. C. (1986). Self-efficacy and the addictive behaviors. Journal of Social and Clinical Psychology, 4, 302-315.
- Donovan, D. M. & Chaney, E. F. (1985). Alcoholic relapse prevention and intervention: Models and methods. In G. A. Marlatt & J. R. Gordon (Eds.), Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. New York: Guilford Press.
- Donovan, D. M., & O'Leary, M. R. (1978). The drinking-related locus of control scale. Journal of Studies on Alcohol, 39, 759-784.
- Donovan, D. M. & O'Leary, M. R. (1979). Control orientation among alcoholics: A cognitive social learning perspective. American Journal of Drug and Alcohol Abuse, 6, 487-499.
- Ellis, A. (1974). Rational-emotive theory: Albert Ellis. In A. Burton (Ed.), Operational theories of personality. New York: Brunner/Mazel.

- Eriksen, L., Bjornstad, S. & Gotestam, K. G. (1986). Social skills training in groups for alcoholics: One-year treatment outcome for groups and individuals. Addictive Behaviors, 11, 309-329.
- Farber, P. D., Khavari, K. A., & Douglass, F. M. (1980). A factor analytic study of reasons for drinking: Empirical validation of positive and negative reinforcement dimensions. Journal of Consulting and Clinical Psychology, 48, 780-781.
- Fensterheim, H. (1972). Assertive methods and marital problems. In R. D. Rubin, H. Fensterheim, J. D. Henderson, & L. P. Ullmann (Eds.), Advances in behavior therapy. New York: Academic Press.
- Gelso, C. J. (1979). Research in counseling: Methodological and professional issues. Counseling Psychologist, 8, 7-36.
- Giacquinta, J. B. (1975). Status, risk, and receptivity to innovations in complex organizations: A study of the responses of four groups of educators to the proposed introduction of sex education in elementary school. Sociology of Education, 48, 38-58.
- Goldfried, M. R. & D'Zurilla, T. J. (1969). A behavioral-analytic model for assessing competence. Current Topics in Clinical and Community Psychology, 1, 151-196.
- Goldfried, M. R. & Robins, C. (1982). On the facilitation of self-efficacy. Cognitive Therapy and Research, 6, 361-380.
- Goldsmith, J. G., & McFall, R. M. (1975). Development and evaluation of an interpersonal skill-training program for psychiatric inpatients. Journal of Abnormal Psychology, 84, 51-58.
- Gottlieb, N. H. (1983). The determination of smoking types: Evidence for a sociological-pharmacological continuum. Addictive Behaviors, 8, 47-51.
- Haase, R. F., & Ellis, M. V. (1987). Multivariate analysis of variance. Journal of Counseling Psychology, 34, 404-413.

- Hawkins, J. D., Catalano, R. F., & Wells, E. A. (1986). Measuring effects of a skills training intervention for drug abusers. Journal of Consulting and Clinical Psychology, 54, 661-664.
- Hearne, E. M., III, Clark, G. M., & Hatch, J. P. (1983). A test for serial correlation in univariate repeated - measures analysis. Biometrics, 39, 237-243.
- Hersen, M., & Bellack, A. S. (1976). Social skills training for chronic psychiatric patients: Rationale, research findings, and future directions. Comprehensive Psychiatry, 17, 559-580.
- Horney, K. (1939). New ways in psychoanalysis. New York: Norton.
- Ivey, A. E., & Authier, J. (1978). Microcounseling: Innovations in interviewing, counseling, psychotherapy, and psychoeducation. Springfield: Charles C. Thomas Publishing.
- Jones, S. L., & Lanyon, R. I. (1981). Relationship between adaptive skills and outcome of alcoholism treatment. Journal of Studies on Alcohol, 42, 521-525.
- Kazdin, A. E. (1974). Effects of covert modeling and model reinforcement on assertive behavior. Journal of Abnormal Psychology, 83, 240-252.
- Kazdin, A. E. (1979). Imagery elaboration and self-efficacy in the covert modeling treatment of unassertive behavior. Journal of Consulting and Clinical Psychology, 47, 725-733.
- Kelley, J. A. (1982). Social skills training. New York: Springer.
- Kraft, T. (1968). Social anxiety and drug addiction. British Journal of Social Psychiatry, 2, 192-195.
- Leventhal, H., & Avis, N. (1976). Pleasure, addiction, and habit: Factors in verbal report on factors in smoking behavior. Journal of Abnormal Psychology, 478-488.
- Leventhal, H., & Cleary, P. D. (1980). The smoking problem: A review of the research and theory in behavioral risk modification. Psychological Bulletin, 88, 370-405.

- Lin, T., Bon, S., Dickinson, J., & Blume, C. (1982). Systematic development and evaluation of a social skills training program for chemical abusers. The International Journal of the Addictions, 17, 585-596.
- Lindblad, R. A. (1977). Self concept and drug addiction: A controlled study of white middle socioeconomic status addicts. DHEW, Washington: U. S. Government Printing Office, Pub. No. 017-024-00595-9.
- Litman, G. K. (1980). Relapse in alcoholism: Traditional and current approaches. In G. Edwards & M. Grant (Eds.), Alcoholism treatment in transition. London: Croom Helm.
- Litman, G. K. (1986). Alcoholism survival: The prevention of relapse. In W. E. Miller & N. Heather (Eds.), Treating addictive behaviors: Processes of change. New York: Plenum Press.
- Litman, G. K., Eiser, J. R., Rawson, N. S. B., & Oppenheim, A. N. (1977). Towards a typology of relapse: A preliminary report. Drug and Alcohol Dependence, 2, 157-162.
- Marlatt, G. A. (1976). Alcohol, stress, and cognitive control. In I. G. Sarason & C. D. Spielberger (Eds.), Stress and anxiety (Vol. 3). Washington, D C: Hemisphere Publishing.
- Marlatt, G. A. (1978). Craving for alcohol, loss of control, and relapse: A cognitive-behavioral analysis. In P. E. Nathan, G. A. Marlatt, & T. Loberg (Eds.), Alcoholism: New directions in behavioral research and treatment. New York: Plenum Press.
- Marlatt, G. A. (1979). Alcohol use and problem drinking: A cognitive-behavioral analysis. In P. C. Kendall & S. D. Hollon (Eds.), Cognitive behavioral intervention: Theory, research, and procedures. New York: Academic Press.
- Marlatt, G. A. (1985a). Coping and substance abuse: Implications for research, prevention, and treatment. In S. Shiffman & T. A. Wills (Eds.), Coping and substance use. Orlando: Academic Press, Inc.
- Marlatt, G. A. (1985b). Relapse prevention: Theoretical rationale and overview of model. In G. A. Marlatt & J. R. Gordon (Eds.), Relapse prevention: Maintenance strategies in the treatment of addictive behaviors (pp. 3-70). New York: Guilford Publications Inc.

- Marlatt, G. A. (1985c). Situational determinants of relapse and skill-training interventions. In G. A. Marlatt & J. R. Gordon (Eds.), Relapse prevention: Maintenance strategies in the treatment of addictive behaviors (pp. 71-127). New York: Guilford Publications Inc.
- Marlatt, G. A. & Gordon, J. R. (1980). Determinants of relapse: Implications for the maintenance of behavior change. In P. Davidson & S. Davidson (Eds.), Behavioral medicine: Changing health lifestyles. New York: Brunner/Mazel Inc.
- McFall, R. M., & Marston, A. R. (1970). An experimental investigation of behavior rehearsal in assertive training. Journal of Abnormal Psychology, 76, 295-303.
- McKennel, A. C., & Thomas, R. K. (1967). Adults' and adolescents' smoking habits and attitudes. London: British Ministry of Health.
- Miller, P. M., & Eisler, R. M. (1977). Assertive behavior of alcoholics: A descriptive analysis. Behavior Therapy, 8, 146-149.
- Mischel, W. (1973). Toward a cognitive social learning reconceptualization of personality. Psychological Review, 80, 252-283.
- Moos, R. H., Finney, J. W., & Chan, D. A. (1981). The process of recovery from alcoholism: I. Comparing alcoholic patients and matched community controls. Journal of Studies on Alcohol, 42, 383-402.
- Neff, J. A., & Husaini, B. A. (1982). Life events, drinking patterns, and depressive symptomatology: The stress-buffering effect of alcohol consumption. Journal of Studies on Alcohol, 43, 301-318.
- Nocks, J. J., & Bradley, D. L. (1969). Self-esteem in an alcoholic population. Diseases of the Nervous System, 30, 611-617.
- O'Brien, R. G., & Kaiser, M. K. (1985). MANOVA method for analyzing repeated measures designs: An extensive primer. Psychological Bulletin, 97, 316-333.
- O'Leary, A. (1985). Self-efficacy and health. Behavioral Research and Therapy, 23, 437-451.

- O'Leary, D. E., O'Leary, M. R., & Donovan, D. M. (1976). Social skill acquisition and psychosocial development of alcoholics: A review. Addictive Behaviors, 1, 111-120.
- Olson, C. L. (1976). On choosing a test statistic in multivariate analysis of variance. Psychological Bulletin, 83, 579-586.
- Pearlin, L. I., & Radabaugh, C. W. (1976). Economic strains and the coping functions of alcohol. American Journal of Sociology, 82, 652-663.
- Pentz, M. A. (1985). Social competence and self-efficacy as determinants of substance use in adolescence. In S. Shiffman & T. A. Wills (Eds.). Coping and substance use. Orlando: Academic Press, Inc.
- Pentz, M. A., & Huba, G. J. (1984). Adolescent drug use, social skills and self-efficacy over two years: A four-wave longitudinal causal model. Unpublished manuscript.
- Rist, F., & Watzl, H. (1983). Self assessment of relapse risk and assertiveness in relation to treatment outcome of female alcoholics. Addictive Behaviors, 8, 121-127.
- Rohsenow, D. J. (1983). Drinking habits and expectancies about alcohol's effects for self versus others. Journal of Consulting and Clinical Psychology, 51, 752-756.
- Rollnick, S., & Heather, N. (1982). The application of Bandura's self-efficacy theory to abstinence-oriented alcoholism treatment. Addictive Behaviors, 7, 243-250.
- Rooney, J., & Volpe, J. (1984). Changes in femininity, masculinity, and self-regard among women alcoholics in residential treatment. Sex Roles, 11, 257-267.
- Rosenberg, M. (1965). Society and the adolescent self-image. Princeton: Princeton University Press.
- Rosenberg, M. (1979). Conceiving the self. New York: Basic Books.
- Silber, E., & Tippet, J. S. (1965). Self-esteem: Clinical assessment and measurement validation. Psychological Reports, 16, 1017-1021

- Smith, K. (1987). Narcissism as a personality trait of alcoholics. Dissertation Abstracts International, 47(9): 3971-B.
- Strecher, V. J., DeVellis, B. M., Becker, M. H., & Rosenstock, I. M. (1986). The role of self-efficacy in achieving health behavior change. Health Education Quarterly, 13, 73-79.
- Sullivan, H. S. (1953). The interpersonal theory of psychiatry. New York: Norton.
- Tippett, J., & Silber, E. (1965). Self-image stability: The problem of validation. Psychological Reports, 17, 323-329.
- Timmer, S. G., Veroff, J., & Colten, M. E. (1985). Life stress, helplessness, and the use of alcohol and drugs to cope: An analysis of national survey data. In S. Shiffman & T. A. Wills (Eds.), Coping and substance use. Orlando: Academic Press, Inc.
- Vanderpool, J. A. (1969). Alcoholism and the self concept. Quarterly Journal of Studies on Alcohol, 30, 59-77.
- Van Hasselt, V. B., Hersen, M., & Milliones, J. (1978). Social skills training for alcoholics and drug addicts: A review. Addictive Behaviors, 3, 221-233.
- Watson, D. W., & Maisto, S. A. (1983). A review of the effectiveness of assertiveness training in the treatment of alcohol abusers. Behavioral Psychotherapy, 11, 36-49.
- Weinberg, R., Gould, D., & Jackson, A. (1979). Expectations and performance: An empirical test of Bandura's self-efficacy theory. Journal of Sport Psychology, 1, 320-331.
- Weiss, H. M. (1978). Social learning of work values in organizations. Journal of Applied Psychology, 63, 711-718.
- Williams, A. F. (1965). Self concept of college problem drinkers: I. A comparison with alcoholics. Quarterly Journal of Studies On Alcohol, 26: 586-594.
- Wills, T. A., & Shiffman, S. (1985). Coping and substance use: A framework. In T. A. Wills & S. Shiffman (Eds.), Coping and substance use. Orlando: Academic Press, Inc.

- Wilson, G. T. (1978). Booze, beliefs and behavior: Cognitive processes in alcohol use and abuse. In P. E. Nathan, G. A. Marlatt, & T. Loberg (Eds.), Alcoholism: New directions in behavioral research and treatment. New York: Plenum Press.
- Wilson, G. T. (1981). Expectations and substance abuse: Does basic research benefit clinical assessment and therapy? Addictive Behaviors, 6, 221-231.
- Wolpe, J., & Lazarus, A. (1969). Behavior therapy techniques. New York: Pergamon Press.
- Wylie, R. C. (1974). The self-concept: A review of methodological considerations and measuring instruments (Vol. 1). Lincoln: University of Nebraska Press.
- Zarantonello, M. M. (1986). Expectations for reinforcement from alcohol use in a clinical sample. Journal of Studies on Alcohol, 47, 485-488.

APPENDIXES

APPENDIX A
QUESTIONNAIRE PACKET

The purpose of this study is to examine the effects of various treatment techniques on the beliefs people have about their ability to abstain from alcohol. You will be asked to complete testing instruments on three different occasions, during the first week of treatment, immediately following a special treatment program, and one week after the special treatment program. One of these instruments will involve the audiotaping of your responses to a series of questions. After you provide your responses, these tapes will be kept in a locked file cabinet until they are collected and scored by the raters. The tapes will be erased or destroyed following the completion of the research project. In addition, you will be asked to answer three or four short questions over the phone approximately one month after leaving treatment.

Participation in this study will require about one hour of your time at each testing occasion plus participation in a special three hour treatment program during the course of your residential treatment program. Only the researchers will have access to the information that you provide, and you will be provided with a code number to place on your tests in order to further insure your confidentiality. The information provided will be kept in the strictest confidence by the researchers.

Statement of Permission

I have read the above description of the research project and understand that the information I provide will be kept confidential. I consent to participate in this project with the understanding that my consent and/or my data may be withdrawn at any time without penalty. I further understand that my participation in this research is on a voluntary basis. If I have questions regarding my participation, now or later, I can contact the person listed below.

Date _____

Signature

Printed Name

Scott Anderson
Lighthouse
702 W. Chestnut
Bloomington, IL 61701
(309) 827-6026

SITUATIONAL CONFIDENCE QUESTIONNAIRE

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SITUATIONAL CONFIDENCE QUESTIONNAIRE

Listed below are a number of situations or events in which some people experience a drinking problem.

Imagine yourself as you are right now in each of these situations. Indicate on the scale provided how confident you are that you will be able to resist the urge to drink heavily in that situation.

Circle 100 if you are 100% confident right now that you could resist the urge to drink heavily; 80 if you are 80% confident; 60 if you are 60% confident. If you are more unconfident than confident, circle 40 to indicate that you are only 40% confident that you could resist the urge to drink heavily; 20 for 20% confident; 0 if you have no confidence at all about that situation.

	I would be able to resist the urge to drink heavily						
	not at all confident			very confident			
1. If I had an argument with a friend,	0	20	40	60	80	100	6
2. If I were depressed about things in general,	0	20	40	60	80	100	1
3. If I felt that things were going to work out well for me at last,	0	20	40	60	80	100	3
4. If I felt shaky and sick,	0	20	40	60	80	100	2
5. If I would decide to test my willpower by showing that I really could stop after one or two drinks,	0	20	40	60	80	100	4
6. If good friends would drop by and I would be full of good feelings,	0	20	40	60	80	100	8
7. If I would see an advertisement for my favourite booze,	0	20	40	60	80	100	5
8. If I felt uneasy in the presence of someone,	0	20	40	60	80	100	6
9. If someone criticized me,	0	20	40	60	80	100	6
10. If I would be invited to someone's home and they would offer me a drink,	0	20	40	60	80	100	7
11. If I would have trouble sleeping,	0	20	40	60	80	100	2
12. If I wanted to heighten my sexual enjoyment,	0	20	40	60	80	100	8
13. If I would get a bottle of my favourite booze as a prize or present,	0	20	40	60	80	100	5

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I would be able to resist the urge to drink heavily

	not at all confident						very confident
14. If I were enjoying myself,	0	20	40	60	80	100	3
15. If I would be in a social situation in which I had always drunk in the past,	0	20	40	60	80	100	7
16. If I would become sad at the memory of something that had happened,	0	20	40	60	80	100	1
17. If I would start to believe that alcohol was no longer a problem for me,	0	20	40	60	80	100	4
18. If other people around me made me tense,	0	20	40	60	80	100	6
19. If I would be out with friends and they would stop by a bar for a drink,	0	20	40	60	80	100	7
20. If I would begin to think how cool and satisfying a drink would be,	0	20	40	60	80	100	5
21. If I wanted to feel closer to someone I liked,	0	20	40	60	80	100	8
22. If someone in the same room would be drinking,	0	20	40	60	80	100	7
23. If I felt that there was nowhere left to turn,	0	20	40	60	80	100	1
24. If I felt that I had let myself down,	0	20	40	60	80	100	1
25. If I felt sexually rejected,	0	20	40	60	80	100	6
26. If I were bored,	0	20	40	60	80	100	1
27. If I were unable to express my feelings for someone,	0	20	40	60	80	100	6
28. If other people treated me unfairly,	0	20	40	60	80	100	6
29. If I would remember how good it tasted,	0	20	40	60	80	100	5
30. If I felt rejected by friends,	0	20	40	60	80	100	6
31. If I felt confident and relaxed,	0	20	40	60	80	100	3
32. If I would see something that reminded me of drinking,	0	20	40	60	80	100	5
33. If I would begin to feel fed up with life,	0	20	40	60	80	100	1

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I would be able to resist the urge to drink heavily

	not at all confident						very confident
34. If I were troubled and wanted to think more clearly,	0	20	40	60	80	100	1
35. If I were lonely,	0	20	40	60	80	100	1
36. If I could convince myself that I was a new person now and could take a few drinks,	0	20	40	60	80	100	4
37. If I were feeling on top of the world,	0	20	40	60	80	100	3
38. If I would pass by a liquor store,	0	20	40	60	80	100	3
39. If I would be in a situation in which I was in the habit of having a drink,	0	20	40	60	80	100	3
40. If I felt drowsy and wanted to stay alert,	0	20	40	60	80	100	2
41. If I were tired,	0	20	40	60	80	100	2
42. If I were in physical pain,	0	20	40	60	80	100	2
43. If I would feel confident that I could handle a few drinks,	0	20	40	60	80	100	4
44. If someone close to me were suffering,	0	20	40	60	80	100	6
45. If I would start thinking that I would never know my limits with alcohol unless I tested them,	0	20	40	60	80	100	4
46. If I would be out with friends "on the town" and wanted to increase my enjoyment,	0	20	40	60	80	100	8
47. If I would unexpectedly find a bottle of my favourite booze,	0	20	40	60	80	100	3
48. If I were having a good conversation with someone and wanted to recount some really good stories,	0	20	40	60	80	100	8
49. If I would be offered a drink and would feel awkward about refusing,	0	20	40	60	80	100	7
50. If other people didn't seem to like me,	0	20	40	60	80	100	6
51. If I felt nauseous,	0	20	40	60	80	100	2
52. If I felt unsure that I could measure up to other people's expectations,	0	20	40	60	80	100	6

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I would be able to resist the urge to drink heavily

	not at all confident						very confident
53. If I felt under a lot of pressure,	0	20	40	60	80	100	1
54. If I would wonder about my self-control over alcohol and would feel like having a drink to try it out,	0	20	40	60	80	100	4
55. If nothing I did seemed right to me,	0	20	40	60	80	100	1
56. If other people interfered with my plans,	0	20	40	60	80	100	6
57. If I would start thinking that I was finally cured and could handle alcohol,	0	20	40	60	80	100	4
58. If everything were going well,	0	20	40	60	80	100	3
59. If I felt that no one really cared what happened to me,	0	20	40	60	80	100	1
60. If I would be at a party and other people would be drinking,	0	20	40	60	80	100	7
61. If I felt unsure of myself and wanted to function better,	0	20	40	60	80	100	1
62. If pressure would build up at work because of the demands of my supervisor,	0	20	40	60	80	100	6
63. If I couldn't seem to do the things I tried to do,	0	20	40	60	80	100	1
64. If I were afraid that things weren't going to work out,	0	20	40	60	80	100	1
65. If I felt satisfied with something I had done,	0	20	40	60	80	100	3
66. If I felt jealous over something someone had done,	0	20	40	60	80	100	6
67. If I would pass by a bar,	0	20	40	60	80	100	5
68. If I felt empty inside,	0	20	40	60	80	100	1
69. If I would be in a restaurant and the people with me would order drinks,	0	20	40	60	80	100	7
70. If I felt exhausted,	0	20	40	60	80	100	2
71. If everything was going badly for me,	0	20	40	60	80	100	1

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I would be able to resist the urge to drink heavily

	not at all confident						very confident
72. If I wanted to celebrate with a friend,	0	20	40	60	80	100	8
73. If someone would pressure me to "be a good sport" and have a drink,	0	20	40	60	80	100	7
74. If I would start to feel guilty about something,	0	20	40	60	80	100	1
75. If I felt jumpy and physically tense,	0	20	40	60	80	100	2
76. If I were angry at the way things had turned out,	0	20	40	60	80	100	1
77. If I would feel under a lot of pressure from family members at home,	0	20	40	60	80	100	6
78. If something good would happen and I would feel like celebrating,	0	20	40	60	80	100	3
79. If I were feeling content with my life,	0	20	40	60	80	100	3
80. If I would start thinking that I wasn't really hooked on alcohol,	0	20	40	60	80	100	4
81. If I would start to think that just one drink could cause no harm,	0	20	40	60	80	100	4
82. If I would be having fun with friends and wanted to increase our enjoyment,	0	20	40	60	80	100	8
83. If I felt confused about what I should do,	0	20	40	60	80	100	1
84. If I would meet a friend and he/she would suggest that we have a drink together,	0	20	40	60	80	100	7
85. If I would want to celebrate special occasions like Christmas or birthdays,	0	20	40	60	80	100	3
86. If I had a headache,	0	20	40	60	80	100	2
87. If I were not getting along well with others at work,	0	20	40	60	80	100	6
88. If I would be enjoying myself at a party and wanted to feel even better,	0	20	40	60	80	100	8
89. If I would suddenly have an urge for a drink,	0	20	40	60	80	100	5

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I would be able to resist the urge to drink heavily

	not at all confident						very confident
90. If I would think of the chances I had missed in life,	0	20	40	60	80	100	1
91. If I wanted to prove to myself that I could take a few drinks without becoming drunk,	0	20	40	60	80	100	4
92. If there were fights at home,	0	20	40	60	80	100	6
93. If I were enjoying a meal with friends and felt that a drink would make it even more enjoyable,	0	20	40	60	80	100	8
94. If there were problems with people at work,	0	20	40	60	80	100	6
95. If I would be relaxed with a good friend and wanted to have a good time,	0	20	40	60	80	100	8
96. If my boss would offer me a drink,	0	20	40	60	80	100	7
97. If my stomach felt like it was tied in knots,	0	20	40	60	80	100	2
98. If I felt happy at the memory of something that had happened,	0	20	40	60	80	100	3
99. If I felt that I needed courage to face up to someone,	0	20	40	60	80	100	6
100. If I felt that someone was trying to control me and I wanted to feel more independent and powerful,	0	20	40	60	80	100	6

THE ADAPTIVE SKILLS BATTERY

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Instructions

As they go through life, people are constantly confronted with situations that are hard to deal with. Many situations are hard for some people and quite comfortable for other people. This tape is a collection of situations with which at least some people experience some difficulty. In these situations, there are many ways to respond. There are no right and wrong responses to these situations, and that's what makes them so hard to deal with.

We are giving this set of situations to you to ask you how you would normally handle these common occurrences. I will describe a certain situation, and the situation might also include certain feelings that you are feeling. What we want you to do is to put yourself in that situation and tell us what you see yourself doing to handle the feelings and circumstances in the situation. We are interested in how you really would respond normally, so please be as honest as you can be about how you think you would respond.

As an example, I might say: "Through a misunderstanding with a friend that was definitely your fault, you have apparently temporarily damaged your friendship. You were hoping that the whole thing would be forgotten, but begin to notice that your friend has been avoiding you. You feel pretty bad about the whole situation. How do you handle it?"

As several examples of your response, you might say, "I would feel too bad to get in touch with that person, so I might send the person some flowers and hope that they would forgive me. If I sent flowers, I wouldn't feel bad anymore." Or you might say, "I don't really think that there is anything I could do to fix things with that friend. I'd probably have a drink to relax and just wait for the whole thing to blow over." There are many other ways you could handle your feelings and handle the situation.

Remember, what we would like you to do is to listen to the situations as they are presented. Imagine you are in that situation and have the feelings described. Then we would like you to tell us as honestly as possible how you would normally handle your feelings and the situation, both in what you would say and do. Try to do this as if you are describing your reactions in real life.

If you have any questions at this time, you may ask them.

1. You buy an expensive watch, but only one week later it suddenly stops running. When you take it back to the jeweler from whom you bought it, he says that he can fix it, but that you will have to pay for the repairs. You feel that you have been cheated and that the work should be done for free. What do you say?
2. You saw someone trip and fall, and without thinking you cracked up laughing because it looked so comical. You soon discover, however, that the person was really hurt by the fall, and the other people are looking at you like you were some kind of animal. You ask yourself, "How could I have been such a fool?" You really feel small. What do you do to handle this?
3. You are at a party where everyone is really getting drunk, and you are beginning to feel very uncomfortable. The last person who left was very cruelly harassed and made a fool of. Everyone put him down after he had gone. What do you do?
4. You tell a friend, in strictest confidence, your negative impressions and feelings about a mutual acquaintance. Later, you discover that what you said about the acquaintance has gotten back to that person. You feel really embarrassed and hurt that your friend would violate your confidence. What do you do?
5. It is late at night and you are unable to sleep as some problems you've been having have been running through your head. You are really tired, but are unable to sleep. What do you do?
6. In looking for a new job, you have applied for one which you feel fits you perfectly and which you really want. You are waiting for an interview, and the personnel manager walks in and tells you, "I'm sorry. I've reviewed your application and you are clearly not suited for the position being offered. Thank you for coming in and goodbye." You still feel you are qualified for the job. What do you say?
7. At work, one of your superiors really humiliates you publicly by criticizing your work. You feel his criticism is unjustified and you try to explain, but he won't listen. He closes with, "and you'd better straighten up, or you will be looking for a new job." He turns and storms off. How do you handle it?

8. It has been one of those days at work. Now on your way home you feel tense, irritable and lonely because there will be no one home when you get there. You hate the thought of how bad the evening is going to be. Just then you remember the bottle you had stashed in the garage for just such occasions. What do you do? 107
9. Your boss, right before quitting time, told you to be in his office first thing the next morning. His tone sounded really anxious, and you know that there have been rumors of lay-offs recently. As you go home that evening, you find yourself getting really depressed thinking about your future, the job market, your family, etc. What do you do?
10. At work you are forced to work in conjunction with a very depressed person who is continually griping about the boss and your co-workers. His continued chatter makes it very hard for you to concentrate and your boss has already made a point of mentioning the fact that he has noticed a fall in your performance. How do you handle it?
11. You've gone to spend some time with some friends socially in the park. Several of your friends are drinking. One shoves a beer in your hand which you do not want at the time. You say, "No, thank you" and set it down, but he says loudly, "Why can't you take a drink; you think you're so much better than the rest of us?" What do you say?
12. After making a costly mistake at work which was your fault and for which you were thoroughly chewed out by your boss, you really feel low. One thought seems to consistently run through your head -- "I'm just no good, I am really worthless." How do you handle this?
13. You and a co-worker are put in charge of a very important project at work. It soon becomes clear to you that your "partner" is not doing his share and is forcing you to do most of the work. The whole situation makes you angry because it is so unjust. What do you do?
14. In the past, you were accustomed to getting drunk after a fight with your spouse. You've just had a really big fight with your spouse and he/she left you at home alone. You still feel like you've got a lot of pent up anger. What do you do?

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15. Every time you get into a fight with your spouse, he/she gives you the "silent treatment" and tries to force you to be the first one to speak. But when you do speak first, you feel that you are admitting that you were wrong. You've just had a big fight, and sure enough you're getting the silent treatment. You really don't feel that you were wrong. What do you do?

The instructions for the next set of items is just a little bit different. For these situations, I would like you to describe the response that you feel you should make; that is, the response that you feel would be the very best to the situation. For some of these situations, the response you would normally give will be what you feel is best; for other situations you might be able to think of a better response than what you think you would normally do. What I would like you to do is to briefly describe your best response to the situation.

If you have any questions at this time, you may ask them.

16. You have rented an apartment, and when you signed the lease, your landlord promised to make certain repairs. Several weeks have passed since then and he hasn't been around to do what he promised in spite of your repeated messages you left for him. You happen to run into him at the mailbox one day, and he gruffly says, "Hello." What do you say?
17. Someone at a party asked you a question. As you are answering it, this person sees someone else walking by and without a word to you, goes charging off to talk with the other person. You really feel snubbed. How do you handle it?
18. You're not sure why, but you really feel like getting drunk; it's really a strong craving. There's really nothing there to stop you, as you have the money and the evening is free. What do you do?
19. A person whom you see every day has found that she can always get a reaction out of you by teasing you about a very sensitive area. This teasing persists, and you cannot avoid the person. Right now you see this person approaching and you feel yourself getting tense and frustrated. What do you say?
20. You find yourself alone on a Saturday afternoon. You've watched T.V. until you can't stand it anymore, and you are really bored. Unfortunately, it seems that everyone you know is busy with other things. You feel that you've had too much time on your hands recently. What do you do?

21. You believe that you deserve a raise in pay on your job, but you realize that you are going to have to go to your boss and ask for it or you will never get one. You go in one morning to make an appointment to talk with him. To your surprise, he is standing right there, and says, "What can I do for you -- what do you want?" What do you say?
22. When calling your spouse during the day from work, they bring up something that you had had a disagreement about last night. You find yourself arguing again, and really feel your temper flaring. During a particularly hostile exchange, your spouse gets in a last word and hangs up on you. What do you do?
23. Every day coming home you pass the liquor store where you used to buy all of the booze you drank. It seems to bother you each time you pass it, and you find yourself thinking vague thoughts about how much fun you used to have getting drunk with your buddies. What do you do?
24. After a tense day at work, you find yourself with a splitting headache. You have taken several aspirin, but they don't seem to have done any good at all. What do you do?
25. It's just before closing time at work, and you are really looking forward to the dinner party that you and your spouse have planned with some close friends. Your supervisor approaches you and states, "Hey look, there's really a big backlog in work and I need you to stay with the rest of the employees and help get caught up on all this." What do you do?
26. The particular situation in which you used to get drunk in was with a friend at a particular bar. Since you made the decision not to do that anymore, you've been avoiding this friend. One day 30 minutes before work is over, this person walks up to you and is very insistent, saying, "Come on, let's have a few for old times sake. It's been a hard day - a couple of cold ones will sure taste good." What do you say?
27. You used to be quite good at meeting people at parties when you had had quite a few drinks. Now that you are trying to do the same thing sober, it really feels awkward. You have tried once to meet someone, but it just didn't seem to go well, and the person excused themselves quickly. Now you really feel tense, nervous, and down on yourself. How do you handle this situation?

28. In spite of your repeated warnings, your long talks and punishments, your child persists in coming home long after the curfew you have set. One night you are waiting 45 minutes after the deadline, and are really angry. She comes in, and as you start to explain why you are angry, she yells at you, "Look you old fossil, I can't live like you did back in the dark ages!" You really feel like you are about to blow up. How do you handle it?
29. You are unemployed and feel really depressed and tempted to get drunk when you are alone. Every day there is no one around during working hours, and the only people you know who are home seem to drink quite heavily all the time. What do you do?
30. Your spouse has asked you to change one of your old habit patterns around the house, but because it is such an old habit (something like leaving dresser drawers open), you are really having a tough time remembering. You've really been trying, but one morning you forget to do it. Your spouse is very angry and yells, "Don't you care about me, or are you that inconsiderate? Won't you do anything to make me happy?" What do you say?

Rosenberg Self Esteem Scale

Please indicate whether you strongly agree, agree, disagree, or strongly disagree with the following items. Circle the response which best reflects how you feel about yourself.

	<u>Strongly Agree</u>	<u>Agree</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
(1) On the whole, I am satisfied with myself.	SA	A	D	SD
(2) At times I think I am no good at all.	SA	A	D	SD
(3) I feel that I have a number of good qualities.	SA	A	D	SD
(4) I am able to do things as well as most other people.	SA	A	D	SD
(5) I feel I do not have much to be proud of.	SA	A	D	SD
(6) I certainly feel useless at times.	SA	A	D	SD
(7) I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
(8) I wish I could have more respect for myself.	SA	A	D	SD
(9) All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
(10) I take a positive attitude toward myself.	SA	A	D	SD

Interviewer _____
Date of interview _____
Client ID # _____

Phone Survey

1. Please briefly describe which parts of the treatment program have been most important (beneficial) to you?

2. Have you consumed any alcoholic beverages at all since you left the treatment center? _____

Note: If answer to this question is yes, continue with questions two and three then terminate the interview. If answer to this question is no, proceed to question four.

- a. How soon after leaving the treatment center did you drink? _____
b. Briefly describe the situation in which you took your first drink? _____

- c. How much have you been drinking since you left treatment? _____

3. What would have helped you to avoid drinking in the above situation?

4. Have you been tempted to drink at any time since leaving treatment? _____

Note: If answer to this question is yes then briefly describe the situation and the factors or reasons why you were able to resist drinking in these situations.

5. What do you think is the main reason that you have been able to stay sober since discharge from the treatment center?

APPENDIX B
SCORING GUIDELINES

TABLE B - I

FACTOR STRUCTURE OF THE SCQ-39

FACTOR NAME	TEST ITEMS	LOADING
1. UNPLEASANT EMOTIONS/ FRUSTRATIONS	(01) if I felt that I had let myself down	.802
	(02) if there were fights at home	.821
	(11) if I were afraid that things weren't going to work out	.853
	(12) if other people interfered with my plans	.866
	(21) if I were angry at the way things had turned out	.906
	(22) if other people treated me unfairly	.849
	(31) if I felt confused about what I should do	.864
	(32) if I felt under a lot of pressure from family members	.820
2. PHYSICAL DISCOMFORT	(03) if I had trouble sleeping	.696
	(13) if I felt drowsy and wanted to stay alert	.691
	(23) if I felt nauseous	.729
	(33) if my stomach felt like it was tied in knots	.789
3. PLEASANT EMOTIONS	(06) if I felt confident and relaxed	.771
	(16) if everything were going well	.855
	(26) if I felt satisfied with something I had done	.864
4. TESTING PERSONAL CONTROL	(10) if I convinced myself that I was a new person and could take a few drinks	.830
	(20) if I wondered about my self-control over alcohol and felt like having a drink to try it out	.839
	(30) if I started to think that just one drink could cause no harm	.886
	(39) if I wanted to prove to myself that I could take a few drinks without becoming drunk	.913
5. URGES AND TEMPTATIONS	(09) if I remembered how good it tasted	.769
	(19) if I passed by a liquor store	.704
	(29) if I unexpectedly found a bottle of my favourite booze	.824
	(38) if I suddenly had an urge to drink	.831

TABLE B - I (Continued)

FACTOR NAME	TEST ITEMS	LOADING
6. SOCIAL PROBLEMS AT WORK	(14) if there were problems with people at work	.963
	(24) if pressure built up at work because of the demands of my supervisor	.833
	(34) if I weren't getting along well with others at work	.932
7. SOCIAL TENSION	(04) if I had an argument with a friend	.675
	(05) if other people didn't seem to like me	.829
	(15) if I felt uneasy in the presence of someone	.808
	(25) if someone criticized me	.847
	(35) if other people around me made me tense	.873
8. POSITIVE SOCIAL SITUATIONS	(07) if I were out with friends and they stopped by a bar for a drink	.851
	(08) if I were enjoying myself at a party and wanted to feel even better	.900
	(17) if I were at a party and other people were drinking	.914
	(18) if I wanted to celebrate with a friend	.928
	(27) if I were relaxed with a good friend and wanted to have a good time	.896
	(28) if I were in a restaurant and the people with me ordered drinks	.839
	(36) if I were out with friends "on the town" and wanted to increase my enjoyment	.884
	(37) if I met a friend and he/she suggested that we have a drink together	.886

Note: Three items were dropped from the original 42 items of the SCQ. These were: 'if I wanted to heighten my sexual enjoyment'; 'if I wanted to feel closer to someone I liked'; and 'if something good happened and I felt like celebrating'. See text.

Note. This table is from Situational Confidence Questionnaire (SCQ): User's Guide (Table 6) by H. M. Annis and J. M. Graham, in press. Toronto: Addiction Research Foundation of Ontario. Copyright 1987 by the Addiction Research Foundation. Reprinted by permission.

STANTON L. JONES
ARIZONA STATE UNIVERSITY

SUMMER, 1978

A. S. B.

SCORING MANUAL

General Scoring Criteria:

Competent Response (2 points) - maximizes possible positive gains in the situation for the individual while minimizing possible negative consequences.

Incompetent Response (0 points) - minimizes potential positive gains and maximizes negative consequences. "I don't know" is always scored zero.

Intermediate Response (1 point) - is neither classified as competent or incompetent. May entail constructive action but it fails to maximize positive gains.

1. The broken watch

2 -- Assertive demand that watch be repaired with alternative courses of action stated.

Ex: I'd tell him that he's responsible and he can either fix it free or I'll be talking to the Better Business Bureau/I'll see my lawyer/ I'll inform the manufacturer.

1 -- Demand for action alone

Ex: You'd better fix it...I want my money back.

0 -- Nothing, or aggressive course of action

Ex: You can fix it or I'll rearrange your face.

2. The person who trips

2 -- Apology plus some helping action

Ex: I'd apologize and see if I could help...I'd apologize (with series of statements indicating that subject would stay and assist).

1-- Apologizing and leaving

0 -- Nothing; leave

3. The uncomfortable party

2 -- Leave without regard for the harassment.

Ex: Who cares what they think; I'd leave and let them talk.

1 -- Leave with aggressive remark or stay without drinking.

Ex: I'd tell them all how much they looked like fools and split...I shouldn't feel uncomfortable, so I'd stay.

0 -- Stay and argue and/or drink.

Ex: I'd just stay and try to fit in...I'd straighten those drunks out.

4. Violation of confidence

2 -- Action to restore both relationships - assertive confrontation with friend and explanation of some sort to the acquaintance.

Ex: I'd tell my friend that his actions made me feel hurt and angry, and I'd explain to the other person exactly how I felt and apologize for gossiping.

1 -- Action to restore either relationship or learning not to spread such feelings around.

0 -- Aggressive response to friend, or never confiding in friend again. Nothing.

5. Unable to sleep

2 -- Implementation of a concrete skill or plan likely to meet with success falling asleep or which the client indicates has met with success in the past.

Ex: Biofeedback...Relaxation exercises...Reading/music puts me to sleep...Prayer would settle my mind so I could sleep.

1 -- Nothing, lay there, or some action not likely to lead to sleep or help resolve problems.

Ex: Pace...Smoke cigarettes and drink coffee...Read (unspecified result).

0 -- Potentially counter productive course of action.

6. The job interview

2 -- Appropriately assertive request to discuss your qualifications.

Ex: I really feel I could fill the position adequately; could I discuss with you what you see as my weaknesses? I'm really excited about the job.

1 -- Nothing, or saying "thank you" and leaving.

0 -- An aggressive response likely to eliminate future job possibilities.

Ex: Thanks for wasting my time!

7. Unjustly critical supervisor

2 -- Recognition that the supervisor may have a personal problem at the time. Subject allows time for things to settle down then assertively confronts supervisor in private.

1 -- Looking for a new job. Going above the supervisor to complain. Ignoring the incident and trying to work harder. Nothing.

Ex: You can't talk to someone like that; forget it... Who needs a job like that?

0 -- Aggressively confronting supervisor immediately.

Ex: I'd follow him to his office and tell him what I thought.

8. Depressed and lonely; remembers bottle

2 -- Appropriate strategy for dealing with feelings; possibly coupled with getting rid of bottle (optional).

Ex: Go to AA discussion group and talk over my feelings and ways to handle them...When I get those feelings, long walks really help.

1 -- Disposing of the bottle, but no dealings with feelings.

0 -- Inadequate or counterproductive strategy for dealing with feelings with no strategy for not drinking.

Ex: Nothing...I'd go home and try not to feel like that.

9. Layoff threat

2 -- No direct action is possible. Therefore client describes strategy for dealing with worry. Possibly thinks about the problem for a reasonable period of time.

Ex: I might prepare a resume and then play tennis or something to get my mind off it...I would talk it over with my wife and then talk about other things... I've learned to live in the here and now - I'd think about right then.

1 -- Unspecified strategy to deal with the worry.

Ex: Try not to let it get to you.

0 -- Nothing; worry.

10. Depressed co-worker

2. Assertive confrontation with peer explaining perceptions and feelings asking for termination of the distracting comments.

Ex: Your complaining really makes it hard for me to work and I'm not happy with that - Please knock it off.

1 -- Aggressive confrontation or goes directly to boss.

0 -- Nothing, ignore the co-worker, quit.

11. Friend in the park

2 -- An assertive refusal which is more than just a second "no, thank you."

Ex: No, I'm not better; I'm just not able to drink... I'm allergic to the stuff and it's bad for me...I can't handle it.

1 -- A false excuse, or a second undefined refusal.

Ex: No, please...That particular brand is horrible.

0 -- Accepts the beer; leaves.

12. "I am really worthless"

2 -- Appropriate strategy likely to lead to a rapid restoration of feelings of self worth.

- Ex: I'd get busy with work and prove to myself I'm a good worker...I'd examine my mistake and be sure I would never do that again...I'd realize that I'm worth a whole lot regardless of my job performance... talk - get some encouragement.
- 1 -- Undefined strategy; continue as usual.
- Ex: Go home and start a new day tomorrow...nothing.
- 0 -- Quit.
13. Co-worker not doing his share
- 2 -- Assertive discussion with co-worker
- Ex: I'd talk to him about it - just exactly how I feel.
- 1 -- Delaying action until work is done, or a response likely to get the employee immediately in trouble.
- Ex: Tell the boss...He'd sure get it when we were through.
- 0 -- Aggressive response; nothing.
14. Fight with spouse
- 2 -- Appropriate strategy for dealing with anger.
- Ex: Go for a walk and think the whole deal through... talk over my feelings and problems with someone to get it into perspective.
- 1 -- Nothing. Person stays around without specified activity - no dealing with anger. Stomps around house.
- 0 -- Aggression.
15. Silent treatment
- 2 -- Speaking first, but expressing feelings about the silent treatment.
- Ex: Communication is important, so I'd let her know what I thought about the silent treatment and try to talk it out anyway.
- 1 -- Speaks first, trying to reestablish communication.
- Ex: I'd just try to talk it out.
- 0 -- Leave or give the silent treatment right back.
- Ex: It's impossible to talk at those times.

16. Uncooperative landlord

2 -- An assertive legal attempt to get action.

Ex: I would get a firm commitment to a date by which the repairs would be done...I'd withhold rent until he repaired it...Get them done or I'll go to the tenants association.

1 -- Non specific demand for action.

Ex: You'd better get those repairs done.

0 -- Aggressive, or no action.

17. Snubbed at a party

2 -- Forget it and go talk to someone else; possibly attempt to complete conversation later.

1 -- Confronts friend assertively at party, leaves.

0 -- Aggressive confrontation.

18. Craving

2 -- Either seeks out effective social support, or implements concrete cognitive/behavioral plan for preventing drinking possibly diversionary activities.

Ex: AA...Call a relative who knows my problem...I think about what awful shape I was in when I drank and that stops it...turning it over to my higher power does it.

1 -- An indefinite or risky strategy.

Ex: Try to hang on as long as possible...Watch some TV instead...Hope I don't drink.

0 -- Nothing, drink.

19. The teasing friend

2.-- Assertive statement why teasing isn't appreciated.

Ex: Look, your teasing makes me tense and makes our relationship unpleasant for me - please stop.

1 -- An aggressive response.

Ex: One more crack out of you and I'll-----I don't want to hear it!!

0 -- Avoid the person; nothing.

20. Alone on Saturday afternoon

2 -- Person takes appropriate short and long term actions.

Ex: I'd get busy mapping out my schedule and make sure I stayed busy...I'd go to AA and see if I couldn't do some volunteer work for them...Go to some sports event and probably do more of that...Get together good books to read.

1 -- Either short or long term strategies alone.

Ex: Go to AA...(only one meeting implied)...Call someone.

0 -- Nothing, unsure.

21. Raise in pay

2 -- Asks to speak with boss in private about the raise or evidences concrete approach to presenting a positive case.

Ex: I'd explain why I thought I deserved a raise in pay considering my skills. How long I had been there, etc.

1 -- Unsupported demand for a raise.

Ex: It's time I had a raise!

0 -- Nothing, passive or aggressive.

22. Argument with spouse on the phone

2 -- Thinks through the problem and prepares to discuss rationally that evening. Possibly calls spouse back after allowing time to cool off and apologizes for arguing on the phone, expressing desire to discuss it that evening.

1 -- Waits until evening to argue again. No intervening activity. Nothing.

Ex: I'd just go at it again when I got home.

0 -- Avoids question, or calls back to argue or get last word in.

23. Passing old liquor store

2 -- Changes route, or engages in effective cognitive strategy to balancing out the positive feelings.

Ex: I'd think of the bad times, too, all the health problems, arguments, misery...

- 1 -- Try not to think about it; just drive on by.
- 0 -- Stop in, drink.
24. Headache
- 2 -- Relaxation or appropriate non chemical alternative. Subject evidences awareness that tension is the problem.
- Ex: Warm shower...rest...take a nap...TV always relaxes me.
- 1 -- No action.
- Ex: Nothing you can do - wait it out.
- 0 -- Stronger drugs, or actions likely to complicate the problem.
25. Overtime request
- 2 -- Recognizes importance of the job but attempts to suggest alternatives to overtime that evening.
- Ex: I'd say that this dinner party was really important, and that I'd be glad to come in early the next morning to do my share...I'd see if I could switch times with someone else.
- 1 -- Assertive refusal; unconditional acceptance.
- Ex: No, I can't stay - you didn't give me any advance notice...You'd have to stay.
- 0 -- Quit; aggressive refusal.
26. Insistent friend - work
- 2 -- An assertive response which allows friendship to continue.
- Ex: No, I don't drink anymore. Let's go to a coffee shop for some coffee...Let's go to my house instead.
- 1 -- Assertive true refusal with no alternatives for maintaining friendship.
- Ex: No, I don't drink anymore. You can go have a few if you want.
- 0 -- Untrue excuses, total avoidance, acceptance of the invitation to have a few, or going along without drinking. Aggressive responses.

27. Meeting people sober

- 2 -- Pursues adaptive strategy for meeting people, recognizing a need to overcome uneasiness.

Ex: I'd probably think the situation over for awhile then try again...I'd look around for someone that looked easy to get along with and try to meet them...get with a gregarious friend and let them help me...try again.

- 1 -- Do nothing.

- 0 -- Leaves party, drinks, is aggressive to the person who gave him the cold shoulder.

28. Curfew violation

- 2 -- Exhibits an appropriate strategy for dealing with anger in disciplining child.

Ex: If I was that hot, I would send her to bed and tell her that we would get down to brass tacks tomorrow.

- 1 -- Appropriate disciplinary action without dealing with anger.

Ex: I'd take the car keys away from her...Ground her.

- 0 -- Reacts out of anger, or uses other inappropriate disciplinary actions. Impossible threats.

Ex: Slap her...Ground her for a year...Kick her out of the house.

29. Unemployed and alone

- 2 -- Primary focus on long range planning. Systematic approach to increasing activities (job, friends, and/or hobbies).

Ex: I'd do volunteer work for AA...I'd make a resume and start job hunting...start lining up art/sport events.

- 1 -- Appropriate short term solution.

Ex: Attend AA meeting...call someone...window shop.

- 0 -- Nothing.

30. Angrv spouse

- 2 -- Appropriate apology, possibly with the statement
 that the mistake was due to carelessness, not
 inconsiderateness.
- 1 -- Apology, coupled with aggressive response; nothing.
- Ex: I'm sorry I did it, but you aren't perfect either.
- 0 -- Aggressive, argumentative response.

Scoring for Rosenberg Self
Esteem Inventory

Scale Item I - This item is contrived from the subject's combined responses to the three questions that follow. A positive score on Scale Item I is achieved by the subject answering either two out of three or three out of three of these items in a "positive" direction (i.e., a direction indicating low self esteem). Astericks indicate positive responses. If the subject answers either one out of three or zero out of three of the items in a positive direction, he/she receives a negative score on this item.

(1) I feel that I'm a person of worth, at least on an equal plane with others.

- 1 _____ Strongly agree
- 2 _____ Agree
- *3 _____ Disagree
- *4 _____ Strongly disagree

(2) I feel that I have a number of good qualities

- 1 _____ Strongly agree
- 2 _____ Agree
- *3 _____ Disagree
- *4 _____ Strongly disagree

(3) All in all, I am inclined to feel that I am a failure.

- *1 _____ Strongly agree
- *2 _____ Agree
- 3 _____ Disagree
- 4 _____ Strongly disagree

Scale Item II - This item is contrived from the subject's responses to the two items that follow. Subjects who indicate either one out of two or two out of two positive responses receive a positive score for Scale Item II.

(1) I am able to do things as well as most other people.

- 1 _____ Strongly agree
- 2 _____ Agree
- *3 _____ Disagree
- *4 _____ Strongly disagree

(2) I feel I do not have much to be proud of.

- *1 ☐ Strongly agree
- *2 ☐ Agree
- 3 ☐ Disagree
- 4 ☐ Strongly disagree

Scale Item III

I take a positive attitude toward myself.

- 1 ☐ Strongly agree
- 2 ☐ Agree
- *3 ☐ Disagree
- *4 ☐ Strongly disagree

Scale Item IV

On the whole, I am satisfied with myself.

- 1 ☐ Strongly agree
- 2 ☐ Agree
- *3 ☐ Disagree
- *4 ☐ Strongly disagree

Scale Item V

I wish I could have more respect for myself.

- *1 ☐ Strongly agree
- *2 ☐ Agree
- 3 ☐ Disagree
- 4 ☐ Strongly disagree

Scale Item VI - This item is contrived from the subject's responses to the two items that follow. Subjects who indicate either one out of two or two out of two items in a positive direction receive a positive score for Scale Item II.

(1) I certainly feel useless at times.

- *1 ☐ Strongly agree
- *2 ☐ Agree
- 3 ☐ Disagree
- 4 ☐ Strongly disagree

(2) At times I think I am no good at all.

- *1 Strongly agree
- *2 Agree
- 3 Disagree
- 4 Strongly disagree

This was taken directly from Rosenberg, M. (1979).
Conceiving the Self. New York: Basic Books.

APPENDIX C
VALIDITY STUDIES

Procedural Studies for Vignettes

Procedural studies were conducted in order to insure the believability of the models and to confirm that the vignettes being enacted were representative of the situations being targeted in the training program. In Validity Study #1, a group of clients currently participating in residential treatment viewed the videotaped role plays and provided feedback on an open-ended questionnaire as to the believability of each role play and their perceptions of the role play's purpose (see this appendix for a sample rating form). These comments were generally favorable, indicating that the role plays illustrated the desired behaviors. The clients were able to accurately describe the type of situation being enacted and were able to identify the purpose of the individual vignettes. For the most part, the clients thought that the acting was "good" although they noted that the acting could be improved in a few of the cases. The vignettes which the clients identified as not being realistic were later replaced after Validity Study #2. The picture and sound quality of the tapes ranged from excellent to adequate. In those cases where consistent comments were made about the quality of the tape, efforts were made to improve the quality of the tape through refinements in the duplication process. No quantitative data was collected in this study.

In Validity Study #2, a group of six addiction therapists viewed the videotaped role plays and provided feedback on a rating form designed for this purpose (see this appendix for a copy of the rating form). The therapists correctly matched the vignettes with the designated categories with 100% accuracy. In the case of interpersonal conflict situations the therapists also correctly identified the subcategory (i.e., non-assertive, aggressive, or assertive). However, two of the videotaped role plays received a believability rating of less than 3.5 on a 5-point scale (see Table C-I for results). Therefore, these role plays were discarded, and new role plays were developed.

Following the development of replacement vignettes, a third validity study was conducted. A different group of eight addiction therapists viewed three newly developed vignettes which were interspersed with vignettes having previously received adequate ratings. Two of the newly developed vignettes received satisfactory ratings, and one was eliminated because it did not receive an adequate believability rating (see Table C-II for results). Again all of the role plays were categorized correctly. Fourteen vignettes were used in this study, 12 from validity study #2 and 2 from validity study #3. Four vignettes were used in the negative emotional states segment, seven vignettes were used in the interpersonal conflict segment, and three vignettes were used in the social pressure to drink segment.

Table C - I

Counselor Validity Study #1

Role Play	Type of Situation	Mean Believability
1	Interpersonal Conflict - Assertive	3.83
2	Negative Emotional State	3.16
3	Social Pressure	4.66
4	Interpersonal Conflict - Passive	4.08
5	Negative Emotional State	4.16
6	Interpersonal Conflict - Aggressive	3.83
7	Social Pressure	4.66
8	Interpersonal Conflict - Aggressive	4.33
9	Negative Emotional State	2.58
10	Social Pressure	4.66
11	Interpersonal Conflict - Assertive	4.00
12	Interpersonal Conflict - Aggressive	4.66
13	Interpersonal Conflict - Assertive	4.66
14	Interpersonal Conflict - Assertive	4.83
15	Interpersonal Conflict - Aggressive	5.00

Table C - II

Counselor Validity Study #2

Role Play	Type of Situation	Mean Believability
1	Negative Emotional State	2.6
2	Social Pressure	4.0
3	Interpersonal Conflict - Aggressive	4.7
4	Negative Emotional State	4.1
5	Social Pressure	4.3
6	Negative Emotional State	3.8

VIDEOTAPE RATING FORMS FOR COUNSELORS

Using the categories defined below, please identify the type of situation portrayed in each of the following videotaped vignettes:

A. Coping With Negative Emotional States

Involves coping with a negative emotional state, mood, or feeling that is primarily intrapersonal in nature, i.e., not precipitated by a present or recent interaction with another person. Can include feelings of fear, anger, anxiety, depression, loneliness, sadness, boredom, etc.

B. Coping With Interpersonal Conflict

Involves coping with current or relatively recent conflict associated with any interpersonal relationship such as marriage, family patterns, friendship, or employer/employee relations.

For situations involving interpersonal conflict, please note whether the conflict was dealt with in an assertive, passive, or aggressive fashion.

1. Assertively
2. Passively
3. Aggressively

C. Dealing With Social Pressure To Drink

Involves responding to the influence of another individual or group of individuals who exert pressure on the individual to use substances.

In addition, for each videotaped vignette, please indicate how believable you feel that the situation was using the scale below:

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
Unbelievable	Somewhat	Neutral	Somewhat	Believable
	Unbelievable		Believable	

Any additional comments would be helpful.

Vignette #1

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #2

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #3

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #4

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #5

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

Vignette #6

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #7

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #8

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #9

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #10

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

Vignette #11

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #12

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #13

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #14

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

_____Vignette #15

Type of Situation _____

Believability (Scale 1-5) _____

Comments: _____

APPENDIX D
VIDEOTAPE TRANSCRIPT

TRANSCRIPT OF TRAINING PROGRAM

Hello, my name is Dr. Alan Sodetz and I'm a psychologist and the Clinical Director at a substance abuse treatment facility, and what we're going to be working with today is a program directed at teaching you some coping skills to increase your effectiveness at dealing with certain situations that frequently lead to drinking. So, we're going to spend the day trying to develop your skills in those areas and we're going to be dealing primarily with three specific areas that research suggests tend to have a high frequency of leading people toward the use of alcohol. The three situations we're going to talk about include

...something that psychologists call Negative Emotional State. Negative Emotional State is a long, fancy way of saying feelings that you have that don't feel very good--you don't like having them very much. The feelings that we're going to be talking about fall primarily into three groups. The first group we're going to talk about are a group of feelings that primarily revolve around the experience of anger. And as you may know, anger tends to be a feeling that has a lot of tension associated with it and a lot of upsettendness and tends to be an experience that very frequently leads to going out and trying to take a couple of drinks, cool yourself down, get out of the situation. So, it's a fairly popular coping style for a lot of people that get angry pretty frequently; and very often, drinkers tend to get angry a little more often than other people, so we're going to focus in on this angry kind of experience.

The second group of feelings that we're going to be talking about as negative are a collection of feelings that we refer to as fear, talking about being frightened. Fear runs a whole gammit from being terrified to being just anxious and tense as it can be a very unpleasant experience for most people, rarely do we seek it out. Sometimes you find people who go to amusement parks and they'll pay money to have somebody scare them to death, but most of us, if we can, tend to avoid feeling frightened and it tends to be one of those experiences that when we feel frightened we're likely to seek out alcohol because that's going to help numb us and that's going to help calm us down and we're not going to feel frightened so much anymore.

The third category that most of these negative feelings relate to is a category called sadness and that covers a whole range of experiences all the way from feeling depressed and that's kind of deep sadness where you feel

teary and sometimes very alone and you just don't know what to do and it can include something as simple as boredom that we just don't have anything to do and we sit around just feeling kind of crummy but it tends to be, once again, one of those experiences that we try to avoid and one of the ways to avoid a lot of different kinds of experiences is to go out and seek drinks, go ahead and get drunk, become intoxicated, and when you do that you may be coping with negative emotional state.

The second situation that we're going to be talking about, and that I'll be teaching you to cope with differently, is a group of situations called Interpersonal Conflict Situation. Interpersonal refers to something that takes place between the two people. When we're talking about negative emotional states, we're talking mostly about internal experiences that we generate that may not have a great deal to do with other people; they have to do with events or situations, they may not necessarily involve other people. When we're talking about interpersonal conflict, we're talking about something that takes place between you and another person and that can be a disagreement, it can be a confrontation, but conflict means that you don't agree on something, there is a difference of opinion. Very often people who use alcohol to cope with difficulties, very often cope with interpersonal conflict by going out and getting drunk. So, we're going to try and teach you some effective ways of dealing with interpersonal conflict without the use of alcohol.

Finally, we're going to talk about a situation that involves social pressure and drinking frequently is a social activity. It has its own social setting, it typically takes place in a bar or a bowling alley, or a social kind of situation, very often involves other people. Those of you who have made the decision to stop drinking will most likely find yourself encountering old drinking buddies, old people that you used to hang around with when you used alcohol, and what you're going to end up doing is you're going to end up experiencing social pressure to drink. Your friend is going to say c'mon have just one, c'mon just of old time sake, c'mon why don't you start drinking again, you can handle it now you've been straight for a while. There's going to be pressure and you're going to need to learn to deal with that if you wish to maintain your sobriety. So, the experience that you're going to have today is a three part experience. We're going to have three separate workshops. All of them are interrelated because as I talk about this you're going to find that feelings relate to interpersonal conflicts relate to social pressures and that there is a

relationship between the three of the, but we're going to deal with them in three separate workshops, the first of which is going to deal with negative emotional states and we are going to very specifically teach you skills that research has demonstrated will effectively cope with these situations without the use of chemical. So, we're going to have a workshop, we're going to teach you the skills, we're going to give an opportunity to practice them so that by the time the workshop is over, you'll be able to leave here and you'll be able to feel like you can cope with those situations better. We're going to them take a small break and we're going to have a second workshop that is going to deal with effectively coping with interpersonal conflict. Once again, there will be a lecture format where we talk about what interpersonal conflict is, how you go about getting yourself into a state where you're likely to drink, and then we're going to teach you how not to do that and how to cope with those situations. So, once again, at the conclusion of that segment of our workshop, you're going to be able to walk away saying that you can now feel better with those interpersonal conflicts without the use of alcohol.

Finally, the third workshop is going to deal with how to cope with those social pressures, so that we'll have an opportunity for you to rehearse and to practice and to experience that kind of pressure in role play situations and we will coach you and teach you very specific ways to deal with it. What we hope we come out of this day with is a whole package so that you can leave here feeling like you have increased your effectiveness and you have improved your ability to deal with a variety of situations that frequently lead to alcohol use, so, we'll be working on that throughout the day.

NEGATIVE EMOTIONAL STATE

Our workshop for this hour is designed to help teach you to to cope more effectively with negative emotional states. When we're talking about negative emotional states, essentially we're talking about those emotional experiences that people find to be unpleasant for the most part and that research suggests lead more people to drink and use substances as a form of coping. Since I'm going to talk about the three states, the one I want to begin with is a state called anger. I'm going to talk some about anger and then we're going talk about fear, and finally we will talk about sadness and if you notice all of these tend to be relatively unpleasant experiences, and for the most part, people tend to think about these experiences as being something that just kind of happens to them. So, before we actually get into talking about

the experiences and talking about how to cope with them, what I want to do is I want to talk about a theory. There is kind of a neat theory that has to do with dealing with these particular kinds of experiences and the theory is called Rational Emotive Theory and there is no reason for you to remember the name of it except that it helps when you can understand the two parts. The theory is called Rational Emotive Theory. Rational means thinking logical, what goes on inside your head. Emotive is emotional feeling/experiential. So this theory tends to talk about how thinking and reasoning tend to lead to emotional states. One of the easiest ways to talk about it is to talk about it using what is called the ABC Theory. ABC is simple for most people to remember and the easiest way to talk about it is for us to start with an example. So then again, we'll go back to the feeling stage and we'll start talking about anger.

Most people think that external events, something that goes on around them caused them to have certain experiences and caused them to feel a certain way. For example, if I were to walk up to you and I were to kick you in the shins, very often people will say, "You made me angry"; that I walked up to you and I kicked you and I made you angry. Well, in the ABC Theory, A is called An Activating Event. That's the A part of ABC; something happened to create a situation and most people believe that that activating event leads to anger which is the emotional consequence of the activated offense; when I walk up to you and kick you in the shins and you end up being angry. You believe that my kicking you causes you to be angry. While ABC Theory says no that's not quite the way feelings work and that's not quite the way logic works. What happens is there is an intervening belief, there is a being that takes place between A and C, that my kicking you in the shins does not cause you to be angry, but the way you think about my kicking you in the shins leads you to be angry. For example, if I were to take all of you in the room and I were to walk up to each one of you and kick each one of you in the shins and turn and then asked you how you felt about it, what would most likely happen is the vast majority of you would tell me that you feel angry, but that's not the only reaction we're going to get. Most of you are going to say angry; some of you are going to say sad, that my kicking you makes you sad. You say how will my kicking you make you sad? Well, if you want me to like you and I walk up and kick you, then maybe you'll feel sad or you'll feel badly that I kicked you as opposed to angry, I'll hurt your feelings. There are probably a few strange folks in the crowd who would like it and they would be happy that I walked up to them and I kicked them in the shins because

if you can think back to high school one of the things that people used to do in high school all the time is they used to walk around and they'd walk up to you in the hallway and they'd pop you on the arm. Popping people on the arm was one of the ways that you expressed affection and caring. So, some people would take a look at this and they'd say, "Gee, that guy really likes me. He came up and he kicked me. He cared enough about me to choose me out of this crowd and he walked up to me and he kicked me." and they like it. Then there's a few folks who might be a little smarter than some of the rest of you and they would experience fear. They would be afraid of me because I'm not a little guy and when someone my size comes up to somebody else and starts kicking them in the shins for no apparent reason, that has the potential to be frightening. So, I guess what I'm say is that this one activating event, walking up to somebody and kicking them in the shins can create anger in some people, sadness in other people, happiness in other people, and fear in other people. Well, if the same activating event can generate those different feelings, then how can we say that the event caused the feelings. So, what this theory turns around and says is it's not the event, it's the way you think about it. So, those people who end up feeling angry, what they're doing is they're talking to themselves, they're saying some things to themselves, they've got this belief that in order to be angry about being kicked in the shin, then you must be saying things to yourself like, "He has no right to do that", "Who said he could touch me", "He hurt me and it's not right, I didn't do anything to him". You basically generate those feelings for yourself by the way you think about what happened, the same way people who feel sad. They sit there and they think, "Gee, I wish he really liked me. He must not like me very much, I don't understand what I did to him to cause him not to like me", and they end up feeling sad, but it's because of the way they're thinking. The same thing with happy; "Boy, he really likes me, that's really neat". These thoughts are going through your head. And the fear, "Oh, oh! Maybe he's going to do something else to me, maybe he's not just going to kick me in the shins, maybe he's going to kick me in the face next time, who knows?" So what we're doing now is we're looking at generating different kinds of experiences with different kinds of beliefs. So, as we start to talk about more effectively coping with negative emotional states, one of the things that is very helpful is for you to understand that you generate your own emotional states. You cause them for yourself on the basis of what's happening to you. So, if you're going to more effectively cope with them, then you need to have a better understanding of how it is you're causing it. So, what

we're going to end up with here eventually is a guided map for you to follow in terms of trying to better understand your experience and better cope with it and the first step is going to be you need to understand what you're thinking. You need to understand your beliefs about the event that happened. So, if your sitting there finding yourself being angry about a situation or sad about it or depressed about it, one of the things you need to be doing is you need to be sitting there asking yourself, "What am I think about? What situation occurred? What happened? and How am I thinking about it?" That's going to be step one. This flows for us into a process called reality testing that most alcoholics are not very good at. They tend to not do reality testing very well. Which means that for the most part, you spend a lot of time in a little fantasy world, you make up stories about how you think things really are. Sometimes they call it denial, sometimes they call it an overactive imagination, but for the most part, they have trouble dealing with reality and reality essentially means what really is. Very often people get themselves in trouble because they don't bother to reality test, they don't bother to check and see if what they're thinking or what they believe is consistant with what really is. Now, using one of the more extreme examples, when you get somebody on LSD they think they can fly even though they happen to be on the top of a 10 story building and if they don't reality test, if they don't check their wings first and find out whether they can get themselves off the ground, if they just walk out the window, I think they're going to get themselves in trouble. So, what we have to do is we have to reality test. Reality testing is very simple. I has four little steps to it. The first step involves thinking, that's an important thing to do in a lot of different coping styles is thinking. The first step is state your belief clearly. You can't find out whether your beliefs are real or not until you figure out what it is you believe. So, the first step is to state your belief clearly. One of the ways to do that, and I suppose an example is we could look at this wall over here, we look at this board and I can ask you what color that is. I can stand here and I can say clearly this is red. So, I'm standing over here and my belief is that this is a red board. Now, there may be some of you in the room here that would dispute that because many of you probably see it as gray, but maybe you don't. How do we find out what it is. This has a little more practical application than things like my boss doesn't like me; by spouse doesn't like me; my children don't like me; if I just don't go into work today because I'm hungover, nobody will mind too much. We can have all those kinds of beliefs that apply to real life that all need to be checked out, but this one right now is fairly

easy, so we're going to start out with the position that says my belief is that this is red, the board is red. Other people may have some other beliefs, but this one's mine. I state my belief clearly--I believe that this is red.

The second step in reality testing has to do with what data do you have to support your belief. No that one gets kind of tough for a lot of folks. What data do you to support your belief...what evidence do I have to support my belief that this is red. Well, low and behold, the only evidence that I have is my perception. So, all I can stand here and do is I can say I see that as red. That is what registers in my eyes in my mind is red. I don't have any other data to support it, which is okay, that doesn't mean it's wrong, it just means that I don't have much data to support it. There are a lot of other situations where people might say things like, "Well, I believe the communists are out to get me." That's my belief, that the communists are out to get me. How do you know that, what evidence is there. Well, the data that there is to support my belief is whenever I walk down the street and it's crowded, there are people who are following me. So, I know that people are following me, therefore, I have evidence to support my belief that the communists are out to get me because they keep these people, I don't know who they are, they're strangers, but they keep following me down the street whenever I'm walking with a crowd. So, I can get strange beliefs, I can get a variety of different kinds of beliefs and I can get a lot of data because I don't defy any of you to go out on a crowded street and you start walking down that street and I guarantee you that there will be a bunch of people following you down the street, so you too will have evidence to support your belief that people are out to get you. Well, that sounds a little weird, so we need this third step.

The third step is is there any other way to interpret the data. You have to ask yourself another question, is there any other way to interpret the question. Now, here I'm saying the only data I have is that I look at this board and I see red. Is there any other way to interpret that besides the board being red? Well, I suppose there is. I suppose I could be color blind and that would mean that maybe this isn't really red, maybe I just see it that way. So, we have at least one other potential explanation for this board being red. Now, here we're talking about the communists following us. Is there any other way to interpret having people walk behind you on a crowded street other than believing that the communists are following you? Of course there are other ways of believing. Maybe they're all going in the same direction

because that's the only way to get from this place to that place and they're all going the same way and it's a crowded street and there's probably people going in lots of direction and by chance, some of them will be going in your direction, but that doesn't mean that they're following you, it may just mean that they're going in the same direction that you're going in. So, there is another possible way to explain the data. So, if we can open your mind to considering other possibilities, it makes it more likely that your beliefs will have some contact with reality because you're going to explore the data that you base it on, you're going to take a look at other possible ways to explain it, and finally, you may consult other beliefs. What do other people believe? That means that I can stand here in front of this room and I can say how many of you see this board being red and nobody puts their hands up. If I see the board as being red and nobody else sees it that way, maybe I need to take a second look at whether these other possible explanations are more realistic, maybe I need to go ahead and take the little color blindness test to find out whether really I see this color, whatever it is, as red because nobody else here seems to see it that way. The same way can happen with your belief that you're being followed. Ask some of your friends and see whether or not they believe you're being followed also. Do they take a look at the same evidence when your walking down the street and they see these people going the same way, do they interpret that as meaning that those people are following you? So you want to consult some other people too. So that gets into personal kinds of things. For example, we talked before about you can skip a days worth of work, you're not going to go in because you believe that the boss won't mind. What data do you have to support that belief. Well, if you've not gone into work four or five times before and the only thing he's ever said is that he wishes you would call first, so you have some data to support it. Is there any other way to interpret the data? Well, sure there is. He's setting you up to fire you, he's just going to let you go out there and hang yourself.

So, now what we've had is we've had a little bit of an introduction to Rational Emotive Theory. And Rational Emotive Theory, as you recall, has to do with the ABC's of understanding how you generate your own feelings. Then we talked about reality testing and reality testing is a step that is extremely important for you to carry out before you act because ultimately what we're talking about is leading up to some kind of action. In essence, we're saying what are you going to do about...What are you going to do about the way you feel? What are you going to do about the situation that you're thinking about. So, first

needing to understand how you're generating your own experiences, then you need to reality test, and then we need to take a look at action and behavior. Now, there's going to be a whole lot of different things that people could do depending upon the kinds of feelings that you happen to be experiencing. So, now we go back to those three basic negative states. Anger tends to be a kind of neat emotion. A lot of people feel it, a lot of people don't allow themselves to feel it because when you get raised as a little kid, very often you're told that that's not an acceptable emotion, you're not supposed to be angry, you're not supposed to be made about things, so a lot of people learn to repress this and they don't experience it very well, but lots of folks, especially for some reason, folks who abuse alcohol and abuse substances, don't seem to have much difficulty experiencing anger, that seems to be one of the things that they're pretty good at. Now, I don't condone going out and beating on somebody because you happen to be angry with them, that doesn't make much sense because it's not constructive. Anger tends to be an energizer. Anger tends to be an experience that give people energy to go out and do things, but what we hope is that you can learn to channel that energy into a constructive way of dealing with the anger. I can give you a couple of examples and then your leader during the workshop today will help you generate more ideas about more ways to deal with anger, but we can talk a little bit about being assertive as opposed to being aggressive. One of the things you can do when you happen to be angry is you can assert yourself and asserting yourself may mean nothing more than walking up to someone and saying, "You know, I got angry over what you did. I would appreciate it if you wouldn't do it anymore." You don't have to walk up and threaten them, you don't have to yell at them and scream. You can say you can be angry merely by walking up to somebody and saying I'm annoyed with what you're doing. It irritates me when you step on my food. I would appreciate it if you wouldn't do that anymore. Now, people that get aggressive, they say things like, "Get off of my foot or I'll break your face." That's not assertive, we consider that to be aggressive because it leads to another confrontation. If I say to you, "I'd appreciate it if you would get off my foot because I find it annoying", they may or may not get off your foot, but at least they know that you're annoyed with them and that's what assertive is being, it's expressing yourself and letting other people know how you feel about them. Ideally, when you express anger, and anger is on a continuum, when it flows all the way from minor irritation on up to fury, so that's just a big classification. I'm only going to give you three classification for negative affect, just because it's

easier to think about the world that way in my mind. It's not the only way to think about it, there's lots of different ways to think about it. It is easier for me to think about negative emotional states in groups. So, one of the things we'll be talking about in anger is a group and it goes from irritation to furious, it passes through annoyance, angry, etc., frustration fits in there very often. Ideally, what you're trying to do when we try to cope with anger constructively is you try to take some action that increases the likelihood that whatever is leading you to be angry will stop. So if you say get off my foot or I'll bust your face, he may get off your foot, you may have to bust his face, you may not be angry about that anymore, but now you may get arrested, so that probably won't help very much. So saying something like I'd appreciate it if you'd get off my foot, seems to be more effective.

One of the other states we were talking about was fear. Fear ranges all the way from nervous, we talked about being nervous, being anxious, being stressed, having feelings of anxiety. Then all the way down here we have terrified. So, we have this collection of feelings, all fit into this category here to range from being nervous to being terrified. You'll find and your leader will discuss with you, a number of possibilities for dealing with fear. They go all the way from, again back here, figure out how you're frightening yourself, figure out what you're afraid of, figure out what you can do about it, along with practicing relaxation techniques, practicing stress management techniques, improving your self-confidence, there's a whole variety of ways for dealing with this class of feelings.

The third class that we're going to talk about is sadness. This ranges all the way from kind of feeling down or blue to being severely depressed. Once again, it's a range of experiences and again, the coping here has to do with figuring out how it is you're going about depressing yourself, what you're sad about, how are you thinking about the situation to create that sadness. Is it real? Is the way you're thinking about the situation real? Is there a basis in reality for feeling that way and then what are you going to do about it and once again, there are a variety of different things depending if you're feeling lonely, if you're feeling bored. When people are bored, it doesn't make sense to go out and drink or go out and get high. When you're bored, it makes sense to go out and do something interesting. That's what people do to alleviate boredom. When you're feeling kind of down in the dumps, you're feeling kind of blue, one of the things that make sense is that you go out and you do something

interesting or you go out and do something exciting--go to the stock car races or go do something kind of interesting to do. So, very frequently, for people with alcohol problems, when they experience one of these negative emotional states, their first response is to feel relatively helpless, "I can't do anything about this, I think I'll go drink". What we're going to be talking about for the next half hour or so is going to be how can you better understand how you generate this for yourself and then what can you do constructively and effectively to cope with these different negative emotional states without the use of alcohol. Okay, I'm going to be stopping now and you're going to be moving on with your leader and you'll be working on this for a while. I hope you have an enjoyable session.

Vignette #1 - Negative Emotional States

I can't believe I got a damn speeding ticket. I finally get myself a car, get out of treatment, get a job, and what happens? No, they're not gonna cut me a break, they don't understand. Some days it just doesn't seem like life's worth anything. I don't have the money to pay for that ticket. Well, I've got to do something to make myself feel better right now. I could go to happy hour, but that would defeat everything I've worked for so far and I could save the money, but I've got to do something to make myself feel better. I could call somebody, I could go out to dinner, I could call a friend, I could go to a meeting, I could to aerobics class. Ya, I think that's what I'll do, go to aerobics class, work out my anger. That'll make me feel better and then I'll figure some ways to save the money to pay off the damn ticket.

Vignette #2 - Negative Emotional States

I've got two tests this week; I've got one tomorrow at eight o'clock. I've got to work 'til midnight. There's no way I'm going to be well prepared for this test. Going back to school was a dumb idea. I can't handle the stress. It's too early in my recovery to do it. Every time I take an exam I feel like I'm putting myself on the line. And that's about as simple as it gets. And I feel like I'm going to explode. Alright hold it, what's going on here. Why am I feeling like I'm putting myself on the line. I've done well before in school. I finished a full year last year and did real well; I was in the Honor Society so I can probably do well this time. My grades haven't been that bad. I know that in the past most of the praise I got from Mom and Dad was because I did well,

that's not the only thing that makes me important. My kids love me. My friends, my coworkers respect me. The grades aren't all that's involved in that. And, I have to realize that I have limitations. That's it. I always set up the expectations that are too high with me; nobody else does. I have to realize that average isn't, isn't ... that average is okay. Maybe I'm learning something through all this. I'm finding out something more about myself by what I can and cannot do ... and that's okay. If I can just get past this fear; I've felt it before, and I've worked through it. Like somehow I just don't quite measure up. I know what I can do. I'll call my sponser. She just finshed her degree. She knows the frustrations of going to school. I'll go in and talk to my advisor and find out how I'm doing in his class and over all. He deals with a lot of different students. And, I think I'll talk to some of the kids in the class that I'm taking and see what their feelings are about it. Maybe I'm not the only one that's feeling uncomfortable, and that can make me feel more normal. Maybe I'm doing better than what I'm feeling. Now, I'm going to put this away and look at it later.

Vignette #3 - Negative Emotional States

F___, I can't believe this. Another G_D___ ticket. I can't afford another ticket. Dad's going to hear about this. He'll blow it all out of proportion. I might even lose my license. Maybe I ought to just sell the car. F___, I need a drink. I need to stop this. I'm blowing things way out of proportion. Maybe I need to go talk to Dale. Do like they taught me in treatment. Talk to my sponsor. Try and figure things out a little bit. I can go talk to my lawyer too. Yeah, I think I am really blowing things out of proportion. Just because I got a ticket doesn't necessarily mean I'm going to lose my license. And, if I have to I can get a ride to work with someone else, or maybe I can get court supervision for the ticket. That's what I'll do; I'll go talk to my sponsor, and I'll get in touch with a lawyer. I'm going to buy new license plates too ... well, it's time. I'll go talk to Dale now.

Vignette #4 - Negative Emotional States

Oh, I'm so ... Oh ... what a lousy, lousy day. Days are supposed to get easier now. Things are supposed to be on the up and up now that I'm not drinking anymore. That evaluation was just terrible. I know I'm going to get fired. Well, things like this are supposed to be different now. I thought that I was getting my life

together. Well, now what do I do. When I was in treatment I learned to look at situations realistically. What's making me feel this way? In the evaluation she gave me some things she wanted me to work on, and the supervisor gave other people things they needed to work on. She didn't talk about firing any of us, and she wouldn't have hired me if she didn't think I could do the job. If I work on those things that were bad in my evaluation then I'll feel better and I'll be better at my job. I sure don't want to go looking for another job. So, how can I work on these things? I can go talk with her; I can go to Happy Hour ... I know, Pam's got a typewriter; I can call her and see if I can borrow it. (Dials phone) Pam,, this is Karen. Listen. I was wondering if you have some time tonight ... you have a typewriter don't you. Okay. Well I was wondering if you have some time tonight to get together and talk for a little bit. Something came up at work, and I was feeling kind of down. I also need to practice my typing and wondered if I could borrow your typewriter. You could bring it over here, or I could come get it. Whatever you wanted to do. You want me just to come get it. Okay. Well, you want to go get something to eat. Oh good, that would make me feel better too, just to talk with a friend. Then, I'll practice my typing after that. Well thanks, I'll see you about seven. Bye.

INTERPERSONAL CONFLICT

The workshop that you're going to be participating in now is intended to assist you in dealing with negative situations pertaining to interpersonal conflict. Interpersonal conflict specifically relates to some sort of disagreement or conflict between you and some other person, or it can be between you and a group of people, but we're talking about something that happens between two people that is conflictual. It can be a disagreement; it can be a breakup of a love affair; it can be asking somebody at McDonald's to give you a Big Mac and they give you a Quarter Pounder With Cheese; it involves conflict between two persons. So, this workshop is to assist you in dealing with those interpersonal conflict situations in some reasonably effective ways without the use of alcohol, because once again research suggests that very frequently when people who abuse alcohol get into interpersonal conflict situations typically they turn to that alcohol for some sort of assistance in coping. We're going to try to teach you how to cope without it.

The first step as far as I'm concerned in dealing with that is an attitude. The attitude that I need to try to convince you of and that I need to try to sell you is something that very few people believe but I believe it very strongly, most of us grow to become aware of it as we get a little older, and the attitude is one of we are not capable of controlling anyone else's behavior. We do not have the ability to make anyone else in this world do anything, and human beings have the right to choose their behaviors, and we can't make them do anything (other than maybe we can assault them physically and we can make them hurt, but we can't make them do anything). I can put a gun in your mouth, and I can say give me your wallet or I'll blow your head off, and you still get to pick whether you want to give me your wallet or you want me to blow your head off. I can't make you give me your wallet. I can only create the situation where you have some choices, and very often in interpersonal conflict situations the conflict often comes about and frequently escalates as a result of one person trying to make the other person do something. I want you to love me so I am going to force you to do that. I am going to shower affection on you; I am going to be attentive; I am going to beat you up if you don't love me. I am going to try to control you in some way to make you do what I want you to do. So again, interpersonal conflict means that there is a disagreement, and I think it is very important for us to approach those disagreements from an attitude of I can't make you do what I want you to do, I can only make you aware of my

preferences and my desires and my wishes and then you are going to choose what you want to do. Essentially what I am talking about right now; I am talking about being assertive.

Assertiveness is a concept that psychologists have been throwing around for a long time, and they use it very frequently in regard to interpersonal conflict. They try to teach people to be assertive, and it is usually assertive versus aggressive. Now, many people are perfectly capable of being aggressive. Apparently few people have the skill or the talent to be assertive. What I would like to help you a little bit with today is help you make a distinction between assertive and aggressive, and hopefully talk to you a little bit about what assertive is and then throughout the course of the workshop you'll have an opportunity to practice being assertive and hopefully you'll get a better appreciation of that. Essentially when we talk about assertive what we're talking about is making another person aware of your thoughts and your feelings and your wishes and your desires; not trying to make them do something.

So, if we're in a situation, standing in line at the theatre and you want to go to the show and there are about ten people in front of you and this person comes up, and he butts in line right in front of you, an aggressive person says get out of the line or I'll kill you. That's an aggressive statement. It's aggressive because it's not intended to make the person aware of you're preferences or your wishes or your thoughts; it is intended to make them do what you want them to do which is to get out of line. So you're threatening them; you're setting up a situation where you're likely to get yourself in difficulty. The person can turn around, and he can say "Oh Yeah," then you have a fight; then the police can come, and then you can go to jail. So you don't help anybody that way. So the assertive response would be to say something like "I admire your audacity, but I certainly don't appreciate it." Now, maybe you wouldn't use a big word. Maybe you would just say "I was here first, and I would really appreciate it if you would go to the end of the line." Now, that's not threatening; that's telling them how you think about a situation or how you feel about the situation. That's when we're talking about the difference between being assertive and being aggressive, letting people know what you think and what you feel about a particular situation. Now, aggressive gets into several different categories, and some of you are fairly adept at something that is called passive-aggressive behavior. Now, passive-aggressive behavior refers to getting even in

ways that you're not likely to get caught for, and you're not likely to get blamed for. So you get angry with someone, and then you figure out how to get even, but you do it in a way that it looks like an accident. Oh, for example when you're a kid and you wanted to go to the show and Daddy says no you can't go to the show because you didn't clean your room. Well, isn't it an interesting coincidence that you just happen to leave your roller skates on the stairs while Daddy's coming down. Now, you were going to put them in your room because you were supposed to clean your room, but you forgot, and if Daddy slips and falls then you turn and you say "But I was just trying to clean up my room; I didn't do it on purpose." So, you got even but you did it in a way that they really couldn't nail you for it. So passive-aggressive has to do with things like that. Now with drinking people, passive-aggressive very often has to do with drinking. Your spouse says, "I can't stand it when you drink." So, you get in a fight and then you go drink. Why you didn't take it out directly on your spouse; you just happened to go out and have something to drink and you just happened to get drunk and you just happened to be driving your spouse's new car and you just happened to scuff it up a little bit while you were out, but you couldn't help it because you had this fight and because you had been drinking. So, it's passive-aggressive which means that it's aggressive in that something happened; something happened to get even, but it's not directly targeted at that person, and it's not done in a way that you can really pin it on them. You get in a fight and your spouse just happens to burn your breakfast, and just happens to burn your toast which just happens to be the last two slices of bread in the house. Now, they were trying to be nice by making you toast. It was an accident that the toast got burnt; so, those kinds of things. And those kinds of things just lead to an escalation eventually, and you have a big fight. So, passive-aggressive, if you use that, then we are hopefully going to be able to work with you in terms of coming up with some better ways to deal with things. So that you can deal more constructively using some better ways, primarily behavior because most of the time people end up angry in interpersonal conflict situations. Conflict has kind of an angry connotation to it any way. So, when you talk about interpersonal conflict most of the time you're talking about something that people end up angry at themselves over, so that people make them mad about situations when people don't do what they want and don't behave the way they want. They end up getting mad; they deal with it passive-aggressively; sometimes they deal with it active-aggressively. Active-aggressive means you go after

the person. You shoot them; you run them over with your automobile; you beat them up or you get a bunch of your buddies to beat them up. It's a direct aggressive activity. So you get angry and you act aggressively, probably active-aggressive and very often you get arrested for it because dealing with anger in an active aggressive typically leads to some sort of violation and the court of law. You get angry with your wife so you pop her in the mouth. If she's smart she'll have you arrested and that's the way that it is supposed to work. So, active-aggressive frequently gets you in trouble.

The third most common way of dealing with the situation, especially an interpersonal conflict situation is withdrawal or avoidance. Many of you may be able to identify with this because all it really means is you get mad at somebody and instead of dealing with them directly you go get drunk. Period, you don't get even, you don't take them on in a fight, you don't bad mouth them, you just withdraw from the situation; you leave the situation and you go to a bar someplace and you deal with all their upsettedness and all that internal disruption by medicating yourself with alcohol. So, you go out and get drunk. None of these are considered to be particularly constructive so then what we are talking about is a constructive alternative for you for dealing with interpersonal conflict with assertiveness or assertive behavior.

Let me talk to you a little bit about some of the skills that go into being assertive. If you participated in the workshop for dealing with negative emotional states, one of the things that you're going to notice is that there is an overlap between dealing with negative emotional states and interpersonal conflict because very often interpersonal conflict generates those kinds of negative states. So, if it seems that the skills we're talking about before in terms of the A-B-C Theory and being aware of how you are thinking about situations, the reality testing in terms of being aware of the data that use to support your beliefs. Those same concepts will continue to apply as far as interpersonal conflict situations are concerned, but some of the specifics that I want to talk about in relation to assertiveness are really some very basic interpersonal skills. Interpersonal skills deal with how do we deal with people, and interpersonal skills have been taught for years. When they teach psychologists or counselors how to do counseling what they're trying to teach them is interpersonal skills, and the first step of good interpersonal interaction is learning how to listen. Well listening means that you need to hear what people are

saying to you, not what you want to hear and not what you imagine they are saying, but you have to be able to listen to the words that other people are saying to you so that very often while we are in the process of getting upset we tend to not listen very carefully and we tend to distort the input; we distort the information in a ways that support our beliefs and will encourage us to do what we want to do anyway, but essentially listening has to do with eye contact. Eye contact means that you look somebody straight in the face when you talk to them. It is very difficult not to hear them if you're looking at them eye to eye. Now, that's different from a stare-down because when you get really angry with them and stare them right in the eye that's an aggressive kind of position, but good eye contact when you're looking somebody right in the eye it means you're interested and you're paying attention and listening to them. So listening also involves eye contact. Assertiveness has some other fairly subtle kinds of skills that most people have never been taught about anyplace because the only place we really talk about this very much are in counseling classrooms and sometimes interpersonal skills groups. But, for the most part, one of the things we are talking about here is a whole collection of nonverbal behavior, and nonverbal behaviors may include eye contact; that may be one of the nonverbal behaviors. Posture - body posture is another one. We communicate a great deal by how we sit, how we stand, how we relate to other people. I know that if I come up face to face with somebody, and I get within two inches of their face, and we're up ther nose to nose that's a challenging body posture that makes most people pretty uncomfortable. I have violated their personal space. So, if I want to make you uncomfortable one of the things I do is I walk up and I get in your face. Well, that's not particularly desireable if you're trying to have a positive interchange. You need to think in terms of keeping a comfortable distance between you, and you have good eye contact. Voice tone is another important general nonverbal in that it's not what you say as much as it is how you say it. That you and I can both say exactly the same thing in exactly the same words, and if I communicate to you in a nice soft tone of voice and you come across in a very threatening, harsh sounding tone of voice then I'm going to get more of what I want, you're going to get more resistance. People are going to become automatically defensive, and it creates more conflict. So as you begin to learn to assert yourself part of what you want is to listen well, and you want to practive nonverbal behaviors, have good eye contact, a comfortable body posture, a neutral, moderate, or soft voice. You can do a

great deal with your voice tone in terms of calming people down who are upset with you.

Another important rule that is helpful as far as an interpersonal interchange, especially in a conflict situation is to think in terms of starting your statement with the word "I." "I feel," "I am," "I want." That's as opposed to starting these statements with the word "you." One of the things that almost always happens when people start sentences or start statement with the word "you," you sounds like an accusation. "You did this," "you did that," "you feel this," "you made me feel angry," "you violated my space," "you took my..." So, as long as you're starting with the word you, about 95% of the time you are putting the person on the defensive that you're talking to. They are automatically getting defensive. If you start out with things like "I feel upset about what happened," "I'm bothered by," "I wish you would do this differently." People don't get nearly as defensive. So, one of the ways that you can start to deal with interpersonal conflict situations in assertive behavior is when you start by using the word "I." This is something that takes a lot of practice. But, you need to begin your statements with the word "I." If you are going to ask questions of other people, one of the words that you need to drop out of your vocabulary is the word "why." "Why did you do that?" "Why didn't you do that?" Most of you remember from when you were a little kid that your Mom and Dad always said "why did you do that?" and right after they said "why did you do that," you got smacked. So as soon as somebody comes up to you and says "why did you do that," "why did that happen," you know that something negative is going to happen and you get on the defensive. If you walk up to somebody and instead of saying "why did you do it," you say "what did you hope to accomplish by that," "what were you trying to do," "what did you want" then you get somebody who can answer the question much less defensively so you want to use words like what, how, when, where and kind of drop the word "why" out of your vocabulary because for the most part people can't answer it anyway. Remember your folks would come up to you and say, "why did you let the water out of the fish tank?" What are you going to say, you don't know ... "because I felt like it." So most of the time when somebody comes up to you and says why the only reasonable answer you can give is "I felt like it." What were you trying to accomplish? Well, you can say "well I wanted to see if the fish could get along very well on dry land so I let the water out of the fish tank. That's what I wanted to do." So, instead of asking people why, you ask them what they were trying to accomplish. One of the things that is

particularly important is that you discuss behavior and not the person. So, instead of saying "I don't like you," or "Yo're a jerk," or "you're a fool," you say something like "I don't like what you did, I don't like that behavior. I would appreciate it if you would change that." You don't call somebody a jerk and dummy, you turn around and say that "I don't like that particular kind of behavior. I don't appreciate it when you behave that way." Once again, it makes people much less defensive. So what we're going to try to do throughout the rest of this workshop, we will try to provide you with some opportunities to observe other people behaving in an assertive way, and we will give you an opportunity to practice some of this. So, it's a lot of concept, but it's not quite as complicated as it sounds. Basically, the idea is that you can't change anybody else's behavior; you can't make them do it your way, but you can tell them how you feel about situations and make them aware of your preferences. And then you can practice some good interpersonal skills; some good interpersonal communication skills to try to diminish the intensity of the conflict and begin talking about some things.

OK, now your leader is going to work with you a little bit on this, and I hope you have a successful workshop.

Vignette #1 - Interpersonal Conflict (Man sitting at drafting table in office setting)

A: Hi, Joe

B: Hi, Barb

A: A bunch of us are going to the Bingo game tonight, want to go?

B: Sure, that sounds like a good idea. I'd like that.

A: Good.

C: Joe, glad I caught you in time. Listen. We've got about three more hours work to do on this project, and I hate it, but it's a contract job, and we really can't justify the time and a half. Can you help us out? ... Great. I knew we could count on you.

A: Are you going to let that turkey do that to you again?

B: (Slams fist down on table, gets up and walks off)

Vignette #2 - Interpersonal Conflict (Man sitting at drafting table in office - same situation as above)

A: Hi, Joe

B: Hi, Barb

A: A bunch of us are going to the Bingo game tonight, want

to go along?

B: Sure, that sounds like a great idea. I'd like that.
What time is it?

A: Oh, about ...

C: Joe, I'm glad I caught you in time. We've got about another three hours to cover on this project, and you know I hate it but it's a contract job. We really can't justify the overtime. Can you help us out tonight?

B: No, if you were any kind of supervisor at all and would get out and do a little bit of work, we wouldn't have to do this overtime. Who do you think you are? ...

C: Now listen, just who in the world do you think you're talking to? We've got places for guys like you. Get down there and collect your check.

Vignette #3 - Interpersonal Conflict (Man sitting at drafting table in office - same situation as above)

A: Hi, Joe

B: Oh, hey Barb

A: A bunch of us are going to a Bingo game after work, you want to go?

B: Yeah, that sounds like a great idea. What time is it?
In about 15 minutes I think.

C: Joe, I'm glad I caught you in time. Listen, we've got about another three hours to do on this project yet tonight, and you know it's a contract job. We really can't justify the time and a half. Can you help us out?

B: Barb, could you excuse us a minute? I need to talk ...

A: Sure

B: Look Mr. Smith. I've already worked six hours overtime this week without any pay. I know we need the work, but I really had plans tonight. I just can't do it tonight.

C: Well, yeah, you're right. I have been asking a lot. I'll tell you what, if you'll come in an hour and a half early in the morning I will too. We'll get the stuff done, and you can turn in the three hours, and my supervisor will be happy with me too.

B: I'll buy that.

C: Great, I'll see you in the morning.

B: See you in the morning

Vignette #4 - Interpersonal Conflict (Woman standing at kitchen sink, banging dishes around)

A: Where is he?

B: (Walks in room)
 A: Well, where the hell have you been?
 B: I've been busy, why?
 A: Doing what? We were supposed to be at my mother's only an hour ago.
 B: I'm sorry.
 A: Well, what's your excuse? You do this all the time. It makes me so mad. You're so inconsiderate.
 B: Just ...
 A: I don't even want to hear it.
 B: Stuff it! Go to your Mom's yourself. (Turns to leave)
 A: Don't even bother to come back. I can't stand this. You're so ...

Vignette #5 - Interpersonal Conflict (Woman standing at kitchen sink, banging dishes around - same situation above)

(Man walks in)
 A: Well where the hell have you been?
 B: I've been busy. I got tied up.
 A: You've been busy. That's just great. We were supposed to be at Mother's an hour ago.
 B: I know. I'm sorry.
 A: You're sorry.
 B: Things come up you know.
 A: Yeah, I know. You do this a lot.
 B: Well, ... can we just talk about this?
 A: Okay, I get really hurt when you're late, especially when it's something that's important to me like visiting my Mom. Plus, I get really scared when you're an hour late. I don't know what happened to you. It scares me.
 B: I'm sorry I did that. I guess I just wasn't thinking today. I got kind of tied up, and I know I shouldn't have. I should have at least given you a call and cut it shorter.
 A: Well, I appreciate you recognizing that you should have called me. Maybe next time. I know how you get caught up, and time just flies by.

Vignette #6 - Interpersonal Conflict (Man and woman preparing for a trip)

A: Got the keys? How long do you think it will take us to get up there?
 B: Two and a half hours I would imagine.
 A: Well, just don't give me two and a half hours of bullshit.

- B: OH, I don't even want to start hearing about all that ... my bad points.
- A: You wouldn't have to hear about it if you would just keep your mouth shut.
- B: You wouldn't have to talk about it if you realized what a poor driver you are. I mean ...
- A: Well, if I am a poor driver it's because I've got someone sitting next to me giving me shit all the way up. If you would just leave me alone, I could relax and I could drive.
- B: Why do you always have to go 75 miles down the road ... and I feel as though I'm being endangered all the time. Why do you have to drive like a maniac.
- A: Well, let's try something different for a change. Why don't you just keep your mouth shut once, and we'll see how that works. Maybe you'll like how I drive then.
- B: You know, you're always so damned defensive when you talk to me. You can't even get through a discussion with you. Just ...
- A: Once again it's all my fault, huh. I don't like someone sitting next to me, giving me a bunch of crap while I'm driving the car. And when I tell you something about it, rather politely I think, I just get a lot of shit.
- B: You don't know what polite is.
- A: I don't, well what is it? It's how you're talking to me right now.
- B: Well, this is the only thing you hear. All you hear is ...
- A: You want to drive the car? Here, why don't you drive the car (Throws the keys down). Here are the keys.

Vignette #7 - Interpersonal Conflict (Man and woman preparing for a trip - same situation as above)

- A: Are we set?
- B: Yeah
- A: Got the keys?
- B: (Hands him keys) Here you go.
- A: What do you think, a couple hour trip?
- B: Yeah, something like that. Chicago's not too far.
- A: It'll be a lot nicer trip for me if you don't give me a lot of instructions and lectures on driving while we're going out there. Just let me drive the car.
- B: Well, I guess it would be a lot nicer drive for me if you wouldn't drive like a maniac.
- A: I don't think I drive like a maniac. I think you're exaggerating. I think if you would just let me drive and not lecture me I'd do better.
- B: Okay, Alright ... Let's just cool down a minute. I

don't want to fight about it. I'd like to have a nice trip to Chicago. Basically, I get to feeling kind of scared when you drive really fast, and I guess I let that out in kind of annoying ways. But, when it comes down to it I feel scared ... when you drive quickly like that.

A: Well, I don't really mean for you to be scared. I guess when I drive fast I feel in control of the car and it doesn't bother me. Maybe you don't feel in control.

B: Yeah

A: If you get scared, why don't you just say, "Hey, I'm scared."

B: Yeah, when I'm not driving it's hard for me to feel like I am in control.

Note. Vignettes one, two, and three were written and produced by Dr. Mark Godley and the staff of the Franklin - Williamson Mental Health Center. Reprinted by permission of Dr. Mark Godley.

Godley, M. D., Akkari, L. C., & Wesch, D. (1984). Relapse prevention: a social skills training videotape, Mental Health Services of Franklin and Williamson Counties, Inc. Marion, Illinois.

SOCIAL PRESSURE TO DRINK

This workshop is designed specifically to help you learn to deal effectively with social pressures to drink. One of the things research has demonstrated over the years has been that one of the downfalls of people who are recovering from alcohol and drug problems, one of the major variables that leads to a downfall is social pressure to use. That when you leave treatment, after you have made your decision to abstain, very often your old acquaintances and your social settings put pressure on you to go about using once again, so this workshop is designed to help you learn to deal with that specific situation. Now, as we go into this workshop, one of the variables that is extremely important that you need to bring with you as you leave treatment is a sense of pride in your decision and your ability to abstain from the use of alcohol, that one of the things I hope you've learned through your treatment experience has been that the decision to abstain from alcohol is a difficult decision to make. Once you've made that decision, abstaining from alcohol is very difficult to accomplish. Therefore, if you've made that decision to abstain, you're entitled to be quite proud of yourself for that decision. You made a tough decision, you've earned the right to be proud of yourself and you're entitled to feel good about yourself for having made that decision. As you leave treatment and you return to your normal living situations, one of the few things that are going to feel good for a while about abstaining is the fact that you are abstaining. You have given up something that was very familiar to you, you've given up something that you used in a variety of ways to make your life more comfortable, so you're going to encounter a variety of situations that are really quite uncomfortable and what's going to be able to get you through that is the pride in your ability to remain abstinent--you made the decision, you made it for yourself, you're doing something good for you and need to remember that you earned the right to be proud of yourself for being abstinent. That's going to drive a lot of your behavior after you leave treatment and it's also going to be very helpful to you when dealing with social pressure.

Let's start to take a look a little bit at some of the variables that go into social pressure. Let's assume for the moment, that you're going to encounter a number of friends and acquaintances when you return to your living situation, typical situation, and these people are going to want to be friendly to you and one of the things that they are going to want to do in terms of being friendly is they're going to want to get you to go back and drink with

them because that's what they're used to, they don't know you as a person who is abstinent, they don't know how important it is to you, they just want to be your friend. So, as you leave here and go back in those situations, those folks are going to ask you to drink, it's just going to happen, guaranteed. When they ask you to drink, what is likely to happen to you is going to cause you to give into that pressure. Psychologists talk about one of the things that happens is that people have a collection of irrational beliefs and we've talked in a variety of settings before about the kinds of ways that you think about situations and what you believe about situations and how those thoughts and those beliefs drive your behavior and they drive your feelings. Well, most folks have a collection of irrational beliefs that social pressure by friends can tap into and one of those that is extremely important is the belief that everyone should like me. That's a belief that many people have--everyone should like me. So, we get caught in these situations where we're concerned that if I don't do what they're asking me to do, they're no longer going to like me. My response to that is, so what. So they don't like you anymore, so what. So what is not an expression of I don't care or it doesn't make any difference. So what is a way to get you to think about the future. It can be translated into so what difference does it make. This person doesn't like you, so what difference does that make in your life. The difference it probably makes is you have one less friend. Is that the end of world? I don't know, maybe if you have only one friend, maybe that is the end of your world, but it's not very likely. So, so what is one of the questions that you can ask yourself when you're struggling with a decision to give in to social pressure and one of the thoughts that you're having is if I don't have a drink with these people, they won't like me. The question is, so what? As yourself that, so what, so what difference does it make? One of the other beliefs that people frequently have is that if I don't have a drink with these people then I'm going to be a wimp, you have to be maucho. That's another belief we have, you have to be strong, you have to be important, you have to be maucho, you have to be something special and drinking gets that for you. Well, number one, it's an irrational belief to believe that drinking gets that for you, but that's another lecture. The belief that I will be a wimp, I will be less than a man, I will be less than whole if I can't drink alcohol, well, the flip side of that is that you should be maucho, well who says you should be, where is that written that you should be? That in and of itself is in your rational belief. If you should be any particular way, you are entitled to be the way you want to be there is no way that you should be. So, anytime you find yourself making

statements that involve the word should, very often, you are pressuring yourself into something that is relatively irrational. There are lots of ways that it might be better for you to be, so instead of the word should, very often you can use better--it would be better if... So, maybe it would be better if you weren't a wimp, but if you are, you are, and so what difference does that make. In fact, does it make you a wimp if you choose not to drink? What evidence is there for that, now we're back to reality testing. So hopefully what we're finding is that we have a package of three workshops that kind of tie together and that very often, the workshop where we talked about reality testing and we talked about Rational Emotive Theory and we talked about interpersonal conflict because in essence, that is what we're dealing with here again. Social pressure leads to interpersonal conflict unless you can deal with those situations effectively. So, what I want to talk a little bit about now are some guidelines that you can use to attempt to affectively deal with those social pressure situations without alienating people, without creating a great deal of conflict, but rather to merely assertive yourself. Well, once again, one of the ways to do that if you have a collection of nonverbal behaviors. So, if you can picture yourself sitting in a situation, someone or a group of friends have come up to you and they say, "Gee, Joe, why don't you c'mon and have a drink with us", when how are you going to respond to that, what do you need to do? You need to go back and look them in the eye, have good eye contact, have reasonable body posture, use a reasonable voice tone, put together that collection of desirable nonverbal behaviors in order to prepare yourself to be assertive in terms of dealing with this situation. Once again, let's assume that those folks are being friendly, that they're not trying to do you in, they're not trying to do bad things to you, so you don't have to try and hurry up and get angry with them, you don't have to become defensive when they invite you to come for a drink. Let's assume that they really do care about you and that they're trying to do what is in your best interest and you need to figure out how to communicate to them that you don't want to drink, so you get your nonverbals in order. Secondly, it would be reasonably appropriate for you to say something like, "Thank you". They're trying to be friendly, acknowledge that you appreciate their desire for you to be friendly with them and that's nice that they want that to happen for you but you also need to clarify for them that you have a problem. So, essentially, you need to state your problem. Your problem is that you would like to remain their friends, but you have made a life decision to abstain from alcohol. That's all you really need to do, say something like, "Thank you. I appreciate the offer to

do something socially. I really do want to be your friend, but I have a problem. The problem is that I have made a decision now to abstain from alcohol and I would like to remain your friend but I don't want to drink. How can we accomplish that?" So now you have a problem solving situation where the two of you, or three of you, or four of you can work together. Now, if they choose not to honor your request, we have a new problem. So, here you're saying we have a problem. I want to be your friend, but I don't want to drink. Then they turn around and say I don't want to be your friend, then we go back to our irrational belief does everybody have to be your friend. No everybody doesn't have to be your friend. You may have to develop a whole new social circle. That's one of the realities of giving up alcohol and giving up substance use is that very often, the majority of the people that you've been acquainted with in the past have been substance users and substance abusers and you may have to develop a new social circle. That may be one of the ways that you're going to end up dealing with the social pressure, you're going to have to go out and make some new friends. So, if they honor your request then you can get into the situation where you can talk about new behavior. If they're willing to say, "Well, gee, I really didn't realize it was so important to you. Okay, let's go someplace for a Coke." "Alright, we'll have a card party but we won't drink, we won't have alcohol present. We'll honor your problem, we'll try to do something with that, we'll work with you." If that's happened, then you've dealt with that social pressure nicely, you've made some progress, things are better. If not, then you need to figure out how you're going to go about developing that new social network. The other things you can do is you need to have a repertoire or a collection of reasons to not drink that are real handy for you to draw on. One of those that are fairly significant for most people is a little reminder of what the family consequences are of drinking, or the life consequences, not just family, but life consequences. What has drinking accomplished for you in the past, has it lost you a spouse, has it lost you your job and your financial resources? What has it accomplished. So, you need to remind yourself of that those consequences are. You need to remind yourself that you made a decision to abstain. It is also very helpful to let people around you know that you have made that decision so that as you join your old network of acquaintances if you can say I've decided to abstain from alcohol, if you can say that verbally, directly, make it public knowledge, and you can be proud of the fact that you're abstaining and you can feel good about that accomplishment, the more people you let know about it, the less out of place you'll feel, the more support you'll be

able to get from people because they'll know what it is you're trying to accomplish with your life. So you need to try and make that decision public and then you need to keep reminding yourself if you are proud of yourself for your ability to abstain. So, one of the things that comes out of this, very often, when people are in a social pressure situation, they walk out of that situation with a negative emotional state. They are upset because even though they are abstaining, they may have lost friends, they have have alienated somebody, they may have had an interpersonal conflict. What I would prefer, my preference is that you walk out of that social pressure situation and feel good about yourself and what you say to yourself is "You know, I made it through another situation where I could have used and I chose not to and I'm proud of myself for that decision." So, instead of feeling badly about the way things turned out, you end up feeling good about yourself because you're able to do something that you want to do, you're able to accomplish something that is important to you. So, each time you pass up a drink, that's an opportunity for you to feel good about yourself instead of saying, "Gee, I wish I had that drink" or "Gee, I wish I was in that situation". Instead, you turn around and say, "Hey, I did something that's important to me. I feel good about it. I stood up to the pressure. I avoided the situation. I feel good about what I've accomplished." Now, the remainder of the session is going to be focused on giving you an opportunity to learn a little more about dealing with social pressures, giving you an opportunity to role play and to rehearse some of those situations and see some folks modeling some constructive and effective ways of dealing with it so that at the end of the workshop you do walk out of here feeling good about your ability to deal with those social pressure situations.

Vignette #1 - Social Pressure (Four people sitting around table playing cards)

- A: I'm about ready for another drink anybody else want one?
 B: Sure
 C: Sure
 A: What'll you have?
 B: Tom Collins
 C: Gin and Tonic
 A: Gin and Tonic; I'll just have a whiskey.
 What do you want Gary?
 D: Just another coke.

- A: Just another coke? Want to have something with that like a little Vodka or ...
- D: Nope, just another coke
- C: Rum and Coke is awfully good.
- D: I'm not interested.
- C: Oh, come on now, you've been out of that stuff since you were out of treatment. You're okay now.
- A: Yeah, you won't have any problem with that.
- D: Well I really understand where you're coming from, and I appreciate your offer, but I would just rather have a coke.
- A: Ah, come on, one ain't going to hurt you.
- D: Well, one will hurt me. I have been through treatment for alcoholism and often one drink does lead to another, and that's one of my problems.
- A: Yeah, but if you went through treatment you can control it now.
- D: Well, I can control it by not drinking. From now on Cokes will be fine.
- A: Well, okay.

Vignette #2 - Social Pressure (Three people in the recreation room at someone's house)

- A: Tell me a joke Carl.
- B: Okay, I've got it for you. Have I told you about the preacher who sent his dog to preacher's obedience school?
- A: No ...
- B: Well, he sent his dog to preacher's obedience school. The dog comes back, and he says, "Rover sit." The dog sits. He says, "Rover, roll over." The dog rolls over. Picks up a stick and says, "Rover fetch," and flings the stick. The dog runs and gets the stick and brings it back. Preacher starts to walk away, and says, "Rover heel." The dog goes ... (Places one hand on person's head and holds one of her hands in his) ... (Laughter)
- C: That's a good one. Here, have something to liven you up a little bit.
- B: I'd love to, but I'd really better not. My jokes deteriorate after a drink. Just let me have a soda.
- C: I've got some wine over here.
- B: No, No I better leave it alone.

Vignette 3 - Social Pressure (Two neighbors meeting after their respective shopping trips)

- A: Hi, I haven't seen you in so long.

B: Yeah, it has been a long time; it goes by fast.
A: Are you as tired from shopping as I am?
B: Worn out ... I just ...
A: Let's sit down and have a drink.
B: Well, what kind of drink are you talking about?
A: I don't know, a martini or anything at this point. I'm
so tired, I need something to pep me up.
B: I don't drink, but I'll have a cup of coffee or a coke.
A: Well, I don't drink coffee but I'll have a coke.

Note. Vignettes two and three were written and produced by Dr. Mark Godley and the staff of the Franklin - Williamson Mental Health Center. Reprinted by permission of Dr. Mark Godley.

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APPENDIX E
SITUATIONAL CONFIDENCE QUESTIONNAIRE
SUBSCALE TABLES

TABLE E' - I

Mean Difference Scores and Standard Deviations for
the Situational Confidence Questionnaire Subscales

	Pre		Post		Follow Up	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Skills Training Group						
Subscale 1	47.62	28.71	69.61	22.88	75.58	23.27
Subscale 2	74.96	22.93	82.69	21.18	88.85	16.27
Subscale 3	74.73	27.13	89.04	15.92	90.62	12.14
Subscale 4	39.23	33.43	51.92	34.82	54.04	41.57
Subscale 5	52.88	27.83	69.23	25.44	78.08	24.86
Subscale 6	60.88	29.30	77.62	21.89	83.12	20.93
Subscale 7	55.31	30.47	76.92	24.14	81.42	24.38
Subscale 8	44.88	35.02	68.81	27.38	75.96	30.72
Lecture/Discussion Group						
Subscale 1	61.08	33.29	68.54	26.45	75.69	18.19
Subscale 2	73.38	29.74	80.96	21.21	84.62	16.85
Subscale 3	74.46	29.05	82.23	16.37	84.85	15.29
Subscale 4	48.27	39.52	50.58	35.39	53.27	35.83
Subscale 5	58.65	33.87	70.31	23.27	75.65	18.84
Subscale 6	64.54	34.18	76.19	23.78	82.77	15.14
Subscale 7	63.00	33.33	72.04	23.70	78.88	16.16
Subscale 8	50.77	33.32	64.27	25.51	75.46	20.92

TABLE E - II

Analyses of Variance for Post versus Pre and Follow up
versus Pre Scores on the Unpleasant Emotions/
Frustration Subscale of the SCQ

Source	<u>df</u>	<u>SS</u>	<u>MS</u>	<u>F</u>
Post vs Pre				
Group difference	1	2747.77	2747.77	6.94*
Error	50	19800.46	396.01	
Follow up vs Pre				
Group difference	1	2315.56	2315.56	3.48
Error	50	33261.12	665.22	

*p < .05

APPENDIX F

RAW DATA

APPENDIX E

RAW DATA

Sub	Grp	Ctr	Age	Rac	Sex	Inc	Day	Rpr	A11	A12	Sp1
1	1	1	31	1	1	3	27	4	11	09	12
2	2	1	20	1	1	2	19	2	40	39	98
3	2	1	20	1	1	1	02	0	37	38	95
4	1	1	32	1	2	1	16	0	36	35	80
5	2	1	21	1	2	1	13	3	34	33	25
6	1	1	28	1	1	1	08	2	44	45	35
7	1	1	37	2	1	1	02	3	53	51	83
8	2	1	26	1	2	1	03	6	43	46	83
9	2	1	23	3	1	2	04	0	38	37	100
10	1	1	36	1	1	2	05	5	39	40	65
11	1	1	23	1	1	1	01	5	43	44	46
12	1	1	21	1	1	1	28	4	21	24	50
13	2	1	22	1	1	2	22	0	43	45	65
14	2	1	24	1	1	2	22	4	38	41	50
15	1	1	19	1	1	1	17	6	20	22	0
16	2	1	22	1	1	1	11	5	45	48	30
17	2	1	31	1	1	1	10	3	21	25	20
18	1	1	34	1	1	1	07	2	31	36	43
19	1	1	20	1	1	1	04	1	36	35	80
20	1	1	23	1	2	1	01	1	30	36	100
21	1	1	50	1	2	1	01	0	20	26	98
22	1	1	20	1	1	1	03	4	26	21	48
23	2	1	22	1	2	2	05	4	48	48	30
24	2	1	36	1	1	1	14	5	28	30	45
25	2	1	37	1	1	1	01	2	36	38	100
26	2	1	24	1	1	2	02	5	42	43	5

SUB = subject number

GRP = experimental condition

CTR = treatment center

AGE = subject age

RAC = subject race

SEX = subject sex

INC = subject income

DAY = days in treatment

prior to intervention

Rpr = RSE pretest score

A11 = ASB pretest score -
rater 1A12 = ASB pretest score -
rater 2Sp1 = SCQ pretest score -
subscale 1

APPENDIX E (Continued)

Sub	Grp	Ctr	Age	Rac	Sex	Inc	Day	Rpr	A11	A12	Sp1
27	2	1	23	1	1	2	01	1	44	47	78
28	2	1	18	1	1	1	16	6	9	15	0
29	2	1	62	1	1	2	04	0	33	31	10
30	1	2	18	1	1	1	08	6	31	32	18
31	2	2	35	2	1	6	21	5	28	33	100
32	1	2	29	1	2	1	09	3	21	25	50
33	2	2	36	1	1	1	04	4	31	31	55
34	1	2	20	1	2	1	14	2	32	34	22
35	2	2	33	2	1	1	01	5	23	28	78
36	2	2	30	1	1	1	11	6	32	30	48
37	1	2	23	1	1	1	24	5	42	43	52
38	2	2	29	1	1	1	18	2	35	37	92
39	1	2	24	1	1	1	22	5	14	13	10
40	1	2	38	1	1	1	14	5	20	21	0
41	2	2	22	1	1	1	01	4	29	28	70
42	1	2	22	1	2	1	01	4	28	31	32
43	1	2	31	1	1	1	02	1	42	40	72
44	1	2	38	1	1	6	04	3	33	31	35
45	1	2	25	1	1	3	17	6	34	33	65
46	2	2	20	1	2	1	15	4	37	38	90
47	1	2	37	1	1	1	17	1	48	44	78
48	1	2	24	1	1	2	18	2	24	27	32
49	2	2	23	1	1	1	11	0	34	35	40
50	2	2	25	1	2	1	05	6	32	32	8
51	1	2	30	2	2	1	14	6	35	36	32
52	2	1	23	1	2	1	26	3	35	36	68

SUB = subject number
 GRP = experimental condition
 CTR = treatment center
 AGE = subject age
 RAC = subject race
 SEX = subject sex

INC = subject income
 DAY = days in treatment
 prior to intervention
 Rpr = RSE pretest score
 A11 = ASB pretest score -
 rater 1
 A12 = ASB pretest score -
 rater 2
 Sp1 = SCQ pretest score -
 subscale 1

APPENDIX E (Continued)

Sub	Sp2	Sp3	Sp4	Sp5	Sp6	Sp7	Sp8	Rpo	A21	A22	Ss1
1	60	80	40	35	40	8	12	0	53	51	90
2	100	100	100	100	100	100	100	2	43	44	90
3	100	87	70	85	80	88	70	0	40	42	95
4	100	100	95	100	93	88	95	2	46	45	100
5	60	100	20	50	40	44	30	2	42	42	35
6	65	87	40	70	53	28	12	2	47	47	70
7	100	93	60	90	93	96	93	1	50	51	88
8	95	100	10	90	100	68	75	6	41	39	94
9	100	100	100	100	100	100	100	2	31	33	100
10	95	67	55	65	73	72	78	5	45	45	65
11	80	100	60	45	93	68	33	2	59	51	58
12	65	53	5	60	60	40	35	1	52	55	88
13	90	100	0	40	100	84	35	1	46	48	73
14	80	60	0	35	60	68	25	2	51	53	60
15	55	67	0	15	5	24	3	2	49	49	33
16	75	73	5	55	27	48	40	3	52	50	70
17	20	73	35	0	0	8	10	1	33	30	55
18	75	80	40	55	53	56	30	2	54	59	98
19	100	73	0	20	100	100	0	3	42	42	88
20	100	100	0	75	100	100	13	3	49	45	100
21	100	100	85	95	100	100	93	1	49	51	100
22	75	80	70	35	33	28	20	2	32	29	52
23	90	87	10	60	47	60	38	3	47	47	45
24	75	73	45	50	67	64	45	6	32	32	60
25	100	100	100	100	100	100	100	2	39	41	100
26	53	53	20	0	27	0	0	6	46	48	12

SUB = subject number

Sp2 = SCQ pretest score -
subscale 2Sp3 = SCQ pretest score -
subscale 3Sp4 = SCQ pretest score -
subscale 4Sp5 = SCQ pretest score -
subscale 5Sp6 = SCQ pretest score -
subscale 6Sp7 = SCQ pretest score -
subscale 7Sp8 = SCQ pretest score -
subscale 8

Rpo = RSE posttest score

A21 = ASB posttest score -
rater 1A22 = ASB posttest score -
rater 2Ss1 = SCQ posttest score -
subscale 1

APPENDIX E (Continued)

Sub	Sp2	Sp3	Sp4	Sp5	Sp6	Sp7	Sp8	Rpo	A21	A22	Ss1
27	80	73	100	50	87	88	42	1	51	50	90
28	0	0	0	0	0	0	0	3	44	48	35
29	10	10	10	10	10	10	10	0	33	32	100
30	80	13	0	20	33	36	10	3	37	39	53
31	100	100	100	100	100	100	100	4	35	37	100
32	90	100	90	55	73	52	85	0	45	44	85
33	95	47	70	55	73	84	38	3	31	33	85
34	85	93	95	65	20	36	70	2	41	41	68
35	95	87	80	75	80	80	55	2	23	26	80
36	55	73	15	65	53	36	50	4	46	48	72
37	75	80	35	40	60	56	42	4	50	46	48
38	100	100	90	95	100	88	90	3	40	43	70
39	7	20	0	5	7	0	5	2	37	35	50
40	35	27	20	20	7	4	0	4	23	20	12
41	60	67	70	90	80	72	82	3	31	32	30
42	45	20	20	45	60	44	62	5	36	39	42
43	65	80	5	85	73	80	70	0	48	47	80
44	100	100	55	95	73	48	75	4	49	47	75
45	75	100	80	75	67	90	100	5	48	48	85
46	100	100	100	100	100	100	95	3	43	44	66
47	80	73	10	60	80	80	78	1	44	46	72
48	87	90	55	30	67	56	45	3	41	45	52
49	45	40	65	50	67	44	40	1	33	39	80
50	45	33	0	15	13	20	5	6	33	34	15
51	55	67	5	20	67	48	8	6	41	41	58
52	85	100	40	55	67	84	45	1	40	39	70

SUB = subject number

Sp2 = SCQ pretest score -
subscale 2Sp3 = SCQ pretest score -
subscale 3Sp4 = SCQ pretest score -
subscale 4Sp5 = SCQ pretest score -
subscale 5Sp6 = SCQ pretest score -
subscale 6Sp7 = SCQ pretest score -
subscale 7Sp8 = SCQ pretest score -
subscale 8

Rpo = RSE posttest score

A21 = ASB posttest score -
rater 1A22 = ASB posttest score -
rater 2Ss1 = SCQ posttest score -
subscale 1

APPENDIX E (Continued)

Sub	Ss2	Ss3	Ss4	Ss5	Ss6	Ss7	Ss8	Rfu	A31	A32	Sf1
1	100	100	85	95	87	96	40	0	51	51	100
2	100	100	55	95	93	96	85	2	46	48	78
3	95	100	65	65	100	100	55	0	38	38	93
4	100	100	100	100	100	100	100	0	49	49	75
5	80	100	10	55	73	72	55	4	49	46	53
6	95	93	75	95	80	88	75	3	45	46	65
7	100	100	80	90	100	100	98	1	46	47	90
8	90	100	35	95	100	48	90	6	48	49	83
9	100	100	100	100	100	100	100	0	40	41	95
10	95	87	50	75	80	68	83	3	43	44	80
11	85	100	95	65	93	96	68	2	40	39	70
12	100	100	0	85	93	84	80	1	56	52	100
13	90	100	35	75	80	84	75	0	52	50	75
14	85	80	25	70	67	76	60	2	53	41	70
15	75	80	40	40	73	52	58	4	48	51	38
16	95	93	5	75	80	84	73	3	56	54	80
17	40	60	65	95	73	52	53	1	38	37	65
18	100	100	0	100	100	100	95	1	52	55	100
19	95	87	0	45	100	100	30	3	47	43	95
20	100	100	85	75	100	100	85	2	43	43	100
21	100	100	85	100	100	100	98	1	46	47	98
22	95	93	80	50	40	60	42	1	35	33	62
23	95	80	35	65	60	52	60	1	47	44	53
24	90	67	60	75	75	64	55	6	40	40	60
25	100	100	100	100	100	100	100	0	20	20	100
26	30	80	20	20	40	16	10	2	48	45	50

SUB = subject number

Ss2 = SCQ posttest score -
subscale 2Ss3 = SCQ posttest score -
subscale 3Ss4 = SCQ posttest score -
subscale 4Ss5 = SCQ posttest score -
subscale 5Ss6 = SCQ posttest score -
subscale 6Ss7 = SCQ posttest score -
subscale 7Ss8 = SCQ posttest score -
subscale 8

Rfu = RSE follow up score

A31 = ASB follow up score -
rater 1A32 = ASB follow up score -
rater 2Sf1 = SCQ follow up score -
subscale 1

APPENDIX E (Continued)

SUB	Ss2	Ss3	Ss4	Ss5	Ss6	Ss7	Ss8	Rfu	A31	A32	Sf1
27	95	80	100	70	87	88	72	2	47	48	95
28	60	66	0	30	27	53	30	0	44	46	68
29	100	100	100	100	100	100	100	0	37	38	100
30	55	87	25	45	60	76	33	2	41	40	50
31	100	93	100	100	100	100	100	1	31	31	100
32	95	100	90	85	80	84	98	2	42	50	98
33	95	73	95	85	93	96	75	0	38	39	80
34	90	100	100	95	80	72	90	2	41	40	85
35	95	80	80	65	80	80	55	1	32	33	80
36	80	87	35	75	80	68	70	4	48	50	100
37	85	87	35	50	67	64	52	1	49	49	50
38	75	73	20	70	73	68	75	1	44	45	78
39	55	87	70	50	53	56	55	0	42	39	82
40	30	40	25	10	33	0	0	3	20	23	25
41	45	73	55	35	20	52	35	2	34	34	40
42	40	47	75	65	33	52	58	3	42	42	30
43	60	87	15	65	80	60	94	0	51	49	100
44	100	100	35	95	100	100	100	4	50	50	77
45	100	100	25	95	100	100	100	5	56	56	85
46	85	80	85	75	80	76	85	1	40	41	72
47	75	80	0	30	73	68	65	1	45	48	60
48	55	67	60	55	60	48	42	3	48	47	95
49	65	40	0	45	93	56	15	1	38	41	80
50	40	53	20	33	27	20	30	0	32	32	40
51	70	93	20	45	53	76	50	5	34	43	55
52	80	80	15	60	80	72	58	0	43	44	80

SUB = subject number

Ss2 = SCQ posttest score -
subscale 2Ss3 = SCQ posttest score -
subscale 3Ss4 = SCQ posttest score -
subscale 4Ss5 = SCQ posttest score -
subscale 5Ss6 = SCQ posttest score -
subscale 6Ss7 = SCQ posttest score -
subscale 7Ss8 = SCQ posttest score -
subscale 8

Rfu = RSE follow up score

A31 = ASB follow up score -
rater 1A32 = ASB follow up score -
rater 2Sf1 = SCQ follow up score -
subscale 1

APPENDIX E (Continued)

Sub	Sf2	Sf3	Sf4	Sf5	Sf6	Sf7	Sf8
1	100	100	90	100	100	96	100
2	75	80	5	80	80	80	75
3	100	100	70	50	100	96	63
4	100	100	100	100	87	96	100
5	95	100	85	90	93	76	83
6	90	87	80	80	80	68	68
7	100	93	100	95	100	96	100
8	100	100	50	95	87	68	93
9	100	100	100	100	100	100	100
10	100	87	30	90	87	84	90
11	90	100	100	75	100	92	78
12	100	100	100	100	100	100	100
13	95	93	55	70	87	92	75
14	80	73	0	55	80	72	75
15	80	73	0	80	80	48	73
16	100	100	5	95	93	92	95
17	75	73	20	70	73	64	80
18	100	100	0	95	100	100	100
19	100	73	0	25	100	100	0
20	100	100	100	100	100	100	100
21	100	100	85	95	100	100	95
22	90	80	25	60	60	75	68
23	95	87	40	70	80	60	68
24	80	73	65	65	73	68	63
25	100	100	100	100	100	100	100
26	80	100	70	75	53	65	83

SUB = subject number

Sf2 = SCQ follow up score -
subscale 2Sf3 = SCQ follow up score -
subscale 3Sf4 = SCQ follow up score -
subscale 4Sf5 = SCQ follow up score -
subscale 5Sf6 = SCQ follow up score -
subscale 6Sf7 = SCQ follow up score -
subscale 7Sf8 = SCQ follow up score -
subscale 8

APPENDIX E (Continued)

Sub	Sf2	Sf3	Sf4	Sf5	Sf6	Sf7	Sf8
27	95	80	100	80	100	92	78
28	80	87	0	67	73	64	42
29	100	100	100	100	100	100	100
30	60	73	60	65	60	72	40
31	100	100	100	100	100	100	100
32	100	100	100	100	100	100	98
33	80	80	80	80	80	80	80
34	85	100	100	95	87	90	95
35	80	80	80	80	80	80	80
36	100	93	65	95	100	96	95
37	85	100	35	50	67	56	62
38	85	87	30	80	80	76	80
39	85	90	85	85	80	100	80
40	60	60	40	50	33	4	10
41	35	60	40	45	53	36	52
42	35	73	15	20	27	32	13
43	100	100	0	100	100	100	100
44	100	100	0	95	100	100	100
45	100	100	20	90	87	92	100
46	80	80	80	75	80	90	80
47	75	80	0	40	60	68	58
48	95	100	100	95	93	72	95
49	65	47	0	50	80	68	12
50	45	53	30	30	47	64	42
51	80	87	40	50	73	76	52
52	80	80	15	70	80	72	68

SUB = subject number

Sf2 = SCQ follow up score -
subscale 2Sf3 = SCQ follow up score -
subscale 3Sf4 = SCQ follow up score -
subscale 4Sf5 = SCQ follow up score -
subscale 5Sf6 = SCQ follow up score -
subscale 6Sf7 = SCQ follow up score -
subscale 7Sf8 = SCQ follow up score -
subscale 8

VITA

Scott Elton Anderson was born in Memphis, Tennessee on December 8, 1956. He attended elementary schools in that city and graduated from Ridgeway High School in June 1974. The following September he entered the University of Tennessee at Knoxville and graduated magna cum laude with a Bachelor of Arts degree in Psychology in March, 1978. He then attended Georgia State University and the Psychological Studies Institute in Atlanta, Georgia from September 1978 until June 1980, while working in a private psychiatric hospital. He graduated with a Master of Education degree in Community Counseling, and in September 1980 he returned to the University of Tennessee at Knoxville to pursue a doctorate in Counseling Psychology. Having completed all coursework for this degree, he began his doctoral internship at the Illinois State University Student Counseling Center in August 1983. He then worked as a staff member at the student counseling center for one year prior to obtaining his current position. He received the Doctor of Philosophy degree in Education with a major in Counseling Psychology in August 1988.

The author is currently Director of Adult Services at Lighthouse, a private non-profit substance abuse treatment agency, in Bloomington, Illinois. He is a member of the American Psychological Association.