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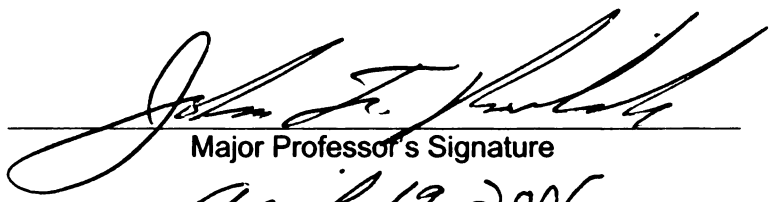

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THE IMPACT OF A RELATIONSHIP SKILLS TRAINING PROGRAM ON THE COMMUNICATION AND PROBLEM SOLVING ABILITIES OF INDIVIDUALS IN A MALE RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM

By

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ABSTRACT

THE IMPACT OF A RELATIONSHIP SKILLS TRAINING PROGRAM ON THE COMMUNICATION AND PROBLEM SOLVING ABILITIES OF INDIVIDUALS IN A MALE RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM

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The biopsychosocial model acknowledges the interaction of biological, psychological, and social influences that impact the exacerbation of addiction. This study addresses the social influences by examining the impact of a relationship skills training program on communication and problem solving abilities of males on probation in a residential substance abuse treatment program. A psychoeducational intervention was chosen instead of a counseling intervention under the assumption that clients need basic knowledge of communication and problem solving before being able to pursue advanced counseling work. Many clients do not yet possess such basic skills, so a psychoeducational intervention was chosen in which such skills could be taught in a short, easily-implemented, cost-effective manner. Six sessions of "Time-Out! For Men: A Communication Skills and Sexuality Workshop for Men," a psychoeducational intervention that specifically addresses relationships, was utilized as the intervention. Using a randomized, control group, pre-test, post-test design, 80 participants were randomly assigned to either the experimental (n= 42) or control group (N = 38). A matched-sample t-test indicated a significant improvement in communication, problem solving, and relationship coping skills learned between the pre-test and post-test in the experimental group. However, such a significant improvement was not observed in the control group. Additional analyses were performed, including an independent sample t-

test and a cluster analysis. Findings have large implications for substance abuse theory, research, and practice.

Dedication

All of the hard work and sacrifice I have put into my education and into this dissertation would mean nothing without the love and support of my family. My husband, my mom, my dad, and my brother in particular have been there throughout my many years of schooling rooting me on. Because of their unending, unconditional support, I dedicate this to them.

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Many people have shaped me personally and professionally throughout my doctoral career and who I will be eternally grateful. First, my husband always has been there, whether it be to give me a shoulder to cry on, to give me that much needed encouragement to continue on with my endeavors, or to be the first there to congratulate me on my successes. My father, mother, and brother also have been ever-present throughout my education and always have been there to listen and provide support during those good days and not-so-good days.

I also cannot say enough about the faculty and staff in the Counseling Psychology Department. During the transition our department has gone through, they always have been there, if it is simply to be a listening board. Dr. Gloria Smith was the first faculty member I met at Michigan State University, and she has provided me endless guidance, support, and encouragement as an advisor, professor, and friend. The adjunct faculty members in the department have also hugely impacted my career. Dr. Tom Novak, Dr. Tawa Sina, Dr. Crewe, Dr. Robert Fabiano, Dr. Jean-Claude Dutès, and Dr. Sonja Gunnings-Moton have each had an influence on my education and career from offering me unique clinical and research experiences and giving me advice about my future endeavors to going out of their way to help me out in any way that they could.

Dr. Shaun LaBlance is a colleague and friend of mine at Community Mental Health. He helped me develop my idea for this dissertation from the beginning and provided constant support and guidance as I continued writing and revising. He is a truly

kind person and a wonderful psychologist, and I am extremely grateful for the help and advice he has given me with this dissertation specifically and with my career in general.

Finally, and most importantly, Dr. John Kosciulek has been a huge influence on my professional career. As our program has gone through transition, my cohort members and I had limited faculty to turn to during times of need. Dr. Kosciulek served for many of us as not only a professor, advisor, and mentor with our studies but also as a main source of personal support during this tough time. Although he is a professor in another department, he always gave us his time and energy, as if we were part of his department. It is evident that Dr. Kosciulek is truly passionate about his job working with and mentoring students, and I am lucky enough to be one of his students. With this dissertation specifically, Dr. Kosciulek has spent countless hours meeting with me, providing me with revisions, and giving me endless guidance throughout this process. I undoubtedly know that without him, this dissertation would not be the quality that it is. He is truly one of the most dedicated and caring faculty members that I have met and worked with, and I greatly value the help, guidance, and support that he has given me throughout the past several years.

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Chapter 1

Introduction

The economic costs substance abuse yields to society are well known. Health care costs and loss of work productivity are just two of the many examples of the financial burden caused by substance abuse. A study prepared by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimated the total economic cost of substance abuse to be $373.3 billion in the United States in 2000. Of this amount, $212.6 billion was due to alcohol abuse alone. These economic cost estimates include substance abuse treatment and prevention costs as well as other healthcare costs, costs associated with reduced job productivity or lost earnings, and other costs to society such as crime and social welfare. It is important to note that these are likely conservative estimates due to the hidden nature of substance abuse.

The necessity of substance abuse treatment is evident due to the extreme costs substance abuse presents to society. However, many substance abuse services are provided from a biomedical perspective (Kumpfer, Trunnell, & Whiteside, 1990), which considers addiction an uncontrollable disease shared by all individuals with substance abuse issues. The biomedical approach to substance abuse places little emphasis on unique factors of the individual such as family, employment, and spirituality (Cloud & Granfield, 2001) and places primary responsibility for the addiction on the individual. According to Kumpfer et al. (1990), the biomedical model is a "mechanistic, linear model, which does not account for the complex experiences of individuals or their social context" (p. 56). Many substance abuse treatment programs have been criticized for

providing treatment from this type of uni-faceted model, as it is used at the "expense of the humanity of the patient" (Engel, 1977, p. 131).

More recently, research has shown the need for more individualized, holistic treatment when treating clients with substance abuse issues (Hanson, Venturelli, & Fleckenstein, 2004). In 1999, NIDA developed 13 principles that delineate effective substance abuse treatment. The third principle states, "Effective treatment attends to multiple needs of the individual, not just his or her drug abuse" (Hanson et al., 2004, p. 99). This principle is further purported by NIDA through the statement that for treatment to be effective it must address the client's substance abuse along with "any associated medical, psychological, social, vocational, and legal problems" (Hanson et al., 2004, p. 99).

These same authors report that the most successful treatment programs provide a combination of therapy and other services to meet the individual needs of each client. Holistic models of treatment have been termed by some researchers as the biopsychosocial model of addiction (Engel, 1977, 1978, 1980; Downing, 1989; Fisher & Harrison, 2000; Kumpfer, 1987) due to the importance of the biological, psychological, and social aspects of the client. According to Kumpfer et al. (1990), the primary stipulation of the biopsychosocial model is that the clinician conceptualizes the person in relation to his or her total biopsychosocial environment. In addition, this model shifts the locus of responsibility of the addiction from solely being on the individual, which is implied by more uni-faceted models like the disease model, to also being exacerbated by external factors, such as social and psychological influences.

The biopsychosocial model implies a comprehensive treatment modality, which includes addressing family issues and conflict, particularly issues with one's significant other. However, little attention has been given to such issues in traditional substance abuse treatment, and this is especially true for men (Dore, 1994; Hodgins, El-Guebaly, & Addington, 1997; Ritter & Cole, 1992). This situation exists despite the fact that the importance and effectiveness of incorporating family issues in treatment have been thoroughly documented (Meyers, Apodaca, Flicker, & Slesnick, 2002; Waldron, 1997) and that addiction often develops within a family context (Heath & Stanton, 1998). According to Aviram and Spitz (2003), a relevant consideration for individuals in substance abuse treatment is their relational ability, as significant relationships may contribute to ongoing substance use as well as support recovery and abstinence.

Following the individualized focus of the biopsychosocial model, more recent research has focused on the specific concerns of men and women separately so that the needs of all clients in substance abuse treatment are met (Dore, 1994; Hodgins, El-Guebaly, & Addington, 1997). However, most of the research and discussion about such differences are focused on the unique needs of women in traditionally male-oriented treatment programs (Schliebner, 1994). Communication, self-esteem, parenting, sexuality, HIV/AIDS, abuse, and sexual health concerns are specific issues addressed in interventions for women (Bartholemew, Rowan-Szal, Chatham, & Simpson, 1994; Bartholemew et al., 2000). Similar issues are very pertinent to men as well.

Despite the fact that there is documentation of the importance of male-specific programming in substance abuse treatment (Dore, 1994; Hodgins, El-Guebaly, & Addington, 1997), few studies have actually examined their effectiveness in terms of

outcomes of specific interventions targeted for men (Bartholomew, Hiller, Knight, Nucatola, & Simpson, 2000). Norwinski (1993) reported that self-esteem, intimacy, and sexuality are key issues for men in recovery. However, this same researcher reports that men can have difficulty admitting their needs, concerns, and fears because of male-gender role socialization. In addition, other researchers have focused on "restrictive emotionality" (Good, O'Neil, Stevens, Robertson, Fitzgerald, DeBord, Bartels, & Braverman, 1995) and "nonrelational sexuality' (Levant, 1997) as primary contributors to men's relationship and psychological difficulties and distress. Because of this rigid socialization pattern, men may experience gender-role conflict and, therefore, may be dissuaded from seeking a type of mutual intimacy that encourages social support (Ritter & Cole, 1992). However, a strong, stable support system is positively correlated with treatment outcomes and compliance (Aviram & Spitz, 2003) and can be an important anchor for recovery (Bartholomew & Simpson, 2002), especially for men (Booth, Russell, Yates, Laughlin, Brown, & Reed, 1992). Therefore, it is essential to address such relationship issues with men in substance abuse treatment.

Scope of the Problem

Substance abuse is correlated with marital discord (O'Farrell, 1995). Partners of individuals with substance abuse issues reported significant dissatisfaction with their marital relationship and desired marked change in multiple areas of functioning that affect relationship quality. Further, partners used maladaptive methods to address relationship conflict and had already taken steps toward relationship dissolution (Fals-Stewart & Birchler, 1998). In addition, problem drinking in one spouse is linked to increased rates of psychological and physical problems among nondrinking spouses

(Moos, Finney, & Gamble, 1985), as well as higher rates of marital aggression, separation, and divorce (Kantor & Strauss, 1990).

Role incompatibility theory (RIT) can be useful for explaining the consequences a relationship can suffer when one partner is abusing substances. RIT emphasizes the necessity of having relationship coping skills training as a part of treatment programs (Newcomb, 1994; Yamaguchi & Kandel, 1985). RIT proposes that involvement in traditional social roles, such as being a partner in a marriage or committed relationship, is antithetical to also maintaining nonconforming attitudes and being involved in socially deviant behaviors, like substance abuse (Fals-Stewart, Birchler, & O'Farrell, 1999). Further, when deviant behavior, like substance abuse, occurs chronically within a dyadic relationship, role conflict eventually occurs. According to Fals-Stewart et al. (1999), for a person who is involved in a relationship and abuses substances, this role conflict is typically resolved by the deterioration or ending of the relationship, reduction or termination of the substance abusing behavior, or modification of the relationship to accommodate the deviant behavior. With effects on the marital relationship such as conflict, aggression, and resulting relationship dissatisfaction and/or dissolution noted consistently throughout research (Fals-Stewart and Birchler, 1998; Fals-Stewart, Birchler, & O'Farrell, 1999), the need and value of incorporating relationship coping skills training, such as communication and problem-solving training, in substance abuse treatment is significant.

Much research has demonstrated that individuals with chronic addictions have inadequate coping skills to resolve interpersonal conflict. For example, according to Monti, Abrams, Kadden, and Cooney (1989), coping skill deficits are a major

predisposing risk factor for developing and maintaining addiction. More specifically, the lack of proper social skill development or interpersonal coping skill deficits can be a high-risk situation for abusive drinking (Marlatt & Gordon, 1985) and can increase the likelihood for abusive drug and alcohol use (Monti et al., 1989). Communication skill deficits have been associated with individuals with substance abuse, and training programs focusing on improving such skills have been shown to be particularly effective in promoting abstinence (Monti, Abrams, Binkoff, Zwick, Liepman, Nirenberg, and Rohsenhow, 1990; Rohsenow, Monti, Binkoff, Liepman, Nirenberg, and Abrams, 1991). In addition, deficiencies in social problem solving are present in those at risk for substance abuse (Platt & Husband, 1993). Larson and Heppner (1989) found that a sample of inpatient alcoholics appraised their problem solving as considerably more negatively than nonclinical adults. Consequently, researchers also have suggested the importance of incorporating problem solving training in substance abuse treatment programs (Miller, 1992; Miller & Brown, 1997).

Fals-Stewart, O'Farrell, and Birchler (2004) espouse communication and problem solving skills training as necessary components of substance abuse treatment that can aid in enhancing relationship functioning and, thus, abstinence. Problem solving and communication skills training will be the focus of the proposed project, as it is believed that learning these specific coping skills will not only have a positive effect on relationship functioning, but also on one's recovery. Bartholomew and Simpson (2002) hypothesized that offering men a program where relationship issues such as communication problems can be openly and honestly discussed will make them feel empowered to make changes that will foster stronger and more supportive relationships

and will thus promote their recovery. Given their potential significance in substance abuse treatment and recovery, the proposed study will focus on problem solving and communication skills.

The Intervention

While more and more substance abuse treatment research has focused on the effectiveness of gender-specific program planning (Dore, 1994; Hodgins, El-Guebaly, & Addington, 1997; Schliebner, 1994), the effectiveness of the method of delivery of such interventions has not been thoroughly studied. According to La Salvia (1993), the focus of most substance abuse treatment programs is on repairing clients' ego function deficits. However, she described this primary focus on ego strengthening as inadequate. Khantzian (1988) stated that substance abusers need as much assistance with their self-care problems as they need help with understanding their feelings about life. La Salvia (1993) further stated that psychotherapy and psychodynamic group therapy may suffice in addressing emotions, but a comprehensive, thorough addictions treatment program also must include the basic set of tools necessary to solve life's day-to-day problems. A psychoeducational group, in particular, which is a specialized, task-oriented, didactic group experience, can address both ego deficits and life skills. Therefore, psychoeducational interventions have been found to be effective in addiction treatment (Marlatt & Donovan, 1982; McAuliffe & Gordon, 1980). Such interventions are particularly effective when they expand on traditional coping skills and problem-solving training (La Salvia, 1993).

"Time-Out! For Men: A Communication Skills and Sexuality Workshop for Men," developed by the Institute of Behavioral Research at Texas Christian University

(Bartholomew and Simpson, 2002) and funded by NIDA, is one such intervention that addresses communication and problem solving. This intervention, consisting of six 2-hour sessions, is specifically targeted for men and addresses communication skills, self-esteem, and problem solving in the context of helping men improve their intimate relationships (Bartholomew & Simpson, 2002). There are two additional sessions in this curriculum that focus on sexuality, specifically sexual myths and sexual stereotypes. However, due to their irrelevance to the focus of this study, they have been eliminated with the permission of the intervention's creators. Because close, stable, supportive relationships have been found to aid one's recovery and treatment compliance (Aviram & Spitz, 2003; Fals-Stewart, Birchler, and O'Farrell, 1999), the "Time Out! For Men" intervention focuses on communication skills, such as listening, assertiveness, I-statements, sharing feelings, and conflict resolution. The "Time Out! For Men" intervention was designed to teach relationship coping skills, specifically communication and problem solving skills, in order for men to make changes that will lead to more stable intimate relationships and a more successful recovery.

Definitions

Because of the multitude of terms used in addiction research, the following are the definitions of the terms that will be used throughout this paper (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th edition*, 2000):

Substance Use – any use, particularly recreational use, of alcohol and/or other drugs.

Substance Abuse – any pattern of substance use that results in repeated adverse social consequences related to substance-taking, such as failure to meet work, family, or school obligations, interpersonal conflicts, or legal problems.

Substance Dependence/Addiction – substance use characterized by related physiological and behavioral symptoms, including tolerance, or the need for increased amounts of the substance to maintain the desired effects, withdrawal if substance-taking ceases, and an inordinate amount of time spent in activities related to substance use.

These terms are on a continuum with substance use being less severe than substance abuse, and substance abuse being less severe than substance dependence/addiction. However, in the substance abuse literature and in practice, it is common to use the terms "substance abuse" to imply "substance dependence" or "addiction." For example, when someone is in inpatient "substance abuse treatment," it is likely that the person is diagnosed with a "substance dependence" issue, as inpatient care is the most intensive form of substance abuse treatment, usually requiring a dependency diagnosis. Therefore, unless otherwise noted, in this paper substance abuse will be used to imply substance dependence or addiction. In other words, these terms will be used interchangeably unless otherwise indicated.

Purpose of the Study

The purpose of this study was to test the effectiveness of a relationship skills training program in enhancing the communication, problem solving, and relationship coping skills of individuals in a male residential substance abuse treatment program.

Research Hypotheses

(1) A relationship skills training program will increase the communication skills of individuals in a male residential substance abuse treatment program.

(2) A relationship skills training program will increase the problem solving skills of individuals in a male residential substance abuse treatment program.

(3) A relationship skills training program will increase the relationship coping skills of individuals in a male residential substance abuse treatment program.

Chapter 2

Literature Review

Society pays a huge price for alcohol and other drug abuse. Although many of the costs of substance abuse are immeasurable, such as broken homes and fatal illnesses, NIDA and NIAAA (1998) estimated that alcohol abuse cost the United States $166.5 billion in 1995, and that drug abuse cost the nation $109.8 billion in 1995. The Office of the National Drug Control Policy (2001) revised and updated NIDA-NIAAA's substance abuse cost figure from 1995, estimating that alcohol and drug abuse cost the nation $373.3 billion in the year 2000. This estimate includes substance abuse treatment and prevention, healthcare, reduced job productivity or lost earnings, and crime. Society continues to pay a great deal of money even after substance abusers and dealers are caught, as it takes from $75 to $1500 per day to keep one person incarcerated. This study performed by NIDA in 1998 also determined that 44 percent of these economic costs of alcohol and other drug abuse are borne by those who abuse drugs and members of their households.

In addition to the costs it presents to society, substance abuse also has a large impact on the individual user and his or her family. Approximately 11.4 million Americans use alcohol and/or other drugs, with 3.1% of these individuals over the age of 18 having been formally diagnosed as having a drug abuse disorder and 7.4% being diagnosed with alcohol dependence (SAMHSA, 1994). One in every four families is affected by alcohol-related problems, and according to MacDonald (1991), one in eight American children has alcohol dependent parents. Further, it is estimated that alcohol plays a role in one out of three failed marriages (Institute of Health Policy, 1993). This

relationship between the substance abuser and his or her spouse or significant other has shown to be a crucial catalyst for recovery. However, this relationship can also lead a substance abuser to relapsing and to be even further engrossed in addiction. Models that have been developed depict the reciprocal relationship between substance abuse and relationship dysfunction (Fals-Stewart et al., 2004). Because the relationship between a substance abuser and his or her partner is such a vital component in the abuser's life, interventions that have been used in substance abuse treatment programs to address this relationship will be discussed. In addition, an intervention that focuses on teaching relationship coping skills (i.e., communication and problem solving skills) that can enhance one's recovery will be proposed.

In this literature review, the following topics will be addressed: (a) the impact of substance abuse on the individual, family, and significant other; (b) theoretical models which describe the importance of addressing relationship issues in substance abuse treatment; (c) interventions that have addressed the significant other relationship; (d) the importance of psychoeducational interventions in substance abuse treatment; (e) the importance of relationship coping skills training in substance abuse treatment; and (f) the "Time Out! For Men" relationship coping skills psychoeducational intervention.

The Impact of Substance Abuse

Substance Abuse and the Individual

Anyone can become dependent on alcohol and/or other drugs. Addiction does not discriminate; it is an "equal-opportunity affliction" (Hanson et al., 2005, p. 18). In other words, addiction is found across all age groups, social classes, occupations, races, and ethnicities. The United States Department of Health and Human Services (2003)

reported that an estimated 21.6 million persons aged 12 or older were classified with substance abuse or dependence. This number equals 9.1 percent of the total United States population. Of these individuals, 3.1 million were classified with dependence on or abuse of both alcohol and illicit, or illegal, drugs, 3.8 million were dependent on or abused illicit drugs but not alcohol, and 14.8 million were dependent on or abused alcohol but not illicit drugs (SAMHSA, 2003). Those who do advance from recreational substance use to abuse and dependence experience the symptoms of excessive use, constant preoccupation with using and obtaining the substance, refusal to admit excessive use, and an over-reliance on the substance (Hanson et al., 2005). Such symptoms often result in producing initial symptoms of withdrawal whenever the individual makes an effort to stop taking the substance. Consequently, the substance abuser begins to neglect other responsibilities, such as his or her family and job, in favor of using the substance.

Individuals who abuse alcohol and other drugs experience numerous consequences as a result of this abuse. First, there are severe health risks associated with substance abuse. Each year, more deaths and disabilities result from substance abuse than from any other preventable cause (Brooks, 1997). Approximately 100,000 people die as a result of alcohol, and more than 19,000 deaths are due to illicit drug abuse and drug-related behavior (Institute of Health Policy, 1993). Health-related problems such as liver disease, heart disease, lung disease, and infections, such as HIV and Hepatitis C, are common among individuals who abuse substances (Brooks, 1997).

Substance abuse also has a large impact upon the user's employment. Only fifty-nine percent of adults who reported using an illicit drug in the previous month are employed (SAMHSA, 1994). A large number of these individuals reported missing work

due to illness or injury, and some stated they have gone to work under the influence of alcohol and/or other drugs. Higher health insurance costs, including more workers compensations claims, decreased productivity, and high turnover rates are all associated with employed individuals who abuse alcohol and/or other drugs.

Finally, individuals who abuse substances are more susceptible to involvement in criminal behaviors and to being victims of crimes. According to Hanson, Venturelli, and Fleckenstein (2004), there is a strong correlation between substance abuse and crime; substance abusers are more likely to commit crimes, arrestees are often under the influence of alcohol and/or other drugs while committing their crimes, and substance abuse and violence are strongly connected. Between one-half and two-thirds of all violent crimes, including murder, sexual assault, and domestic violence, involves the abuse of alcohol (SAMHSA, 1994). In addition, McNeece and DiNitto (1998) state that substance abusers engage in high-risk activities, such as "hanging around bars drinking or going into inner-city crack houses" (p. 199), that make them more susceptible to being victims of crimes.

In addition to these substance-related consequences to the individual and society as a whole, the substance abuser also has deficits in his or her ability to cope with everyday life stressors. According to Wills and Shiffman (1985), stress results from an imbalance between environmental demands and an individual's resources to cope with those demands. Stressors may include major life events, such as a death in the family, everyday hassles, and family and work concerns. Coping, on the other hand, is an attempt to meet the demand in order to restore the balance in a person's life (Monti, Abrams, Kadden, & Cooney, 1989). Coping skills are developed to help protect

individuals from being psychologically harmed by difficult experiences in their lives (Pearlin & Schooler, 1978). According to Lazarus and Folkman (1984), there are two types of coping: problem-focused coping and emotion-focused coping. Problem-focused coping is designed to manage or alter the problem that is causing the distress, while emotion-focused coping regulates emotional responses elicited by the problem (Lazarus & Folkman, 1984). If the individual does not have adequate coping skills, both problem-focused and emotion-focused, then alcohol and other drugs may be used as a coping mechanism in an attempt to restore the equilibrium (Monti et al., 1989).

There is much documented evidence that substance abusers possess inadequate coping skills, specifically interpersonal coping skills. According to O'Leary, O'Leary, and Donovan (1976), prealcoholics, those with abusive drinking patterns who do not yet meet criteria for alcohol dependence, can be considered deficient in interpersonal skills. Bandura (1969) reported that this is a learned behavior, as in households where alcohol and drug consumption is modeled across a variety of circumstances as a means to cope with stress, children learn a similar pattern of substance abuse to cope with a variety of situations. Monti et al. (1989) further stated that some children of problem drinkers learn that heavy drinking is necessary for adequate coping in interpersonal situations. Unfortunately, these children may never learn appropriate coping skills and carry such deficits into adulthood (Monti et al., 1989). A lack of appropriate coping skills may lead to additional interpersonal problems as the individual enters relationships with friends and significant others.

Social learning theory (SLT) has been useful in explaining the link between coping skills deficits in substance abusers and the maintenance of the substance abusing

behaviors. According to SLT, alcohol dependence is maintained in part as a means of coping with stressful experiences in individuals with a limited repertoire of coping skills (Abrams & Niaura, 1987). In addition, the factors considered to maintain alcohol abuse include conditioned reactions to drinking-related stimuli and coping skills deficits (Rohsenow, Monti, Rubonis, Gulliver, Colby, Binkoff, & Abrams, 2001). For substance abusers, high-risk situations include increased urges to drink, psychophysiological reactivity, decreased self-efficacy, and impaired coping skills (Abrams & Niaura, 1987; Rohsenow, Monti & Abrams, 1995). Marlatt and Gordon (1985) stated that there is a high risk for relapse when negative, interpersonal emotional states exist. According to Rohsenow et al. (2001), focusing on coping skills in substance abuse treatment designed to address such interpersonal difficulties is highly beneficial.

Substance Abuse and the Family

There are numerous definitions of family that vary due to culture and context. The definition of family is not constant and can change according to different circumstances. Sargent (1983) proposed one definition that is widely accepted. He stated that family is "a group of people with common ties of affection and responsibility who live in proximity to one another" (as cited in Brooks & Rice, 1997, p. 57). Sargent (1983) reported that families have four primary traits. The first trait is nonsummativity, or the family as a whole is greater than—and different from—the sum of its individual members. The second trait is circular causality which holds that if one family member changes his or her behavior, as with substance use, the others also will change, which in turn causes successive changes in the member who changed initially. Next, each family possesses a pattern of communication traits, which can be verbal or nonverbal, overt or

subtle means of expressing emotion, conflict, and affection. Finally, families strive to achieve homeostasis, which portrays family systems as self-regulating with a primary need to maintain balance. For instance, when one family member, especially a parent, is a substance user, other members of the family will take on this parent's responsibilities that he or she is neglecting due to the substance use, such as cooking and taking care of children, in order for the homeostasis of the family to be maintained.

When one family member has an addiction, each of the above four traits are affected in some way, as addiction is described as a "family disease" (Brooks & Rice, 1997, p. 92). Addiction is described as a disease of the family because each family member suffers the consequences of the using member's addiction, and each plays some role in maintaining the destructive relational patterns that result from addiction (Brown, 1985). Each member of the family struggles with the addiction in his or her own way and, therefore, copes with the disease in a unique manner.

Alcoholism and drug addiction take a toll on families. However, because family structures have become more complex, growing from the traditional nuclear family to single-parent families, stepfamilies, foster families, and multigenerational families, when a family member abuses substances, the effect on the family may differ according to the structure (Center for Substance Abuse Treatment, 2004). For instance, according to Brown and Lewis (1999), a parent of small children may try to compensate for deficiencies that his or her substance-abusing spouse has developed as a consequence of the substance abuse. Further, children may act as surrogate spouses for the parent who abuses substances (Center for Substance Abuse Treatment, 2004), which is seen

commonly when the oldest child takes on responsibilities of cooking and cleaning, as the parent who is responsible for these duties is preoccupied with substance abuse.

Children are particularly vulnerable to addiction when a parent abuses alcohol and/or other drugs. In the United States, 8.3 million children live with a parent who is in need of treatment for alcohol or drug dependency (SAMHSA, 2003). One in four children under the age of 18 is living in a home where alcoholism or alcohol abuse is a fact of daily life, and countless others are exposed to illegal drug abuse in their families (SAMHSA, 2003).

The toll addiction takes on children can be substantial. Children of alcoholics (COAs) are at significantly greater risk for mental illness or emotional problems, such as depression or anxiety, physical health problems, and learning problems including difficulty with cognitive and verbal skills, conceptual reasoning, and abstract thinking (SAMHSA, 2003). Further, children whose parents abuse alcohol and/or other drugs are almost three times more likely to be verbally, physically or sexually abused, and they are four times more likely than other children to be neglected. Strong scientific evidence also suggests that addiction tends to run in families. Children of alcoholics are four times more likely than non-COAs to develop alcoholism or other drug problems (SAMHSA, 2003).

The effects of substance abuse also can extend beyond the nuclear family. Feelings of abandonment, anxiety, fear, anger, concern, embarrassment, or guilt are commonly experienced by extended family members to the point that they may ignore or cut ties with the person abusing substances. Some family members may even seek legal protection from the person abusing substances. In addition, the effects on families may

continue for generations. Intergenerational effects of substance abuse can have a negative impact on role modeling, trust, and concepts of normative behavior, which can damage the relationships between generations.

It is evident that the substance abuser suffers from personal impairment and contributes to the impairment of his or her family (McNeece & DiNitto, 1998). Similarly, other family members, such as the substance abuser's spouse or significant other, can develop individual impairment (i.e., codependency) and contribute to the impairment of the family. Likewise, this family dysfunction can exacerbate each individual family member's problems (McNeece & DiNitto, 1998). This reciprocal process of family dysfunction, specifically between the substance abuser and his or her spouse or significant other, is the focus of the next session of this literature review.

Substance Abuse and the Significant Other

Regardless of the type of substance, substance abuse affects numerous couples and families throughout the world (Pascoe, 2001). Woititz (1979) reported that each alcoholic affects at least six other people directly. One person directly involved is the client's spouse or significant other. Addiction can destroy an intimate relationship due to its devastating economic and psychological consequences. For instance, an excessive amount of money may be spent for substance use, and the partner who is not abusing substances often must assume the provider role. Psychological consequences may include denial or protection of the person with the substance abuse problem, chronic anger, stress, anxiety, hopelessness, inappropriate sexual behavior, neglected health, shame, stigma, and isolation (Center for Substance Abuse Treatment, 2004).

Intimate relationships have the potential to enhance or diminish psychological and physical health through specific coping efforts (Hansson, Jones, Carpenter, & Remondat, 1986-87). For instance, effective social support-related coping in close relationships can reduce the risk for physical and mental impairment (Coyne, Aldwin, & Lazarus, 1981), while maladaptive coping strategies such as those possessed by individuals with substance abuse issues, adversely affect psychological health (Aldwin & Revenson, 1987). In addition, marital happiness is a function of different methods of coping (Bowman, 1990). Positive approach coping and effective problem solving, for example, tend to increase marital satisfaction (Bowman, 1990). Avoidant problem solving activities, on the other hand, often lead to marital dysfunction (Noller, Feeney, Bonnell, & Callan, 1994). Such an avoidant style of coping is a characteristic of individuals with addiction.

According to Fals-Stewart, O'Farrell, and Birchler (2004), the causal relationship between substance abuse and relationship discord are intricate and reciprocal. Couples in which one partner abuses alcohol and/or drugs have significant relationship problems, including high levels of relationship dissatisfaction, instability, and verbal and physical aggression (Fals-Stewart, Birchler, & O'Farrell, 1999). Newcomb (1994) found that current substance abuse is associated with reduced dyadic adjustment and general relationship quality in non-clinical samples. Further, Wilsnack and Wilsnack (1993) determined that poor marital functioning was associated with incongruent alcohol consumption patterns (i.e., infrequent drinking wife with a frequently drinking husband or vice versa). With clinical samples, a number of studies have concluded that alcoholic

couples have distressed relationships (McCrady, Stout, Noel, Abrams, & Nelson, 1991; O'Farrell & Birchler, 1987).

In a study of dyadic adjustment and relationship satisfaction among couples, Fals-Stewart, Birchler, and O'Farrell (1999) found that for couples with one substance-abusing partner, a higher percentage of days abstinent during the year before treatment was correlated with a higher level of relationship satisfaction. In addition, one year following treatment, a higher percentage of days abstinent was associated with relationship stability for these same couples. In general, the partners in a relationship with someone abusing substances were significantly dissatisfied with their relationships, desired marked change in multiple areas of functioning that influenced relationship quality, and had taken several steps toward ending the relationship (Fals-Stewart & Birchler, 1998). Finally, Fals-Stewart and Birchler (1998) compared couples with a substance-abusing husband and non-substance abusing, distressed couples. These researchers concluded that the substance-abusing couples had higher scores on 3 of the 5 subscales of the Clinician Rating of Adult Communication (CRAC), including Abusiveness, Problem Solving Skills, and Attribution of Blame, and a higher total score on the CRAC.

According to Maisto, O'Farrell, Connors, McKay (1988), relationship dysfunction is correlated with increased substance abuse and post-treatment relapse among drug abusers and alcoholics, and this cycle continues to be perpetuated. This cycle has been termed the "destructive cycle" by Fals-Stewart et al. (2004) and illustrates the reciprocal nature of substance abuse and relationship problems. This destructive cycle illustrates how relationship and family difficulties including poor communication and problem

solving often form the basis for excessive substance use (Fals-Stewart et al., 2004). Heath and Stanton (1998) report that addiction can be maintained and even worsened by family interactions. Enabling and codependency, for instance, foster the continuation of substance abuse by one partner covering up the substance use and its consequences for the using partner (Hanson et al., 2004). Therefore, it is important to have an intervention that focuses on improving relationship functioning by enhancing problem solving and communication skills. In addition, because most relapses have been found to occur in interpersonal situations and negative affect situations, communication skills training can be extremely valuable for individuals with substance abuse issues (Marlatt & Gordon, 1985).

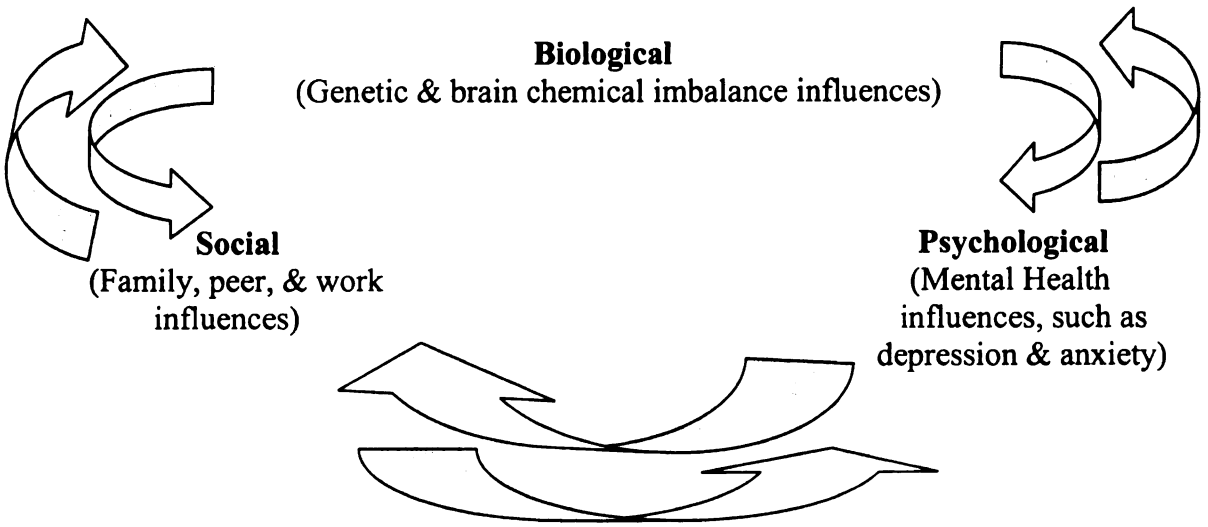
Models of Substance Abuse Treatment

The Biopsychosocial Model

According to the Department of Health and Human Services, which conducted an integrated report of the provision of services in the Northwest Territory in 2002, there are at least 15 conceptual models of addiction. The plethora of models is indicative of the lack of agreement between experts in the field as to the etiology of alcohol and other drug problems. Models, such as the disease model, which indicates a biological basis for addiction, and the sociocultural model, which dictates predominantly a societal influence on addiction, are very specific as to the cause of addiction. However, such models lack attention to other factors such as psychological and family components, which also play a part in addiction. The limitation of such models is that variables affecting substance abuse often interact with each other and cut across multiple levels (Donovan & Marlatt, 1988).

As an understanding of addiction has evolved and knowledge has been acquired through research, the mechanisms of the causes and persistence of substance abuse have been expanded. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2002), it is now evident that multiple factors can be associated with initiation and maintenance of chemical use and dependency. No single explanation appears adequate in most cases. Likewise, across the range of persons affected by substance abuse, there are wide variances in precipitating factors and motivations for continued use (SAMHSA, 2002). To address the multitude of factors exacerbating substance abuse and the variability among individuals, a more holistic model, called the biopsychosocial model, has gained broad acceptance in the field (Fisher & Harrison, 2000; Downing, 1989). Engel (1977) originally developed the model to specifically address multiple causes of mental illness. However, in the past decade this model has gained increased recognition in the field of substance abuse. The biopsychosocial model depicted in Figure 1 describes addiction as a primary illness, which progresses developmentally from increasing tolerance and dependency to a progressive loss of control to erosion of bio-psycho-social health (SAMHSA, 2002).

Figure 1. The Biopsychosocial Model



This model considers the interactions of biological, psychological, cognitive, social, developmental, environmental, and cultural variables to explain addiction (Fisher & Harrison, 2000). For instance, biological causes of substance abuse include a possible hereditary component, and recent research is also pointing to an altering of brain chemistry in those with addictions. Substance abuse also may begin and continue because individuals experience psychological and emotional problems. Finally, substance abuse may originate in social situations. It is through social interactions that substance use and abuse often is learned and reinforced. Further, addiction is often correlated with multiple social problems, including family dysfunction, unemployment, and poverty. Such a multifaceted model shifts the locus of responsibility of the addiction from solely being on the individual, which is implied by more uni-faceted models like the disease model, to also being exacerbated by external factors, like relationship dysfunction.

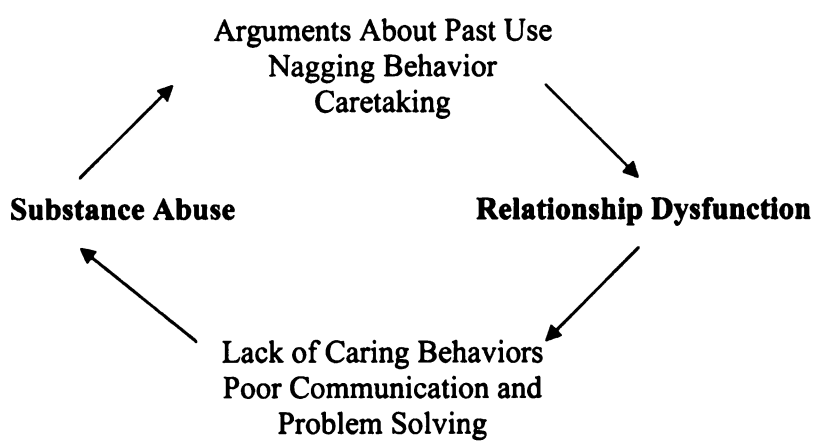
The biopsychosocial model provides a structure for the provision of substance abuse treatment services. Because treatment providers do not believe that any one approach adequately describes the causes or suggests a single preferred treatment for substance abuse disorders, this model provides practitioners with a way to understand the multifaceted problem of addiction (Wallace, 1989). Fisher and Harrison (2000) state that the biopsychosocial model dictates that people working in the field of addictions need to thoroughly assess clients, develop multiple hypotheses to explain the client's problem, avoid forcing clients to fit a rigid definition of addiction, and use a variety of interventions to address cooperatively the needs of the client. A biopsychosocial approach necessitates comprehensive services and appropriate patient-treatment

matching. A continuum of treatment and supportive services is necessary to adequately meet the variety of needs presented by addicted persons (SAMHSA, 2002).

Specific relationship-focused models

It is hypothesized that substance abuse and relationship issues have a complex and reciprocal relationship (Fals-Stewart et al., 2004). In a relationship in which one partner abuses substances, significant relationship dissatisfaction and dysfunction arises. In addition, instability and sometimes verbal and physical aggression are a part of the volatility (Fals-Stewart et al., 1999). Likewise, relationship problems are related to increased problem substance use and relapse following treatment (Maisto et al., 1988). To depict this give-and-take, mutual relationship between problematic relationship issues and substance abuse, Fals-Stewart et al. (2004) developed the destructive cycle model illustrated in Figure 2.

Figure 2. The Destructive Cycle of Addiction

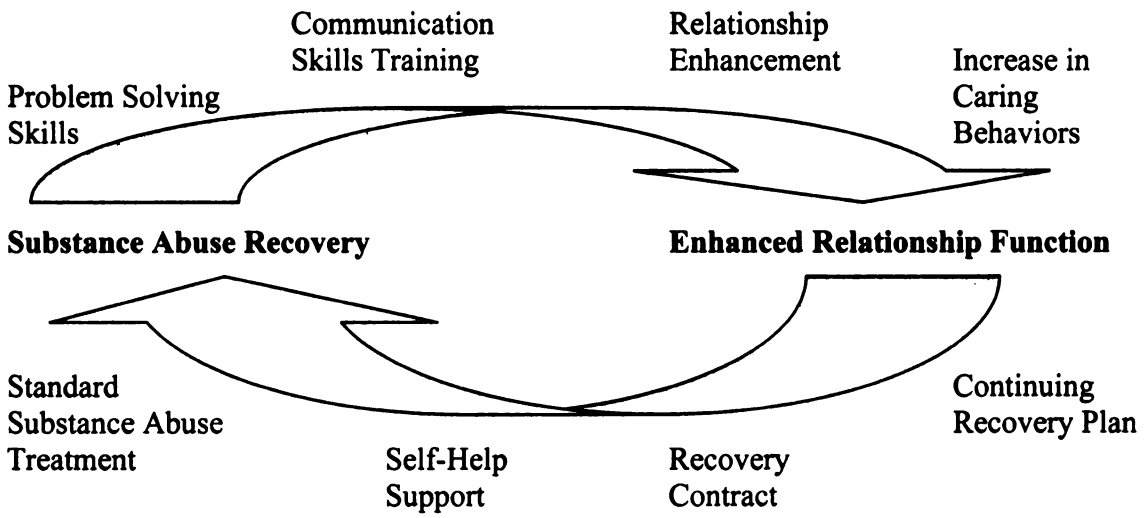


According to this model, the cycle of addiction is perpetuated because marital/relationship and related family problems often form the basis for excessive substance use. Such relationship problems include a lack of caring behaviors, poor

communication, and poor problem solving. Next, there can be ways in which the partner's or other family members' responses to the substance abuse unintentionally promotes ensuing use (Fals-Stewart et al., 2004). For instance, when a partner is co-dependent, or equally dependent on assuming the caretaker role, to his or her using partner, he or she is enabling the using partner to continue his or her substance abuse by not giving the user negative consequences for this type of dysfunctional behavior.

To counteract this destructive cycle, Fals-Stewart et al. (2004) developed an additional model, called the "constructive cycle" depicted in Figure 3 below:

Figure 3. The Constructive Cycle of Addiction



In this model, the components needed for substance abuse recovery which lead to the mending of relationships are illustrated. In substance abuse recovery, typical treatment interventions are needed, which include a continued recovery plan, a recovery contract, self-help support, and traditional substance abuse treatment, such as counseling. For these interventions to aid in enhancing relationship functioning, Fals-Stewart et al. (2004) state that additional treatment components are needed, such as problem solving skills

training, communication skills training, and interventions focused on relationship enhancement and increasing caring behaviors. In the constructive cycle, combining traditional substance abuse treatment methods that are provSided in most treatment programs, such as recovery contracts and counseling with interventions addressing relationship needs, such as communication skills and problems solving training, further promotes and enhances recovery. Two of the primary components in this model, problem solving skills and communication skills training, provide the basis for this study.

Interventions Addressing the Significant Other/Marital Relationship

Couples-focused interventions

Much of the research that has addressed and investigated the significant other/ spousal relationship in individuals with substance abuse issues has focused on interventions that have directly involved the spouse with their substance abusing partner. Such couples-focused interventions have been associated with greater marital satisfaction and increased rates of abstinence. Marital/couples therapy has been most often investigated and found to be particularly effective in the treatment of adult problem drinkers (Meyers et al., 2002), and interest in conjoint interventions became popular through successful efforts with alcoholic couples (Aviram & Spitz, 2003).

O'Farrell (1995), for instance, found that marital treatment yields better outcomes than individual treatment during the 12 months following the conclusion of treatment. Behavioral marital therapy (BMT), which has a relationship and a substance abuse focus, in particular has shown to reduce marital and/or drinking deterioration during long-term recovery better so than individual treatment (Meyers et al., 2002). O'Farrell, Cutter, Choquette, Floyd, and Bayog (1992) concluded that couples receiving BMT remained

significantly improved on marital and substance abuse outcomes throughout the 2-year follow-up. In a study performed by Fals-Stewart, Birchler, and O'Farrell (1996), couples that received behavior couples therapy (BCT) as a supplement to individual-based treatment had better relationship outcomes, including more positive dyadic adjustment and less time separated, than couples in which husbands received individual treatment only. The husbands in the BCT group also reported fewer days of substance use, longer periods of abstinence, fewer substance-related arrests, and fewer substance-related hospitalizations through the 12-month follow-up.

BCT has also been shown to be effective with women. Winters, Fals-Stewart, O'Farrell, Birchler, and Kelley (2002) randomly assigned 75 married or cohabitating females to either a BCT group or an equally intensive individual-based treatment condition. Those who received BCT reported fewer days of substance use, longer periods of continued abstinence, lower levels of alcohol, drug, and family problems, and higher relationship satisfaction.

Substance abuse is associated with relationship conflict and dissatisfaction. Substance abuse interventions focusing on couples and relationship concerns have shown consistently to be effective in comparison to equally intensive individually based interventions to address such relationship conflict. The above findings indicate that it is important to address relationship issues with an individual who has an addiction. However, according to SAMHSA (2002), the implementation of family interventions is still relatively rare. There is a common belief that there is too much expense, including costs for training and additional staff, associated with adding this component to treatment, and many agencies and/or therapists are unable or unwilling to provide such

services (Meyers et al., 2002). According to McCrady et al. (1991), in many cases a therapist's own clinical experiences may dictate his or her beliefs about treatment and the way it should be conducted. In addition, without extensive empirical validation, many therapists may believe the therapy they provide is efficacious, and, therefore, there is no need to provide additional interventions that require more training and funding (Meyers et al., 2002). More recent research, however, has substantiated that family and couples interventions are more cost-effective across an extended period of time. For instance, Fals-Stewart, O'Farrell, and Birchler (1997) concluded that BCT was more cost-beneficial than individual based treatment (IBT). O'Farrell, Choquette, Cutter, Floyd, Bayog, Brown, Lowe, Chan, and Deneault (1996) also found similar results in demonstrating that BMT is more cost-effective than individual-based treatment alone.

Despite data demonstrating its cost-effectiveness, many substance abuse treatment programs do not have additional staff to incorporate relationship interventions in addition to the traditional approaches already utilized, and/or treatment programs do not have staff trained to provide marital and couples interventions. However, there are interventions, such as psychoeducational approaches, that do not require additional training to administer and can address relationship and couples issues. In addition, due to chronic substance abuse, many substance abusers may not have the necessary foundational skills, such as communication skills and other coping skills, to be able to fully benefit from and engage in therapy interventions. Such foundational relationship coping skills, including communication and problem solving skills, can be better learned through psychoeducational approaches.

Psychoeducational Approaches

With increasing research in the area of couples therapy being performed in substance abuse settings, it is evident that addressing relationship and family issues has a positive impact on abstinence rates and relationship satisfaction. However, there is a dearth of research that addresses relationship issues using other modalities such as psychoeducational treatment that could be equally beneficial for the client. According to La Salvia (1993), much of substance abuse counseling or therapy is focused on repairing ego function deficits. However, she reported that focusing solely on ego strengthening in substance abuse treatment is inadequate. Khantzian (1988) stated that substance abusers need as much assistance with their self-care problems as they need help with understanding their feelings about life. La Salvia (1993) further stated that psychotherapy and psychodynamic group therapy may suffice in addressing emotions, but a comprehensive, thorough treatment plan for addictions also must include the basic set of tools necessary to solve life's day-to-day problems. A psychoeducational group in particular, one that is a specialized, task-oriented, didactic group experience, can address both ego deficits and life skills. Psychoeducational interventions have been found to be beneficial in addiction treatment (Marlatt & Donovan, 1982; McAuliffe & Gordon, 1980).

A psychoeducational group in addiction treatment must expand on traditional coping skills and problem-solving training (La Salvia, 1993). In a psychoeducational group, the group leader presents and leads discussions and activities on topics such as relationship communication, money management, and childcare. The therapeutic process of the group then addresses the feelings of success, failure, and ambivalence clients have

or may experience surrounding these areas and skills. Involving the family, specifically the significant other, and/or addressing family issues in this stage of treatment, is desirable, as many of the skills learned in psychoeducation apply to the family and marital relationships. Goldstein and Miklowitz (1995) note that psychoeducational approaches are useful in providing communication training, coping strategies, and problem solving skills.

Relationship Coping Skills

Coping skill deficits are a major predisposing individual risk factor for developing and maintaining addiction. Such skill deficits interact with situational demands and genetic susceptibility to decrease an individual's ability to cope effectively (Monti et al., 1989). Monti et al. (1989) identify two major categories of factors that can increase the risk of alcohol abuse or of relapse after a period of abstinence. These are intrapersonal and interpersonal factors. Interpersonal factors include marital/relationship and family supports, work relationships, and friend/peer supports. Intrapersonal factors are characteristics within the individual and include perceptions, expectations, cognitions, and mood.

Interpersonal factors can have an enormous influence on one's recovery. They can promote abstinence and help maintain recovery, but also can be a trigger for relapse. According to Bandura's cognitive-social learning approach to drug and alcohol abuse (1969, 1977, 1986), interpersonal issues, such as social skill deficits, can limit alternatives of action in a social situation, minimize one's subjective feeling of control over the situation, and can decrease the individual's access to desired resources, such as coping skills. Further, Bandura (1986) posits that substance abuse is largely the result of

having few of these coping strategies to deal with situations that are appraised as stressful and having expectations that a substance will help in coping. For instance, when an individual with addiction has an argument with his or her significant other, because of lack of development of specific interpersonal skills, he or she is not aware of different ways to handle the situation, does not feel in control, and does not have the necessary coping skills to help resolve the situation. Therefore, the individual turns to what is familiar and predictable to solve the problem, their substance of choice. Likewise, such interpersonal deficits may prevent the person from obtaining social and emotional support from others that may be necessary to maintain abstinence (Monti et al., 1989). This can help explain why many individuals with addiction have no supports or have strained relationships, as they do not have the skills to interact interpersonally in an effective manner.

In the past, research on coping and interpersonal support has tended to be conceptually and empirically separate (Greenglass, 1993). More recently, however, research has emerged linking coping and social support in order to evolve an interpersonal therapy of coping with stress. Hobfoll, Dunahoo, Ben-Porth, and Monnier (1994) discuss the interpersonal, interactive, nature of coping and social resource acquisition. Wills (1990) developed the Functional Support Model, which posits that close relationships can help a person cope with stress, as these relationships can help an individual disclose and discuss problems and share concerns. This model indicates that close relationships contribute to well being through increasing the use of more effective coping skills. However, with individuals with substance abuse issues, when a significant

relationship is full of conflict, this relationship will not be an effective source of coping for the individual and will not promote the use of effective coping skills.

Not having these proper coping skills to interact with peers and family members, including one's significant other, can be a high-risk situation for increased substance abuse. According to Marlatt and Gordon (1985), situations can be conceptualized as high-risk for drinking if the individual does not have the necessary coping skills for the situation at hand and if drinking has been learned through conditioning as a response that provides at least some short-term relief (i.e., stress relief from an argument with a spouse). Such situations include interpersonal anger and frustration, which can occur often in relationships in which one spouse or partner is using alcohol and/or other drugs. Further, if the impairment in social skills is chronic over the course of psychosocial development (which is typically the case with chronic substance abusers), the individual's potential for abusive drinking and drug using may increase (Monti et al., 1989).

Lazarus (1965) was one of the first researchers to propose a behavioral approach to the treatment of alcohol and drug abuse. He also was a pioneer in the introduction of coping skills to traditional substance abuse treatment. Lazarus (1965) introduced a behavioral approach to substance abuse treatment which included seven components. In addition to medical attention to treat the physical symptoms of addiction, he proposed assertiveness training to help the client cope with interpersonal stressful situations, behavioral rehearsal to develop interpersonal coping skills, and marital therapy to help the client's partner modify his or her role in maintaining the drinking behaviors.

A number of studies have determined that specific coping skills training interventions are more effective than standard substance abuse treatment (Monti, Abrams, Binkoff, Zwick, Liepman, Nirenberg, & Rohsenow, 1990). Eriksen, Bjornstad, and Gortestam (1986) found social skills training to be more effective than a control group in increasing the number of days abstinent and the number of days attending work following discharge from treatment. Oei and Jackson (1980) determined that both individual and group social skills training in comparison to traditional supportive therapy resulted in significantly greater reduction in alcohol abuse following discharge. In addition, the group format was found to show quicker skills acquisition. Monti, Abrams, Binkoff, Zwick, Liepman, Nirenberg, and Rohsenhow (1990) compared communication skills training with cognitive-behavioral mood management training among 69 inpatient male alcoholics. Although both groups improved in the skills presented in the training, the participants that received communication skills training improved more on skills related to alcohol-specific high-risk situations ($p < .05$). In a similar study, Rohsenow, Monti, Binkoff, Liepman, Nirenberg, and Abrams (1991) implemented communication skills training with 100 inpatient alcoholics and found this training to be equally effective as mood management cognitive-behavioral training, but the communication skills training had the advantage of benefiting a broader spectrum of patients. Finally, differential improvement using communication skills training has been particularly noteworthy among patients with lower education, higher urge to drink, or lower socialization (Cooney, Kadden, Litt, & Gerter, 1991; Rohsenow et al., 1991).

Implementing communication skills interventions is beneficial, as there is a linkage between individuals with substance abuse issues and problems with assertiveness.

Assertiveness has been continuously shown to be particularly difficult for substance abusing individuals. Sturgis, Best, and Calhoun (as cited in Monti et al., 1989) identified a link between assertiveness deficits and abusive drinking patterns. In addition, Hamilton and Maisto (1979) compared problem drinkers and non-problem drinkers on scales of assertiveness and social discomfort. Although there were no differences between the groups on assertiveness, problem drinkers reported more discomfort in situations that required them to be assertive.

In addition to communication skills deficits, individuals with addiction have also shown a lack of competency in social problem solving (Marlatt, 1979). According to Platt and Husband (1993), populations at high risk for substance abuse have deficits in problem solving and social skills. These researchers report that there are two ways in which poor problem solving skills and social skills can be related to substance abuse. First, deficiencies in these skills can lead to failures in interpersonal areas that can lead to substance use. Second, individuals with such deficits may find themselves unable to negotiate their way out of situations that carry a high risk of substance abuse.

Descriptive research has shown that individuals progressing well through their recovery programs exhibit more skills in problem-solving scenarios (Appel & Keastner, 1979). More recent research has concluded that families with adolescents who abuse alcohol and/or other drugs often lack skills in family problem solving and in coping with simple, everyday problems (Hops, Tildesley, Lichenstein, & Ary, 1990). Such a lack of problem solving skills has also been exhibited among young adults (Fromme & Rivet, 1994) and college students (Evans & Dunn, 1995) who abuse alcohol.

There also have been studies conducted measuring self-appraised problem-solving abilities, which have indicated a relationship between problem-solving competencies and substance abuse. Heppner and Peterson (1982) suggested that problem-solving appraisal, or the perception of one's problem-solving ability, is an important component of the coping process. Cameron and Michenbaum (1993) noted that effective coping predisposes an adequate repertoire of skills for dealing with life problems, such as substance abuse, and the use of such skills may depend initially on self-perceived efficacy as a problem solver. Elliot, Johnson, and Jackson (1997) found that self-appraised ineffective problem solving was associated with retrospective accounts of substance abuse among undergraduates. Such a relationship was also supported with a sample consisting of adult children of alcoholics (Wright & Heppner, 1991). In a clinical sample of inpatient alcoholics, Larson and Heppner (1989) found that these individuals appraised their problem solving considerably more negatively than nonclinical adults.

With both descriptive and self-report studies supporting a relationship between substance abuse and problem solving skills deficits, it would appear beneficial to incorporate such skills training in substance abuse treatment. According to Platt and Husband (1993), problem-solving skills training in substance abuse treatment is designed to provide clients new skills that will allow them to maintain their abstinence. Other studies also support such skills training in substance abuse treatment by reporting that interventions that incorporate training in self-control, social skills, stress management, and problem solving are crucial in recovery and in coping with concurrent social, personal, and health problems that co-occur with substance abuse (Miller, 1992; Miller & Brown, 1997).

Time Out! For Men Intervention

"Time Out! For Men: A Communication Skills and Sexuality Workshop for Men" (Bartholomew & Simpson, 2002) is a psychoeducational curriculum developed as part of the NIDA-funded Drug Abuse Treatment Assessment and Research (DATAR) project conducted by the Institute of Behavioral Research at Texas Christian University. The intervention was designed to aid substance abuse treatment providers in working with men who have sexuality and relationship issues. This six-session, psychoeducational curriculum addresses communication skills, such as listening, assertiveness, expressing feelings, and conflict resolution. Sexual health concerns and sexual functioning and human sexual response are also discussed in two additional sessions, but these have been eliminated for the purposes of this study with permission from the intervention's creators. Such a curriculum not only allows clients to improve their communication and problem solving skills, but also provides a forum to examine gender roles and socialization issues.

Bartholomew, Hiller, Knight, Nucatola, and Simpson (2000) conducted a study examining the efficacy of the "Time Out! For Men" intervention with 122 male felony probationers who were court-mandated to a 6-month residential substance abuse treatment program in lieu of incarceration. This study indicated a significant increase in the experimental group's ($n = 64$) knowledge of communication, sexuality, sexual health, and gender-role and socialization issues ($p < .0001$) in comparison to the control group ($n = 58$). Participation in the intervention was also associated with a reduction in attitudes associated with rigid socialization and rigid role conflict ($p < .003$) in comparison to the control group.

It has been shown that individuals with a chronic history of substance abuse are likely to have under-developed coping skills, specifically interpersonal and relationship coping skills, such as communication and problem-solving skills. As illustrated by the destructive-cycle model developed by Fals-Stewart et al. (2004) described above, the inclusion of relationship coping skills training in substance abuse treatment focusing on two components of the model, problem-solving and communication skills training, can enhance relationship functioning. Since relationship dissatisfaction and conflict can be high-risk situations for continued substance abuse and/or relapse after a significant period of abstinence, and individuals with addictions likely do not have the necessary skills to cope with such conflict when it occurs, incorporating an intervention, like "Time Out! For Men" in traditional substance abuse treatment to teach such skills is likely to be beneficial to the individual, his recovery, and his relationship with his spouse or significant other.

Chapter 3

Method

Participants

The sample in this study consisted of men in the residential substance abuse facility, House of Commons. The House of Commons, a component of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties, located in Mason, Michigan, with a capacity of 40 beds, is a high-intensity residential program designed to address significant problems with living skills experienced by adult males with substance abuse and criminal conduct. The facility offers a variable length of stay up to 90 days. Referrals to House of Commons originate from several sources, the Michigan Department of Corrections Office of Community Corrections, the Michigan Department of Corrections Substance Abuse Services, the Mid-South Substance Abuse Commission with funding for indigent individuals, and Central Diagnostic and Referral Services, a referring agency for those with Medicaid or without any insurance.

The House of Commons uses a cognitive-behavioral approach to teach clients strategies for self-improvement and change. Treatment is specific to maintaining abstinence and preventing relapse, but the program also vigorously promotes social responsibility and positive character change. Some of the treatment groups that are implemented on a daily basis include anger management, relapse prevention, and a group focused on learning and working through the 12 steps of Alcoholics Anonymous. In addition, the House of Commons relies on the treatment community as a therapeutic agent that introduces and reinforces appropriate social values and behaviors. The

program also focuses on reintegration of the clients into the greater community with specific emphasis on employment and education.

Because both an experimental and control group were used in this study, the participants were chosen to participate in the study based on their legal status. Both clients on probation and those on parole are accepted at House of Commons. Due to court system requirements and judge mandate, those clients on probation must stay at House of Commons 60-90 days. Those on parole are required to undergo treatment for 30 days or less. Due to the duration of the intervention being three weeks, a significant time constraint would have been introduced if the clients on parole were included in the study. In addition, because this study included random assignment, using a more homogenous group ensured better equality of the groups. Therefore, only clients on probation were utilized in the study and were randomly assigned to either the experimental or control group. To document the similarities between the groups and to be able to describe the sample, specific demographic information, including age, race, education, number of attempts in substance abuse treatment, and relationship status were collected from each participant (see Appendix A for Participant Information Sheet). Because of the constraints of this study, diagnoses were not obtained from the clients. However, in general, the sample was comprised of participants diagnosed with alcohol dependence or polysubstance dependence (i.e., addicted to more than one substance). The following tables summarize the similarities between the groups:

Table 1.Descriptive Statistics for the Experimental and Control Groups

	Exp.	Ctl.	Exp.	Ctl.
	Mean		SD	
N	42	38		
Age	35.52	37.61	9.766	11.726
Ed Level	11.87	12.28	1.436	1.758
Txt Attempts	2.86	3.00	3.842	3.353

Table 2. Frequency Table of Race for the Experimental and Control Groups

	Exp.	Ctl.	Exp.	Ctl.
	Frequency		Percent	
1 (White)	21	24	51.2	63.2
2 (Black)	13	12	31.7	31.6
4 (Hispanic)	4	1	9.8	2.6
7 (Multiracial)	3	1	7.3	2.6
Total	41	38		
Missing	1	0		

Table 3. Frequency Table of Relationship Status for the Experimental and Control Groups

	Exp.	Ctl.	Exp.	Ctl.
	Frequency		Percent	
1	27	21	64.3	55.3
2	15	17	35.7	44.7
Total	42	38		
Missing	0	0		

In a relationship =1, Not in a relationship=2

Each client that is considered for admission to the House of Commons is assessed for and diagnosed with substance abuse or dependence using the Addiction Severity Index (ASI) (McLellan, Luborsky, O'Brien, & Woody, 1980). The ASI is a semi-structured interview designed to address seven potential problem areas in substance-abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. The ASI provides an overview of problems related to substance, rather than focusing on any single area. The ASI has been shown to be consistently valid using criterion (.54 to .95) and construct validity (.45 to .73) and reliable using a test-retest measure (.92) and an interrater measure (.89 to .92). Because residential substance abuse treatment is the most intense of treatment interventions in terms of length of stay and provision of services, every client admitted to the House of Commons meets criteria for Substance Abuse or Dependence.

In addition, to assure that these clients meet the diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision* (DSM-IV-TR) (American Psychiatric Association, 2000) for Substance Abuse or Dependence, the

ASAM (American Society of Addiction Medicine) criteria (Hoffmann, Halikas, Mee-Lee, & Weedman, 1991) are used by the House of Commons. The ASAM criteria were designed to ensure a voice for substance abuse practitioners in defining a continuum of care. The main elements of the ASAM Criteria consist of six assessment dimensions used to define biopsychosocial severity of the client in order to guide placement. Further, when such dimensions are assessed, there are four levels of care that describe the intensity of service that needs to be provided. The six assessment dimensions include acute intoxication and/or withdrawal potential, biomedical conditions and complications, emotional/behavioral conditions and complications, treatment acceptance/resistance, relapse potential, and recovery environment. The four levels of care, named to be descriptive of the intensity of service, are Outpatient Treatment (Level 1), Intensive Outpatient/Partial Hospitalization (Level II), Medically Monitored Intensive Inpatient Treatment (Level III), and Medically Managed Intensive Inpatient Treatment (Level IV). To meet criteria for Level III or Level IV of care, a client must have a significant substance abuse or dependence problem affecting most, if not all, areas of his or her life. The House of Commons is a Level III facility, as it is a residential, or inpatient facility, and there are medical personnel, including psychiatrists and nurses, that provide services to the clients.

Variables and Measure

Communication

Communications skills training in substance abuse treatment has been established as extremely important (Fals-Stewart et al., 2004), as those with substance abuse issues possess inadequate interpersonal coping skills (Abrams & Niaura, 1987; Rohsenow et al.,

2001). Not only can including such training promote abstinence, but it can also enhance relationship functioning (Fals-Stewart et al., 2004). According to the Communications skills glossary, communication skills are learned patterns of communicating with others. Communication skills include the ability to read and comprehend information, the ability to express ideas effectively in written and spoken form, and the ability to listen attentively (UA Fort Smith, 2005). In this study, communication skills knowledge were operationally defined by a higher score on the Communication Competence Scale.

The Communication Competence Scale (CCS) (Wiemann, 1977) is a 36-item questionnaire that measures one's perceived knowledge and use of communication skills (See Appendix B for CCS). The participant responds to each question using a 5-point Likert-type scale ranging from Strongly Agree (5) to Strongly Disagree (1). Scores range from 36 to 180, and individuals high in CCS (108) are generally more sensitive, flexible, and assertive communicators than those lower in CCS. In addition, the higher the score, the more competent a communicator the individual perceives himself/herself to be. With permission from the author, a modified version of the CCS was used in which the directions were altered to instruct participants to respond to the questions based on how they communicate in their intimate relationship. The questions were not altered.

The CCS contains five subscales, including general communicative competence, affiliation/support, social relaxation, behavioral flexibility, and empathy. Initially 57 Likert-type items were written and pretested by Wiemann (1977); those showing the greatest between-treatment discrimination were retained. In a post hoc analysis of the revised instrument, its reliability using Cronbach's alpha was estimated at .96. Wiemann (1977) used Friedman's Estimation of the Magnitude of Experimental Effect to calculate

statistical power. Power was determined to be .74, indicating more than sufficient protection against Type II error. In addition, a factor analysis was performed, and Factor I, general communicative competence, accounted for 82.8 percent of the variance.

Problem Solving

Substance abusers have been shown to have inadequate problem solving skills (Marlatt, 1979), and the development of such skills has been determined to be crucial for one's recovery (Platt & Husband, 1993) and essential for relationship satisfaction (Fals-Stewart et al., 2004). According to Huitt (1992), problem solving is a process in which one perceives and resolves a gap between a present situation and a desired goal, with the path to the goal blocked by known or unknown obstacles. In this study, the possession of problem solving skills knowledge was operationally defined by a lower score on the Problem Solving Inventory.

The Problem-Solving Inventory (PSI) (Heppner, 1982) is a 35-item self-report measure in a 6-point Likert style format (Strongly agree to Strongly disagree) (See Appendix C for PSI). The PSI is designed to assess an individual's perceptions of his or her capabilities with regards to problem solving behaviors and attitudes. In other words, this measure assesses one's level of self-efficacy as a problem solver. The PSI provides a single, general index of Problem-Solving Confidence (self assurance while engaging in problem solving activities), Approach-Avoidance Style (a general tendency to either approach or avoid problem solving activities), and Personal Control (determines the extent of control one has over their emotions and behaviors while solving problems). High scores indicate general negative self-appraisal. With permission from the author, a modified version of the PSI was used in which the directions were altered to instruct

participants to respond to the questions based on how they problem solve in their intimate relationship. The questions were not altered.

An estimate of internal consistency was computed for each of the three factors and the total inventory (n = 150), which are as follows: problem solving confidence, α = .85; approach-avoidance style, α = .84; personal control, α = .72; total inventory, α = .90. Test-retest reliability was established by administering the inventory to an additional sample on two occasions two weeks apart. The test-retest reliabilities were as follows: problem-solving confidence, r = .85; approach-avoidance style, r = .88; personal control, r = .83; and the total inventory, r = .89.

Estimates of concurrent and construct validity were established through several means. Scores on the three factors and the total PSI were correlated with the Level of Problem Solving Skills Estimate Form (LPSSEF), specifically with students' ratings of their levels of problem solving skills (rs = -.44, -.29, -.43, and -.43, respectively), and students' perceived satisfaction/dissatisfaction with their problem-solving skills (rs = -.42, -.24, -.39, and -.42, respectively). All correlations were statistically significant (p< .0001). Therefore, scores on the PSI correlate moderately well with scores on a simple self-rating scale. Other research studies have further corroborated the concurrent, discriminant, and construct validity of the PSI.

Relationship Coping Skills

There is much documented evidence that substance abusers possess inadequate coping skills, specifically interpersonal coping skills. Alcohol dependence, for instance, has been found to continue in part as a means of coping with stressful experiences (Abrams & Niaura, 1987). In addition, the factors considered to maintain alcohol abuse

include coping skills deficits (Rohsenow, Monti, Rubonis, Gulliver, Colby, Binkoff, & Abrams, 2001). Finally, Marlatt and Gordon (1985) stated that there is a high risk for relapse when negative, interpersonal emotional states exist. Coping may be problem-focused or emotion-focused (Folkman & Lazarus, 1988), but coping behaviors used to manage intimate relationship stress may differ from those that are used to cope with other common life problems (Pollina & Snell, 1999). In this study, the possession of relationship coping skills was operationally defined by a higher score on a modified version of the Multidimensional Intimate Coping Questionnaire (MICQ) (Pollina & Snell, 1999).

The MICQ consists of 100 items and 25 subscales. COPE (Carver, Scheier, & Weintraub, 1989), a well-researched general coping skills inventory, was the basis for the first 15 subscales. The Coping Inventory for Stressful Situations (CISS) and the Marital Coping Inventory (MCI) were used to prepare items for ten additional subscales. Where necessary, Pollina and Snell (1999) re-worded items from these instruments to reflect relationship stressors. With the MICQ, participants are asked to think about their current intimate relationship and indicate how much each statement describes them using a 5-point Likert scale from 0 (not at all characteristic of me) to 4 (very characteristic of me).

Nine subscales of the MICQ (see Appendix D for the modified version of MICQ) were utilized in this research study. This modified version of the MICQ more directly corresponds to the "Time Out! For Men" curriculum than does the entire 100-item questionnaire. The nine subscales which constituted the 36 items include: positive reinterpretation and growth (α = .82), active coping (α = .71), seeking social support for instrumental reasons (α = .84), acceptance coping (α = .61), focus on and venting of

emotions (α = .81), behavioral disengagement (α = .73), restraint coping (α = .71), self-bolstering (α = .81), and emotional expression and reaction (α = .71).

Principal components analysis was utilized by the authors to determine whether any of the coping strategies assessed by the MICQ would form conceptually similar groupings representing broad coping dimensions. Six factors emerged and accounted for 68.8 percent of the variance in MICQ total scores. The six factors include having a problem-solving orientation with some efforts to reduce negative affect (28.2%), an orientation towards escaping from problems rather than confronting them (15,7%), emotional orientation towards relationship issues (7.8%), focus on devoting greater time to relationship issues (6.7%), social support coping mechanisms (6.0%), and escape orientation including humor coping (4.4%).

Procedure

Following receipt of UCHRIS (University Committee on Research Involving Human Subjects) approval, study procedures began, as consent from House of Commons to conduct a research study with its clients had already been obtained by the director of the facility and the Community Mental Health Authority. Although participation in all activities is mandatory at House of Commons, participation in this intervention was voluntary. The following procedure outlines the direction of this study:

Week 1	• Discussed study with clients at the House of Commons in the weekly business meeting in which all clients were in attendance. A sign-up sheet with an office number and times I would be available was given during my discussion of the study so that those interested could sign up and come by to get more information about the study, sign the consent form (see Appendix E), fill out the questionnaires, and for those in the experimental group, get informed of the day and time the intervention was to begin.

	• During these "office hours," all clients were randomly assigned to the experimental and control groups. Regardless of group assignment, the consent form was explained in verbal and written form, and each participant signed the consent form, filled out the Participant Information sheet, and completed the three questionnaires (CCS, PSI, and MICQ). • Those in the control group were given a date and time to come back in three weeks (after the conclusion of the intervention) to complete the same three questionnaires and also to go through the intervention if they chose. • All client data was stored in a locked file drawer in the facility's records room that I only had a key to.
Week 2-4	• Began 6-session intervention (2 sessions weekly) with the experimental group. • All client data was stored in a locked file drawer in the facility's records room that I only had a key to.
Week 4	• Intervention concluded. • Each participant in the experimental group completed the same three questionnaires during the last session of the intervention. • Each participant in the control group completed the same three questionnaires at the pre-designated date and time described above, and they went through the intervention if they chose. • Questionnaires were stored in a locked file drawer in the records room that I only had a key to.
Week 5 - Completion	• Same above procedures were performed until an adequate sample size was obtained.

The intervention, "Time Out! For Men" (Bartholomew & Simpson, 2002), consists of six sessions designed to address relationship issues, including listening, assertiveness, expressing feelings, and conflict resolution. The six sessions that were presented to the participants are as follows (see Appendix F for a detailed outline of each session):

Session 1: A New Outlook on Relationships –Exploration of new ways of thinking about love and intimacy will be made and personal goals for improving relationships will be developed.

Session 2: An Assertive Attitude – Skills for effective communication will be introduced, particularly using assertiveness and I-statements in relationships.

Session 3: Listening – Listening is presented as a skill that can improve relationships and facilitate self-growth.

Session 4: Talking It Over – Feelings and Needs - Openness and self-expression in relationships is presented as a helpful tool to facilitate communication. Participants are aided in identifying and accepting feelings as normal and instructed on how the inappropriate management of feelings can result in a communication breakdown.

Session 5: Talking It Over – Resolving Conflict – A model for conflict resolution, highlighting solutions rather than blame, is introduced. The importance of "fighting fair" and active problem solving is emphasized.

Session 6: Making Relationships Work – The importance of self-esteem is emphasized and affirmations are introduced as a positive self-help technique. In addition, relationship skills and the application of those skills are reviewed to conclude the intervention.

Two sessions were conducted each week and were two hours in duration. Therefore, the intervention took three weeks for participants to complete.

Research Design and Data Analyses

The purpose of this study was to assess the efficacy of a relationship skills training program for enhancing communication, problem solving, and coping skills among males in a residential, substance abuse treatment program. An experimental research design was thus required. The most appropriate and useful design to test the research hypotheses of interest in this study was a randomized, control group, pre-test, post-test design (Leedy & Ormrod, 2001). As per Figure 4 below, the aim of a research study in which such a design is used is to show that two groups are equivalent with respect to a particular variable prior to the treatment, thus eliminating initial group differences as an explanation for post-treatment differences. In this study, the intention was to show that the experimental and control groups were equivalent with respect to communication, problem solving, and coping, and thus eliminate initial group differences as an explanation for difference following the delivery of the "Time Out! For Men" program.

Figure 4. Research Design

Group Time ⟶

Group 1	Observation	Treatment	Observation
Group 2	Observation	_____	Observation

In accord with the purpose of the investigation and the nature of the experimental, randomized, control group, pre-test, post-test research design, t-tests for a difference between two, paired groups were used to test the three research hypotheses of interest. The following statistical null hypotheses were tested:

1. There is no significant difference between experimental group pre-test and post-test scores on the Communication Competence Scale.
2. There is no significant difference between experimental group pre-test and post-test scores on the Problem Solving Inventory.
3. There is no significant difference between experimental group pre-test and post-test scores on the Multidimensional Intimate Coping Questionnaire - Modified.

As recommended by Cohen (1988) and Lipsey (1990), a pre-analysis statistical power estimate was conducted to determine the appropriate alpha level and sample size requirements under the condition of an assumed small effect size. Given an alpha level of .05 and assuming a small effect size, the pre-analysis power estimate yielded a power of .79 for testing the research hypotheses using paired sample t-tests. A statistical power approaching .80 is considered adequate for rejecting a null hypothesis if it were false (Cohen, 1988). The t-tests were therefore planned at the .05 alpha level, assuming a small effect size, and with the requirement of a sample size of approximately 33 experimental group participants.

Because the coping measure used in this study is a modified version of the Multidimensional Intimate Coping Questionnaire (Pollina & Snell, 1999) for which the psychometric properties are unknown, exploratory data analyses were conducted on this instrument to evaluate its utility in the investigation. First, an internal consistency reliability analysis was conducted. Second, to examine the possibility whether the modified version of the Multidimensional Intimate Coping Questionnaire used in the present study contained subscales meaningful to the process of relationship coping, a cluster analysis was conducted. It was anticipated that the sample size in this study

would prevent a valid application of factor analysis. Ward's method was used because at each step it produces hierarchical clusters that minimize within-cluster variance and maximize between-cluster variance. A visual inspection of the resulting dendrogram and numerical output was conducted to determine the most parsimonious cluster solution. To evaluate the meaning of the clusters, the content of the items that loaded on the clusters were inspected and compared to the MICQ, as developed and presented by Pollina and Snell (1999).

Chapter 4

Results

The purpose of this study was to test the effectiveness of a relationship skills training program in enhancing the communication, problem solving, and relationship coping skills abilities of individuals in a male residential substance abuse treatment program. The following are the research hypotheses tested in this study:

(1) A relationship skills training program will increase the communication skills of individuals in a male residential substance abuse treatment program.

(2) A relationship skills training program will increase the problem solving skills of individuals in a male residential substance abuse treatment program.

(3) A relationship skills training program will increase the relationship coping skills of individuals in a male residential substance abuse treatment program.

Descriptive statistics of the study variables (Pre CCS = Pre-test of Communication Competence Scale, Post CCS = Post-test of Communication Competence Scale; Pre PSI = Pre-test of Problem Solving Inventory, Post PSI = Post-test of Problem Solving Inventory; Pre MICQ = Pre-test of Multidimensional Intimate Coping Questionnaire, Post MICQ = Post-test of Multidimensional Intimate Coping Questionnaire) are presented in Table 4.

Table 4. Descriptive Statistics of Study Variables for Experimental and Control Groups

	Exp.	Ctl.	Exp.	Ctl.
	Mean		SD	
Pre CCS	130.05	132.29	16.49	16.81
Post CCS	138.36	134.24	15.43	16.68
CCS Range	36-180			
Cronbach's alpha	0.81	0.86		
Pre PSI	101.67	103.55	26.68	14.53
Post PSI	87.40	101.18	22.13	14.01
PSI Range	35-210			
Cronbach's alpha	0.76	0.88		
Pre MICQ	113.86	118.55	16.33	15.21
Post MICQ	127.70	120.37	15.17	15.90
MICQ Range	36-175			
Cronbach's alpha	0.63	0.92		

Note: Improved performance on the PSI is indicated by a lower score on the PSI, while higher scores on the MICQ and CCS indicate improved performance.

A correlational matrix of the post-test study variables is provided in Table 5. All three measures have moderate and statistically significant relationships. This finding suggests that the constructs of communication, problem solving, and relationship coping skills are correlated, yet distinct.

Table 5. Correlational Matrix of the Post-Test Study Variables in the Experimental Group

	Post CCS	Post PSI	Post MICQ
Post CCS		-.53**	.53**
Post PSI			-.66**
Post MICQ			

** Correlation is significant at the 0.01 level (2-tailed).

Results Related to Research Hypothesis One

As shown in Table 6, in a paired-sample (within group) t-test, there was a statistically significant difference for the experimental group (n = 42) on learning communication skills (t = -4.24, p < .0001) based on pre- and post-test CCS scores. For the control group (n = 38), there was no statistically significant difference (t = -1.02, p = .32) between pre- and post-test CCS scores.

Table 6. Communication Skills Ability Differences Among the Experimental and Control Groups

	Experimental				Control			
	M	SD	df	t	M	SD	df	t
Pre CCS – Post CCS	-8.31	12.72	41	-4.24*	-1.95	11.81	37	-1.02

*p<.0001

Results Related to Research Hypothesis Two

As shown in Table 7, in a paired-sample (within group) t-test, there was a statistically significant difference for the experimental group (n = 42) on learning problem solving skills (t = 4.28, p < .0001) based on pre- and post-test PSI scores. For the control group (n = 38), there was no statistically significant difference (t = 1.54, p = .13) between pre- and post-test PSI scores.

Table 7. Problem Solving Skills Ability Differences Among the Experimental and Control Groups

	Experimental				Control			
	M	SD	df	t	M	SD	df	t
Pre PSI – Post PSI	14.26	21.61	41	4.28*	2.37	9.50	37	1.54

*p<.0001

Results Related to Research Hypothesis Three

As shown in Table 8, in a paired-sample (within group) t-test, there was a statistically significant difference for the experimental group (n = 42) on learning relationship coping skills (t = -5.47, p < .0001) based on pre- and post-test MICQ scores. For the control group (n = 38), there was no statistically significant difference (t = -1.33, p = .19) between pre- and post-test MICQ scores.

Table 8. Relationship Coping Skills Ability Differences Among the Experimental and Control Groups

	Experimental				Control			
	M	SD	df	t	M	SD	df	t
Pre MICQ – Post MICQ	-13.83	16.38	41	-5.47*	-1.82	8.39	37	-1.33

*p<.0001

Additional Analyses

Independent sample t-tests also were conducted on both the pre-test measures and the post-test measures to further examine the impact of the intervention in influencing the development of problem solving, relationship coping, and communication skills. An

independent sample t-test was conducted using pre- and post-test PSI data. As shown in Table 9, there was no statistically significant difference between the experimental and control groups ($t = -.40$, $p = .69$) on pre-test PSI scores. However, there was a statistically significant difference between the experimental and control groups ($t = -3.36$, $p = .001$) on post-test PSI scores.

Table 9. Problem Solving Skills Ability Differences Between the Experimental and Control Groups

	t	df	p
Pre PSI	-.40	78	.69
Post PSI	-3.36	78	.001

Next, an independent sample t-test was conducted using the pre-test and post-test scores of the MICQ. As shown in Table 10, there was no statistically significant difference between the experimental and control groups ($t = -1.33$, $p = .19$) on the pre-test MICQ scores. However, on the post-test of the MICQ, there was a statistically significant difference between the experimental and control groups ($t = 2.11$, $p = .04$).

Table 10. Relationship Coping Skills Ability Differences Between the Experimental and Control Groups

	t	df	p
Pre MICQ	-1.33	78	.19
Post MICQ	2.11	78	.04

Finally, an independent sample t-test was conducted using the pre-test and the post-test scores of the CCS. As shown in Table 11, on the pre-test CCS scores, there was

no statistically significant difference between the experimental and control groups ($t = -.60$, $p = .55$). In addition, on the post-test of the CCS, there was no statistically significant difference between the experimental and control groups ($t = 1.15$, $p = .26$).

Table 11. Communication Skills Ability Differences Between the Experimental and Control Groups

	t	df	p
Pre CCS	-.60	78	.55
Post CCS	1.15	78	.26

A modified version of the MICQ was used incorporating the subscales that were most meaningful to relationship coping. Cluster analysis of the 36 items in the modified version of the MICQ yielded a 6-cluster solution. The six clusters were distinct and interpretable based on the substance abuse treatment and coping research. The number of clusters was determined using strategies reported by Hair, Anderson, and Tatham (1987). Initial cluster analyses resulting in two to six clusters were inspected to determine the number of clusters that incorporated the information most relevant to clinical substance abuse treatment, research, and theory (i.e., the biopsychosocial model). In addition, examination of intercluster distances for each of these six steps found that the great successive distance difference occurred between the five- and six-cluster solution.

The clusters were labeled as follows: (a) Cluster 1 – *acceptance coping style*, (b) Cluster 2 – *emotional coping style*, (c) Cluster 3 – *avoidance coping style*, (d) Cluster 4 – *action-oriented coping style* (e) Cluster 5 – *self-promoting*, and (f) Cluster 6 – *self-awareness and expression*. The six clusters represent styles and strategies individuals in a relationship use to respond to and cope with difficult or stressful events that occur in

intimate relationships. The relationship coping clusters and individual items from the MICQ comprising each cluster are presented in Table 12. The Cronbach's alpha for the 36 items on the modified version of the MICQ was .84, indicating a high level of internal consistency in the measurement of relationship coping skills with the sample in this study.

Table 12. Relationship Coping Style Clusters and Corresponding Items

Acceptance coping style

I learn something from the stressful experience.
I do what has to be done, one step at a time.
I learn to live with it.
I reassure myself that I can cope with the situation.
I bolster my self-confidence by telling myself that I can deal with the problem.
I get used to the idea that it happened.
I accept the reality of the fact that it happened.
I accept that this has happened and that it can't be changed.

Emotional coping style

I restrain myself from doing anything too quickly.
I start feeling anxious, tense, and unsettled.
I feel a lot of emotional distress, and I find myself expressing those feelings a lot.
I find I can't concentrate on my work or other interests.
I get upset and let my emotions out.

Avoidance coping style

I give up the attempt to get what I want.
I reduce the amount of effort I'm putting into solving the problem.
I hold off doing anything about it until the situation permits.
I admit to myself that I can't deal with it, and quit trying.
I just give up trying to reach a desirable resolution.
I start feeling that I am a failure.
I start feeling depressed and blue.

Action-oriented coping style

I try to get advice from someone about what to do.
I talk to someone to find out more about the situation.
I talk to someone who could do something concrete about the problem.
I take additional action to try to get rid of the problem.
I ask people who have had similar experiences what they did.
I take direct action to get around the problem.

Self-promoting

I try to see it in a different light, to make it seem more positive.
I keep my self-esteem up by saying positive things to myself.
I provide myself with reassurance that I can cope with the situation.
I look for something good in what is happening.
I force myself to wait for the right time to do something.
I make sure not to make matters worse by acting too soon.

Self-awareness and expression

I try to grow as a person as a result of the stressful experience.
I concentrate my efforts on doing something about it.
I let my feelings out.
I get upset, and am really aware of it.

Chapter 5

Discussion

The purpose of this study was to test the effectiveness of a relationship skills training program, "Time Out! For Men," in enhancing the communication, problem solving, and relationship coping skills of individuals in a male residential substance abuse treatment program. This Discussion chapter addresses the following areas: (a) limitations of the study, (b) narrative summary of findings, (c) relation of results to previous research, (d) implications for theory, research, and practice, and (e) future research needed.

Limitations of the Study

The first limitation was potential measurement issues. For instance, the reliability and construct validity of the Communication Competence Scale (CCS) may have been affected by modifications being made in an effort to enhance the fit of the measure for the study. More specifically, the instructions on the CCS were altered slightly to fit the context of this study. Similarly, the instructions were altered slightly on the Problem Solving Inventory (PSI).

A potential second limitation was that the participants were also receiving interventions at the House of Commons in which communication skills were addressed, including in anger management and relapse prevention groups. Receiving such information concurrently may have yielded a similar improvement in learning communication skills and, therefore, perhaps influenced insignificant findings between the experimental and control groups.

A third limitation of this study was its limited external validity, or the degree to which the findings of the proposed investigation can be generalized across persons, times, and settings. Given the convenience and volunteer nature of the sampling procedure, study results are not generalizable to all individuals who participate in House of Commons treatment programs (i.e., individuals on parole) or other substance abuse treatment programs. The cross-sectional nature of data collection procedures allows only for interpretation of results concerning participants at the time of the study. Given this limitation, results cannot be generalized beyond the sample used in this investigation.

The results of this study may have been influenced by the House of Commons agency and the group leader. More specifically, House of Commons was very receptive to having this researcher come to the facility and offer the intervention to its clients. The climate was very positive, and this atmosphere made the data-gathering process simple and unproblematic. Other agencies may not be as receptive and open to the research process making data collection more difficult. In addition, this researcher has extensive clinical experience working with clients with substance abuse issues in a community mental health setting and, consequently, understands the personality needed to elicit positive client participation. Other researchers without such experience may not be as successful in engaging clients, which would likely affect the efficacy of the intervention.

A final limitation of this study is the lack of a long-term follow-up component for evaluating the efficacy of the intervention. Results suggest that participant communication, problem solving, and relationship coping skills increased as a result of the "Time Out! For Men" program across a three-week time period. However, the study yielded no data in relation to whether such skills were retained, whether the participants

incorporated the skills in their relationships, and whether such skills helped promote their long-term abstinence.

Narrative Summary of Findings

Among the individuals who participated in the "Time Out! For Men" psychoeducational intervention (i.e., experimental group), there was a significant improvement in their communication skills, problem solving skills, and general relationship coping skills from the pre-test to the post-test. However, there was not a significant improvement in communication, problem solving, and general relationship coping skills from the pre-test to the post-test for the participants who did not receive the intervention (i.e., control group). This finding is particularly noteworthy because the material in the intervention pertaining to relationship skills did not significantly overlap with the standard treatment programming provided at House of Commons. Rather, staff at House of Commons reported that the material complemented their programming well, and participants made similar comments with the majority rating each session as "very good" to "excellent" on post-session satisfaction questionnaires.

Study participants in the experimental group improved significantly on problem solving and general relationship coping skills acquisition when compared to individuals who did not participate in the intervention. However, there was not a statistically significant improvement in communication skills acquisition of those who participated in the intervention when compared to individuals who did not participate in the intervention. As mentioned above, this finding may be attributed in part to the low reliability of the measure used to assess communication skills, the CCS. Further, participants not receiving the intervention also participated in other groups at the House of Commons

treatment program, such as anger management, in which similar communication skills were presented. This situation may have contributed to a similar increase in communication skills acquisition across the groups and, therefore, introduced a confound in this study.

Relation of Results to Previous Research

Fals-Stewart et al. (2004) describe a model for substance abuse treatment, the constructive cycle of addiction, that depicts the necessary components for the mending of strained relationships that can result from substance dependence. In substance abuse treatment and recovery, typical treatment interventions are needed, which include a continued recovery plan, a recovery contract, self-help support, and counseling (Fals-Stewart et al., 2004). Such interventions are offered at the House of Commons. However, according to Fals-Stewart et al. (2004), for these interventions to aid in enhancing relationship functioning, additional treatment components are necessary, such as problem solving skills training, communication skills training, and interventions focused on relationship enhancement and increasing caring behaviors. In this constructive cycle, combining traditional substance abuse treatment methods that are provided in typical treatment programs like House of Commons, such as recovery contracts and counseling, with interventions addressing relationship needs, such as communication skills and problem solving training, further promotes and enhances recovery. This study introduced the relationship treatment components of communication and problem solving skills training to a traditional treatment program in an efficacious manner. In addition, this study illustrated that a psychoeducational

intervention could effectively complete the constructive cycle of addiction in which traditional treatment modalities are combined with skills training.

A number of studies have determined that specific coping skills training interventions are more effective than standard substance abuse treatment in teaching such skills (Monti et al., 1990). Oei and Jackson (1980) determined that both individual and group social skills training in comparison to traditional supportive therapy resulted in significantly greater reduction in alcohol abuse following discharge. In addition, the group format was found to show more rapid skills acquisition than individually-focused approaches. Monti et al. (1990) compared communication skills training with cognitive behavioral mood management training among 69 inpatient male alcoholics. In this study, participants who received communication skills training improved more on skills related to alcohol-specific high-risk situations than those who did not receive the training. Finally, Rohsenow et al. (2001) examined the effects of cue exposure treatment (CET) compared to a meditation-relaxation control, and communication skills training (CST) compared to an education control when all were added to intensive treatment programs for alcoholics. Participants who received either CET or CST had fewer heavy drinking days in the first 6 months than the participants who did not receive either treatment. Further, CST resulted in fewer alcohol-related problems reported at 12 months. The present study, similar to the findings of Monti et al. (1990), Oei and Jackson (1980), and Rohsenow et al. (2001), demonstrated the value of specific coping skills training. In addition, the current study extended the research by focusing specifically on coping skills in relationships and not only general social or communication skills.

In addition to communication skills deficits, individuals with addiction also have shown a lack of competency in social problem solving (Marlatt, 1979). Further, according to Platt and Husband (1993), populations at high risk for substance abuse have deficits in problem solving and social skills. These researchers reported that there are two ways in which poor problem solving skills and social skills can be related to substance abuse. First, deficiencies in these skills can lead to failures in interpersonal areas that can lead to substance use. Second, individuals with such deficits may find themselves unable to negotiate their way out of situations that carry a high risk of substance abuse. Such data indicate the importance of the possession of problem solving skills, not only in one's interpersonal relationships, but also in more expanded life contexts in which a person encounters situations that make them more susceptible to relapse. Elliot, Johnson, and Jackson (1997) also found evidence to support the importance of incorporating problem solving skills training in substance abuse treatment when they concluded that self-appraised ineffective problem solving was associated with retrospective accounts of substance abuse among undergraduates. Again, having an easily-implemented treatment component in which problem solving skills are presented such as "Time Out! For Men" incorporated in a traditional substance abuse treatment program will aid clients in acquiring such crucial skills that will help them better cope with and/or avoid high risk situations such as relationship conflict.

To teach skills such as communication and problem solving, this study used a psychoeducational intervention, "Time Out! For Men." According to La Salvia (1993), however, much of substance abuse treatment is focused on repairing ego function deficits, which can be inadequate, rather than on developing certain necessary skills via

psychoeducation. Substance abusers need as much assistance with their self-care problems as with understanding their feelings about life (Khantzian, 1988). La Salvia (1993) further stated that psychotherapy and psychodynamic group therapy may suffice in addressing emotions, but a comprehensive, thorough treatment plan for addictions also must include the basic set of tools necessary to solve life's day-to-day problems. A psychoeducational group, in particular, which is a specialized, task-oriented, didactic group experience, can address both ego deficits and life skills. Psychoeducational interventions have been found to be beneficial in addiction treatment (Marlatt & Donovan, 1982; McAuliffe & Gordon, 1980). In this study, the "Time Out! For Men" psychoeducational intervention was found to be effective in teaching life skills, including communication and problem solving, with the goal of providing clients with the necessary tools to cope with stress and conflict in their relationships.

Bartholomew et al. (2000) conducted a study examining the efficacy of the "Time Out! For Men" psychoeducational intervention with 122 male felony probationers who were court-mandated to a 6-month residential substance abuse treatment program in lieu of incarceration. This study indicated a significant increase in the experimental group's knowledge of communication, sexuality, sexual health, and gender-role and socialization issues in comparison to the control group. The present study used a similar sample, males on probation in a residential substance abuse treatment program, and also found an increase in clients' knowledge of communications skills for those who participated in the intervention. However, the current study expanded beyond the Bartholomew et al. (2000) investigation to include the constructs of problem solving skills and general

relationship coping skills and psychometrically sound pre- and post-test measures to assess such skills.

Implications for Theory, Research, and Practice

The findings in the present study have implications for theory, research, and practice. The biopsychosocial model is becoming the dominant model in substance abuse treatment theory. This model considers the interactions of biological, psychological, cognitive, social, developmental, environmental, and cultural variables to explain addiction (Fisher & Harrison, 2000). Further, this model provides practitioners with a way to understand the multifaceted problem of addiction (Wallace, 1989). Traditionally, the field of substance abuse treatment has adhered to a disease model, which solely implies a biological basis for addiction. Although the biological component should not be neglected, it is not the only component or aspect of an individual. The limitation of unifaceted models, like the disease model, is that variables affecting substance abuse often interact with each other and cut across multiple levels (Donovan & Marlatt, 1988). Neglecting the psychological and social aspects of addiction will likely lead to clients not receiving the most comprehensive substance abuse treatment. In addition, uni-faceted models, like the disease model, place sole responsibility on the substance abuser, while the biopsychosocial model also recognizes the influence of external factors, like relationship dysfunction, on the exacerbation of addiction. The present study provides additional data to support the biospsychosocial model. The importance of the social component, which includes one's relationship with his or her significant other, is further supported as a crucial component in substance abuse treatment. Not only does this study lend credence to the importance of addressing social components in substance abuse

treatment, it also illustrates the simplicity and cost-effectiveness of attending to this component using a psychoeducational modality.

This study also informs clinical substance abuse research. Much of the research performed on clinical populations is survey research. Although valuable, the field of substance abuse counseling is in much need of experimental research which supports effective treatment modalities. The lack of empirically-supported treatment designs is likely one reason why many substance abuse treatment facilities continue to rely on traditional treatment modalities, such as the 12-step support group models of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). NA and AA are support groups, not treatment groups. They are useful adjuncts to treatment but are not treatment. It is imperative to have various treatment options in order to have better client-treatment matching. Perhaps, the most effective method for validating substance abuse treatment interventions, such as "Time Out! For Men," is through experimental research.

As mentioned previously, much of clinical substance abuse treatment focuses on repairing ego deficits and other therapeutic work, which typically can only be performed by a licensed counselor or therapist. However, many clients do not have the basic skills to participate in such advanced therapeutic work, as they have never learned skills such as communication due to substance abuse which began at a young age. As one participant in the present study commented after the first group session in which communication skills were covered, "I can't believe how much of this material I don't know." In essence, beginning advanced therapy work with a client (and his or her significant other) may be counterproductive because such work requires basic skills that many clients do not yet possess. The present study illustrated that clients in a male

residential substance abuse facility can learn such skills in a brief, short-term intervention format, which would enable them to not only incorporate such skills in their relationships, but also to move on to more advanced relationship therapy/counseling.

Many substance abuse facilities, including House of Commons, have attempted to incorporate relationship counseling components as a part of their treatment programming. However, according to the director of House of Commons, the cost to hire a licensed therapist to do such work does not justify the less than stellar outcome of such interventions. Unsuccessful therapy outcomes may be due in part to the lack of client communication and problem solving skills. Further, the director reported that time is a big issue, since staff at the facility are required to do the required treatment programming (i.e., treatment planning, recovery contracts, and relapse prevention groups) with little time to do additional work. The "Time Out! For Men" program can be helpful for addressing these types of real-world substance abuse treatment issues by allowing for a brief intervention format, which can be implemented by a paraprofessional.

Finally, substance abuse treatment program staff need to be made aware that substance abuse/dependence is a symptom of an underlying issue. Whether the issue is a relationship problem or another issue, such as low self-esteem, depression, or anxiety, focusing solely on the substance abuse behavior is not going to resolve the addiction. Rather, substance abuse treatment programs need to focus on such core issues that originally led to the addictive behavior patterns. In this study, the social component of the biopsychosocial model was shown to be a valuable component in substance abuse treatment. Although the connection was made between addictive behaviors and relationship dysfunction, substance abuse behavior was not a focus of the "Time Out! For

Men" intervention. Giving attention to the symptom and not the underlying issue is doing a potentially huge disservice to clients needing substance abuse services. The findings of the present and other studies (Bartholomew et al, 2004; Monti et al., 1990) suggest that clients may benefit from services that do not focus solely on their substance abusing behaviors. Adhering to the biopsychosocial model, it seems clear that addressing the biological (family substance abuse history, brain chemistry, etc.), the psychological (counseling and medications for depression, anxiety, etc.), and the social (family issues, employment, etc.) is needed rather than solely presenting traditional techniques that address only the substance using behavior.

Future Research Needed

There are three primary areas in which the substance abuse treatment field would benefit from future research in this area. First, the study performed specifically on the "Time Out! For Men" intervention by Bartholomew et al. (2000) and this present study both used a sample consisting of men on probation in a residential substance abuse facility. To expand the available data on "Time Out! For Men," future research should test its effectiveness in an outpatient sample. Such a study would increase the external validity of the intervention because the participants would have the opportunity to return home after each session to practice what they have learned with their significant others. Testing the effectiveness of the intervention with a sample of men not court-ordered to treatment also may enhance the generalizability of the intervention.

Gathering longitudinal data is a second area of research that would be valuable. While the present study illustrated the value and effectiveness of incorporating a psychoeducational, relationship coping skills intervention, it did not possess a follow-up

component to determine whether the participants retained the skills developed during the intervention. In addition, it would be useful to determine whether such skills, if retained, were found to be helpful when relationship conflict arises. Finally, while relationship conflict has been established as a main contributing factor to substance abuse relapse (Maisto et al., 1988), the present study did not determine whether such skills prevented an imminent relapse when relationship conflict presented. Addressing all of these areas in a longitudinal study would provide additional evidence regarding the effectiveness of "Time Out! For Men" as a relationship coping skills development tool. Assessing and comparing relationship satisfaction and general relationship functioning among participants and their significant others before and after the intervention also would illustrate the value of incorporating relationship skills interventions, such as "Time Out! For Men," in traditional substance abuse treatment programs.

The intervention used in this study implies that relationship coping skills, specifically communication skills, are universal. More specifically, it addresses communication from a Western perspective and does not take into account that such relationship skills vary across cultures. A final area of beneficial research would be to examine cultural differences in communication patterns in relationships and to design and validate an intervention that is culturally sensitive.

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APPENDICES

APPENDIX A

Participant Information Sheet

ID# _____

Participant Information Sheet

Please answer the following questions:

1. What is your age? _____

2. What is your race/ethnicity?
   a. White
   b. African American/ Black
   c. American Indian
   d. Hispanic
   e. Asian
   f. Unknown
   g. Multi-racial
   h. Arab American

3. What is the highest grade you completed in school? _____

4. How many times have you attempted substance abuse treatment (include both inpatient and outpatient treatment)? _____

5. Are you currently in an intimate relationship? _____

   a. If yes, how long have you been in your present relationship? _____

   b. If no, how long ago was your most recent relationship? _____

APPENDIX B

Communication Competence Scale

ID# _____

Communication Competence Scale

The following are statements about how people generally communicate with others. **Answer each item as it relates to your general style of communicating in your personal relationship(s).** Complete the questionnaire by indicating the extent to which you agree or disagree with each statement by noting whether you:

(5) strongly agree
(4) agree
(3) are neutral or undecided
(2) disagree
(1) strongly disagree

1. I find it easy to get along with others. _____

2. I adapt to changing situations. _____

3. I treat people as individuals. _____

4. I interrupt others too much. _____

5. Others find it "rewarding" to talk with me. _____

6. I deal with others effectively. _____

7. I am a good listener. _____

8. My personal relationships are cold and distant. _____

9. I am easy to talk to. _____

10. I won't argue with someone just to prove I am right. _____

11. My conversation behavior is not "smooth." _____

12. I ignore other people's feelings. _____

13. I generally know how others feel. _____

14. I let others know I understand what they mean. _____

(5) strongly agree
(4) agree
(3) are neutral or undecided
(2) disagree
(1) strongly disagree

15. I understand other people. _____

16. I am relaxed and comfortable when speaking. _____

17. I listen to what people say to me. _____

18. I like to be close and personal with people. _____

19. I generally know what type of behavior is appropriate in any given situation. _____

20. I usually do not make unusual demands on my friends. _____

21. I am an effective conversationalist. _____

22. I am supportive of others. _____

23. I do not mind meeting strangers. _____

24. I can easily put myself in another person's shoes. _____

25. I pay attention to the conversation. _____

26. I am generally relaxed when conversing with a new acquaintance. _____

27. I am interested in what others have to say. _____

28. I don't follow the conversation very well. _____

29. I enjoy social gatherings where I meet new people. _____

30. I am a likable person. _____

31. I am flexible. _____

(5) strongly agree
(4) agree
(3) are neutral or undecided
(2) disagree
(1) strongly disagree

32. I am not afraid to speak with people in authority. _____

33. People can come to me with their problems. _____

34. I generally say the right thing at the right time. _____

35. I like to use my voice and body expressively to communicate. _____

36. I am sensitive to others' needs of the moment. _____

APPENDIX C

Problem Solving Inventory

ID#_____

Problem Solving Inventory

People respond to personal problems in different ways. The statements on this inventory deal with how people react to personal difficulties and problems in their day-to-day life. The term "problems" refers to personal problems that everyone experiences at times, such as depression, inability to get along with friends, choosing a vocation, or deciding whether to get a divorce. Please respond to the items as honestly as possible so as to most accurately portray how *you* handle such personal problems. Your responses should reflect what you *actually* do to solve problems, not how you thing you *should* solve them. When you read an item, ask yourself: Do I ever behave this way? Please answer every item.

Read each statement and indicate the extent to which you agree or disagree with that statement as it relates to your personal relationships.

(1) strongly agree
(2) moderately agree
(3) slightly agree
(4) slightly disagree
(5) moderately disagree
(6) strongly disagree

1. When a solution to a problem has failed, I do not examine why it didn't work. _____

2. When I am confronted with a complex problem, I don't take the time to develop a strategy for collecting information that will help define the nature of the problem. _____

3. When my first efforts to solve a problem fail, I become uneasy about my ability to handle the situation. _____

4. After I solve a problem, I do not analyze what went right and what went wrong. _____

5. I am usually able to think of creative and effective alternatives to my problems. _____

6. After following a course of action to solve a problem, I compare the actual outcome with the one I had anticipated. _____

7. When I have a problem, I think of as many possible ways to handle it as I can until I can't come up with any more ideas. _____

(1) strongly agree
(2) moderately agree
(3) slightly agree
(4) slightly disagree
(5) moderately disagree
(6) strongly disagree

8. When confronted with a problem, I consistently examine my feelings to find out what is going on in a problem situation. _____

9. When confused about a problem, I don't clarify vague ideas or feelings by thinking of them in concrete terms. _____

10. I have the ability to solve most problems even though initially no solution is immediately apparent. _____

11. Many of the problems I face are too complex for me to solve. _____

12. When solving a problem, I make decision that I am happy with later. _____

13. When confronted with a problem, I tend to do the first thing that I can think of to solve it. _____

14. Sometimes I do not stop and take time to deal with my problems, but just kind of muddle ahead. _____

15. When considering solutions to a problem, I do not take the time to assess the potential success of each alternative. _____

16. When confronted with a problem, I stop and think about it before deciding on a next step. _____

17. I generally act on the first idea that comes to mind in solving a problem. _____

18. When making a decision, I compare alternatives and weigh the consequences of one against the other. _____

19. When I make plans to solve a problem, I am almost certain that I can make them work. _____

20. I try to predict the result of a particular course of action. _____

21. When I try to think of possible solutions to a problem, I do not come up with very many alternatives. _____

(1) strongly agree
(2) moderately agree
(3) slightly agree
(4) slightly disagree
(5) moderately disagree
(6) strongly disagree

22. When trying to solve a problem, one strategy I often use is to think of past problems that have been similar. _____

23. Given enough time and effort, I believe I can solve most problems that confront me. _____

24. When faced with a novel situation, I have confidence that I can handle problems that arise. _____

25. Even though I work on a problem, sometimes I feel like I'm groping or wandering and not getting down to the real issue. ____

26. I make snap judgments and later regret them. _____

27. I trust my ability to solve new and difficult problems. _____

28. I use a systematic method to compare alternatives and make decisions. _____

29. When thinking of ways to handle a problem, I seldom combine ideas from various alternatives to arrive at a workable solution. _____

30. When faced with a problem, I seldom assess the external forces that may be contributing to the problem. _____

31. When confronted with a problem, I usually first survey the situation to determine the relevant information. _____

32. There are times when I become so emotionally charged that I can no longer see the alternatives for solving a particular problem. _____

33. After making a decision, the actual outcome is usually similar to what I had anticipated. _____

34. When confronted with a problem, I am unsure of whether I can handle the situation. _____

35. When I become aware of a problem, one of the first things I do is try to find out exactly what the problem is. _____

APPENDIX D

Multidimensional Intimate Coping Questionnaire - Modified

ID# _____

Multidimensional Intimate Coping Questionnaire - Modified

INSTRUCTIONS: People can experience stress in many areas of their life. Listed below are some of the ways that people can respond and deal with difficult ore stressful events in their intimate relationships. This questionnaire asks you to indicate what you generally do and feel when you experience stressful experiences in your intimate relationships. Obviously, different stressful experiences can bring out different responses, but we are interested in what you USUALLY do when your relationships is under a great deal of stress. Whenever possible, answer the questions with your current partner in mind. If you are not dating or married to anyone, answer the questions with your most recent partner in mind. If you have never had an intimate relationship, answer in terms of what you think your responses would most likely be.

Respond to each of the following statement by writing the letter that corresponds to the appropriate answer on the blank provided. Please try to respond to each item separately from every other item. Choose your answers thoughtfully, and make your answers as truthful FOR YOU as you can. Please answer every item. There are no "right" or "wrong" responses, so choose the most accurate answer for YOU – not what you think "most people" would say or do.

Indicate how often you tend to do each of these things when dealing with stressful experiences in your intimate relationship. Use the following scale.

When I experience stress in my intimate relationship:

A = I never do this
B = I rarely do this
C = I sometimes do this
D = I often do this
E = I usually do this

1. I am responding to the following items based on:
   (A) My current intimate relationship
   (B) A past intimate relationship
   (C) An imagined close relationship

2. I try to grow as a person as a result of the stressful experience. _____

3. I concentrate my efforts on doing something about it. _____

4. I try to get advice from someone about what to do. _____

5. I get used to the idea that it happened. _____

A = I never do this
B = I rarely do this
C = I sometimes do this
D = I often do this
E = I usually do this

6. I get upset and let my emotions out. _____

7. I admit to myself that I can't deal with it, and quit trying. _____

8. I force myself to wait for the right time to do something. _____

9. I reassure myself that I can cope with the situation. _____

10. I start feeling that I am a failure. _____

11. I try to see it in a different light, to make it seem more positive. _____

12. I take additional action to try to get rid of the problem. _____

13. I talk to someone to find out more about the situation. _____

14. I accept that this has happened and that it can't be changed. _____

15. I get upset, and am really aware of it. _____

16. I just give up trying to reach a desirable resolution. _____

17. I make sure not to make matters worse by acting too soon. _____

18. I provide myself with reassurance that I can cope with the situation. _____

19. I start feeling depressed and blue. ____

20. I look for something good in what is happening. _____

21. I take direct action to get around the problem. _____

22. I talk to someone who could do something concrete about the problem. _____

23. I accept the reality of the fact that it happened. _____

24. I let my feelings out. _____

25. I give up the attempt to get what I want. _____

A = I never do this
B = I rarely do this
C = I sometimes do this
D = I often do this
E = I usually do this

26. I restrain myself from doing anything too quickly. _____

27. I bolster my self-confidence by telling myself that I can deal with the problem. _____

28. I start feeling anxious, tense, and unsettled. _____

29. I learn something from the stressful experience. _____

30. I do what has to be done, one step at a time. _____

31. I ask people who have had similar experiences what they did. _____

32. I learn to live with it. _____

33. I feel a lot of emotional distress, and I find myself expressing those feelings a lot. _____

34. I reduce the amount of effort I'm putting into solving the problem. _____

35. I hold off doing anything about it until the situation permits. _____

36. I keep my self-esteem up by saying positive things to myself. _____

37. I find I can't concentrate on my work or other interests. _____

APPENDIX E

Informed Consent Forms

Experimental Group

The Impact of a Relationship Skills Training Program on the Communication and Problem Solving Abilities of Individuals in a Male Residential Substance Abuse Treatment Program

The purpose of this letter is to ask for your participation in a study being conducted by researchers at Michigan State University entitled The Impact of a Relationship Skills Training Program on the Communication and Problem Solving Abilities of Individuals in a Male Residential Substance Abuse Treatment Program. The purpose of this study is to determine the effectiveness of a 3-week training program on your ability to use problem solving and communicating skills along with general coping skills in your personal relationships. It is believed that the project will assist in enhancing the knowledge of the skills possessed and needed by those in a substance abuse treatment program to form and maintain personal relationships.

If you are willing to participate in this study, you will go through a 3-week group training program in which relationship coping skills, communication skills, and problem solving skills will be presented and taught. You will be in a group with 9-11 other individuals. You will participate in 2 groups per week, 2 hours per session for three weeks for a total of 6 group sessions. Before beginning the group, researchers will obtain brief demographic information (age, race, etc.) from you and have you answer three surveys related to how you currently use communication skills, problem solving skills, and general coping skills in your personal relationships. You will complete these same three questionnaires after the group is completed. Your privacy will be protected to the maximum extent allowable by law. The following precautions will be taken to protect your confidentiality: No individual names or other identifying information will be used in any reports or publications that may result from this study, and your name will not be connected to any of your answers.

Your participation in the study would be greatly appreciated. However, your participation in this study is voluntary; you may refuse to participate, refuse to answer certain questions, or discontinue your participation at any time without penalty. If you have any questions concerning this study, please contact: John Kosciulek, Ph.D. (jkosciul@msu.edu or 517-353-9443) at 458 Erickson Hall, East Lansing, MI 48824 or Kristin Humphrey, M.S., L.P.C. (coxkris1@msu.edu or 517-712-0043) at 401C Erickson Hall, East Lansing, MI 48824. If you have questions about your rights as a participant, contact the chairperson of the University Committee on Research Involving Human Subjects (Dr. Peter Vasilenko at 517-355-2180, email: ucrihs@msu.edu), or by writing: Committee on Human Research, 202 Olds Hall, East Lansing, MI 48824-1046.

I voluntarily agree to participate in the study.

Signed _____

Date _____

Control Group

The Impact of a Relationship Skills Training Program on the Communication and Problem Solving Abilities of Individuals in a Male Residential Substance Abuse Treatment Program

The purpose of this letter is to ask for your participation in a study being conducted by researchers at Michigan State University entitled The Impact of a Relationship Skills Training Program on the Communication and Problem Solving Abilities of Individuals in a Male Residential Substance Abuse Treatment Program. The purpose of this study is to determine the effectiveness of a 3-week training program on an individual's ability to use problem solving and communicating skills along with general coping skills in personal relationships. It is believed that the project will assist in enhancing the knowledge of the skills possessed and needed by those in a substance abuse treatment program to form and maintain personal relationships.

If you are willing to participate in this study, researchers will obtain brief demographic information (age, race, etc.) from you and have you answer three surveys related to how you currently use communication skills, problem solving skills, and general coping skills in your personal relationships. You will complete these same three questionnaires three weeks later. Next, you will go through a 3-week group training program in which relationship coping skills, communication skills, and problem solving skills will be presented and taught. You will be in a group with 9-11 other individuals. You will participate in 2 groups per week, 2 hours per session for three weeks for a total of 6 group sessions. Your privacy will be protected to the maximum extent allowable by law. The following precautions will be taken to protect your confidentiality: No individual names or other identifying information will be used in any reports or publications that may result from this study, and your name will not be connected to any of your answers.

Your participation in the study would be greatly appreciated. However, your participation in this study is voluntary; you may refuse to participate, refuse to answer certain questions, or discontinue your participation at any time without penalty. If you have any questions concerning this study, please contact: John Kosciulek, Ph.D. (jkosciul@msu.edu or 517-353-9443) at 458 Erickson Hall, East Lansing, MI 48824 or Kristin Humphrey, M.S., L.P.C. (coxkris1@msu.edu or 517-712-0043) at 401C Erickson Hall, East Lansing, MI 48824. If you have questions about your rights as a participant, contact the chairperson of the University Committee on Research Involving Human Subjects (Dr. Peter Vasilenko at 517-355-2180, email: ucrihs@msu.edu), or by writing: Committee on Human Research, 202 Olds Hall, East Lansing, MI 48824-1046.

I voluntarily agree to participate in the study.

Signed _____

Date _____

APPENDIX F

Outline of Each Psychoeducational Session

1 A New Outlook on Relationships

Session Length: 2 hours

Objectives

Establish the goals and purpose of the workshop

Explore male and female sex roles and their impact on relationships

Define personal goals for improving intimate relationships

Rationale

Most men have had few opportunities to seriously explore and define their sexuality and their need for intimacy. This lack of opportunity is perpetuated by social and cultural beliefs that often go unchallenged. This session seeks to increase participants' willingness to explore new ways of thinking about sexuality, love, and intimacy, and to work on personal goals for improving relationships.

Session Outline

Procedure	Time
Client Survey (pretest)	15 minutes
Getting Started	10 minutes
Group Introductions and Guidelines	20 minutes
Challenging Stereotypes	20 minutes
Break	10 minutes
Improving Relationships	35 minutes
Homework: *Partner Interview*	10 minutes
Total Time for Session 1	120 minutes

2 An Assertive Attitude

Session Length: 2 hours

Objectives

Understand importance of communication in maintaining relationships

Distinguish assertiveness from aggressive and passive communication

Learn how to use "I-Statements" in communication situations

Rationale

Many problems in intimate relationships are communication problems. Men often have been socialized to approach communication in relationships from an aggressive or controlling stance and may benefit from learning the parameters of different communication styles, especially the assertiveness option. This session seeks to introduce skills for effective communication by helping participants embrace the importance of an assertive attitude in communication interactions with their partners. I-Statements are highlighted as a foundation skill for good communication.

Session Outline

Procedure	Time
Welcome and Process Homework	15 minutes
An Assertive Attitude	25 minutes
Discussion: Understanding Assertiveness	15 minutes
Break	10 minutes
Using I-Statements	20 minutes
Practice: Making an I-Statement	25 minutes
Homework: *Assertiveness Logbook*	10 minutes
Total Time for Session 2	120 minutes

3 Listening

Session Length: 2 hours

Objectives

Understand listening as a learnable skill

Explore common listening problems

Identify good listening habits and practice listening skills

Rationale

Listening is a foundation skill for all good interpersonal relationships, intimate and otherwise. In addition, the ability to listen is associated with both learning and reasoning, critical issues in behavior change and recovery. This session seeks to emphasize that listening is a skill that can improve relationships and facilitate self-growth, and to provide practice toward skills building.

Session Outline

Procedure	Time
Welcome and Process Homework	10 minutes
Exercise: Focused Listening	30 minutes
Listening Skills	25 minutes
Break	10 minutes
Practice: Listening Skills	35 minutes
Homework: *Listening to Each Other*	10 minutes
Total Time for Session 3	120 minutes

4 Talk It Over

Part 1: Feelings and Needs

Session Length: 2 hours

Objectives

Explore feelings and how feelings are expressed in relationships

Understand the nature of feelings and feeling states

Learn how to use an assertion "formula" to express feelings and needs and negotiate solutions

Rationale

Identifying and managing feelings in intimate relationships is a common communication issue. Accepting and expressing feelings in constructive ways is often challenging for men. When emotions arise in communication situations, men often attempt to control or minimize what they are feeling, resulting in roadblocks and impasses. This session seeks to help men identify and accept feelings as normal and better understand how inappropriate management of feelings results in communication breakdowns. An assertion formula (*Talk It Over*) is introduced as a framework for practicing openness and self-expression in intimate relationships.

Session Outline

Procedure	Time
Welcome and Process Homework	10 minutes
Feelings and Communication	25 minutes
Discussion: Accepting Feelings	15 minutes
Break	10 minutes
Talk It Over Formula	25 minutes
Practice: Using the Formula	25 minutes
Homework: *Talk It Over Practice*	10 minutes
Total Time for Session 4	120 minutes

5 Talk It Over
Part 2: Resolving Conflict

Session Length: 2 hours

Objectives

Understand common issues involved in partner conflicts

Identify rules for "fair fights" and negotiation

Discuss and practice a conflict resolution model

Rationale

The ability to resolve relationship conflicts in a way that improves intimacy rather than weakens it is an important skill. Unsettled or recurring conflict creates emotional turmoil in relationships that can work against recovery. This session seeks to introduce men to a model for conflict resolution, emphasizing solutions rather than blame. The importance of "fighting fair" and active problem solving is highlighted and assertiveness skills are reviewed.

Session Outline

Procedure	Time
Welcome and Process Homework	10 minutes
Conflict in Relationships	25 minutes
Conflict Resolution Skills	25 minutes
Break	10 minutes
Exercise: Conflict Case Studies	40 minutes
Homework: *Fighting Fair*	10 minutes
Total Time for Session 5	120 minutes

8 Making Relationships Work

Session Length: 2 hours

Objectives

Explore techniques for enhancing self-esteem

Review skills for improving communication in relationships

Identify solutions to common relationship problems

Rationale

A healthy sense of self-esteem is important in maintaining close, intimate relationships. This session seeks to increase participants' awareness of the importance of self-esteem and to introduce affirmations as a positive self-help technique. In addition, the session provides closure for the workshop by reviewing relationship skills and discussing the application of those skills.

Session Outline

Procedure	Time
Welcome and Process Homework	10 minutes
Self-Esteem and Affirmations	20 minutes
Review: Communication and Relationships	15 minutes
Break	10 minutes
Handling Problems in Relationships	25 minutes
Workshop Closure	10 minutes
Graduation and *Client Survey* (posttest)	30 minutes
Total Time for Session 8	120 minutes