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An Interpersonal communication skills approach to the treatment of alcoholism

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AN INTERPERSONAL COMMUNICATION SKILLS APPROACH TO THE TREATMENT OF ALCOHOLISM

by

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ABSTRACT

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166 alcoholic patients admitted to a state alcoholism treatment center were assigned to one of seven experimental and three control groups. Experimental patients received all or part of a four week Interpersonal Communication Skills Program in addition to treatment provided by the treatment facility. Controls received no Skills Treatment.

Dependent variables consisted of a follow-up questionnaire, and Shostrum's Personal Orientation Inventory (POI) for the measurement of self-actualization in a pre- and post-test paradigm.

It was hypothesized that: (a) experimental patients would have higher POI ratios upon dismissal than controls, (b) experimental patients would have a higher rate of return of follow-up questionnaires than controls, (c) experimental patients would be more cooperative in complying with recommended A. A. follow-up than controls, (d) the longer the exposure to Skills Treatment, the greater the change between the pre- and post-POI scores, and (e) patients voluntarily committed to treatment would attain a higher degree of self-actualization in all conditions than patients on a non-voluntary commitment.

Results failed to support the hypotheses, with the exception of "type of commitment" which attained significance on two POI scales.

Several "types" of alcoholic patients presented themselves in treatment consisting of: (a) patients completing treatment (AT&R patients), (b) patients walking away from the treatment center (A. M. A. patients), (c) early discharge patients and, (d) patients with emotional problems in addition to alcoholism. The "Early Discharge Type" represented an entirely different type of alcoholic patient.

Graphic results indicated no apparent effect of treatment as measured by the POI. The effects of partial versus full Skills Treatment showed the first two and the last three weeks of the Skills Program as being more effective in terms of Self-Actualization. The full treatment group showed signs of stabilizing around a "middle" response.

Findings suggested that the alcoholic in treatment presented an extremely unpredictable individual; that Self-Actualization was, perhaps, an unreliable dependent measure for alcoholism studies, and that the interaction of two treatment modalities operating concurrently tended to confound results.

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CHAPTER 1

STATEMENT OF THE PROBLEM

Compared to other human activities, for example, working eating, and recreation, interpersonal communication is undoubtedly the most pervasive and significant event in which individuals engage. Interpersonal communication is utilized by man to facilitate, enhance, and in other ways, increase the enjoyment derived from those activities in which he engages. It is through such communication transactions that meaningful interpersonal relationships such as husband-wife, mother-son, employer-employee, brother-sister, friend-foe are both formed and maintained. Interpersonal communication is, then, a highly significant component of any given human activity.

Interpersonal relationships are also an integral component essential in the treatment of alcoholism. Fox (1973) defined alcoholism as being both an addiction and a behavioral disturbance in which the excessive use of alcohol interferes with the physical and/or mental health of the individual. It is usually accompanied by a disturbance in the interpersonal relationships within the family, work life, and social environment. Much has been done in various treatment and rehabilitation programs to alleviate much of this interpersonal disturbance via drugs, group therapy, psychotherapy, and aversion therapy. Little, however, has been done to deal directly with the alcoholics' interpersonal communication problems which constitute a large part of

their problems whether drinking or abstinent.

This study is an attempt to assess the significance of an interpersonal approach to the treatment and rehabilitation of alcoholic patients by means of introducing an Interpersonal Communication Skills Program at the Montana State Alcoholism Treatment Center, Galen, Montana, as part of the treatment process.

It has long been recognized by those dealing with the treatment and rehabilitation of alcoholics that a primary problem lies in getting the alcoholic to participate in follow-up therapy after discharge from the treatment center. Patients tend to avoid new interpersonal relationships that might be beneficial to them. Bowen and Androes (1963-1965) found in a follow-up study of 79 alcoholics that about one in five patients who participated in treatment at a V. A. hospital made a successful post-hospital adjustment and about one in four of those who completed the program remained abstinent. Pokorny, Miller, and Valles (1973) in a follow-up interview with 122 alcoholics found that one year after participation in a treatment program and participation in weekly group sessions on an outpatient basis, 91 of the patients never attended the sessions and if they did, did so far less than eight times; only 31 attended the sessions eight or more times; 53% of the latter and only 15% of the former were still abstinent after one year. Relapse was found to be less among those who attended the sessions.

In all treatment centers, some type of follow-up therapy is suggested upon discharge. Moore and Buchanan (1964) in a nationwide survey of treatment techniques discovered that 82% of the follow-up care

rested in the hands of Alcoholics Anonymous (A. A.) in the majority of hospitals and those individuals not receptive to A. A. were left to fend for themselves. Chafetz (1959) identified the crucial problem in the outpatient treatment of alcoholics when he reported that 73% of his patients dropped out before three visits. Pokorny, et al. (1973) further showed that hospital treatment for the alcoholic is only the first step in a program of his integration into society and that rehabilitation efforts must be continued after discharge, if possible with A. A. In a related follow-up study of discharged alcoholics at the Sheridan, Wyoming Treatment Center, the best prognosis was given for alcoholics who showed enthusiasm for the program, ability to change, and utilization of the A. A. aftercare (Tomsovic, 1970).

As various studies show, in typical rehabilitation programs, follow-up therapy with A. A. is crucial. Often, however, the alcoholic does not contact A. A. Such is the situation as cited by Mr. Ed Gendle, Director of Services, Montana Alcoholism Services Treatment Center, Galen, Montana. This led to the author's belief that perhaps one of the reasons for this follow-up failure on the part of the alcoholic patient is due to the fact that the alcoholic perceives the new group outside the treatment center as a threatening situation. This has been substantiated by Sethna and Huntington (1971) in their study of a group of patients who lapsed from group psychotherapy. They found that the thought of active participation in group therapy in which inner thoughts, feelings, and experiences are revealed presented a threat to patients, so they lapsed. From this, then followed the present no-

tion that by teaching alcoholic patients various interpersonal communication skills, a stepping stone could be provided for the patient to go from the treatment center to the A. A. group or group therapy, and function in the world as it is outside the protection of the treatment center environment.

Alcoholics Anonymous, the aftercare prescribed by a majority of hospitals and treatment centers, is a fellowship in which men and women share their experience, strength, and hope with each other that they may solve their common problem and help others recover from alcoholism (Alcoholics Anonymous, 1957). The A. A. philosophy is centered around its "Twelve Steps" (see Appendix A), which essentially call for an admission of the disease, belief in a higher power, a personal moral inventory, making amends to persons harmed, helping other alcoholics, facing the problem, doing something about it, and accepting responsibility for one's behavior. There are various types of A. A. meetings (A. A., 1973), the most common of which is the "Step Meeting" and "Discussion Meeting." In the former, a chairman gives his view on the particular step in relation to his life and his sobriety. Each member is then called upon to do the same and may either speak or "pass" at his option. In the latter, a similar format is followed only the topic for the meeting is open and each member relates how he feels about a given idea, experience, or value. Each member shares his view with the group, again at his option. A topic may or may not be chosen for this type of meeting. One aspect which is stressed in A. A. is sharing -- experiences, feelings, views, ideas. This follows, no doubt, from the fact

that when one speaks, one shares and is in essence convincing one further of the concept of which one speaks. Anderson (1971) stated that the most important long-range effect upon a source is that his participation in a communication continually conditions his patterns of behavior, personality, and self-image to a significant degree. In essence, the source is changed by virtue of the fact that he spoke. In the A. A. setting when a member speaks, one of two things occurs: (1) personal views are confirmed by the other members by way of agreement or pats on the back, or (2) the member is told in a non-threatening manner that he is wrong or at least misled in his thoughts on the given topic. This mild group pressure in the latter situation causes him to reconsider personal views regardless of whether he wants to or not. When a member does not speak or share at a meeting, he is left with his own thoughts, be they good or bad, and his growth is restricted. This was substantiated by Wenburg and Wilmot (1973) when they stated that the expression of thought creates new thoughts and that we are susceptible to change as a direct result of our own encoding behavior.

Aside from A. A., group therapy is the most effective type of treatment for the alcoholic (Fox, 1967). It is similar to A. A. in that there is almost immediate identification and mutual support, which makes the alcoholic feel immediately accepted. The group represents a non-threatening, socially rewarding, yet challenging atmosphere in which individual problems can be discussed.

A third type of treatment for alcoholics is aversion treatment,

which consists of several methods, ranging from electrical shock (Wolpe, 1954) to chemically produced aversion in which the patient is administered emetine or apomorphine which produces vomiting within seven or eight minutes (Franks, 1960; Voegtlin, 1940). One or two minutes before vomiting, the patient is given several types of alcoholic drinks which are subsequently vomited. The patient then associates the sight, smell and taste of alcohol with vomiting (Fox, 1967). The use of disulfaram (antabuse) is a medication which interferes with the metabolism of alcohol so that even one drink will cause a toxic reaction of a shock-like nature (Fox, 1967).

Comparatively, the most widely used treatment device currently used in the state hospitals was A. A. (88%), followed by group psychotherapy (78%), chemotherapy (76%), individual psychotherapy (57%), and aversion therapy (20%) (Buchanan, et al., 1967).

A less well known and developed method of alcoholic treatment lies in the area of interpersonal communication training. Soskin (1970) compared personality and attitude change after two alcoholism programs, lysergide (LSD) and human relations training. A number of significant changes occurred in both programs. The results were essentially the same, only the LSD program required less time (26 days as opposed to 60 days in the human relations training program). In surveying the nature of the personality changes produced by both types of treatment, the most consistent finding was that feelings of psychic discomfort were substantially reduced. The alcoholic was less disturbed by depression, guilt, anxiety, and tension after both treatments. The human re-

lations training program was a modification of the HRTL program developed at the Houston, Texas V. A. hospital for pyschiatric patients (Rothaus, Morton, Johnson, Cleveland, and Lyle, 1963). It was based upon the assumption that the alcoholic is unable to cope effectively with environmental problems, particularly in the area of interpersonal skills. The program depended heavily on prepared exercises and was designed to improve sensitivity in interpersonal communication. It also emphasized principles of interpersonal communication and the use of feedback techniques so that the individual could learn how his behavior affects others. Three basic teaching methods were employed. First, lectures were given on how to increase the effectiveness of groups and on the kinds of effects people have on each other. Second, laboratory exercises were conducted to highlight characteristics of group and individual problems. Third, rating of self and group were used to evaluate progress.

The utilization of interpersonal communication skills as a treatment modality for alcoholic patients appears to be largely overlooked; however, the use of such skills and their effectiveness have been borne out in several other areas. Arbes and Hubbell (1973) developed a structured Communication Skills Workshop for college students because many of their clients presented problems concerning inefficiency in interpersonal communication skills. The areas most frequently cited as problematical were the inability to establish interpersonal relationships with one or more people, feelings of inadequacy in relating to the opposite sex, and feelings of anxiety in group settings. They em-

ployed five methods in the process of facilitating change: Structure, self-disclosure, feedback, behavior change goals, and intimacy. Results of pre and post FIRO-B (Fundamental Interpersonal Relations Orientation-Behavior), CSAS (Concept Specific Anxiety Scale), and IRRS (Interpersonal Relationship Rating Scale) showed that on the pre-tests control and experimental groups differed in only three variables whereas on the post-test they differed on fourteen variables. All changes were in a positive direction for the skills treatment group. The workshop participants perceived themselves as being more aware of feelings of others, expressing their thoughts more clearly, more willing to discuss their thoughts and emotions with others, being more influential and more willing to establish new interpersonal relationships.

In the present study, Interpersonal Communication is defined as those concepts and skills which enable people to deal with the everyday communication problems occurring in family and work groups, between parent and child, husband and wife, and employer and employee (Stewart, 1973). It also stresses the notions that each person influences and affects the other, that each depends upon the other for his identity in the given situation.

Swenson (1973) pointed out that the development of the personality is a function of relationships between people which are carried on through communication. Cooley (1902) stated that communication is a matter of self-preservation, because without expression, thought cannot live. The mere fact that man has the potential to communicate implies the need to communicate as well. Sullivan (1954) posited that behavior

is driven or motivated to achieve satisfaction and security, the former dealing largely with satisfying physical needs, the latter with securing relationships with other people. However, the satisfaction of physical needs is bound up with relationships to other people. May (1971) highlighted that if ANY organism fails to fulfill its potentialities, it becomes sick; for example, if it never walks, the legs soon atrophy. Similarly, then, if man does not fulfill his potentialities as a communicator, he also becomes sick. This, May claimed, is the essence of neurosis. Maslow stated that every human being carries within his own life what he terms the "actualization of self-hood," in which each is capable of satisfying his deepest needs. However, in order to guarantee the satisfaction of his deepest needs, he must be concerned with the need satisfaction of others (Brenneke and Amick, 1971). This implies a systemic view of communication depicted in Diagram A, in which each component or person develops from and with the other, affects and is affected by the other, ad infinitum.

This lends itself to the systemic approach to alcoholism suggested by Ward and Faillace (1970), in which alcoholism is viewed as a symptom of a complex interactional process where drinking is a circular, self-perpetuating process which is maintained to preserve homeostasis. The main idea from general systems theory is that the behavior of any particular element in the system is highly dependent upon the complex processes within the total system. Human systems (i.e., a family) function through the communication occurring in complex networks in which varying levels of integrity (Goal-directed behavior) and homeos-

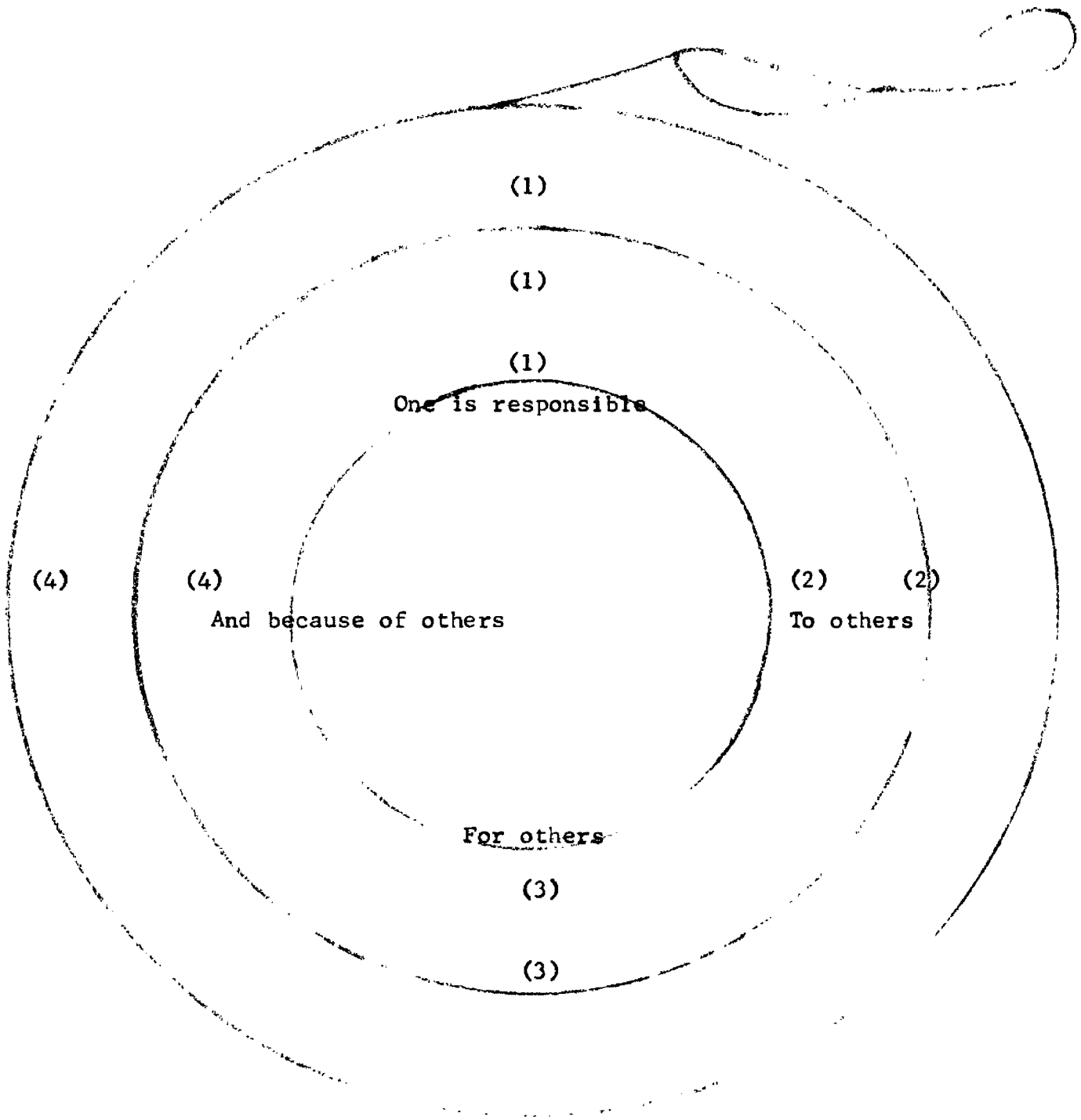

Diagram A. "Cycle of Responsibility"

tasis (a lack of stress and strain) in the system are maintained through feedback mechanisms. This "information" may be any kind of verbal or behavioral message from one to another member of the system. The response prompted in the receiver in turn influences the sender in a continuous process of feedback which tends to move the system to a level of homeostatis in which there is least strain; that is, least anxiety and greatest gratification of needs for each member of the system. But in the case of the alcoholic, this may maintain drinking behavior (Ward and Faillace, 1970). Perhaps the Interpersonal Communication Skills approach, once learned, can likewise become a circular, self-perpetuating response in the behavioral repertoire of the recovering alcoholic, thus helping him achieve involvement in the "Cycle of Responsibility" and maintenance of a new type of homeostasis as depicted in Diagram B in which the cycle is turned in a new direction and a new equillibrium obtained.

Originally, the purpose behind the Interpersonal Communication Skills Program as a treatment modality in this study was to provide a a stepping stone from the treatment center to the A. A. group upon discharge. However, in view of the virtual impossibility of utilizing this criterion as a measure of effectiveness of the program, due to follow-up difficulties, it was discarded as a measure. Self-Actualization, as measured by Shostrum's POI as a pre- and post-treatment measure appeared to be a far more realistic variable by which to measure the effectiveness of the Skills Program and thus used as the dependent measure. For comparative purposes, some patients were given the Commun-

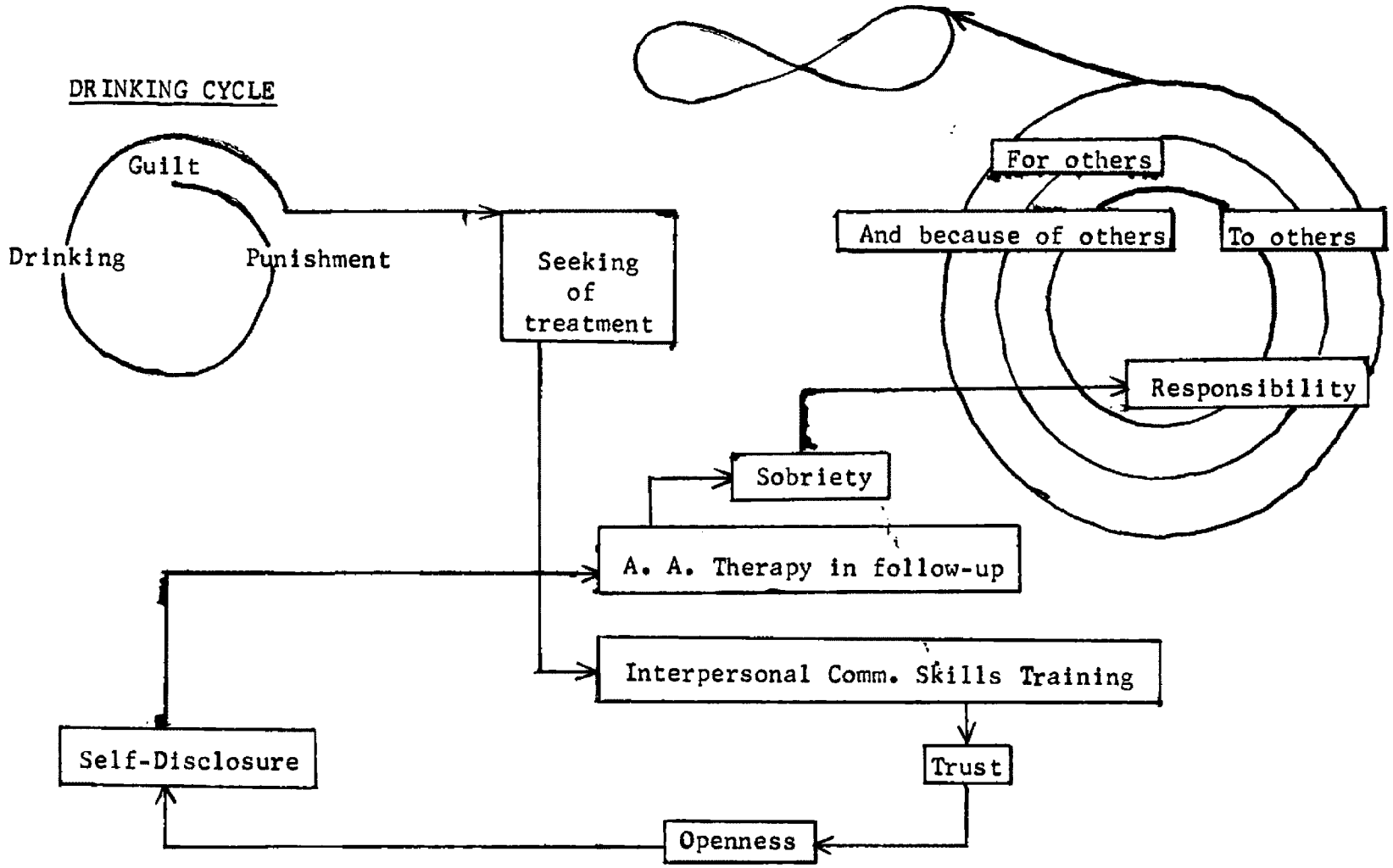

Diagram B. The "New Direction"

ication Skills Program (experimental) and some were not (control).

CHAPTER 2

METHOD

Subjects

Ss consisted of 166 patients admitted to the State of Montana Alcoholism Treatment Center, Galen, Montana, for a five-week alcoholism treatment program. Ss varied in age (18-68), race (white, Indian), sex, occupation, degree of physical and psychological damage from alcoholism, and type of commitment (voluntary/involuntary). Ss were assigned to one of seven experimental and three control groups.

Experimental Design

The design of the experiment consists of non-randomly assigned experimental and control groups, a modification of the Nonequivalent Control Group Design (Campbell and Stanley, 1966) in which the experimental and control groups are given a pre- and post-test but without random assignment of Ss to either group. Experimental Ss are designated as such by means of their date of admission. Johuda, Deutsch, and Cook (1959) stated that in Substitutes for Random Assignment of Subjects to Experimental and Control Groups, the investigator may gather data from which he can make inferences as to whether Ss who have undergone different treatments and who now show differences on the dependent variable were comparable before they were exposed to the experiences in question. In this case the dependent variable is

self-actualization. Newcomb (1939, 1939) used this procedure efficiently in his study on attitudes of college freshmen at three colleges. Wilner, Walkley, and Coock (1955) also utilized this procedure in their study of attitudes of white tenants toward Negroes in public housing projects with success.

Random assignment of Ss to experimental and control conditions was not possible in the present study, because, to give treatment to some Ss and not others would serve to undermine any success the treatment might have due to the "air of mystery" perceived by those not receiving the treatment and the ensuing rumor, distrust, and rejection of the investigator and those participating in the program. Random assignment to mini-groups was used to preclude Ss from pairing up with with "buddies" and to enhance the development of interpersonal skills and the formation of <u>new</u> relationships, which is the crux of the experiment.

The experimental design is graphically summarized in Figure 1. Experimental groups (E) received the POI pre-test (O_1), some portion of Skills Treatment ($X_1 . X_7$) and the POI post-test (O_2). Control groups (C) received only the POI pre-test (O_1) and POI post-test (O_2).

<u>Apparatus</u>

Materials used consisted of a follow-up questionnaire (See Appendix B) and E. L. Shostrum's Personal Orientation Inventory (POI) for the measurement of self-actualization. The POI was developed as a diagnostic instrument which gives a new patient a measure of his current level of positive mental health or self-actualization (Shostrum,

GROUP	TREATMENT
E_1	O_1 X_1 O_2
E_2	O_1 X_2 O_2
E_3	O_1 X_3 O_2
$^1E_4$	O_1 X_4 O_2
$^2E_4$	O_1 X_4 O_2
$^3E_4$	O_1 X_4 O_2
$^4E_4$	O_1 X_4 O_2
$^5E_4$	O_1 X_4 O_2
$^6E_4$	O_1 X_4 O_2
$^7E_4$	O_1 X_4 O_2
E_5	O_1 X_5 O_2
E_6	O_1 X_6 O_2
E_7	O_1 X_7 O_2
C_1	O_1 O_2
C_2	O_1 O_2
C_3	O_1 O_2

O_1: POI Pre-Test

O_2: POI Post-Test

X_1: First Week of Skills Program

X_2: First 2 Weeks of Skills Program

X_3: First 3 Weeks of Skills Program

X_4: Total 4 Week Skills Program

X_5: Last 3 Weeks of Skills Program

X_6: Last 2 Weeks of Skills Program

X_7: Last or fourth Week of Skills Program

Figure 1. Experimental Design

1963). The POI consists of 150 two-choice comparative value judgments, each of which were chosen because they reflect commonly held value judgments, each of which were chosen because they reflect commonly held value orientations and are held to be significant to one's approach to living. This test is unique in that unlike most paper and pencil personality tests, value items are stated twice so that the particular continuum of the dichotomy in question are made explicitly clear and therefore easy for Ss to understand (Shostrum, 1963). Validation studies indicate that the test discriminates between the self-actualized, normal, and non-self-actualized groups on 11 of the 12 dimensions measured (Shostrum, 1963).

The test dimensions which appear to discriminate between these groups are:

1. Inner Orientation (I)/Other Orientation (O) -- These are related to freedom from social pressures. Self-actualized people seem to have liberated themselves from pressures of this kind, to which normal and non-self-actualized people conform.

2. Time Competence -- The self-actualized person appears to live in the here and now more fully, and is able to tie the past and the future into the present in meaningful continuity. He is less burdened by guilt, regret, and resentment from the past than is the non-self-actualized person and his aspirations are tied meaningfully to the present working goals. His use of time in a competent way is expressed in a ratio of 1:8 as opposed to the non-self-actualized ratio of 1:3 on the POI.

Adjectives used to describe persons nominated by psychologists and psychiatrists as "non-self-actualized" (Shostrum, 1964) are:

Anxious, worried, apprehensive, tense, bigoted, biased, rigid, compulsive, frustrated, blocked, seeking, unfulfilled, empty, unsatisfied, egocentric, self-pitying, self-conscious, sensitive, guilty, moody, inauthentic, unorganized, hostile, critical, projecting, suspicious, dominating, to name a few.

Adjectives used to describe "self-actualized" persons (Shostrum, 1964) are:

Involved, busy, giving, optimistic, confident, responsible, stable, mature, independent, reliable, patient, aware, responsive, sincere, content, satisfied, modest, tolerant, capable, and organized to name a few.

The POI utilizes scores of relative time competence/incompetence, relative inner (I)/other (O) directedness for the four main scales, and ten additional subscales which measure:

1. Self-Actualizing Values -- A high score means the individual holds and lives by values of self-actualizing people, and a low score means he rejects such values.

2. Existentiality -- Measures one's flexibility in applying self-actualizing values to one's life. Higher scores reflect such an ability. People with low scores tend to hold values so rigidly that they become dogmatic or compulsive.

3. Feeling Reactivity -- A high score measures sensitivity to one's own needs and feelings.

4. Spontaneity -- A high score measures the ability to express

feelings in spontaneous action. A low score indicates that one is fearful of expressing feelings behaviorally.

5. Self Regard -- A high score measures the ability to like oneself because of one's strength as a person. A low score indicates low self worth.

6. Nature of Man, Constructive -- A high score means one sees man as essentially good; he can resolve the dichotomies in the nature of man, i.e., selfish-unselfish. A high score, therefore, measures the self-actualizing ability to be synergic in understanding of human nature. A low score means that one sees man as eseentially evil or bad and is not synnergistic.

7. Synnergy -- A high score is a measure of the ability to see opposites of life as meaningfully related. A low score means that one sees opposites of life as antagonistic.

8. Acceptance of Aggression -- A high score measures the ability to accept anger or aggression within one's self as natural. A low score means that one denies having such feelings.

9. Capacity for Intimate Contact -- A high score measures the person's ability to develop meaningful, contactful relationships with others. A low score means one has difficulty with warm interpersonal relationships.

10. Self Acceptance -- A high score measures acceptance of oneself in spite of one's weaknesses or deficiencies. A low score indicates inability to accept one's weaknesses.

Test-retest reliability coefficients have been obtained for

POI scales based on samples of college students (Klavetter and Mogar, 1967) and range from .52 to .82. Illardi and May (1968) reported coefficients ranging from .32 to .74, all of which are held to be well within ranges of comparable test-retest studies with personality inventories such as the MMPI.

In relation to studies on alcoholism and the POI, Zaccaria and Weir (1966) studied 70 alcoholics and their non-alcoholic spouses participating in an alcoholic treatment program. They report all mean POI scores for this sample to be significantly lower than the original validating, clinically nominated, self-actualized sample. Apparently, the alcoholic in particular is apt to be the person dwelling on past or future events, lacking the full awareness, contact, and feeling reactivity of the more time competent person. The Zaccaria and Weir study sought to determine if the POI could differentiate between:

1. Male and female alcoholics.
2. Male alcoholics and their non-alcoholic spouses.
3. Alcoholics and relatively self-actualized individuals.
4. Alcoholics and normal individuals.
5. Alcoholics and relatively non-self-actualized individuals.

The results were:

The POI appears to differentiate between groups of alcoholics and self-actualized individuals and also between alcoholics and normal individuals. A finding consistent with the theory that suggests that there is a continuum of relative self-actualization

to relative non-self-actualization with alcoholism representing one form of non-self-actualization.

The POI did not differentiate between alcoholics and non-self actualized persons. This is also consistent with the theory because of the functionally debilitating effects of alcoholism. Thus, alcoholism appears to impair normal development and funtioning in a variety of ways which, together, result in non-self-actualization.

Weir and Gade (1969) found the POI to be an effective tool in the counseling of male alcoholics and their non-alcoholic spouses. Those who recevied a POI interpretation had a higher marital stability, a more stable work history, and a higher abstinence record than control Ss. In a related study, Arbes and Hubbell (1973) developed a structured Communication Skills Workshop, after which the present experiment is designed, for the purpose of developing more efficient interpersonal skills. During the first year of designing this workshop, some initial research was conducted using the POI. No controls were utilized so the results were inconclusive; however, within the experimental population, there was significant movement on seven of the 14 subscales using a pre-test/post-test procedure, hence providing a basis for the use of the POI in the current experiment based on the following rationale:

Self actualization is achieved through relating to others in competent ways. A person's interpersonal skills are the foundation for his self-actualization. To initiate, develop, and maintain effective and fulfilling relationships, certain basic skills must be

present (Johnson, 1972). These skills are: (1) knowing and trusting each other, (2) accurate and unambiguous understanding of each other, (3) influencing and helping each other, (4) constructive resolution of problems and conflicts in the relationship.

Skills taught in the present program consist of self-disclosure, listening, adequate communication to others, "feedback," and behavior change.

The area of interpersonal skill development involves self-disclosure (Johnson, 1972). Inherent in this skill are self-awareness, self-acceptance, and trust. The POI taps these elements in the Sponteneity, Self-Regard, Self-Acceptance, Nature of Man Constructive, Acceptance of Aggression, Capacity for Intimate Contact, Inner/Other Directedness, Feeling Reactivity, and Self-Actualizing Values Scales.

The second area of skill development focuses upon the ability to communicate one's ideas and feelings accurately and unambiguously. Especially important is the communication of warmth and liking. Unless a person feels that the other person likes him, and visa-versa, the relationship will not grow. POI scales measuring this type of communication are: Capacity for Intimate Contact, Acceptance of Aggression, Self-Regard, Existentionality, and Self-Actualizing Scales.

The third area of skill development cited by Johnson (1972) concerns mutual support and influence in the relationship. This requires responding in helpful ways to another's problems, communicating acceptance and support, constructive confrontation, reinforcement of the other person. In the current program, this is taught

via feedback and listening skills and is measured on the POI by the scales: Synnergy, Nature of Man Constructive, Time Ratio Scales for listening, Feedback, the Self-Actualizing Values, Existentionality, Feeling Reactively, Spontaneity, Self-Regard, Self-Acceptance, Aggression and Capacity for Internal Control Scales are utilized.

The last area cited by Johnson (1972) was that of learning how to resolve problems and conflicts in ways that bring both parties closer together and facilitate the growth and development of the relationship. This skill is taught in the present program by use of behavior change and behavior change goals and is measured by the Time and Support Ratios, Feeling Reactivity, Spontaneity, Self-Regard, and Capacity for Internal Control Scales on the POI.

A questionnaire (Appendix B) was devised and mailed to all patients receiving any exposure to Shostrum's POI. It was designed to assess a post-treatment measure of successful A. A. contact and stability of POI attitudes after passage of time.

Procedure

Administration of Shostrum's Personal Orientation Inventory (POI) by counselors at the treatment center began May 1, 1974 as a pre-treatment measure of self-actualization, to all patients admitted on that date. However, due to a patient overload on the counseling personnel at the treatment center, testing was terminated for a period of time with the group entering on May 9, 1974. New patients were admitted each Wednesday after initial dianosis at Warm Springs

State Mental Hospital, Warm Springs, Montana, until July 1, 1974. From that date, patients were admitted to Galen State Hospital, detoxified, interviewed, diagnosed, and then transferred to the Alcoholism Services Center, located on the hospital grounds. All patients admitted from June 12, 1974 to August 8, 1974 received Shostrum's POI as a pre- and post-treatment measure of self-actualization, and all or part of the Skills Program in addition to the treatment provided by the Center as depicted in Figure 1 (page 16). Patients admitted from August 13 - 27, 1974 received no treatment other than that normally provided by the treatment center. The first treatment group was comprised of patients scheduled for discharge June 19, 1974, one week later.

The experimental treatment (Interpersonal Communication Skills Program) consisted of a four-week program (see Appendix C) in which alcoholic patients were instructed in, and participated in, various interpersonal communication concepts, applications, and exercises. It is a modification of the Arbes and Hubbell (1973) Structured Communication Skills Workshop and stresses structure, self-disclosure, feedback, behavior change goals, and intimacy. Due to the nature of the facility and the problems associated with the institutionalization of human beings, psychopathy and varying degrees of neurosis of some of the patients, nonverbal exercises were eliminated. Those exercises which were utilized were modified where necessary to instruct in <u>verbal</u> communication, its effects and application.

CHAPTER 3

RESULTS

Data for Table 1 was analyzed by means of the one-tailed extension of the median test. Medians were obtained by computing differences between pre- and post-POI tests on the basis of whether post-test scores should have been higher or lower than pre-test scores. For example, a reduced post-test score on the Other Directed Scale (O) denoted a positive (+) change whereas a lower post-test score on the Inner Directed (I) scale denoted a negative change (-). All other POI changes were recorded as the difference of pre-test minus post-test scores. Ss scoring at or below the median were placed below the median in accordance with the Extension of the Median Test (Siegel, 1956). Coefficients of Determination representing degree of association were computed with Cramer's V: $V^2 = \frac{\text{Chi Square}}{N}$ (Siegel, 1956).

Questions 1, 2, and 3 on the follow-up questionnaire (Appendix B) were scored 1 for a "yes" response, or 0 for a "no" response. Question 4 was scored 1 for "improved," 0 for "no change," or -1 for negative change or become worse. Question 5 was scored -1 for a past or future oriented response and 1 for a present oriented response. Questions 6-18 were scored 4 (always), 3 (usually), 2 (sometimes), 1 (never); a 4 representing the most favorable response. The data returned regarding persistence of POI attitudes, however, was not

suitable for analysis due to a lack of return of questionnaires which resulted in an overload of zero scores and could not be subject to analysis.

Table 1 (page 27) indicates that the results of the study fail to support in their entirety the stated hypotheses. $H:_1$ which predicted experimental patients would have higher POI ratio changes than control patients upon discharge, field to attain significance. It is therefore assumed that alcoholic patients receiving no Communication Skills Treatment are as likely to be present-oriented and inner-directed as those patients receiving any or all portions of the experimental treatment.

$H:_2$, stating that experimental patients would have a higher rate of return of follow-up questionnaires, also failed to attain significance. For the experimental group, N = 90 questionnaires sent, 26 were returned and completed (29%), 47 failed to be returned (52%), and 17 were returned as being either unclaimed or non-deliverable (19%). For the control group, N = 55 questionnaires sent, 18 were returned completed (33%), 24 failed to be returned (57%), and 6 were returned as either unclaimed or non-deliverable (10%). Although failing to achieve statistical significance, an important finding was exhibited in the overall ineffectiveness of the self-reporting questionnaire as a data gathering instrument for the field of alcoholism. Based upon actual return of questionnaires, the implication is that the majority of patients flatly refused to cooperate with the questionnaire request, an action contrary to the "self-actualizing individual." This

TABLE 1

COMPUTED CHI SQUARE VALUES AND COEFFICIENTS OF DETERMINATION FOR HYPOTHESES TESTED AND POI SCALES ON BASIS OF CHANGE SCORES FOR EXPERIMENTAL AND CONTROL GROUPS

Hypothesis	POI Scale	Chi Square Value	Coefficient of Determination
$H:_1$ POI Ratios	Time Ratio	1.460	.014
	Support Ratio	1.688	.016
$H:_2$ Return of Questionnaires		1.645	.011
$H:_3$ A.A. Contact		1.515	.034
$H:_3$ Current A.A. Attendance		3.223	.073
$H:_4$ Length of Treatment and POI Changes	Time Incompetence	1.432	.017
	Time Competence	1.288	.015
	Other Directed	5.103	.061
	Inner Directed	5.951	.071
	Self-Act Values	2.874	.034
	Existentiality	2.781	.033
	Feeling Reactivity	1.449	.017
	Spontaneity	1.147	.014
	Self-Regard	3.347	.040
	Self-Acceptance	5.021	.060
	Nature of Man Constructive	4.165	.050
	Synergy	1.247	.015
	Aggression	3.030	.036
	Capacity for Intimate Contact	1.149	.014
	Time Ratio	1.022	.012
	Support Ratio	1.967	.023
$H:_5$ Type of Commitment, Voluntary/ Involuntary	Time Incompetence	0.738	.007
	Time Competence	0.738	.007
	Other Directed	0.489	.005
	Inner Directed	0.946	.009

All data tested at .05 level

TABLE 1 (CONTINUED)

Hypothesis	POI Scale	Chi Square Value	Coefficient of Determination
$H:_5$ Type of Commitment, Voluntary/ Involuntary	Self-Act. Values	5.146*	.048
	Existentiality	0.109	.001
	Feeling Reactivity	2.142	.020
	Spontaneity	0.679	.006
	Self-Regard	1.326	.012
	Self Acceptance	1.044	.010
	Nature of Man Constructive	0.127	.001
	Synergy	0.602	.006
	Aggression	1.907	.018
	Capacity for Intimate Contact	0.273	.003
	Time Ratio	4.960*	.046
	Support Ratio	1.460	.014

* p .05

suggests that self-actualization is not a goal of a rehabilitation program, or is at least not perceived as such by patients.

$H:_3$, which hypothesized that experimental patients would be more cooperative in complying with the suggested A. A. follow-up also failed to attain significance. Data was gathered by questionnaire where N = 44 completed out of 145 sent out. Questions 1 and 2 which dealt with whether the patient made A. A. contact immediately upon discharge and if he was currently attending A. A. were utilized in relation to the hypothesis. Fifty-four percent of the experimental patients reported making immediate A. A. contact, whereas 72% of the control patients reported immediate contact; 69% of the experimental patients reported current A. A. attendance as opposed to 66 2/3% of the control patients.

Results indicate that : (a) patients receiving no Communication Skills Treatment made initial A. A. contact, but failed to continue A. A. follow-up, and (b) patients receiving Communication Skills were not as likely to make contact immediately upon discharge, yet persisted in continued A. A. therapy after having once made the initial contact. This information is in support of the original intention of the study -- to provide the patient with a means whereby he can go from treatment to the A. A. group outside the treatment center. On one hand, the patient makes contact, then lapses, on the other hand, the patient delays in making contact, yet eventually does, and then continues to do so. In either event the patient has been exposed to A. A. in the community, and his chances of returning

at a later date, or being sponsored* (A. A., 1955) by an A. A. member are enhanced, thus increasing the probability of the patient's recovery.

Questions 3 and 4 of the questionnaire dealt with employment and status of family relationships after discharge. In the experimental group N = 18 returned questionaires. Fifty percent reported being employed. Implications here are that the recovering alcoholic has at least a 50-50 chance of gainful employment following rehabilitation. An encouraging finding which suggests the success of current attempts by various organizations to remove the stigma once attached to alcoholism.

In the experimental group, N = 26 completed questionnaires. Sixty-nine percent reported an improvement in family relationships after treatment, 23% reported no change, and eight percent reportedly worsened. In the control group, N = 18 completed questionnaires, 70% reported improved family relationship, 22% remained the same, and eight percent became worse after treatment. This data lends support to the concept of alcoholism as a family disease, in which all members of the family are affected, not just the alcoholic (Fox, 1955). It also suggests the converse in that the entire family is positively affected by alcoholism treatment and rehabilitation measures.

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* Sponsorship: A situation whereby one A. A. member becomes a "big brother" to a new member, bringing him to meetings, and helping him to recover on a one-to-one basis in addition to group support.

Questions 5-18 (appendix B) were taken from paired POI test items. Each question has one POI response for each scale. Its purpose was to determine the persistence of self-actualizing attitudes after discharge. However, due to an inadequate return of questionnaires, the data which was obtained could not be subject to statistical analysis; thus the persistence of POI attitudes from four to 15 weeks after discharge could not be determined.

$H:_4$ predicted that the longer the patients' exposure to Communication Skills treatment, the greater the change between pre- and post-POI scores, also failed to attain significance. This suggests that either Interpersonal Communication Skills is ineffective as a treatment modality in alcoholism, the POI is ineffective in assessing the effects of Interpersonal Communication Skills, or that self-actualization is not a suitable variable in dealing with the alcoholic in treatment.

$H:_5$ stated that patients voluntarily committed to treatment would attain a higher degree of self-actualization in all conditions than patients involuntarily committed. In relation to this hypothesis, Table 1 (page 27) denoted two scales achieving significance: Self-Actualizing Values (5.156 $p < .05$) and the Time Ratio (4.960 $p < .05$), both of which are deemed of extreme importance in relation to the alcoholic and recovery due to the alcoholics' apparent lack of self-actualization and pre-occupation with past and future events as opposed to the present ongoing events of daily living.

Table 2 (Appendix D, page 119) notes medians and percentages of

patients scoring above and below the median change by treatment group for each POI scale. Percentages were determined by collapsing the data into four main groups -- Partial treatment: first three weeks, Partial treatment: last three weeks, Full treatment, and No treatment -- and noting the percentgage of patients lying above and below the median for each group.

CHAPTER 4

DISCUSSION

Discussion of Significant Hypotheses

One major ratio scale, Time (T) ratio, and one complementary scale, Self-Actualizing Values (SAV) attained significance. All other scales did not. Shostrum (1966) offered the following explanation of the self-actualized person and the time ratio: the self-actualized person is primarily time competent and thus appears to live more fully in the here-and-now. He appears to be less hindered by guilts, regrets, and resentments from the past than is the non-self-acutalized person, and his aspirations are tied meaningfully to present working goals. He has faith in the future without rigid or over-idealistic goals. The ratio score is utilized to show that there is still some imperfection in the use of time on the part of the self-actualized person. He is, to a degree, Time Incompetent; he can be thought of as being "incompetent" in his use of a comparatively small portion of his time. He is time incompetent 1/9 of the time; the "normal" person is time incompetent 1/6 of the time; the non-self-actualized person is time incompetent 1/4 of the time. This marked time incompetence suggests that the non-self-actualized person does not discriminate well between past or future. He is characterized by guilt, regret, remorse, blaming, and resentments from the past, and idealized goals, plans, expectations, predictions, and fears regarding

the future.

In the present study, the implications are that the alcoholic who voluntarily committed himself to treatment was better able to tie both past and future into meaningful continuity in the present after treatment than the involuntary patient. It is suggested that the voluntary patient was aware of his problem and wanted to do something about his drinking, whereas the involuntary patient's drinking was not perceived as a problem by him, but rather by those who had him committed to treatment. The prognosis is generally not good for alcoholics who do not perceive their drinking as a source of difficulty for them. Kissen (1961) suggested that the long-term treatment of alcoholism is directed toward achieving the following ends: (1) identification by the patient himself as an alcoholic, (2) surrender by the patient to the fact that any quantity of alcohol taken will lead to his particular pattern of drinking, and (3) realization by the patient of the egocentricity of alcoholic behavior and of the need for creating meaningful social relationships.

The Self-Actualizing Value Scale which attained significance was derived from Maslow's concept of self-actualizing people. This means that those individuals who voluntarily committed themselves to treatment apparently held and attempted to live by values of self-actualizing people. Maslow (1954) claimed self-actualizing people take responsibility for others as well as themselves; customarily have some mission in life, some task to fulfill, some problem outside themselves which enlists much of their energies; they appear to be

more in touch with their own human potential, and have the capacity to repeatedly appreciate the basics of life with awe, pleasure and wonder, however stale these experiences may have become to others. Patients who recognized their need for treatment and subsequently subjected themselves to treatment, had apparently become aware of the absence of this value from their present life styles, and thus readily adhered to such principles when presented in treatment. In an A. A. oriented rehabilitation program, the overriding theme is that of helping yourself by helping others (12th step, A. A., 1955). Thus providing the individual with the opportunity and rationale for taking responsibility for others as well as themselves and providing patients with a heretofore absent "purpose in life."

Post Hoc Discussion and Interpretation of POI Profiles

Figure 2 (page 37) compares pre-test means of patients completing treatment (AT&R) patients with those leaving against medical advice (A. M. A. patients) before completing treatment and subsequent post-testing. Several differences are noted here, the most significant being the Time Competency and Spontaneity scales. A. M. A. patients appeared to be living more in terms of the past or future, suggesting that they were less self-actualized upon admission than AT&R patients.

With regard to Figure 2 (page 37), the A. M. A. type had apparently not yet come to grips with his problem and still desired to continue drinking in a more controlled manner.

PROFILE SHEET FOR THE PERSONAL ORIENTATION INVENTORY

AT&R = _____

A. M. A. = ----------

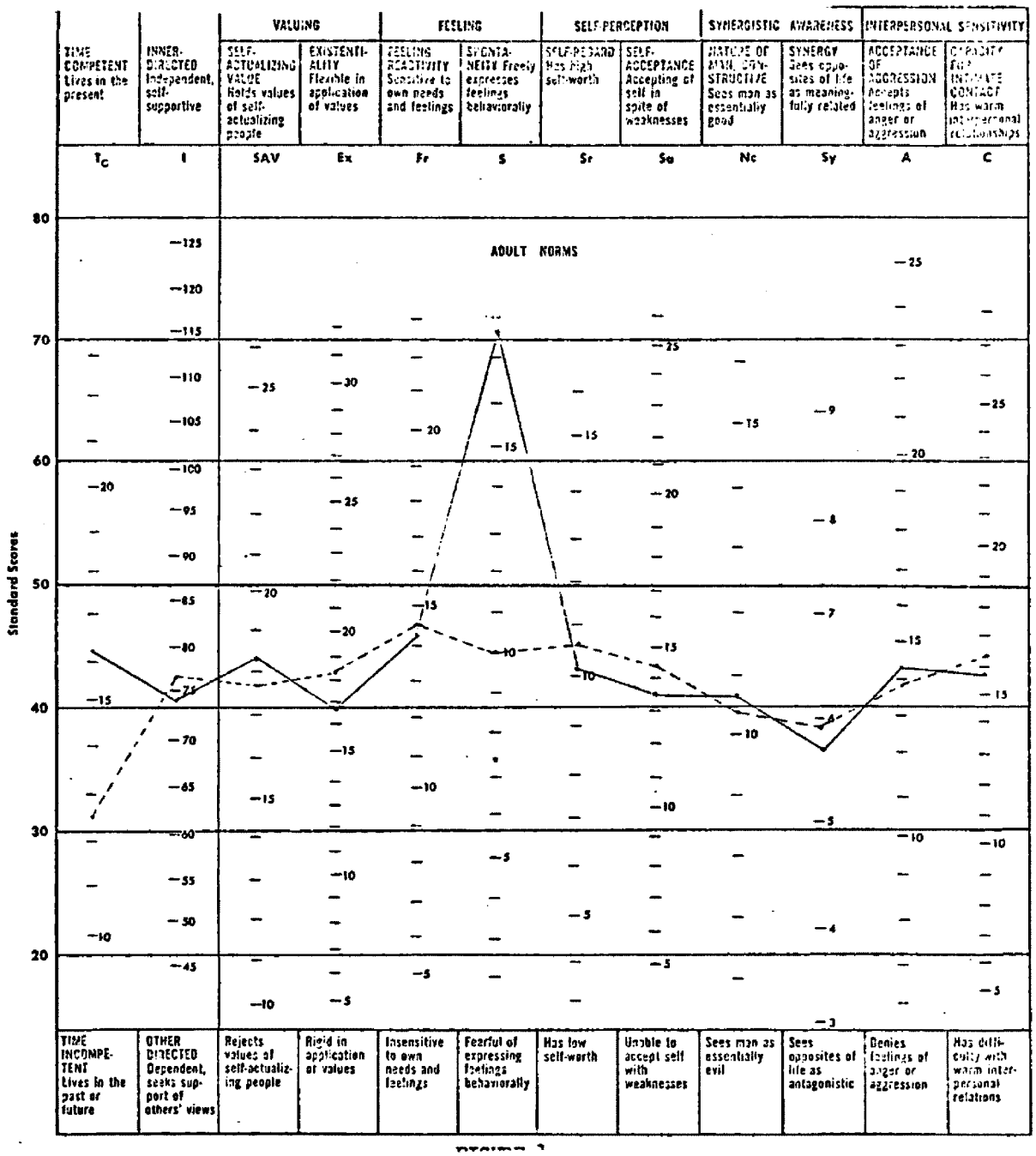

Figure 2. Pre-Test Means of Patients Completing Program and Those Leaving A. M. A.

Figure 3 (page 39) reflects pre-test means of Early Discharge and AT&R patients. Early discharge patients were those authorized to leave the treatment facility before completing treatment for a variety of reasons, i.e. health, family, and legal problems which could not be handled on an in-patient basis. Early discharge patients attained lower pre-test scores than AT&R patients, suggesting a possible link with A. M. A. patients.

Figure 4 (page 40) illustrates pre-test means for patients returned to Warm Springs State Hospital and A. M. A. patients. Patients were returned to the State Hospital for having other problems in addition to alcohol, which became manifest after alcoholism treatment began. Returnees obtained scores which suggested they were more idealistic, rigid, insensitive to their own needs, had a high self-regard, yet were unable to accept themselves and had difficulty with warm interpersonal relationships.

Figure 5 (page 41) compares pre-test means of patients returned to Warm Springs with those of AT&R patients. A substantial difference was found. The most striking differences were in the areas of Time Competence, Feeling Reactivity, Spontaneity, Self-Regard, and Capacity for Intimate Contact. Patients returned to Warm Springs scored significantly lower on all scales but Self-Regard.

Figure 6 (page 42) notes pre- and post-test means for all patients completing the treatment program (AT&R). The most striking feature here was that post-test scores were lower than pre-test scores for all scales except Self-Regard.

PROFILE SHEET FOR THE PERSONAL ORIENTATION INVENTORY

Early D/C = ---------

AT&R = _____

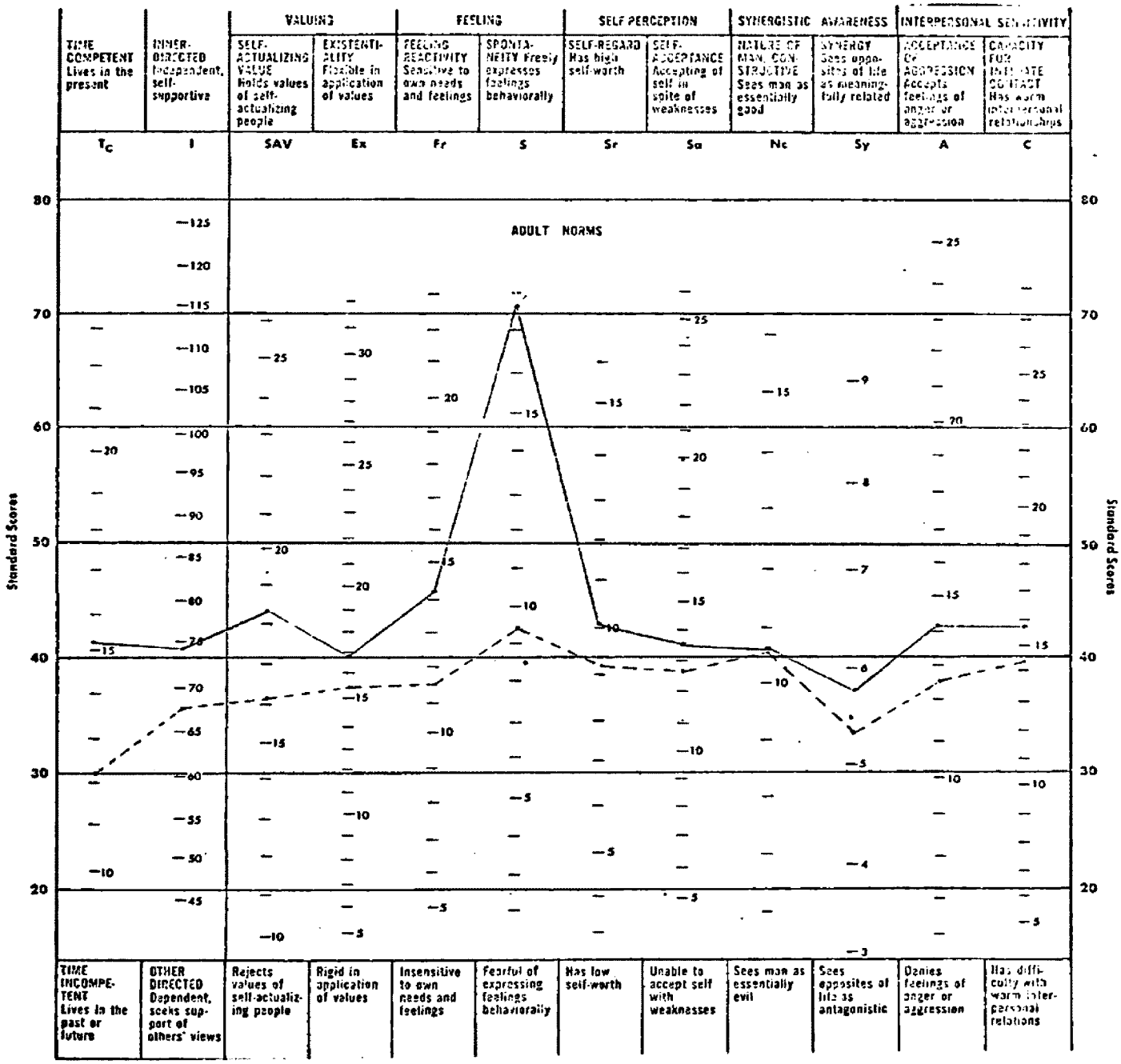

Figure 3. Pre-Test Means for Early Discharge Patients and AT&R Patients

PROFILE SHEET FOR THE PERSONAL ORIENTATION INVENTORY

A. M. A. = --------

Warm Springs Returnees = _____

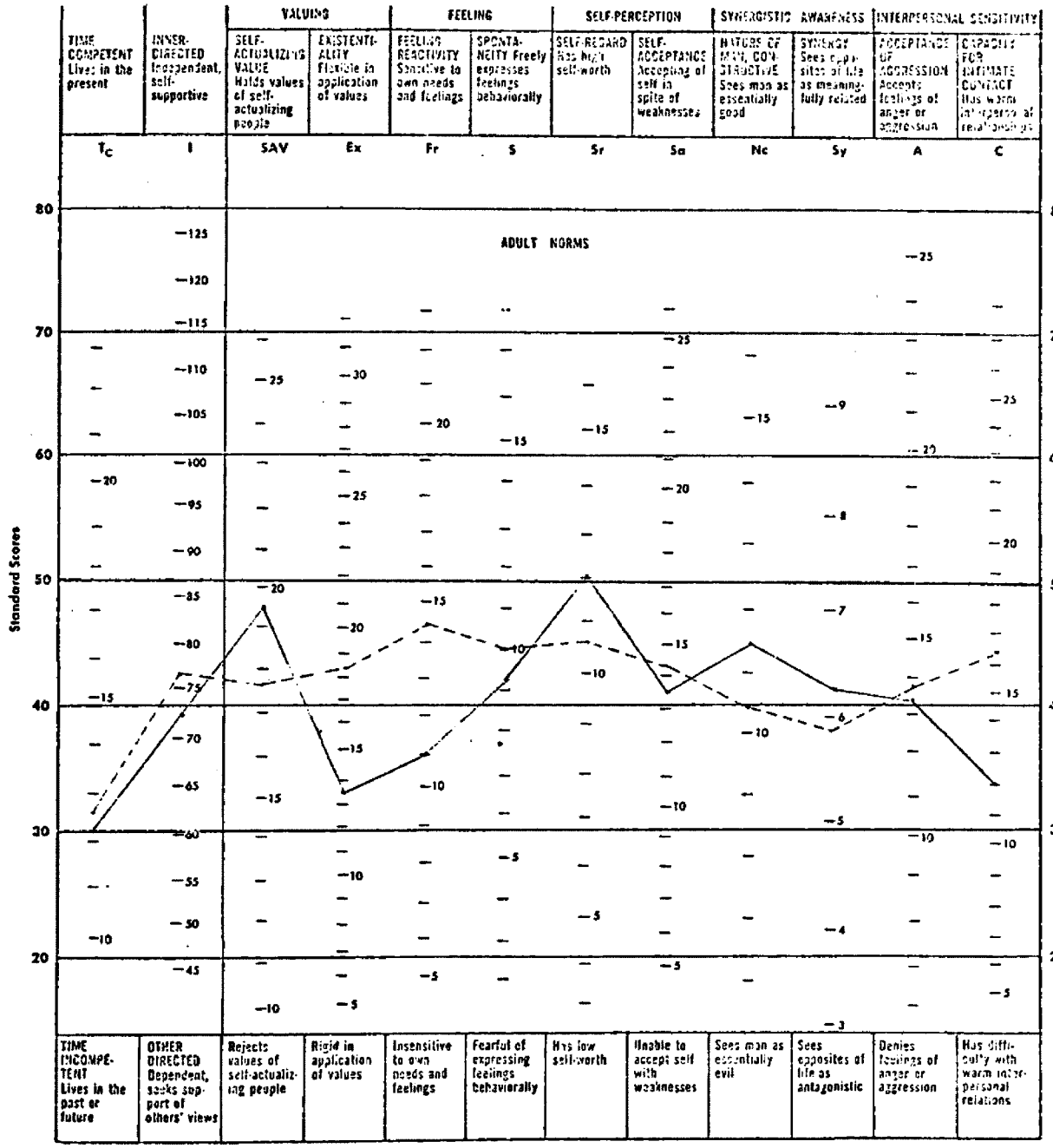

Figure 4. Pre-Test Means for Patients Returned to Warm Springs and Patients Leaving A. M. A.

PROFILE SHEET FOR THE PERSONAL ORIENTATION INVENTORY

Returnees = _____

AT&R = - - - - - - - - - - -

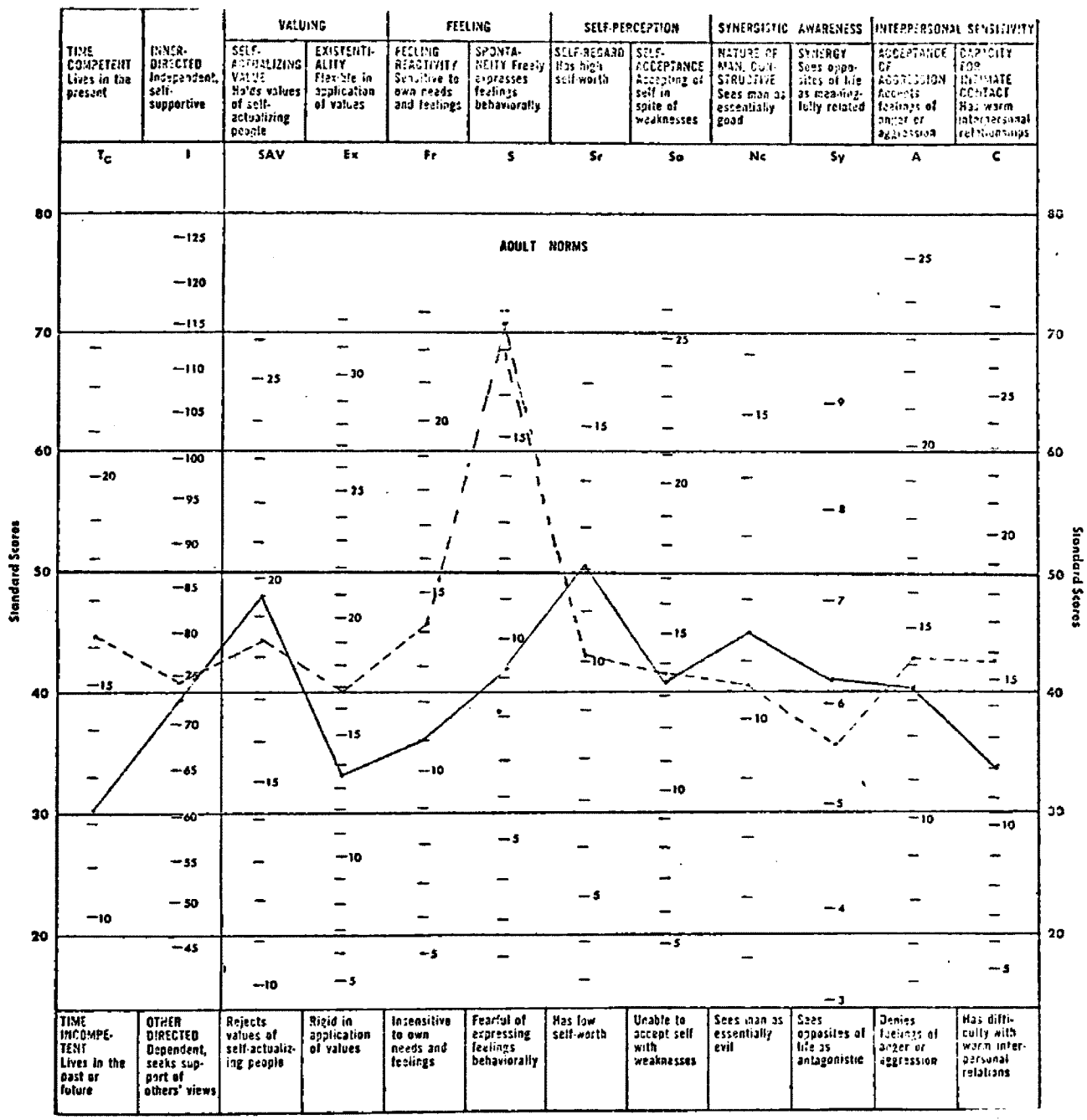

Figure 5. Pre-Test Means for Patients Returned to Warm Springs and AT&R Patients

PROFILE SHEET FOR THE PERSONAL ORIENTATION INVENTORY

Pre = -------

Post = _____

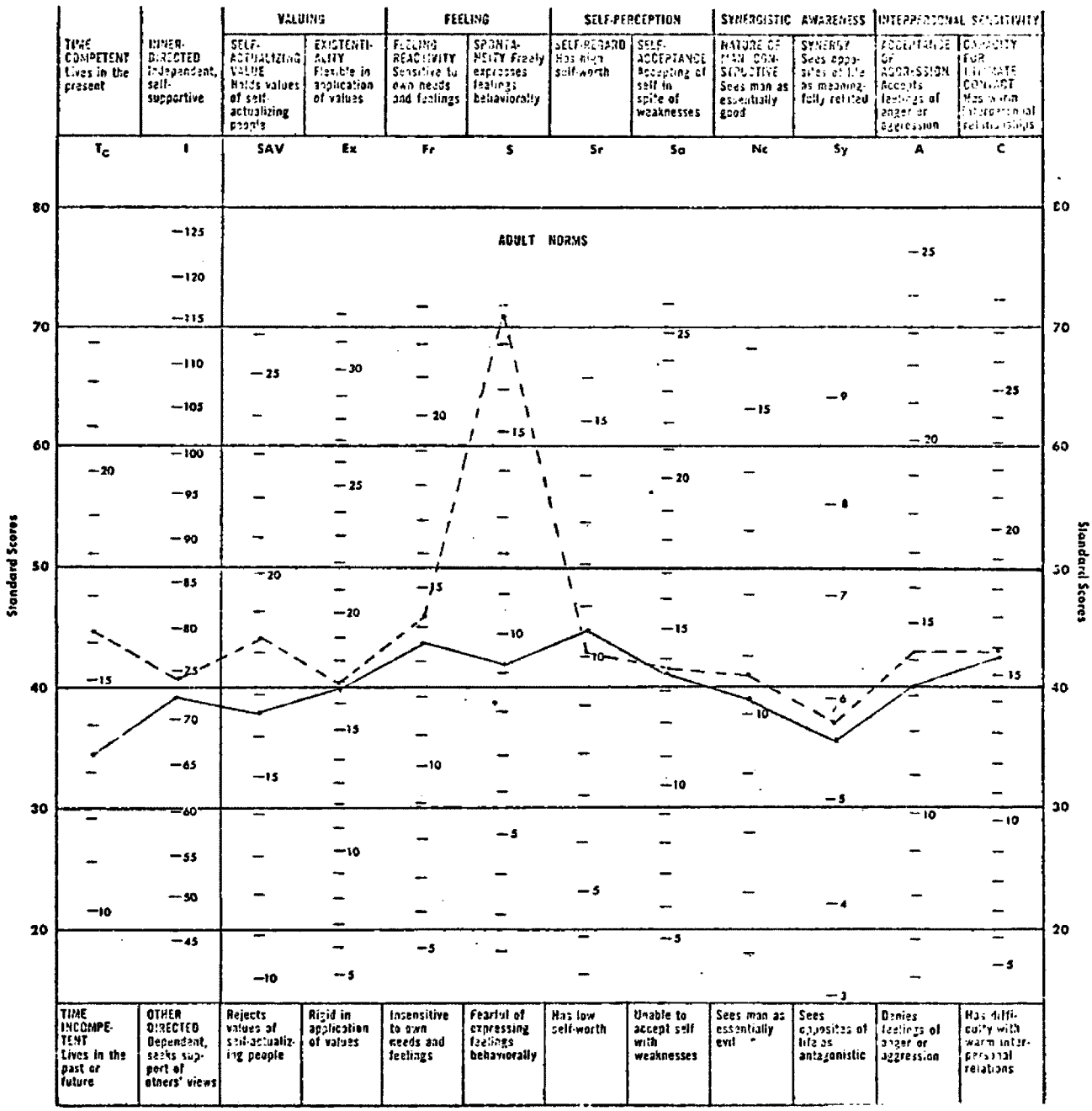

Figure 6. Pre- and Post-Test Means for AT&R Patients

Figure 7 (page 44) illustrates the percentage of full skills treatment versus no skills treatment patients scoring above the median POI change. Although latter scored higher than the former on most scales, the former appeared less extreme in their attained scores. This suggested that the full skills treatment group tended to stabilize at a median response. The implication here is that patients receiving the full four weeks of the Communication Skills Program were less likely to reach extreme highs and lows, either of which prove to be extremely hazardous to alcoholics. These patients were more inclined to attain a "middle of the road" frame of mind. Figure 7 (page 44) notes that the "peaks" are not as high, nor the "valleys" as low for the full skills treatment group. Indications are that interpersonal communication skills seemed to facilitate advocation of the less radical and more conservative response choices on the POI.

Figure 8 (page 45) highlights the percentage of patients scoring above the median POI change scores, in groups receiving the first, first two, or first three weeks of Communication Skills Treatment. The scale on which the majority of patients scored highest was the Self-Actualizing Values (SAV) scale for patients receiving the first week only of Skills Treatment. Other scales on which 50% or more scored high were: Time Incompetence (a high score here is unfavorable), Time Competence (a high score here is favorable) -- this indicates that half were time competent and half were not -- Spontaneity, and Acceptance of Aggression.

Figure 8b (page 45) depicts the percentage of patients scoring

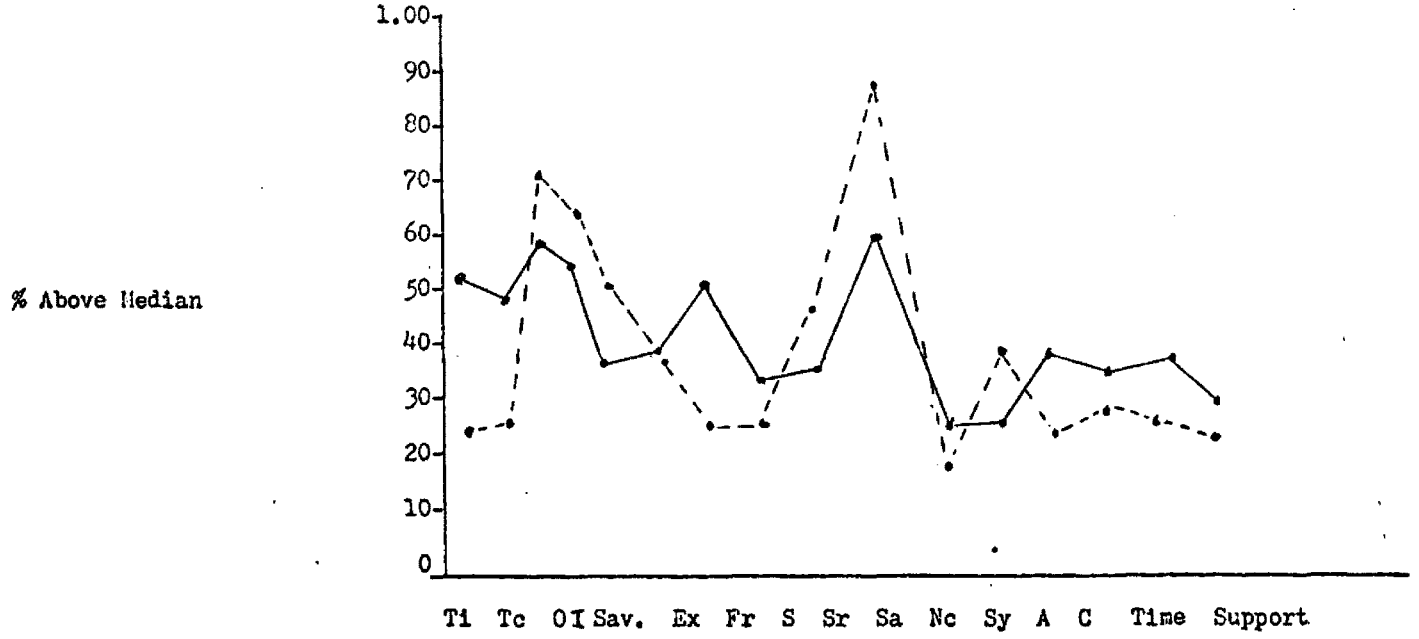

Figure 7. % of Patients Scoring Above Median
Full Treatment vs. No Treatment

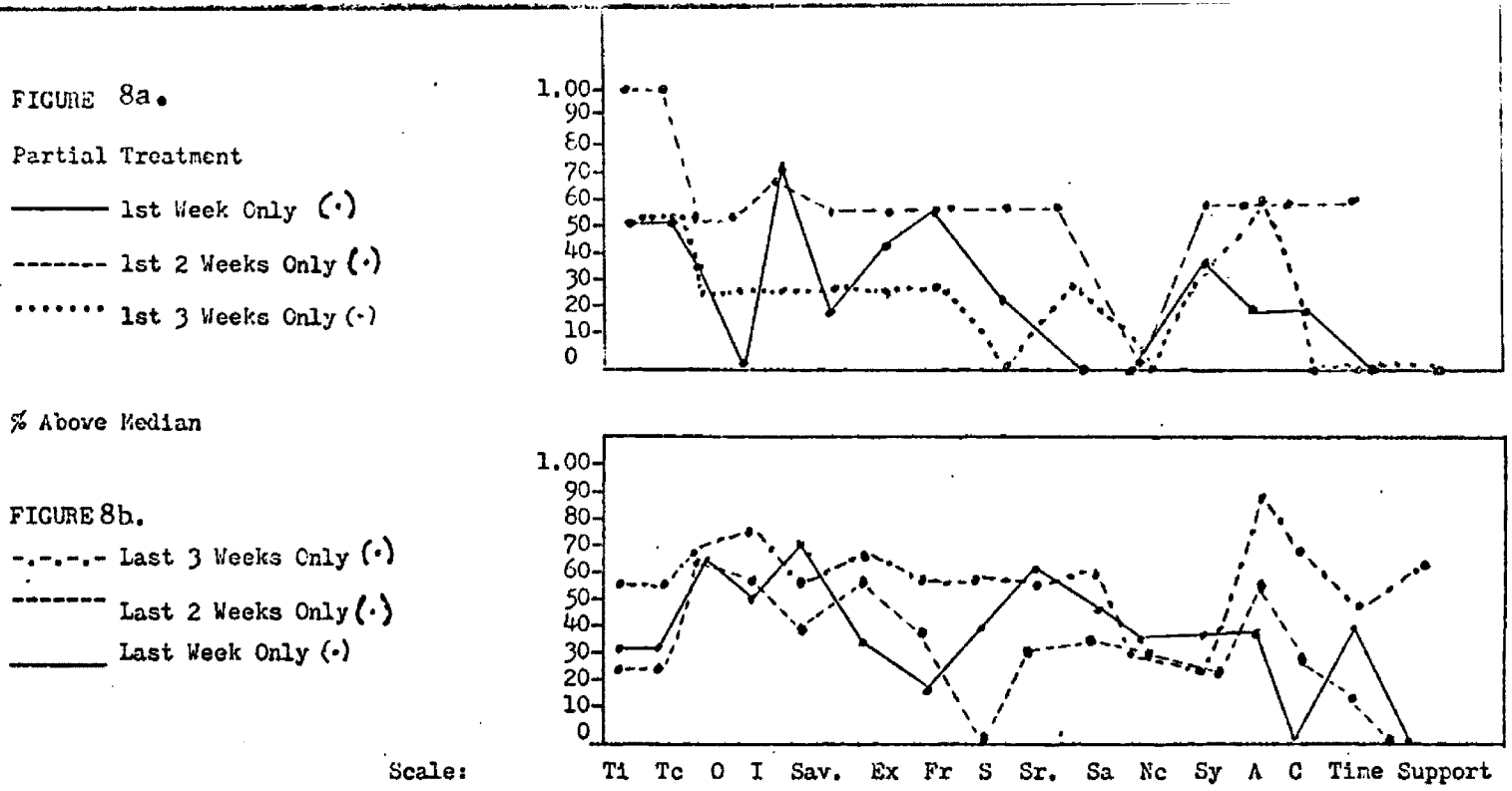

Figure 8 a, b. % of Patients Scoring Above Median POI Change: Partial Treatment Groups

above the median POI change score receiving either the last three, two, or one week of the Communication Skills Program. Patients receiving the last three weeks of Skills seemed to have fared better than the other groups thus far. More than 50% of all patients in this group scored above the median change score on all scales except Nature of Man Constructive (Nc), Synnergy (Sy) and the Time Ratio. This group received the second and third weeks of Skills. In addition, they received the fourth week of Skills Treatment consisting of a lecture summarizing the goals of the Skills Program, discussion on behavior change goal setting and a mini-group exercise using the Group Member Interview Guide (Appendix C_8).

Supplementary Discussion: Experimenter Observations

The A. M. A. type (patients leaving against medical advice) had apparently not yet come to grips with their problem and still desired to continue drinking in a more controlled manner. Perhaps this patient type could not cope with successful achievement of sobriety so he ran away from treatment. Aronson and Carlsmith (1962) hypothesized that if individuals continuously failed in a task and then suddenly succeeded, they would purposefully engage in behavior which would cause them to fail once again. The prediction, based on the assumption that sudden success would be dissonant with the person's continued failure, was verified. This suggests that the A. M. A. type could have been purposefully engaging in behavior to cause him to fail in order to provide himself with a rationale for further drinking in the excuse, "I can't do anything right anyway." The AT&R

patient however, apparently realized that he had a problem and that the future would be no better than the past if he failed to act in the present.

AT&R patients scored much higher on the Spontaneity Scale than A. M. A. patients. This indicates the ability to express feelings in spontaneous action. The large discrepancy here suggests that the AT&R type admitted, and more importantly, accepted their alcoholism, and was therefore better able to react freely and openly as they were hiding nothing. The A. M. A. type was apparently afraid to express themselves for fear of identifying with their self-admitted alcoholic counterparts in the treatment facility. If they were to admit and accept their alcoholism, there would be no need to run away from treatment. By running away, they deluded themselves into believing that they were not "like the others" and therefore not alcoholic. Their running away can be interpreted as an overt manifestation of denial, a defense mechanism utilized to an extreme by the alcoholic. In the alcoholic, denial is a conscious difficulty in admitting to others that alcohol determines much of his behavior and inner life. Where the facts are clear cut, the alcoholic will admit that he has had one or more unfortunate episodes because of excessive drinking, although he will not admit to others that alcohol is a vitally necessary part of his existence. In each instance the individual sways back and forth between wish and reality; when the wish dominates, denial is intense, when reality dominates, denial is weak. This alternation reflects an internal conflict between the wish that

he were free of alcohol and the inner knowledge that he is not (Blane, 1968).

The A. M. A. type scored higher on two additional scales, Self-Regard, and Self-Acceptance. The assumption here is that the A. M. A. had not yet reached his "bottom" or the lowest point he felt he could possibly reach physically, emotionally, and/or spiritually (A. A., 1958). Figure 2 (page 37) suggests that the A. M. A. type still perceives himself as being a worthwhile person and was able to accept his alcoholic lifestyle. The AT&R patient, however, is shown to have reached a point where he could no longer accept himself due to a perceived low self worth. He appears to have reached his "bottom," in which he became extremely dissatisfied with himself and his life style and was willing to change.

The data implies that perhaps the early discharge type had predetermined that he would leave the treatment center, but managed to find legitimate methods of doing so. The question then arises as to whether these individuals would leave A. M. A. if they had failed to obtain legitimate reasons for early discharge. It is speculated that the answer is no for two reasons. First, if the individual did not fear repercussions, he would not have gone to the trouble of finding a legitimate means of release, but would have left on impulse as did the A. M. A. type. Second, the early discharge type exhibited a lower self-perception as measured by the POI than either the A. M. A. or AT&R types. Implications here are that the early discharge patient is an entirely different type of alcoholic patient. Ravensborg (1973)

reported early terminators from an A. A. oriented program to exhibit more fatigue, depression, restlessness, and inability to relax than did completers of the program as reflected in mood reports.

Patients returned to Warm Springs attained significantly lower scores on all scales but Self-Regard. They apparently perceived themselves as worthwhile, yet could not accept themselves. A situation in which one level of the self-concept (Self-Regard) was contradicting another level of the self-concept (Self-Acceptance). Bateson, Jackson, Haley, and Weakland (1956) present what they term the "double-bind" theory of schizophrenia in which the patient is never able to develop a clear idea of who he is as a result of these types of contradictions. Although diagnosis is beyond the scope of this study and investigator, the existence of such a possibility evolving is noteworthy.

Since higher POI scores denote a more positive change, the immediate assumption is that treatment per se appears to have a negative effect upon alcoholic patients. Since this is not in line with the hypotheses, explanation is necessary. The active alcoholic, and even the pre-treatment alcoholic lives in a world of delusions in which reality is distorted in the direction of satisfying the compulsion to drink, thereby achieving a state of equilibrium which enables him to function. Although alcohol is the primary substance causing alcohol addiction, there are other variables which either enhance, promote, or provide a rationale to engage in drinking behavior. Investigators have pointed out that alcoholism is a chronic illness that probably

springs from the interplay of at least three conditions operating concurrently (Zapalla and Ketcham, 1954; Jellinek, 1951, 1952; Demone, 1963; and Rathstein and Sigel, 1964). Jellinek (1951, 1952) in particular was an exponent of this thesis. He contended that no single factor acting alone can account for drinking in any given individual, but that three circumstances interweaving and reinforcing one another must be held accountable. He lists these three factors as: (1) a constitutional liability factor which postulates that certain individuals have an inborn vulnerability to the action of alcohol. These people lose control of their alcoholic intake because of biochemical sensitivity to alcohol. Such sensitivity may be hereditary or congenital and, theoretically, may have its roots in nutritional deficiency, brain pathology, or endocrine dysfunction. (2) A personality or psychological factor which suggests that psychological strain, a sense of personal inadequacy, and an estrangement from and rejection by the rest of society are among the personality traits of the "psychologically vulnerable" individuals -- men and women accustomed to taking alcohol as a solution to personal problems, and (3) A social factor. A folkway in many social circles, the consumption of alcoholic beverages with friends, associates, and relatives brings a "small social reward": acceptance by the group and approbation. If a person is then "marked" by (a) an endogenous sensitivity to alcohol and (b) a personality inadequacy, and if (c) he enters a circle of drinking people, the stage is set for symptomatic drinking.

What lies ahead, according to Jellinek, is the prospect of 10 to 25 years of alcoholism during which the individual goes through three successive stages: (1) the prodromal phase in which drinking is not conspicuous, and intoxications are not severe; (2) the curcial or basic phase in which intoxications are the rule, but still limited to evenings, followed by hangover. Onset of solitary drinking varies greatly among drinkers, but usually occurs in the basic phase; (3) the chronic phase in which tolerance decreases, drinking becomes nearly constant and the drinker moves on to defeat. If the cycle is not broken somewhere along the line, the individual ultimately reaches the last state.

During pre-test periods variables, psychological and social, similar to Jellinek's three factors were present and contributed to inflating test scores, while during post-testing periods these variables were absent.

Treatment supplied at the Galen facility at the time of this study consisted of individual and group therapy, A. A. meetings, daily lectures, and films. The main thrust of the treatment program was that of educating the patients to make them aware of alcohol and alcoholism how and why it affects them, and more importantly, how to come to grips honestly with themselves. It is suggested here that the elements of honesty, self-discovery, and elimination of egocentricity which were brought about by AT&R treatment account for the apparent negative shift in POI scores. Such treatment enables patients to step out of their pre-treatment world, distorted alternately

by attitudes of inferiority and superiority and bring them closer to the realities of life, particularly the reality of alcoholism in their lives. Figure 6 (page 42) shows that the patient was living more in the present upon admission than upon discharge. Such could have been the case; however, considering the immediate anxiety associated with admission to a facility in which one is to be literally incarcarated for a period of five weeks, the present, or very immediate future logically takes precedence over any far-reaching future plans. Upon dismissal from such a facility, however, patients reported thinking about whether they would remain sober, have a job to return to, and how their friends and family would react to them. Questions of this nature are decidedly future oriented.

The Spontaneity (S) scale dropped drastically from pre- to post-testing. The rationale offered for this is that during the pre-tests, all newly admitted patients were together in a group and all knew each other from their stay in detox. A great amount of anxiety and tension, associated with their new environment and situation, was released via laughs, jokes, and remarks concerning test items. In this situation, feelings were very definitely being expressed behaviorally. In the pre-test situation, however, patients completed the test in the privacy of their rooms; thus any anxiety or tension that may have been present was not as readily expressed behaviorally. Since the POI emphasizes present attitudes and feelings, in responding to questions, this appears to be a logical assumption.

The Self-Regard (Sr) Scale was the only scale to attain a

higher mean score upon post-testing. The underlying assumption here is that during the course of treatment, the self concept improved to a point where patients perceived themselves as being of value once again. This result is consistent with, and supportive of, the Alcoholism Treatment and Rehabilitation Program's goal of motivating the patient to assume a worthwhile position in society upon discharge, by providing the patient with a more positive self-concept during treatment.

Since both rehabilitation and self-actualization must have their roots from within the individual patient, the AT&R program is successful in its approach to bringing about change through self-awareness and that this success is not detracted from by use of Interpersonal Communication Skills as a treatment modality.

The Interpersonal Skills utilized as the experimental treatment and their effects consisted of the following:

Week 1 of the Skills Program (See Appendix C) was essentially a lesson in communication theory, emphasizing the need to communicate.

The skills exercises utilized were the One-Way and Two-Way Communication exercise (Appendix C_1) after which followed a discussion on the one-way communication ordinarily engaged in by the active alcoholic. The mini-group exercise was the Group Conversation Exercise (Appendix C_2), the goals of which were to develop a compatible group climate and readiness for interaction through sharing common personal experiences. It remains unclear, however, how such lectures and exercises account for Time Competency/Incompetency, as they appear

to be totally unrelated to the material covered in the first week of the treatment. This factor can only be attributed either to chance, or the patients' pre- or early-treatment time orientation. That 67% of the patients in this group scored above the median POI change indicates that these individuals hold and attempt to live by values of Self-Actualizing people. A more accurate statement, perhaps, is that these individuals at least do not reject such values. The implication is that an element of open-mindedness, along with a willingness to try is present. It is conceivable that the first week of the Skills Program could foster the formation of such attitudes by virtue of the lectures and exercises focusing on a different approach to life. It is, however, also conceivable that the mere fact that they were "in treatment" could have the same effect in that they felt they "should" change via demand characteristics and expectations. It remains unclear which factor was the influencing force in this case. Scales in which 0% of the patients scored above the median change were Self-Acceptance, Nature of Man Constructive, Synnergy, and the Support Ratio. This was not startling as these areas were not touched upon in lecture nor in the exercises utilized thus far. The exception being the Nature of Man Constructive (Nc) Scale. The mini-group exercise utilized was selected precisely to enhance both the development of trust in others and viewing man as essentially good. The fact that none of this group scored above the median change score suggests that they perceived man as essentially evil, and that the mini-group exercise (Group Conversation Exercise, Appendix C_2) was ineffective. Per-

haps the fact that information pertaining to this scale was not mentioned in lecture accounts for this effect or perhaps the length of time necessary to form such trusting relationships was inadequate, therefore negating the effects of the exercise. If such was the case, any further study in this area should include this time element as a variable and delay such exercises until later in treatment.

For patients receiving the first two weeks of Skills Treatment, the results were considerably more positive. Fifty percent or more of all patients in this group scored above the median change scores with the exception being, again, the Nature of Man Constructive (Nc) Scale. This group received the same lectures and exercises for the first week as the previous group, with the addition of a lecture focusing on meanings being in people via an example of message distortion (Appendix C), utilization of a Serial Transmission Effect exercise and a mini-group exercise consisting of a modification of Jourard's Intimacy Game (Appendix C_3) to facilitate self-disclosure and to develop a sense of authenticity in the mini-groups. The only explanation available to account for patients continuing to view man as essentially evil is the lack of noting the lecture that man is NOT bad. The implications are that this oversight had profound effects upon how patients viewed others, and that patients in treatment tended to adhere to and believe in that which was conveyed through the counselor, a fact well worth noting on the part of counselor, working with alcoholics. Apparently the alcoholic in treatment is quite mallable and can be molded by the counselor, to a large degree concerning the at-

titudes he will develop and hold while in treatment. On the basis of the present data, however, persistence of such attitudes cannot be generalized to the environment outside the treatment center. Data implies that a two week time period is also inadequate to facilitate the trust required to form relationships of the type required in the Group Conversation Exercise (Appendix C_2). This suggested that the alcoholic maintained a basic mistrust in fellow-patients (fellow-man as well?) well into treatment. The implication is that attempts should be made to TELL patients that man is basically good, and then demonstrate it by providing experiences which facilitate trust and hence break down interpersonal barriers early in treatment. Apparently, however, the experiences provided thus far in the Skills Program did not accomplish this objective.

An apparent paradox existed regarding patients receiving the first three weeks of Skills Treatment in that they appeared to be on the decline insofar as scoring above the median change score was concerned. In relation to data supplied in Figure 8 (page 45), which pointed out that full treatment patients attained lower scores than no-treatment patients, the third week of treatment appeared to be the point at which patients started to decline. Perhaps a saturation point was reached at this time and all new incoming information was either channelled out or gone unnoticed. Week 3 of the Skills Program centered on a lecture on feedback (Appendix C_2). Of particular importance was a portion of the lecture focusing on the point that the type of feedback received from others is paramount in formation of

the self-concept and therefore the type of person one "must" be. Figure 8a (page 45) illustrates that the Self-Regard (Sr) Scale attained a zero percentage of patients scoring above the median change score. Perhaps the lecture content facilitated reflection by patients on feedback received prior to treatment in which case their self-regard ebbed. This ebbing being a function of, perhaps, a realization of how others perceived them as active alcoholics, characteristically referred to as "irresponsible," "moral degenerates," "no-goods," "drunks," and "phonies." Another seeming paradox was that their Capacity for Intimate Contact (C Scale) fell off in the third week of Skills Treatment although the mini-group exercise utilized was a modification of the Dyadic Encounter (Appendix C_5), the goal of which was to facilitate knowing and trusting another person through deeper and more involved self-disclosure and risk-taking. The success of this exercise was not supported by the Nature of Man Constructive (Nc) Scale which remained stable at zero percent above the median change score. This suggests that patients remained steadfastly resistant to trusting others even under therapeutic or laboratory conditions. Perhaps the hypothesized reflection on past adverse feedback stimulated a fear of receiving adverse feedback from fellow patients in which case they became less intimate and more guarded in their disclosure. This appears to have been a rational and logical behavior in light of the closeness developed as a result of "being in the same boat" at the treatment center, thus accounting for the reduction of their capacity for intimate contact. For many patients the treatment center environ-

ment provided them with the first positive feedback in many years. The fear of eliminating such feedback appeared to be stimulus of sufficient strength to trigger guarded responses. Perhaps the fear of "not belonging" far outreaches the desire to trust others. Other scales noting a decline were the Time and Support Ratios. Apparently, during the third week of treatment patients became more other-directed and reliant upon the group for support and identity. Patients also became more future-oriented at this time, perhaps due to the realization that they were past the half-way point in the program and subsequently began to think in terms of life "outside" once again. This phase of treatment appears to be crucial, therefore intensive counselor/patient interraction should be maintained if the patients earlier level of aspiration and self-actualization is to be maintained.

Thus far, implications are that Communication Skills should be a part of treatment, but only during the first two weeks of treatment, if maximum benefits are to be obtained and maintained. One positive finding here was that patients appeared to have stabilized more toward a middle score in the third week, a factor cited earlier as being favorable to the alcoholic.

The purpose of the Group Member Interview Guide (Appendix C_8) was to provide patients with an opportunity to try out the new behaviors listed by them on their Behavior Change Goal Setting Worksheets (Appendix C_7); allow them to give and receive feedback; practice active, accurate listening; and one last opportunity to speak

in a group similar to the recommended A. A. follow-up group before discharge. Noteworthy here was that virtually all scores rose including the seeming change resistant Nature of man Constructive (Nc) Scale. This suggests that either by virtue of the exercises and lectures contained in the fourth week, the interaction with other patients and staff, the combined effect of Skills plus AT&R treatment or the knowledge of imminent discharge, patients' outlooks had improved to a point where they no longer viewed man as essentially bad or evil. A possible explanation for this Nc Scale phenomenon was that on their Behavior Change Goal Setting Worksheets (Appendix C_7), many patients cited the goals of "getting along with others" and "being more outgoing and friendly" as major goals, second only to sobriety. Inherent in such statements is an element of trust which was heretofore absent. By putting such statements down in black and white, a more concrete commitment seemed to have been obtained, although such was not the original intent of the exercise. Its original intent was to force the patient to develop a plan of action to be taken to help insure continued sobriety by listing specific behaviors in which to engage in the event of a sobriety-threatening situation after discharge. Although both the AT&R and Communication Skills Programs were A. A. oriented, an interesting sidelight was that few patients cited attending A. A. meetings as a behavior they would engage in to maintain their sobriety in such situations. No explanation can be offered for this phenomenon at present. The fourth week of Skills Treatment supplied patients with (a) time with which to begin trusting others,

(b) a higher degree of Self-Actualization, and (c) a concrete commitment to change old behaviors.

Patients receiving the last two weeks of Skills Treatment dropped drastically on the Time Competency Scale. This was possibly due to a lack of Communication Skills in the early stages of treatment, or because patients were closer to discharge and thus more future oriented. Patients in this group also scored lower on the Spontaneity (S) Scale with none scoring above the median change score. A low score indicates a fear of expressing feelings behaviorally. These patients were not informed of the need to communicate; differences between one- and two-way communication, Group Conversation, distortion in communication and its effects; not did they participate in the exercise to develop a sense of group authenticity. Implications are that the first two weeks of Skills were beneficial in this area by providing both the rationale and the opportunity to express-feelings behaviorally via communicative behaviors. The Support Ratio also fell off to zero percent above the median indicating that this group was dominated by social pressure such as what "others" thought of them. In only two groups did a majority of patients seem to have been "liberated" from such social pressures; those receiving the first two weeks of Skills Training and those receiving the last three weeks. A finding which appears to make little sense as, in combination, the two groups represent the entire Communication Skills Program with the central component being an overlap of the material and exercises of the second week of the Skills Program. It could be

hypothesized that the second week of the Skills Program was most valuable, although the reasoning remains unclear.

Patients receiving only the fourth week of Skills Treatment appeared slightly more erratic in their scores with "peaks" and "valleys" higher and lower than other treatment groups. This was adjudged to be the effect of AT&R treatment in combination with the final week of Skills Treatment. The Nature of Man Constructive (Nc) Scale was higher for this group, suggesting that the lectures provided in the fourth week of the Skills Program seemed to facilitate an improved view of human nature.

The findings of this study, although relatively inconclusive, suggest that in dealing with the alcoholic in treatment, one is dealing with a highly unpredictable individual. Therefore, the utilization of Self-Actualization as a dependent measure of effects of treatment is, perhaps, not an appropriate dimension with which to work. In the context of the present study, it was difficult to determine precisely which were the effects of (a) Skills Treatment, (b) AT&R treatment, and (c) the interaction of the two treatments. As both treatments were in operation simultaneously, isolation of factors was impossible. Further research in the area of Communication Skills as a treatment modality in alcoholism should focus on such skills treatment as the only one in operation, to avoid confounding effects. Posttesting of patients should be at a specific time, i.e., either directly before or after notification if discharge. In the present study patients were notified of discharge from one week to a few hours prior

to actual discharge. Such information could feasibly influence the patients' "frame of mind" at the time of testing and hence test scores could be influenced accordingly. Future research should also include the concept of time as a variable in relation to forming interpersonal relationship of the type proposed in this study and by various other Human Relations Training exercises. Altman and Taylor (1973) intimated that time is a crucial element in proceeding to those central areas of personality which the aforementioned exercises seek to reach.

Effectiveness of the POI in Treatment

Shostrum's POI was found to be a highly effective means of supplying the patient with a positive measure of self-actualization, and more importantly, with a measure of positive effects of treatment. Patients frequently made jokes in regard to "flunking" the test. Although stated in a light-hearted vein, such comments reflected a degree of seriousness. The alcoholic is typified as being a perfectionist in whom anything less than perfect causes frustration. Lisansky (1960) suggested that the personality type predisposed to alcoholism has a low degree of tolerance for frustration or tension. Blane (1970) set forth some of the personality characteristics commonly seen in alcoholism as including low frustration tolerance and feelings of inferiority combined with attitudes of superiority. The alcoholic is characterized by a low frustration tolerance level, coupled with gross immaturity. Fox and Lyon (1955) pointed out that the extremely low tension tolerance of many alcoholics is also characteristic of

the infant; when the infant experiences tension, because of hunger, perhaps, he demands immediate relief. Similarly, the alcoholic reacts as swiftly, and almost as possionately, when things go wrong in his life. Korman and Stubblefield (1961), while studying 61 alcoholic outpatients, recorded such capsule clinical judgments as: "Has a low threshold for feeling rejected," and "Has a readiness to withdraw or become disorganized in the face of frustration and adversity." This does not conclude that there is a specific "alcoholic personality." Conger (1956) noted that only one conclusion seems justified from the various attempts to describe a specific alcoholic personality: no matter what defense or group of defenses the individual alcoholic picks in his struggle with reality, he is unable to contain the anxiety against which the defenses were erected. He remains intolerant to tension and frustration; he resents responsibilities; he demands immediate gratification of his unrealistically high goals. Any interference with his aims is perceived as an intolerable blow to his self-esteem, and his life is marked by frequent, recurrent periods of rejection. For these latter, only alcohol seems to afford relief.

The idea of failing is not new to the alcoholic, since repeated failure has been a way of life in the past. However, the notion of "flunking" treatment seemed to be a source of anxiety and totally repulsive to patients in the current study. The POI provided a means by which the patient could see, graphically, what progress was made, and what changes did occur as a result of treatment. Cross-analysis and interpretation of scales and test scores were utilized to show

where positive changes occured, even when scores presented what appeared to be a negative change on a given scale. An additional advantage in the present study was that the researcher was allowed to live at the treatment center during the course of study. This afforded the opportunity to observe patients' behavior in the absence of any therapeutic stimulation. This enabled the researcher to interpret test scores by citing actual behavior in which the patient engaged relative to the scale (s) being interpreted. The gross impact of using the POI in this manner was to provide the patient with a positive view of both himself and effects of treatment even in the face of an apparent negative change. By citing actual behavior engaged in during treatment, the scales became personalized and more meaningful. This aided in the patients' internalization of both AT&R and self-actualization concepts. The ultimate goal of using the POI in such a manner was to provide a strong positive note upon which to leave the treatment center environment as patients were post-tested immediately after notification of discharge.

During the course of research the POI appeared capable of distinguishing between different types of patients such as A. M. A.'s early discharge patients, completers (AT&R), and patients likely to be sent to Warm Springs State Hospital, on the basis of pre-test scores alone. This suggested that perhaps the POI could enhance the effectiveness of treatment by providing the counseling staff with additional insight and knowledge with which to treat the individual patient. In treating the A. M. A. type, the advantages of such pre-

treatment knowledge could be unlimited. Patients scoring similar to past A. M. A. patients could be given pre-treatment counseling while in the detoxification center, prior to actual AT&R treatment. An effective use of such information could be to confront the A. M. A. candidate with the fact that his test scores suggest that he does not feel he needs treatment. This could serve to facilitate admission of alcoholism, a factor crucial for recovery. Fox (1957) noted that if the alcoholic has not suffered too much from his drinking, he will probably not even consider giving it up. That is why Alcoholics Anonymous speaks of the necessity for "hitting bottom." The individual must lose something important to him through his drinking, or at least be threatened with such a loss. This may be a job, the threat of divorce, the loss of social prestige, or may be merely a feeling within the patient that he does not like himself or what he is doing because of his involvement with alcohol. It seems that the patient must suffer, and he must become convinced by reality factors that drinking is impossible for him. The counselor could, perhaps, facilitate "hitting bottom" by such pre-treatment information. More patient-counselor contact in the crucial initial stages of treatment could also be facilitated by this type of pre-treatment information. It was noted that during the period immediately following detoxification the patient often "forgets" how bad his condition was upon admission and was ready to leave professing that he had "learned his lesson." Fox (1957) stated that the desire to get well may come and go, depending upon the immediate circumstances surrounding the patient,

a point exemplified frequently in the treatment facility.

The use of such pre-treatment knowledge, however, could also have deleterious effects upon both patient and counselor alike. Goldstein, Hallerk, and Sechrest (1966) reported that the therapists' expectancies regarding improvement are positively related to actual improvement in therapy. Such pre-treatment information regarding motivation for treatment could serve to bias the counselor's attitude and subsequent approach toward the patient, thus affecting the relationship negatively. Goldfreid (1969) found that the initial impressions by both intake workers and therapists regarding the alcoholic's motivation for treatment, their personal liking for the patient, and the estimate of recovery were all intercorrelated. Knowledge that perhaps the patient is not yet motivated to stop drinking could serve to inhibit the counselor's approach by a projection of negative feelings onto the patient. The counselor then faces the possibility of reacting to his own negative attitude, rather than the patient's attitude. Such an interaction could serve to encourage further rejection of treatment in the patient, in which case the therapeutic effects of counselor contact are entirely eliminated.

In dealing with the patient scoring as an Early Discharge type, implications are that this type of patient can be predicted on the basis of POI pre-test scores. This type could also benefit from additional counseling or therapy. He has apparently "hit bottom" as far "self-concept" scores are concerned and could profit much more than the likely A. M. A. type from a concentrated early pre-treatment effort

on the part of the counselors. However, there is the possibility of confusing an early discharge type with an A. M. A. type in which case more harm than good would result. The A. M. A. obviously does not care about conforming to treatment. The early discharge type apparently does, yet does not want to complete treatment. A rationale is supplied by Ravensborg (1963) and in the POI scales measuring Capacity for Intimate Contact (C), Spontaneity (S), and Aggression (A). These scales suggest that the early discharge type is fearful of expressing his feelings behaviorally (perhaps one reason he does not leave A. M. A.), has difficulty making friends, and denies or represses feelings of anger. The combination of these three traits creates a picture of an individual who almost walks away, almost becomes angry enough to act on impulse, almost steps outside himself to relate to others, and almost finishes what he starts. This type of patient could very definitely benefit from additional counselor contact and treatment, the net effect being to enhance the probability of his actually completing treatment. Completion could serve to provide a positive experience with which to build the patient's self-confidence and improve the self-concept. By completing treatment, the patient would have a positive point of reference for completing other tasks which he felt heretofore impossibly difficult, thus enhancing continued growth and recovery.

In determining which patients would require treatment at the state mental facility, the POI pre-test shows existence of a great deal of overlap between all patients who fail to complete treatment

regardless of the reason why. Because of this, prediction of which patients belong is a specific patient type would be highly questionable. Perhaps the POI could be useful in determining the existance of "double-bind" situations frequently found in schizophrenics by looking at paired interpretations of scales comprising the areas of Valuing, Feeling, Self-Perception, Synnergistic Awareness, and Interpersonal Sensitivity. By noting differences in pairs, a measure of internal confusion and ambiguity could possibly be obtained for use in the patient-counselor relationship, or serve to promote further testing or psychotherapy.

In using the POI for the purpose of gathering pre-treatment data as an adjunct to alcoholism treatment, extreme caution should be utilized if the patient is to be helped and not hindered by the effects of such data. The only apparent value in use of such POI pre-test data would be to aid in determining who is likely to complete treatment, and who is likely not to. Even this could be a tenuous prediction to make on the basis of current data, and care would have to be taken so that it did not become a self-fulfilling prophecy.

As a dependent measure, the POI appeared to be adequate in terms of change over time. However, on the basis of the data obtained, it appears that Self-Actualization is not an accurate and adequate variable in dealing with the alcoholic in the treatment center environment. In this setting, the alcoholic is restricted to a certain extent in the methods whereby he may become "self-actualized." He is in a more regimented and protected environment and has little if any

contact with the "real" world. However, he is in constant contact with other individuals with a common problem: alcoholism. It is on the basis of this commonality that a more accurate dependent measure would perhaps be Schutz' FIRO-B (Schutz, 1958, 1967) which explains interpersonal behavior in terms of orientations to others. This orientation is explained in terms of the interpersonal needs of inclusion, affection, and control. The general assumption of Schutz' theory is that compatible groups will be more efficient than incompatible groups. Using the common affliction with the disease of alcoholism as a basis of comparability, it is believed that a more accurate measure of both the dynamics and effects of treatment and interpersonal interaction could be more accurately measure with FIRO-B. Since, however, the alcoholic has both a time orientation problem (he lives in the past and/or future) as well as a problem in being Other Directed and has difficulty relying on himself (the alcoholic is a very dependent individual), the POI is extremely useful in tapping these aspects. Perhaps a measure utilizing appropriate components of time and person orientation, and interpersonal needs would be more effective in measuring effects of treatment on the alcoholic.

Questionnaires, Implications, and Values of

The self-reporting questionnaire as a follow-up device for use with alcoholic patients N weeks after discharge proved to be inadequate. Over 50% failed to be returned at all. Thirty percent of 145 questionnaires were returned from both experimental and control groups combined. This suggests that a more effective means of

follow-up would perhaps be the direct interview; however, a pilot follow-up study of alcoholism patients (Wanberg, 1968) revealed some rather disconcerting information regarding alcoholics and follow-up. In a sample of 1,000 patients in which every tenth patient was selected for follow-up, (N = 100), 41 could not be located, five had died, 27 would not consent, and 27 did consent to be interviewed. The apparent mobility of the 41% who could not be traced suggests that alcoholics may be markedly alienated persons. This finding is consistent with findings in the present study utilizing the questionnaire. The outlook for post-treatment follow-up with alcoholics appears to be bleak indeed.

CHAPTER 5

SUMMARY

166 alcoholic patients admitted to a state alcoholism treatment center were assigned to one of seven experimental and three control groups. Experimental patients received all or part of a four week Interpersonal Communication Skills Program in addition to treatment provided by the treatment facility. Control patients received no Communication Skills Treatment.

Materials used consisted of a follow-up questionnaire, and Shostrum's Personal Orientation Inventory (POI) for the measurement of self-actualization in a pre- and post-test paradigm.

It was hypothesized that: (a) experimental patients would have higher POI ratios upon dismissal than controls, (b) experimental patients would have a higher rate of return of follow-up questionnaires than controls, (c) experimental patients would be more cooperative in complying with recommended A. A. follow-up than controls, (d) the longer the exposure to Skills treatment, the greater the change between pre- and post-POI scores, and (e) patients voluntarily committed to treatment would attain a higher degree of self-actualization in all conditions than patients on a non-voluntary commitment.

Results failed to support the hypotheses; the only exception being "type of commitment" which attained significance on two POI scales,

Self-Actualizing Values (Sav) Scale, and the Time Ratio.

Results suggested that patients who recognized their need for treatment and subsequently sought treatment were aware of the lack of self-actualizing values in their life-styles and therefore readily adhered to such principles. Voluntarily committed patients apparently realized that the future would be no better than the past if steps were not taken in the present, thus suggesting a greater degree of time competency for voluntary patients.

Several "types" of alcoholic patients presented themselves in treatment consisting of: (a) patients completing treatment (AT&R patients), (b) patients walking away from the treatment center (A. M. A. patients), (c) early discharge patients and, (d) patients with emotional problems in addition to alcoholism. Implications were that the "early Discharge Type" represented an entirely different type of alcoholic patient.

Graphic results indicated no apparent effect of treatment as measured by POI. The effects of partial versus full Skills Treatment showed the first two and the last three weeks of the Skills Program as being most effective in terms of Self-Actualization. The full four week experimental program patients noted a decline in Self-Actualization compared to no experimental treatment groups. However, the full treatment group showed signs of stabilizing around a "middle" response.

Findings suggested that the alcoholic in treatment presented an extremely unpredictable individual; that Self-actualization was,

perhaps, an unreliable dependent measure for alcoholism studies; and that interaction of two treatment modalities operating concurrently tended to confound results.

It was suggested that: (a) further research should focus on Communication Skills as the only modality in operation at a given time, (b) post-testing be administered at a specific time in relation to notification of discharge, and (c) the concept of time be included as a variable for Communication Skills exercise.

The POI was deemed a valuable adjunct to counseling; however, as a predictive device, extreme caution was suggested.

The self-reporting questionnaire was found to be of no value as a means of follow-up with alcoholic patients.

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APPENDIX A

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol. . . that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humble asked him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of his will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we

tried to carry this message to alcoholics, and to practice these principles in all our affairs.

APPENDIX B

FOLLOW-UP QUESTIONNAIRE

Dear AT & R Graduate:

The following questionnaire is part of a follow-up study being done by the Alcoholism Treatment Center at Galen, Montana in conjunction with a special project dealing with alcoholism treatment and recovery. Your help will be greatly appreciated in assisting in this study. The information you supply will be used for further research in alcoholism. We hope that things are going well for you since you left the treatment center. Thank you in advance for your participation and help. Please read the following instructions before completing the questionnaire.

INSTRUCTIONS

DO NOT sign your name or break your anonymity in any way. Please check the space which most closely represents the way you now feel about the questions asked. Please try to answer ALL the questions and return the questionnaire in the enclosed envelope. Thank you. Your help is greatly needed and appreciated.

1. Are you currently attending A. A. meetings? Yes___. No___.
2. Did you contact A. A. as soon as you returned home? Yes___. No___.
3. Are you currently employed? Yes___. No___.
4. Has you relationship with you family
   Improved___, Remained the same___, or gotten worse___ since you returned home?

5. Do you find yourself thinking more in terms of the past___, present___, future___?

6. Do you feel that what a person has been in the past means that he will be that kind of person?

   Always___ Usually___ Sometimes___ Never___

7. Do you feel obligated when someone does you a favor?

   Always___ Usually___ Sometimes___ Never___

8. Do you feel that it is important to accept others as they are?

   Never___ Sometimes___ Usually___ Always

9. Do you feel as if you can risk "being yourself" now?

   Never___ Sometimes___ Usually___ Always___

10. Can you express affection toward another even if it is not returned?

    Never___ Sometimes___ Usually___ Always___

11. Can you give without requiring the other person to appreciate what you give?

    Never___ Sometimes___ Usually___ Always___

12. Do you trust the "Spur of the Moment" decisions you sometimes have to make?

    Never___ Sometimes___ Usually___ Always___

13. Do you find it necessary for others to accept your point of view?

    Sometimes___ Never___ Always___ Usually___

14. Do you feel it necessary to defend your past actions?

    Usually___ Always___ Sometimes___ Never___

15. Do you feel that being yourself is helpful to others?

    Never___ Always___ Sometimes___ Usually___

16. Do you feel that people are basically good?

Always___ Sometimes___ Usually___ Never___

17. Would you risk a friendship in order to say or do what you believe is right? Always___ Usually___ Sometimes___ Never___

18. Do you believe in saying what you feel when dealing with others?

Never___ Sometimes___ Usually___ Always___

APPENDIX C

INTERPERSONAL COMMUNICATION SKILLS PROGRAM

Week #1
Day #1

Total Group Meeting
Time Required: 60 Minutes

An introductory session in which all patients were assembled in the main lounge and informed by the investigator as to the purpose, rationale, and brief overview of the Skills Program. A brief lecture focusing on the following communication principles was given.

1. You cannot, not communicate.
2. Meanings for words lie in people, not in the words they use.
3. When people speak, they are actually convincing themselves further of that which they speak.
4. The interpersonal needs of inclusion, affection and control: how they are satisfied by communication.
5. New thought, which is essential to A. A. recovery, is given birth by virtue of communicating with others.

Interpersonal Communication Skills were defined as those skills which enable people to deal with the communication problems encountered in daily living; as a learned phenomenon which can help in the maintenance of sobriety by:

1. Enabling people to "speak up" at A. A. meetings.
2. Helping to build lasting, meaningful, and NEW relationships with people other than "drinking buddies" by enhancing in each person the development of

a. Honesty

b. Openness

c. Trust

The purpose of the Communication Skills Program was explained as being the teaching of basic interpersonal communication skills by means of active participation in which the patients could see for themselves that everybody and anybody can be a good communicator and reap benefits from it.

The One-Way and Two-Way Communication Exercise (Appendix C_1) was utilized to show the superior functioning of a Two-Way Communication through participatory demonstration and to examine the application of communication in family, social, and occupational settings. A post-exercise discussion in which active participation was encouraged focused on the following points.

1. What are the differences between the two types of communication?
2. The one-way type of communication is characteristic of the active alcoholic. . . even during "dry" periods.
   a. When the alcoholic becomes angry and defensive, he "clams up." No questions are asked, no feedback is given. . . One-Way Communication ensues.
   b. How does this apply to YOUR individual communication?
3. It is your responsibility to communicate.
4. One-Way communication is ineffective, and ineffective is

what the alcoholic becomes when he/she drinks.

Patients were informed of the mini-groups to which they were assigned along with the day and time each group met with the investigator for communication skills exercises. This information was then posted on the bulletin board of the main lounge. It was stated that each patient was responsible to check each week to see which group he was in as the group membership rotated to facilitate new relationships among individuals. The entire group was instructed to assemble each Thursday evening from 6 to 7 p.m. in the main lounge with the investigator for communication lectures, discussion, and exercises.

The mini-group exercises utilized for week #1 was the Group Conversation Exercise (Appendix C_2). The goals of this exercise were to develop a compatible group climate and readiness for interaction through sharing common personal experiences, a factor crucial in the recommended A. A. follow-up.

Week #2

Total Group Meeting
Time Required: 60 minutes

All patients were assembled in the main lounge. A brief lecture on the concept of meaning and the distortions brought about by individual meanings assigned to words used by another person. The lecture content consisted of:

1. A restatement of "meanings are in people, not words."
2. An example showing how distortion occurs by using real patients and real occurrances at the hospital known to all

patients, and to which all could relate.

A Serial Transmission Effect exercise was used as a total group exercise to substantiate the previous lecture and examples of distortion. Five patients were recruited from the group. Four were asked to leave the room while the other stayed and read an article from a local newspaper. This patient was then asked to read the article aloud to the entire group and then tell, from memory, one of the four patients outside what was stated in the article. This all took place in the presence of the entire group. The remaining patients did likewise, with the ensuing distortions serving to substantiate the point of the exercise on distortion, how it occurs, and its effects.

A post-exercise lecture/discussion focusing on how and why distortion in message occur included the following:

1. Differences in backgrounds, personalities, and expectations.
2. Selective listening.
3. Rumors.
4. Effects of distorted communication.
    a. Resentment: a number one enemy of the alcoholic.
    b. Family problems.
    c. Job problems.
    d. Distrust.
5. A possible solution: active, accurate listening.

The mini-group exercise utilized was a modification of Jourand's Intimacy Game (Appendix C_3) in order to begin to experience self-

disclosure and to develop a sense of authenticity in the mini-groups.

Week #3 — Total Group Meeting
Time Required: 60 minutes

All patients assembled in the main lounge. A lecture/discussion focusing on the concept of "Feedback" was held. Examples were given of feedback in daily living, and then in relation to communication. The positive-negative/helpful-unhelpful feedback matrix and good feedback model (Appendix C_4) was illustrated. A lecture followed focusing on:

1. Feedback was defined as what you do when something is said, done, or happens to you.
2. In human communication, feedback occurs when you see or hear what someone else says or does as being a response or reaction to you.
   a. Awareness as to how the other person reacts is necessary for feedback to exist.
3. People have a need to receive feedback in order to:
   a. Satisfy the interpersonal needs of inclusion, affection, and control.
   b. To determine how others perceive you.
4. The type of feedback received is what forms our self-concepts to a great extent, and therefore the kind of person we "must" be.
5. The need to give feedback
   a. Not only does a person need other people, he also has

a need to know that he too is needed.

6. There are two types of feedback, positive and negative. There are helpful and unhelpful types of each.

7. In good feedback, awareness on <u>your</u> part is the key word.

The mini-group exercise used for the week was a modification of the Dyadic Encounter (Appendix C_5). The goal was to explore knowing and trusting another person through deeper and more involved self-disclosure and risk-taking.

Week #4 — Total Group Meeting
Time Required: 60 minutes

All patients assembled in the main lounge. A brief lecturette summing up the Communication Skills Program was given. The summary consisted of the following:

1. Communication is a necessary part of daily living.
2. Good communication practices can be learned by anybody.
3. Some of the effects of good communication practices are:
   a. Understanding of self and others.
   b. Trust.
   c. Awareness of self and others.
   d. Development of new and meaningful relationships.

A brief discussion was held on behavior change and behavior change goal setting (Appendix C_6). Each patient was given a copy of the Behavior Change Goal Setting Worksheet (Appendix C_7) and instructed to fill it out and bring it to their mini-group meeting that week. It was announced that those patients being dismissed that week

could come to the investigator's office to take the POI post-test and compare pre- and post-treatment POI scores.

The mini-group exercise for the week was the interviewing Pairs Exercise using the Group Member Interview Guide (Appendix C_8). The purpose of the exercise was to give the patients an opportunity to try out new behaviors, particularly those listed by them on their Behavior Change Goal Setting Worksheets; to allow them to give and receive feedback; practice active, accurate listening; and one last opportunity to speak in a group similar to the recommended A. A. follow-up group before being discharged.

APPENDIX C_1

ONE-WAY AND TWO-WAY COMMUNICATION

Goals

I. To conceptualize the superior functioning of two-way communication through participatory demonstration.

II. To examine the application of communication in family, social and occupational settings.

Group Size

Minimum of ten.

Time Required

Unlimited.

Materials Utilized

I. Chalkboard, chalk, and eraser.

II. Two sheets of paper and a pencil for each participant.

III. Reproductions of Chart I and Chart II.

Physical Setting

Participants should be facing the demonstrator and sitting in such a way that it will be difficult, if not impossible, to see each other's drawings. In the first phase of the exercise the demonstrator turns his back to the group or stands behind a screen.

Process

I. The facilitator may wish to begin with a discussion of ways of looking at communication in terms of content, direction, networks, or interference.

II. The facilitator indicates that the group will experiment with the directions aspects of communication by participating in the following exercise:

A. Preliminaries: The facilitator selects a demonstrator and one or two observers. Participants are supplied with a pencil and two sheets of paper, one labeled Chart I and the other labeled Chart II.

B. Directions: The group is told that the demonstrator will give directions to draw a series of squares. The participants are instructed to draw the squares exactly as they are told by the demonstrator. These drawings will be made on the paper labeled Chart I. The participants may neither ask questions nor give audible responses.

1. Demonstrator is asked to study the diagram of squares for a period of two minutes.
2. The facilitator instructs the observers to take notes on the behavior and reactions of the demonstrator and/or the participants.
3. The facilitator places three small tables, as follows, on the chalkboard.

TABLE 1

MEDIANS	I	II
Time Elapsed		
Guess Accuracy		
Actual Accuracy		

TABLE 2

Number Correct	Guess	Actual
5		
4		
3		
2		
1		
0		

TABLE 3

Number Correct	Guess	Actual
5		
4		
3		
2		
1		
0		

4. The facilitator asks the demonstrator to proceed, reminding him to tell the group what to draw as quickly and accurately as he can. The facilitator will also caution the group not to ask questions and not to give audible reactions.
5. The time it takes the demonstrator to complete his instructions is recorded in Table 1.
6. Each participant is asked to estimate the number of squares he has drawn correctly in relation to the other squares.

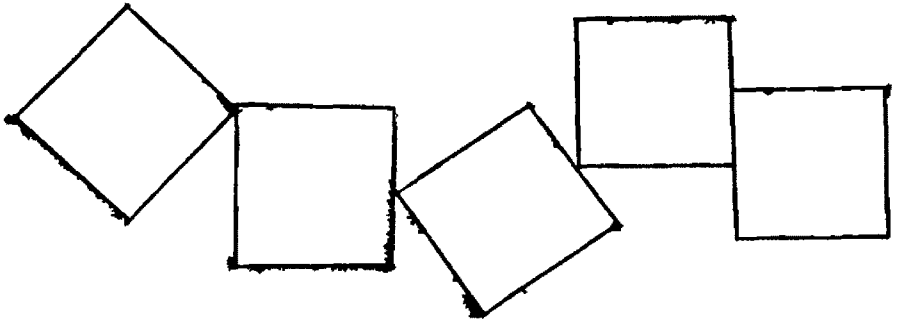
7. Repeat the experience with the following modifications: the demonstrator uses Chart II, facing the group, and is allowed to reply to questions from the group.
8. The facilitator determines the median for guess accuracy for trials one and two based upon the individual estimations of accuracy and and indicates these on Table 2 and Table 3.
9. The group is then shown the master charts for the two sets of squares and asked to determine the actual accuracy.
10. The facilitator determines the median for actual accuracy for trials one and two based upon the individual scores.

III. A discussion of the results in terms of time, accuracy, and level of confidence should follow, calling upon "back-home" experience and application.

IV. The observers offer their data, and the group discusses it in relation to the data generated during the first phase of the discussion.

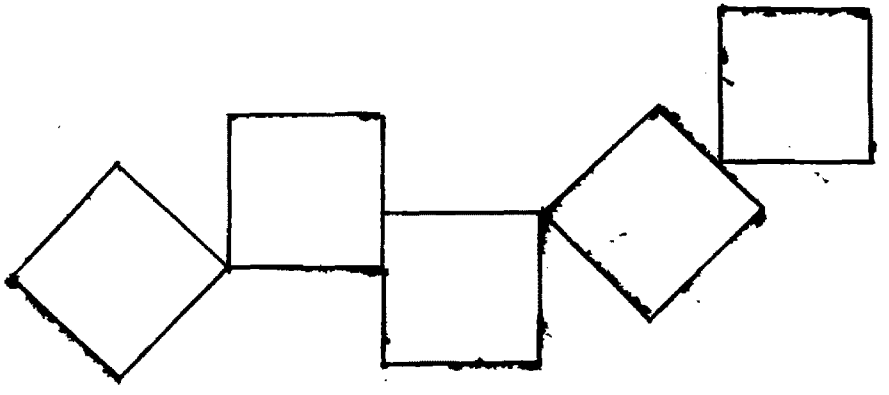
This exercise is adapted from Harold J. Leavitt's book, Managerial Psychology, University of Chicago Press, 1958, pp. 118-128.

CHART I. ONE-WAY COMMUNICATION



INSTRUCTIONS: Study the figures above. With your back to the group, you are to instruct the participants how to draw them. Begin with the top square and describe each in succession, taking particular note of the relationship of each to the preceding one. No questions are allowed.

CHART II. TWO-WAY COMMUNICATION



INSTRUCTIONS: Study the figures above. Facing the group, you are to instruct the participants how to draw them. Begin with the top square and describe each in succession, taking particular note of the relation of each to the preceding one. Answer all questions from participants and repeat if necessary.

APPENDIX C_2

GROUP CONVERSATION

Goal

To develop a compatible climate and readiness for interaction in a group through sharing the commalities of personal experience.

Sub-goals for specific group situations:

I. To involve those who do not know each other or who have prejudices or resentments toward each other by relating quickly at an affective level.

II. To give members of a group a feeling for and appreciation for what appears commonplace in their lives.

III. To get people off the intellectual treadmill.

IV. As an ice breaker.

V. To integrate newcomers into a group.

VI. For intercultural, interracial, interreligious sharing.

Group Size

Twelve or more members. When the group consists of fewer than twelve members, the experience may become more intense than intended.

Time Required

Group conversation can be a fifteen minute prelude to other group activities or may be palnned for up to an entire evening or sev-

eral meetings, depending upon the needs of the individual group.

Materials Utilized

Conversation Starters from the facilitator.

Physical Setting

Group members should sit in a circle. This is the most effective setting since it provides for easier verbal communication, group observation of individuals' reactions, and an atmosphere of inclusion.

Process

The facilitator must be able to provide a comfortable balance between autocratic and democratic leadership of the group is to function well. This means that he must be prepared to refocus the group on personal feelings and experiences if it shifts to intellectualizing; it also means that he must tactfully intervene if one member is taking up more than his share of the time.

I. The facilitator prepares the group by explaining that in Group Conversation, the participants share experiences rather than opinions. Thus it is not to be confused with group discussion, which is problem-and-intellect centered as opposed to person-and-feeling centered, as is Group Conversation. He may wish to lecture briefly on the following theme: When a group of persons exchange memories of experiences of sorrow and/or joy, a warmth and closeness usually developes quietly and quickly.

II. The facilitator chooses a general theme or an item from

the Conversation Starters Form.

III. The facilitator encourages conversation to begin with descriptions of childhood experiences which illustrate the individual member's feelings and attitudes toward the subject. The facilitator may need to ask questions which help group members to describe their experiences. As the conversation progresses, the facilitator allows it to move on into post-childhood experiences and then into the present. The participants should see the progression of certain ideas or themes.

IV. The facilitator leads a brief discussion of the Group Conversation Experiences.

Conversation Starters

1. Other people usually. . .
2. The best measure of personal success is. . .
3. Anybody will work hard if. . .
4. People will think of me as . . .
5. When I let go. . .
6. Marriage can be. . .
7. Nothing is so frustrating as . . .
8. People who run things should be. . .
9. I miss. . .
10. The thing I like about myself is. . .
11. There are times when I. . .
12. I would like to be. . .

13. When I have something to say. . .

14. As a child I. . .

15. The teacher I liked best was a person who. . .

16. It is fun to. . .

17. My body is. . .

18. When it comes to girls. . .

19. Loving someone. . .

20. Ten years from now, I. . .

APPENDIX C_3

INTIMACY GAME GUIDELINES

Directions: During the time allotted for this experience you are to ask questions from this list. The questions vary in terms of their intimacy, and you may want to begin with some relatively less intimate ones. You may take turns initiating the questions. Follow the rules below.

1. Your communication with your partner will be held in confidence.
2. Any question that you ask your partner you must be willing to answer yourself.
3. You may decline to answer any questions initiated by your partner.

How important is religion in your life?

What is the source of your financial income?

What is your favorite hobby or leisure interest?

What do you feel most ashamed of in your past?

Have you ever cheated?

Have you deliberately lied about a serious matter?

What is the most serious lie you have told?

Have you been arrested or fined for violating any law?

Have you any health problems? What are they?

Have you ever had a mystical experience?

What do you regard as your chief fault in personality?

What turns you on the most?

How do you feel about interracial dating or marriages?

Do you consider yourself a liberal or conservative with regard to political parties?

What turns you off the fastest?

What features of your appearance do you consider most attractive to members of the opposite sex?

What do you regard as your least attractive features?

How important is money to you?

Are you divorced? Have you ever considered divorce?

To what clubs do you belong?

What person would you most like to take a trip with right now?

How do you feel about swearing?

Do you smoke marijuana or use drugs?

Do you enjoy manipulating or directing people?

Are females equal, inferior, or superior to males?

How often have you needed to see a doctor in the past year?

Have you ever been tempted to kill yourself?

Have you ever been tempted to kill someone else?

Would you participate in a public demonstration?

What emotions do you find it most difficult to control?

Is there a particular person you wish would be attracted to you? Who? Give name.

What foods do you most dislike?

What are you most reluctant to discuss now?

To what person are you responding the most and how?

What is your IQ?

Is there any feature of your personality that you are proud of? What is it?

What was your worst failure in life, your biggest disappointment to yourself or your family?

What is your favorite TV program(s)?

What is your most chronic problem at present?

What is the subject of the most serious quarrels you have had with your parents?

What is the subject of your most frequent daydreams?

How are you feeling about me?

What are your career goals?

With what do you feel the greatest need for help?

What were you most punished or criticized for when you were a child?

How do you feel about crying in the presence of others?

What activities did you take part in in high school?

How could you improve your present living arrangement?

Do you have any misgivings about this group so far?

What is your main complaint about this group?

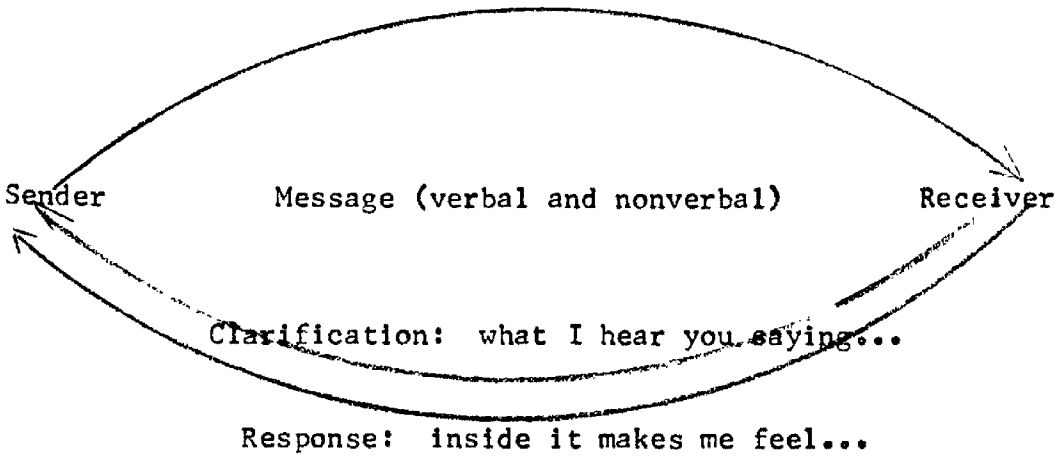
Do you like your name?

If you could be anything/anyone--besides yourself--what/who would you be?

Who in the group don't you like?

APPENDIX C_4

THE GOOD FEEDBACK MODEL



Effective Feedback Should Be:

1. Descriptive of my feelings rather than evaluative of others
2. Specific rather than general
3. About behavior that is observable and can be changed

NOTE: The receiver of feedback is in charge of his own life. He can accept or reject the feedback. He can change or not change, whether or not he accepts the validity of the feedback.

HANDOUT SESSION #3 (CSW)

POSITIVE-NEGATIVE/FUNCTIONAL-DYSFUNCTIONAL FEEDBACK MATRIX

	(+)Positive Feedback Purpose: Reinforcing and approving of behavior.	(-)Negative Feedback Purpose: Suggesting that change is necessary.
Functional Feedback (helpful)	Examples: 1. "It really made me feel good when you took your time to talk to me when I was so upset." 2. I like it when you look at me while I am talking to you. I feel comfortable and it lets me know you are understanding me.	Examples: 1. I feel uncomfortable when you avoid looking at me while talking. It seems like you are not interested in what I am saying. 2. I feel hurt when you keep borrowing my things without asking because it seems like you have no respect for me.
Dysfunctional Feedback (unhelpful)	1. You're really a neat person. 2. You really have cool eyes.	1. Quit being so bashful. 2. You are such a slob.

APPENDIX C_5

MODIFIED DYADIC ENCOUNTER

Read silently. Do not look ahead in this booklet. 1

A theme that is frequently voiced when persons are brought together for the first time is "I'd like to get to know you, but I don't know how."

Getting to know another person involves a learnable set of skills and attitudes. The basic dimensions of encountering another person are self-disclosure, self-awareness, non-possive caring,

risk-taking, trust, acceptance, and feedback. In an under- 2
standing, non-evaluative atmosphere one confides significant data about himself to another, who reciprocates by disclosing himself. This "stretching" results in a greater feeling of trust, understanding, and acceptance, and the relationship becomes closer, allowing more significant self-disclosure and greater risk-taking.

This dyadic encounter experience is designed to facilitate 3
getting to know another person on a fairly intimate level. The discussion items are open-ended statements and can be completed

at whatever level of self-disclosure one wishes.

The following ground rules should govern this experience:

All of the data discussed should be kept strictly confi- 4
dential.

Don't look ahead in the booklet.

Each partner responds to each statement before continuing. The statements are to be completed in the order in which they appear. Don't skip items.

You may decline to answer any questions asked by your partner.

Stop the exercise when either partner is becoming obviously uncomfortable or anxious. Either partner can stop the exchange. Look up. If your partner has finished reading, turn the page and begin.

My name is_____ 5

_____

My titles are_____ 6

_____

My marital status is_____ 7

_____

My home town is_____ 8

_____

The reason I'm here is_____ 9

_____

Right now I'm feeling_____ 10

One of the most important skills in getting to know another person is listening. In order to get a check on your ability to understand what your partner is communicating, the two of you should go through the following steps one at a time. 11

Decide which one of you is to speak first in this unit.

The first speaker is to complete the following item in two or three sentences:

When I think about the future, I see myself_____ 12

The second speaker repeats in his own words what the first speaker has just said. The speaker must be satisfied that he has heard accurately.

The seond speaker then completes the item himself in two or three sentences.

The first speaker paraphrases what the second speaker just said, to the satisfaction of the second speaker.

Share what you may have learned about yourself as a listener with your partner. The two of you may find yourselves later saying to each other, "What I hear you saying is_____." To keep a check on the accuracy of your listening and understanding. 13

When I am in a new group I_____ 14

_____

When I enter a room full of people I usually feel_____ 15

_____

When I am feeling anxious in a new situation I usually_____ 16

_____

In groups I feel most comfortable when the leader_____ 17

_____

Social norms make me feel_____ 18

_____

I am happiest when_____ 19

_____

The thing that turns me on the most is_____ 20

_____

Right now I'm feeling_____ 21

_____

The thing that concerns me the most about joining groups is____ 22

_____

When I am rejected I usually_____ 23

_____

To me, belonging is_____ 24

_____

A forceful leader makes me feel_____ 25

_____

Breaking rules that seem arbitrary makes me feel_____ 26

_____

I like to be just a follower when_____ 27

_____

The thing that turns me off the most is_____ 28

_____

I feel most affectionate when_____ 29

_____

Toward you right now, I feel_____ 30

_____

When I am alone I usually_____ 31

_____

In crowds I _____ 32

_____

In a group I usually get most involved when_____ 33

Listening check: "What I hear you saying is_____

_____

To me, taking orders from another person_____ 34

_____

I am rebellious when_____ 35

_____

Checkup: Have a two or three minute discussion this exper- 36
ience so far. Keep eye contact as much as you can, and try
to cover the following points:

How well are you listening?

How open and honest have you been?

How eager are you to continue this interchange?

Do you feel that you are getting to know each other?

The emotion I find most difficult to control is_____ 37

My most frequent daydreams are about_____ 38

My weakest point is_____ 39

I love_____ 40

I feel jealous about_____ 41

Right now I'm feeling_____ 42

I am afraid of_____ 43

I am most ashamed of_____ 44

I believe in_____ 45

Right now I am most reluctant to discuss_____ 46

Right now this experience is making me feel_____ 47

The thing I like best about you is_____ 48

You are_____ 49

_____

What I think you need to know is_____ 50

_____

APPENDIX C_6

BEHAVIOR-CHANGE GOAL SETTING

You have entered this workshop experience with the hope, indeed the expectation, that it will be growth producing in some way. By this it is generally meant that as a result of your participation in this experience, you will be better able to change some aspect of yourself in a way that is deemed important to you.

Two goals of this program were initially stated:

1. To learn more effective ways of communicating to others, and
2. To be able to enter into personal relationships in a more meaningful way.

Although these goals were rather explicitly stated and, in fact, provided the guidelines upon which to structure this workshop experience, such goals, nevertheless, continue to pose some problems for you, the individual group member. First, concepts such as "effective communication" and "meaningful personal relationships" are so global as to make it difficult for individuals to understand exactly what is implied in them. Second, and more important, such terms in no way provide for <u>unique</u> and <u>personal</u> ways of receiving such goals and approaching them within the framework of your own <u>needs</u> and <u>life style</u>. For this reason, it is felt that each group member should begin to tune in on the above goals, to <u>redefine</u> them in a more <u>concrete</u>

and specific way, and to make them more personally relevant. We call this behavior-change goal setting.

It should be noted that the emphasis of this process is on behavioral change rather than a change in feelings or attitudes. This is not to infer than underlying feelings are unimportant. Rather, it felt that overt behaviors are more easily dealt with (changed) than feelings. Secondly, because behaviors are observable not only to self, but also to others, they provide a more objective and accurate measure of how much change has actually taken place. It should be mentioned also that it is our strong conviction that behavioral change does in fact lead to changes in feelings and attitudes. (You may want to discuss this further.)

The following procedure has been found to be helpful in assisting people to develop individualized behavioral-change goals that are very specific. The assumption is that you can work on changing a specific behavior and that your success in this endeavor will generalize to broader aspects of both behavior and feelings.

Behavioral change-goals, then, have the following characteristics:

1. They represent behaviors that are overt (observable by others),
2. They are individualized for each participant,
3. They are very specific.

In order to assist you in developing your own individualized behavior change goals, the following steps should be followed:

1. Goal: Think about what change(s) you would consider to be most important as a result of this workshop experience.
2. Behavioral Goal: "Translate" the above mentioned desired changes into behavioral terms. One good way to do this is to ask yourself "How would I behave differently if I reached my goal?"
3. Observable Behavioral Goal: The next step is to assist making this behavioral goal as observable as possible. It is often helpful to think in terms of:
   a. how might someone else know that I have changed
   b. what would I be doing
   c. when will I be doing it
   d. where would I be doing it
   e. what would I be saying.
4. Specific Observable Behavioral Goal: In order to make your observable behavioral goal even more specific, two helpful guides are mentioned:
   a. Limit the scope of the behavior. For example, you might limit your behavioral goal in to talking in conversations initiated by others, leaving out initiating conversation yourself (which might be a later goal).
   b. Limit the time, place, person or context. For example, you might limit your behavioral goal to talking in conversations initiated by others
      1) During the dinner hour
      2) In the cafeteria

3) To your counselor

4) When men are present, when women are present.

5. Base Rate: Where are you now in terms of your specific goal? To answer this question, consideration should be given to how frequently you do this now or how well you do this now. Assessing your current level and rate of functioning will help you to evaluate the extent to which change has in fact taken place.

6. Criteria of Failure: Your specific behavioral goal(s) can be even further refined by considering "How would I or somebody else know that I have failed in achieving my goal?" Criteria of failure, again, should be observable and specific.

7. Realistic: Evaluate your behavioral goal(s) to see whether it is realistic in terms of:

   a. your present behavior in that area,

   b. whether external circumstances would make it possible for you to achieve this goal. It is vital that you generate goals that are achievable!

8. Important Check: After doing all this, stop and think (one last time) if the behavioral goal(s) you have chosen is the one(s) that is really the most important one to you.

APPENDIX C_7

BEHAVIOR GOAL-SETTING WORKSHEET

1. Go off by yourself and begin thinking of behavior change goals which you feel are important and relevent to improving your level of social interaction: _____within this group, _____within your present living environment. You might begin by asking the question, "In what way would I like to see myself behaving that would be different than I am now?" List three or four ideas below:

   a.

   b.

   c.

   d.

   e.

2. Out of this list, choose the two most important goals and write them below in order of their importance to you:

   Goal 1

   Goal 2

3. Now, let's see if these two goals can be (or need be) stated in more behavioral or specific terms. Refer back to our discussion of goal setting when needed.

   a. Goal 1 - Answer the following questions about Goal 1:

      1. What would I be doing if I were accomplishing my goal?

2. What specific things would I be saying while I was accomplishing my goal?

3. How might someone else know that I have changed?

4. When will I be doing it?

5. Where will I be doing it?

b. Goal 2 - Answer the same questions about Goal 2 in the spaces below:

1. What would I be doing if I were accomplishing my goal?

2. What specific things would I be saying while I was accomplishing my goal?

3. How might someone else know that I have changed?

4. When will I be doing it?

5. Where will I be doing it?

4. Which of your two goals do you think you have the greatest possibility of accomplishing? Goal_____ Why?

5. After tentatively identifying the two most important behavior goals, get together with other group members and a group leader. During this time work with each other to further clarify your goals if necessary.

a. Each participant read his goals to the group.

b. Review each other's goals if they can be stated any more specifically (behaviorally).

c. After you have clarified your goals with others in your group, state your goals below with any changes you have made.

Goal 1

Goal 2

d. Choose the one goal that you feel you have the highest probability of accomplishing within the shortest time period. Write this goal on a separate sheet of paper along with your name and give this to the group leader. This becomes your immediate change goal to be worked on during the coming workshop sessions.

APPENDIX C_8

GROUP MEMBER INTERVIEW GUIDE

Directions:

1. Decide who will be the first to be interviewed.
2. Conduct a ten-minute interview focusing on the interview questions below. The interviewer (the one asking the questions) should give feedback to the one answering the questions by summarizing the answer to each question before going on to the next question.
3. After ten minutes, repeat the process by switching roles so that each person has a chance to interview the other person.
4. Take about three minutes to talk about what you just did (the interview experience).
5. GIVE A BRIEF REPORT TO THE ENTIRE GROUP ON THE PERSON YOU JUST INTERVIEWED.

Interview Questions:

1. What personal goals do you have which you might work toward at this time? (Be as specific as possible.)
2. What concerns do you have about your stay here so far? About this group so far? (Be as specific as possible.)
3. What personal concerns are you willing to share with this whole group right now? (For example, concerns about how you see yourself, about your impact on the group, your weaknesses, your interpersonal relationships.)

APPENDIX D

TABLE 2. PERCENT OF PATIENTS LYING ABOVE AND BELOW MEDIAN CHANGE BY TREATMENT GROUP

POI Scale	Treatment Group		% Above	Median	% Below
Time Incompetence (Ti)	E_1		50	2.0	50
	E_2	Partial	100		0
	E_3		50		50
	$^1E_4$ $^6E_4$	Full	50		50
	E_5		55		45
	E_6	Partial	27		73
	E_7		$33\frac{1}{3}$		$66\frac{2}{3}$
	C_1 C_4	No Skills	25		75
Support Ratio	E_1		0	.36	100
	E_2	Partial	50		50
	E_3		0		100
	$^1E_4$ $^6E_4$	Full	28		72
	E_5		55		45
	E_6	Partial	0		100
	E_7		0		100
	C_1 C_4	No Skills	16		84

TABLE 2. (CONTINUED)

POI Scale	Treatment Group		% Above	Median	% Below
Time Competence (Tc)	E_1		50	2.0	50
	E_2	Partial	100		0
	E_3		50		50
	$^1E_4$ $^6E_4$	Full	48		52
	E_5		55		45
	E_6	Partial	27		73
	E_7		$33\frac{1}{3}$		$66\frac{2}{3}$
	C_1 C_4	No Skills	25		75
Other Directed (O)	E_1		$33\frac{1}{3}$	1.0	$66\frac{2}{3}$
	E_2	Partial	50		50
	E_3		25		75
	$^1E_4$ $^6E_4$	Full	57		43
	E_5		$66\frac{2}{3}$		$33\frac{1}{3}$
	E_6	Partial	64		36
	E_7		$66\frac{2}{3}$		$33\frac{1}{3}$
	C_1 C_4	No Skills	71		29
Inner Directed (I)	E_1		0	5.2	100
	E_2	Partial	50		50
	E_3		25		75
	$^1E_4$ $^6E_4$	Full	53		47

TABLE 2. (CONTINUED)

POI Scale	Treatment Group		% Above	Median	% Below
Inner Directed (I)	E_5		71	5.2	37
	E_6	Partial	55		45
	E_7		50		50
	C_1 C_4	No Skills	63		37
Self-Actualizing Value (Sav)	E_1		67	1.5	33
	E_2	Partial	66		34
	E_3		25		75
	$^1E_4$ $^6E_4$	Full	32		68
	E_5		55		45
	E_6	Partial	37		63
	E_7		67		33
	C_1 C_4	No Skills	50		50
Existentiality (Ex)	E_1		17	2.0	83
	E_2	Partial	50		50
	E_3		25		75
	$^1E_4$ $^6E_4$	Full	34		66
	E_5		64		36
	E_6	Partial	55		45
	E_7		34		66
	C_1 C_4	No Skills	34		66

TABLE 2. (CONTINUED)

POI Scale	Treatment Group		% Above	Median	% Below
Feeling Reactivity (Fr)	E_1		36	1.0	64
	E_2	Partial	50		50
	E_3		25		75
	$^1E_4$ $^6E_4$	Full	50		50
	E_5		55		45
	E_6	Partial	37		63
	E_7		17		83
	C_1 C_4	No Skills	25		75
Spontaneity (S)	E_1		50	2.5	50
	E_2	Partial	50		50
	E_3		25		75
	$^1E_4$ $^6E_4$	Full	32		68
	E_5		55		45
	E_6	Partial	0		100
	E_7		34		67
	C_1 C_4	No Skills	25		75
Self-Regard (Sr)	E_1		17	2.5	83
	E_2	Partial	50		50
	E_3		0		100

TABLE 2. (CONTINUED)

POI Scale	Treatment Group		% Above	Median	% Below
Self-Regard (Sr)	$^{1}E_{4}$ $^{6}E_{4}$	Full	34	2.5	66
	E_5		55		45
	E_6	Partial	28		72
	E_7		66		34
	C_1 C_4	No Skills	45		55
Self-Acceptance (Sa)	E_1		0	1.5	100
	E_2	Partial	50		50
	E_3		25		75
	$^{1}E_{4}$ $^{6}E_{4}$	Full	53		47
	E_5		64		36
	E_6	Partial	36		64
	E_7		50		50
	C_1 C_4	No Skills	83		17
Nature of Man, Constructive (Nc)	E_1		0	2.0	100
	E_2	Partial	0		100
	E_3		0		100
	$^{1}E_{4}$ $^{6}E_{4}$	Full	23		77
	E_5		28		72
	E_6	Partial	28		72
	E_7		34		66

TABLE 2. (CONTINUED)

POI Scale	Treatment Group		% Above	Median	% Below
Nature of Man, Constructive (Nc)	C_1 C_4	No Skills	16	2.0	84
Synnergy (Sy)	E_1		0	1.0	100
	E_2	Partial	0		100
	E_3		25		75
	$^1E_4$ $^6E_4$	Full	23		77
	E_5		19		81
	E_6	Partial	19		81
	E_7		34		66
	C_1 C_4	No Skills	33		67
Aggression (A)	E_1		34	1.5	66
	E_2		50		50
	E_3		50		50
	$^1E_4$ $^6E_4$	Full	37		63
	E_5		82		18
	E_6	Partial	46		54
	E_7		34		66
	C_1 C_4	No Skills	19		81

TABLE 2. (CONTINUED)

POI Scale	Treatment Group		% Above	Median	% Below
Capacity for Interpersonal Relationships (C)	E_1		17	3.0	83
	E_2	Partial	50		50
	E_3		0		100
	$^1E_4$ $^6E_4$	Full	32		68
	E_5		63		37
	E_6	Partial	19		81
	E_7		0		100
	C_1 C_4	No Skills	21		79
Time Ratio	E_1		17	.66	83
	E_2	Partial	50		50
	E_3		0		100
	$^1E_4$ $^6E_4$	Full	36		64
	E_5		37		63
	E_6	Partial	9		91
	E_7		34		66
	C_1 C_4	No Skills	19		81