

REDUCTION OF ANOMIE THROUGH THE USE OF
SAY IT STRAIGHT™ TRAINING

Thomas Erin Wood, B. M., M. Ed.

Dissertation Prepared for the Degree of
DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

December 2004

APPROVED:

James Kitchens, Major Professor
Paula Englander-Golden, Minor Professor
Vijay Pillai, Committee Member
Mahmoud Sadri, Committee Member
M. Deb Corley, Committee Member
Rudy Ray Seward, Chair of the Department of
Sociology
David Hartman, Dean of the School of
Community Service
Sandra L. Terrell, Dean of the Robert B.
Toulouse School of Graduate Studies

Wood, Thomas Erin, Reduction of Anomie through the Use of Say It Straight™ Training. Doctor of Philosophy (Sociology), December 2004, 92 pp., 5 tables, references, 47 titles.

This study evaluated the Say It Straight™ (SIS) Training Program for its ability to improve straightforward communication, increase self-esteem, increase an individual's overall perception of group and family belonging or cohesiveness within a residential treatment setting and decrease an individual's perceived level of anomie. Effectiveness of SIS training was evaluated with paired sample *t*-tests (2-tailed) on six objective questionnaires given before and after training.

Participation in the study was voluntary. Of the 39 patients in residence, 26 participated in SIS training, (23 attended over 80% of the sessions and 3 attended over 50%). Three were excluded from the study due to developmental or dementia-related diagnoses, 3 chose not to participate, 5 were discharged routinely prior to completion and were not post-tested; and 2 were discharged against medical advice during the training. It is interesting to notice that on the average there are about 5 discharges against medical advice per month at the facility, but during the five weeks of SIS there were only 2.

Self-reports of empowering behaviors, quality of family and group life and self-esteem showed highly significant increases following SIS. Self-reports of disempowering behaviors (placating, passive-aggressive, blaming, irrelevant, intellectualizing) showed highly significant decreases following SIS and anomie showed a significant decrease. All *p* values are results from 2-tailed *t*-tests for paired observations. Subjective reports regarding training effectiveness were also very positive.

Recommendations include: 1) follow-up and compare SIS trained Sante alumni and non-SIS trained Sante alumni for recidivism rate and participation in recovery oriented group activities; 2) develop a tool for measuring anomie specifically related to treatment settings as a construct versus a single variable, and 3) develop a tool for measuring group cohesiveness specifically related to treatment settings as a construct versus a single variable.

Copyright 2004

by

Thomas Erin Wood

ACKNOWLEDGEMENTS

To Dr. Jim Kitchens: thank you for your encouragement, guidance and compassion and for the courage to show and teach love. To Dr. Paula Englander-Golden: thank you for believing in me, for sharing and teaching me the sacredness of this work and shining a light on a beautiful path of Life—for pointing me inwards to my Self—you have given me gifts of inestimable value. To Dr. David Golden: thank you for so much warmth and hospitality throughout these years and for your incredible generosity and assistance with the statistical analyses. To Dr. Vijay Pillai: thank you so much for your guidance, encouragement and expertise--your brilliance is only outshined by your kindness and generosity of spirit, intellect and personal time. To Dr. Sadri: thank you for inspiring me with brilliant insight and a great sense of humor and for encouraging me to keep going when I didn't think I could or should go on. To Dr. Deb Corley: thank you for sharing your incredible clinical insight, knowledge and experience and most of all--your friendship. To Susan: thank you for unflagging support, encouragement, tireless editing, organization, motivation, sheer brain power and going on before me, showing me that "I'm made of the right stuff." To George: for unyielding belief, support, creative, spiritual and intellectual contributions; for love, food, money, and laughs. My thanks to: Lee--for love, humor and "synergy" and Laurie--for unconditional love and friendship.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	iii
LIST OF TABLES	vi
Chapters	
1. INTRODUCTION.....	1
Say It Straight™ Training	1
Statement of the Problem.....	3
Problem of Addiction in the U.S.....	3
Treatment of Addiction	4
Theoretical Assumptions of the Investigation	7
Research Questions	8
Research Hypotheses	8
Sources and Methods of Collecting Data	9
Significance of the Investigation	10
Review of the Literature.....	11
Theoretical Framework.....	17
Say It Straight™ Training	27
2. METHOD	39
Residential Facility	39
Participants.....	40
Procedure.....	41
Questionnaires	42
3. RESULTS	45
Paired Observations	45
Correlations	48
Summary Statement of Results.....	50
Summary of Subjective Feedback.....	51

4.	DISCUSSION.....	54
	Statement of the Problem.....	54
	Relevance of the Study	55
	Say It Straight™ as Intervention of Choice.....	56
	Review of Research Questions	57
	Review of the Results.....	58
	Unexpected Result	59
	Clinical Observations.....	60
	Limitations of Methods.....	66
	Implications for Current Theory	67
	Implications for Treatment Settings	67
	Research Recommendations	70
	Conclusions.....	71
APPENDICES		
A.	INFORMED CONSENTt	74
B.	THE MCCLOSKEY AND SCHAAR ANOMIE SCALE	77
C.	THE SIS COMMUNICATION SKILLS QUESTIONNAIRE	79
D.	THE QUALITY OF LIFE QUESTIONNAIRE FOR PEER GROUP (QLQ-GROUP).....	81
E.	THE QUALITY OF LIFE QUESTIONNAIRE FOR FAMILY (QLQ- FAMILY).....	83
F.	THE ROSENBERG SELF-ESTEEM SCALE (RSES) -SHORT- FORM	85
G.	SUBJECTIVE FEEDBACK FORM	87
	REFERENCES	89

LIST OF TABLES

Table 1 Mean Scores Before and After SIS Training for 26 Residents on SIS Communication Skills, Variance and Results of <i>t</i> -Tests for Paired Observations.	46
Table 2 Mean Scores Before and After SIS Training for 26 Residents on SIS Quality of Life-Group and Quality of Life-Family Questionnaires, Variance and Results of <i>t</i> -Tests for Paired Observations.	47
Table 3 Mean Scores Before and After SIS Training on the Short Rosenberg Self-Esteem Scale for 22 Residents, Variance and Results of <i>t</i> -Tests for Paired Observations.	48
Table 4 Mean Scores Before and After SIS Training on Anomie for 26 Residents, Variance and Results of <i>t</i> -Tests for Paired Observations.	48
Table 5 Correlations between Fractional Changes in Anomie (ΔA), Self Esteem (ΔSE), Quality of Life-Group (ΔG), Quality of Life-Family (ΔF) and Empowering Communication/Behavior (ΔSIS), Disempowering Communications/Behavior (ΔDCB), and Communication/Behavior Excellence (ΔCBE), and <i>p</i> Values	50

CHAPTER 1

INTRODUCTION

Anomie, as defined from a socio-psychological perspective, is an individual's perceived level of normlessness, meaninglessness, and lack of belonging or alienation from self and from others. A review of literature suggests that individual manifestations of anomie are often associated with deficits related to the following variables: an individual's perception of quality of group and family life, and self-esteem. Previous research in residential treatment settings and schools indicates that straightforward communication positively correlates with higher scores on these variables (Englander-Golden & Golden, 2002). This study utilizes the Say It Straight™ (SIS) training program (SAY IT STRAIGHT FOUNDATION, Carlsbad, CA, www.sayitstraight.org) to study the effect of training in straightforward communication on an individual's perceived level of self-esteem, group belonging (cohesiveness), and anomie.

Say It Straight™ Training

Many addicted persons describe a family history of disempowering communication that has contributed to feelings of normlessness, meaninglessness, and lack of belonging (anomie). They report rules governing family life such as don't see, don't hear, don't feel, don't trust. Englander-Golden and Satir (1991) defined disempowering communication in terms of a lack of congruence between what a person feels and thinks and what the person

expresses. Recently, Englander-Golden and her collaborators (2002) started making the distinction between empowering and disempowering communication to bring attention to the effects these ways of being in the world impact intimate relationships--within, between and among.

Empowering communication is one in which all the components of a message flow in the same direction. What a person thinks and feels matches what and how the person expresses it. Disempowering types of communication include placating, blaming, being passive-aggressive, being irrelevant, and splitting off from feelings (Englander-Golden and Golden, 1996). Disempowering behaviors are the results of powerful rules that come from our families of origin. For instance, placating behavior can be a result of the rule "I must never put my needs first." Splitting away from feelings can be the result of the rule "I must never be vulnerable." Irrelevant behavior can be the result of rules such as "I must never see or hear what is really going on here." Aggressive behavior can be the result of rules such as "I must always win." These disempowering behaviors contribute to a state of being or condition consistent with our previous definition of anomie.

Prior to entering into a residential treatment setting, addicted persons often experience difficulty in establishing and maintaining healthy interpersonal relationships (Flores, 1997). In fact, many people affected by addictions have described a family history of disempowering communication that contributes to a sense of normlessness, meaninglessness, low self-esteem and lack of belonging

or alienation from self and from others (Yalom, 1995). Modern sociologists often refer to this cluster of conditions as anomie.

Englander-Golden and Satir (1991) defined disempowering communication as a lack of congruence between what a person feels and thinks and what the person expresses. These persons have difficulty developing healthy intimacy with others due to disempowering communication processes that are often indirect, manipulative, and disrespectful of their own or other persons' feelings and thoughts regarding an issue, and/or the issue itself. They report rules governing family life such as don't see, don't hear, don't feel, don't trust.

Statement of the Problem

Anomie, as defined by a sense of normlessness, meaninglessness, low self-esteem and lack of belonging or alienation from self/others, is perpetuated and transmitted through disempowering communication processes and hinders the development of group cohesiveness (Yalom, 2002). Group cohesiveness within a residential treatment setting is of the utmost importance as it is seen as "an essential condition that allows the other mechanisms of change and cure to be set in motion" (Flores, 1997). Recently Yalom has suggested moving from the use of the word cure to the phrase therapeutic factors when explaining the importance of group cohesiveness (Yalom, 2002).

Problem of Addiction in the U.S.

According to the results from the 2001 National Household Survey on Drug Abuse by the National Institute on Drug Abuse (NIDA), addiction and abuse

of alcohol and other substances (AOS) affects a significant portion of persons living within the United States. The following is an excerpt from the 2001

National Household Survey on Drug Abuse:

About 10.1 million persons age 12 to 20 years reported current use of alcohol in 2001. This number represents 28.5% of this age group for whom alcohol is an illicit substance. Of this number, nearly 6.8 million or 10.0% were binge drinkers and 2.1 million or 6.0% were heavy drinkers.

When the NIDA examined the population by age groups through use of the 2001 National Household Survey on Drug Abuse, it found that 10.8% of youths age 12 to 17 were current drug users compared with 9.7% in 2000.

Similarly, among adults age 18 to 25 years, current drug use increased between 2000 and 2001 from 15.9 to 18.8%.

In addition, there is a growing recognition of process addictions that do not involve substances as such, but include such behaviors as compulsive gambling, compulsive sexual behaviors, compulsive shopping, and various addictive eating disordered behaviors (bulimia, anorexia nervosa). Carnes estimated that upwards of 12 million persons in this country struggle with sexual compulsivity (Carnes, 2001); other experts estimate that approximately 6% of the general population meet criteria for being diagnosed as sexually addicted. Together, these statistics suggest that addiction is a problem of significant magnitude and with far-reaching impact on social issues and society in general.

Treatment of Addiction

Levels of Care

The American Society of Addiction Medicine (ASAM) model for level of care and criteria is currently the industry standard for most addiction treatment

programs, and most managed care organizations (MCO) use this level system and criteria in utilization management (approval of insurance benefits covering various levels of care). The following is a brief outline of the standard levels of care as well as a brief description of the activities at these various levels of intensity:

ASAM criteria for levels of care:

- ◆ Level I: Outpatient treatment: Nonresidential service or office visits, totaling fewer than 9 hours a week.
- ◆ Level II: Intensive outpatient/partial hospitalization is a programmatic therapeutic milieu consisting of regularly scheduled sessions for a minimum of 9 hours a week in a structured program.
- ◆ Level III: Medically monitored intensive inpatient treatment in a planned regimen of 24-hour observation, monitoring, and treatment, commonly known as residential treatment.
- ◆ Level IV: Medically managed intensive inpatient: Primary medical and nursing services and the full resources of a general hospital available on a 24-hour basis.

Modes of Treatment

There are numerous modalities of treatment employed but most of these will fall into one of the following general categories: (Treatment Improvement Protocol (TIP) # 13, 2000)

- ◆ Biomedical modalities focus on improved detoxification regimens, anti-craving medication, antagonist medication, methadone treatment, and psychopharmacological approaches.

- ◆ Psychological treatment modalities range from addiction counseling to psychodynamic and cognitive-behavioral treatment modalities, including insight-oriented psychotherapy, aversion therapy, and behavioral self-control training.
- ◆ Sociocultural treatment modalities include the community reinforcement approach, family therapy, therapeutic communities, vocational rehabilitation, various motivational techniques, culturally specific interventions, and contingency management.

Many modalities include more than one dimension such as social skills training, relapse prevention techniques, self-and mutual-help programs, 12-step programs, and chemical aversion therapy.

Additionally, there are three common approaches related to the comprehensiveness of the treatment models (TIP #9, 2000):

- ◆ Sequential: The resident participates in one system, then the other.
- ◆ Parallel: The resident participates in two systems simultaneously.
- ◆ Integrated: The resident participates in a single unified and comprehensive treatment program for dual disorders.

Factors contributing to addicted persons being admitted to residential treatment include lack of sufficient social support, environmental risks for relapse, certain medical and diagnostic issues, and relapses while attending a lower level of care.

Theoretical Assumptions of the Investigation

This study assumes the disease of addiction itself can be a stimulus for both social and psychological anomie. Anomie can manifest on psychological levels owing to the underlying psychological responses to the phenomena of craving, and the individual's ultimate inability or lack of means to satisfy this craving due to the phenomena of tolerance and dependence, either physical or psychological.

Anomic social conditions ensue as the above responses become obstacles to both continued social learning and the ability to communicate any previous adaptive social learning effectively (Parsons, 1951). Accordingly,

- ◆ Anomie can be a result of the disease of addiction and as such, can be an obstacle to an individual's recovery within the context of a residential treatment setting.
- ◆ Psychological characteristics commonly associated with anomie, such as low self-esteem, contribute to a breakdown of functional communication as manifested by alienation to one's self and to others.
- ◆ Dysfunctional communication, or disempowering communication, as a factor of anomic conditions, is an obstacle to an individual's willingness to participate in activities commonly associated with successful treatment outcomes such as group participation, adherence to group rules (norms), and one's willingness to develop sober social support networks (Yalom, 1995).

Research Questions

- ◆ Does SIS training improve an individual's ability to communicate in a straightforward, non-manipulative manner and decrease communication/behaviors such as Placating, Blaming, Passive-aggressive, Irrelevant and Super-reasonable?
- ◆ Does SIS training decrease an individual's experience of normlessness, meaninglessness, and lack of belonging (anomie) while within a residential treatment center?
- ◆ Does SIS training increase the individual's perceived sense of belonging as regards group (group cohesiveness) and family while within a residential treatment center?
- ◆ Does SIS training increase self-esteem?

Research Hypotheses

The following hypotheses were developed from the above research questions:

- ◆ As straightforward communication increases (saying it straight), self-esteem increases.
- ◆ As group cohesiveness increases, as measured by the QLQ-G, anomie decreases. As straightforward communication increases (saying it straight), anomie decreases.
- ◆ As disempowering communication decreases, group cohesiveness increases, as measured by the QLQ-G.
- ◆ As blaming communication decreases, anomie decreases.

- ◆ As blaming communication decreases, group cohesiveness increases, as measured by the QLQ-G.
- ◆ As placating communication decreases, anomie decreases.
- ◆ As placating communication decreases, group cohesiveness increases, as measured by the QLQ-G.
- ◆ As super reasonable communication decreases, anomie decreases.
- ◆ As super reasonable communication decreases, group cohesiveness increases, as measured by the QLQ-G.
- ◆ As irrelevant communication decreases, anomie decreases.
- ◆ As irrelevant communication decreases, group cohesiveness increases, as measured by the QLQ-G.
- ◆ As passive-aggressive communication decreases, anomie decreases.
- ◆ As passive-aggressive communication decreases, group cohesiveness increases, as measured by the QLQ-G.

Sources and Methods of Collecting Data

The source of participants for this study was addicted persons in residence at Santé Center for Healing (Santé). Santé is a residential treatment center specializing in the treatment of addictive disorders and concomitant psychiatric diagnoses. The primary researcher informed participants that the training offered was an opportunity for improving communication skills, relationship skills and quality of life.

It is important to note that Sante adopted SIS training as the primary component of their ongoing skills-building curriculum for the duration of the study;

as such, any resident required to attend skills-building courses as a part of their treatment plan for this period would attend SIS training. However, residents were informed that their participation in the research portion (data collection and analysis) was voluntary and they could decline participation in the research portion at any time, and without consequence.

Data collection included the use of five previously validated questionnaires administered before and after SIS training. Please refer to Section IV Methods for detailed descriptions.

Questionnaires included:

- ◆ The McCloskey and Schaar Anomie Scale
- ◆ The SIS Communication Skills Questionnaire
- ◆ The Quality of Life Questionnaire for peer group (QLQ-Group)
- ◆ The Quality of Life Questionnaire for family (QLQ-Family)
- ◆ The Rosenberg Self-Esteem Scale (RSES) -short-form

Additional Questionnaires included:

- ◆ Collection of demographic information
- ◆ Form providing participants with an opportunity to respond in their own words to SIS training.

Significance of the Investigation

Addictive behaviors are in part socially learned. Individuals belong to myriads of social groups, both primary and secondary. The ability to engage in social interactions that contribute to individual as well as group well-being is essential for healthy social functioning. The likelihood for pathological behaviors

such as addiction increases as an individual's ability to function in social groups decreases, owing to several social as well as individual-level constraints (Parsons, 1951).

However, this is a bidirectional dynamic, for the disease of addiction itself becomes a constraint both individually (psychologically) and socially and contributes significantly to a decrease in an individual's ability to interact (communicate functionally) in normative social groups, that is, those that are not currently centered on support of continuation of addictive behaviors (Yalom, 2002).

SIS training employs specific experiential interventions which serve to identify and transform an individual's previous maladaptive or disempowering social learning and encourage adaptive social learning through the practice of empowering communication styles, even in the midst of challenging social interactions or circumstances.

SIS training, if shown to be effective in increasing healthy communication and group cohesiveness, could be applied to any residential treatment setting where disempowering communication processes and other characteristics associated with addiction-related anomie may be contributing to a lack of group cohesiveness.

Review of the Literature

Theoretical Foundation

The definition and conceptualization of anomie has undergone extensive criticism since Durkheim introduced it in 1897. Durkheim, Merton, Parsons and

Srole roughly comprise the major points of departure for subsequent theoretical discussion on the subject of anomie.

Durkheim

Sociologists generally acknowledge Durkheim as the originator of the concept as a sociological artifact in his seminal study on suicide originally published in 1897. Most, if not all scholars of Durkheimian sociological thought describe his concept of anomie to be a macro-level or societal level condition of normlessness. Durkheim posited that, due to various societal level conditions, society periodically loses its ability to influence social behavior and anomie or normlessness ensues. Durkheim found this condition to be harmful, even when the societal level stimulus might be economic prosperity: “With increased prosperity, desires increase...the richer the prize offered, these appetites stimulate them and makes them more exigent and impatient of control” (Durkheim, 1966). These desires are apparently insatiable and their satisfaction becomes an unobtainable goal towards that which is “always moving out of reach” (Teevan, 1973).

According to Durkheim, the effect of such a dynamic can result in despair and ultimately suicide. At the time of Durkheim’s writing, the disease model of addiction had not been developed. However, the above definition could be seen as at least similar if not parallel to the common description of addiction as being characterized by craving and increased tolerance, either physical or psychological, a desire that leads to severe deterioration of psychological and

social functioning over time and ultimately results in either institutionalization, jail or death (DSM IV-R, Big Book).

Merton

Merton's theory assumes that anomie is a function of societal or cultural/ economic conditions and whether or not an individual has the means to achieve culturally prescribed goals. Merton proposed that one form of a subjective (individual) reaction to anomic conditions, retreatism, could be addiction.

However, according to the most current understanding of the disease model of addiction, retreatism (individual response to anomic conditions) can also be a result of addiction (Merton, 1964).

In other words, the disease of addiction itself can be a stimulus for anomic conditions, due to the underlying psychological responses to the phenomenon of craving, and the individual's ultimate inability or lack of means to satisfy this craving due to the phenomena of tolerance and dependence, either physical or psychological, and not simply the result of pre-existing anomic conditions.

A review of the literature reveals much disagreement on where Merton fits in the continuum of thought regarding anomie. Some have described Merton as purporting that anomie exists strictly in a macro or societal level domain (Teevan, 1975), while Merton himself spent a great deal of time discussing the need for a subjective or individual measure of one's perception of anomie (subjective).

Merton spoke of the need for methodological and statistical development that could then allow for aggregation of these individual scores to achieve a group measure of perceived anomie and even proposed a model for potential development (Merton, 1964). McCloskey and Schaar described both Durkheim

and Merton's' model or causal chain as follows: social condition→psychological state →deviant behavior (McCloskey and Schaar, 1965).

Parsons

Talcott Parsons described functional collectives or institutions (groups of collectivities) as being comprised of persons who have internalized certain cultural values and in turn have certain expectations of others' reactions, which he referred to as social learning. He proposed that humans have a particular sensitivity to the influence of others (through social interaction) and that this sensitivity enables societies or collectivities to achieve sufficient integration for sustained existence. Parsons also considered this sensitivity to the influence of others to be the mechanism by which individual personality develops and learns by allowing the integration of the value-orientations of others and expectations upon their fulfillment (Parsons, 1951).

Parsons theorized that functional communication is essential in the development of any cultural system (collectivity) and that in fact, if disrupted, can be just as dangerous or harmful as a breakdown in a society's economic or governmental structures. He believed that such a disruption or failure in communication can just as likely be the cause of anomie as would a break-down of economic or governmental structures. Parsons posited that the role of language is of utmost importance in transmitting cultural values, which, in turn he believed was "directly constitutive of personalities" through the psychological process of "internalization" (Parsons, 1951). The collectivity known as the addicted person's family-of-origin sometimes experiences such a breakdown, often as a result of either a parent or grandparent's addictive disease.

Disempowering communication patterns are often long-standing (multi-generational) family rules resulting in a lack of congruence between what a person feels and thinks and what the person expresses (Englander-Golden and Satir, 1991).

Particularly relevant to this study, Parsons addressed the interaction of internal, narcissistic, or non-social aspects of an individual's personality which are interdependent with social aspects of personality. The addicted person becomes increasingly concerned with this narcissistic aspect of personality and thus becomes decreasingly motivated or unable to fulfill former social role expectations, particularly when they are in conflict with the need or psychological or physiological demand for the addictive substance or process (Parsons, 1951).

Srole

The discussion and development of anomie in sociological literature is often centered on whether anomie can be reduced to an individual level variable without losing its meaning or usefulness as a sociological concept. According to Srole, anomie manifests at the individual level, as well as at the societal level. Srole, in a study of social integration, developed a scale to measure the individual's degree of anomie which he referred to as anomia. Srole used the term anomia to represent a "molecular view of individuals as they are integrated in the total action fields of their interpersonal relationships and reference groups" (Srole, 1956). Srole used the phrases social mal-integration and interpersonal alienation as equivalent terms—referring to a socio-psychological condition of individuals' perception of self-to-others distance and self-to-others alienation, a

condition which he considered dependent on both sociological and psychological processes.

Srole's five-question scale has undergone much subsequent methodological examination and criticism. Overall, the Srole scale has not withstood a rigorous standard for validity and has shown to be an inconsistent measure across cultural and economic contexts. One criticism of Srole's scale is that he phrased the questions in such a way as to be asking about an individual's perception of others' level of anomie, rather than personal perception of anomic conditions. Another criticism is that Srole's scale may not be measuring normlessness at all (Eckart and Durand, 1971).

Srole posited that anomie could be found at the intersection of social class and social function—a strong inverse linear relationship with socio-economic status. But this will not always be the case with anomie found in relationship to addiction, as the Big Book of Alcoholics Anonymous and much subsequent research indicates that the disease of alcoholism cuts across all social, economic, gender, age, religious and ethnic sectors. Srole believed, as well as Merton and Durkheim, “the psychological state of anomie reflects economic and social conditions” (McCloskey and Schaar, 1965). More recently, McCloskey and Schaar devised and tested a nine-item scale measuring anomie utilizing and expanding upon Srole's theory of anomie being the result of the interplay of both psychological and sociological forces acting upon and from within the individual (McCloskey and Schaar, 1965).

McCloskey and Schaar

McCloskey and Schaar, two more recent anomie theorists, explored the value and logic of defining and conceptualizing anomie from both a sociological direction and a psychological direction, bridged by a dialectical dynamic. They proposed that either one without the other has less usefulness or relevance and in fact leaves out what is needed to fully understand both the origins, which can be many, and the influence of anomie. McClosky and Schaar conceptualized anomie as a bidirectional continuum between the individual or psychological level and a group or societal level. They based their research on Srole's stance that the origin of anomie can be of sociogenic or psychogenic origins (McCloskey and Schaar, 1965).

McClosky and Schaar sought to understand the subject of anomie by exploring how psychic states may contribute to anomie independent of a person's social status and created a scale for measuring individual levels of anomie. This scale has withstood rigorous standards for testing validity, reliability, and consistency across cultural and demographic markers.

Theoretical Framework

Characteristics of Addiction

Many treatment professionals regard the treatment of addiction as being a combination of biological, psychological, and social factors. Louis R. Ormonth, Ph.D. credits Dr. Phillip J. Flores with presenting "convincing evidence that it is the alcoholics' and addicts' inability to establish and maintain healthy

interpersonal relationships that contributes not only to their addiction, but also to their difficulty maintaining sobriety and abstinence” (Flores, 1997).

Former Executive Director of the Ethel Daniels Foundation (a non-profit residential treatment center serving primarily the medically indigent population) George Stephenson, observed that addicted persons become increasingly egocentric and anti-social as the disease of addiction progresses. Stephenson stated that, in his experience, addicted persons in end-stage disease are often distrustful of themselves and others. He believes this distrust to be a result of repeatedly violating one’s own ethics, values, and norms in the service of sustaining the disease. Stephenson states that these individuals find it difficult to join with and bond with other group members. Stephenson adds that Alcoholics Anonymous works largely through and because of those members with longer-term sobriety who provide leadership and modeling; however, a residential treatment center does not always have such role models or leaders in residence and this represents another challenge for developing group cohesiveness. (Stephenson interview, November 2003).

The Addiction Resource Guide defines addiction as “the physical and psychological craving for a substance that develops into a dependency and continues even though it is causing the addicted person physical, psychological and social harm. The disease of addiction is chronic and progressive, and the craving may apply to behaviors as well as substances.” This definition encompasses and summarizes succinctly many of the most widely accepted definitions of addiction and addresses addictive behaviors or process addictions

as well. This study addresses the socio-psychological aspects of addiction as defined above.

Prior to entering into residential treatment the lives of addicted persons are often characterized by an ever-increasing level of estrangement from family and friends not associated with addictive rituals (Flores, 1997). Over the course of the disease of addiction, the addicted person's life gradually becomes "out-of-synch" with the common norms of society as the pursuit and experience of the addictive process or substance takes precedence over every other facet of daily life. In fact, the addict in recovery often speaks of having always felt out-of-step with "normal" society and being at odds with perceived authority even prior to addiction (Snyder/Clinard, 1964).

Anomie and Addiction

Contemporary sociologists sometimes refer to these deteriorating social conditions as anomie. Anomie, in its current and most common sociological usage, usually refers to a social structural condition or state or "...a condition of social instability or personal unrest resulting from a breakdown of standards and values or from a lack of purpose or ideals" (Britannica Concise Encyclopedia, 2003). Contemporary sociologist Robert Merton defined anomie as "a breakdown in the cultural structure, occurring particularly when there is an acute disjunction between the cultural [group] norms and goals and the socially structured capacities of [individual] members of the group to act in accord with them" (Merton, 1964).

Mizruchi, a contemporary sociologist, defines anomie as "... a social state in which the society's norms and goals are no longer capable of exerting social control over its members, and the individual rather than the group, must now determine for himself what goals would be sought and in what degree. The individual is, however, essentially incapable of providing meaningful limits to his own desires and is thus doomed to a life of constant seeking without genuine fulfillment" (Mizruchi, 1964).

Mizruchi might just as well have been describing the addicted person's life prior to entering residential treatment. In fact, the American Society of Addiction Medicine (ASAM) criteria for determining the need for residential level of care for addicted persons (the standard by which most managed care companies and treatment providers utilize) mirrors the major points of Mizruchi's definition of anomie. ASAM states that an addicted person requires a residential level of care when that person no longer has ties to, or is no longer influenced by a social group who is supportive of recovery and has repeatedly been unable to moderate use or maintain abstinence despite negative consequences and the desire to do so (ASAM, 1999).

Individual Perception of Group Cohesiveness

Charles R. Snyder contends "that alcoholics, not only at the terminal stages but also at the inception of their illness are indeed anomic persons—disorganized, empty, anxious, compulsively independent and knowing no authority—yet persons who unconsciously long for a genuine moral community upon which to depend" (Snyder/Clinard, 1964). Maclver described anomic

individuals as having “the state of mind of one who has been pulled up by his moral roots....The anomic man has become spiritually sterile, responsive only to himself, responsible to no one. He lives on the thin line of sensation between no future and no past.” The residential treatment group can become and serve as this community upon which to depend, at least in initial recovery, provided these anomic individuals can begin to experience cohesiveness as a group (Flores, 1997).

Alienation, Anomie, and Addiction

Mizruchi, exploring Merton’s definition of anomie as provided above, proposed that anomie can result in the alienation of individual members from the group and render an individual “...essentially incapable of providing meaningful limits to his own desires and thus doomed to a life of constant seeking without genuine fulfillment” (Mizruchi, 1964). This is particularly relevant to addicted persons, who often report feeling a sense of alienation from peer groups whose norms do not include the behaviors and rituals often associated with the advanced stages of the disease of addiction (Flores, 1997).

Sociologist Gwynn Nettler describes alienation as “a feeling of estrangement from society.” Further, he proposed that “the alienated are prone to narcotics addiction” and found that a sense of self-estrangement and meaninglessness are highly correlated to those experiencing alienation (Nettler, 1957). This is similar to Srole’s well-known sociological study of the individual’s experience of anomie being characterized by estrangement or alienation of self-to-others and distance-to-others (Srole, 1956).

Alienation, as defined by Ziller, is “an attitude of hopelessness resulting from an inability to structure the environment in terms of either a stable self orientation or a stable other orientation, and a cessation in the individual’s attempts to confront the social environment” (Ziller, 1969). According to Ziller, the alienated individual experiences a sense of “meaninglessness, powerlessness, and normlessness...perceiving themselves as unguided persons in an unchartered environment” (Ziller, 1969) and could be considered synonymous with previously cited individual responses to anomie, particularly with regard to addicted individuals (Snyder, 1964).

Anomie and Communication

Confronting one’s social environment necessarily involves communication, both with self and with others. Communication appears to be both the mechanism and an obstacle (when maladaptive) to the amelioration of anomie and the process of integration within the residential treatment group. Residents often experience problems communicating with their peers (Flores, 1997). They defend their behaviors through communication processes that are indirect, manipulative or without regard for either their own or other persons’ feelings and thoughts regarding an issue (Ziller, 1969). Research indicates that the resulting isolation or estrangement from others contributes to addiction and serves as an obstacle to participating in group activities that support the achievement and maintenance of sobriety and abstinence (Flores, 1997). Parsons stated that anomie will ensue following a sufficient disruption in functional communication, which then prevents continued social learning (Parsons, 1951).

Communication and Symbolic Interactionism

In a review of the addiction treatment-related literature, clinicians and researchers refer frequently to self destructive interpersonal styles (disempowering communication processes) characteristic of addicted persons. These communication processes have direct social implications such as a sense of normlessness and difficulty communicating with peers (Flores, 1997). However, clinicians and researchers do not often address the process by which this takes place, indicating a need for utilizing sociological understanding in the treatment of these self-destructive or disempowering communication processes.

Utilizing sociological concepts and theory regarding communication processes can provide treatment professionals with insight and perspective if incorporated into the current research and treatment literature on addictions. This study proposes the use of symbolic interactionism as a theoretical framework for understanding communication processes and specifically, SIS experiential interventions. SIS techniques and theory addresses how one's ability to communicate and ascertain accurate social meanings affects an individual's perception of belonging, within, between, and among.

The theory of communication known as symbolic interactionism as introduced by sociologist George Herbert Mead and further developed by subsequent theorists such as Blumer and Charon provides a sociological explanation and context for understanding the effectiveness of SIS interventions.

According to Herbert Blumer,

the position of symbolic interactionism...is that the meanings that things have for human beings are central in their own

right. To ignore the meaning of the things toward which people act is seen as falsifying the behavior under study. To bypass the meaning in favor of factors alleged to produce the behavior is seen as a grievous neglect of the role of meaning in the formation of behavior (Blumer, 1969).

Mead acknowledged the importance of mind and symbols in understanding how both individuals and society develops. He described mind as a process or activity, distinct from objects or symbols and represents actions taken toward one's self (Charon, 1998).

Contemporary sociologist Charon goes on to explain that individuals not only take action towards objects (or others) in their environment, referred to as overt, but also towards self, referred to as covert action representing the mind. Most relevant to this context is Charon's definition of mind as being "all thinking, all active manipulation of symbols by the actor in conversation within his head and toward self" (Charon, 1998). Blumer referred to this process of self-interaction as "social—a form of communication, with the person addressing himself as a person and responding thereto" (Blumer, 1969). In this way, Blumer utilizes a sociological stance in explaining the inner-workings or processes of the self, a domain often considered purely psychological.

SIS training can be understood to intervene on this level by increasing one's awareness of their own covert actions towards self in response to familial/childhood as well as current internal and external social interactions. Satir and Englander-Golden's explanation for the etiology of disempowering communication stances and family rules as described in the book *Say It Straight* are parallel to Halliday's explanation of human socialization through symbolic

interactionism as happening “indirectly, through the accumulated experience of numerous small events, insignificant in themselves, in which his behavior is guided and controlled, and in the course of which he contracts and develops personal relationships of all kinds” (Halliday, 1978).

Mead, as well as Blumer referred to symbolic interaction as “a presentation of gestures and a response to the meaning of those gestures” (Blumer, 1969). SIS training allows for these meanings to be explored, expressed or made manifest and experienced through physically sculpting these meanings; accounting for the etiology in family-of-origin but taking responsibility for current meanings made and related behaviors. In fact, SIS training interventions such as physically sculpting the six stances (placating, blaming, super-reasonable, irrelevant and passive-aggressive and saying it straight) are actually an operationalized form of symbolic interaction.

Durkheim, Merton, Srole, and many of the modern anomie theorists recognize that anomic conditions are often manifested as social malintegration. According to symbolic interactionists and social learning theorists such as Talcott Parsons, as well as systems theorists from the psychological camp, social objects or facts (various manifestations of social malintegration) are often introjected psychologically, representing an intra-psychic social construct influenced by anomie as well (Parsons, 1951). This leads to what Srole described as the individual’s generalized, pervasive sense of self-to-others belongingness at one extreme compared with self-to-others distance and self-to-others alienation at the other end of the continuum (Srole, 1956).

While modern theorists make a compelling case that intermittent periods of anomie may be a necessary phase in the cycle of change and growth, and thus functionally adaptive, none describe any such value for remaining in this state, as is experienced in the end stages of addiction. Thus, as an addicted person enters the residential treatment center, they bring with them their own introjected alienation (social malintegration) and are faced with the challenge of integrating themselves within a very small community where there are prescribed norms and some degree of cohesiveness of previously admitted residents. On the other hand, the residential group's existing level of cohesiveness is frequently challenged by the introduction of newly admitted persons who, by virtue of meeting the criteria for admission to a residential level of care, can be assumed to be experiencing anomic stress or introjected social malintegration and which, according to social learning theorists and symbolic interactionists, will often manifest in or affect the group via maladaptive communication. McClosky and Schaar described anomie, at least in part, as a reflection of maladaptive communication or "patterns of communication and interaction that reduce opportunities to see and understand how the society [group] works, and what its goals and values are" (McCloskey and Schaar, 1965). They, like Parsons, propose that clinicians and researchers can best understand anomie as "a set of learned attitudes" (McCloskey and Schaar 1965).

While McClosky and Schaar propose that a primary determinant of anomie is anything that interferes with one's ability to learn the norms of a society, this study, based on the progression of the disease of addiction,

subsumes this and adds that the progression of this disease also gradually impairs one's ability to operate according to previously learned norms. And, while it is true that even individuals who share the same social or psychological characteristics will often react in a completely different manner, the unifying factor for the population of this study is the now widely held conceptualization of addiction as a disease process, which assumes a predictable course or progression and related symptoms. That being said, for the purposes of this study, the main factors contributing to anomie will be assumed to be the symptoms (both social and psychological) commonly associated with the progression of the disease of addiction, and not directly related to social status or even personality traits that pre-existed the onset of addiction.

In summary, SIS training is ostensibly an applied sociological intervention that may reduce an individual's sense of anomie, as characterized by disempowering communication, normlessness, feelings of alienation, and low self-esteem (Martindale, 1960). SIS training intervenes on these conditions by providing opportunities to practice empowering and congruent communication and as evidenced by increasing one's sense of group cohesiveness, self-esteem, purpose and belonging (Englander-Golden & Golden, 1996).

Say It Straight™ Training

Theoretical Foundation of Say It Straight Training

Virginia Satir hypothesized that all humans share the yearning to be loved and valued and Englander-Golden found equally universal the yearning for the opportunity to love and value others. Their collaborative work reflects their belief

that we all have everything we need for positive change within us and need to connect to these resources. SIS training was designed with the purpose of facilitating greater awareness of one's inner resources and ability for making positive changes by increasing awareness of past disempowering patterns of communication/interactions and providing vehicles for practicing new interactions based on genuine, congruent communication. SIS training, based on the premise that we (human beings) are all connected, utilizes interventions intended to facilitate sharing our deepest yearnings for experiencing this connectedness both within ourselves and to others.

SIS training combines Satir's therapeutic tenets and practices regarding communication with interventions developed by Englander-Golden and based on action-oriented skills practice whose theoretical roots were influenced at least in part by modeling theory (Bandura, 1977) reactance theory (Bern, 1967; Brehm, 1966), development of empathy (Feshbach, 1983), moral development (Kohlberg, 1964) and inoculation theory (McGuire, 1964).

The goal of SIS training, as described by Englander-Golden, is effective prevention of destructive behaviors and promotion of wellness and "to develop culturally sensitive and age appropriate strategies that decrease risk factors and increase protective factors in six domains that impact personal and interpersonal life" (Englander-Golden & Golden, 1996). These six domains are identified as individual, family/significant others, school, peer group, neighborhood/community and society/media. Englander-Golden states that SIS training does not yet address the sixth domain involving mass media.

Satir and Englander-Golden came to believe that a rule commonly shared by many students and young adults is “I must never have any rules” and believed this to be a key target for transformation. They observed that “they (students) discover how impossible it is to live in a community with this rule. At the same time, they discover the nugget of gold that pertains to the desire for freedom and choice” (Englander-Golden & Golden, 1996). Rokeach found freedom to be among the most strongly and commonly held values by adolescents (Rokeach, 1973). This is particularly relevant when considering a tenet of reactance theory (Bem, 1967; Brehm, 1966) which predicts that adolescents may be at greater risk for engaging in deviant behavior when they perceive their freedom is being limited or infringed upon.

Similarly, many addiction professionals report that addicts often present with a distinctly adolescent attitude or world view (particularly those who began their use of addictive substances or behaviors at a young age) and so are also sensitive and reactive to their perceived level of freedom. This is directly applicable to a residential treatment setting such as Santé Center for Healing where residents often bristle initially to newfound structure and campus rules regarding boundaries/behaviors. Research indicates that SIS training may mitigate this phenomenon of rebellion against structure and authority by increasing one’s perception of group affiliation, trust, and safety and thus affecting factors such as completion of treatment and drop-out rate (Englander-Golden & Golden, 1996).

Sociological Relevance of Say It Straight Training

Satir's beliefs regarding the individual and society can be described in sociological terms as a bidirectional relationship between micro-level interactions, or family system level, and macro-level interactions or society at large (Satir, 1988). Satir described this relationship when she stated "it is now clear to me that the family is a microcosm of the world" (Satir, 1988). Satir goes on to say that "to understand the world, we can study the family: issues such as power, intimacy, autonomy, trust, and communication skills are vital parts of understanding how we live in the world. To change the world is to change the family" (Satir, 1988).

The description of several risk factors for the peer group domain (anti-social norms, sense of isolation, deviant risk-taking and pleasure-seeking norms) is similar to what Merton considered characteristic traits of those experiencing anomie. Previous studies indicate SIS increases protective factors in this domain by increasing one's sense of positive peer acceptance and ability to make friends, increased ability to resist negative peer pressure, mediation training, communication, and other life skills training, development of internalized positive values and social sensitivity within peer settings (Englander-Golden, 1993b; Englander-Golden & Golden, 1992; Englander-Golden & Golden, 1996). Thus a decrease in these risk factors should decrease characteristics commonly associated with individuals experiencing anomie.

Theoretical Links to Say It Straight Training

Merton alludes to symptoms of anomie as “the alienation of modern man, to his isolation and estrangement, and the frequent aftermath of this condition, the wish to believe and to belong” (Merton, 1964). This wish to believe and belong is closely associated with what Satir and Englander-Golden believed to be human beings’ deepest yearning—to be loved and valued. Further, Englander-Golden found this deepest yearning to be coupled with another core yearning or desire of human beings—the ability and opportunity to love and value others. These deepest yearnings are in fact foundational to SIS training.

Previous research indicates that SIS training increases one’s sense of group affiliation and belonging. SIS training targets two primary factors contributing to what Merton described as the alienation of modern man (Merton, 1964): disempowering communication and erroneous thinking errors developed in response to past family-of-origin rules. Englander-Golden administered the Quality of Life—Group survey pre and post SIS training to measure participants’ willingness to access group support and sense of belonging and consistently found a significant increase on these two dimensions following SIS training as compared to pre-test measures (Englander-Golden, Gitchele, Henderson, Golden, & Hardy, 2002).

Description of Say It Straight Training Program

Say It Straight training (SIS) represents a set of experiential activities designed to 1.) Help individuals and groups to move from a model of submission-dominance in relationships, to a model of equal value, and 2.) Increase non-

hierarchical, congruent communication affording opportunities to practice empowering communication through purposeful and intentional symbolic interaction. In this way, SIS training makes concrete and overt the internal experience of a relapse sequence (thoughts, sensations, feelings and behaviors that often lead to relapse) and helps the individual to transform the sequence of relapse into the sequence of recovery. Englander-Golden hypothesizes that the following steps facilitates the process of change: 1.) Becoming of aware that one has repeated the old reactive pattern. 2.) While is repeating the pattern one is now aware of this pattern. 3.) Moving awareness up even further in advance of relapse by noticing thinking errors or behaviors that often precede relapse. 4.) Intervene at these earlier times, to the point that a trigger for relapse becomes a trigger for recovery behaviors.

Englander-Golden designed SIS training to facilitate persons, groups, and families in moving from incongruent and confusing (disempowering) communication to approaching themselves, each other, and their issues with congruent communication. Often persons' behaviors or response/communication patterns within a family system will crystallize along one of five dimensions or communication processes referred to by Englander-Golden in SIS training as placating, blaming, passive-aggressive, irrelevant and super-reasonable.

A goal of SIS training is to learn how to transform these processes into a sixth communication process--the ability to say it straight. This process represents one's ability to communicate congruently, honoring what Englander-Golden and Satir believed to be three essential parts of healthy communication:

You, me, and the issue. Most people utilize these communications processes sometimes and when sufficiently stressed, will resort to a favored order of response that they largely form during childhood in response to family communication/crises.

The following is a brief description of how each of these communication processes contributes to disempowering communication as well as an empowering communication process of saying it straight:

- ◆ Placating: characterized by people-pleasing, not counting one's self and one's own needs and placing value only on others and their needs of others—manifested often by giving excuses for self and others' actions or lack thereof.
- ◆ Blaming: manifested by putting others down, use of verbal threats or intimidating expression of anger, use of sarcasm and rarely assuming personal responsibility; consistently placing one's own needs before the needs of others.
- ◆ Passive-aggressive: appearing to go along with others' wishes but secretly resenting them and planning ways to get even.
- ◆ Irrelevant: persons who employ this stance are often the "class clowns", often distracting, disruptive or can also manifest as "spaced out" or having difficulty focusing on the issue at hand or remaining on topic; operating from this communication process one fails to honor one's self, one's own needs, others, the needs of others or the issue at hand.

- ◆ Super-reasonable: this communication process adopts a strictly factual approach, largely ignoring or de-valuing emotional expression, one's own feelings, or the feelings of others.
- ◆ Saying it straight: honoring one's self, the "other" within an interaction and the issue between them.

Previous research indicates that SIS training significantly decreases disempowering communication processes while significantly increasing empowering communication, self-esteem, quality of life, and one's willingness to implement constructive decisions in difficult situations (Englander-Golden et al., 2002). The goals of SIS training are 1.) Identify the positive aspects of each communication process, for example, the ability to compromise that is inherent in the ability to placate; 2.) Identify the rule that compels people to turn a potentially empowering communication into a disempowering communication; for example, in the placating process, a rule such as "I must always put other peoples' needs before my own;" 3.) Transform these rules into healthy guidelines that promote congruent communication. By transforming disempowering behaviors into empowering behaviors, rather than disowning one's disempowering behaviors, people can more readily achieve an integration of all that they are and can be. This integration prevents judging some aspect of one's personality in negative terms which leads to humiliation and shame, a common trigger for relapse, and the hallmark of an addicted person (Englander-Golden & Golden, 1996, 2001).

SIS training transforms these patterns of disempowering communication into the ability to say it straight: "we count ourselves, we count others and we

count the issues between us; we honor our deepest wishes without demeaning others, we can express our feelings, what we say and how we say it is congruent with what we feel and think” (Englander-Golden & Golden, 1996).

Techniques

Sculpting Communication Processes

Experiential exercises include “sculpting” these communication processes by assuming a physical pose symbolizing these various communication processes individually and in relation to one another. Through these sculptures participants have an opportunity to experience viscerally and visually these characteristically manipulative, though often previously unconscious, approaches to communication. Likewise, participants are then encouraged to explore ways of interacting and communicating which honor what Satir and Englander-Golden described as the three essential elements of healthy communication: you, me and the issue (Englander-Golden and Satir, 1990). Participants are encouraged to focus awareness on body sensations experienced while in these symbolic sculptures or gestures and in so doing may later utilize these sensations as “cues which alert them when they are about to respond in habitual ways, thereby facilitating change” (Englander-Golden & Golden, 1996).

Parts Party

SIS training, in designing experiential interventions to address incongruent or disempowering communication, acknowledges and utilizes a type of symbolic interactionism. The parts party, an experiential intervention within SIS, provides a context in which all participants can examine personal meanings made in

response to family interactions/dynamics during developmental stages of childhood and adolescence as well as current interactions. The SIS trainer asks for a volunteer to be the star of the parts party and in that role, to describe the most influential persons from his/her family-of-origin. The trainer also facilitates the star in considering multi-generational messages/meanings which may have been transmitted from persons no longer living but whose influence remains powerful in the form of stories and meanings made of these stories passed on through living family members/generations.

This star is then asked to choose a cultural or historical icon to represent these persons symbolically. In this way SIS acknowledges a sociological realm in which participants share a consciousness of cultural and historical relatedness. This serves as a point of reference for participants of the parts party but allows for individual interpretation and subsequent meanings made by each individual. Though one person is designated the star of a parts party, each participant is asked to respond from her or his own experiencing and schema and often report learning much about their own internal and external communication patterns.

Making Movies

Making movies is another experiential intervention that involves participants identifying stressful interactions and rehearsing various outcomes, once from a maladaptive or incongruent stance, once from a level stance that honors the participant's desired response and then again reversing roles. Reversing roles allows participants to develop empathy and insight into how others' may experience and approach the same issue differently.

To practice this exercise, the SIS trainer divides the group into triads. The smaller groups provide everyone with an opportunity for participation and a forum for developing refusal skills in a safe environment. Each member alternately plays the role of facilitator or director of the movie, a placating or submissive role and a blaming or dominant role. The intervention continues until each person has had an opportunity to play each of these roles. Participants are encouraged to explore ways of interacting and communicating that honors each person, where each person's voice is neither submissive nor dominant but considered equally.

Rule Transformations

Rule transformations, another SIS intervention, addresses disempowering communication and behaviors that Satir and Englander-Golden conceptualized as "compulsive behaviors rooted in our early learnings" (Englander-Golden & Golden, 1996). These behaviors and disempowering forms of communication are related to beliefs such as "I must never disagree," "I must always put the needs of others before my own," "I must always keep the peace" [placating]; "I must always win," "I must always be right" or "I must never be held responsible" [blaming]; "I must never be vulnerable," or "I must always have all the answers" [super-reasonable]; "I must always be the life of the party," or "I must never take anything too seriously" [irrelevant] (Englander-Golden et al., 2002). Each rule or belief is often associated with an unconscious catastrophic expectation of severe harm or even death when one of these personal rules is broken.

In SIS training, participants learn to transform these rules into guidelines for effective living. This process starts with an awareness of the inner experience of a rule in terms of breathing, body sensations, and feelings. It ends with the discovery of the conditions under which the rule can be [transformed into] a useful guideline. For instance, a rule such as, “I must never be vulnerable” is transformed into, “I can be vulnerable when...” It is up to each person to find at least three conditions under which they can allow themselves to be vulnerable and become aware of the internal experience as they transform the rule (Englander-Golden et al., 2002).

CHAPTER 2

METHOD

Residential Facility

Santé Center for Healing (Santé) is a residential treatment center specializing in the treatment of addictive disorders and concomitant psychiatric diagnoses. Addictive disorders addressed include alcohol and other substances, sexual addiction, eating disorders, and other process disorders such as compulsive shopping and gambling. The average length of stay is approximately 70 days. Santé accepts adults age 18 and older. The treatment curriculum includes at least one hour of individual therapy per week, five hours of didactic education, nine hours of small group process, eleven hours of experiential group that includes psychodrama, social skills building and ropes course; daily 12 Step meetings and at least two hours per week of 12 Step education, two hours per week of peer-led community group/presentations, and finally, at least one two-day (16 hours) family intensive per treatment episode. The family intensive involves spouses, children and significant others as deemed appropriate through assessment. All residents have two hours of Eye Movement Desensitization and Reprocessing® therapy (EMDR Institute, Inc., Watsonville, CA, www.EMDR.com), and some have more as indicated by assessment. EMDR is a therapeutic technique involving bilateral stimulation through eye movements, auditory tones or taps, coupled with a cognitive behavioral protocol that together

facilitates resolution of past trauma and reinforcement of current internal resources. Some participants also receive from 15 to 30 hours of neuro-feedback training.

Participants

Guidelines for participation followed the University of North Texas Human Subjects Research Policies and Procedures. The primary researcher informed participants that the training provided an opportunity for improving communication skills, relationship skills, and quality of life. Participants were comprised of persons with diverse addictive diagnoses including substance dependence, sexual compulsivity, compulsive gambling, eating disordered behaviors, as well as psychiatric diagnoses that included but not limited to depression, bipolar disorders, attention deficit disorders, and anxiety-related disorders such as obsessive-compulsive disorders.

Participation in the study was voluntary and the primary researcher informed participants they could discontinue at any time without negative consequences. It is important to note that Santé adopted Say It Straight™ (SAY IT STRAIGHT FOUNDATION, Carlsbad, CA, www.sayitstraight.org) training as the primary component of their ongoing skills-building curriculum for the duration of the study; as such, any resident required to attend skills-building courses as a part of their treatment plan for this period would attend SIS training. However, residents were informed that their participation in the research portion (data collection and analysis) was voluntary and they could decline participation in the research portion at any time, and without consequence. Of the 39 residents in

residence, 26 participated in SIS training, (23 attended over 80% of the sessions, and three attended over 50%). Developmental or dementia-related diagnoses excluded three from the study, three chose not to participate, five discharged routinely prior to completion and were not post-tested; and two discharged against medical advice during the training.

Procedure

Training groups consisted of persons in residence at Santé Center for Healing. The primary researcher conducted two groups of SIS, each for five weeks, twice weekly, in one two-hour session and one three-hour session for a total of 25 hours of SIS training. The primary researcher invited all residents to participate in the research portion of SIS training. However, the primary researcher excluded from the statistical analysis residents deemed developmentally disabled through either pre-admission screening or assessment following admission.

The primary researcher monitored and recorded attrition and completion rates for SIS training. The sample included anyone completing 50 to 80 % of the SIS training. The primary researcher did not record psychiatric diagnoses or demographic data that would identify any participant outside of the medical chart. For the purposes of analyses requiring paired observations, the primary researcher provided each participant with an identification number, and recorded these in a manner that preserved anonymity. During the study, no additional treatments were provided that were not already present prior to and at the time of pre-testing.

Questionnaires

The primary researcher preserved anonymity in all data collection with identification numbers used to match pre and post training questionnaire scores for each participant to allow t-test for paired observations. The primary researcher administered five objective questionnaires prior to SIS and again upon completion of SIS with the addition of one subjective questionnaire only after SIS training. Questionnaires included the following:

- ◆ The Quality of Life Questionnaire for family (QLQ-Family) consists of fourteen questions that measure trust, caring and attitude toward change (such as “I like and trust the people in my family”) and utilized to measure change in an individual’s attitude toward family affiliation.
- ◆ The Quality of Life Questionnaire for peer group (QLQ-Group) consists of fourteen questions that measure trust, caring and attitude toward change (such as “I like and trust the people in my group”) and will be utilized to measure change in an individual’s attitude toward integration/group affiliation (group cohesiveness).
- ◆ The SIS Communication Skills Questionnaire consists of 32 questions measuring disempowering and empowering behaviors such as the degree to which one employs placating, blaming, or passive-aggressive communication styles.
- ◆ The Rosenberg Self-Esteem Scale (RSES) -- short-form consists of ten items and has been modified from a six-point scale to a nine-point scale to allow participants a larger range of responses (1 indicating “strongly

agree,” 5 indicating “not sure,” and 9 indicating “strongly disagree) with higher scores indicating higher self-esteem. The questions are phrased in such a way that a higher score indicates higher self-esteem when the scores on five questions are inverted (questions 1, 2, 4, 6 and 7). An example of a question for which the score is not inverted (question 3) is, “I am inclined to feel that I am a failure.” A high score on this question indicates high self-esteem because the respondent does not agree with this statement. An example of a question for which the score is inverted (question 2) is, “I feel that I have a number of good qualities.” A high score on this question indicates low self-esteem because the respondent disagrees and therefore the score must be inverted.

- ◆ McClosky and Schaar Anomie Scale (MSA) consist of nine questions designed to measure attitudes, beliefs and feelings towards the social and political community. The authors rigorously tested the items and found them to be a valid measure of the feelings and thoughts that many social scientists interviewed by the authors commonly associated with anomie. Some item examples include statements such as: “people today lack firm convictions and standards; “it is difficult to tell right from wrong in our complex and disorderly world;” “the traditional values which gave meaning to the individual and order to the society have lost their force; and “the social ties which once bound men together have dissolved.”

One subjective questionnaire was administered at post-testing to provide participants with an opportunity to respond in their own words to questions such

as, what was most useful or least useful in the training, what they learned and what they still do not understand and information such as age, reason for being in treatment, how many times they had been in treatment.

Additionally, clinical staff rated a few of the participants on the SIS Communication Skills questionnaire prior to and following SIS training to allow an anecdotal comparison between self-reported changes and staff perceptions of individual and group behaviors and attitudes related to affiliation, cohesiveness and participation.

CHAPTER 3

RESULTS

Paired Observations

Effectiveness of Say It Straight™ (SIS) training program (SAY IT STRAIGHT FOUNDATION, Carlsbad, CA, www.sayitstraight.org) was evaluated with paired sample *t*-tests (2-tailed) on six objective questionnaires given before and after training. Subjective questionnaires were given following completion of SIS training with some of the comments from the subjective feedback reported at the end of this section. Participation in the study was voluntary. SIS training was offered to 39 residents, of these, three residents were excluded from the study due to developmental or dementia-related diagnoses, three chose not to participate, five were discharged routinely prior to completion and were not post-tested and two subjects were discharged against medical advice during the training. Of the remaining 26 residents in the study, 23 attended over 80% of the training sessions and three attended over 50% of the training sessions.

Table 1 shows mean scores on self-reports of empowering (SIS) and disempowering behaviors before and after SIS training for 26 residents as measured on the SIS Communication Skills Questionnaire, variance and results of 2-tailed *t*-tests for paired observations, degrees of freedom and *p*-values. The scores for disempowering communications are illustrated in two ways: 1) as a composite score composed of placating, blaming, passive-aggressive, irrelevant,

and super-reasonable behaviors and 2) for each of these individual components, separately. A negative *t*-value indicates the average score was higher after training than before training. The desired result is an increase in empowering behaviors and a decrease in disempowering behaviors.

Table 1

Mean Scores Before and After SIS Training for 26 Residents on SIS Communication Skills, Variance and Results of t-Tests for Paired Observations

	<u>Before Training</u>		<u>After Training</u>		<i>t</i>	<i>df</i>	<i>p</i>
	Mean	Variance	Mean	Variance			
Empowering Behaviors (SIS)	3.453	0.487	4.087	0.439	-3.512	25	1.71E ⁻⁰³
Disempowering Behaviors Composite (P, PA, B, I, SR)	2.974	0.226	2.493	0.238	4.897	25	4.87E ⁻⁰⁵
Placating (P)	3.700	0.810	2.762	0.43	5.55	2	8.90E ⁻⁰⁶
Passive-Aggressive (PA)	2.500	0.404	2.002	0.797	3.164	25	4.06E ⁻⁰³
Blaming (B)	2.446	0.427	2.331	0.413	0.982	25	0.336
Irrelevant (I)	3.008	0.485	2.658	0.277	2.919	25	7.33E ⁻⁰³
Super-Reasonable (SR)	3.223	0.692	2.746	0.517	3.408	25	2.22E ⁻⁰³

As can be seen in Table 1, there is a significant increase in empowering behaviors ($p = 0.002$) evident following SIS training. The composite score for disempowering behaviors and four of the five individual components (placating, passive-aggressive, super-reasonable, and irrelevant) show significant decreases (p values ranging from $p = 0.00000890$ to $p = 0.002$) following SIS training. The change in the blaming component score decreased after training but it was not statistically significant. Several possible explanations for this

statistically insignificant change in blaming behaviors will be further explored in the discussion section.

This study also evaluated the effectiveness of SIS training in facilitating an increase in an individual's perceived group affiliation/group cohesiveness and family life. Table 2 shows mean scores for 26 residents on the Quality of Life Questionnaires in the training group (QLQ-Group, measure of group cohesiveness) and the family (QLQ-Family), variances and results of 2-tailed *t*-tests for paired observations, degrees of freedom and *p*-values.

Table 2

Mean Scores Before and After SIS Training for 26 Residents on SIS Quality of Life-Group and Quality of Life-Family Questionnaires, Variance and Results of t-Tests for Paired Observations.

	Before Training		After Training		<i>t</i>	<i>df</i>	<i>p</i>
	Mean	Variance	Mean	Variance			
QLQ-Group	7.069	1.211	7.970	1.137	-4.784	25	6.52E ⁻⁰⁵
QLQ-Family	6.692	3.809	7.578	1.611	-3.399	25	2.27E ⁻⁰³

Results in Table 2 show that scores for both quality of life in the peer group (group cohesiveness) and the family significantly increased following SIS training, with *p* values ranging from 6.52E-05 for QLQ-Group to 2.27E-03 for QLQ-Family. All *p* values are results from 2-tailed *t*-tests for paired observations.

Each resident also completed a short form of the Rosenberg Self-Esteem Scale (Rosenberg, 1965) before and after SIS training. Average scores before and after SIS training, variance, and results of 2-tailed *t*-tests for paired observations, degrees of freedom and *p*-values are provided in Table 3.

Table 3

Mean Scores Before and After SIS Training on the Short Rosenberg Self-Esteem Scale for 22 Residents, Variance and Results of t-Tests for Paired Observations.

	Before Training		After Training		<i>t</i>	<i>df</i>	<i>p</i>
	Mean	Variance	Mean	Variance			
Self Esteem	4.769	2.656	6.267	2.519	-6.602	25	6.46E ⁻⁰⁷

As can be seen in Table 3, residents reported a significant increase in self-esteem following SIS training, with $p < 0.001$.

Residents were also given a nine-item scale measuring what McClosky and Shaar believed to represent an individual's perceived level of anomie.

Average scores before and after SIS training, variance, and results of 2-tailed *t*-tests for paired observations, degrees of freedom and *p*-values are provided in Table 4.

Table 4

Mean Scores Before and After SIS Training on Anomie for 26 Residents, Variance and Results of t-Tests for Paired Observations.

	Before Training		After Training		<i>t</i>	<i>df</i>	<i>p</i>
	Mean	Variance	Mean	Variance			
Anomie	4.813	1.186	4.174	1.279	2.702	25	0.0122

Results displayed in Table 4, show a significant decrease in self-reported level of anomie following SIS training with $p = .012$.

Correlations

An increase in empowering communication/behaviors was predicted to correlate with a decrease in anomie and an increase in self-esteem, quality of life in the group and quality of life in the family. In addition, a decrease in disempowering communication/behaviors was predicted to correlate with a decrease in anomie and an increase in self-esteem, quality of life in the group

and quality of life in the family. In all previous research, SIS training has been shown to increase empowering communication/behavior and decrease disempowering communication/behavior. Therefore, Englander-Golden suggested the concept of Communication/Behavior Excellence (CBE) defined as the change in empowering communication/behavior before and after SIS training minus the change in disempowering communication/behavior. Correlations in this study were done between fractional changes in all variables. A fractional change is defined as the difference between an individual's score on a variable after SIS training (V2) minus the same individual's score before SIS training (V1), divided by the average value of the variable for the whole sample at time 1:

$$(V2-V1)/ \text{average } V1 = \Delta V$$

Table 5 shows Pearson *r* correlations coefficients between fractional changes in empowering communication/behavior (Δ SIS), combined disempowering communication/behavior (Δ CDCB), communication/behavior excellence (Δ CBE) and anomie (Δ A), self esteem (Δ SE), quality of life in group (Δ G) and quality of life in family (Δ F).

As can be seen in Table 5, anomie is positively correlated with disempowering communications/behavior, although the correlation barely missed the required value of $p < 0.36$ for a 0.05 significance level. It is significantly negatively correlated with empowering and communication/behavior excellence, with $p < 0.01$. Self-esteem is negatively correlated with disempowering communications/behavior, with $p < 0.0005$ and highly positively correlated with communication/behavior excellence. The correlation with only empowering

communication/behavior is positive but missed the acceptable p value for significance. Quality of life in the group approached a significant negative correlation with disempowering communications/behavior with $p < -0.304$. It was positively correlated with empowering and communication/behavior excellence, however these correlations were not significant. Quality of life in the family was negatively correlated with disempowering communications/behavior with $p < 0.025$, significantly positively correlated with empowering communication/behavior with $p < 0.05$ and highly positively correlated with communication/behavior excellence, with $p < 0.01$.

Table 5

Correlations between Fractional Changes in Anomie (ΔA), Self Esteem (ΔSE), Quality of Life-Group (ΔG), Quality of Life-Family (ΔF) and Empowering Communication/Behavior (ΔSIS), Disempowering Communications/Behavior (ΔDCB), and Communication/Behavior Excellence (ΔCBE), and p Values

	ΔSIS		ΔDCB		ΔCBE	
	R	p	R	p	R	p
ΔA	-0.509	< 0.01	0.347	ns	-0.506	< 0.01
ΔSE	0.320	ns	-0.665	< 0.0005	0.515	< 0.01
ΔG	0.076	ns	-0.304	ns	0.186	ns
ΔF	0.409	< 0.05	-0.485	< 0.025	0.497	< 0.01

Summary Statement of Results

In summary, all hypotheses were supported by the statistical analyses of data, and resulted in significant differences in the proposed direction for each hypothesis with two exceptions. The reduction in blaming was not statistically significant.

Summary of Subjective Feedback

Overall, comments on the subjective feedback questionnaires were quite positive, and indicated that SIS training was found to be helpful to participants. The following are the written responses (without correction or editing) to the following sentence prompts:

The most useful things to me were: “to watch how say it straight could change the outcome”; “...learning body language and mental postures with physical appearance”; “...being aware of my feelings and matching to what I was saying”; “...the learning of how poorly I was interacting or speaking straight”; “...group temperature readings”; “...circle of influence, genealogy, parts party, sculpting [communication stances]”; “...parts party (all of them were very helpful), meditation at the beginning of some sessions—I would recommend doing it before all sessions, modeling different styles—silently and then with feeling”; “...how to have a good, fair conversation/argument and still value the speaker, the other person and the topic”; “role-play, parts parties and group discussion”; “learning how much I placate when I interact with others, I am also passive-aggressive”; “The couple’s parts party showed me the parts of ourselves we deny and how our parts interact”; “The lectures on placating, blaming...role playing”; “dissecting roles within families and way I relate to them”; “my exercise on communication with my wife”; “Parts party and family sculpture”; “Time spent doing practical activities”; “modeling different styles, silently and then with feeling; all of the parts parties were very helpful; meditation at the beginning of some sessions—I would recommend doing it before all sessions”; “How to have a

good, fair conversation/argument and value the speaker, value the other person and value the topic”; “Parts parties—seeing how all parts can offer some benefit and help make a person whole.”

What I learned about saying no was: “...it’s healthy and sometimes more honest”; “...how to be direct”; “...I can say it, there are ways to say what I mean and not have to feel guilty or responsible for other peoples’ feelings”; “...that you can say it straight without hurting someone feeling or making them mad”; “...it is ok to say no”; “...that I can say no...and still be respected and loved”; “...you don’t have to explain why you are saying no—it’s okay to say no”; “...to set boundaries...make myself #1”; “...It’s okay to say no, to stand up for yourself, to stand up for me”; “...I need to better respect myself and say it straight”; “to stand up for myself and honor my boundaries, let my no really mean no and stick with it”; “it’s okay to say no without justifying why”; “I can say no, I can say no without excuses, I can say no to a loved one, and I can express my feelings”; “It’s okay to say it straight”; “I can and the world does not stop”; “I can say what I need to say to people honestly and honor me, them and the topic without stressing out about whether I sacrificed my own needs and beliefs”; “It’s okay”; “People will never respect my boundaries unless I honor them”; “I do not have to explain why or sit around and discuss”; “That I don’t need to be defensive and stick by my no”; “To do it effectively without hurting others but respecting my wants/needs”; “That I can do it without lengthy excuses.”

What I learned about Saying It Straight™: “how to be honest more honest with why I am saying no or yes, to actually follow through on my decisions”; “...to

respect one another when communicating”; “...we are not interacting with each as single individuals, but as a myriad of characteristics”; “...to be direct with people, speaking my mind without blaming, and how to make compromises, have empathy, and come to a consensus. No means no;” “...it’s important and can be done effectively” ; “...I’ve learned a format for giving feedback without attacking”; “...I felt like I already was fairly upfront with people, I could learn to be more honest with me;” “...when I practice it with my family, communication improved vastly; ”I can say what I need to say to people honestly and honor me, them and the topic without stressing out about whether I sacrificed my own needs and beliefs”; “I can say what I mean and mean what I say”; “How to say no;” “to not dress up what I say with things that reflect my position in the interaction.”

CHAPTER 4

DISCUSSION

This chapter begins with a review of the problem initially identified, the relevance of the study, the manner in which Say It Straight™ (SIS) training program (SAY IT STRAIGHT FOUNDATION, Carlsbad, CA, www.sayitstraight.org) was chosen as an intervention and a review of the research questions originally formulated. The remaining sections include the following:

- ◆ Review of the results
- ◆ Unexpected result
- ◆ Clinical observations
- ◆ Limitations and criticism of methods
- ◆ Implications for current theory
- ◆ Implications for treatment settings
- ◆ Research recommendations
- ◆ Conclusions

Statement of the Problem

Anomie (as defined by a sense of normlessness, meaninglessness, low self-esteem and lack of belonging or alienation from self) is perpetuated and transmitted through disempowering communication processes and hinders the development of group cohesiveness (Yalom, 1995). Group cohesiveness within a residential treatment setting is of the utmost importance as it is seen as “an essential condition that allows the other mechanisms of change and cure to be set in motion” (Flores, 1997).

Relevance of the Study

Anomie, as defined from a socio-psychological perspective, is an individual's perceived level of normlessness, meaninglessness, and lack of belonging or alienation from self and self from others.

Prior to entering into a residential treatment setting, addicted persons often experience difficulty in establishing and maintaining healthy interpersonal relationships (Flores, 1997). In fact, many people affected by addictions have described a family history of disempowering communication that contributes to a sense of normlessness, meaninglessness, low self-esteem and lack of belonging or alienation from self and from others (Yalom, 1995). Modern sociologists often refer to this cluster of conditions as anomie.

Yalom (2002), in his foundational book on group psychotherapy, describes the therapy group as a social microcosm where therapeutic gains made through these interactions are then translated in the group members' world outside of group. However, he reports that residents in weekly outpatient groups often question the validity and therapeutic value of the interactions within group, suggesting that their own behavior within group interactions is peculiar to that particular group and doesn't reflect their "real behaviors" (Yalom, 2002). This is a complaint often heard by residents within the residential group setting, who, in addition, sometimes question the relevance and efficacy of the residential treatment process for maintaining gains following discharge.

Yalom concedes that the group is artificial in the sense that the formation of the group is purposeful, goal focused, and with an expectation that the

relationships are transient, but states confidently that the therapy group does indeed represent a real world. In fact, Yalom uses case examples to illustrate that the relationship interactions that take place within group can be substantial, not representative of the real world but “far more real than the world out there” (Yalom, 2002). One may easily assume that the residential setting would provide the same or even more real world experience interacting with others.

Say It Straight™ as Intervention of Choice

Relapse and recidivism rates are astoundingly high for persons suffering from the disease of addiction. A commonly cited statistic is that only one out of 10 persons attempting sobriety for the first time will remain relapse free. Hence, the importance of providing addicted residents within a residential treatment setting with opportunities to practice empowering behaviors and communication skills that have been shown to be powerful tools for avoiding relapse into destructive behaviors far beyond the duration of treatment and training.

SIS is a research-based program shown to increase straightforward communication/behaviors and decrease disempowering communication and behaviors. This is important in light of previous studies indicating the efficacy of SIS in decreasing the likelihood of engaging in destructive behaviors for up to 19 months following SIS training (Englander-Golden, Jackson, Crane, Schwarzkopf, & Lyle, 1989).

In previous SIS research with juvenile police offenders, Englander-Golden provided strong evidence of the long-range effectiveness of SIS in real world situations. Englander-Golden found that over the entire 19-month period of the

study, high school students who did not participate in the 5-day SIS training period had approximately 4.5 times as many criminal offenses as the SIS-trained high school students (Englander-Golden et al., 1989).

SIS, because the experiential nature of the training such as the physical sculptures and parts party, was expected to help individuals to access their emotions congruently, and avoiding what Yalom refers to as the less effective method of remaining distant and experiencing concepts from a purely intellectual perspective (Yalom, 2002).

Englander-Golden described the process of change through SIS as facilitating an increase in participants' insight as follows: 1.) recognition of past behavior: "I have done this before"; 2.) awareness of present behavior: "I am doing it now"; 3) awareness of anticipated behavior: "I am about to do it"; 4.) awareness of deep wishes for desired behavior; 5.) choosing behaviors congruent with one's deepest wishes; and 6.) implementing the new choices (Englander-Golden et al., 1989)."

This change process is entirely compatible with and supportive of the Santé Center for Healing (Santé) approach to relapse prevention planning. Over the course of the study SIS training provided Santé residents with opportunities to practice or operationalize relapse prevention behaviors through empowering communication (with self and others) during related experiential interventions.

Review of Research Questions

This study evaluated SIS training for its ability to improve straightforward communication, increase self-esteem, increase an individual's overall perception

of group and family belonging or cohesiveness within a residential treatment setting and decrease an individual's perceived level of anomie. Four main research questions were addressed:

1. Does SIS training improve an individual's ability to communicate in a straightforward, non-manipulative manner and decrease communication/behaviors such placating, blaming, passive-aggressive, Irrelevant and super-reasonable?
2. Does SIS training decrease an individual's experience of normlessness, meaninglessness, and lack of belonging (anomie) while within a residential treatment center?
3. Does SIS training increase the individual's perceived sense of belonging as regards group (group cohesiveness) and family while within a residential treatment center?
4. Does SIS training increase self-esteem?

Review of the Results

In answering question one, statistical analysis provides compelling evidence that SIS does indeed increase one's ability to communicate in a straightforward and empowering manner as evidenced by a statistically significant increase on this measure following SIS training with $p = 0.002$ (see table 1). In addition, the composite of disempowering behaviors show a statistically significant decrease following SIS training with $p = .000487$ (see table 1). Analysis of the individual components that make up the disempowering composite score showed significant decreases in placating passive-aggressive,

irrelevant, and super-reasonable communication/behaviors with p values ranging from $p = 0.00000890$ to $p = 0.002$. The reduction in blaming was not statistically significant.

Analysis of the data for Questions 2, 3, and 4 indicate that Anomie decreased significantly with $p = .0122$ following SIS training, while Group cohesiveness as measured by QLQ-G and QLQ-F increased significantly with p values ranging from $6.52E-05$ to $5.47E-03$ respectively, and self-esteem increased significantly with $p < 0.001$ ($6.46E-07$).

Unexpected Result

The blaming did not show a significant reduction following training although it did show improvement. Several alternate explanations for the failure of the blaming change score to reach statistical significance are feasible. This is a surprising result because Englander-Golden's study, working with indigent mothers in treatment, showed a significant reduction on this measure. The difference may be due to this population in the present study being much more educated on average and in professions where overt expression of anger is unacceptable, as a fair portion of the population in this study were educators, attorneys, registered nurses, medical researchers, professors and physicians.

As a result of the rules for comportment intrinsic to these professions, residents may have been reluctant to or even fearful of expressing their anger overtly within group (Yalom, 2002). Results of this study suggest this may be true, as residents scored higher on pre-test measures of the placating and passive-aggressive scales as compared to pre-test blaming scores. Yalom

refers to this underlying group energy as unexpressed hostility which, if left unaddressed, will hinder the development of group cohesiveness (Yalom, 2002).

In this study, placating and passive-aggressive scores decreased following SIS training, while group cohesiveness scores increased. This is consistent with Yalom's findings that addressing unexpressed hostility will enhance group cohesiveness. Residents shifted more readily from placating and passive-aggressive behaviors and as group cohesiveness developed, residents felt safer expressing their anger, frustrations and conflicts with one another. This may also explain why blaming scores, though improving, did not show a significant decrease as was expected initially. Again, this is consistent with Yalom's findings that group cohesiveness is enhanced as members are facilitated in giving voice to previously unexpressed hostility (Yalom, 2002).

Clinical Observations

Noticeable behavioral changes occurred as a result of SIS training. Following are four examples of positive changes for both group interactions and individual behavior.

Those who did not participate in the SIS training were more likely to leave against medical advice. As previously explained, Santé adopted SIS training as the primary component of the ongoing skills-building curriculum for the duration of the research, and as such, residents were required to attend SIS training sessions. Residents were informed that participation in the research portion (data collection and analysis) was voluntary and residents could decline participation in the research portion at any time, and without consequence. In

one instance however, a case manager excused one resident from participation in the SIS training sessions as well as the research portion of the study. Several weeks later this person subsequently attempted to leave against medical advice (AMA) and decided to remain in treatment only following a spontaneous group intervention by his SIS-trained peers. In SIS training such an intervention is called positive support and is modeled and practiced in the movies that are played out by the residents.

This type of spontaneous group intervention was a new behavior, at least in this writer's four-year tenure at Sante. This turned out to be representative of what became a prevalent attitude of increased concern for one another's recovery and willingness on the part of residents to go out of their way to assist staff in forestalling residents leaving AMA as well as intervene informally on their own with greater frequency.

In fact, results of this study indicate that SIS contributed to a significantly reduced rate of AMA discharges for the period of this study, and thus increased the chances for treatment completion. The average rate of AMA discharges per four weeks over a five-month period prior to the initial SIS training was six and dropped to only two during the time period of each five-week SIS training period.

The changes in group attitude evident in group members' willingness to intervene as a group on one another's behalf during the SIS study are consistent with Yalom's findings that individuals belonging to groups with high levels of cohesiveness are more likely to put forth more effort to influence other members, more likely to exert pressure on individuals deviating from the norms of the group

and are also more likely to allow themselves to be influenced by other group members toward more positive behavior (Yalom, 2002). It is important to note that the administration of Santé reported that SIS resulted in a greatly reduced rate of AMA discharges during the period of the study (10 weeks) and thus increased the chances for treatment completion. The average rate of AMA discharges during 20 weeks prior to the beginning of SIS training was 27. This number dropped to 4 AMA during the 10 weeks of SIS training. The administration is at present reviewing the records to be able to compare the average number of residents per week during the 20 weeks prior to SIS training as compared to the average number of residents per week during the 10 weeks of SIS training for the purposes of Chi Square analysis.

Some individuals who initially identified most strongly with placating behaviors significantly increased their ability to communicate in a straight forward manner as a result of SIS training. This is strongly supported by data analysis and several are described below.

One of the residents, a physician, described “finding his voice” as a result of SIS training and began moving from placating to saying it straight in interactions with peers and staff. This resident verbalized how this change in behavior was directly applicable to coping with triggers for relapse identified in his written relapse prevention work and operationalized during SIS training. He began to explore communicating with peers and staff in a straightforward and empowered manner in his last few weeks of treatment. He experienced a temporary increase in self-reported anxiety as he moved from habitual placating

behaviors to one of congruence and honesty in speaking his deepest wishes. He reported that his anxiety gradually subsided as he gained increased self-efficacy and self-esteem as result of risking new behaviors and ways of being in the world in a more empowered way.

SIS training was shown to increase self-esteem and facilitates one's ability to make healthier decisions regarding relationships. As an example, a young woman shared at the beginning of SIS that she was currently in a relationship in which she felt abused emotionally by her boyfriend. She stated that previously, she had been unable to communicate to her boyfriend her deepest wishes for herself and their relationship; instead, she placated him constantly, often at the expense of her own dignity and self-esteem. Near the end of the five-week SIS training session, this young woman proudly and happily informed the group that she had ended this relationship. She subsequently struggled with falling into previous disempowering patterns of behavior with several male peers, also in treatment, but reported increased awareness of these behaviors and a desire to practice making different choices.

One of the ways in which SIS training encourages the above changes is by providing residents with an opportunity to try out and practice new behaviors. Residents identified difficult interpersonal situations they either anticipated or drew from their own experiences; the residents were then cast as actors and experienced themselves in these situation from several different perspectives: 1.) being the person whose deepest wish is to say no to pressure to engage in high risk behaviors and experiencing one's feelings as they handle the situation

in empowering and disempowering ways; 2.) discovering the effect they have on the person trying to pressure them as they are responding to the pressure in empowering and disempowering ways; 3.) discovering how others (the observers and the coercer) see their verbal and non-verbal behaviors; 4.) being a person coercing another to engage in a high risk behaviors and experiencing one's feelings toward the other person when that person placates, blames, begins lecturing, or changes the subject rather than saying what is their deepest wish in the situation—to say no; 5.) to experience one's feelings toward another person when that person is able to say no in a manner that is focused, straightforward, firm and yet respectful of the coercer; and 6.) to experience the situation as an objective observer in the role of director and assisting the actors in playing each part “to the hilt” and assisting each to process their feelings while experiencing each perspective. The actors are switched to assume the various parts in a movie until each has an opportunity to experience responding from each perspective and practice empowering behaviors. From their own experiences and feedback from their peers, residents discover how they feel and what effect they have on others as they take care of themselves in ways that honor themselves and are respectful of others, compared to demeaning themselves and/or others (Englander-Golden et al., 1989, Englander-Golden & Golden, 1996, Yalom, 1995).

Through playing parts as actors, residents were afforded a sense of safety and distance from the part played. Yet at the same time, they were asked to be aware of their own feelings as they were playing the parts. This process

facilitates experiencing one's own feelings in difficult situations. The residents were not only asked to identify difficult situations in the "outside" world they have experienced or anticipate, but also situations experienced within treatment in which they are challenged to speak their deepest truth in difficult situations. For example, being asked to lie for someone or keep a secret covering destructive or addictive behavior of another or speaking up when others are deviating from passes or purchasing and consuming contraband such as cigarettes.

Prior to this exercise, participants in this study were asked to identify any fears they had about voicing their deepest wishes in their identified situations. They voiced fears that if they honored themselves and spoke their deepest wish (not to engage in high-risk behavior) they would be rejected by the pressurer or seen as "un-cool", and become isolated from or abandoned by their friends. These comments were strikingly similar to Englander-Golden's report of comments made by young people participating in SIS training in third through twelfth grade as well as mothers in addictions treatment (Englander-Golden et al., 1989, Englander-Golden, Gitchele, Henderson, Golden, & Hardy, 2002).

In these studies, participants reported that by honoring their deepest wishes they not only gained self-esteem but opened up opportunities for increased emotional intimacy within their friendships and relationships with peers. As in the present study, Englander-Golden and Golden also found a showed a significant increase in self-esteem following SIS training (Englander-Golden et al., 2002).

Limitations of Methods

One of the limitations might be the risk of expectancy demand in either a positive or negative direction as the primary researcher and facilitator of training is also a staff case manager and therapist. It is interesting to note here that several therapists observed positive behavioral changes in residents such as tolerating and resolving conflict more readily in groups and utilizing the ideas and language of SIS training while participating in other group settings such as group case management and process groups.

Another limitation of this study is not having a control group for comparison; it would be helpful to have a control group with a similar group composition, level of care, and curriculum that includes an experiential training program comparable to SIS.

Yalom (2002) also spoke of the limitations of any objective measure of group cohesiveness due to the myriad of human manifestations; for example, cohesiveness may also be expressed or manifested as a resident's willingness to express hostility openly as a result of the group's increased tolerance for conflict due to increased group cohesiveness. Most measures of group cohesiveness are unable to account for this type of indicator and the Anomie, QLQ-G and QLQ-F utilized in this study probably have similar difficulties.

Englander-Golden, in a study of mothers in residential treatment for addiction, found that SIS rapidly decreased the disparity of characteristics associated with recovery between those newly admitted and those who have been in treatment long term, essentially "catching up" those newly admitted and

still showing improvement in those long-term residents (Englander-Golden et al., 2002). However, this type of analysis was not available for this study because the number of subjects in each range required for this analysis was not sufficient.

Implications for Current Theory

Current theoretical trends indicate a movement toward a more empirically-focused definition of anomie. Moving from Durkheim, Merton and even Srole, present-day theorists are defining and measuring anomie by identifying and measuring what have come to be known as “anomic characteristics” (Orru, 1987). These characteristics, related to social interactions with family, family of choice, and work group, also have an effect on the social system within which these individuals exist, contributing to anomie at a group level, not just a unidirectional relationship from macro-level anomie to individuals. Thus, all of the measures utilized in this study may be seen as components that together represent a construct of anomie, perhaps assessing the variable more completely than any single measure.

Implications for Treatment Settings

Some modern anomie theorists view anomie as an inevitable part of a creative process, not necessarily pathological in a certain context and if limited in duration. However, there are instances in residential treatment when circumstances contributing to anomic conditions seem to be put forth intentionally by clinicians. For example, a discrepancy of interpretation between a resident (often an impaired professional with licensing issues) and the treatment team sometimes occurs regarding whether or not the resident has fulfilled the criteria

required for discharge stated on the treatment plan. The resident, having completed all written assignments, will often press the treatment team for a firm discharge date (usually in the immediate future) but will be asked to remain in treatment for an unspecified length of time in order to demonstrate his or her ability to implement recovery behaviors addressed in written assignments.

Residents in such a situation will often express their perception of the means to reach a firm discharge date as unavailable, even after having completed the written (and thus tangible) portion of the stated criteria. This can result in what some residents have reported as feelings of helplessness, frustration, “drifting” and despair, or what Sternberg refers to as a “cluster of predictable feelings” resulting from anomic conditions, especially if a resident’s return to previous career depends upon successful completion of treatment (Sternberg, 1981).

In reaction to this anomic condition, these residents may resort to disempowering behaviors. Further, if left unaddressed, this condition can lead to deviance (rule-breaking) or outright rebellion, resulting in an even longer delay in successfully discharging from treatment.

This purposefully induced form of anomie is sometimes therapeutic if limited in duration and is intended to encourage the more intransigent and controlling residents to decrease attempts to manipulate treatment outcomes and deepen their understanding of recovery principles, particularly that of surrender.

It is this writer’s observation that this type of approach has only been effective when the resident feels empowered (by self and treatment team) to

communicate congruently regarding his or her perceived obstacles, struggles and frustration. The therapist can then assist the resident in finding internal resources and motivation to co-create with the treatment team, tangible, objective and measurable criteria for a successful discharge.

Cycles of change in group cohesiveness are inevitable in a residential treatment setting where the resident population changes sometimes on a daily basis (Yalom, 2002). Orru (1987), a modern anomie theorist, describes periods during which anomic situations/conditions are an important part of a growth or change process and refers to this form of anomie as normative flexibility. According to Orru, social anomie triggers individual change which is then mirrored in society. Orru summarizes his stance when he states “Normative flexibility and anomie are necessary requirements of social change” (Orru,1987).

Likewise, Milton and Yinger view anomie as having some benefit, and “as an inevitable part of the process whereby old tyrannies are broken and new values given in a field of growth” (Yinger, 1965). Interpreting the results using Orru’s model, SIS facilitates residents in the transition from or transformation of anomie into normative flexibility, encouraging positive social change in the treatment milieu by providing residents with training that is based on present-focused, level, and congruent communication.

Letting go of old ideas and disempowering ways of being in the world necessitates a period of discomfort. Group cohesiveness fostered by SIS training allows for positive risk taking and increased tolerance of these periods of normative flexibility.

Continuing with this paradigm, results of this study suggests that SIS facilitates the development of normative flexibility within the culture of the residential treatment setting by helping residents learn to move from previous or historical patterns associated with addiction to empowering behaviors and communication (Yinger, 1987).

In summary, anomie, if left unchecked and characterized by detachment and alienation from self and others leads to deviance and rebellion and is destructive to group cohesiveness. Normlessness (without detachment) however, in the presence of high group cohesiveness, and accompanied by self-esteem, can be transformed into a creative, transitional stage of recovery referred to by some present-day sociologists as normative flexibility, which allows one to let go of disempowering behaviors and try out new and empowering behaviors supportive of sustained recovery.

Research Recommendations

- Follow-up with Sante alumni participating in the SIS training regarding participation in recovery behaviors following discharge such as participating in meaningful recovery-oriented group activities supporting recovery, and compare frequency of these behaviors and recidivism rate for SIS trained alumni with Sante alumni who were not SIS trained.
- Develop a tool for measuring the characteristics of anomie specifically related to treatment settings, including additional measures to reflect anomie as a construct versus a single variable.

- Develop a tool for measuring the characteristics of group cohesiveness specifically related to treatment settings, including additional measures reflecting group cohesiveness as a construct versus a single variable.
- Replicate the study and include a control group that has similar group composition, level of care, and curriculum and includes an experiential training program comparable to SIS

Conclusions

Anomie can be both destructive and creative. The destructive type is inherent in active addiction and can also result from the distress that inevitably accompanies the treatment process and sometimes even be exacerbated by the clinical team and the facility itself. It is indicated by some or all of the following: increased detachment, feelings of hopelessness or resignation (vs. surrender), alienation from self and others, isolating behaviors and increased deviance from group norms and rules. It is anathema to group cohesiveness.

Likewise, the creative form of anomie, or what Orru termed normative flexibility, is inherent in the recovery process as a stage of transition for residents moving from “old ideas” and disempowering behaviors to unfamiliar but empowering behaviors supportive of recovery. It is sometimes purposefully or therapeutically induced by certain practices of the clinical team designed to encourage “letting go” or surrendering attempts to shortcut or manipulate one’s own treatment outcomes, often employed by the more narcissistic residents in residence at Sante Center for Healing.

High group cohesiveness is essential for transforming destructive anomie and in supporting individuals experiencing creative or constructive anomie. Group cohesiveness allows for increased tolerance of emotional discomfort through group support experienced as residents risk trying out new behaviors that are congruent, honest and less manipulative and thus encourages greater emotional intimacy with self, peers and family.

However, a single group cohesiveness measure may not be adequate to assess this important variable of successful treatment outcomes (Yalom, 2002). The presence of group cohesiveness allows for and even requires that members learn to express any hostility and anger openly with one another and even the therapists leading the group. Current measures are limited in their ability to distinguish varied affective manifestations of group cohesiveness from an anomic or less cohesive group milieu. For example, a resident may feel safe enough within a highly cohesive group to express hostility to staff or other group members on a given day, but this may be viewed by staff and recorded by assessment tools as an increase in disempowering behavior such as blaming, particularly on a resident's first attempts.

For this reason and in order to understand and assess both anomie and group cohesiveness effectively, it was helpful to view them both as constructs made up of several variables (in addition to their individual measures) such as higher or lower self-esteem, alienation (from self and self to others) and the empowering and disempowering communication behaviors as measured by the SIS communication questionnaire. The five assessment tools utilized in this

study collectively provided a more meaningful picture of both anomie, and group cohesiveness.

APPENDIX A
INFORMED CONSENTt

Informed Consent for Research

Dear Participant

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks, and potential discomforts of the study. It also describes resources available to you during the study and your right to withdraw from the study at any time without consequence.

The purpose of the study is to examine the relationship between training in congruent and honest communication and an individual's feeling of group affiliation and belonging while in treatment in a residential treatment setting. The study is performed as a partial fulfillment of the requirements for the researcher's Ph.D. in sociology at the University of North Texas.

Say It Straight Training will become part of the ongoing skills-building curriculum at Sante Center for Healing for the duration of the research. During that time, each patient will receive five hours of Say It Straight Training each week for five weeks.

Participation in the research includes completing five self-report measures prior to the Say It Straight Training and again following completion of the five-week training series. Additionally, some demographic information will be collected such as age, gender and income. Participants will also be provided the opportunity to respond in their own words about their experience with the Say It Straight Training.

Anonymity will be preserved in all data collection by the following: participants will be assigned an identification number used to match pre and post training questionnaires; any identifying information will be encrypted and protected by password and stored on a secured server. The primary investigator will be the only person with the password to access data and all identifying data will be destroyed following completion of the post-training questionnaires.

The use of your data in the research aspect of this training is entirely voluntary and will have no effect on decisions regarding your ongoing progress in treatment. You may decline from participating in the testing at any point in this project without negative consequences.

There are potential risks associated with the research including but not limited to test-taking anxiety, boredom, or emotional discomfort as a result of issues addressed related to your family of origin. If any emotional discomfort should arise as a result of this research and remains unresolved following any of the training sessions, you are encouraged to inform your individual case manager for additional assistance.

Say it Straight is offered as an opportunity for improving communication skills, relationship skills, and quality of life. Previous research results indicate that Say It Straight Training has been successful in promoting high self-esteem, empathy, positive relationships, personal and social responsibility, good communication skills, willingness to implement constructive decisions in difficult interpersonal situations and feeling more at ease when doing so, and increasing quality of life on group and family levels.

This project has been reviewed and approved by the UNT Committee for the protection of Human Subjects (940-565-3940),

Research Subject's Rights .

I have read or have had read to me all of the above. Research study personnel have explained the study to me and answered all of my questions. I have been told the risks and/or discomforts as well as the possible benefits of the study. I understand that I do not have to take part in this study and my refusal to participate or to withdraw will involve no penalty, loss of rights, loss of benefits, or legal recourse to which I am entitled. The study personnel may choose to stop my participation at any time.

In case problems or questions arise, I have been told I can contact Tom Wood at (940-464^7222) and/or James Kitchens, Ph.D. Professor of Sociology, University Of North Texas (940-565-2396).

I understand my rights as research subject and I voluntarily consent to participate in this study. I understand what the study is about how the study is conducted, and why it is being performed. I have been told I will receive a signed copy of this consent form.

Signature of Subject

Date

Signature of Witness

Date

For the Investigator or Designee:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the known benefits and risks of the research. It is my opinion that the subject understood the explanation.

Signature of Principal Investigator

Date

APPROVED BY THE UNT IRB
FROM 2/25/04 TO 2/24/05

APPENDIX B

THE MCCLOSKEY AND SCHAAR ANOMIE SCALE

Reproduced from McCloskey and Schaar (1965). Psychological dimensions of
anomy. *American Sociological Review*, 30(1), 14-40.

TIME 1

NB: TIME 2 is identical to TIME 1

TIME 1 DATE: _____

INSTRUCTIONS: Please indicate the degree to which you agree or disagree with the following statements by circling the number which most closely corresponds with your feeling about each statement.

1. With everything so uncertain these days, it almost seems as though anything could happen.

9	8	7	6	5	4	3	2	1
strongly		agree		not sure		disagree		strongly
agree								disagree

2. What is lacking in the world today is the old kind of friendship that lasted for a lifetime.

9	8	7	6	5	4	3	2	1
strongly		agree		not sure		disagree		strongly
agree								disagree

3. With everything in such a state of disorder, it's hard for a person to know where he stands from one day to the next.

9	8	7	6	5	4	3	2	1
strongly		agree		not sure		disagree		strongly
agree								disagree

4. Everything changes so quickly these days that I often have trouble deciding which are the right rules to follow.

9	8	7	6	5	4	3	2	1
strongly		agree		not sure		disagree		strongly
agree								disagree

5. I often feel that many things our parents stood for are just going to ruin before our very eyes.

9	8	7	6	5	4	3	2	1
strongly		agree		not sure		disagree		strongly
agree								disagree

6. The trouble with the world today is that most people really don't believe in anything.

9	8	7	6	5	4	3	2	1
strongly		agree		not sure		disagree		strongly
agree								disagree

7. I often feel awkward and out of place.

9	8	7	6	5	4	3	2	1
strongly		agree		not sure		disagree		strongly
agree								disagree

8. People were better off in the old days when everyone knew just how he was expected to act.

9	8	7	6	5	4	3	2	1
strongly		agree		not sure		disagree		strongly
agree								disagree

9. It seems to me that other people find it easier to decide what is right to do.

9	8	7	6	5	4	3	2	1
strongly		agree		not sure		disagree		strongly
agree								disagree

APPENDIX C

THE SIS COMMUNICATION SKILLS QUESTIONNAIRE

Copyright by Paula Englander-Golden, 2004. Used with permission.

TIME 1

NB: TIME 2 is identical to TIME 1

TIME 1 DATE: _____

COMMUNICATIONS QUESTIONNAIRE

(Time 1 - at beginning of training)

Think of difficult situations that sometimes come up. Respond to the statements below in the way that best describes what you do at such times. On the line next to each statement, write the number 1 if the statement does not describe you at all. Write the number 6 if the statement describes you very well. Write a number between 1 and 6 depending on how well the statement describes you, with the higher numbers describing you better.

1	2	3	4	5	6
Never	Rarely	Sometimes	Often	Very Often	Always

When I am in a difficult situation:

1. I give a lot of excuses when I want to say no _____
2. I let people talk me into doing things, even when it's not in my best interest _____
3. I put everybody's needs before my own _____
4. I feel that I have to please everybody _____
5. I say yes when I want to say no _____
6. I appear to go along, but I carry resentments _____
7. I appear to go along, but I hold grudges _____
8. I appear to go along, but I make plans to get even _____
9. I go along with somebody's plan, but I sabotage it _____
10. I say yes, but silently I add you'll pay for this _____
11. I threaten others _____
12. I blame others _____
13. I ridicule others or get sarcastic _____
14. I put people down _____
15. I push other people around _____
16. I change the subject or I crack a joke _____
17. I talk about everything except what is really on my mind or in my heart _____
18. I will do anything to distract other people _____
19. I disrupt what's going on _____
20. I "zone out" or "space out" _____
21. I pretend that I know it all _____
22. I lecture or give a lot of facts, without expressing my feelings _____
23. I play smart _____
24. I hide my feelings _____
25. I sound like a computer _____
26. I respect myself and others _____
27. I express my feelings honestly _____
28. I state my decisions without excuses _____
29. I honor my deepest wishes without stepping on others _____
30. I express caring for my loved one, not necessarily for his/her behavior _____
31. I express my hope and my wish for a good outcome _____
32. What I say, my tone of voice and my "body language" match how I feel _____

APPENDIX D

THE QUALITY OF LIFE QUESTIONNAIRE FOR PEER GROUP (QLQ-GROUP)

Copyright by Paula Englander-Golden, 2004. Used with permission.

TIME 1

NB: TIME 2 is identical to TIME 1

QUALITY OF LIFE QUESTIONNAIRE - GROUP

Time 1 before SIS training Date: _____

Next to each statement put the number that best describes you, from 1 to 10

1	2	3	4	5	6	7	8	9	10
not at all			somewhat				very much		

1. I feel good with my group right now _____
2. I like and trust the people in my group _____
3. The people in my group like and trust me _____
4. It is fun and exciting to be a member of my group _____
5. If I make a mistake, my group will still care about me _____
6. I can apologize for something I have done without apologizing for my existence _____
7. I can let go of resentments toward group members _____
8. I hope my group life can improve _____
9. I can give someone my observations without blaming _____
10. I can receive criticism from the group without freaking out _____
11. It's OK for me to be aware of how I feel in my group _____
12. I can give information in my group without playing smart _____
13. I take responsibility for my actions in group, even when they have negative consequences, without blaming others or making excuses for myself _____
14. I give myself permission to take all the steps I can to change what needs changing _____

APPENDIX E

THE QUALITY OF LIFE QUESTIONNAIRE FOR FAMILY (QLQ-FAMILY)

Copyright by Paula Englander-Golden, 2004. Used with permission.

TIME 1

NB: TIME 2 is identical to TIME 1

QUALITY OF LIFE QUESTIONNAIRE - FAMILY

Time 1 before SIS training **Date:** _____

Next to each statement put the number that best describes you, from 1 to 10

1	2	3	4	5	6	7	8	9	10
not at all			somewhat				very much		

1. I feel good with my family right now _____
2. I like and trust the people in my family _____
3. The people in my family like and trust me _____
4. It is fun and exciting to be a member of my family _____
5. If I make a mistake, my family will still care about me _____
6. I can apologize for something I have done without apologizing for my existence _____
7. I can let go of resentments toward family members _____
8. I hope my family life can improve _____
9. I can give a family member my observations without blaming _____
10. I can receive criticism from a family member without freaking out _____
11. It's OK for me to be aware of how I feel in my family _____
12. I can give information in my family without playing smart _____
13. I take responsibility for my actions in my family, even when they have negative consequences, without blaming others or making excuses for myself _____
14. I give myself permission to take all the steps I can to change what needs changing _____

APPENDIX F

THE ROSENBERG SELF-ESTEEM SCALE (RSES) -SHORT-FORM

Reproduced from Rosenberg, M. (1965). Society and the adolescent self-image.

Princeton, NJ: Princeton University Press.

TIME 1

NB: TIME 2 is identical to TIME 1

Time 1
Date _____

ID _____

INSTRUCTION: Please take a moment to consider how you feel about yourself in general. Indicate how much you agree or disagree with the following statements based upon these feelings about yourself.

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

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

2. I feel that I have a number of good qualities.

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

3. I am inclined to feel that I am a failure.

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

4. I am able to do things as well as most other people.

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

5. I do not have much to be proud of.

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

6. I take a positive attitude toward myself.

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

7. I am satisfied with myself.

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

8. I wish I could have more respect for myself.

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

9. I certainly feel useless at times.

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

10. At times I think I am no good at all.

1	2	3	4	5	6	7	8	9
Strongly agree		agree		not sure		Disagree		Strongly disagree

APPENDIX G

SUBJECTIVE FEEDBACK FORM

Copyright by Paula Englander-Golden, 2004. Used with permission.

Date _____

SAY IT STRAIGHT FEEDBACK

1. The most useful things to me were:

2. The least useful things to me were:

3. What I learned about saying **NO** was:

4. What I learned about **Saying It Straight**:

5. I still don't understand:

6. I found out that is **OK** to:
(check any or all of the following)
 - a. _____ Say **NO**
 - b. _____ Say **NO** without giving excuses or explanations
 - c. _____ Leave the scene
 - d. _____ Risk someone getting angry at me
 - e. _____ Risk getting angry at someone I care about
 - f. _____ Other (anything else you want to add):

7. If I were worried about someone I care for, I would:

REFERENCES

- Addiction Resource Guide (2005). www.addictionresourceguide.com, Tarrytown, NY.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Blumer, Herbert (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, N.J.: Prentice-Hall, Inc.
- Big book of Alcoholics Anonymous (2003). Alcoholics Anonymous, New York.
- Britannica concise encyclopedia (2003). Chicago, Ill: Encyclopedia Britannica, Inc.
- Carnes, P. (2001). *Facing the shadow*. Wickenburg, AZ: Gentle Path Press.
- Charon, J.M. (1998). *Symbolic interactionism: An introduction, an interpretation, an integration*. Sixth edition. Upper Saddle River, New Jersey: Prentice Hall.
- Clinard, M.B. (1964). Anomie and deviant behavior. In M. B. Clinard (Ed.), *Anomie and deviant behavior*, (pp.1-56). New York: The Free Press.
- Davol S. H. and Reimanis G. (1959). The role of anomie as a psychological concept. *Journal of Individual Psychology*. 15, 215-225.
- Deflem M. (1989). From anomie to anomia and anomic depression: A sociological critique on the use of anomie in psychiatric research. *Social Science and Medicine* 29(5), 627-634.
- Douglas J. (1967). *The social meanings of suicide*. N.J.: Princeton University Press.
- Durkheim E. (1933) [originally published in 1893] *The Division of Labor in Society* (Translated by Simpson G.). Glencoe, Il: The Free Press,
- Durkheim E. (1952) [originally published in 1897]. *Suicide: A study in sociology*. (Translated by Spaulding J. A. and Simpson G. and edited with an introduction by Simpson G.). London: Routledge & Kegan Paul.
- Eckart, D. R. and Durand, R. (1975). The effect of context in measuring anomia. *The Public Opinion Quarterly*, 39(2), 199-206.

- Englander-Golden, P., Elconin J., and Satir, V. (1986). Assertive/leveling communication and empathy in adolescent drug abuse prevention. *Journal of Primary Prevention*, 6(4), 231-243.
- Englander-Golden, P., Gitchel, E., Henderson, C., Golden, D.E., & Hardy, R. (2002). Say It Straight training with mothers in chemical dependency treatment. *Journal of Offender Rehabilitation*, 35(1), 1-22.
- Englander-Golden, Paula and Golden, D. E. (1996). The impact of Virginia Satir on prevention of destructive behaviors and promotion of wellness. *Journal of Couples Therapy*, 6(3/4), 69-93.
- Englander-Golden, P. & Golden, D..E. (2002). Say It Straight: Training in straightforward communication. Trainer manual for training with parents and community. Denton, TX: Golden Communication Books/Say It Straight Foundation.
- Englander-Golden, P., Jackson, J.E., Crane, K., Schwarzkopf, A.B., & Lyle, P. (1989). Communication skills and self-esteem in prevention of destructive behavior. *Adolescence*, 24(94), 481-502.
- Englander-Golden, P., and Satir, V. (1990). *Say It Straight: From compulsions to choices*. Palo Alto, CA: Science and Behavior Books.
- Flores, Philip J. (1997). *Group psychotherapy with addicted populations: An integration of twelve-step and psychodynamic theory*. New York: The Haworth Press.
- Halliday, M.A.K. (1978). *Language as social semiotic*. Baltimore, MD: University Park Press.
- Lindesmith, A.R. and Gagnon, J. (1964). Anomie and drug addiction. In M. B. Clinard (Ed.), *Anomie and deviant behavior* (pp. 158-188). New York: The Free Press.
- Maclver, Robert M. (1950). *The ramparts we guard*. New York: Macmillan, p.84.
- Martindale, D. (1960). *The nature and types of sociological theory*. Boston: Houghton Mifflin Co.
- McCloskey, H. and Schaar, J. H. (1965). Psychological dimensions of anomy. *American Sociological Review*, 30(1), 14-40.
- Mead, G.H. (1982). 1914 class lectures in social psychology. In David L. Miller (Ed.), *The individual and the social self* (pp.27-105). Chicago: University of Chicago Press.

- Merton, R. K. (1964). Anomie, anomia and social interaction: Contexts of deviant behavior. In M. B. Clinard (Ed.), *Anomie and deviant behavior* (pp. 213-242). New York: The Free Press.
- Merton, R. K. (1938). Social structure and anomie. *American Social Review*. 3, 672-682.
- Merton, R. K. (1957). *Social theory and social structure*. Glencoe, Ill The Free Press.
- Merton, R.K., (1964). *Anomie, anomia, and social interaction: Contexts of deviant behavior*. New York: Crowell-Collier Publishing Company.
- Mizruchi, Ephraim H. (1964). *Success and opportunity*. New York: The Free Press.
- Nettler, G. 1957. A measure of alienation. *American Sociological Review*, 22, 670-77.
- Orru, M. (1987). *Anomie: History and meanings*. Winchester, Mass: Allen and Unwin.
- Parsons, T. (1951). *The social system*. New York: The Free Press.
- Raymond, Frank B. (1975 January). A sociological view of narcotics addiction. *Crime and Delinquency*, 11-18.
- Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.
- Satir, V. (1988). *The new people making*. Mountain View, CA: Science and Behavior Books.
- Snyder, C.R. (1964). Anomie and addiction. In M. B. Clinard (Ed.), *Anomie and deviant behavior* (pp. 189-212). New York: The Free Press.
- Srole, L. (1956). Social integration and certain corollaries: An exploratory study. *American Sociological Review*, 21, 709-716.
- Srole L., Langner T. S., Michael S. T., Kirkpatrick P., Opler M. K. and Rennie T. (1978). *Mental health in the metropolis: The midtown Manhattan study* (revised and enlarged edition). New York: New York University Press.
- Sternberg, R. (1981). *How to complete and survive a doctoral dissertation*. New York: St. Martin's Press.

- Treatment Improvement Protocol (TIP) 9. (2000). Washington, DC: Substance Abuse and Mental Health Services Administration.
- Treatment Improvement Protocol (TIP) 13. (2000). Washington, DC: Substance Abuse and Mental Health Services Administration.
- Yalom, Irving D. (1995). *The theory and practice of group psychotherapy*. Fourth edition. New York, NY: Basic Books.
- Yinger, Milton J. (1965). *Toward a field theory of behavior: Personality and social structure*. New York: McGraw-Hill.
- Ziller, R. C. (1969). The alienation syndrome: A triadic pattern of self-other orientation. *Sociometry*, 32(3), 27-300.