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LEVEL OF DISTRESS AND PERCEPTION OF CONTROL IN CONCERNED
SIGNIFICANT OTHERS OF SUBSTANCE ABUSERS

by
Heather Tonzczyn

A Thesis

Submitted for partial fulfillment of the requirements of the
Master of Arts Degree
of
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at
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Advisor

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ABSTRACT

Heather Tonczyczyn

LEVEL OF DISTRESS AND PERCEPTION OF CONTROL IN CONCERNED SIGNIFICANT OTHERS OF SUBSTANCE ABUSERS

2005/06

Dr. Mary Louise E. Kerwin

Master of Arts in Mental Health Counseling and Applied Psychology

The purpose of this study is to determine the perception of control and level of distress in Concerned Significant Others (CSO) seeking help for their loved one's drug abuse or dependence; and the effect of Community Reinforcement and Family Training (CRAFT) intervention on CSO's perception of control as a possible mediator of the outcome. Participants were part of a larger treatment study conducted at the Treatment Research Institute and consisted of two significant others of substance abusers. The Shapiro Control Inventory (SCI) and the Drinkers Partners Distress Scale (DPD) were used to assess variables of control and distress at intake, monthly, and after treatment. Subjects were randomly assigned to receive CRAFT or 12-Step facilitation. Preliminary results indicate a negative correlation between a CSO perception of control and level of distress ($r = -.823$, $p = .192$, $n = 2$). However, due to lack of participants and data, results are inconclusive and cannot allow the determination of the relationship between distress and control or the effect the CRAFT intervention has on CSOs perception of control and level of distress.

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Chapter 1

Introduction

The range of problems that substance abusers experience is broad and devastating. These problems negatively affect all aspects of their lives such as social, vocational, physical, emotional, and psychological functioning (Kirby, Dugosh, Benishek, & Harrington, 2005). Consequently, these problems are not limited to the substance abuser. In fact, these issues have a significant negative impact on the lives of the concerned significant others (CSOs) of the substance abuser (Kirby et al., 2005). Very often those individuals closest to the substance abuser are the first to feel the negative effects. The CSOs impairment is related to the stress of being involved with a substance abuser (Moos, Finney, & Gamble, 1982). In turn, the CSO suffers substantial distress, danger, and adverse consequences such as: decreased psychological functioning, impaired social adjustment, reduced family cohesion, deterioration of relationships, interpersonal conflict, financial difficulties, emotional distress, and domestic violence (Kirby et al., 2005; Miller, Meyers, & Tonigan, 1999). For example, Velleman, Miller, Orford, Rigby, and Tod (1993) found in his sample of 50 families that relatives of drug abusers commonly reported experiences of physical violence at the hands of the drug abuser (50%), along with verbal aggression (44%), unpredictable behavior (42%), stealing from family members (42%), and embarrassing behavior in front of others (38%).

Because CSOs are impacted by the negative effects of substance abuse, they represent a population that is invested in the substance abusers recovery as well as their own. In turn, CSOs are prompted to seek help because of the array of stressors they experience (Meyers, Dominguez, & Smith, 1996). Therefore, involving the CSO is crucial for two reasons: 1) the CSOs can facilitate drug treatment entry; 2) treatment can have an impact on the CSOs well being (Hudson, Kirby, Firely, Festinger, & Marlowe, 2002). Like the substance abuser, the CSO would benefit from treatment to deal with the stress brought on by their loved one's addiction. For this reason it is imperative that interventions are directed at the well being of the CSO (Barber & Gilbertson, 1997).

A better understanding of the negative consequences of addiction for family members may encourage clinicians to find ways to more frequently include CSOs in the treatment process. Although there is a considerable amount of research that demonstrates the negative consequences experienced by CSOs of drug users (Barber & Gilbertson, 1997; Fals-Stewart, Kashdan, O'Farrell, & Birchler, 2002; Kirby et al., 2005; Meyers et al., 1996; Miller et al., 1999; Moos et al., 1982; Thomas & Santa, 1982; Thomas & Yoshioka, 1989; Velleman et al., 1993); there are very few treatment options for them. Unfortunately, the majorities of the interventions that are available for substance abuse problems prioritize promoting change in the substance abuser and typically do not support the CSO (Barber & Gilbertson, 1997). Moreover, the programs that do exist for CSOs, such as Al-Anon, lack empirical support (Barber & Gilbertson, 1997).

Interventions for Concerned Significant Others

Even though most research has been conducted on dyads in which one or both individuals are alcohol dependent, it is important to note that the relationships of couples in which psychoactive substances are involved are also relatively distressed (Fals-Stewart et al., 2002). Although there are similarities, CSOs involved with drug abusers may have different experiences than CSOs involved with alcohol abusers. For example, CSOs of drug abusers deal with the legal ramifications caused by their loved ones (i.e., most of the drugs being abused are illegal), excessive financial difficulties, and threat of HIV from the sharing of needles. Therefore, the treatment needs of CSOs of drug users and CSOs of alcoholics may be different. The review of each of the interventions presents research evidence for CSOs involved with individuals with a primary alcohol problem versus individuals with a primary drug condition.

The interventions available to CSOs focus on one or more of the following areas:

1) assisting the CSO in reducing substance use and increasing the likelihood of treatment entry (Kirby, Marlowe, Festinger, Garvey, & LaMonaca, 1999); 2) improving the relationship between the CSO and substance abuser (Kirby et al., 1999); 3) reducing the negative impact of substance abuse on the CSOs life (Meyers et al., 1996). Included in the interventions are: the Johnson Intervention (Johnson, 1986), Unilateral Family Therapy (McCrary, 1991; Thomas, Santa, Bronson, & Oyserman, 1987), Pressures to Change Intervention (Barber & Crisp, 1995), Behavioral Couples Therapy (Fals-Stewart, Birchler, & O'Farrell, 1996), Twelve-Step Program (Al-Anon or Nar-Anon), and CRAFT (Kirby et al., 1999; Meyers, Miller, Hill, & Tonigan, 1998; Miller et al., 1999; Sisson &

Azrin, 1986). In order to evaluate the impact and effectiveness of these interventions on the CSO, I have reviewed relevant literature on each and described it below.

Regardless of the drug of choice, interventions based on behavioral principles have been among the most effective treatments for initiating alcohol/drug abstinence and producing long term improvements outcomes for alcoholics/drug abusers and their CSOs (Higgins, Badger, & Budney, 2000). Majority of the literature I have reviewed has been on treatment options for alcoholics and their partners; with the exception of BCT, 12-Step, and CRAFT. Although there are very few studies on the efficacy BCT has on CSOs of drug abusers, there is some evidence that it holds promise for CSOs (Fals-Stewart et al., 1996). Nar-Anon and its effect on the CSOs of drug abusers has been studied, however there is little empirical evidence to support this intervention (Barber & Gilbertson, 1996). The development of CRAFT was influenced by Community Reinforcement Training (CRT), which was originally developed for family members of alcoholics (Sisson & Azrin, 1986). CRAFT is devoted to helping CSOs of drug abusers and provides the most literature on this population. CRFAT has been effective in reducing drug use and getting the drug user to enter treatment, and it works for the CSOs of both alcoholics (Miller et al., 1999) and illicit drug users (Kirby et al., 1999).

Johnson Intervention. One of the interventions involving significant others is the Johnson Intervention (Johnson, 1986). The Johnson Intervention is a confrontational approach used by the CSO to attempt to get the substance user into treatment (Johnson, 1986). This intervention prepares a CSO for a meeting in which he/she confronts the substance abuser with the adverse effects of their substance use and urge them to seek

treatment. Miller et al. (1999) reported that there is a higher rate of treatment entry for the substance abuser when families complete a Johnson Intervention; however only a minority of those who initially seek consultation go through with the family confrontation. Most research has focused on the rate of treatment engagement, and little is known about the long-term impact of Johnson Intervention on the CSOs who participate, on the substance abuser, and on their relationships (Miller et al., 1999).

Unilateral Family Therapy. Thomas and Santa (1982) developed another intervention known as Unilateral Family Therapy that involved CSOs, specifically spouses. This intervention was designed to influence alcoholics to enter treatment and also to help the spouse learn to cope. The treatment aims to improve the spouses' well being by disengaging the spouse from the substance abuser, and teaching coping skills for stress, anxiety, lack of assertiveness, depression, and anger (McCrary, 1991). Furthermore, Miller et al. (1999) report that the CSO is taught coping skills and strategies to use at home to alter a loved ones drinking and motivate change in their behavior.

Thomas and his colleagues (Thomas & Santa, 1982; Thomas et al., 1987; Yoshika, Thomas, & Anger, 1982) developed a unilateral approach for spouses of alcohol abusers. The treatment includes orientation and clinical assessment, followed by teaching of techniques for influencing the alcohol abuser to reduce drinking or enter treatment. These techniques include confrontation with the abuser, requests for the abuser to carry out specific actions, spouse behaviors that promote alternatives to drinking, self-control, and a process of decision making by the partners. In addition, the treatment attempts to improve the spouse's well-being by disengaging the spouse from the drinker, and by

teaching skills for coping with stress, anxiety, lack of assertiveness, depression, and anger.

According to Thomas (1991), Unilateral Family Therapy pilot study resulted in 73% of alcohol abusers decreasing or stopping drinking and 57% entering treatment. According to the study, satisfaction with relationships had increased, and spouse-enabling behaviors, such as nagging the drinker, making excuses for the drinker, and trying to control the drinker's behavior had decreased. Additionally, in a controlled trial comparing unilateral family therapy with no treatment, Thomas et al. (1987) reported that eight of the thirteen drinkers whose significant others received treatment either reduced their drinking or entered treatment, compared to none of the drinkers whose spouses were assigned to the no-treatment condition. The authors did not report scores on their measures of partner well-being (Barber & Gilbertson, 1997).

Barber & Gilbertson (1997) report Unilateral Family Therapy has now been implemented in controlled trials with a total of 68 problem drinkers. Only 36 clients have ever completed the intervention in its entirety. The treatment can be effective, especially in getting drinkers into treatment, but there is little evidence that the technique improves the well-being of the spouses who participate in treatment (Thomas, 1991; Yoshika et al. 1992). Further studies are needed in order to evaluate the efficacy in enhancing overall functioning of spouses. In addition, there haven't been any clinical studies involving drug abusers and the impact unilateral family therapy has on drug abusers and their partners. Therefore, it is unsubstantiated whether or not the intervention would be useful for drug abuse.

Pressures to Change. Another intervention that includes the CSO in treatment is the Pressures to Change Approach. This intervention, developed by Barber (Barber & Crisp, 1995) is focused on getting the drug user into treatment via confrontation by a loved one. The intervention is based on learning theory principles to train partners in coping responses both to empower the partner and provide incentive for the drinker to change. This intervention differs from Johnson Intervention in that, it has two objectives: 1) to provide the spouse with a greater measure of control over their own life, and 2) to place the drinker under escalating pressure to change (i.e. reduce drinking or enter treatment). Although both interventions prepare the CSOs to confront the drinker and suggest treatment, the Pressures to Change Approach teaches the CSOs ways to avoid enabling behavior as well as to use contingency management techniques.

The biggest difference between the two approaches is that the Pressure to Change Approach uses confrontation as a last resort to promote change in the drinker. Instead, this approach trains CSOs in how to use five levels of pressure on drinkers to seek help or moderate drinking. The first level is feedback and education. The objective of this stage is to educate the client on the purpose of the intervention. The second level of pressure involves teaching the CSO to identify the drinker's triggers and plan alternative activities to coincide. The third level of pressure is responding. Ways of providing feedback to the drinker are discussed and rehearsed, as well as knowing how to respond when drinkers are sober or intoxicated. Partners are also taught to recognize and take advantage of times when the drinker may be responsive to the idea of treatment. The fourth level of pressure is contracting. The partners try to negotiate a contract with the drinker. In some

cases, reinforcement is exchanged for sobriety. The assumption is that the pressure of being on a contract will influence a change in the drinkers' behavior. The final stage of pressure is confrontation. Clients are introduced to a confrontation technique similar to Johnson Intervention (Johnson, 1986). Confrontation is not arguing or fighting, but providing feedback about the effects of drinking on those who mean most to the drinker. This technique is reserved as a last resort when all other levels have been unsuccessful in promoting change in the drinker.

Results indicate that the Pressure to Change Intervention has significant influence on getting the drinker into treatment, getting the drinker to cut down, or getting the drinker to quit (Barber & Gilbertson, 1997). According to Barber and Crisp (1995), the Pressures to Change Approach has two advantages over other partner interventions: 1) it is brief, and 2) it is easy to describe and replicate. However, there are contradictory reports on the impact that this intervention has on the CSO. According to the results, CSOs reported no effect of the treatment on life satisfaction or distress variables (Barber & Crisp, 1995). On the contrary, there were self-reports of significant improvements in their level of depression and personal problems after receiving treatment (Barber & Gilbertson, 1996). Even though the Pressures to Change intervention may be capable of improving the well-being of the CSOs, this technique has been subjected to few controlled trials and the results are inconsistent (Barber & Gilbertson, 1997).

Behavioral Couples Therapy. Behavioral Couples Therapy (BCT) is a family based treatment approach for treating substance abuse that has significant empirical support (Fals-Stewart et al., 1996; McCrady, 1991; McCrady, Noel, Abrams, Stout,

Nelson & Hay, 1986; Winters, Fals-Stewart, O'Farrell, & Birchler, 2002). Behavioral Couples Therapy is grounded in social learning theory and family systems models for conceptualizing human behavior. The intervention encompasses cognitive-behavioral coping skills to enhance positive interactions for the couple, effective communication skills, problem solving skills in order to assist with abstinence and substance abuse (McCrary, 1991).

BCT is mainly associated with positive outcomes for alcoholic couples in terms of drinking behavior and relationship adjustment (McCrary, Stout, Noel, Abrams, & Nelson, 1991). Despite the efficacy of BCT with alcoholic couples, there is a lack of research examining the effects of BCT on marital functioning or drug use outcomes among couples dealing with drug abuse (Fals-Stewart et al., 1996).

Fals-Stewart et al. (1996) conducted the first and one of the few randomized clinical trials of BCT with drug-abusing patients and their CSOs. Couples who received Behavioral Couples Therapy were compared with drug abusers who received individual therapy. Subjects assigned to the individual therapy group consisted of the drug abusers only (their CSOs received no treatment). Treatment consisted of two 60-minute individual therapy sessions and one 90-min therapy group (involving 6-8 patients) each week. The intervention was an adapted form that was used in cognitive-behavioral treatment programs for alcoholism. The goal of this intervention was to help the drug abuser develop skills to assist in abstinence from drugs and alcohol. The emphasis of each session was on cognitive and behavioral skills training including: managing thoughts about drugs through cognitive behavioral restructuring, problem-solving for alternatives

to drug use, increasing pleasant activities without the use of drugs or alcohol, relaxation training, anger management, improving drug and drink refusal skills, assertiveness training, and enhancing social support networks. The CSOs were asked to come to the clinic once per week so both partners could complete the Marital Happiness Scale. However, the couples did not meet conjointly with a therapist to complete the measure or discuss it. The drug abusers assigned to the BCT group received one 60-minute individual therapy session and one 90-minute group therapy (both of which emphasized cognitive-behavioral coping skills training described above). In addition, the drug abuser and their CSO met conjointly with a therapist once per week over a 12-week period for 60 minute BCT sessions. The first few sessions assessed the relationship, described the treatment package, and developed a verbal agreement between the partners to provide a constructive communication ritual. The remaining sessions were used to reinforce communication between the couple, explore strategies to cope with drug cravings, conduct crisis interventions for drug using episodes, learn active listening skills, expressing feelings, and increasing positive behavioral exchanges between partners by encouraging them to acknowledge pleasing behaviors and plan shared recreational activities that did not include drug or alcohol use. Results indicate that those drug abusers who received BCT, in addition to individual therapy, reported fewer days of drug use, longer periods of abstinence, fewer drug-related arrests, fewer drug related hospitalizations, and higher relationship satisfaction through 12-month follow up than did patients receiving individual therapy only. In addition, CSOs involved in BCT reported

higher levels of dyadic adjustment and marital functioning, than CSOs who did not receive BCT.

Overall findings suggest that spouse-involved treatment and couples therapy hold promise for improving treatment outcomes for alcoholic and drug abusing patients (Fals-Stewart & Birchler, 2001; McCrady, 1991). However, more randomized clinical trials that include drug abusing patients and their CSOs are needed to examine the efficacy and benefits of well-validated relationship treatment methods, such as BCT, to determine whether they lead to improvements in relationship adjustment, drug-using behavior, and other psychosocial outcomes (Fals-Stewart et al., 1996).

12-Step. Al-Anon/ Nar-Anon, also known as 12-Step Program, is the most widespread approach for partners of substance abusers (Barber & Gilbertson, 1997.) This self- help program emphasizes changing the family member's beliefs and attitudes about addiction. The main objective is to provide support to the CSO through group support and education on addiction. Al-Anon/Nar-Anon advocates loving detachment, acceptance of the CSO's helplessness to control the alcoholic, and group support for the CSO.

Surprisingly, although the 12-Step approach is the most widely used source of support for CSOs, little is known about the nature and determinants of outcomes for CSO's that participate in this approach (Miller et al., 1999.) According to Barber and Gilbertson (1996), in the case of Al-Anon, empirical support for the procedure is almost entirely lacking. Nevertheless, there have been some studies on the outcome of 12-Step programs and results indicate that a 12-Step Program can lead to improvements in CSO

functioning once the CSOs detach and become powerless over their loved one's addiction (Barber & Gilbertson, 1996; Dittrich & Trapold, 1984; Miller et al., 1999; Sisson & Azrin, 1986). Conversely, Barber and Gilbertson (1996) report that CSOs involvement in a 12-Step program was unsuccessful in promoting change in their loved ones drinking behavior. Although few controlled studies have been focused on this approach, 12-Step programs are often used as a control condition against which to test strategies for engaging unmotivated drinkers into treatment.

Community Reinforcement and Family Training. Community Reinforcement and Family Training (CRAFT) is another intervention in which the primary focus is on the CSO (Kirby et al., 2005; Meyers et al., 1996; Meyers, Miller, Smith, & Tonigan, 2002; Miller et al., 1999). CRAFT intervention was developed from behavioral principles that include: a functional analysis that outlines the drug user's triggers for using as well as the typical consequences of drug use, contingency management training, communication skills training, treatment entry training, arranging to have treatment available when drug user is ready, awareness training, increasing social activities of CSO, and safety training (Meyers et al., 1996; Meyers et al., 2002; Meyers & Smith, 1997; Miller et al., 1999). The CSO attends twelve 1-hour individual therapy sessions over a course of about 14 weeks. Each session focuses on teaching the CSO one of the behavioral techniques mentioned above. Significant differences in treatment entry were detected when CSOs who received CRAFT intervention were compared to CSOs who attended 12-Step meetings (Kirby et al., 1999).

CRAFT is based on Community Reinforcement Training (CRT; Sisson & Azrin, 1986). CRT is based on learning theory and aims to teach the partner how to avoid or minimize physical abuse, how to encourage sobriety, how to coax the drinker into treatment, and eventually how to assist in treatment. CRAFT and CRT have been applied to drug –abusing populations.

In a small sample study, CRT was compared to Al-Anon and results indicate that all but one of the drinkers whose spouse was in CRT group came into treatment as compared to Al-Anon where none of the drinkers came into treatment. Moreover, even before entering treatment, drinkers with relatives in CRT had already reduced their alcohol consumption significantly. Although the results indicated CRT to be superior to 12-Step programs in getting the drug user into treatment, no outcomes were reported for the functioning of the CSOs after treatment (Sisson & Azrin, 1986).

Dominguez, Miller, and Meyers (as cited in Meyers et al., 1996) conducted a study in which 26 CSOs were randomly assigned to receive up to seven sessions of either CRT or Al-Anon meetings. While both groups showed improvements in CSO functioning, the CRT group evidenced more rapid relief of symptoms and depressed mood in the CSO. In terms of overall functioning, the CRT group reported a more positive family environment for social, cultural, and recreational activities; independence and self-sufficiency; and achievement orientation. Results indicated that three drinkers entered treatment. All three cases of the drinker entering treatment were from the CRT condition, whereas in the Al-Anon facilitation approach, none entered treatment.

Although the latter finding was not statistically significant, it mirrored the general pattern of outcome reported by Sisson and Azrin (1986) (cited in Meyers et al., 1996).

Miller et al. (1999) in a randomized clinical trial, offered 130 CSOs one of three different counseling approaches: Al-Anon facilitation therapy designed to encourage involvement in the 12-Step Program, a Johnson Institute Intervention to prepare for a confrontational family meeting or community reinforcement, and family training approach (CRAFT) which teaches behavior change skills to use at home. Results show that the CRAFT approach was more effective in engaging drinkers into treatment (64%) as compared to Al-Anon (13%) and Johnson Intervention (30%). According to the literature, all three approaches were associated with similar improvement in CSO functioning and relationship quality. However, the extent to which the CSO's improved was not reported.

Summary. In summary, there is a large body of growing research indicating that treatments involving CSOs are effective interventions for initiating treatment entry for patients with alcohol or drug problems. Hence, substance abuse treatment programs can no longer justify providing little or no spouse or family involvement. In the past, self-help programs advised individuals who were concerned about their loved one's drug use to disengage or detach from the problems of the drug user and to concentrate on taking care of themselves (i.e., Al-Anon). Recently, intervention approaches have been developed that include procedures for training CSOs in more active strategies in dealing with someone's drug use (e.g., Unilateral Family Therapy, Behavioral Couples Therapy, and CRAFT.) Furthermore, these interventions help CSOs address areas of their own

lives, such that they are better able to recognize and cope with the problems and stresses associated with being close to someone with a substance abuse problem (Meyers et al., 1996).

Evidence supports the treatment approaches that include the CSOs (Barber & Crisp, 1995; Cunningham, Sobell, Sobell, & Kapur, 1995; Fals-Stewart et al., 1996; Johnson, 1986; Kirby et al., 1999; McCrady, 1991; Meyers et al., 1998; Miller et al., 1999; Sisson & Azrin, 1996; Smith, Meyers, & Miller, 2001; Thomas et al., 1987). One of these interventions, CRAFT, is based on CRT, which is based on learning theory and aims to teach the partner how to avoid or minimize physical abuse, how to encourage sobriety, how to coax the drinker into treatment, and eventually how to assist in treatment (Sisson & Azrin, 1986). CRAFT is an efficient procedure in stabilizing CSOs and training them in more effective ways of dealing with the substance abuse of a loved one (Kirby et al., 1999). Overall, the CRAFT intervention gives the CSO a sense of empowerment over their situation.

For example, Meyers et al. (2002) conducted a study involving the CSOs of illicit drug users. Ninety CSOs were randomly assigned to one of three treatment conditions: 12 hours of Nar-Anon facilitation, CRAFT, or CRAFT with aftercare. The CSOs assigned to the Nar-Anon facilitation group received manual-guided therapy to facilitate their understanding of the 12-Step family program. The Al-Nar facilitation emphasized detachment and CSOs powerlessness to control his/her loved one's drug use. The Nar-Anon facilitation differed from traditional Al-Anon/Nar-Anon in that there was an emphasis on getting their loved one to enter treatment. The CSOs assigned to both

CRAFT and CRAFT & aftercare group received behavioral skills training designed to influence the drug use and to persuade the user to enter treatment. CRAFT components included domestic violence precautions, motivational strategies, assessment of drug use, communication training, positive-reinforcement training, discouragement of drug use, training CSOs to reward themselves, and suggesting treatment to the drug user. Both CRAFT conditions offered 12 individual sessions. Participants in the CRAFT and aftercare group were eligible to receive aftercare that included the same CRAFT principles they had received already and were conducted by the same therapists. Results indicated that the differences in treatment entry were significant between CRAFT and Nar-Anon facilitation group; however there was no significant difference between the two CRAFT groups. In addition, improvement in CSO depression, physical symptoms, and family functioning were reported using various measures. Although CSOs' well-being improved, analyses indicated no significant difference between the two CRAFT groups. Therefore, this study demonstrates the efficacy of the CRAFT intervention in getting drug users into treatment and enhancing the well-being of CSOs (Kirby et al., 1999; Meyers et al., 2002).

Mechanism of Action

While the efficacy of CRAFT as an approach to facilitate drug users' entry into treatment has been recognized, little is known about why it works and how it affects the CSOs well-being. Miller et al. (1999) suggests that CRAFT is successful because CSOs can do something to bring about change via specific behavioral management skills. By teaching CSOs that they can make a difference in the loved one's substance abuse and

treatment engagement, they are empowered to be in control of the situation. The empowerment assumption underlying CRAFT is in conflict with the 12-Step programs' message of powerlessness and detachment. CRAFT is an enhanced version of the Community Reinforcement Training program for CSOs and is an outgrowth of well-supported, learning theory (Sisson & Azrin, 1986). Within CRAFT, the CSO is told that they could have a substantial impact on the substance abuser's drug use and decision to enter treatment (Miller et al., 1999). In order to enhance the CSO's empowerment, they are taught skills to promote changes in their loved one's substance use and to improve their own quality of life. The idea that family members can do something to instigate change in their loved one and enhance their own well-being is generally the opposite of 12-Step program's message of powerlessness and detachment. Within Nar-Anon, the CSO would be encouraged not to try to control or influence their loved ones substance use. This distinction is the basis for the present research study.

Research and theory suggests that an increase in perceived personal control is preferred by humans and will result in positive reactions; whereas a decrease in personal control (powerlessness) is not desired and will result in negative reactions (Burger, 1989). For example, maintaining a sense of personal control has been found to aid in the ability to cope with stressors (Glass & Singer, 1972). Similarly, extensive literature on learned helplessness (Peterson & Seligman, 1984; Seligman, 1975) has implicated a perception of no control as a central agent in the development of depression. In addition, many theorists have placed great emphasis on human motivation to seek out and maintain control (DeCharms, 1968; Seligman, 1976; White, 1959). Patients across diagnoses

entering therapy make significantly more statements regarding “loss and lack of control” and “fear of losing control” than statements reflecting “having control” or the “belief that they can gain control” (Shapiro, Bates, Greensang, & Carrere, 1991). Drug and alcohol addictions are among one of the several disorders in which an impairment of control has been suggested as one of the central features, (Shapiro & Zifferblatt, 1976). In general, research shows that those who believe there is something they can do about their disease, or about the stresses resulting from the disease, have a healthier psychological adaptation than those who do not (Shapiro, Schwartz, & Astin, 1996).

Hence, the purpose of this study is to investigate the relationship between the CSO’s perception of control and their level of distress. The primary goal of this study is to determine the perception of control and level of distress in CSOs seeking help for their loved one’s drug abuse or dependence; and the effect of CRAFT intervention on CSO’s perceived perception of control as a possible mediator of the outcome. Therefore, there are two hypotheses being evaluated in the current study: 1) at intake, regardless of the condition, there will be a significant correlation between lack of control and distress and 2) CSO’s perceived level of control and level of distress will be higher and lower, respectively, at the end of treatment in the CRAFT group compared to the 12-step group.

Chapter 2

Methodology

Participants

Subjects for this study were recruited from an existing study being conducted at Treatment Research Institute (TRI) in Philadelphia, as part of a National Institute for Drug Abuse (NIDA) funded behavior therapy development grant. In order to participate in the study, CSOs met all of the following criteria: (a) be a close relative, spouse, or intimate partner that has been living with the drug user for at least one year; (b) have regular, daily contact with the drug user; (c) be at least 18 years of age (both the CSO and the drug user); (d) be willing to participate in the research, (e) the drug user meets the DSM-IV criteria for substance use disorder; (f) the CSO and drug user have never been in treatment for substance abuse; (g) the CSO speaks English. The exclusion criteria for the study are: (a) the CSO met the DSM-IV criteria for a substance use disorder; or (b) CSO or the drug user displays psychosis or other psychiatric condition that could impair ability to participate.

Three participants were recruited for the study; two female and one male. Sixty-seven percent ($n=2$) presented for treatment because of the substance abuse of their spouse, and 33% ($n=1$) because of that of a child. The amount of time the CSO has known the drug user ranged from 16-34 years (mean=25.0; SD=9.0). The sample ($n=3$) ranged from 54 to 61 years of age (mean=57.6 years; SD=3.5), all identified themselves as white, and had 19.6 (SD= 6.6) years of education. Sixty-seven percent ($n=2$) of the

participants were married and 33% (n=1) were divorced. At the time of intake, all three of the participants were employed full time and the average household income was \$57, 600 (range= \$ 25,000-\$95,000).

In regards to CSO substance use, the following results were reported: alcohol use in past 30 days ranged from 1-20 days (mean=8.6; SD=10.0); years of alcohol use ranged from 0-16 years (mean=5.3; SD=9.2); alcohol use to intoxication in the last 30 days ranged from 0-4 days (mean=1.3; SD=2.3); tobacco use in past 30 days ranged from 0-30 days (mean=10.0; SD=17.3); years of tobacco use ranged from 0-40 years (mean=13.6; SD=22.8); prescription medication use (as prescribed by doctor) in last 30 days ranged from 0-8 days (mean=2.6; SD=4.6); years of prescription medication use (as prescribed by doctor) ranged from 0-6 years (mean=2.0; SD=3.4); prescription medication not prescribed by a doctor and recreational drug use in the past 30 days and amount of years was 0 across all participants and time periods.

Experimental Design

The experimental design was a true experimental repeated measures design. There are three basic criteria to be considered a true experimental design: 1) random selection of participants from a population to a sample 2) random assignment to the experimental and control conditions 3) equal treatment of the members in experimental and control group, except in relation to the independent variable. Additionally, in order to be considered a repeated measures design, the dependent variable (i.e. level of distress, perception of control) was assessed prior to the introduction of the independent variable (i.e. CRAFT, 12-Step). The independent variable was then introduced followed by monthly

measurement of the dependent variables. In other words, the measures were repeated over time.

Independent Variables

The experimental group consisted of those randomly assigned to the CRAFT intervention group. Subjects received intervention, by a trained therapist, on the principles of CRAFT as well as the behavioral techniques associated with this approach. The control group consisted of those assigned to the 12-Step facilitation group. This group is coached on the principles of 12-Step with a goal towards guiding them to seek out and become involved in existing Nar-Anon groups in the community. Each intervention was manualized and treatment integrity was assessed throughout the study. Treatment lasted 12-14 weeks for one hour a week.

Dependent Variables and Measures

There were two dependent variables being measured in this study. The first dependent variable measured in this study is the level of distress a CSO feels, using a modified version of the Drinkers Partners Distress Scale (DPD, Crisp & Barber, 1995). The DPD includes two scales; marital discord scale and depression scale. The modified version of the DPD is a 12-item, 5-point scale, (5=extremely distressed, 4=high distress, 3=moderate distress, 2=low distress, 1=no distress, 0=not applicable), used to gauge the extent of problems/distress caused by a partner's drinking. For use in this study, the scale was adapted by substituting drugs and drugs use for alcohol and drinking. The scale asks partners to indicate on 5-point scales the frequency with which certain problems (for

example, loneliness, worry, physical, and verbal abuse) can be attributed to their partner's drinking, and the level of distress caused by these problems (Barber & Crisp, 1995).

The second dependent variable measured in this study is the CSO's perception of control using the Shapiro Control Inventory (SCI; Shapiro, 1994). The SCI is a nine-scale, 187-item standardized assessment tool that takes about 25 minutes to complete. The first section of the SCI was utilized in this study to assess the variable of control. It consists of 37-items on a 7-point Likert scale (7=always, 6=very often, 5=often, 4=sometimes, 3=occasionally, 2=rarely, 1=never) and gives an overall sense of control. The SCI has been used to assess therapeutic change pre, during, and post treatment. Since research indicates that sense of control is related to psychological health, and the lack of control is related to pathology (Shapiro, 1994), it is possible to assess progress in therapeutic treatment regardless of the approach you are using. This instrument assesses a person's current sense of control and whether he or she would like to change. A differential diagnosis citing the dimensions of control that are most deviant from the psychologically healthy profile is produced. In addition, the SCI assesses whether the person currently feels a sense of control, in addition to his or her motivation for control and the specific agency for control (self, others, and environment). The SCI is divided into four areas: General Domain-Sense of Control, Specific Domains of Control, Modes of Control, and Desire for Control. The scale has been written on an eighth grade reading level. Experts who were knowledgeable and experienced in three specific areas determined the interrater reliability: Type A behavior, East-West psychology, and sex-role psychology. Reliability was demonstrated for internal consistency of items as well as

for test-retest (5 week interval) reproducibility (ELSA= .70-.89 and test-retest $r = .67-.93$, consecutively). The validity of the instrument is based on 12 or more different studies conducted on various populations showing that personal control is predictive of level of anxiety, depression, and recovery among cancer patients. This demonstrates the fact that the SCI has fairly good predictive validity. Overall, the SCI is an instrument with substantial validity and reliability that measures control comprehensively across several different domains. It is appropriate for use with a broad population of both normal and clinical participants.

Procedure

Subjects who met the inclusion/exclusion criteria were randomly assigned to a treatment (CRAFT) or control group (12-Step facilitation.) Each subject completed the distress measure, Drinkers Partners Distress Scale, and control measure, Shapiro Control Inventory, prior to receiving intervention, at monthly intervals during treatment sessions, and upon completion of the last session; totaling 4 separate time periods.

Planned Data Analysis

To address the first hypothesis, the relationship between perceived control and level of distress in CSOs before treatment, a Pearson R was used to analyze the data.

To address the second hypothesis, that both level of control and distress differ between groups as a function of intervention, a repeated measures split plot approach was used to analyze the data from pre, during, and post scores on the Drinkers Partners Distress Scale and the Shapiro Control Inventory. The between subjects factor was group (CRAFT vs. 12-step facilitation). The within subjects factor was time.

Chapter 3

Results

Characteristics of the drug users

Demographic information is being reported based on three participants. Subject recruitment has been a challenge because of the nature of the population being studied. Because this thesis project was part of a larger National Institute on Drug Abuse (NIDA) funded project, the recruitment of participants for this project was dependent upon the recruitment of participants for the larger study. The larger study is a treatment outcome study; it is not uncommon for therapists to require 6-12 months of training in the intervention before data collection can begin. At the time this thesis project was proposed, therapists had been in training for 5 months; however, both therapists resigned from the larger project during the past 12 months. This slowed the recruitment of participants into the larger study, thereby affecting the recruitment of participants for this thesis project.

The drug users ranged in age from 35 to 63 years (mean=49.3, SD= 14.0). Sixty seven percent of the drug users were male, and 33% were female. All of the drug users were white, which was the same race as the participants. According to the CSOs, the primary drug of choice by the drug user was alcohol; there was no secondary drug of choice listed. Sixty-seven percent of the drug users were married, and 33% were never married. Two of the drug users being represented were spouses, and one was a child.

Educational level of the drug users ranged from 11 to 18 years, with an average of 13.6 years (SD=3.7). At the time their family member entered treatment, 100% of the drug users were reported by the participants to be employed for the past three years. Average annual income reported for the drug users was \$63, 700 (range=\$6,000-\$120,000).

Adverse Consequences Experienced by CSOs

CSOs of substance abusers suffer substantial distress, danger, and adverse consequences such as: decreased psychological functioning, impaired social adjustment, reduced family cohesion, deterioration of relationships, interpersonal conflict, financial difficulties, emotional distress, and domestic violence (Kirby, et al, 2005).

In order to assess the frequency of these consequences, CSOs completed the Significant Other Checklist (SOC; Kirby et al., 2005) at intake. The Significant Other Checklist is a self-report checklist designed to measure the problems experienced by significant others of substance abusers due to a substance abuser's behaviors. This instrument assesses problems experienced by significant others of substance abusers along the dimensions of physical abuse, legal issues, emotional concerns, relationship issues, finances, health issues, and lifestyle issues.

The results indicate that significant others in this study reported the most problems on the emotional, family, and relationship subscales of the Significant Other Checklist. The Emotional Subscale included items that assessed difficulties that a significant other may be experiencing due to a substance abuser's drug use. Significant others reported having difficulty sleeping, eating, and concentrating. Items on this subscale also included items that examined the emotional reaction of the significant other.

Significant others reported feelings of guilt, embarrassment, anger, anxiety, sadness, and hopelessness. Items required significant others to report the frequency of these problems on a 5-point Likert scale, ranging from 0=never to 4= almost always. The Relational subscale included items that examined difficulties that significant others may have experienced in their relationship with the substance abuser. Significant others reported various difficulties in these relationships that included arguments, experiencing verbal abuse, feeling distant from the substance abuser, doing things for the substance abuser that the substance abuser should have done, spending a lot of time thinking about how to help the substance abuser, and giving up things that they wanted to do due to the substance abuser's problem. Items on the Family subscale examined how the substance abuser's behaviors have effected the functioning of the significant other's family. Significant others reported arguments the family had with the substance abuser, family arguments about the substance abuser, the substance abuser disrupting family gatherings, the relationship with the substance abuser interfering with relationships with family or friends, not having time with friends, not enjoying time spent with family, and seeing the substance abuser use alcohol in the significant other's home.

Significant others reported the least problems on the health, financial, and legal subscales of the SOC (see Figure 1).

Insert Figure 1 about here

Control and Distress Scores

At intake, the mean score on the DPD for the CRAFT group (n=1) was M=1.0 on the depression scale and M=1.4 on the marital discord scale. Overall mean score at intake was M=1.16. After one month of CRAFT intervention, the participant reported “not applicable” across the depression and marital discord scale (M=0) (see Figure 2). At intake, mean score for 12-Step facilitation group (n=1) was M=2.42 on the depression scale and M=2.4 on the marital discord scale. Overall mean score at intake was M=2.42. After receiving one month of 12-Step facilitation, mean scores on the depression scale were M=1.29 and M=1.6 on the marital discord scale. Overall mean score after one month was M=1.25 (see Figure 2). Barber & Crisp (1995) conducted a study (n=32) that utilized the DPD to measure the amount of distress CSOs of alcoholics were feeling before and after treatment. Pretest results indicate mean scores of M=11.38 on the depression scale and M=10.41 on the marital discord scale. Posttest results indicate mean scores of M=9.7 on the depression scale and M=8.08 on the marital discord scale. Results of this study indicate a decrease in level of distress after treatment. When compared to the mean scores of the present study, there is not enough data to compare the results. Therefore, the effect of treatment on level of distress can not be determined at this time.

At intake, mean scores on the SCI for the CRAFT group (n=1) were M=4.59; and after one month of treatment M=4.40. At intake, the mean score for 12-Step facilitation group (n=1) was M=3.59; and after one month of treatment M=3.84 (see Figure 2). When compared to data collected on adult children of alcoholics, M=4.58 (Shapiro, 1994), the participants in the CRAFT group report a similar overall sense of control; and

those in the 12-Step facilitation group reported less control than adult children of alcoholics. When compared to data collected from the normal population, $M=5.59$, participants in both CRAFT and 12-Step facilitation groups reported less control than the normal population (see Table1). However, at this time, the effect of the intervention as a mediator of outcome can not be determined due to small sample size ($n=2$).

Insert Table 1 about here

Relationship Between Control and Distress at Intake

A Pearson correlation was conducted between the Drinkers Partners Distress Scale and Shapiro Control Inventory to examine the correlation between the lack of perceived control and level of distress at intake. Results indicate a negative correlation between a CSO perception of control and level of distress ($r = -.823, p = .192, n = 2$). The size of the correlation indicates the strength of the relationship between the variables control and distress. A correlation of 1.0 represents a perfect correlation, therefore, the closer to 1.0, the stronger the relationship between the two variables. A correlation $-.823$ represents a negative correlation; as one variable increases, the other variable decreases. In this study, results demonstrate that a high level of distress is related to a low perception of control, and vice versa; lower level of distress is related to a higher perception of control.

Effect of CRAFT Intervention on CSO's Perception of Control as a Possible Mediator of Outcome

A repeated measures split plot design was conducted to analyze the effect of CRAFT intervention on CSO perception of control as a possible mediator of outcome as compared to 12-Step. Results were inconclusive due to lack of participants and data. Currently, there are 3 participants, however only 2 of their data sets are being analyzed for this portion of the study because one of the participants is placed in a group other than CRAFT or 12-Step facilitation. However, if the data were representative of the sample, the trend would be that subjects would report a lower amount of distress after receiving one month of intervention. The higher the DPD raw score, the more distress a person feels. Additionally, the higher the raw score on the SCI, the more in control the person feels. Therefore, the 12-Step group displays a lower amount of distress and a higher sense of control after one month of treatment. The CRAFT group displays a slight decrease in overall sense of control and a raw score of zero for distress (0= not applicable) after one month of intervention (see Figure 2).

Insert Figure 2 about here

Chapter 4

Discussion

Demographic information is being reported based on three participants. Subject recruitment has been a challenge because of the nature of the population being studied. For instance, there are various emotions that a CSO experience (including guilt, shame, embarrassment, insecurity, denial, fear); which impedes their ability to seek treatment for themselves and their loved ones. Because this thesis project was part of a larger NIDA funded project, the recruitment of participants for this project was dependent upon the recruitment of participants for the larger study. Recruitment difficulties slowed the recruitment of participants into the larger study, thereby affecting the recruitment of participants for this thesis project. Therefore, statistical analysis was unable to be conducted because of lack of data and participants. As the study continues, more data will be collected in order to evaluate the results. Preliminary results indicate that there is a negative correlation between a CSO's level of distress and perception of control. If this trend continues, we could determine the significance of the correlation between a CSO's level of distress and perception of control. However, at this time, inclusive results make it difficult to see a trend regarding CRAFT as a possible mediator of outcome.

The central reason for exploring the variables of control and distress among significant others of substance abusers, is to determine if a person's sense of control over their situation has an effect on their well being. Drug and alcohol addictions are among

one of the several disorders in which an impairment of control has been suggested as one of the central features of unhealthy adaptation (Shapiro & Zifferblatt, 1976). In general, research shows that those who believe there is something they can do about their disease or about the stresses resulting from the disease, have a healthier psychological adaptation than those who do not (Shapiro et al., 1996). For example, maintaining a sense of personal control has been found to aid in the ability to cope with stressors (Glass & Singer, 1972). Therefore, if CSOs believe they can help their loved ones and themselves, their distress will decrease. CRAFT was designed to help CSOs facilitate drug treatment entry for the substance abuser as well as have an impact on their well-being (Hudson et al., 2002; Meyers et al., 1998; Kirby et al., 2005). CRAFT teaches CSOs behavioral techniques such as: contingency management, communication skills, awareness training, safety training, social skills training, how to encourage sobriety, how to coax the drinker into treatment, and eventually how to assist in treatment. The underlying premise for the current study is that these techniques will empower a CSO to be in control of their situation. There have been some studies on the outcome of 12-Step programs and results indicate that a 12-Step Program can lead to improvements in CSO functioning once the CSOs detach and become powerless over their loved one's addiction (Barber & Gilbertson, 1996; Dittrich & Trapold, 1984; Miller et al., 1999; Sisson & Azrin, 1986). On the contrary, research and theory suggests that an increase in perceived personal control is preferred by humans and will result in positive reactions, whereas a decrease in personal control (powerlessness) is not desired and will result in negative reactions (Burger, 1989).

The independent variables in the study included CRAFT and 12-Step facilitation in order to determine if the CRAFT intervention had an effect on a CSO's perception of control as compared to the 12-Step facilitation group. Results indicate that there is not enough data at this time to determine the effect of CRAFT intervention on CSO's perception of control as a possible mediator of outcome.

Implications

At this point in time, the results of this study are preliminary, but future results of may have some implications. If these preliminary results reflect the results with an appropriately powered sample size, one implication of this study may be that if a high level of distress is related to a lack of control, then interceding with the variable of control would be the focus of treatment for this population. Another implication implies, if the CRAFT intervention is associated with increasing a person's perception of control then, according to the literature, this gives the CSO a sense of empowerment which leads to a healthier psychological adaptation and an increased ability to handle stressors (Shapiro, et al., 1996; Glass & Singer, 1972).

Limitations

Limitations of this study include recruitment difficulties, small sample size, and time constraints. Recruitment difficulties may be result of the nature of the population in this study. Being involved with a substance abuser has stigmas attached, which prevents CSOs of substance abusers to initiate treatment. For instance, the embarrassment, shame, guilt, hopelessness, and insecurity a CSO feels impedes their ability to seek help.

Additionally, the bias of this population reflects a general reluctance to seek help (Hudson et al., 2002.)

The small sample used in this study did not provide enough data to accept or reject the hypotheses. The subjects in this project are required to receive a 12 week intervention, CRAFT or 12-Step facilitation. Because of time constraints and recruitment difficulties, the subjects had only completed 4 weeks of intervention when the data was collected. Therefore an incomplete data set was collected for the participants. These participants will continue to receive the DPD and SCI measurements on a monthly basis throughout the 12-week intervention in order to collect a complete data set. Additionally, subject recruitment will continue in order to incorporate an appropriately powered sample size.

Future Directions

Currently, most clinical interventions for substance abusers focus solely on the drug user and exclude the CSOs. Since the CSOs suffer a substantial amount of distress, a logical focus of future interventions should be on ways to reduce their distress. Therefore, if a CSO's perception of control has an impact on their level of distress, then intervening with the variable of control through behavioral techniques can be a focus of future interventions such as CRAFT. In addition, gaining a sense of control may eliminate the stigmas CSOs feel as a result of their situation, which will encourage them to seek treatment on a consistent basis.

Clearly, continuing subject recruitment is needed to collect enough data to determine if the CRAFT intervention has an effect on a CSO's perception of control and

level of distress. At this time, the results of this study cannot allow the determination of the relationship between distress and control or the effect the CRAFT intervention has on CSOs perception of control and level of distress. As more is learned about the impairments suffered by a CSO, clinicians should become better able to target interventions to meet the unique treatment needs of this population.

Chapter 5

References

- Barber, J.G., & Crisp, B.R. (1995). The 'pressures to change' approach to working with the partners of heavy drinkers. *Addiction, 90*, 269-276.
- Barber, J.G., & Gilbertson, R. (1996). An experimental study of brief unilateral intervention for the partners of heavy drinkers. *Research on Social Work Practice, 6*, 325-336.
- Barber, J.G., & Gilbertson, R. (1997). Unilateral interventions for women living with heavy drinkers. *Social Work, 42*, 69-78.
- Burger, J.M. (1989). Negative reactions to increases in perceived personal control. *Journal of Personality and Social Psychology, 56*, 246-256.
- Cunningham, J.A., Sobell, L.C., Sobell, M.B., & Kapur, G. (1995). Resolution from alcohol treatment problems with and without treatment: Reasons for change. *Journal of Substance Abuse, 7*, 365-372.
- DeCharms, R. (1968). *Personal causation*. New York: Academic Press.
- Ditrich, J.E., & Trapold, M.A. (1984). A treatment program for wives of alcoholics: An evaluation. *Bulletin of Society of Psychologists in Addictive Behaviors, 3*, 91-102.
- Fals-Stewart, W., & Birchler, G.R. (2001). A national survey of the use of couples therapy in substance abuse treatment. *Journal of Substance Abuse Treatment, 20*, 277-283.

- Fals-Stewart, W., Birchler, G.R., & O'Farrell, T.J. (1996). Behavioral couples therapy for male substance abusing patients: Effects on relationship adjustment and drug using behavior. *Journal of Consulting and Clinical Psychology, 64*, 959-972.
- Fals-Stewart, W., Kashdan, T.B., O'Farrell, T.J., & Birchler, G.R. (2002). Behavioral couples therapy for drug-abusing patients: Effects on partner violence. *Journal of Substance Abuse Treatment, 22*, 87-96.
- Glass, D.C. & Singer, J.E. (1972). *Urban stress*. New York: Academic Press.
- Higgins, S.T., Badger, G., & Budney, A.J. (2000). Initial abstinence and success in achieving longer term cocaine abstinence. *Experimental and Clinical Psychopharmacology, 8*, 377-386.
- Hudson, C.R., Kirby, K.C., Firley, M.L., Festinger, D.S., & Marlowe D.B. (2002). Social adjustment of family members and significant others (FSO's) of drug users. *Journal of Substance Abuse Treatment, 23*, 171-181.
- Johnson, V.E. (1986). *Intervention: How to help those who don't want help*. Minneapolis, MN: Johnson Institute.
- Kirby, K.C., Dugosh-Leggett, K., Benishek, L.A., & Harrington, V.M. (2005). The Significant Other Checklist: Measuring problems experienced by family members of drug users. *Addictive Behaviors, 30*, 29-47.
- Kirby, K.C., Marlowe, D.B., Festinger, D.S., Garvey, K.A., & LaMonaca, V. (1999). Community reinforcement training for family and significant others of drug abusers: a unilateral intervention to increase treatment entry of drug users. *Drug and Alcohol Dependence, 56*, 85-96.

- McCrary, B.S. (1991). Promising but underutilized treatment approaches. *Alcohol Health & Research World, 15*, 1-6.
- McCrary, B.S., Noel, N.E., Abrams, D.B., Stout, R.L., Nelson, H.F., & Hay, W.M. (1986). Comparative effectiveness of three types of spouse involvement in outpatient behavioral alcoholism treatment. *Journal of Studies on Alcohol, 47*, 459-467.
- McCrary, B.S., Stout, R.L., Noel, N.E., Abrams, D.B., & Nelson, H.F. (1991). Effectiveness of three types of spouse involved behavioral alcoholism treatment. *British Journal of Addictions, 86*, 1415-1424.
- Meyers, R.J., Dominguez, T.P., & Smith, J.E. (1996). Community reinforcement training with concerned others. In V.B. Van Hasselt & M. Hersen (Eds.), *Sourcebook of psychological treatment manuals for adult disorders* (pp. 257-294). New York: Plenum.
- Meyers, R.J., Miller, W.R., Hill, D.E., & Tonigan, J.S. (1998). Community reinforcement and family training (CRAFT): engaging unmotivated drug users in treatment. *Journal of Substance Abuse, 10*, 291-308.
- Meyers, R.J., Miller, W.R., Smith, J.E., & Tonigan, J.S. (2002). A randomized trial of two methods for engaging treatment refusing drug users through concerned significant others. *Journal of Consulting and Clinical Psychology, 70*, 1182-1185.
- Meyers, R.J., & Smith, J.E. (1997). Getting off the fence: Procedures to engage treatment to resistant drinkers. *Journal of Substance Abuse Treatment, 14*, 467-472.

- Miller, W.R., Meyers, R.J., & Tonigan, J.S. (1999). Engaging the unmotivated in treatment for alcohol problems: A comparison of three strategies for intervention through family members. *Journal of Consulting and Clinical Psychology*, 67, 688- 697.
- Moos, R.H., Finney, J.W., & Gamble, W. (1982). The process of recovery from alcoholism: Comparing spouses of alcoholic patients and matched community controls. *Journal of Studies on Alcohol*, 43, 888-909.
- Muchowski-Conley, P.M. (1982). Surveying the need for significant-other involvement in the treatment of female alcoholism. *International Journal of Addictions*, 17, 1253-1258.
- Peterson, C. & Seligman, M.E.P. (1984). Casual explanations as a risk factor for depression: Theory and evidence. *Psychological Review*, 91, 347-374.
- Clinical Psychology*, 73, 249-261.
- Seligman, M.E.P. (1975). *Helplessness: On depression, development, and death*. San Francisco, CA: Freeman.
- Seligman, M.E.P. (1976). *Learned helplessness and depression in animals and men*. Morristown, NJ: General Learning Press.
- Shapiro, D.H., Jr. (1994). *Manual for the Shapiro Control Inventory (1st ed.)*. San Jose, CA: Behaviordata, Inc.
- Shapiro, D.H., Bates, D., Greensang, T., & Carrere, S. (1991). A control content analysis scale applied to verbal samples of psychiatric outpatients: Correlation with anxiety and hostility scales. *Psychologia*, 34, 86-97.

- Shapiro, D.H., Schwartz, C.E., & Astin, J.A. (1996). Controlling ourselves, controlling our world: Psychology's role in understanding positive and negative consequences of seeking and gaining control. *American Psychologist*, 51, 1213-1230.
- Shapiro, D.H. & Zifferblatt, S. (1976). An applied clinical combination of Zen medication and behavioral self-control strategies: Reducing methadone usage in drug addiction. *Behavior Therapy*, 7, 694-695.
- Sisson, R.W., & Azrin, H.H. (1986). Family member involvement to initiate and promote treatment of problem drinkers. *Journal of Behavior Therapy Exp Psychiatry*, 17, 15-21.
- Smith, J.E., Meyers, R.J., & Miller, W.R. (2001). The community reinforcement approach to the treatment of substance use disorders. *The American Journal of Addictions*, 10, 51-59.
- Thomas, E.J. (1991, January). "Reaching the Uncooperative Alcohol Abuser Through a Cooperative Spouse: The Unilateral Approach." Paper presented at the NIDA National Conference on Drug Abuse Research and Practice, Washington, DC.
- Thomas, E.J., & Santa, C.A. (1982). Unilateral family therapy for alcohol abuse: A working conception. *Social Work Research and Abstracts*, 21, 49-58.
- Thomas, E.J., Santa, C.A., Bronson, D., & Oyserman, D. (1987). Unilateral family therapy with the spouses of alcoholics. *Journal of Social Service Research*, 10, 145-162.
- Thomas, E.J., & Yoshioka, M.R. (1989). Spouse interventive confrontations in unilateral family therapy for alcohol abuse. *Social Casework*, 70, 340-347.

- Thompson, V.K., (2003). A community reinforcement approach to addiction treatment. *International Journal of Social Psychiatry*, 49, 312.
- Velleman, R., Miller, T., Orford, J., Rigby, K., & Tod, A. (1993). The families of problem drug users: A study of 50 close relatives. *Addiction*, 88, 1282-1289.
- White, R. (1959). Motivation reconsidered: The concept of competence. *Psychological Review*, 66, 297-330.
- Winters, J., Fals-Stewart, W., O'Farrell, T.J., & Birchler, G.R. (2002). Behavioral couples therapy for female substance abusing patients: Effects on substance use and relationship adjustment. *Journal of Clinical and Counseling Psychology*, 70, 344-355.
- Yoshika, M.R., Thomas, E.J., & Ager, R.D. (1992). Nagging and other drinking control efforts of spouses of uncooperative alcohol abusers: assessment and modification. *Journal of Substance Abuse*, 4, 309-318.

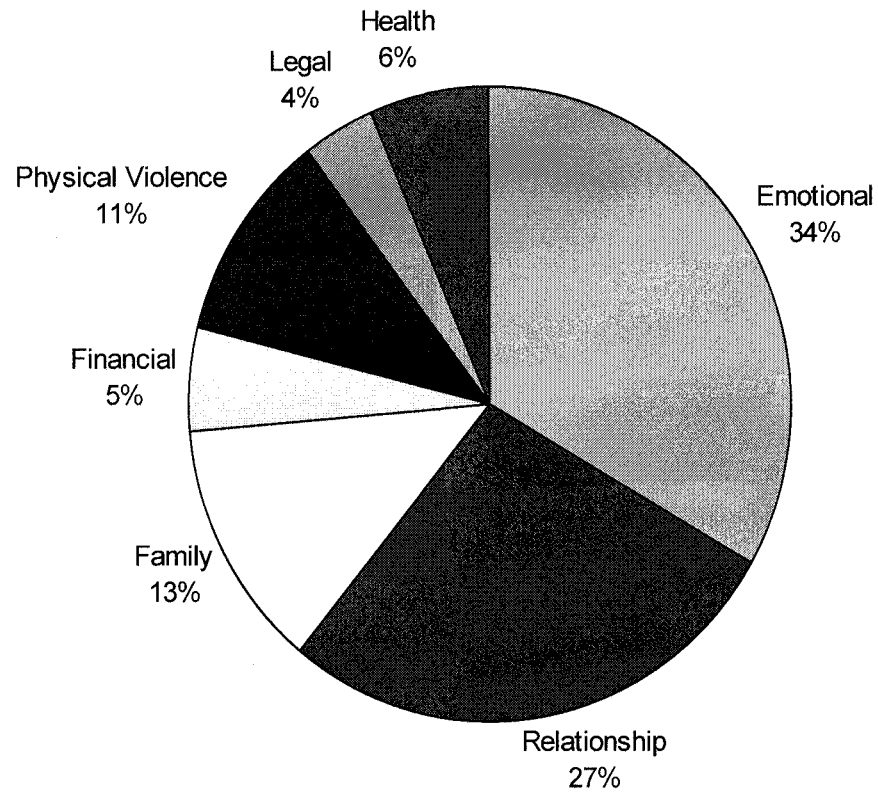
TABLE 1

Drinkers Partners Distress Scale (DPD) and Shapiro Control Inventory (SCI) Mean
Scores

Measure	Condition	Intake	One Month
DPD	CRAFT	1.16	0
	12-Step	2.42	1.25
SCI	CRAFT	4.59	4.40
	12-Step	3.59	3.84

FIGURE 1

Significant Other Checklist (SOC) Results



Problems reported by Concerned Significant Others (CSOs) on the Significant Other Checklist.

FIGURE 2

Drinkers Partners Distress Scale (DPD) and Shapiro Control Inventory (SCI) Mean Scores

