The effects of group therapy on a substance abuser's depression and self-esteem

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THE EFFECTS OF GROUP THERAPY ON A SUBSTANCE ABUSER'S DEPRESSION AND SELF-ESTEEM

This study examined the effectiveness of the use of group therapy as an intervention on the depression and self-esteem levels of a substance abuser. The study was based on the premise that participation in a group counseling setting would increase the client's self-esteem and decrease the client's depression. This study was conducted over a three-month period with instruments administered during each weekly session. The results indicated that the client experienced significant improvement in self-esteem as well as depression level.
THE EFFECTS OF GROUP THERAPY ON A SUBSTANCE ABUSER'S
DEPRESSION AND SELF-ESTEEM

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY

DRAYTON T. SUMMERS

SCHOOL OF SOCIAL WORK

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CHAPTER ONE
INTRODUCTION

During the past decade, there has been a tremendous increase in the number of individuals and families affected by substance abuse. The causes and ramifications of substance abuse in today's society are multi-faceted, complex and confusing.¹

D. J. Lettieri of the U.S. Department of Health and Human Services stated that drug abuse is a complex, contemporary social problem. Its complexity derives in part from the impact it has on the individual user, psychologically, socially and biologically and in part from its effects on society, law, economics and politics.²

Illicit drug use continues to be one of the nation's most serious problems. Although considerable progress has been made in reducing the number of casual drug users, much remains to be done to reduce the number of chronic, hard core drug users. Compared with the casual drug user, the chronic, hard core user consumes substantially more drugs


and is responsible for the preponderance of crime and other negative social consequences.³

According to Gellman and Gage, the only way for a drug abuser to overcome addiction is by confronting self-doubt and to work on self-esteem.⁴ Most drug addicts think they can stop whenever they want. Families and friends are often devastated when they realize it is not easy to stop. Drug abuse can injure friends and families, because of financial disaster and legal problems. Like alcohol, drugs can affect the users entire network.

There are numerous reasons why substance abuse has emerged as a major concern in the United States. The widespread distribution and use of cocaine among all social classes and the introduction of crack cocaine during the 1980’s clearly have alarmed our society. Illicit drug use and the associated drug trade are major contributors to crime and violence. The various forms of substance abuse have other serious health consequences that contribute to the current cost crisis in the nation’s health care system. Finally, alcohol and drug dependency are frequently implicated in individual and family dysfunction. Lowered self-worth and depression may coexist with substance abuse to complicate the situation. Increases in substance abuse


at all levels of society have made the roles of social workers and other helping professionals that much more complex and demanding.₅

**Statement of the Problem**

Drug abuse has always been a subject clouded by myths. The classic image of a "drug addict" was a miserable, poverty-stricken, immoral wretch, who stole, mugged and murdered to obtain drugs. Today, the image of the addict has changed. People recognize that addicts come from all social and economic classes; that they do not exist in a vacuum.₆ Recent statistics indicate that about six million Americans use cocaine and many of these users have family and friends who suffer as well.₇

In the United States since 1992, levels of use of marijuana and other illicit drugs among young people have increased for the first time in over ten years. Lifetime use of any illicit drug among 18 year olds in school peaked at 66% in 1981, declined to 41% in 1992 and increased to 46% in 1994.

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A major study, the Epidemiologic Catchment Area Study, showed that the lifetime chance of an American developing an abuse or dependence disorder is 15% for alcohol and 6% for other drugs. These are the most prevalent disorders among men of all age groups and the most prevalent among women 18 to 24. The cost of alcohol and drug problems is greater than that of all other mental illnesses combined—$144 billion versus $129 billion in a recent year.8

A common symptom of addiction is many promises that are not fulfilled, promises to the addicts and their families, friends and associates. This simple example of the constant failure and frustration inherent in addictive behavior illustrates how addiction reduces the confidence and self-worth of the individual. It is no surprise that adult addicts see themselves as lacking in stereotypical sex-role traits, such as assertiveness or compassion, and consequently rate themselves low on masculinity and femininity.9

Addiction has to be viewed as a chronic and unpredictable illness that almost always includes episodes of relapse. A true recovery needs to be viewed not only as

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recovery from substance abuse itself but also as recovery from poverty, abusive relationships, mental disturbance, low self-esteem, and negative patterns that have in many cases become entrenched over generations.¹⁰

Self-identity is intermeshed with self-esteem (i.e., the need to feel good about oneself and worthy of the respect of other people). Within the context of the family, self-esteem has its early start in parental affirmation of self-worth and in mastery of early development tasks.¹¹

Parental modeling shapes the child's values, attitudes and behavior. In addition, the atmosphere created in the family and the behavior of the parents toward the child can be the determining factor in whether the child who reaches the adolescent development stage will begin the use of drugs.

The lack of parental warmth, support, and interest can impact the adolescent's personality and behavior. It is human nature to want to belong and be accepted by significant others. If the family does not supply the attention and emotional nourishment the adolescent needs,


then he/she may become involved with friends who use drugs.\textsuperscript{12}

The involvement with drugs in the adolescent years may become a solution for dealing with problems that carry over into adulthood. Many adults began the use of drugs, such as alcohol, marijuana and cocaine, to gain euphoria (a sense of well-being), or they become dependent on drugs to escape their problems.\textsuperscript{13}

Many adults often turn to alcohol and drugs as a coping mechanism and once they become daily users the body's reaction to and the tolerance of these substances change so the body craves for more. Thirty percent of those with a diagnosis of depression have an additional diagnosis of substance abuse and conversely, forty percent with a diagnosis of substance dependence also are diagnosed with depression.\textsuperscript{14}

A certain amount of minor depression and stress is a normal part of life and the use of mood altering substances to relieve these unpleasant feelings may produce long term consequences if the use becomes abuse and then dependence. Each individual differs in their response to these

\textsuperscript{12}Ibid., 200.


substances and these differences may or may not lead to more psychological problems such as increased symptoms of major depression including lowered self-esteem.

Depressive disorders are quite common, affecting one in eight individuals at some time during their lives, or approximately 11 million Americans each year, but fewer than one third of those are properly diagnosed and treated. Fewer than one third of patients with manic or bipolar disorder are in treatment.

These illnesses are costly in both human and economic terms. Two thirds of suicides are related to depression, and 15% of severe depression will lead to suicide if untreated. In 1989, depression cost the United States an estimated $27 billion, of which more than $17 billion was due to lost work time.15

**Purpose of the Study**

The purpose of this study was to examine the effects of group therapy on the depression and self-esteem of an adult who frequently ingests alcohol, prescription medication or illegal mood altering substances for non-medicinal purposes.

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CHAPTER TWO
LITERATURE REVIEW

It is in the familial arena that principles about the self develop. Within the family the object that the child intimately scrutinizes is the self. Parental modeling helps shape the child's values, attitudes and behavior. In addition, the atmosphere created in the family unit and this behavior of the parents toward the child shape personality and behavior. Parental warmth, support and interest has been shown to relate significantly to adolescent drug use.¹

Capuzzi and Lecog suggested that the less close an adolescent feels towards family members, the more likely the involvement with friends who use drugs. The researchers also noted that multiple drug use increases relative to a decrease in family affinity. In addition, research findings have pointed out that a significant positive correlation exists between the number of overall family problems and the number of different substances abused by an adolescent.²

A study of 81 adolescent drug and/or alcohol addicts produced results quite similar to those found among adult addicted populations. On the Bem Sex-Role Inventor these young people rated themselves as follows: undifferentiated

²Ibid., 200.
(43.2%), masculine (23.5%), androgynous (18.5%), and feminine (14.8%). Despite their exaggerated "macho" and "seductive" attitudes and behaviors, which resembled their adult counterparts, chemically dependent adolescents suffer similarly from low self-esteem and poor adjustment. Addictions appear to have already damaged these young people in areas of self-worth and sex-role perception.³

The study by Capuzzi and Locog revealed that drug-using adolescents poor self-image was caused by feeling rejected at home, that their parents did not trust them or genuinely care about them, and that there was little to talk about with their parents.⁴ Also cited was low parental aspirations for children as predictive of marijuana initiation. Capuzzi and Locog suggested that a lack of perceived parent-child closeness is predictive of what leads to the third stage of drug involvement, i.e., initiation to drugs other than marijuana.⁵

Many adult drug abusers grew up in families with a parent who was addicted to alcohol or other drugs. The experience of broken promises demonstrates the constant


⁵Ibid., 203.
failure and frustration inherent in addictive behavior. It also illustrates how addiction reduces the confidence and self-worth of the individual.6

Schwalbe and Staples have noted gender differences in the importance of reflected appraisals, self-perceived competence, and social comparisons as sources of self-esteem. They noted that women attach greater importance to social comparison than men; however, they found no difference for self-perceived competence. They also noted men and women were also much alike, in that reflected appraisals are the most important source of self-esteem for both groups followed by self-perceived competence and then by social comparisons. These findings were interpreted in terms of compensations/availability dynamic that was hypothesized to underline self-esteem formation.7

Heatherton and Polivy described self-esteem as similar to a barometer that rises and falls as a function of one's aspirations and success experiences. They also noted that there is a certain average tone to the self-feelings people maintain that is largely independent of objective


feedback that might contradict the self-concept. People derive their overall sense of self-esteem by averaging feelings about themselves across a number of different social situations.

Guglielmo, Polak, and Sullivan conducted studies involving development of self-esteem as a function of familial reception. They found that low self-esteem and familial environment are separately linked to substance use and abuse. They argued that these are causatively linked, that parental relationship with the child provides the experiences from which self-esteem is learned. Cognitive errors are made in the process and faulty experimentation results in these errors being confirmed, rather than refuted by peers. Once learned self-esteem, or evaluation of the self, is very resistant to change. When low, it becomes a source of background pain in a person's life. Substance abuse is a frequently observed, maladaptive attempt to cope with this experience of pain.

In the continuous efforts to measure self-esteem among substance abusers, researchers have implemented

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studies from a health perspective to determine levels of use of alcohol, marijuana and cigarettes.\textsuperscript{10}

As part of a school-based alcohol misuse prevention study, Dielman, administered questionnaires to 2589 fifth and sixth grade students. Six factors were identified which were both internally consistent and replicable, and indices were constructed. The indices measuring susceptibility to peer pressure, self-esteem, and internal health locus of control were significantly and negatively correlated with most of the substance use, misuse, and intention items and an external health locus of control index was not significantly related to most of the substance use, misuse and intention items. The results of the study showed that internal factors of negative self-worth, poor self-image and low self esteem directly correlated with increased substance abuse.\textsuperscript{11}

Individuals with low self-esteem tend to withdraw from others, are more intropunitve, and passively adapt to environmental demands. Persons with low self-esteem experience higher anxiety, self-hatred, and inferiority. They are self-conscious and lack self-confidence.\textsuperscript{12}


\textsuperscript{11}Ibid., 218.

\textsuperscript{12}Matthew Workman and John Beer, "Self-Esteem,
According to Lettieri drug abuse may be regarded as the individual’s only available mean of coping with feelings of disillusionment, loneliness, guilt, anxiety, rage, alienation and isolation.\textsuperscript{13}

In Cohen’s study of 1,034 fifth grade students and 1,226 seventh graders who were tracked for two positive parent-child relationship and low alcohol and drug use by children. Peer pressure has been linked as the primary cause of drinking, smoking and drug abuse in adolescents. But, even though it’s a major factor, it is also important that children have a positive relationship with their parents. The study revealed it is counter-productive to screen your children’s friends. If you have a positive parent-child relationship, they will be less likely to choose friends who could lead them in the direction of drugs and alcohol.\textsuperscript{14}

In early recovery, chemically dependent people require support and education about what they are experiencing and why. An early abstinence support group provides this and gives group members an opportunity to

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incorporate some structure into their often chaotic lives. Furthermore, in talking about what they are going through, clients experience relief from some of the power of the struggle. The support encompasses comfort, knowledge, normalization, and the realization that one is not unique in one’s difficulties.15

Group therapy is a common treatment modality for the substance abuser. The purpose of alcohol and drug group therapy is to provide support to serve as a role model for people who are often not used to functioning in public without the aid of alcohol and drugs, and to exert peer pressure in confronting denial. For group therapy to be effective, the members must want to be there and should express in both words and actions their wish to be clean and sober before they enter the group. If they do not, the strength of their ambivalence can have a harmful effect on the group.16

In Lenihan’s research of 93 chemically dependent adults, 46% attended the therapy group consistently, arranged with the group to leave, and set up further treatment. Thirty-seven percent dropped out of the group, 7% felt the group was not helpful and 10% were asked to leave the group. Although it was not measured, many group


16Ibid., 276.
members were involved with the 12-step programs before, during and after their participation in the group. Considering that most of the group members who graduated from the group went on to other treatment, it is evident that the support group provided effective initial treatment for many chemically dependent people.\textsuperscript{17}

There are many studies linking substance abuse and self-esteem and others linking substance abuse and depression. Each stressing a particular set of factors, variables and populations. Substance abuse is a pervasive problem, which cuts across geographical and sociocultural boundaries. The consistent findings in the literature are that at an early age, those with lower self-esteem, minimal self-worth and signs of depressive symptoms are much more susceptible to continued substance abuse which will significantly impact the individuals self-concept as well as lead to grave physical and psychological consequences.

\textbf{Theoretical Framework}

This study views substance abuse as a spectrum of disorders requiring a flexible model of treatment. Eclectic therapy is characterized by the integration of psychodynamic, sociological, cognitive, behavioral and environmental theories and techniques. The diversity of a

group of substance abusers demands a diverse eclectic theoretical framework from which to draw upon. There is a shared element to all therapies (i.e., the benign human relationship, which includes empathy and a positive regard). The goal of therapy is to establish an alliance whereby affective cognitive and behavioral change may be produced. Selective system variables may be addressed differently by each mode of therapy.

In psychodynamic psychotherapy the core conceptualization of the ideology and pathogenesis is seen as ego regression with the promotion of personality change through transference in a therapeutic relationship as the means producing resolution of symptoms. In cognitive therapy, distorted thinking is addressed in that symptomatic relief is provided by behavioral and cognitive alternatives to the negative cognition and through a positive relationship with a therapist. In interpersonal therapy, the focus is on communicative skills through active therapist influence and peer support as well as socializing within a self-help, 12-step program are the means to address these difficulties.18

Psychologists Bandura and Mischel maintain that children learn socialization behavior through imitative play. They acquire moral standards in the same way that

they learn other behaviors. They insist that social behavior is dependent on situational contexts and not on one single aspect of the superego. They also believe that behavior is the result of modeling.19

Modeling refers to a change in behavior as a result of the observation of another's behavior; that is learning by experience or imitation. Modeling has been used in behavior modification to develop new behaviors that a person does not possess. Clients in group therapy for drug addiction are taught new ways of dealing with their problems that led them to start using drugs.

Lettieri defines five phases which comprise the cycle of drug abuse: (a) initiation of drug use, (b) continuation of drug use, (c) transition from drug abuse, (d) cessation of drug abuse, and (e) relapse into drug abuse. He classifies theories on drug abuse into four categories: (1) theories which explain drug abuse in terms of the drug abuser's relation to himself or herself, (2) theories which explain drug abuse in terms of the drug abuser's relationship to others, (3) theories which explain drug abuse in terms of the drug abuser's relationship to nature.20


Theories from the disciplines of psychiatry and psychology focus on the relationship to self. Social-psychological theories focus on the relationship to others, sociological theories focus on drug abuse stem from the disciplines of psychiatry, psychology and social psychology, which includes social work.21

Psychosocial and sociological theories emphasize peer and family influence, and the interaction of psychological, sociological and environmental factors. One researcher’s theory of substance abuse is based on the concept of mutual over-dependence between the substance abuser and family. Since the primary issue is the substance abuser’s inability to achieve a successful separation from the family, the potential for beginning the substance abuse cycle is particularly great during adolescence.22

In reference to the above theories, it appears that the drug abuser is dependent on the family for guidance and emotional nourishment especially during the adolescent developmental stage. There are theories such as the psychological and personality theories that are based on the cognitive and affective processes of the individual. However, these theories extend to the relevance of family influence on the adolescent’s and adult’s self-concept and the ability to cope with responsibility. Psychological

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21Ibid., 20.

22Ibid., 28.
theories of drug abuse often note the existence of dysfunctional family systems. This type of environment tends to create certain personality deficiencies in the adult. A lack of emotional and psychological coping skills, in combination with environmental factors, may lead the adult to abuse alcohol and drugs.23

Behavior modification techniques are used for managing impulses for drug-seeking, along with a supportive network for self-examination. Awareness of the relationship between addiction and symptoms of depression and anxiety is also essential; alcoholics and drug addicts are prone to depression and suicide. All these issues must be brought together for effective treatment.

Group psychotherapy more directly influences interpersonal relationships and social adjustment. Therefore, selective symptom variables may be addressed differently by each mode of therapy, and the proposed approach to substance abuse is both integrative and selective.24

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23Ibid., 30.

CHAPTER THREE
METHODOLOGY

Setting
This study was conducted at a county outpatient mental health center located in Fayette County, Georgia. The target population served ranges between the ages of 4 to 84, male and female, Caucasian, African-American and Hispanic clients. The agency offers three program areas of need (a) child and adolescent (b) adult mental health, and (c) substance abuse. The substance abuse program also serves many of the county probation/parole population. There is also an affiliated mental retardation center located in another area of the county. There are nine full-time therapists specializing in various mental health areas. Two part-time psychiatrists handle all consumers medication needs. There are also three pad-time interns. The agency provides services for any county resident based on a sliding scale fee and the ability to pay.

Client Background
Jane D. is a 28 year old white female. During the initial interview with Jane D., it was revealed that she was molested at age 9 by her uncle. She began using marijuana and alcohol at age 12 along with her sister. She has two brothers and one sister. While she claimed there is no psychiatric history in her family, both her parents drink
heavily and an older brother "drinks and drugs a lot more than they do."

Jane recalled very little of her early childhood and her recent memory was also impaired. She denied any homicidal or suicidal ideations, although she did admit to feeling at times that she wished her uncle was dead. Jane had never formulated any type of plan in which to harm her uncle. Her mood was especially depressed, sad and tearful when discussing the molestation.

She stated that her father was verbally and physically abusive to everyone in the family. She denied any sexual abuse by her father and has no knowledge of any other siblings being sexually abused by her uncle. Jane D. recalled being called ugly by her brothers and never hearing either parent say, "I love you." At age 17, she dropped out of high school because she was pregnant. She eventually received her GED and a certificate as a Nursing Assistant.

Jane D. has been married twice. She described her first husband as neglectful. They used cocaine together. She has one child from the marriage. Jane D. divorced her first husband after one year of marriage. She is currently separated from her second husband who also uses cocaine. Her children are in the custody of the Department of Family and Children Services due to her drug abuse, physical abuse and neglect. Jane D. says she has never felt good about herself and has never dealt with the pains of her early
childhood, especially the molestation. She stated that she wanted to find a solution to her drug problem and to regain her self-esteem. She describes episodes of overwhelming feelings of worthlessness and hopelessness.

Jane has crying spells and difficulty sleeping, yet she spends countless hours isolated in the bed thinking about how terrible a wife and mother she has been. Jane states that the world would be better off if she were dead, but she denies suicidal ideation or any plan to harm herself. She felt as if there was no direction or future to her life. Jane explained that her drug use no longer gives her even a temporary escape from life.

Treatment Hypothesis

It was hypothesized that participation in group therapy would increase the client’s level of self-esteem. It was also hypothesized that the client’s level of depression would improve.

Intervention Strategy

In establishing a therapeutic relationship with the client, specific techniques were employed which are common to all psychotherapies. Warmth, genuineness, empathy and proper timing are an integral part of establishing a trusting relationship with a client which facilitates growth and change.
During the initial interview with Jane D., a psychosocial assessment was completed and questionnaires regarding self-esteem and depression were administered to her. This session also focused on creating a hopeful atmosphere and letting her know that the future would be different and better than the past or present has been.

During the second session with Jane D., treatment plans were developed. Jane D.'s plan included the following: (a) she was encouraged to utilize group sessions to discuss issues that relate to her low self-esteem, depression and drug use; (b) she agreed to remain drug free while in the group; (c) she agreed to attend three narcotics anonymous meetings per week; (d) she agreed to obtain a sponsor for the purpose of building a positive support system from someone who has a year or more recovery time in Narcotics Anonymous; and (e) she agreed to comply with Department of Family and Children Services regulations for regaining custody of her children.

The clients families were encouraged to attend the family education group held on Thursday nights to work on family issues and to understand the cycle of addiction. Jane was required to attend group sessions with nine other substance abusing group members.

The intervention strategy used with Jane D. consisted of an intensive eight week education and therapy group centered on the effects of substance abuse. Topics
discussed included consequences of abuse, risk factors, managing emotions, building self-esteem, benefits of abstinence and spirituality.

Group sessions were held every Monday evening for one hour and fifteen minutes. Sessions were co-facilitated by a full time substance abuse therapist and the researcher. The main intervention methods used in group sessions fell into three categories: 12-step support group information/education provisions, exploring feelings, and the impact of drug abuse on self and family. The group setting and discussion of specific issues with others with similar problems allowed members to develop strength needed to increase self-esteem and to reduce depression.

Twelve step education. These sessions were facilitated by a recovering alcoholic/drug addict with five years of active involvement in Alcoholics Anonymous and Narcotics Anonymous. These groups focus on the sharing of personal life stories while in active addiction and the dramatic positive changes through the recovery process. All group members were required to attend at least three 12 step meetings per week. Every session began by each group member taking time to discuss their meeting experiences and were encouraged to ask questions regarding. The 12 step program of recovery.

Exploring feelings. Group members participated in a number of exercises in the identification and processing of
feelings beginning with mad, sad and glad. Substance abusers' feelings and emotions are blunted or numbed by the drugs that are ingested. These feelings are medicated, denied and may surface in many inappropriate behaviors. This perpetuates the cycle of addiction by using drugs to diminish the feelings of guilt and shame caused by the behavior. Cognitive and behavior modification methods were employed.

Members of the group were asked to share what they perceived as positive attributes. Each member could agree or disagree with the statements. All other group members were encouraged to give positive reinforcing feedback to increase self-esteem, feelings of support and client strengths.

**Impact of drug abuse.** Group members discussed the continued use of drugs despite the progression of negative consequences resulting directly or indirectly from substance abuse. Relationships deteriorate, loved ones become resentful and isolation from others were common problems among group members. Drug abuse causes physical, emotional and psychological damage. Relationship building with oneself as well as with others was emphasized through the making of amends to those harmed by past behaviors and self forgiveness.

Group sessions included behavioral changes or modification with regard to places or situations that
trigger cravings for the drugs. A proper diet and exercise was stressed to begin to feel better physically and ways to productively fill their leisure time with beneficial activities. Cognitive sessions were used to validate or invalidate the consumers automatic negative cognition regarding situations that may frequently arise. The recognition and management of feelings were highlighted. Participation and honest feedback of each group member allowed each to become an important link, not only to their own recovery, but in helping in the recovery of others in the group. This support is especially necessary for overcoming the denial and relapse that is so common among substance abusers.

Outcome Measures

Two standardized questionnaires, from the WALMYR Assessment Scales, were implemented as measuring instruments in this study. These measures were chosen for their efficiency and pretested reliability. The Index of Self-Esteem Scale contains 25 items and the client is asked to rate each item on a 7-point scale ranging from 1, "none of the time", to 7, "all of the time". The Generalized Contentment Scale contains 25 items on the same 7-point scale. For each scale the lowest possible total score is 0, the highest is 100, and higher scores indicate greater magnitude of the problem. The questionnaires have a clinical cuffing score of approximately 30. Clients who
score over 30 generally have been found to have problems in the area being measured. Both scales have a reliability of .90 or better.¹

The questionnaires were administered by the researcher on a weekly basis for a ten week period. The objective was to assess if there would be an increase in the level of self-esteem and a decrease in the level of depression during the intervention. The same two instruments were administered the two weeks after the intervention phase for follow-up data.

**Research Design**

The research design used in this study is outlined by Bloom, Fischer and Orme. It is designated the "basic single system design: (A-B). The design consists of a baseline "phase A" and an intervention "phase B". In addition there is a follow-up phase.² This design is extremely useful for social workers as it assists the clinician in determining whether the consumer has improved over time. Should the client remain at baseline without improvement or a decrease in the problem symptomatology, the clinician has the opportunity to attempt a different intervention.


²Ibid.
A limitation of this design lies in the assumption that the intervention applied is the only reason for a change in baseline behavior. This cannot clearly be established with an A-B design. On the other hand, for the clinician operating "in the field" whose primary objective is the alleviation of the discomfort of his or her clients, the simpler the design the more likely it is to be used. This allows for at least some degree of accountability and hopefully a more ethical application of an effective treatment modality.
CHAPTER FOUR

RESULTS

This chapter is a summary of the data collected from the consumer in this study. The results of the study are presented in Figure 1 and Figure 2. The consumer participated in group therapy for a period of eight weeks. Baseline, intervention and follow up measures were taken on self-esteem and depression.

Figure 1 presents level of self-esteem during baseline, intervention and follow-up. As depicted, self esteem level at baseline was a mean score of 61 standard deviation (s.d.) = 1.0. At the end of the eight-week period of intervention, the consumer's level of self-esteem was a mean score of 42.25 (s.d.) = 12.58. And at the end of the two-week period of the follow-up the level of self-esteem was 22. The results demonstrated that group therapy was able to generate a drastic improvement in the consumer's level of self-esteem.

Figure 2 presents depression levels during baseline, intervention and follow-up. As depicted, depression level at baseline was a mean score of 70 (s.d.) = 14.90. At the end of the eight-week period of intervention, the consumer's level of depression had decreased to 25. And at the end of the two-week period of follow-up the level of depression was 25. The results demonstrate that group therapy was able to
Figure 1. Self-Esteem Scores During Baseline, Intervention and Follow-Up Phases
Figure 2. Depression Scores During Baseline, Intervention and Follow-Up Phases
generate a drastic improvement in the consumer's level of depression.

The client's greatest stumbling block centered around her tendency to view events or possible events in the worse possible light in order to "be prepared." She felt that in this way she could not be hurt or disappointed. This belief began when, as a child, every weekend she would anticipate her father getting drunk and abusing her mother. It remained with her and increased when she was sexually abused. Unfortunately, this tendency often became a self-fulfilling prophecy and was perpetuated by increased substance abuse.

Jane D. stated that she now understood that had she not always expected the worst possible behavior from her ex-husbands, she may not have behaved in such a rejecting fashion and perhaps the marriages could have been better. This is a very positive step for Jane. In addition, she has also come to have a more accurate idea of what, in her daily life, she is and is not responsible for and can or cannot control. She is responsible for her recovery and she cannot control her addiction after even one time using. This outlook has greatly contributed to a lowering of her feelings of anxiety, anger, guilt, out of lack of control, and subsequent depression. It has substantially raised her esteem and self-worth. It has also facilitated a better relationship with her children and ex-husband. Her sexual
abuse issues have been successfully worked through as indicated by her ability to discuss it with less confusion and anger and more of an acceptance and moving on to how to deal with in without blaming herself.
CHAPTER FIVE
SUMMARY AND CONCLUSION

In this study, group therapy had an impact on the client’s higher levels of self-esteem as well as lower levels of depression. The research findings support the hypothesis that an adult substance abuser who received a structurally-oriented substance abuse outpatient program will have (a) higher self-esteem, and (b) less depression.

The data from this study provides significant support about the effectiveness of group therapy intervention. The consumer increased her level of self-esteem and her level of depression decreased. She improved her relationship with family and set some positive attainable goals during the eight-week period of intervention. This study demonstrated that the clients participation in the sessions brought about the positive changes in self-esteem and depression.

Limitations of the Study

Limitations of this study include the threat to validity of the regular attendance of Narcotics Anonymous was responsible for the observed improvements in the consumer’s levels of self-esteem and depression.

Also, the limitations of this design lies in the assumption that the intervention applied is the only reason for change in baseline behavior. This cannot clearly be established with an A-B design. On the other hand, for the
clinician operating "in the field" whose primary objective is the alleviation of the discomfort of his or her clients, the simpler the design the more likely it is to be used. This allows for at least some degree of accountability and hopefully a more ethical application of an effective treatment modality.
CHAPTER SIX
IMPLICATIONS FOR SOCIAL WORK PRACTICE

There are many implications for social work practice from this study. One of the primary focuses of social work intervention should be to assist clients in raising their self-esteem and confidence.

An adult substance abusing client cannot receive appropriate treatment for their drug problems if there has not been a significant amount of research done to build a knowledge base for the understanding of the developments and process of addiction and its psychological repercussions.

The lack of in-depth research on the adult substance abuser leaves room for social workers to begin advocating on behalf of this population. There is an abundance of studies, written materials, and numerous programs concerning adolescent drug use and prevention, but the information on the adult substance abuser is very limited.

The involvement of social workers in substance abuse treatment could be increased in several ways. Greater availability of substance abuse course offerings in graduate education would prepare more social workers for service in this area. There is no area of social work that is not impacted by substance abuse and should become a required course in the social work curriculum. Social workers currently employed in substance abuse programs could network
to a greater degree and develop joint recommendations for program improvement.

Social workers who lead group therapy should have extensive training in drug abuse and group counseling. They must enhance their interfacing with clients and demonstrate a knowledge base concerning racial, cultural, sexual and gender issues. This will increase social workers' sensitivity as consumers begin the recovery process.
This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. _____ I feel that people would not like me if they really knew me well.
2. _____ I feel that others get along much better than I do.
3. _____ I feel that I am a beautiful person.
4. _____ When I am with others I feel they are glad I am with them.
5. _____ I feel that people really like to talk with me.
6. _____ I feel that I am a very competent person.
7. _____ I think I make a good impression on others.
8. _____ I feel that I need more self-confidence.
9. _____ When I am with strangers I am very nervous.
10. _____ I think that I am a dull person.
11. _____ I feel ugly.
12. _____ I feel that others have more fun than I do.
13. _____ I feel that I bore people.
14. _____ I think my friends find me interesting.
15. _____ I think I have a good sense of humor.
16. _____ I feel very self-conscious when I am with strangers.
17. _____ I feel that if I could be more like other people I would have it made.
18. ____ I feel that people have a good time when they are with me.
19. ____ I feel like a wallflower when I go out.
20. ____ I feel I get pushed around more than others.
21. ____ I think I am a rather nice person.
22. ____ I feel that people really like me very much.
23. ____ I feel that I am a likable person.
24. ____ I am afraid I will appear foolish to others.
25. ____ My friends think very highly of me.
APPENDIX B

GENERALIZED CONTENTMENT SCALE (GCS)

Name______________________________  Today’s Date__________________

This questionnaire is designed to measure how you feel about your life and surroundings. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. ______ I feel powerless to do anything about my life.
2. ______ I feel blue.
3. ______ I think about ending my life.
4. ______ I have crying spells.
5. ______ It is easy for me to enjoy myself.
6. ______ I have a hard time getting started on things that I need to do.
7. ______ I get very depressed.
8. ______ I feel there is always someone I can depend on when things get tough.
9. ______ I feel that the future looks bright for me.
10. ______ I feel downhearted.
11. ______ I feel that I am needed.
12. ______ I feel that I am appreciated by others.
13. ______ I enjoy being with other people.
14. ______ I feel that others would be better off without me.
15. ______ I enjoy being with other people.
16. ______ I feel that it is easy for me to make decisions.
17. ______ I feel downtrodden.
18. ______ I feel terribly lonely.
19. ______ I get upset easily.

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20. ____ I feel that nobody really cares about me.
21. ____ I have a full life.
22. ____ I feel that people really care about me.
23. ____ I have a great deal of fun.
24. ____ I feel great in the morning.
25. ____ I feel that my situation is hopeless.
BIBLIOGRAPHY


