A descriptive study of the relationship between attitudinal change toward addiction and addictive behavior among substance abusers entering an inpatient treatment program

Jeffrey Sanders
Clark Atlanta University

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ABSTRACT

SOCIAL WORK

SANDERS, JEFFREY B.S. University of South Carolina, 1995

A DESCRIPTIVE STUDY OF THE RELATIONSHIP BETWEEN ATTITUDINAL CHANGE TOWARD ADDICTION AND ADDICTIVE BEHAVIOR AMONG SUBSTANCE ABUSERS ENTERING AN INPATIENT TREATMENT PROGRAM.

Advisor: Dr. Gale Horton

Thesis dated May, 1997

The overall objective of this study was to expound on the relationship between attitudinal change toward addiction and addictive behavior among substance abusers entering an inpatient treatment programs. To achieve this objective the following determinants were addressed by the author: 1) Effects of Substance Abuse, (2) Attitudinal/Behavioral Change and (3) Inpatient Treatment Program. The study involved thirty adults, males and females, ranging between the ages of 18 to 57. The participants entered an inpatient treatment program at a local treatment facility in Atlanta, Georgia.

This study was an attempt to look at the change of attitude and change of behavior among substance abusers entering an inpatient treatment program. The results indicated there was a change in attitude, but did not indicate if there was a change in behavior. In observing the participants in the study there was a decrease in addictive behavior. This may have occurred because the client went through four weeks of educational classes about addiction and its consequences during the course of this study.
A DESCRIPTIVE STUDY OF THE RELATIONSHIP BETWEEN ATTITUINAL CHANGE TOWARD ADDICTION AND ADDICTIVE BEHAVIOR AMONG SUBSTANCE ABUSERS ENTERING AN INPATIENT TREATMENT PROGRAM

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
JEFFREY SANDERS

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
MAY 1998
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I would first like to thank my Lord and Savior, Jesus Christ, for allowing me this opportunity. I would like to recognize my mother Vernell Sanders for her support and unconditional love through all my years. Thank you for everything and I love you Vernell. I would like to give thanks to my grandfather Moody Sanders for his support and care while in school. I would like to give thanks to my mentor, Dr. Ralph Johnson, for encouraging and supporting me throughout my education. I would like to thank all my friends and family who supported me throughout my time in school. Thank you to Dr. Sandra G. Foster for your support and unconditional love through my time of need. I would like to give thanks and appreciation to Dr. Gale Horton for his help and support as my educational and thesis advisor. Finally I would like to give thanks to my best friend Tawanda R. Grant for all her support and love through the good and bad times.

THIS THESIS IS IN LOVING MEMORY OF MY GRANDMOTHER, EVELENA SANDERS AND MY GREAT-GRANDMOTHER NANCY FIELDS.
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CHAPTER ONE

INTRODUCTION

As a significant health problem in the country, substance abuse places a major burden on the nation's health care system and contributes to the high cost of health care.

In fact, substance abuse, identified as the problematic use of alcohol and illicit drugs, places an enormous burden on American society as a whole. It can harm health, family life, the economy and public safety, and it threatens many other aspects of life as well. Substance abuse affects all segments of society, but it disproportionately affects disadvantaged groups and threatens the future of young people.¹

In 1996, an estimated 13.0 million Americans were current drug users, meaning they had used drugs within the month prior to the interview.² In 1996, 109 million Americans age 12 and older had used alcohol in the month prior to the interview, constituting 51 percent of the population. About 32 million engaged in binge drinking, 5 or more drinks on at least one occasion in the past month and about 11 million were heavy drinkers, drinking five or more drinks per occasion on 5 or more days in the past 30 days.³ About 9 million current drinkers were age 12-20 in 1996. Of these, 4.4 million

¹ Institute For Health Policy, Brandeis University, Substance Abuse: The Nation's Number One Health Problem, (October 1993): 3

² Substance Abuse and Mental Health Services Administration, Preliminary Results From The 1996 National Household Survey on Drug Abuse, Series H-3: 2

³ Ibid., 2
were binge drinkers, including the 1.9 million heavy drinkers.\textsuperscript{4}

Approximately 54 percent of current illicit drug users used marijuana only, 23 percent used marijuana and other illicit drugs, and the remaining 23 percent used only an illicit drug other than marijuana in the month prior to the interview. Therefore, about 46 percent of current illicit drug users in 1996, an estimated 5.8 million Americans, were current users of illicit drugs other than marijuana and hashish.\textsuperscript{5}

The rates of drug use has shown substantial variation by age. Among youths age 12-13, 2.2 percent were current illicit drug users. The highest rates were found among young people ages 16-17 at 15.6 percent and ages 18-20 at 20.0 percent.\textsuperscript{6} Rates of use were lower in each successive age group, with only about one percent of persons age 50 and older reporting current illicit drug use.\textsuperscript{7} Half of the young adults ages 21-25 had tried illicit drugs at least once in their lifetime, and 13 percent were current users. More than half of adults ages 26-49 had tried illicit drugs, but rates of current use were only 8.4 percent for those ages 26-34 and 5.2 percent for those ages 35-49. The percentage of current illicit drug users that were age 35 and older increased from 10.3 percent in 1979 to 26.1 percent in 1990. Between 1990 and 1996, the percent remained fairly constant at 28.3 percent in 1996.\textsuperscript{8}

\textsuperscript{4} Substance Abuse and Mental Health Services Administration, Preliminary Results From The 1996 National Household Survey on Drug Abuse, Series H-3, 2.

\textsuperscript{5} Ibid., 7.

\textsuperscript{6} Ibid., 7.

\textsuperscript{7} Ibid., 9.

\textsuperscript{8} Ibid., 9.
The rate of current illicit drug use for blacks at 7.5 percent remained somewhat higher than for whites at 6.1 percent and Hispanics at 5.2 percent in 1996. However, among youths, the rates of use are about the same for the three groups. The most common illicit drug users were white. There were an estimated 9.7 million whites or 74 percent of all users, 1.8 million blacks at 14 percent, and 1.1 million Hispanics at 8 percent that were current illicit drug users in 1996. As in prior years, men continued to have a higher rate of current illicit drug use than women at 8.1 percent vs. 4.2 percent in 1996. The current illicit drug use rate was 7.3 percent in the West region, 6.9 percent in the North Central region, 5.5 percent in the South and 4.8 percent in the Northeast. As a result of a significant decrease in the rate of use in nonmetropolitan areas, rates were higher in metropolitan areas than in nonmetropolitan areas in 1996.

Illicit drug rates remain highly correlated with educational status. Among young adults age 18-34 years old in 1996, those who had not completed high school had the highest rate of current use at 16.8 percent, while college graduates had the lower rate of use at 6.9 percent. This is despite the fact that young adults at different educational levels are equally as likely to have tried illicit drugs in their lifetime with 49.0 percent of those not completing high school and 48.6 percent of college graduates.

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9 Substance Abuse and Mental Health Services Administration, Preliminary Results From The 1996 National Household Survey on Drug Abuse, Series H-3, 12.

10 Ibid., 12.

11 Ibid., 12.

12 Ibid., 12.

13 Ibid., 12.
In employee assistance programs, 30 percent to 40 percent of people needing services require them for substance abuse, and about 60 percent to 65 percent of these use alcohol. Unfortunately, it is likely that most alcohol and substance abuse goes untreated.  

Rates of current alcohol use were about or above 60 percent for age groups 21-25, 26-29, 30-34, 35-39, and 40-44 in 1996. For younger and older age groups rates were lower. Young adult (18-25 years old) drinkers were the most likely to binge or drink heavily. About half of the drinkers in this age group were drinkers and about one in five were heavy drinkers.

In 1996, whites continued to have the highest rate of current alcohol use at 54 percent. Rates for Hispanics and blacks were 43 percent and 42 percent, respectively. The rate of binge use was lower among blacks at 13.1 percent than among whites at 16.1 percent and Hispanics at 16.7 percent. Heavy use showed no statistically significant differences by race/ethnicity with 5.5 percent for whites, 6.2 percent for Hispanics, and 5.3 percent for blacks. Fifty-nine percent of men were past month alcohol users, compared with 44 percent of women. Men were much more likely than women to be

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16 Ibid., 19.

17 Ibid., 20.

18 Ibid., 20.
binge drinkers at 22.8 percent and 8.7 percent, respectively and heavy drinkers at 98.1 and 1.9 percent, respectively.\(^{19}\)

The rate of current alcohol use was 54 percent in the North Central region, 55 percent in the Northeast region, 50 percent in the West region, and 47 percent in the South in 1996. Rates of binge use were 19 percent in the North Central, 15 percent in the West, 14 percent in the South, and 13 percent Northeast.\(^{20}\) Heavy alcohol use rates were 6.4 percent in the North Central, 5.1 percent in the West, 4.5 percent in North east and 5.5 percent in the South. The rate of past month alcohol use was 54 percent in large metropolitan areas, 53 percent in small metropolitan areas, but only 42 percent in nonmetropolitan areas. There was little variation in binge and heavy alcohol use rates by population density.\(^{21}\)

In contrast to the pattern for illicit drugs, the higher the level of educational attainment, the more likely was the current use of alcohol. In 1996, 66 percent of adults with college degrees were current drinkers, compared with only 39 percent of those having less than a high school education.\(^{22}\) Binge alcohol use rates did not vary across different levels of education. However, the rate of heavy alcohol use was 3.7 percent among adults who had completed college and 6.8 percent among adults who had not

\(^{19}\) Substance Abuse and Mental Health Services Administration, Preliminary Results From The 1996 National Household Survey on Drug Abuse, Series H-3, 20.

\(^{20}\) Ibid., 20.

\(^{21}\) Ibid., 20.

\(^{22}\) Ibid., 20.
completed high school.\textsuperscript{23}

Since many people in the United States are addicted to drugs and alcohol, this is a vital area for social workers. It is important for social workers to increase their knowledge about the role that drugs and alcohol play in an individual's everyday life. Research has shown that people that abuse drugs and alcohol cause an increase in crime, and child abuse. There are many educational programs to educate people about drug and alcohol abuse but many people are still affected by it every day.

Statement of the Problem

Substance abuse is a major concern for society because many individuals are addicted to drugs and/or alcohol. Many people may feel that they can control their drug or alcohol use, but for many their drug or alcohol use is out of control. A person's attitude and belief system sometimes determine the use of drugs and alcohol. If a person can change his or her attitude about drugs and/or alcohol use, they will then be able to decrease their addictive behavior over time.

The use of drugs and alcohol creates many problems for the family, job, community, and the nation. The family is the first place where the effects of drug and alcohol abuse is felt. The parent may become abusive towards their spouse and/or children. This may cause the child to become withdrawn from the family. The child

\textsuperscript{23} Substance Abuse and Mental Health Services Administration, Preliminary Results From The 1996 National Household Survey on Drug Abuse, Series H-3, 20.
may begin to have problems in school such as a decrease in grades and/or behavioral problems. This may also cause the child to become emotionally and/or mentally impaired, causing the child to be unable to form a meaningful friendship or relationship. If the person is married the relationship may then come to an end, causing the family to split and leaving the children feeling as if they are the cause of the divorce.

In starting a family the effect of drugs and alcohol can also cause problems. If the male is using drugs and/or alcohol the quality of his sperm may decrease and cause the fetus to form abnormally. If the female is using drugs and/or alcohol during the pregnancy it could cause the child to be born addicted to drugs and/or alcohol. The child may develop slower than other children his/her age and the child may have some type of learning disability that could affect him/her. The child could be born handicapped, with some type of disease, or not fully developed physically. The use of drugs and alcohol could also cause the mother to have a spontaneous abortion (miscarriage) or the baby stillborn.

The use of drugs and alcohol can have a great effect on the community where it is sold and used. If the community is a low-income community, people may look at it as an unsafe place to live and people in that area as corrupt. The community is then labeled as unsafe and no profitable business would want to move into the community leaving the area on the lower end of the economic scale. Families may began to move out of the community causing the value of the property in the community to fall and no other family would want to move into the community. The crime rate in the community may increase also because of the use of drugs and alcohol.
If the person lives in a high income area they may not have as many problems as people living in a low-income area, but they will have some problems. The most noticeable problem being family problems. The person may drive under the influence of drugs or alcohol causing an accident in the community which may hurt someone. Other problems that may occur because of drug and alcohol use is an increase in debt, and the selling of property, including the family home. The last area, of many, that the use of drugs and alcohol effects is the nation economy. Many people may feel that it does not affect them because they do not live in the area where drug and alcohol is being used, but it does effect them merely because they are tax payers. As a tax payer you are covering the cost for everyone that goes into drug and alcohol treatment and receives aid or grant money. The government may cover the cost of hospital care for people who do not have health insurance or those that cannot afford to pay on their own. The government also covers the cost for the care of the child if they are taken away or abandoned by the parents that uses alcohol and/or drugs. If you have car and/or health insurance you are also affected by drug and alcohol use. When a person goes into the hospital and stays for a long period of time, the insurance company may pass the cost onto their other consumers. The same thing happens with car insurance companies, if a person gets into an accident and the insurance company assumes liability they will pass on the cost to the other consumers by raising the rates.
Significance and Purpose of the Study

In recent years, researchers have produced information on addiction and the effect it has on the family, job, community, and the nation's economy. Many studies have also focused on inpatient treatment programs, but few have focused on the effect that attitudinal change has on the use of drugs and alcohol. Many programs have been developed to help patients that are addicted to drugs, but little have been done to change the attitude of the patient toward drugs and alcohol.

The significance of this study is to add to the discussion of substance abuse treatment by social workers and other professionals who work in the field of substance abuse. The purpose of this study is to examine whether a relationship exists between a change in attitude about substance abuse and actual substance use among patients entering an inpatient treatment program. It also seeks to expand the knowledge base of existing research on substance abuse regardless of the form it takes. Previous research has demonstrated that there is a possible relationship between, attitudinal and behavioral change, and this study seeks to elaborate on these findings.
CHAPTER TWO

REVIEW OF THE LITERATURE

This literature review will summarize previous research on substance abuse, attitudinal and behavioral change, and inpatient treatment programs. To provide an effective treatment program for the substance abuse population a greater understanding of treatment topics is very necessary. The review of literature will discuss areas regarding the effect of substance abuse and its relationship to the attitudinal and behavioral change of clients receiving treatment for substance abuse.

The Effects of Substance Abuse

The abuse of alcohol and other drugs contributes in a major way to such problems as violent crime, child abuse and neglect, and unemployment. Problems associated with alcohol and drug abuse weaken the social fabric of society resulting in lost productivity, destruction of families and lives. To illustrate this fact, the Research Triangle Institute calculated the economic cost to society of alcohol and other drug problems at $177 billion dollars per year.¹

The most used or abused drugs in our country, excluding tobacco, fall under the sedative-hypnotic group. These drugs include alcohol, minor tranquilizers such as

¹ Judith A. Lewis, Addictions: Concepts and Strategies for Treatment (Gaithersburg, Maryland, Aspen Publishers, Inc.), 24.
Valium and Librium, barbiturates, and other sedatives. Alcohol is the most frequently abused drug in this category.\textsuperscript{2} There are currently 103 million consumers of alcohol, which is approximately two-thirds of the population. The minor tranquilizers, some of them prescribed, follow second to alcohol in the sedative-hypnotic group.\textsuperscript{3} Alcohol alone accounts for more than 100,000 deaths per year. In contrast, illegal drugs account for less than 4,000 deaths per year.\textsuperscript{4} The third most frequently abused drugs are classed as stimulants, such as cocaine and crack cocaine. Cocaine and crack cocaine have become a national epidemic as this drug is extremely addictive. An estimated twenty-two million Americans have tried it and nearly one-half million can be labeled as addicted.\textsuperscript{5}

In the past few years substance abuse has created many substantial problems within society. Problems that related to substance abuse range from complications with pregnancies to problems with the national economy. More than half of human pregnancies are lost in the first 30 weeks of gestation and almost 80% before term. Of the survivors, about 1% to 3% are born with gross structural defects and a similar percentage with more subtle abnormalities.\textsuperscript{6} The cause of spontaneous abortions, miscarriages, stillbirths, and live births with abnormal conditions are often unknown, but

\textsuperscript{2} George Pratsinak and Robert Alexander, \textit{Understanding Substance Abuse and Treatment} (Laurer, MD., American Correctional Association), 33.

\textsuperscript{3} Ibid., 33.

\textsuperscript{4} Ibid., 33.

\textsuperscript{5} Ibid., 34.

\textsuperscript{6} Fred Leavitt, \textit{Drugs & Behavior} 3ed. (London, SAGE Publications), 155.
the use of drugs during pregnancy is the major preventable cause.\textsuperscript{7} Drug-exposed infants are also much more likely than unexposed infants to have withdrawal symptoms and be infected by syphilis and/or the human immunodeficiency virus (HIV).\textsuperscript{8}

Every year in the United States, at least 30,000 infants are born with alcohol related birth defects, which may cause mild to severe birth defects. They range from subtle behavior alterations, through full fetal alcohol syndrome, to death.\textsuperscript{9} Based on a hospital survey conducted, in Florida, by the National Association for Perinatal Addiction Research and Education, it was estimated that 11% of newborns delivered each year will be exposed to the negative effects of their mother’s prenatal drug use.\textsuperscript{10} At the hospital where the study was conducted, approximately 4,500 babies are born annually, with 10% having been exposed to cocaine and 5% of those babies showing clinical signs of cocaine addiction. Similar statistics has been reported throughout the United States.\textsuperscript{11}

Some of the effects that cocaine has on the fetus include premature separation of the placenta and intrauterine vascular accidents in the fetus. Fetal vascular disruption associated with cocaine use is thought to be responsible for a spectrum of congenital

\textsuperscript{7} Fred Leavitt, \textit{Drugs \& Behavior} 3ed. (London, SAGE Publications), 156.

\textsuperscript{8} Ibid., 156.


\textsuperscript{11} Ibid., 451.
anomalies and may be responsible for spontaneous abortion or stillbirth. The birth weight of cocaine-affected babies is lower than that of their normal counterpart. Cocaine exposure in-utero also affects the infant's neurobehavior. Also, many babies exposed to cocaine prenatally experience withdrawal, which carries with it direct and indirect morbidity. The indirect morbidity is the result of the lack of interactive behavior with caretakers and the environment. As a result, mothers and their cocaine exposed infants may have great difficulty in the early bonding process.

Fetal alcohol syndrome (FAS) afflicts alarmingly large numbers of the babies born to mothers who are active alcoholics and in dramatic lifelong ways, the most serious being mental retardation. Fetal alcohol syndrome affected babies often display typical malformations of the head such as a disproportionately small diameter of the head, underslung jaw, low-set ears, flattened bridge of the nose, varying bone structure and joints are often malformed. Substance abuse may also cause infants to have heart defects.

The burden to society of drug-exposed infants only begins with the costs of delivery. These children are at a relatively high risk for congenital birth defects and for

13 Ibid., 451.
14 Ibid., 451.
15 Ibid., 452.
17 Ibid., 184.
infection with the human immunodeficiency virus, syphilis, and other potentially crippling or fatal conditions.^{18} Children exposed to drugs in the womb tend to develop poor feeding reflexes and intermittent sleep patterns. They also are more susceptible to infectious disease and failure to thrive symptoms.^{19} Even when physical problems are not visible at birth, victims of fetal alcohol syndrome and other prenatal drug exposure often are mentally and visually impaired through adulthood, adding to the cost of special education and welfare.^{20} The children may later exhibit learning disabilities, including attention deficit and hyperactivity disorder, and ultimately run a higher than average risk of becoming involved in drug use at an early age.^{21}

Substance abuse places tremendous psychological and financial burdens on families. Nearly 20% of men and more than 25% of women reported that drinking has been a cause of trouble in their family.^{22} Problem drinking can affect a family in many ways, even resulting in a divorce for couples. More than one-third of the women who are separated or divorced were married at one time to a problem drinker or alcoholic.^{23} Families with a problem drinker often experience a host of social problems, such as


^{19} Ibid., 14.

^{20} Ibid., 14.

^{21} Ibid., 14.

^{22} Institute for Health Policy, Brandeis University, *Substance Abuse: The Nation's Number One Health Problem* (New Jersey: Institute for Health Policy, Brandies University), 40.

^{23} Ibid., 40.
violence between spouses, child abuse and a greater likelihood of raising children, particularly boys, who themselves become problem drinkers.24

Children in alcoholic families exhibit emotional and adjustment difficulties. These problems include aggressive behavior, difficulties with peers, conduct problems, bouts of hyperactivity and poor school adjustment.25 In addition, these youngsters miss school more often and have more physical ailments and serious injuries than do children raised in non-alcoholic homes.26

In a study conducted by Lenore Olsen, it was concluded that parents struggling with substance abuse are among the most challenging to serve. Parents that are brought to the attention of the child welfare system are often very poor, with few work skills and lower levels of educational attainment.27 They are often living in high crime areas saturated with drugs. The parent with a long history of substance abuse are quite likely to be in denial about their addiction.28

In 1989, the National Committee for the Prevention of Child Abuse (NCPCA), estimated that 9 million to 10 million children were affected by substance-abusing parents and that 675,000 children were maltreated each year by an alcoholic or drug

24 Institute for Health Policy, Brandeis University, Substance Abuse: The Nation's Number One Health Problem (New Jersey: Institute for Health Policy, Brandies University), 40.

25 Ibid. , 40.

26 Ibid. , 40.


28 Ibid. , 193.
addicted caretaker. Among confirmed cases of child maltreatment, the estimated percentage involving substance abuse averages 40 percent nationwide.\textsuperscript{29}

There is mounting evidence that children reared in chemically dependent families are more likely to be exposed to abuse and neglect than children in the general population. Consistent statistical findings reveal that over 50\% of abuse incidents are related to alcohol alone.\textsuperscript{30} It was found that parental abuse of alcohol and other drugs were involved in 43\% of the serious child abuse or neglect cases brought before a metropolitan juvenile court.\textsuperscript{31} In another study, Famularo, Kinscherff, and Fenton reported that 67\% of significant child maltreatment cases in a large juvenile court involved parents who abused alcohol and/or drugs.\textsuperscript{32}

In her discussion, Sheridan stated, although parental substance abuse was found to be directly related to child maltreatment, results suggest it may also be indirectly associated through its relationship with the family-of-origin competence.\textsuperscript{33} Specifically, the negative impact of parental substance abuse may best be understood as having adverse consequences on family dynamics; which in turn, increases the likelihood of


\textsuperscript{30} D. Finkelhor et al. The Dark Side of Families: Cultural Violence Research (Beverly Hills, CA Sage Publications), 132.


exposure to child abuse and neglect. This speculation is supported by evidence that substance abusing families tend to be characterized by low levels of cohesion, low frustration tolerance, unrealistic expectations of children, role reversal, and poor parenting skills; these traits also have been linked to abusive family systems.

Economic problems are also problems that families of substance abusers experience. To fund the use of drugs and/or alcohol, it will take a large chunk out of a 'normal' family's income-money otherwise needed for clothes, shoes, school outings, and in some cases even food. The debt creates tensions, resentments, misery, and even bankruptcy; which can contribute to the divorce of the parents and homelessness. Debt can lead to crime, such as petty theft to subsidize the habit of using drugs or alcohol, burglary to reclaim spent resources, and begging and violence in an attempt to gain desperately needed funds.

After the child has left the home the effect of the substance abuse by a parent continues to be apparent in that child's life. Studies indicate that people with alcoholic parents who do not themselves become an alcoholic have a 50 percent greater chance of marrying an alcoholic than does the rest of the population. Even if no one in the family

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35 Ibid. , 526


37 Ibid. , 9.

abuses drugs or alcohol, parenting practices and attitudes about alcohol and drug use may
contribute to future use of drugs and alcohol.\textsuperscript{39}

A significant amount of substance use takes place among the American work
force outside the work place, but some of the drug and alcohol use does occur at work.
One-third of all full-time workers are smokers, about two-thirds reported that they had
consumed alcohol in the month prior to the survey and about 15 percent said they used
illicit drugs during the year prior to the survey.\textsuperscript{40} With heavy alcohol consumption or the
use of illicit drugs, concentration diminishes, work performance decreases, and the
likelihood of accidents and the danger to others increases; attendance slips, promotions
are lost, and redundancy or dismissal is possible. If unemployment results, this may
cause an increase in economic hardship for the family, and substance abuse may cause it
to be difficult to rejoin the work force.\textsuperscript{41}

The link between alcohol and illicit drug use and crime is visible every day in
courtrooms, jails, and prisons across the country. Many offenders have stated that they
were under the influence of drugs, or alcohol, or both when they committed their crime.\textsuperscript{42}
At least half of the people arrested for major crimes such as homicide, theft, and assault

\textsuperscript{39} Micheal J. Stoil and Gary Hill, \textit{Preventing Substance Abuse: Interventions that Work} (New

\textsuperscript{40} Institute for Health Policy, Brandeis University, \textit{Substance Abuse: The Nation's Number One
Health Problem} (New Jersey: Institute for Health Policy, Brandeis University), 44.

\textsuperscript{41} Gillie Ruscombe-King and Sheila Harst, \textit{Alcohol Problems: Talking with Drinkers} (Bristol,

\textsuperscript{42} Institute for Health Policy, Brandeis University, \textit{Substance Abuse: The Nation's Number One
Health Problem} (New Jersey: Institute for Health Policy, Brandeis University), 42.
were using illicit drugs around the time of their arrest, and about half of the people in state prisons for committing violent crimes reported they were under the influence of alcohol or drugs at the time of their offense.43

Alcohol-related disorders are costly to the nation in terms of medical resources for care, treatment, and rehabilitation; reduced or lost productivity as a result of both illness and premature death; expenses of law enforcement and the pain and suffering experienced by alcohol abusers and their families and friends.44 In 1985, the United States economy endured the burden of alcohol abuse at the cost of 70.3 billion dollars. The cost of direct treatment and support accounted for 10 percent of the total cost in 1985.45 In 1988, the total economic cost of alcohol abuse was estimated at $85.8 billion dollars. Other related costs including crime, motor vehicle crashes, alcohol abuse-related destruction of property, and lost productivity for persons incarcerated, accounts for 15 percent of the total cost in 1985.46

More than two-fifths, or 44 percent of the direct cost $3.0 billion for drugs and alcohol abuse are for short-stay hospital care. Of this amount, $2.3 billion is the cost of care for the 1.1 million patients discharged with a primary diagnosis of alcohol abuse,

43 Institute for Health Policy, Brandeis University, Substance Abuse: The Nation's Number One Health Problem (New Jersey: Institute for Health Policy, Brandeis University), 42.


46 Ibid., 310.
who spent a total of 5 million days in the hospital.\textsuperscript{47} Productivity loses for the 44,325 people institutionalized with alcohol abuse disorder amounted to $180 million.\textsuperscript{48} A total of 65,319 men or 69 percent died as a result of alcohol abuse in 1985, with an estimated loss of productivity at $19.1 billion dollars or $291,661 per death. For the 29,448 women who died from alcohol abuse, productivity losses amounted to $4.9 billion dollars or $167,516 per death.\textsuperscript{49}

Other costs related to alcohol abuse are estimated at $10.5 billion dollars or 15 percent of the total. The largest cost is the expenditures for crime, amounting to $4.3 billion or 40 percent of the total for other related cost.\textsuperscript{50} The cost of motor vehicle crashes due to alcohol abuse is also high, amounting to $2.6 billion dollars. The value of lost productivity for victims of alcohol related crimes amounts to $465 million dollars; and the lost productivity for those who are incarcerated amounts to $2.7 billion dollars.\textsuperscript{51}

Public sources account for 65 percent or $4.4 billion dollars of the total direct expenditures for treatment of people with alcohol abuse: 37 percent of the payments are from federal sources and 29 percent of the payments are from State and local sources. The remaining 35 percent are from private sources.\textsuperscript{52}


\textsuperscript{48} Ibid. , 310.

\textsuperscript{49} Ibid. , 310.

\textsuperscript{50} Ibid. , 310.

\textsuperscript{51} Ibid. , 311.

\textsuperscript{52} Ibid. , 312.
Attitudinal/Behavioral Change

Many clients may hold an attitude or belief that contributes to their alcohol and illicit drug abuse. If the client, with the help of a therapist, can foster a change in his/her attitude towards the use of drugs and/or alcohol, their addictive behavior may begin to decrease until it diminishes. A cognitive appraisal process has been reported in studies of naturally recovered alcohol abusers and has also been found to be associated with the long-term recoveries of treated alcohol abusers. Similar processes have also been reported for cocaine and heroin addicts who have recovered on their own.53

Alcohol abusers whose recoveries are associated with cognitive evaluations are of particular interest as these recoveries have implications for clients in treatments as well as for individuals who want to change their drinking, but who would otherwise not seek treatment. A cognitive appraisal process facilitates the resolution of alcohol problems, then outcomes for problem drinkers might be important by their engaging in a cognitive appraisal of their alcohol use.54 The intent of such an exercise would be (a) to accentuate or make more salient the cost of the person’s drinking; (b) when possible, to lessen the perceived rewards of drinking; (c) to make apparent the benefits of change, and (d) to identify potential obstacles to change.55 Applying this approach, individuals formulate


54 Ibid., 819.

55 Ibid., 819.
their drinking concerns as a payoff matrix or a balance sheet of "pros" and "cons" for different courses of action. A decisional balance process has also been successfully used with smokers and for weight loss.56

Zarb stated that therapeutic interventions are designed to reduce the frequency of the client's maladaptive responses and to teach new cognitive and behavioral skills until there is a significant decrease in unwanted behaviors and an increase in more adaptive behaviors.57 Beck, Wright, Newman, and Liese stated that with cognitive therapy the emphasis is on: (1) The identification and modification of belief that exacerbate cravings, (2) the amelioration of negative affective states that often trigger drug use, (3) teaching patients to apply a battery of cognitive and behavioral skills and techniques, and not just willpower, to become and remain drug-free, and (4) helping patients to go beyond abstinence to make fundamental positive changes in the ways they view themselves, their life, and their future, thus leading to new lifestyles.58 Behavioral management without concurrent change in beliefs and attitudes is less effective and/or may lead to relapse.59

Beck, Wright, Newman, and Liese discussed from their reviews that alcoholism treatment is best approached as a two-stage process, requiring different interventions at


59 Judith A. Lewis, Addictions: Concepts and Strategies for Treatment (Gaithersburg, Maryland, Aspen Publishers, Inc.), 104.
each stage. The first set of interventions should be focused on changing drinking behaviors to abstinence or moderation. The second set of intervention should be focused on maintenance of sobriety.60

In helping the client recognize and change the misbeliefs that he/she holds, it is useful to monitor and challenge automatic, irrational beliefs.61 The client may use words such as “good” and “bad” as perfectionistic labels and the therapist must be careful not to fall into using such labels in similar ways.62 In a study conducted by Goldbloom and Olmsted it was concluded that attitudinal change and behavioral change are linked and it can help a person recover from their problem.63

Inpatient Treatment Program

The term inpatient treatment actually refers to a variety of forms of treatment that may take place in one of a number of different settings. Inpatient treatment may involve detoxification, rehabilitation, a combination of the two, or one followed sequentially by the other.64

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61 Judith A. Lewis, Addictions: Concepts and Strategies for Treatment (Gaithersburg, Maryland, Aspen Publishers, Inc.), 104.

62 Ibid., 104.


The 18 million people who use alcohol and the 5 million who use illicit drugs are in need of substance abuse treatment. Incidentally, less than one-fourth of those needing treatment get it either due to the lack of available space, funding, or because alcohol and substance abusers do not admit they are in need of treatment.\textsuperscript{65} On any given day, more than 800,000 clients receive alcohol and/or drug treatment in a specialized substance abuse treatment program. In 1991, most clients, 82 percent, were outpatients and only 8 percent were in long-term residential programs or therapeutic communities and the other 10 percent in short-term residential program, detoxification, and hospital inpatient programs.\textsuperscript{66}

Virtually all inpatient substance abuse programs in the United States stress the importance of abstinence from all drugs of abuse, including alcohol, as the cornerstone of successful treatment.\textsuperscript{67} The most common form of inpatient treatment in this country is the Minnesota Model, so named because of its development in the state of Minnesota in the 1950's. The Minnesota Model treatment program often has a standardized, fixed length of stay, which varies from program to program.\textsuperscript{68}

The Minnesota Model program provide an intense immersion in an environment that is dedicated to challenging addictive thoughts and beliefs through group therapy, 

\textsuperscript{65} Institute for Health Policy, Brandeis University, Substance Abuse: The Nation's Number One Health Problem (New Jersey: Institute for Health Policy, Brandeis University), 60.

\textsuperscript{66} Ibid., 60.


\textsuperscript{68} Ibid., 360.
peer evaluation, and meeting with counselors who themselves are recovering from substance use disorders. The "comprehensive and dogmatic ideology" of Minnesota Model programs is one of their most powerful therapeutic tools.  

The intensity of inpatient treatment may also be helpful to patients who, for whatever reason, do not respond to lesser measures, such as outpatient treatment, and only attending Alcoholics Anonymous and Narcotics Anonymous meetings. Inpatient treatment may benefit some individuals by increasing their awareness of the internal triggers that place them at risk to return to substance abuse. By being in an inpatient treatment program, the client may began to understand their limitations and learn how to deal with situations in a more appropriate way.  

In 1975, Burt called for Alcoholics Anonymous (AA) and behavioral psychology to benefit from one another through "cooperation, consideration and shared knowledge."

Ninety-five percent of inpatient addiction treatment programs in the United States incorporate Alcoholics Anonymous and Narcotics Anonymous (NA) at some level. In a study with Alcoholics Anonymous participants, it has been found that 77% had experienced some form of psychotherapy before abstinence and 45% after abstinence.

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70 Ibid., 361.

71 Ibid., 361.


In another survey of Alcoholics Anonymous members, it was reported that 31.5% seek additional professional help after entering Alcoholic Anonymous. Because relapse rates across chemical addictions and across addiction treatment modalities are fairly uniform and discouraging at least 75% of addicts may be using a maximizing strategy by availing themselves to the diversity of treatment approaches.74

It has been observed that the addictions field is in a “preparadigm” stage in its development as a discipline. That is, various treatment models and explanatory mechanisms for addiction have been put forth by a variety of workers. No single approach or combination of approaches dominates current research, theory, or treatment.75

Among the various modalities used in treating chemical dependency are the “twelve-step program” of Alcoholics Anonymous (AA), professional counseling and psychiatric care, family systems therapy, and therapeutic community treatment. Historically, these approaches have often been at odds with one another.76 Some of the debates have involved whether chemical dependency is a disease in and of itself or is reflective of some underlying psychopathology.77


76 Ibid., 376.

77 Ibid., 376.
The disease perspective of Alcoholics Anonymous emphasizes the individual’s inability to control drug consumption as a primary symptom. The twelve-step program begins with accepting one’s powerlessness over drugs and then developing a sense of one’s “Higher Power.” The individual’s relationship with his or her Higher Power, honesty, openness, communication, and willingness to learn and grow are central to the twelve-step recovery process.78

In counseling, rather than viewing chemical dependency as a disease in and of itself, traditional psychiatric and counseling approaches have tended to emphasize a host of emotional disorders as causal factors. Therefore, treatment has focused on understanding and resolving the emotional problems that underlie drug use.79

The therapeutic community model of treatment strongly emphasize the views of both Alcoholic Anonymous and the counseling model in abstaining from alcohol consumption and addressing emotional factors associated with drug use.80 Emotional issues, however, are addressed primarily in terms of how they are reflected in behaviors and attitudes in the milieu environment. There is less emphasis on resolving past developmental or family-of-origin issues.81 Clients are involved in process groups, confrontation groups, support groups, and community meeting groups. It has been stated,


79 Ibid., 377.

80 Ibid., 377.

81 Ibid., 377.
the therapeutic community perspective views drug abuse as "a disorder of the whole person, reflecting problems in conduct, attitudes, values, moods, and emotional management."82

In family therapy, the focus is on family-of-origin conflicts and issues as a central part in developing and maintaining chemical dependency. Family therapy points out that drug abuse usually begins in adolescence and is the result of intense fears of separation. A central goal of family therapy is to help the parents address conflicts between themselves, which may have been ignored because of their focusing on the addict’s drug-using and antisocial behavior.83

Although the aforementioned treatment approaches have often been at odds with one another, the drug treatment field seems to be moving in the direction of using multimodal approaches that incorporate several different models simultaneously, such as family therapy, counseling and Alcoholics Anonymous. The shift may reflect the increasing recognition that chemically dependent clients require a broad-based approach because of the various needs presented by them.84

A somewhat different multimodal approach has been described by Brown, Peterson, and Cunningham, who emphasized cognitive behavioral techniques along with


83 Ibid., 377.

84 Ibid., 377.
a strong focus on the spirituality found in the twelve-step program of AA.\textsuperscript{85} The growing recognition that twelve-step approaches are a critical part of recovery for many clients can be seen in the data. It is reported that more than 90% of psychiatrists interested in addictive disorders work closely with the twelve-step model in addition to providing professional care.\textsuperscript{86}

In a study of inpatient alcoholism treatment programs, it was found that factors related to successful outcome included the following: (1) a group-oriented, milieu approach to treatment; (2) interdisciplinary assessment and treatment; (3) a focus on psychiatric disorders in addition to alcoholism; (4) judicious use of medications; (5) medical evaluation; (6) involvement of clients in AA/NA meetings; and (7) a strong focus on aftercare treatment.\textsuperscript{87}

In a study of a follow-up assessment, after inpatient treatment, it was found that 73% of those who had completed the questionnaires were abstinent from alcohol at the time of the 6-month assessment, and 58% of the respondents were abstinent 1 year following discharge. In a 4-year follow-up of inpatients treated for substance abuse, approximately half of the study sample had favorable outcomes, however only one-fourth


\textsuperscript{87} Ibid., 377.
of the patients were continuously abstinent for all 4 years.88

Theoretical Framework

The theoretical framework for this study is cognitive-behavioral theory, which was developed in part from the social learning theory and cognitive theory. Social learning theory argues that most learning is gained by people’s perceptions and thinking about what they experience. They learn by copying the example of others around them.89 Cognitive theory argues that behavior is affected by perception or interpretation of the environment during the process of learning.90 A major objective of cognitive therapy is to help clients to gain new perspectives on their problems. Clients are taught how their cognitions can help to explain the etiology and maintenance of their maladaptive emotional and behavioral responses.91 They are also taught that cognitive change is of central importance in the therapy process. Once clients have grasped these points, they are more likely to be motivated to engage in therapeutic interventions.92

Cognitive-behavioral methods are therapeutic procedures which focus on changing thoughts and feelings alongside, instead of as a precursor to changing


90 Ibid., 115.


92 Ibid., 4.
behaviors. In cognitive-behavioral approaches, targeted problem behaviors are specified precisely in operational terms, while seminal cognitions related to the problem behaviors are identified, since they function as stimuli in controlling the dysfunctional overt behaviors. Therapists use devices such as modeling and behavioral and covert rehearsal during the therapy session to teach the client new coping skills.

Scott and Dryden classify cognitive-behavior therapies into four categories: (1) coping skills which contain two elements, a ‘self-verbalization, that is an instruction to ourselves, and the behavior that results; (2) Problem-solving, the clients are encouraged to ‘lock on’ to and define a problem, generate solutions to it, chose the best solution, plan ways of acting on it and reviewing progress; (3) cognitive restructuring helping the client to dispel thoughts of not being able to do something or that they are not worth of anything; (4) Structural cognitive therapy is concern with changing the way the person perceives themselves and actions.

Statement of the Hypothesis

Hypothesis 1: There will be a significant change in the attitude of substance abusers entering an inpatient treatment program toward substance abuse, which will cause a decrease in addictive behavior.


Variables

The independent variables of this study are addiction and inpatient treatment program. The dependent variables of this study are attitudinal change and decrease in addictive behavior.

Terms and Definitions

Addiction: The dependence of alcohol or drugs.

Child Maltreatment: Not taking care of the children basic needs, such as food, clothing and shelter.

Fetal Alcohol Syndrome: The baby is born addicted to alcohol.96

Inpatient Treatment: Patients stay in a residence from treatment of alcohol and drug abuse.

Stillbirth: When the baby is born dead.

Spontaneous Abortion: To lose a baby during the pregnancy, also know as a miscarriage.

Substance Abuse: The over use of a drug and/or alcohol until it affects a person’s everyday life.

CHAPTER THREE
METHODOLOGY

Research Design

The goal of this study was to determine if there is an attitudinal change among substance abusers which would then result in decreased addictive behavior. The research design is descriptive. This is a descriptive study because it is being used to expand the knowledge base about attitudinal and behavioral change. Grinnell describes a descriptive study as research undertaken to increase the precision in the definition of knowledge in a problem area where less is known than at the explanatory level.1

Sampling

The sampling utilized for this study was convenience sampling. A convenience sample, sometimes called availability sample, relies on the closest and most available subjects to constitute the sample.2 A sample of thirty males and females, between the


2 Ibid., 162
Data Collection

The data for this study were obtained through a fifty-one item pretest and a thirty-one item posttest that focused on the change of the client’s attitude about drugs and alcohol while in treatment. The pretest consisted of thirteen demographic questions and thirty-eight attitude and belief questions. The posttest consisted of the same thirty-eight questions on attitude and belief that was given in the pretest. The questionnaire consisted of questions taken from the McMullin Addiction Thought Scale and revised by the researcher.

Before administering the questionnaire, the individuals were informed that this was a voluntary study, the purpose and the goals were given, and the individuals confidentiality was ensured. The admissions coordinator administered the pretest and the posttest was given to the individual to taken into the privacy of their rooms.

Permission to administer the questionnaire was provided by the Program Director of the inpatient treatment program. The Director of this local treatment facility was also notified and made aware of this study.
Data Analysis

The data analysis was conducted using the Statistical Package for the Social Sciences Windows (SPSSWIN) in order to determine if there was a change in attitude about substance abuse between the pretest and posttest. The paired t-test was utilized to analyze any differences between the pretest and posttest and to test the null hypothesis.

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## FINDINGS

### TABLE I
Demographics
Frequency Distribution
(N=30)

<table>
<thead>
<tr>
<th>Question</th>
<th>Response 1</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gender</td>
<td>Female</td>
<td>43.3%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>56.7%</td>
</tr>
<tr>
<td>2. Age</td>
<td>18-27</td>
<td>6.7%</td>
</tr>
<tr>
<td></td>
<td>28-37</td>
<td>53.3%</td>
</tr>
<tr>
<td></td>
<td>38-47</td>
<td>30.0%</td>
</tr>
<tr>
<td></td>
<td>48-57</td>
<td>10.0%</td>
</tr>
<tr>
<td>3. Ethnic Background</td>
<td>African American</td>
<td>60.0%</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>30.0%</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>6.7%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>3.3%</td>
</tr>
<tr>
<td>4. Marital Status</td>
<td>Never Married</td>
<td>33.3%</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>20.0%</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>10.0%</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>33.3%</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>3.3%</td>
</tr>
<tr>
<td>5. Children</td>
<td>None</td>
<td>36.7%</td>
</tr>
<tr>
<td></td>
<td>One</td>
<td>23.3%</td>
</tr>
<tr>
<td></td>
<td>Two</td>
<td>30.0%</td>
</tr>
<tr>
<td></td>
<td>Three +</td>
<td>10.0%</td>
</tr>
</tbody>
</table>
6. What is your educational level?
   - 10.0%: 11\textsuperscript{th} grade or less
   - 20.0%: High school graduate
   - 3.3%: GED
   - 26.7%: Some college
   - 6.7%: Associate degree
   - 20.0%: Bachelor degree
   - 13.3%: Graduate Education

7. What area of the country do you live in?
   - 60.0%: South East
   - 10.0%: North East
   - 13.3%: Mid-West
   - 3.3%: North West
   - 13.3%: South West

8. Who referred you to this recovery center?
   - 16.7%: Fox Recovery Center
   - 20.0%: TMRC
   - 6.7%: Voluntary/Involuntary
   - 3.3%: Job
   - 50.0%: Other
   - 3.3%: Court System

9. What age did you first use drugs and/or alcohol?
   - 10.0%: 8 or below
   - 36.7%: 9-14
   - 46.7%: 15-20
   - 3.3%: 21-25
   - 3.3%: 26 or more

10. Did or does anyone in your family use alcohol and/or drugs?
    - 80.0%: Yes
    - 20.0%: No
(TABLE I CONTINUED: )

11. What is you drug of choice?
   - 53.3%: Alcohol
   - 33.3%: Cocaine
   - 6.7%: Heroin
   - 3.3%: Crank
   - 3.3%: Other amphetamines

12. Have you been in another treatment program prior to entering this treatment center?
   - 63.3%: Yes
   - 36.7%: No

13. How many times have you been in treatment?
   - 33.3%: None
   - 36.7%: One
   - 6.7%: Two
   - 6.7%: Three
   - 16.7%: Four or more

Table I displays the demographics of the respondents in the study. The data shows that 56.7 percent of the participants were male and 43.3 percent was female. Of the respondents 63.3 percent stated that they were in another substance abuse treatment center prior to entering the center where the test was administered. At least 66.7 of the respondents stated that they were in substance abuse treatment one or more times prior to this study. The participants age group, ethnic background, marital status, amount of children, and educational level are also displayed.
TABLE II
Pretest/Posttest Scores
(N=30)

<table>
<thead>
<tr>
<th>PRETEST SCORES</th>
<th>POSTTEST SCORE</th>
<th>DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>169.00</td>
<td>169.00</td>
<td>00</td>
</tr>
<tr>
<td>172.00</td>
<td>161.00</td>
<td>-11.00</td>
</tr>
<tr>
<td>164.00</td>
<td>167.00</td>
<td>3.00</td>
</tr>
<tr>
<td>170.00</td>
<td>167.00</td>
<td>-3.00</td>
</tr>
<tr>
<td>164.00</td>
<td>157.00</td>
<td>-7.00</td>
</tr>
<tr>
<td>164.00</td>
<td>181.00</td>
<td>16.00</td>
</tr>
<tr>
<td>166.00</td>
<td>169.00</td>
<td>3.00</td>
</tr>
<tr>
<td>175.00</td>
<td>180.00</td>
<td>5.00</td>
</tr>
<tr>
<td>172.00</td>
<td>165.00</td>
<td>-7.00</td>
</tr>
<tr>
<td>160.00</td>
<td>168.00</td>
<td>8.00</td>
</tr>
<tr>
<td>152.00</td>
<td>153.00</td>
<td>1.00</td>
</tr>
<tr>
<td>145.00</td>
<td>177.00</td>
<td>32.00</td>
</tr>
<tr>
<td>157.00</td>
<td>141.00</td>
<td>-16.00</td>
</tr>
<tr>
<td>151.00</td>
<td>166.00</td>
<td>15.00</td>
</tr>
<tr>
<td>175.00</td>
<td>161.00</td>
<td>-14.00</td>
</tr>
<tr>
<td>183.00</td>
<td>154.00</td>
<td>-29.00</td>
</tr>
<tr>
<td>175.00</td>
<td>172.00</td>
<td>-3.00</td>
</tr>
<tr>
<td>165.00</td>
<td>181.00</td>
<td>16.00</td>
</tr>
<tr>
<td>131.00</td>
<td>151.00</td>
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<td>163.00</td>
<td>178.00</td>
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<td>150.00</td>
<td>156.00</td>
<td>6.00</td>
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<tr>
<td>160.00</td>
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<td>6.00</td>
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<td>169.00</td>
<td>14.00</td>
</tr>
<tr>
<td>159.00</td>
<td>170.00</td>
<td>11.00</td>
</tr>
</tbody>
</table>

Mean 158.800 164.733 5.900
Mode 164.000 169.000 3.000
S.D. 17.215 12.537 14.006
N 30 30 30
Table II displays the results of the scores each subject made on the pretest and the posttest. The scores represent the total scores the subject made from the thirty-eight question questionnaire. The table also displays the differences in the scores from the pretest and posttest questionnaire. The mean score of the pretest is 158.00 and the mode of the pretest is 164.00. The mean score for the posttest is 164.733 and the mode of the posttest is 169.000. This demonstrates that there is an overall change in the scores from the pretest to the posttest. There are some cases where the pretest had a greater score than that of the posttest. The third column in table two represents the difference in scores for each participant in the study, which include the pretest and posttest. The mean of the difference for the pretest and posttest is 5.900 and the mode is 3.000. Also, in table two the standard deviation for the pretest, posttest and the difference is respectively displayed. The N indicates the number of participants that took part in this study.
TABLE III
T-Test For Paired Samples
(N=30)

<table>
<thead>
<tr>
<th>Attitudinal Change</th>
<th>t-value</th>
<th>df</th>
<th>2-tail Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.32*</td>
<td>29</td>
<td></td>
<td>.028</td>
</tr>
</tbody>
</table>

Table three displays the results of the paired samples t-test. The test was set up by comparing the means of both the pretest and posttest. The t-value, degrees of freedom and significance of the test is also indicated.

The mean of the subjects from the pretest is 158.8000 and the mean of the subjects in the posttest is 164.7333 which means the mean of the two pairs are 5.9333. The t value of the paired test is 2.32 and the degrees of freedom is 29. The significance level of the test is .028 which mean the test is statistically significant. The difference between the pretest and posttest was 5.9333, which indicates that there was a change in scores form the pretest to the posttest. Thus the test indicates that there is a difference in the variable between the pretest and posttest.
CHAPTER FIVE

DISCUSSION AND SUMMARY

Clinical social workers are going to be faced with new challenges as the next millennium approaches. The use of substance abuse will continue to be a problem for many people within society through the development of stronger and newer illicit drugs. The attitude of substance abusers needs to be changed in order to help decrease or even stop the problem.

Based on the literature reviewed for this study the findings indicate that if there is a change in attitude there maybe a decrease in the activity. This study concluded that there is a change in the attitude of the participants but not in behavior because the clients are living in a non-using supportive community. The best way to determine if there is a change in the addictive behavior of the client is to continue to follow the client after he or she exits an inpatient treatment program. Based on the findings of the change in attitude, the client will continue to decrease their addictive behavior if they continue to change their attitude about substance abuse after they exit treatment.

Though I have concluded that there was a change of attitude among substance abusers, it cannot be concluded that the addictive behavior will decrease because of the limited amount of time to for the study. Zarb stated that teaching a client new cognitive
and behavioral skills through interventions will help decrease the unwanted behavior and cause an increase in more adaptive behavior.\textsuperscript{1} Lewis also concluded that behavioral management without concurrent change in beliefs and attitudes is less effective and/or may lead to relapse.\textsuperscript{2}

**Limitations of the Study**

This study was limited to thirty respondents which could have had an influence on the generalizability of the study. This number of responses is inadequate to generalize the finding to the entire population of addicted persons. The findings of the study were also limited to a specific geographical location, and the limited amount of time to administer the test also affected the results of the study. The respondents prior knowledge of substance abuse and the disease model may also have an affect on their responses to the questions in this study. Another limitation concerns how the respondents entered into treatment weather through employment or the court system may also have an affect on the findings. If the client was forced into treatment they may feel they do not have a problem or be highly resistant to change. The client may also have other social influences that are not present during treatment, such as friends and family, that will affect his/her attitude once they leave treatment.

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\textsuperscript{2} Judith A. Lewis, *Addictions: Concepts and Strategies for treatment* (Gaithersburg, Maryland, Aspen Publishers, Inc.), 104.
Suggested Research Directions

While the literature states there is a relationship between attitudinal and behavior change in regard to substance abuse, there are still additional areas needing research: For example how can we effectively change a person's attitude toward substance abuse; second, a longitudinal study on the change of attitude during inpatient treatment and the effect it has on decreasing addictive behavior after a person is released from treatment; third, a study comparing the change of attitude of patients in an inpatient program and those that are in an outpatient program. By conducting further research in this area may provide insight on how to effectively treat a substance abuser.
CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Currently, many more companies are testing their employees for illicit drug use. If they test positive many are sent to treatment. Many employers and insurance companies are looking for a cost effective and time effective treatment program to send their employees and customers. As social workers we must be able to develop effective ways to treat clients in a limited amount of time and have a great impact on the clients use of addictive substance.

In counseling substance abusers a social worker should be aware of the different types of techniques available to help the client through his or her problems. Social workers, as substance abuse counselors have the responsibility to help develop and describe state of the art treatment programs and advocate their use. Social workers should also advocate for funding of substance abuse programs.¹

Social workers should continue to act based on the humanistic values and help those that are in need of service for substance abuse. By developing programs for children and adolescents it can help decrease some of the problems of substance abuse. Social workers cannot prevent anyone from using drugs and alcohol but they may be able to help them decrease their addictive behavior.

APPENDIX A

Dear Sir or Madam:

I would first like to thank you for your consideration in taking part in my research study. I am currently a student at Clark Atlanta University, School Of Social Work. I am a candidate for a Master’s of Social Work degree. I am currently seeking information about how the change in attitude will determine the decrease in the use of alcohol and drugs of clients entering an inpatient treatment program. The purpose of the study is to determine if there is a change in attitude about substance abuse, it will cause a decrease in the use of alcohol and drugs. By participating in this you are helping to produce information that will help addiction counselors better serve substance abusers.

As a client entering an inpatient treatment program you are being ask to complete two questionnaire one now during your intake process and one when you complete the day program, in 28 days, during treatment. The questionnaire consist of 13 questions about yourself and the other 38 questions is dealing with you attitude about substance abuse. The questionnaire will take about 10-15 minutes to complete. I would like you to complete the first questionnaire and if you have any questions or comments please feel free to ask. This questionnaire is entirely voluntary and you may stop at any time you wish. If you choose not to take the posttest you will not be forced to participate, mark on the questionnaire dropped out. You will not suffer any consequences if you chose not to participate in this study.

I would like you to know that the answers you give will be held in the utmost confidentiality. You do not need to put you name, identification number, or any other identifying information on the questionnaire when you return it to me. I would again like to thank you for you cooperation in this research study.

________________________
Jeffrey Sanders

I will participate in this research study _______
I will not participate in this research study _______

________________________
Participant Signature
APPENDIX B

Attitudes and Beliefs about Substance Abuse
Pretest/Posttest

Demographics

Please circle the answer(s) that best apply to you.

1. What is your gender?
   A. Female
   B. Male

2. What is your age range
   A. 18-27
   B. 28-37
   C. 38-47
   D. 48-57
   E. 58 or older

3. What is your ethnic background?
   A. Hispanic
   B. African American
   C. White
   D. Asian
   E. Bi-Racial
   F. Other

4. What is your current marital status?
   A. Never Married
   B. Married
   C. Separated
   D. Divorced
   E. Widowed
5. How many children do you have?
   A. None
   B. One
   C. Two
   D. Three or more

6. What is your education level?
   A. 11th Grade or less
   B. High School Graduate
   C. GED
   D. Some College
   E. Associate Degree
   F. College Graduate
   G. Graduate Education

7. What area of the country do you live in?
   A. South East
   B. North East
   C. Mid-West
   D. North West
   E. South West

8. Who referred you to St. Jude’s Recovery Center, INC?
   1. VA Hospital
   2. Fox
   3. TMRC
   4. Anchor
   5. Charter
   6. Grady Hospital or another Hospital
   7. Voluntary/Involuntary
   8. Court System
   9. Job
   10. Other

9. At what age did you first use drugs or alcohol?
   A. 8 or younger
   B. 9-14
   C. 15-20
   D. 21-25
   E. 26 or older

10. Did or Does anyone in your family use alcohol and/or drugs (such as mother, wife, brother)?
    A. Yes
    B. No
11. What is your drug of choice?
   A. Alcohol
   B. Cocaine
   C. Marijuana/Hashish
   D. Heroin
   E. Crank
   F. Hallucinogens
   G. Barbiturates
   H. Inhalants
   I. Methamphetamine
   J. Tranquilizers
   K. Other amphetamines
   L. Opioids
   M. Other

12. Have you been in another treatment program prior to entering St. Jude’s Recovery Center (not including detox)?
   A. Yes
   B. No

13. How many times have you been in treatment?
   A. None
   B. One
   C. Two
   D. Three
   E. Four or more

Attitude and Belief scale

Please answer the following questions using the following scale according to your level of agreement. Place your answer in the space provide next to each number.

1. Strongly Disagree
2. Disagree
3. Neutral/Unsure
4. Agree
5. Strongly Agree

____1. I do not have an alcohol and/or drugs problem
____2. I feel I can stop drinking and or using drugs at any time.
3. I can control my drinking.
4. I can control my drug use
5. A couple of drinks or a little drugs will not hurt me.
6. I feel "I can handle my drugs and/or alcohol use."
7. I feel the best way to stop feeling bad is to use drugs or alcohol.
8. I feel that I cannot die from using drugs or alcohol.
9. I feel as if I can do no wrong while I am using drugs and/or alcohol.
10. I am justified in my using of drugs and alcohol.
11. Using drugs and/or alcohol does not interfere with my personal life.
12. I am not an alcoholic or a drug addict.
13. I do not have a disease.
14. I do not have a substance abuse problem.
15. The best way to handle problems is not to think about them.
16. The amount of drugs and/or alcohol I use makes me an addict.
17. People trust me.
18. I can trust other people.
19. I do not have stress in my life.
20. I am a self-centered person.
21. I am a self-seeking person.
22. I am a manipulative person.
23. I am at risk while using.
24. It is shameful to be an addict.
25. I use drugs and/or alcohol to become a social person.

26. I feel that I use too much drugs and/or alcohol.

27. Stress causes me to drink or use.

28. It is my fault that I am an alcoholic and/or addict.

29. Being addicted to a drug and/or alcohol does not affect my job performance.

30. Addiction is a disease.

31. I am not powerless over alcohol or drugs.

32. I only came to recovery because I had to.

33. I have to be honest with others and myself in order to stop using.

34. Belief in a higher power will help me during my recovery.

35. I am not responsible for my addiction.

36. I believe that recovery is an easy process.

37. I can be cured of my addiction.

38. The disease I have is chronic, progressive and fatal.
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