Social Support and Self-esteem of Chemically Dependent Veterans

by

Shawn Gaddy, R.N., B.S.N.

A Master's Research Project

Presented to

The Oregon Health Sciences University

School of Nursing

in partial fulfillment

of the requirements for the degree

Master of Science

June 1990

APPROVED

[redacted]

Carol Burckhardt, RN, Ph.D., Associate Professor, MRP Advisor

[redacted]

Joanne Hall, RN, Ph.D., Professor, Reader

[redacted]

Janet Mathews, RN, MS., Assistant Professor, Reader

[redacted]an, School of Nursing

Acknowledgements

I wish to thank Carol Burckhardt, my advisor, for the direction and support she gave me during my proposal, data collection and analysis. Thanks also to Joanne Hall for her knowledgeable editing in APA format, and to Janet Mathews for her kind support and encouragement.

Thanks to all of the VA staff that gave their valuable time and knowledge to help me gather and collect the data in a timely fashion.

A special thanks to my daughter Kealey for her timely arrival and for tolerating my frequent distractions so pleasantly.

In memory of Carol Crispin who directed me toward the correct path and helped keep me focused.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

LIST OF TABLES

INTRODUCTION

The consensus of the treatment community is that chemical dependency affects between 3% and 10% of the population. Chenitz & Granfors (1988) estimate that there may be as many as 10 million adults and 3.3 million teens who have problems with chemical dependency. The Oregon Council of Alcohol and Drug Addictions estimates conservatively that 15% of the general population is affected by poly-drug and alcohol abuse, including prescription drugs as well as illegal drugs (Oregon Council of Alcohol and Drug Addictions, personal comunication, 1988).

The Veterans Administration (VA) estimates that approximately 40% of all admissions to V.A. hospitals have alcohol-related health problems. The VA also estimates
that 20-40% of their population have ongoing chemical dependency problems that have not yet impaired their work performance and/or come to the attention of their superior officers, employers or their health care provider (C. Crispin, personel communication, 1989).

Alcoholism is an insidious, often denied problem that affects the whole family not just the individual who is chemically dependent. The stress of living in an unpredictable and unstable environment creates an

adeptness in family members to survive the consistent inconsistencies of the family environment (Liepman, White & Nirenberg, 1986). The cost of this resiliency is a variety of emotional, developmental, social, psychological and physiological problems (Akerman, 1983). The potential for abuse and neglect of members in the family by the chemically-dependent person is always a threat. The family unit, functioning as best as it can, offers the developing children a role model for behaviors that may seem acceptable at the time and even necessary for survival, but create many problems as they grow older (Akerman, 1983).

The impact of chemical dependency in and on the work force is apparent in problems with decreased work productivity, increase in errors, absenteeism, loss of productive work time related to feeling ill, and leaving early and/or planning on how to get the next drink or fix. Theft by employees of company goods is a significant problem as addicted individuals attempt any means available to support their habit.

Cost to both state and federal governments is high related to those families and individuals who require continuous public assistance. The cost of medical assistance for habilitation and rehabilitation is significant for those involved in assaults or motor vehicle accidents. The cost in court time to prosecute

and defend those individuals is expensive and time consuming for the government.

Increased morbidity and mortality creates problems not only for government and business but also for families. The resulting chronic illnesses related to chemical abuse cost not only the government but the health care industry, which in turn passes the expenses along to the consumer. The loss of valuable members of society and their contributions to the work force and society due to the development of chronic debilitating diseases, depression, suicide or death leave a vacuous hole in the fabric of society that is hard to repair.

Clinical specialists in nursing, medicine, allied health and social sciences have noted for some time that social support and positive self-esteem are important to the recovery from illness and maintenance of health. However, the role that social support and self-esteem play in recovery from chemical dependency (CD) has not been well researched (MacDonald, 1987). The purpose of this research project was to study the relationship between social support and self-esteem in chemically dependent veterans in a behavioral-based treatment program. To be noted were changes perceived by the veteran in social support and self-esteem at days 1, 30 and 60 in his treatment program.

REVIEW OF THE LITERATURE

This review will summarize the literature on social support, self-esteem and health or deviation from health practices and the relationship among these concepts. The review also will address these variables in relationship to chemical dependency.

Social Support, Self-esteem and Health

It is known that a nurturing social environment and feelings of enhanced self-esteem influence positive health practices (Muhlenkamp & Sayles, 1986). It could be expected that those individuals who have a strong social support system are also inclined to feel the need for good health practices as a method of promoting health and longevity. The study by Antonucci and Jackson (1983) noted that the severity of reported health problems versus no reported health problems related to lower levels of self-esteem in those individuals reporting health problems. The authors suggested that a predisposing risk factor for poor health may be low self-esteem. Lin, Ensel, Simeone & Kuo (1979) noted that social support was important in mediating stressful life events but also very important in influencing illness symptoms.

Early studies cited by Gottlieb (1985) noted that

concentration camp victims' ability to withstand the cruelties heaped upon them was determined mainly by the contacts that they were able to maintain with either family members or prewar friends. Cassel concluded that "... the property common to those (health protective) processes is the strength of the social supports provided by the primary groups of most importance to the individual" (Gottlieb, 1985, p.9). In a nine year follow-up study of the relationship between social and community ties and mortality of Alameda County residents, Berkman & Syme (1979) noted that people with many social ties and strong relationships had a lower mortality rate than those who did not.

Social Support, Self-esteem and Recovery from Illness

Just as social support and self-esteem play important functions in the maintenance of health and positive health practices, they also play a viable role in recovery from physical illness. The results of the Sarason, Saronson, Potter & Antoni (1985) study suggested that negative life events in the recent past were related to reports of current illness. The relationships between the negative life events and illness were stronger in individuals with a perceived low level of social support.

In an experimental investigation by Whitcher and

Fisher (1979) with surgical patients, social support was defined as therapeutic touching by the nurses on a prescribed schedule. The practice was noted to have added significantly to both the physiologic progress and recovery of the patients. Physical illness is often accompanied by a number of fears and potential problems, such as pain, progressive deterioration, disfigurement and dependency on others, if the illness is not or can not be resolved. Wortman & Conway (1985) note that the threat to the individual's self-esteem can be mediated by social support. The variety of social support received by the seriously ill individual may be very important in easing the burdens that are encountered on the road to recovery. Social support given at any time in the illness - recovery cycle may greatly influence compliance, psychological as well as social functioning and improve physiological recovery.

Social support has been shown to have a positive effect in dealing with the mentally ill. Research indicates that social support affects a person's mental health in a positive manner by fulfilling needs associated with affiliation, respect, affection and nurturance (Schilit & Gomberg, 1987). O'Connell, Mayo, Eng & Jones (1985) observed the effect that social support had on long-term lithium therapy and noted that social support was a buffer to life stresses. The

perceived social support allowed for or may have even provided a means of adaptation to the stressors or allowed for withdrawal or respite from them. The same study also noted that social support had a positive influence on the social adjustment of the patient and may prevent a downward spiral and positively influenced social adaption.

An example of social support for the chronically mentally ill are group living arrangements outside of institutions such as half-way houses or group homes. These houses attempt to incorporate social support in the form of social ties to other individuals in the community as well as self-help groups. While they offer no dramatic cure rate for the chronically mentally ill, group homes have shown that the recidivism rate for returning to the hospital can be reduced (Gottleib, 1985).

Social Support, Self-esteem and Chemical Dependency

Schilit and Gomberg (1987) found that female alcoholics have comparatively few people in their support systems and that the nature and type of relationship changes or decrease as the alcoholism increases. It was also noted that there was a greater willingness by the support members, i.e. family and friends, to provide material support rather than

emotional support (Favazza & Thompson, 1984; Schilit & Gomberg, 1987).

Alcoholics Anonymous (AA) is an example of social support provided by a group as a method of health promotion. AA attempts to supply a new group of social ties that have more positive perspectives and practices than the old group of social ties (Cohen & Syme, 1985).

Clinically it has been noted that the chemically dependent (CD) have a negative or poor sense of self-esteem. The CD individual relies increasingly on alcohol and/or drugs to manage negative feelings. Chemicals then become the major tool for self enhancement as well as the means to handle daily stresses (Bennett, 1988).

There have been few longitudinal or experimental studies to confirm the clinical experience that the CD individual has a poor or low self-esteem. However consensus does exist among those working in the field of chemical dependence that low self-esteem is an antecedent to chemical abuse rather than a negative consequence (Beckman, 1978; Bennett, 1988; Berg, 1971).

Bergs' study (1971) of alcohol consumption under controlled laboratory conditions of both alcoholics and non-alcoholic social drinkers, supported the observation that intoxication alters the self-concept of the social drinkers and that the shift is toward a

more critical and less favorable position in analyzing their behavior. The alcoholic with low self-esteem and with the resulting anxiety may be more inclined to engage in alcohol abuse to enhance perceived negative self-concept.

Although social support is usually perceived as positive, there are some circumstances where it can be conceived as having a negative aspect. Tilden and Galyen (1987) noted that interpersonal as well as social relationships are sources of stress as well as support. In those individuals who see themselves as receiving more support than they feel they deserve or might be able to reciprocate, the benefit of that support may be lessened. A decrease in the ability to reciprocate may lead to impaired relations, feelings of depression, poor self- esteem and dependency (Tilden & Weinert, 1987).

Individuals who perceive that a strong social support system is available may be in a more favorable position to ask for and receive help if the need arose. Whereas, those who are troubled may believe that they have no one to call upon for help, can not ask for nor accept support when offered, and lack the ability to develop supportive relationships (Bruhn & Philips, 1987). Although Tilden and others have not tied these findings directly to chemical dependency, it seems

reasonable to suspect the chemically dependent person has many of these feelings and experiences.

Summary

Social support has been studied in relation to mortality, positive health practices and physical and mental illness. It has been noted that social support positively influences the outcome and helps reduce possible recidivism in cases of mental illness. Social support also may have negative consequences in that the cost to the individual receiving the support may be too great to accept and/or their perception of their ability to reciprocate the support may be inadequate. Self-esteem in the chemically dependent individual has been noted to be low, an antecedent to drug and alcohol abuse, and the individual may rely increasingly on chemicals to manage negative feelings.

Few research studies relating social support and self-esteem to drug and alcohol abuse have been done, thus making it difficult to form any conclusions as to how social support and positive self-esteem are related to the chemically dependent individual and his recovery.

CONCEPTUAL FRAMEWORK

Having reviewed the literature associated with social support, self-esteem, physical and mental illness and chemical dependency the forthcoming pages define the concepts of social support, self-esteem, chemical dependency and recovery as they relate to this project.

Social Support

An immediate problem that appears after a review of the literature is the lack of consensus about what constitutes social support and how to measure it with reasonable accuracy (Kaplan, Cassel & Gore, 1977; Oyabu & Garland, 1987). Cobb (1976) developed three classes of information that he beleived adequately covered the concept of social support. They are as follows:

1. Information leading the subject to believe that he is cared for and loved.

2. Information leading the subject to believe that he is esteemed and valued.

3. Information leading the subject to believe that he belongs to a network of communication and mutual obligation (p.300).

Weiss (1974) in his work on the function of social relationships substantiated Cobbs' theory using his

catagories of social intergration. Weiss' theory allows for the development of social networks that share similar ideas, experiences' and provides a source of companionship, and reassurance of worth, which may be provided by familial or colleagial relationships in attesting to the individual's competence in various roles (p.23).

Tilden (1987) using social exchange and equity theories held " that human relationships involve reciprocated exchange of valued commodities, the pursuit of which produces cost and conflicts." (p.13). For the purpose of this project, both Cobb and Tilden's concepts will be used with the understanding that it is helpful to have a positive self-concept and a developed network of social support, but in achieving the same, cost and conflict may arise.

Self-esteem

As with the other concepts involved in this project, self-esteem has a variety of definitions. For the purposes of this study, self-esteem is the evaluation and valuation of ones' own self-worth in relationship to one's ideal self and to the performance of others. Self-esteem may be positive or negative and may influence how one relates to others (Beck, Rawlins & Williams, 1984).

Chemical Dependency

Chemical dependency is also a concept that is difficult to define in that there are no prescribed or detailed studies that clearly elucidate what is means to be chemically dependent or what must happen in order for someone to be diagnosed formally or informally as chemically dependent.

Jellinek (1960) developed four stages that define progressive alcoholism. The first is the pre-alcoholic, experimental or social drinking stage. The second is the early alcoholic with excessive drinking. The third is the addicted alcoholic with loss of control over where, when and how much drinking occurs. The fourth stage is the chronic alcoholic, in which the personal, family and economic situation is in shambles. The physical health of the chronic alcoholic is rapidly deteriorating and death is an expected end. For the purposes of this paper the term chemically dependent will refer to those individuals who use chemicals in such a manner as to produce harmful results and are unable to control the consumption of chemicals.

Recovery

Recovery is a term that is frequently used in conjunction with the treatment program. It is the valued end result of taking part in a treatment

program. Just as there are a variety of definitions of social support and chemical dependency, there are a variety of definitions for recovery. For those persons who favor the AA approach, complete abstinence is considered to be the only road to recovery and the method for maintaining sustained sobriety. For the purpose of this project, recovery will be defined as sustained abstinence from the use of chemicals.

Summary

Chemically dependent individuals have been noted to have a low self-esteem. Their perception of social support may be minimal and the feeling that the cost to them of obtaining and/or maintaining social support may be too great. It is the valued end of a treatment program that allows the chemically dependent individual to maintain abstinence in their use of chemicals and to develop an improved sense of self-esteem and a strong social support system complementary to their new life style.

Research Questions

After investigating the literature and developing a conceptual framework these were the questions for which answers were sought in this research project:

1. Is there a relationship between social support

and self-esteem in a group of chemically dependent veterans in an in-patient behavioral-based treatment program?

2. Does the social support and self-esteem of the veteran change over the course of sixty days in treatment?

METHODS

Design Description

This project was a prospective, correlational study measuring perceived levels of social support and self-esteem of chemically dependent veterans in a behavioral- based treatment program. Data were gathered on entry to the program, at the end of the 30 day in-patient program and at 30 days into the after-care phase of treatment.

Subjects

The subjects were male veterans admitted to a VA based in-patient drug and alcohol treatment program. A sample of 50 male veterans was obtained. There have been female veterans in the treatment program but during the data collection period none entered into treatment. Although the subjects varied in age, they had in common their veteran status, chemical

dependency, significant upheaval in their personal and family life, and economic and legal standing. Veterans were pre-screened before entry into the program and did not include those veterans with primary psychiatric or medical problems, or significant psychological or cognitive deficits.

The veterans' age ranged from 25 to 61 with a mean age of 36.3 years. Ninety-two percent of the veterans were White, 4% were Black and 4% were Hispanic. For 60% of the veterans alcohol was the primary drug of choice, 12% chose cocaine or marijuana, 10% used heroine and 5% used methamphetamines. Sixty percent of the veterans listed secondary drug usage. Forty-three percent used marijauna, 23% used alcohol, 16% used cocaine, 10% methamphetamines, 3% heroine and 3% LSD. Sixty-two percent of the veterans were of the Vietnam War era, 6% were from the Korean Conflict and 31% enlistd after the Vietnam War. Twenty-nine percent of the veterans had a high school diploma, 20% had obtained a general education diploma (GED), 4% had nether diploma or GED. Twelve percent had vocational/technical training, 23% had some college without a degree and 10% had a college degree. Twelve percent of the veterans were married, 14% were seperated and 41% were divorced, 4% were widowed and 27% were single. Fourteen percent of the unmarried veterans had a Significant Other with whom

they were involved at the time of treatment. Seventy-three percent of the veterans were unemployed while 23% were employed and 4% were retired. Sixty-four percent of the veterans stated that they were self-refered, 13% were referred by VA staff, 10% by family or court and 4% by friends. Twenty-two percent stated that in addition to electing to enter into treatment the court system requested that they enter treatment also. Ninety-eight percent of the veterans ranked their drinking and/or drug use as at a critical level. One veteran ranked himself at the crucial level.

The total number of usable responses was 49. At the second testing 16 of the original 49 subjects were not available for testing and at the third testing 23 of the 33 subjects available at the second testing were not available, leaving only 10 out of the initial 49 to participate in the final testing. The decrease in subjects can be related to either dropping out of the treatment program or electing to no longer participate. No attempt was made to contact those veterans who dropped out of treatment.

Setting

A Veterans Administration (VA) in-patient drug and alcohol treatment program in a Pacific Northwest city was the site chosen to obtain data for analysis of this

research project. The in-patient program is one month in length with an aftercare program of up to one year which is not mandatory but is very highly encouraged.

There are four mandatory pre-admission and orientation meetings over a two week period. The veteran must be abstinent from chemicals while attending these meetings. Random urine and breathalyzer screens may be requested at the staff's discretion throughout the evaluation period of treatment.

After orientation and evaluation, two veterans per day are scheduled for admission to the medical unit for baseline evaluation of their health status. This is to ensure that the veteran is safely detoxified and any medical or other health problems discovered are stabilized.

The maximum census for the in-patient unit is 28 veterans per day. The usual census is 25 residents or 90% of the beds occupied per day The unit historically has a 10% early discharge rate due to some residents electing not to continue the treatment program or not being able to adhere to the behavioral standards set.

The treatment program is based on a behavioral model and on the concept that there is both a biological and psychological component to the addiction. Treatment of the physiological, psychological and sociological aspects is beleived to

be necessary in order to regain optimum physical and social functioning. Problematic behaviors that may be dealt with include such aspects as thoughts, feelings, attitudes and self-images as well as more directly recognizable behaviors such as affect and action (Steffan, Steffan & Nathan, 1977).

Measurement Scales

The Interpersonal Relationships Inventory developed by Tilden (1983) was used for the data collection relating to social support. It is a five-point Likert-type scale with sub-scales measuring interpersonal support, reciprocity and conflict. Each sub-scale contains 13 items for a total of 39 questions. For this study only the social support and conflict scales were used. Extensive psychometric testing of the instrument has been done and indicates that the instrument has acceptable internal consistency, reliability, test - retest reliability and content and construct validity. (See Appendix A.)

Self-esteem was measured with the Rosenberg Self-Evaluation Questionnaire. The questionnaire is a ten item, four point Likert-type scale that measures the self-acceptance aspect of self-esteem. Over a two week period both reliability and test - retest reliability measure 0.85. Concurrent validity with other self-

esteem measures averages .57. The advantages of using the Rosenberg scale include its brevity and adequate reliability and validity (Robinson & Shaver,1973). (See Appendix B.)

A self-evaluation of the stages of alcoholism was also administered. The participant rated his stage of alcholism or drug use accorrding to being in the early stage, crucial stage or the critical stage. (See Appendix C.)

Data Collection Procedures

New admissions to the VA inpatient drug and alcohol program occur daily. During the treatment units' regularly scheduled weekly testing, it was explained to the new patients that the purpose of this research project was to obtain information on social support and self-esteem of chemically dependent veterans. In order to obtain this information the patients were asked to fill out two paper and pencil tests. The time involved in taking the test was approximately 20 minutes. The veterans' voluntary participation was requested, and all questions they had were answered. An Informed Consent (Appendix D) was attached to the scales for the subjects to read and sign. Assurance was given that the information gathered would be confidential and not seen by anyone connected with the treatment program, and that the veterans

answers would not effect their current treatment program. The last four digits of the patients' social security number were used to identify and correlate their sequential test answers.

The initial data collection occurred at entrance to the program on the scheduled weekly testing day. Just prior to completion of the 30 day program, the scales were administered again. At one month post inpatient treatment the scales were administered during an after-care meeting. In keeping with the intention of anonymity no attempt was made to contact those veterans who dropped out before completing the 30 day program or who did not complete the aftercare program.

Data Analysis

Means and Frequencies were calculated to determine averages for the group at each time period. Data were analyzed using the Pearson r co-efficient test to determine if there was a relationship between social support and self-esteem. An alpha of .05 was set to indicate statistical significance.

RESULTS AND DISCUSSION

Results

The initial mean score for 49 subjects on the social support scale was 43, with the range being from 13 or low support to 65 or high support. At the second testing it was 50.3 with 33 participants and at the third testing it 51.4 with 10 participants. The scores showed an overall increase in the veterans' perceived sense of social support. The increase between the first and second testing was statistically significant while the results between the second and third testings was not.

The mean score for the initial conflict scale was 40.4 with 13 being low conflict and 65 being high conflict. The second testing score was 38.9 with 33 participants and the third testing score was 39.4 with 10 participants. A slight decrease in the conflict was noted by the veterans between the first and second testing and a slight rise in scores after the veteran had been out of the treatment program for 30 days.

The initial self-esteem score was 23.5 with a range of 10 for a high self-esteem score to 40 for a low self-esteem score. The second testing with 33 participants was 17.8 and the third testing was 17.1 with 10 participants. The self-esteem scores improved

although the difference between the second and third testing was minimal.

Table 1

The means and standard deviations of the scales at the 3 testing times

INSTRUMENT	TIME					
	1		2		3	
	M	(SD)	M	(SD)	M	(SD)
Self-esteem:	23.5	(4.17)	17.9	(5.02)	17.1	(4.86)
Conflict:	40.39	(8.53)	38.9	(6.85)	39.4	(4.45)
Social Support:	43.0	(8.85)	50.3	(7.27)	51.4	(8.51)

The results of the correlation procedure (Table 2) indicated that self-esteem and social support had moderate positive significant relationships at entry into the program and at the end of thirty days. In other words, the higher the self-esteem the higher the perception of social support. The coefficient at time three was also moderate but not statistically significant because of the small number of subjects. Self-esteem and conflict and social support and conflict were not statistically significantly related to each other.

Table 2

Correlations among social support, conflict and self-esteem by time.

	Time 1	Time 2	Time 3
self-esteem/conflict	.04	-.27	-.29
self-esteem/social suport	.36*	.59**	.49
social support/conflict	-.12	-.14	-.37

*= p <.01

**= p <.001

Discussion

The literature supports the findings that initially the self-esteem of the chemically dependent individual is low (Bennett, 1988), and it can be expected that those individuals with low self-esteem may exhibit destructive behaviors such as drug and alcohol abuse (Beckman, 1978).

What is not known is whether low self-esteem is an antecedent to the chemical abuse or a result of chemical abuse. The literature also supports the concept that social support increases along with self-esteem as the individual becomes drug and alcohol free (Bennett, 1988). It can be proposed that there may be a reciprocal relationship between social support and

self-esteem, i.e. when one increases then the other may also increase.

One possible reason for the increase in self-esteem and social support noted at the end of the treatment program may be related to the commraderie that the men develop with each other during the treatment program. The veterans share mutual problems and may develop similar insights into behaviors that led them into treatment. They are encouraged to develop a trust in others that allows for positive communication and to be able to accept criticism with out feeling rejected or threatened. These feelings of positive self-worth and belief in themselves follow both Cobbs'and Weiss' theory of social support (Cobb, 1987; Weiss, 1974). The new skills, positive beliefs and a new network of friends who are not chemically dependent are what is needed to prevent the return to the use of drugs and alcohol.

There are some very valid limitations to this research project. A nonrandom sample was obtained making it difficult to make generalizations to other populations and indicating that further research needs to be done in respect to self-esteem, social support and drug and alcohol use. The use of a very limited population, all male veterans coming from a small region in the Northwest is also a limiting factor. The

majority of the veterans were unemployed and without any other available insurance coverage, which was a requisite for entering the VA treatment program. Fifty-five percent were either divorced or separated and 27% were single. This finding may indicate that they did not have a strong social support network. The ethnic diversity was limited in that there were only 2 Blacks and 2 Hispanics who participated in the testing. Many had limited socio-economic resources related to the lack of job skills, training and being unemployed, all of which lend themselves to perpetuating a poor sense of self-esteem, which, in turn may allow for the continued use of chemicals. The decrease in the participants from 49 initially to 10 by the final testing creates problems of reliability and validity of the data. There is reason to question whether a true picture of the veterans' status 30 days post treatment was obtained with only 10 participants at the final testing.

The drop-out rate during treatment was 32% leaving 33 veterans who completed the 30 day treatment program. The number of drop-outs during the first 30 days of aftercare was 24 leaving 10 of the original participants completeing the 60 days of aftercare. The drop-out rate appears high but for drug and alcohol treatment programs this is expected and within usual

limits (D.Delaphine Feb.1990, personal communication.)

An additional limitation is that data was obtained dealing only with the veterans' perceptions of social support, conflict and self-esteem. The wives and significant others (SO) may have had a very different perception of those items before, during and after treatment. One of the drawbacks to this particular treatment program is that family and friends are limited to visiting one day per week. There are few counseling and education sessions available through the VA for friends and family to develop an understanding of what has happened and what can happen to the veteran and his relationships in the future. Because alcohol and drug abuse have been blamed for the problems that often arise in the family, when the chemically dependent individual receives treatment the families' expectation is that family life will be improved. This expectation is often thwarted by old behaviors and indeed more problems seem to arise. Family involvement in the treatment program and counseling could help to alleviate some of these problems (Akerman, 1983).

Implications for Nursing

With the advent of new knowledge gained in bio-chemical research and alcoholism it poses interesting questions on how it will effect the future of chemical

dependency treatment programs. In doing away with the blaming stance, i.e. you could quit if you really wanted to, to an understanding and acceptance of the knowledge that there is a chemical imbalance that occurs in the body when drugs and alcohol are used may change not only the individuals perception of chemical dependency but also family members.

This new knowledge may impact significantly on how the treatment facilities change their philosophy and program course in working with the chemically dependent individual. Centers may encourage more social support coming from within the treatment group towards each other and to continue contact with each other after treatment in helping to build a drug free support network. Lengthening treatment programs or including day treatment programs after the initial 30 days may be a consideration. Day treatment would allow the chemically dependent individual to spend the day time hours in treatment but the nights with family members so that the stress of having to return to society and potential problems would be reduced. The drug and alcohol dependent individual would still have a strong social support base on which to rely as well as guidance and support in making decisions. The feelings of camaraderie would not cease at the end of the treatment program. The positive self-image that the

individual was working on in treatment would have an opportunity to continue to develop in a very supportive and caring atmosphere. Hopefully, with such positive encouragement the recidivism rate would drop.

The primary implication for nursing is to recognize the signs of drug and alcohol abuse in patients. It is also beneficial to make the assessment known to the appropriate medical care providers in the hope that an intervention or at least an awareness of the problem is made known to the patient. It is essential to educate the other family members to the disease process and let them know what options are available not only to the patient but for themselves as well.

To deal effectively with the drug and alcohol abuser the nurses' feelings and knowledge about the disease must be addressed. What the nurses' beliefs are will effect the relationship with the patient and the patients family or social support network, provided there is one available. It is difficult and frustrating to work with a patient who is in denial of a health problem. But, it is important to be there in a supportive, non-judgmental role that will allow the patient to arrive at the acceptance of the disease as he is able and then allow the individual to make the choice of receiving treatment or not. Understanding

that the chemically dependent individual is involved in what frequently appears to be a self-defeating and often destructive cycle nurses have the opportunity to interrupt that cycle by providing support and knowledge to the patient and family about the disease of alcoholism and drug abuse.

Summary

This research project looked at the role of self-esteem and social support in the chemically dependent veteran. Using the Rosenberg Self-Evaluation scale and the Interpersonal Relationships Inventory 49 veterans were tested three times over a 60 day period. The resulting data indicated there was a positive relationship between self-esteem and social support and that as the self-esteem increased the perceived social support increased with a slight decrease in conflict. The literature supports the findings that as self-esteem improves so does the social support for the individual. The data collected at the end of the 30 days in aftercare continued to show a positive relationship but should be viewed with caution because of too small a number of participants testing at that time.

References

Akerman, R.J. (1983). Children of alcoholics: a guide for parents and therapists. New York: Simon & Schuster.

Antonucci,T.C., & Jackson,J.S. (1983). Physical health and self-esteem. Family and Community Health, 6(8), 1-9.

Beck,C.M., Rawlins, R.P., & Willaims, S.R. (Eds.). (1984). Mental health - psychiatric nursing: A holistic life cycle approach. (p.303). St. Louis: Mosby.

Beckman, L.J. (1978). Self-esteem of women alcoholics. Journal of Studies on Alcoholism, 39(3), 491-499.

Bennett, G. (1988). Stress, social support & self-esteem of young alcoholics in recovery. Issues in Mental Health Nursing, 9, 151-167.

Berg, N.L. (1971). Effects of alcohol intoxication on self-concept. Quaterly Journal of Studies on Alcoholism, 32, 442-453.

Berkman, L.F., & Syme, S.L. (1979). Social networks, host resistance and mortality: a nine year follow-up study of alameda county residents. American Journal of Epidemiology, 109(2), 186-204.

Bruhn, J.G., & Phillips, B. U. (1987). A developmental basis for social support. Journal of Behavioral Medicine, 10(3), 213-229.

Chenitz, W.C.,& Granfors, W. (1988). Alcoholism and the family. In C.L.Gillis, B.L.Gighly, B.M.Roberts, & I.M. Martinson (Eds.), Toward a science of family nursing. (p.472-485). Menlo Park, Ca. Addison-Wesely.

Cobb, S. (1976). Social support as a moderator of life stress. Psychsomatic Medicine, 38(5), 300-313.

Cohen, S., & Syme, S.L. (1985). Issues in the study and application of social support. In S.Cohen, & S.L.Syme, (Eds.), Social support and health. (p.3-20). New York, Academic Press.

Favazza, A.R., & Thompson, J.J. (1984). Social networks of alcoholics: Some early findings. Alcoholism: Clinical and Experimental Research, 8(1), 9-15.

Gottlieb, B.H. (1985). Social networks and social support: An overview of research, practice and policy implications. Health Education Quaterly, 12(1), 5-22.

Jellinek, E.M. (1960). The disease concept of alcoholism. New Haven, Ct.: Hillhouse Press.

Kaplan, B.H., Cassel, J.C., & Gore, S. (1977). Social support and health. Medical Care, 15(5) 47-58.

Liepman, M., White, W.T., & Nirenberg, T.D. (1986). Children in alcoholic families. In D.C.Lewis, & C.N.Williams (Eds.), Providing care for children of alcoholics.(p.39-64). Pompano Beach, Fl.: Health Communications.

Lin, N., Ensel, W.M., Simeone, R.S., & Kuo, W. (1979). Social support, stressful life events, and illness: a model and empirical test. Journal of Health and Social Behavior, 20(6), 108-119.

Macdonald, J.G. (1987) Predictors of treatment outcome for alcoholic women. The International Journal of Addictions, 22(3), 235-248.

Muhlenkamp, A.F., & Sayles, J.A. (1985). Self-esteem, social support and positive health practices. Nursing Research, 35(6), 334-338.

O'Connell, R.A., Mayo,J.A., Eng, L.K., Jones, J.S., & Gabel, R.H. (1985). Social support and long-term lithium outcome. British Journal of Psychiatry, 147, 272-275.

Oyabu, N., & Garland, T.N. (1987). An investigation of the impact of social support on the outcome of an alcoholism treatment program. The International Journal of the Addictions, 22(3), 221-234.

Robinson,J.P., & Shaver, P.R. (1973). Measures of social psychological attitudes (Rev.Ed.) Survey Research Center Institute for Social Research.

Saronson, I.J., Saronson,B.R., Potter, E.H.III, & Antoni, M.H. (1985). Life events, social support and illness. Psychosomatic Medicine, 47(2), 156-162.

Schilit, R., & Gomberg, E.L. (1987). Social support structures of women in treatment for alcoholism. Health and Social Work, 12(3), 187-195.

Stefan, J.S., Steffan, V.B., & Nathan, P.E. (1987). Behavioral approaches to alcohol abuse. In N.J.Estes, & M.E.Heinemann (Eds.), Alcoholism: Development, consequences and interventions.(p 283-293). St.Louis: Mosby.

Tilden, V.P., & Galyen, R.D. (1987). Cost and conflict: the darker side of social support. Western Journal of Nursing Research, 9(1), 9-18.

Tilden, V.P., & Weinert, C. (1987) Social support and the chronically ill individual. Nursing Clinics of North America, 22(3), 613-620.

Weiss, R.S. (1974). The provisions of social support. In Zick Rubin (Eds.), Doing unto others. (17-26). Englewood Cliffs: Prentice-Hall.

Whitcher, S.J., & Fisher, J.D. (1979). Multidimensional reaction to therapeutic touch in a hospital setting. Journal of Personality and Social Psychology, 37(1), 87-96.

Wortman, B.C., & Conway, T.L. (1985). The role of social support in adaption and recovery from physical illness. In S.Cohen, & S.L.Syme (Eds.), Social support and health. (p.201-298). New York: Academic Press.

Appendix A

Interpersonel Inventory

INTERPERSONAL RELATIONSHIPS INVENTORY

ost relationships with people we feel close to are both helpful and stressful. Below are statements that describe close ersonal relationships. Please read each statement and mark an X in the box that best fits your situation. There are no ght or wrong answers.

hese first statements ask you to disagree or agree.

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
I know someone who makes me feel confident in myself	☐1	☐2	☐3	☐4	☐5
Within my circle of friends, I get just as much as I give	☐1	☐2	☐3	☐4	☐5
Some people I care about share similar views with me	☐1	☐2	☐3	☐4	☐5
I'm available to my friends when they need to talk	☐1	☐2	☐3	☐4	☐5
When I have helpful information, I try to pass it on to someone who could use it	☐1	☐2	☐3	☐4	☐5
I think I put more effort into my friends than they put into me	☐1	☐2	☐3	☐4	☐5
There is someone I can turn to for helpful advice about a problem.	☐1	☐2	☐3	☐4	☐5
I don't mind loaning money if a person I care about needs it	☐1	☐2	☐3	☐4	☐5
I can talk openly about anything with at least one person I care about	☐1	☐2	☐3	☐4	☐5
0. I'm satisfied with the give and take between me and people I care about	☐1	☐2	☐3	☐4	☐5
11. There is someone I could go to for anything	☐1	☐2	☐3	☐4	☐5
12. Some people in my life are too pushy	☐1	☐2	☐3	☐4	☐5
13. I'm happy with the balance of how much I do for others and how much they do for me	☐1	☐2	☐3	☐4	☐5
14. I can count on a friend to make me feel better when I need it	☐1	☐2	☐3	☐4	☐5
15. When I need help, I get it from my friends, and when they need help, I give it back	☐1	☐2	☐3	☐4	☐5
16. There is someone in my life who gets mad if we have different opinions	☐1	☐2	☐3	☐4	☐5
17. It's safe for me to reveal my weaknesses to someone I know	☐1	☐2	☐3	☐4	☐5
18. Someone I care about stands by me through good times and bad times	☐1	☐2	☐3	☐4	☐5

These statements ask you to disagree or agree.

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
19. I have the kind of neighbors who really help out in an emergency	☐1	☐2	☐3	☐4	☐5
20. There is someone I care about that I can't count on	☐1	☐2	☐3	☐4	☐5
21. If I need help, all I have to do is ask	☐1	☐2	☐3	☐4	☐5
22. I have enough opportunity to talk things over with people I care about	☐1	☐2	☐3	☐4	☐5

These next statements ask you how often something happens

	NEVER	ALMOST NEVER	SOMETIMES	FAIRLY OFTEN	VERY OFTEN
23. I have enjoyable times with people I care about	☐1	☐2	☐3	☐4	☐5
24. I spend time doing things for others when I'd really rather not	☐1	☐2	☐3	☐4	☐5
25. Some people I care about invade my privacy	☐1	☐2	☐3	☐4	☐5
26. I let people I care about know that I appreciate them	☐1	☐2	☐3	☐4	☐5
27. I am embarrassed by what someone I care about does	☐1	☐2	☐3	☐4	☐5
28. Some people come to me for a boost in their spirits	☐1	☐2	☐3	☐4	☐5
29. Someone I care about tends to take advantage of me	☐1	☐2	☐3	☐4	☐5
30. Some people I care about are a burden to me	☐1	☐2	☐3	☐4	☐5
31. I tell others when I think they're great	☐1	☐2	☐3	☐4	☐5
32. I wish some people I care about were more sensitive to my needs	☐1	☐2	☐3	☐4	☐5
33. People I care about make me do things I don't want to do	☐1	☐2	☐3	☐4	☐5
34. Some people I care about come to me for advice	☐1	☐2	☐3	☐4	☐5
35. There is tension between me and someone I care about	☐1	☐2	☐3	☐4	☐5
36. I have trouble pleasing some people I care about	☐1	☐2	☐3	☐4	☐5
37. At least one person I care about lets me know they believe in me	☐1	☐2	☐3	☐4	☐5
38. Some people I feel close to expect too much of me	☐1	☐2	☐3	☐4	☐5
39. I let others know I care about them	☐1	☐2	☐3	☐4	☐5

IPRI

Interpersonal Relationships Inventory

Scoring Information

The IPRI consists of 39 Likert items, each scored from 1 to 5. Item 6 requires recoding to reverse score.

Items were derived initially from qualititive interview data from 44 respondents, and were written to be congruent conceptually with the multidimensions of interpersonal relationships within support networks. There are three subscales: interpersonal support, reciprocity, and conflict. Items from the 3 scales are mixed to avoid response sets.

Definitions of the subscales and the items that comprise each follow:

interpersonal support: The perceived availability or enactment of helping behaviors by persons with whom one is engaged in relationships that are usually informal or non-contractual. 13 items; numbers 1, 3, 7, 9, 11, 14, 17, 18, 19, 21, 22, 23, 37.

reciprocity: The perceived occurence or availability of an exchange or returning of psychological or tangible goods and services; occurences are informal or non-contractual. 13 items; numbers 2, 4, 5, 6, 8, 10, 13, 15, 26, 28, 31, 34, 39.

conflict: Perceived discord or stress in relationships is considered ubiquitous in social networks. Conflict can be occasional, periodic, or consistent, and can either be caused by behaviors of others actually enacted, or by the absence of behavior enacted by others, such as the withholding of supportive behaviors. 13 items; numbers 12, 16, 20, 24, 25, 27, 29, 30, 32, 33, 35, 36, 38.

Two different anchor styles were needed. Items were clustered by perceived states and anchored with agree-disagree (those numbered 1 through 22), or by enacted behaviors and anchored with often-never (those numbered 23 through 39.) Thus the interpersonal support subscale consists of 11 perceived and 2 enacted behaviors; the reciprocity subscale consists of 8 perceived and 5 enacted behaviors; and the conflict subscale consists of 3 perceived and 10 enacted behaviors.

The IPRI yields three scores, one for each subscale. Construct validity testing, including factor analysis, have shown that social support and reciprocity scores can be added in order to derive a single score for social support. The conflict score stands alone as an index of interpersonal stresses. Thus, the three subscales can be reduced to two main scores, one for social support and one for interpersonal stresses.

7/13/87

Appendix B

Rosenberg Self-Evaluation Questionnaire

Self-Evaluation Questionnaire

Developed by M. Rosenberg

Directions:

For each statement, please circle the response on the right which best describes how you feel about yourself.

	1. Strongly agree	2. Agree	3. Disagree	4. Strongly disagree
1. I feel that I'm a person of worth, at least on an equal basis with others.	1	2	3	4
2. I feel that I have a number of good qualities.	1	2	3	4
3. All in all, I am inclined to feel that I am a failure.	1	2	3	4
4. I am able to do things as well as most other people.	1	2	3	4
5. I feel I do not have much to be proud of.	1	2	3	4
6. I take a positive attitude toward myself.	1	2	3	4
7. On the whole, I am satisfied with myself.	1	2	3	4
8. I wish I could have more respect for myself.	1	2	3	4
9. I certainly feel useless at times.	1	2	3	4
10. At times I think I am no good at all.	1	2	3	4

Appendix C

Personalized Disease Chart

PERSONALIZED DISEASE CHART

E S .....( ) Begins using for relief
A T ( ) Sneaks/Preoccupied with chemical
R A ( ) Has memory blackouts
L G .....( ) Has increased chemical tolerance
Y E
C .....( ) Repeated chemical related arrests
R ( ) Experiences loss of control
U ( ) Is dishonest about chemical use/supply
C ( ) Tries period of forced abstinence
I S ( ) Has guilt about chemical use
A T ( ) Considers geographic escapes
L A ( ) Experiences urgent need for chemicals
G ( ) Quits or loses jobs
E .....( ) Uses alone

C .....( ) Experiences tremors and shakes
R ( ) Lengthy chemical binges occur
I ( ) Thinking is impaired
T ( ) Loses tolerance for chemicals
I S ( ) Has indefinable fears/remorse
C T ( ) Physical health deteriorates
A A ( ) Is admitted to hospitals/programs
L G .....( ) Loses family and friends
E

Appendix D

INFORMED CONSENT

Informed Consent Form

I,_____ agree to participate as a subject in the Reasearch Project named " A Descriptive Study Relating Social Support and Self-Esteem to the Recovery Process of Chemically Dependent Veterans". This study is to be conducted by Shawn Gaddy, R.N., B.S.N. under the supervision of Carol Crispen, R.N., M.Ed, Ms. at the VAMC Chemical Addiction Treatment Unit.

I understand that I will be asked to fill out two (2) paper and pencil questionnaires regarding social support and self-esteem a total of three (3) times, on admission to the program, at the time of discharge (28 days) and 30 days after discharge. The questionnaires will take about 20 minutes to complete.

I understand that this study is being conducted at Ward 24 of the Veterans Hospital Treatment Center for Chemical Dependency, but it will have no connection with my current treatment program.

All information will be handled confidentially. My anonymity will be maintained on all documents, which will be identified by code number. Neither my name or identity will be used for publication or publicity purposes.

By serving as a subject I may benefit by being able to examine my social support system and contribute new informaion to the treatment process which may benefit patients in the future.

In completeing the survey, my participation does not involve any known harm or risks.

I understand that I am free to leave this study at any time and it will in no way affect my relationship with or treatment from my Physician, the Portland Veterans Hospital, heealthcare provider or treatment unit.

Every effort to prevent any injury that could result from this study will be taken. In the event of physical injuries resulting from the study, medical care and treatment will be available at this institution. For eligible veterans, compensation damages may be payable under 38 USC 251 or, in some circumstances, under the Federal Tort Claims Act. For non-eligiable veterans and non-veterans,compensation would be limited to situations where negligence occurred and would be controlled by the provisions of the Federal Tort Claims Act. For clarification of these laws, contact District Counsel (503) 221-2441. You have not waived any legal rights or released the hospital or its agents from liability for negligence by signing this form.

Shawn Gaddy has offered to answer any and all questions I might have regarding this study and what is required of me.

I have read the explanation and agree to participate as a subject in the study described.

Date _____ Signature_____

SS#_____ Witness _____

PART I-AGREEMENT TO PARTICIPATE IN RESEARCH BY OR UNDER THE DIRECTION OF THE VETERANS ADMINISTRATION

DATE

1. I, _____, voluntarily consent to participate as a subject
(Type or print subject's name)

in the investigation entitled Social Support and Self-Esteem in the Chemically Dependent Veteran
(Title of study)

2. I have signed one or more information sheets with this title to show that I have read the description including the purpose and nature of the investigation, the procedures to be used, the risks, inconveniences, side effects and benefits to be expected, as well as other courses of action open to me and my right to withdraw from the investigation at any time. Each of these items has been explained to me by the investigator in the presence of a witness. The investigator has answered my questions concerning the investigation and I believe I understand what is intended.

3. I understand that no guarantees or assurances have been given me since the results and risks of an investigation are not always known beforehand. I have been told that this investigation has been carefully planned, that the plan has been reviewed by knowledgeable people, and that every reasonable precaution will be taken to protect my well-being.

4. In the event I sustain physical injury as a result of participation in this investigation, if I am eligible for medical care as a veteran, all necessary and appropriate care will be provided. If I am not eligible for medical care as a veteran, humanitarian emergency care will nevertheless be provided.

5. I realize I have not released this institution from liability for negligence. Compensation may or may not be payable, in the event of physical injury arising from such research, under applicable federal laws.

6. I understand that all information obtained about me during the course of this study will be made available only to doctors who are taking care of me and to qualified investigators and their assistants where their access to this information is appropriate and authorized. They will be bound by the same requirements to maintain my privacy and anonymity as apply to all medical personnel within the Veterans Administration.

7. I further understand that, where required by law, the appropriate federal officer or agency will have free access to information obtained in this study should it become necessary. Generally, I may expect the same respect for my privacy and anonymity from these agencies as is afforded by the Veterans Administration and its employees. The provisions of the Privacy Act apply to all agencies.

8. In the event that research in which I participate involves certain new drugs, information concerning my response to the drug(s) will be supplied to the sponsoring pharmaceutical house(s) that made the drug(s) available. This information will be given to them in such a way that I cannot be identified.

I_____
NAME OF VOLUNTEER

HAVE READ THIS CONSENT FORM. ALL MY QUESTIONS HAVE BEEN ANSWERED, AND I FREELY AND VOLUNTARILY CHOOSE TO PARTICIPATE. I UNDERSTAND THAT MY RIGHTS AND PRIVACY WILL BE MAINTAINED. I AGREE TO PARTICIPATE AS A VOLUNTEER IN THIS PROGRAM.

9. Nevertheless, I wish to limit my participation in the investigation as follows:

VA FACILITY	SUBJECT'S SIGNATURE
Vancouver Division/Portland VAMC	
WITNESS'S NAME AND ADDRESS *(Print or type)*	WITNESS'S SIGNATURE
INVESTIGATOR'S NAME *(Print or type)*	INVESTIGATOR'S SIGNATURE
Shawn Gaddy, RN, BSN	Shawn Gaddy R.N.

☐ Signed information sheets attached. ☐ Signed information sheets available at:

SUBJECT'S IDENTIFICATION *(I.D. plate or give name - last, first, middle)*	SUBJECT'S I.D. NO.	WARD

AGREEMENT TO PARTICIPATE IN RESEARCH BY OR UNDER THE DIRECTION OF THE VETERANS ADMINISTRATION

VA FORM SEP 1979 10-1086

SUPERSEDES VA FORM 10-1086 JUN 1975, WHICH WILL NOT BE USED.

AN ABSTRACT OF THE

MASTERS RESEARCH PROJECT OF

SHAWN GADDY

For the MASTER OF SCIENCE

Date of Receiving this Degree: June 8, 1990

Title: Social Support and Self-esteem of the Chemically Dependent Veteran

Approved: Carol Burckhardt

Carol Burckhardt, RN, Ph.D., MRP Advisor

The purpose of this study was to determine whether self-esteem and social support of chemically dependent veterans changes over a 60 day period of time while participating in a behavioral-based treatment program. The Interpersonal Inventory was used to measure social support and conflict. The Rosenberg Self-Evaluation Questionnaire was used to measure self-esteem. After data analysis it was shown that there is a positive relationship between social support and self-esteem. The veterans perceived that their self-esteem increased and that their social support improved and that conflict in their relationships was slightly decreased at the end of 60 days in treatment. Research questions 1 and 2 were answered positively in that there was a moderate positive relationship between social support and self-esteem and that both self-esteem and social

support changed in the chemically dependent veteran over 60 days in a treatment program. The decrease in participants from 49 initially to 10 by the final testing creates problems of validity of the data. There is reason to question whether a true picture of the veterans status 30 days post treatment was obtained.