2005

Levels of social intimacy among women in substance abuse treatment

Jean Emiko Ishihara

Follow this and additional works at: https://scholarworks.lib.csusb.edu/etd-project
Part of the Social Work Commons, and the Substance Abuse and Addiction Commons

Recommended Citation
https://scholarworks.lib.csusb.edu/etd-project/2880

This Project is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact scholarworks@csusb.edu.
LEVELS OF SOCIAL INTIMACY AMONG WOMEN IN SUBSTANCE ABUSE TREATMENT

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Jean Emiko Ishihara

June 2005
LEVELS OF SOCIAL INTIMACY AMONG WOMEN IN SUBSTANCE ABUSE TREATMENT

A Project
Presented to the
Faculty of
California State University,
San Bernardino

by
Jean Emiko Ishihara
June 2005

Approved by:

Tom Davis, Faculty Supervisor
Social Work

Tom Davis, Proposal Supervisor

Dr. Rosemary McCaslin,
M.S.W. Research Coordinator

Date 5/24/05
ABSTRACT

Intimacy is an important aspect of a woman’s life. Its development and subsequent mastery affects a woman’s self-esteem, interpersonal relationships, and ability to recover from substance abuse. Erickson’s psychosocial stages describe the adolescent’s primary need to acquire intimacy or isolation will occur. The achieving of this task leads to healthy relationships with others and allows for the achievement of more developmental tasks and maturation. This study found that women in substance abuse treatment have higher levels of social intimacy than women with no history of substance abuse (treatment). This study also found that a history of being abused had an effect on level of intimacy. This may imply that being abused has a detrimental affect on the development of intimacy. Other factors that were tested and discussed include type and number of substances used, length of use, length of treatment, participation in mental health treatment, and childhood substance abuse in the home. Implications of this study and possible areas of future research are also discussed in this paper.
ACKNOWLEDGMENTS

I would like to acknowledge the support, educational and personal, that Dr. Tom Davis has extended to me throughout the process of completing this project. Dr. Davis has contributed invaluable knowledge and provided needed encouragement during my planning, gathering data, and analyzing stages. Thank you to Tim Thelander for two years of helpful hints that made the writing process bearable.

I would also like to thank the substance abuse treatment agency, Community Education Department of the community college and all the women who participated in this research. Both locations were extremely supportive during the IRB and data gathering process, which was difficult at times.

And mostly, I would like to thank my family and friends. They have kept me going, never letting me give in to the exhaustion. I am ever grateful for their love and support. It is to them that I owe the success of this great accomplishment.
# TABLE OF CONTENTS

ABSTRACT .................................................................................. iii

ACKNOWLEDGMENTS ................................................................. iv

LIST OF TABLES ........................................................................ vii

CHAPTER ONE: INTRODUCTION

- Problem Statement ................................................................. 1
- Purpose of the Study ............................................................. 4
- Significance of the Project for Social Work ......................... 6

CHAPTER TWO: LITERATURE REVIEW

- Introduction ............................................................................. 8
- Theories Guiding Conceptualization ................................. 8
- Development of Intimacy as It Pertains to Women ............... 9
- Treatment Theories ............................................................... 13
- Summary .................................................................................. 17

CHAPTER THREE: METHODS

- Introduction ............................................................................. 18
- Study Design .......................................................................... 18
- Sampling .................................................................................. 19
- Data Collection and Instruments ........................................ 20
- Procedures ............................................................................... 22
- Protection of Human Subjects .............................................. 24
- Data Analysis .......................................................................... 25
- Summary .................................................................................. 25
CHAPTER FOUR: RESULTS

Introduction .................................................. 26
Presentation of the Findings ................................. 26
Summary ................................................................ 33

CHAPTER FIVE: DISCUSSION

Introduction ...................................................... 34
Discussion .......................................................... 34
Limitations .......................................................... 41
Recommendations for Social Work Practice,
Policy and Research ............................................. 42
Conclusions ......................................................... 44

APPENDIX A: QUESTIONNAIRE ............................ 46
APPENDIX B: INFORMED CONSENT ....................... 52
APPENDIX C: DEBRIEFING STATEMENT ................. 54
APPENDIX D: FIGURES ........................................ 56
REFERENCES ..................................................... 62
LIST OF TABLES

Table 1. Demographic and Predictor Items for Group B .................................. 28

Table 2. Survey Scores: Means, Standard Deviations, Minimum and Maximum, by Group A and B ................................. 29
Chapter One will present an overview of the problem and population being studied. Additionally, it will provide information regarding the social work relevance to this problem, the purpose of this study and how the results of this study will contribute to social work practice.

Problem Statement

Many people with alcohol addiction and/or drug addiction have poor interpersonal relationships. For some, this lack of healthy relationships can lead to more substance abuse and can also present problems while the abuser is in recovery or treatment. Many substance abuse treatment programs address only the substance abuse problem. While many programs and treatment options recognize the importance of social support while in recovery, it seems to be overlooked that the person in treatment may lack the ability to form and maintain healthy intimate relationships. Therefore, the recovery may be undermined by other interpersonal problems not being addressed by the current treatment.
Intimacy is a concept that encompasses many different features. According to Hook, Gerstein, Detterich, and Gridley (2003) intimacy includes love and affection, personal validation, trust, and self-disclosure. When one feels love and affection from someone they are more likely to open up and share with that person; and it also provides the recipient with a sense of validation and acceptance (Hook et al., 2003). Self-disclosure usually comes as one builds trust within the relationship. This typically comes about when one feels love and affection from the other person and does not fear being rejected. The level of intimacy rises in a relationship as the information shared becomes deeper and more meaningful (Hook et al., 2003).

Women tend to be more emotional beings and may place more importance on intimate relationships. However, when a woman abuses alcohol or drugs she may be providing herself with a false sense of intimacy in important relationships through the high that is achieved from alcohol or drugs. According to Kelly, Halford, and Young (2002), for women, as opposed to men, relationship distress is more closely related to drinking, and women tend to see relationship difficulties as a more severe
problems and often report drinking in response to those
difficulties.

The lack of attention to relational issues for
clients in substance abuse treatment may be attributed to
a number of factors. Funding may be an issue that affects
more than one factor. The treatment center may not be
able to afford to hire licensed and trained therapists to
effectively address these issues with the client, or as
in twelve-step programs there is no professional at all.
Also, treatment centers may be funded by private or
government grants that have specific guidelines that must
be followed in order to receive the monies. These
guidelines may include treatment modalities that do not
include psychotherapy type treatments. Also, time and
high number of caseload constraints may critically limit
the clinicians’ ability to provide effective treatment in
this manner. And finally tradition and/or comfort, some
clinicians are more comfortable with traditional recovery
modalities or providing treatment in a manner that is
most comfortable. In other words what they have been
doing they will keep doing because it is comfortable.

Social workers are taught to view the client as made
up of many parts. Each person is a system made up of many
systems, and when working with any person one must be aware of all systems. In substance abuse treatment, just addressing the addiction would be ignoring underlying causes and contributors to the addiction. To effectively treat the addiction a social worker would treat the whole person, not only the localized problem.

Purpose of the Study

Despite the significance of this issue there has been little research done in this specific area. Therefore, the purpose of this study is to explore the levels of social intimacy among women in substance abuse treatment in comparison to women who do not have a history of substance abuse treatment in an effort to provide more effective treatment.

The type of design selected for this research is a comparative survey of levels of intimacy between women in substance abuse treatment against women of similar age and geographical location but who have no history of substance abuse treatment. The first data source (Group A) for the current study is clients at a local substance abuse treatment center. This location offers residential and outpatient services. Any client that participated in
the study was offered two dollars in gift certificates for local fast food restaurants. All clients at the agency were offered the opportunity to participate which put this in the convenience sampling category. Criteria were limited to gender (female) and participation in a substance abuse treatment program.

The other data set (Group B) came from a local community college center offering classes such as basic education and GED preparation. Individuals that participated were given a dollar gift certificate and a candy bar.

The independent variable, women in substance abuse treatment, was created because the convenience of gathering data from the population of women with histories of substance abuse/dependence being in one place. The underlying assumption of this variable is women with histories of substance abuse (Group A), and women with no history of substance abuse (Group B).

The reason for using a comparative design using substance abuse (treatment) and no substance abuse (treatment) as the independent variable is to try to ascertain a difference between the two groups showing that the substance use may be a factor of lower levels of
intimacy. Therefore it would be valid to include intimacy as a topic of treatment.

The independent variable was substance abuse and the dependent variable being measured is level of social intimacy. The quantitative instrument that was used was the Miller Social Intimacy Scale (MSIS). The MSIS is a likert scale instrument designed to measure closeness to others, in the context of friendship or marriage (Miller & Lefcourt, 1982). Additional information was obtained from subjects including what kind of substance was used, length of substance use, length of time in treatment, if there was substance abuse in the home during childhood, marital status, and age of participant.

Significance of the Project for Social Work

Clients and clinicians would both benefit from having a clearer picture of the client’s interpersonal relationships and intimacy abilities. By assessing the client in the beginning stages of treatment, more specifically, the assessment phase, the clinician has a clear starting point to begin work with the client, by creating an individualized treatment plan, in the planning phase. Substance abusing clients may turn to
drugs or alcohol as a way to replace feelings of intimacy. By addressing these relational issues and offering the client a safe venue to work out and build interpersonal skills to have the capacity for intimate relationships, the clinician is not only addressing multiple aspects of the abusers addiction, but also offering the client tools for a more meaningful life.

There is a high relapse rate for those that have gone though substance abuse treatment. This could be due to client resistance to abstinence, poor social supports, or the ineffectiveness of the treatment modality to name a few.

However, this study aims to address treatment modalities and simply asks the question, "Do women in alcohol or substance abuse treatment have low levels of social intimacy?"
CHAPTER TWO

LITERATURE REVIEW

Introduction

Chapter Two is a review of literature that will provide a foundation for this project. The theories from which this study is conceptualized will be discussed first. Then the significance of women and their development as it pertains to intimacy and possible substance abuse. Current trends of substance abuse treatment modalities will be covered followed by a summary of the literature review.

Theories Guiding Conceptualization

Erikson’s theory of psychosocial stages includes intimacy as a primary developmental task in adolescence (Zastrow & Kirst-Ashman, 2004). A healthy individual should have a sense of identity prior to achieving intimacy, according to Erickson. Intimacy must be achieved to be able to be a part of strong committed relationships or isolation will occur (Zastrow & Kirst-Ashman, 2004). Developmentally, intimacy is very important to having and maintaining a healthy and happy adult life. According to Hook et al. (2003), intimacy has
been linked to "happiness, contentment, a sense of well-being, and social support" (p. 463).

From a developmental view, if the woman has been using substances for a long period of time it may be possible that she has damaged her abilities to form healthy relationships with others. Another speculation may be that adult children of alcoholics never learned about intimacy for they didn’t have good role models for affection. For example, a child raised with alcoholic parents may be confused as to what real intimacy is and develop a deficit in that area of development (Sandoz, 1998). Then as they grow up they too turn to alcohol or drugs. There have been studies on the formation of intimacy (Gleason, 1994) and early substance use being predictive of adverse effects on relationships (Newcomb, 1995).

Development of Intimacy as It Pertains to Women

Gleason reports that normal psychological development begins at birth and women grow through their connections with other individuals (1994). Healthy emotional interactions with mothers, fathers, other
family members, and peers involve being sensitive to others and offer the girl affirmation (Gleason, 1994).

Contrary to healthy development a woman who grows up in a dysfunctional family may do her best to make poor relationships work; therefore, she may develop feelings of failure, disempowerment, and/or devaluation of the self (Gleason, 1994). She may learn to cope by blaming herself and may not gain the ability to recognize or acknowledge her painful feelings, let alone share them with another person (Gleason, 1994). This downward spiral can have terrible effects in that several studies have shown that intimacy deficits are closely related with many mental health disorders (Hook et al., 2003).

In a study by Newcomb, Vargas-Carmona, and Galaif (1999) the direction of the relationship between psychological distress and substance abuse problems was examined in a community sample of 470 adults through a self-administered questionnaire. They found that as a person progressed through adulthood, earlier drug problems had negatively affected their psychological functioning (Newcomb, Vargas-Carmona, & Galaif, 1999). Developmental implications may be that drug problems interfere with an individual’s ability to accomplish
developmental tasks at the appropriate stage (Newcomb, Vargas-Carmona, & Galaif, 1999).

Following in line with the previous study, Newcomb (2003) found that drug use has a deteriorating effect on the quality and stability of relationships over time. Newcomb’s data were from an ongoing longitudinal study of 424 participants (307 of which were women) gotten from the 9 and 13 year follow-ups, average ages were 21.5 and 25.5, and participants not in a relationship were excluded (Newcomb, 2003). This study found that for women, the use of more than one substance (alcohol, marijuana, and/or cocaine) lowered satisfaction, increased difficulty in relationships, and increased divorce (Newcomb, 2003). Looking at the causal directionality and developmental implications, Newcomb found that the ability to engage in satisfying and stable relationships is more affected by earlier drug use than vice versa (2003). Additionally, women with relationship and alcohol problems have low relational efficacy and moreover, expect that their alcohol consumption has no effect on the relationship efficacy or intimacy (Kelly, Halford, & Young, 2002)
Developmental theories of intimacy maintain that intimacy is formed through healthy emotional relationships that begin at birth and continue as one grows. A study of 146 9th grade girls' sexual attitudes found that adolescents that drink alcohol tend to engage in risky sexual behavior (Gowen, Feldman, Diaz, & Yisrael, 2004). The girls, all of whom had reported having a boyfriend, were surveyed by using self-report measures on sexual attitudes, behaviors, and risky practices (Gowen et al., 2004). The same study also noted that early sexual activity and substance use were highly correlated and likely to be comorbid (Gowen, et al, 2004). Erikson’s theory stresses that in adolescence one needs to master the task of intimacy (intimacy vs. isolation) to have healthy relationships into adulthood (Zastrow & Kirst-Ashman, 2004). The findings in the Gowen study link adolescent girls that use alcohol or drugs with risky sexual behavior; by Erikson’s theory this could be highly problematic in that this behavior could lead to faulty perceptions of intimacy. Thereby causing relational issues in later years.
Treatment Theories

When treating women with alcohol or substance addictions the importance of social relationships needs to be recognized. People with alcohol problems and relationship problems are at high-risk for relapse (Kelly, Halford, & Young, 2002). From a cognitive-social learning perspective drinking may continue in the presence of a distressed relationship because it may be expected that alcohol will reduce depressed feelings about the relationship and enhance emotional closeness (Kelly, Halford, & Young, 2002). In other words, the person continues to drink because they believe it will improve the relationship. Relational issues should be considered part of the problem, not a separate issue.

Social support as part of treatment is important, and according to Beattie and Longbaugh “the strongest measure of support, in relation to physical and psychological outcomes, is the presence of an intimate, confiding relationship” (1997, Background section, ¶ 10). Intimacy is linked to social support and studies have found that intimate relationships may lessen the negative impact of stress (Hook et al., 2003). In particular, a study on females’ biobehavioral responses
to stress report that females, as opposed to males, tend
to “tend and befriend” a more social/relational coping
mechanism rather than “fight or flight” (Taylor, Klein,
Lewis, Gruenewald, Gurung, & Updegraff, 2000).

In today’s funding crunch, many programs are
shifting to an outpatient type program, or day treatment.
Additionally, in trying to serve as many clients as
possible with the least amount of resources group
treatment is heavily relied upon. Two popular group
treatment modalities are cognitive-behavioral and
twelve-step type groups.

According to the National Institute on Alcohol Abuse
and Alcoholism’s (2004) Social Work Education for the
Prevention and Treatment of Alcohol Use Disorder
curriculum material,

Cognitive Behavioral Therapy (CBT) is based on
principles of social learning theory,
indicating that the problem behaviors are
determined by factors in the social
environment. As such, the behaviors can be
“unlearned” in the same ways that they were
first acquired and are now maintained. CBT
focuses on learning alternative coping
strategies, rather than alcohol use, to deal with potentially high-risk situations.

(section 10)

A study by Ouimette, using Veterans Affairs Centers, found both cognitive-behavioral and alcohol twelve-steps groups to be effective treatments for substance abuse (as cited in Polcin, 2000).

Twelve-step programs use a type of peer support as a recovery process. These programs are run by the addicts themselves, with no professional staff. While these types of programs can be effective for some, without the integration of other professional treatment there is a danger that some clients will not receive much needed services (Polcin, 2000).

Motivational therapies (motivational enhancement therapy, and motivational interviewing) are also effective in helping the client in recovery. Miller and Rollnick identified six critical elements that are needed to induce change: feedback regarding personal risk, emphasis on responsibility, clear advice, change options, empathy from therapist, and facilitation of self-efficacy (as cited in Sampl & Kadden, 2001). In a review of multiple studies of brief interventions Bien, Miller &
Tonigan (1993) noted that brief motivational therapy had a positive influence on the client’s progress at a three-month follow-up.

While there have been increasing studies on the relational effect of intimacy and substance abuse there seems to be a lack of information on the incorporation of these issues into substance abuse treatment programs. The effectiveness of traditional treatment modalities such as cognitive-behavioral, twelve-step programs, and motivational therapies, have been studied and found to have a measure of effectiveness. However, it seems evident that these types of treatments address only surface characteristics of the addict. In Polcin’s examination of major studies on the effectiveness of treatment modalities, he concludes that the best treatment for substance abusers is an integrated treatment drawing on individual therapy, specialized programs, and self-help groups (such as AA) to be the ideal in addressing the client’s needs (2000).

There seems to be a gap in the study of effective treatment modalities that addresses long-term successes, and life satisfaction, specifically relating to relationship and intimacy issues. Furthermore, there is a
deficit in literature on whether or not women in
treatment actually have a low capacity for forming
intimate social relationships.

Summary

The formation of intimacy is an important aspect of
healthy development. While the direction of causality is
unclear, substance use/abuse can have a detrimental
impact on a woman’s ability to form healthy intimate
relationships. Mainstream substance abuse treatments do
not typically address these relational issues that may be
essential in maintaining an alcohol/drug free lifestyle.
Since women tend to put an emphasis on relationships in
their lives it would be important to incorporate intimacy
skills in treatment.
CHAPTER THREE

METHODS

Introduction

Chapter Three will describe the research methods utilized in the current study. The overall study design, information regarding the sample, the measurement instrument, data collection, and procedures will be presented. Additionally, the protection of human subjects will be addressed. The specific quantitative statistical techniques for analyzing the data will be described as well.

Study Design

The current study explored the relationship between substance abuse and levels of social intimacy in women. The results of this study will be useful in evaluating current treatment modalities for women in substance abuse treatment. A quantitative self-report survey was used to collect participants' responses. The use of a self-report survey was chosen for its aspect of anonymity, a concept very important to those in substance abuse treatment.

The type of design selected for this research is a comparative survey of levels of social intimacy between
women in substance abuse treatment against women of similar geographical location but who have no history of substance abuse. While the data may show a correlation between the two variables there are limitations to interpreting the findings.

Self-report surveys have limitations in that the participants may not answer the questions truthfully. The Intimacy survey may contain questions that are personal in nature to some individuals and therefore, some participants may be ashamed and answer dishonestly.

Another limitation of this study is the lack of generalizability to the larger population. The study was conducted among a sample within a specific geographic area. Additionally, other demographic criteria was used that will further limit the analysis such as gender, history of abuse, and history of treatment. While the sample size is statistically significant, it needs to be acknowledged this study used a relatively small sample and inference to a larger population should be cautioned.

Sampling

The data was obtained from two groups for this comparative design. The first group (Group A) was
selected by the following criteria: gender (female), currently in substance abuse treatment, and reside in the Upland, California area (or 30 mile radius). This sample came from a local substance abuse treatment agency in Upland, California. The geographical criterion is needed to select a group for comparative purposes. The sample size was 33.

The second group (Group B) was selected by the following criteria: gender (female), no history of substance abuse treatment, and reside in a 30 mile radius of Upland California. Note the only difference is the substance abuse criterion. This comparative sample will be obtained from a local community college program offering GED preparation classes and basic skill education. This group was used to compare the levels of social intimacy against the group of women in substance abuse treatment. Sample size is 30. Both groups fell in the convenience-sampling category.

Data Collection and Instruments

Participants were given a self-report questionnaire consisting of a demographic page and the Miller Social Intimacy Scale (MSIS). The demographic questions
addressed the independent variable of substance abuse treatment, and the MSIS addressed the dependent variable of level of social intimacy using ordinal measures.

Demographic information obtained included: gender, marital status, age, highest grade completed, what type of substance was used, length of substance use, length of time in substance abuse treatment, any mental health counseling, participation in 12-step program, if there was substance abuse in the home while growing up, and history of abuse. The demographic information will be used to screen for possible differences (and predictors) in responses.

The quantitative instrument used to measure the dependent variable is the Miller Social Intimacy Scale (MSIS). The MSIS is an instrument designed to measure closeness to others, in the context of friendship or marriage (Miller & Lefcourt, 1982). The survey consists of 22 questions, 17 of which are intimacy items scored on a scale of 1-5. Each item is scored and summed up to produce an overall score; the higher the total score indicates higher levels of intimacy (Corcoran & Fischer, 2000). The MSIS holds to be internally consistent with alphas in two samples of .86 and .91 and, test re-test
correlations of .96 and .84 over one-month period show
stability (Corcoran & Fischer, 2000).

The MSIS has good construct validity and has been
established by predicting directional correlations
against other measures such as the UCLA Loneliness Scale,
the Interpersonal Relationship Scale, and the Tennessee
Self-Concept Scale (Corcoran & Fischer, 2000).

While this instrument is statistically reliable and
valid, it is still a self-report survey and has its
limitations regarding honesty, as discussed earlier.
While it was stressed to the participants that their
identities will not be recorded nor will there be any
identifying information on the survey, this limitation
will need to be regarded when interpreting the results of
the study.

Procedures

The data from the group of participants in substance
abuse treatment will be gathered in the residential
program at a local substance abuse treatment agency. This
author personally gathered some of the data by soliciting
participation from the clients and also left some surveys
with the staff and picked them up at a later date. In the
substance abuse treatment agency, this researcher attended a morning meeting with the clients and asked them for their participation at the end of the meeting. Those that choose to participate in the study received $2 in gift certificates in return. The participants were given an informed consent form explaining the general construct of the study, confidentiality, and voluntary participation. The participants were instructed to mark the form with an "X" to indicate their consent to participate, then continue on to the next page beginning the survey. Following the last page of the survey will be a debriefing statement regarding the study. They will be instructed to tear this last page off for them to keep.

To administer the survey to the community college class, the researcher visited the classes, and asked for their individual participation. This process took place over several days. Candy and a $1 gift certificated was also offered to those that participated in exchange for their time.

These data collection activities listed took place during February and March 2005.
Protection of Human Subjects

To protect the participants in the study the following steps were taken. Limited demographic information was gathered, none of which was personally identifying information such as names, addresses, phone numbers, etc. Each survey was accompanied by an informed consent form that must be marked by the participant. The informed consent offered the participants information regarding the study, when research information will be available, and contact phone numbers for more information.

To further protect confidentiality, limited people had access to survey responses. The researcher and faculty advisor had access to the data and kept surveys locked in a drawer. Once the data had been analyzed all questionnaires were be destroyed.

In the instructions to the survey, participants were informed that they should feel free to skip any question they are not comfortable answering and may stop at any time. At the end of the survey, debriefing will include local mental health providers for those who may feel distress from their participation in this survey.
Data Analysis

The data analysis included nominal data from the demographic survey and ordinal data from the MSIS. This study utilized bivariate statistics to determine if there is a relationship between substance abuse and levels of intimacy. Additionally, descriptive statistics such as frequency distribution, measures of central tendency and measures of variability were used to describe the demographics of the sample.

Summary

The current study exploring the relationship between levels of intimacy and substance abuse utilized quantitative measures through a self-report instrument. The participants were solicited from a local substance abuse treatment agency and local community college. Participation was voluntary and confidentiality was maintained. Data analysis includes bivariate statistics looking at correlations between the two variables.
CHAPTER FOUR

RESULTS

Introduction

Chapter four will outline the demographics of the study sample as a whole, additional predictor information for the treatment group, and differences between the two groups. Statistical findings will be presented including sample frequencies, t-test, and ANOVA results.

Presentation of the Findings

There were a total of sixty-three participants in this study. Thirty-three were in Group A, women with a history of substance abuse and currently in substance abuse treatment; and thirty in Group B, women with no history of ever being in substance abuse treatment. The women ranged in age from 18 years-old to 59 years-old, with a mean age of 32.69 years. Group A had a mean age of 32.24 (SD = 8.93) and Group B had a mean age of 33.21 (SD = 11.87). The participants reported their education level as follows: 33% had less than a high school degree, 43% had a high school diploma, 16% had completed some college, and 8% had a college bachelor’s degree or
higher. Figure one shows the distribution of education level between the two groups.

Marital status was comprised of 48% single women, 43% married women, 6% were divorced, and 3% of the women were widowed. Figure Two demonstrates the difference between the two comparison groups.

Forty-four percent of all respondents reported growing up in a home with a substance abuser. Twenty of thirty-three subjects in Group A reported growing up in a home with substance abuse, as opposed to eight of thirty subjects in Group B reported the same. Figure Three illustrates the difference in distribution of the responses. Additionally, 33 reported a history of being abused (52%), 29 reported no history of abuse (46%), and 9 (2%) chose not to answer this item. Figure Four illustrates the difference between Groups A and B, and defines the specific type of abuse reported, with the category “emotional, physical, and sexual” being reported most by women in Group A. “No abuse” was reported most frequently (19 of 29 surveyed) in Group B.

The following table displays the demographics and predictors specific to Group A, those with histories of substance abuse and currently in treatment.
Table 1. Demographic and Predictor Items for Group B

<table>
<thead>
<tr>
<th>N = 33</th>
<th>Frequency (n)</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (in years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 - 27</td>
<td>14</td>
<td>42.42</td>
</tr>
<tr>
<td>28 - 37</td>
<td>7</td>
<td>21.21</td>
</tr>
<tr>
<td>38 - 47</td>
<td>9</td>
<td>27.27</td>
</tr>
<tr>
<td>48 - 57</td>
<td>3</td>
<td>9.10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Length of Substance Abuse Treatment (in weeks)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 13</td>
<td>19</td>
<td>57.58</td>
</tr>
<tr>
<td>14 - 26</td>
<td>10</td>
<td>30.30</td>
</tr>
<tr>
<td>27 - 39</td>
<td>2</td>
<td>6.06</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>6.06</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Previous or Current Mental Health Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>39.40</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>60.60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Type of Substances Used</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine (exclusively)</td>
<td>4</td>
<td>12.10</td>
</tr>
<tr>
<td>Cocaine (exclusively)</td>
<td>1</td>
<td>3.00</td>
</tr>
<tr>
<td>Marijuana (exclusively)</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Heroine (exclusively)</td>
<td>1</td>
<td>3.00</td>
</tr>
<tr>
<td>Alcohol (exclusively)</td>
<td>1</td>
<td>3.00</td>
</tr>
<tr>
<td>Polysubstance (2 types)</td>
<td>5</td>
<td>15.20</td>
</tr>
<tr>
<td>Polysubstance (3 types)</td>
<td>9</td>
<td>27.30</td>
</tr>
<tr>
<td>Polysubstance (4 types)</td>
<td>5</td>
<td>15.20</td>
</tr>
<tr>
<td>Polysubstance (5 types)</td>
<td>5</td>
<td>15.20</td>
</tr>
<tr>
<td>Polysubstance (6 types)</td>
<td>2</td>
<td>6.10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Main (primary) Substance Used</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>19</td>
<td>59.40</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1</td>
<td>3.10</td>
</tr>
<tr>
<td>Marijuana</td>
<td>2</td>
<td>6.30</td>
</tr>
<tr>
<td>Heroine</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td>Alcohol</td>
<td>2</td>
<td>6.30</td>
</tr>
<tr>
<td>Polysubstance</td>
<td>4</td>
<td>12.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Length of Substance Use (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 5</td>
<td>4</td>
<td>12.10</td>
</tr>
<tr>
<td>6 - 15</td>
<td>16</td>
<td>48.50</td>
</tr>
<tr>
<td>15 or more</td>
<td>13</td>
<td>39.40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33</td>
<td>100.00</td>
</tr>
</tbody>
</table>
According to Corcoran & Fischer (2000) the Miller Social Intimacy Scale has good internal consistency with alphas in two samples of .86 and .91. In the current study the internal consistency was good with an alpha of .75.

Table Two shows the means, standard deviations, and minimum and maximum responses on the continuous variable, Miller Social Intimacy Scale as they apply to the two groups. The mean survey score across both groups was 72.33 (SD = 7.38, min = 50, max = 83).

Table 2. Survey Scores: Means, Standard Deviations, Minimum and Maximum, by Group A and B

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean Score</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>32</td>
<td>75.36</td>
<td>4.74</td>
<td>60.00</td>
<td>83.00</td>
</tr>
<tr>
<td>B</td>
<td>29</td>
<td>68.97</td>
<td>8.33</td>
<td>50.00</td>
<td>83.00</td>
</tr>
</tbody>
</table>

Further, cut-off scores were determined creating three, Low (lowest to 71), Average (72-77), and High (77 to highest), levels of survey scores. Figures five and six illustrate the difference in distribution of level of survey scores between Group A and B. Group A has more scores falling in the Average to High levels (Low = 5,
Average = 15, and High = 12), and Group B scores are mostly Low, followed by Average, and few falling into the High category (Low = 15, Average = 10, and High = 4).

An independent samples t-test was used to compare the total score of the Social Intimacy Scale between Group A and Group B. There was a significant difference in scores for Group A (M = 75.38, SD = 4.74), and Group B (M = 68.97, SD = 8.33; t(59) = 3.64, p = .001). The magnitude of the difference in the means produced a large effect (eta squared = .183).

An independent samples t-test was used to test the effect of a childhood history of substance abuse in the home on the total score of the Social Intimacy Scale across both groups. There was no significant difference in scores for history of abuse in the home (M = 73.85, SD = 5.52), and no history of abuse in the home (M = 71.12, SD = 8.46; t(57) = 1.52, p = .13). However, there was a correlation of medium strength between childhood history of substance abuse in the home and being in Group A (history of substance abuse and treatment) with a significance at .006, r = .34.

There was not a statistically significant difference found in an independent samples t-test used to test the
effect of current or past participation in mental health
treatment on the total score of the Social Intimacy Scale
for Group A (item asked only of women in group A). The
two groups tested were survey scores on mental health
treatment (M = 76.77, SD = 3.83), and no mental health
treatment (M = 74.42, SD = 5.15; t(30) = 1.40, p = .17).

The mean survey scores of both Groups A and B were
tested using the predictor "History of being abused." An
independent samples t-test was used. There was a
significant difference in scores for those with a history
of being abused (M = 74.53, SD = 5.85), and no history of
being abused (M = 69.64, SD = 8.22; t(48) = 2.62,
p = .01). The magnitude of the difference in the means
produced a small effect (eta squared = .017).

A one-way between-groups analysis of variance was
conducted to explore the impact of length of substance
abuse treatment on intimacy survey scores in Group A and
B, as measured by the Miller Social Intimacy Scale.
Subjects were divided into three groups according to the
length of time in substance abuse treatment: (1) 0 – 13
weeks, (2) 14 – 26 weeks, and (3) 27 – 39 weeks. There
was no significant difference between the groups mean
scores (M's = 75.00, 77.44, and 74.50 for groups 1, 2 and 3, respectively) $F(2,27) = 1.39, p = .267$).

To explore the impact of length of substance use on intimacy survey scores, a one-way between-groups analysis of variance was used. Subjects were divided into three groups according to the length of time in substance abuse treatment: (1) 0 - 5 years, (2) 6 - 15 years, and (3) 15 or more years. There was no significant difference between the groups mean scores (M's = 77.25, 75.81, and 74.14 for groups 1, 2 and 3, respectively) $F(2,29) = 0.76, p = .477$).

There was also no significant difference between the mean survey scores and the primary type of substance used $F(4,25) = 1.95, p = .122$. or the type/quantity of substances used $F(5,24) = 1.41, p = .248$. A one-way between-groups analysis of variance using the means of the five categories of primary substances used (methamphetamine $M = 75.63$, cocaine $M = 81.00$, marijuana $M = 76.00$, heroine $M = 69.67$, alcohol $M = 80.50$, polysubstance $M = 75.75$), and eight categories of types/quantity of substances (methamphetamine (n)4, $M = 77.75$, cocaine (n)1, $M = 81.00$, alcohol (n)1, $M = 78.00$, 2 polysubstance (n)5, $M = 72.40$, 3
polysubstance (n)9, $M = 74.67$, 4 polysubstance (n)5, $M = 75.60$, 5 polysubstance (n)5, $M = 78.00$, 6 polysubstance (n)2, $M = 70.00$) was used.

Summary

The study found significant differences in the comparison between Group A (women with histories of substance abuse and currently in treatment) and Group B (women with no history of ever being in substance abuse treatment) in the means of the survey scores of the Miller Social Intimacy Scale. Additionally, a history of being abused has a statistically significant effect of the survey score, although a small effect. No significant effects on the survey score were found for growing up in a home with a substance abuser, previous/current mental health treatment, length of substance abuse treatment, length of substance abuse, or different types of substances used.
CHAPTER FIVE

DISCUSSION

Introduction

Chapter five will discuss in detail the findings of the current study, including significance and correlation when appropriate. Theoretical perspectives will be used to describe these finding. Limitations of the current study will be discussed. Implications to social work practice and policy and future areas of research will also be discussed.

Discussion

The results of this study posed some interesting results in that the direction of the significance between the groups' survey scores is opposite of the hypothesis. The test question that was posed indicated the possibility that women with substance abuse issues may have lower levels of social intimacy than those with no history of substance abuse. The results of the current study indicate that women with substance abuse histories tend to have higher levels of social intimacy than those of the comparison group.
The reason for the results could lie in the survey itself. While the survey is intended to measure closeness to others, the wording of the questions may also inquire about the value of the notion in the question. For example Items 18 and 16 read: “How important is it to you that this person shows you affection?” and “How much damage is caused in your relationship by a typical disagreement with this person?” If a person has low self-esteem and self-worth and needs acceptance and validation from external sources, the responses to these types of questions would concur with the results of this study. It would be extremely important to them that the other person shows affection and offers support to them because they do not meet that need of their own.

According to Erickson, a healthy individual should have a sense of identity prior to achieving intimacy, one of his psychosocial stages of development. Intimacy must be achieved to be able to be a part of strong committed relationships or isolation will occur (Zastrow & Kirst-Ashman, 2004). Applying Erickson’s theory, it would make sense that these women who may not have healthy self-worth and self-esteem would score higher than those that have achieved Erickson’s stage of intimacy.
The predictor variable of childhood substance abuse in the home has no significant effect on the survey score for all participants (Group A and B). However, there was a significant correlation between growing up in a home with a substance abuser and later involvement in substance abuse treatment. This is evidence that elements of a person's environment in childhood can carry through to adulthood. The connection between the correlation between childhood substance abuse in the home and intimacy issues in adulthood is, for example, a child raised with alcoholic parents may be confused as to what real intimacy is and develop a deficit in that area of development (Sandoz, 1998). While intimacy may not be directly related to substance abuse, in this study's findings, events in a person's development can indirectly affect many other areas in their life.

Mental health treatment information was attained to screen for possible differences in survey scores. This study showed no effect or correlation between mental health treatment and survey scores of those in Group A. The sample size for this group (n) 30 was small and the question was asked in a yes/no fashion. Further questioning in this area, such as length of treatment,
type of treatment, reason for treatment, may produce
different results. Further study in this area may be an
interesting topic of research, and show the effects of
different treatment modalities for substance abuse.

As pointed out in the literature review, normal
psychological development begins at birth and women grow
through their connections with other individuals
(Gleason, 1994). This may explain why having a history of
being abused significantly affected the score on the
social intimacy scale. Being abused would hinder healthy
interactions with others and if the abuser is a primary
caregiver in childhood years healthy development would be
distorted, slowed, or stopped. If the abuse takes place
in later years by a significant other over time a woman's
conception of a healthy relationship and intimate
relations would become distorted.

From the viewpoint of developing a healthy
self-esteem and identity, tasks necessary for healthy
intimacy development, according to Erickson, being a
victim of abuse would have detrimental effects on that
process. Healthy emotional interactions with mothers,
fathers, other family members, and peers involve being
sensitive to others and offer the girl affirmation, and
contribute to healthy development of self-esteem (Gleason, 1994).

For example, a woman who grows up in a dysfunctional family may do her best to make poor relationships work; therefore, she may develop feelings of failure, disempowerment, and/or devaluation of the self (Gleason, 1994). And to connect abuse with growing up in a home with a substance abuser, again, as Sandoz states, a child raised with alcoholic parents may be confused as to what real intimacy is and develop a deficit in that area of development (1998).

Neither length of substance abuse treatment nor length of substance use had a significant effect on social intimacy survey scores. This could indicate that intimacy is something that forms prior to the use of substances and current substance abuse treatment doesn’t address intimacy issues that affect the woman. This is not to say that the length of time or the time a person begins using drugs does not affect a person’s ability to form healthy relationships. The study by Newcomb, Vargas-Carmona, and Galaif (1999) on direction of the relationship between psychological distress and substance abuse problems found that as a person progressed through
adulthood, earlier drug problems had negatively affected their psychological functioning.

In a study by Newcomb it was found that for women, the use of more than one substance (alcohol, marijuana, and/or cocaine) lowered satisfaction, increased difficulty in relationships, and increased divorce (2003). This finding provides track to further investigate social intimacy and substance abuse. However in this current study no significant differences were found in the type or quantity of types of substances used. It is notable that 79% of Group A reported polysubstance use at 2 or more substances, and use of 3 substances was reported the highest at 27.3%.

What this study, in conjunction with previous research, makes apparent is a cycle that begins with an unhealthy development of self-esteem and worth that is detrimental to the development of intimacy. Without healthy experiences and understanding of intimacy in important relationships women may seek out that feeling in other places. Women may place more importance on intimate relationships than men and according to Kelly, Halford, and Young (2002), for women, relationship distress is more closely related to drinking, and women
tend to see relationship difficulties as a more severe problem and often report drinking in response to those difficulties. So in essence, she uses drugs/alcohol to replace intimacy, the substance use can cause additional stress on the relationship, so again she uses drugs/alcohol to feel better. To stop the cycle it would be beneficial to build self-esteem, self-worth and tools for healthy interpersonal relationships.

This issue of relapse in substance abuse treatment is debated among different treatment models. Some prefer abstinence; others prefer harm reduction with abstinence as the goal. What is agreed upon is the notion of social support. Social support as part of treatment is important, and according to Beattie and Longbaugh "the strongest measure of support, in relation to physical and psychological outcomes, is the presence of an intimate, confiding relationship" (1997, Background section, ¶10). Intimacy is linked to social support and studies have found that intimate relationships may lessen the negative impact of stress (Hook et al., 2003). If intimacy is linked to social support and social support is important in the treatment process, one can see how a lack of intimacy can impact a full recovery. For example, a woman
is in treatment and her main source of support is her boyfriend. Indicative of this study's results, she places high importance on the validation and acceptance she gets from her boyfriend. A big fight occurs between her and her boyfriend and she no longer feels worthy and validated by this man, and does not have the self-esteem and self-worth to soothe herself. Without her boyfriend, whom she relied upon for social support, she likely to relapse. This may be an extreme example, however even typical disagreements may have the same effect if the woman does not have the ability to self-soothe through a healthy self-esteem.

Limitations

The population surveyed for this study came from a local treatment center for women. The factor of the independent variable that was of importance was the history of substance abuse, independent of treatment. To alleviate the difficulty and reduce data gathering time it was convenient to survey women in treatment, all of whom have histories of substance abuse. This limits the generalizability to the female substance abuse population.
Another limitation is the self-report survey. All answers are assumed to be honest, when in fact there is no guarantee that this is so. Additionally, the specific criteria uses such as, gender, geographical location, and being in treatment also limit generalizability.

This study had 63 participants, however only 33 in the treatment group. To further look at predictors of level of social intimacy a larger sample would have provided more useful results. The small sample size should at the least warrant caution in reading the results whether significant or not.

Recommendations for Social Work Practice, Policy and Research

This study raises many questions and provides a researcher with a number of possible avenues to take. It would be interesting to survey women on self-esteem issues and intimacy issues to see if any significant correlations exist. Additionally, from a developmental viewpoint, one could assess developmental milestones and the correlations with intimacy and self-esteem. It seems that the three concepts, self-esteem, early developmental milestones, and intimacy are interrelated. Further clarity on the relationship between the three could
provide valuable information to the substance abuse
treatment providers.

The issue of mental health treatment was of little
significance in the current research. However, mental
health treatment may have a large impact of the recovery
of those in substance abuse treatment. Through therapy an
individual can identify developmental milestones that
were not achieved and build self-esteem. Further research
should include the different treatment theories and
modalities, and the impact it has on the recovery
process.

The history of being abused had a significant impact
on the social intimacy of all women in this study.
However this study did not clarify how that impact was
made. Questions raised include how the type of abuse,
perpetrator of abuse, and time of abuse affect intimacy.

In the field of social work a systems perspective is
valued. By understanding the effect of parenting,
developmental stages, social support, and the importance
of intimate relationships the social worker can better
serve the client. While most of the past research has
been done by other disciplines, these issues are
prominent in the world of the social worker. Many social
workers are direct providers of substance abuse treatment and should engage in these practices of researching these issues from a social work perspective and create evidence-based practices for other direct providers in this specialization.

Conclusions

This study found that women with a history of substance abuse (treatment) have higher levels of social intimacy than women who have no history of substance abuse (treatment). The interpretation of these findings concludes that women with the higher levels of intimacy are placing a disproportionate amount of value on the validation and approval of another person. This value may be due to a lack of healthy self-esteem and self-worth possibly stemming from unachieved developmental milestones. The negative effect of this for the woman in recovery is that her social support has too much influence on her recovery. The woman may essentially define herself by the interactions and quality of her relationships. Any dysfunction in the relationship may be absorbed into the woman's definition of herself. Further research is needed to clarify the direction and
implication of the relationship between intimacy, self-esteem, and psychosocial development.
APPENDIX A

QUESTIONNAIRE
Part A: Background Information

This section includes a few questions about you. Please write or circle your answer. DO NOT WRITE YOUR NAME.

Section I

1. How old are you? __________________ years.

2. Are you 1. Female 2. Male

3. What is your highest school grade completed? __________________ Grade


Section II

1. While growing up was there substance abuse in your home? 1. Yes 2. No

2. Do you have a history of abuse? Please circle all that apply. a) Emotional b) Physical c) Sexual d) None
Section III

1. Have you ever been in substance abuse treatment (current or past)?
   1. Yes (please answer the following questions)
   2. No (go to next page)

2. How long in treatment? _______ weeks _____ months _______ years
   (please add total time of all past treatment)

3. Have you ever participated in therapy (mental health)?
   1. Yes  How long? _____ months _____ years
   2. No

4. What type of substance used? Circle all that apply.
   1. Methamphetamine/Amphetamine
   2. Cocaine
   3. Marijuana
   4. Heroin
   5. Alcohol
   6. Other ______________________

5. What was the Main substance used. Circle one.
   1. Methamphetamine/Amphetamine
   2. Cocaine
   3. Marijuana
   4. Heroin
   5. Alcohol
   6. Other ______________________

6. How long have you used the substance?
   ______________ months ______________ years

7. Last relapse:
   1. Date ______________________
   2. None

8. Have you ever participated in a 12-step program, such as AA or NA?
   1. Yes  How long? ______________
   2. No
Part B: Relationships (MSIS Scale)

- The phrases listed describe the kinds of relationships people have with others.
- Please circle a number 1 through 5 describing your current relationship with your closest friend.
- The friend can be male or female and should be your closest friend at this time.

Remember to think of your CURRENT relationship with your closest friend when answering.

1. Sex of your closest friend: 
   Male  Female

2. Is the friend you describe your husband, wife, or significant other? 
   Yes  No

3. When you have free time how often do you choose to spend it with this person alone? 
   Very rarely  Some of the time  Almost always
   1  2  3  4  5

4. How often do you keep very personal information to yourself and do not share it with this person? 
   1  2  3  4  5

5. How often do you show this person affection? 
   1  2  3  4  5

6. How often do you confide very personal information to this person? 
   1  2  3  4  5

7. How often are you able to understand this person’s feelings? 
   1  2  3  4  5

8. How often do you feel close to this person? 
   1  2  3  4  5

Please continue on the next page
<table>
<thead>
<tr>
<th>Question</th>
<th>Not much</th>
<th>A little</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. How much do you like to spend time alone with this person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. How much do you feel like being encouraging and supportive to this person when he/she is unhappy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. How close do you feel to this person most of the time?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. How important is it to you to listen to this person share their personal information with you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. How satisfying is your relationship with this person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. How affectionate do you feel towards this person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. How important is it to you that this person understands your feelings?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. How much damage is caused in your relationship by a typical disagreement with this person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. How important is it to you that this person be encouraging and supportive to you when you are unhappy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. How important is it to you that this person shows you affection?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. How important is your relationship with this person in your life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
20. How long has this person been your closest friend?
   a. Less than a month
   b. 1-4 months
   c. 5-8 months
   d. 9-12 months
   e. over a year

21. Think of your previous closest friend. Are you…
   a. Less close with current friend you just described in this survey
   b. Just as close with current friend you just described in this survey
   c. Closer with current friend you just described in this survey
INFORMED CONSENT

The study in which you are being asked to participate in is designed to investigate personal relationships. Jean Ishihara is conducting this study under the supervision of Assistant Professor Tom Davis, Department of Social Work. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

In this study you will be asked to read a statement then rate it on a scale of 1 to 5. The survey should take about 10 to 15 minutes to complete. All of your responses will be confidential and only the researchers will have access. Your name will not be reported with your responses. All data will be reported in group form only. You may receive the group results of this study upon completion after July 2005 at the following location: California State University, San Bernardino Pfau Library.

Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the survey you will receive a debriefing statement describing the study in more detail. In order to ensure to validity of the study, we ask that you not discuss this study with other students or participants.

If you have any questions or concerns about this study, please fell free to contact Assistant Professor Tom Davis at (909) 880-5000 extension 3839.

By placing a check mark in the box below, I acknowledge:
• I have been informed of, and that I understand, the nature and purpose of this study, and
• I freely consent to participate.
• I also acknowledge that I am at least 18 years of age.

Place a check mark here □ Today's date:________
APPENDIX C

DEBRIEFING STATEMENT
Study of Personal Relationships
Debriefing Statement

This study you have just completed was designed to investigate personal relationships. In this study the level of intimacy in friendships and/or marriage was looked at in two contexts: females with a history of substance abuse and females with no history of substance abuse. Relationships with others play an important role in peoples’ lives and this study is looking to see if substance abuse affects a female’s ability to form healthy friendships and/or marriages. The results of this study can be used to effectively treat women with substance abuse issues by attending to their relational issues.

Thank you for your participation and for not discussing the contents of the decision question with other students. If you have any questions about the study, please feel free to contact Jean Ishihara or Assistant Professor Tom Davis at (909) 880-5000 extension 3839.

If this study has brought up any emotional discomfort please contact the counseling center on this campus at (909) 594-5611, Ext. 4380 to speak to a counselor.

If you would like to obtain a copy of the group results of this study, please contact Assistant Professor Tom Davis at (909) 880-5000 extension 3839 at the end of Spring Quarter of 2005 (June 2005).
APPENDIX D

FIGURES
Figure 1. Level of Education between Groups

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>14</td>
</tr>
<tr>
<td>High school diploma</td>
<td>12</td>
</tr>
<tr>
<td>Some college</td>
<td>10</td>
</tr>
<tr>
<td>College graduate</td>
<td>8</td>
</tr>
</tbody>
</table>

Group A: 14
Group B: 12

Count
Figure 2. Marital Status between Groups

Marital status:
- Single
- Married
- Divorced
- Widowed

Group A and Group B counts for marital status.
Figure 3. Childhood History of Substance Abuse in the Home between Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>20</td>
</tr>
<tr>
<td>B</td>
<td>25</td>
</tr>
</tbody>
</table>

History of Substance Abuse in the Home
- Yes
- No
Figure 4. History of Being Abused by Type of Abuse between Groups
Figure 5. Group A: Level of Intimacy

Figure 6. Group B: Level of Intimacy
REFERENCES


