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ABSTRACT

This paper describes a Behavior Modification Training Program, emphasizing self-control, for staff working with drug addicts. The program, which is primarily geared toward training paraprofessionals, takes place in 10 one-and-a-half hour sessions and includes an overview of behavior modification as well as instruction in behavior control, assertive training, rational thinking, and how to set up and run similar behavior modification training programs for staff and patients. To date, 17 staff training programs have been conducted at the New Jersy Neuropsychiatric Institute training 563 persons, while 1,368 patients have been trained in similar programs. Preliminary evaluation data have been promising and the response of participants enthusiastic. (Author)

A BEHAVIOR MODIFICATION TRAINING PROGRAM FOR STAFF WORKING WITH DRUG ADDICTS

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Therapy for the heroin addict has proven to be a highly problematical area, in which, as in alcoholism, one of the most viable approaches has been formulated by the addicted themselves. However, while therapeutic communities such as Daytop and Synanon, have achieved remarkable success with many addicts, programs such as these have tended to socialize individuals into a life style that is not readily transferable to the general community.

On the other hand, physiological treatments such as methadone maintenance, now in widespread use, have suffered from the fact that it is impossible to hand out the necessarily new life style "over the counter", so that, where supportive therapy is not offered results have proven unimpressive (Dobbs, 1971). Moreover, encounter and sensitivity techniques, the usual psychoadjuvant therapies offered, have aroused the lasting

antipathy of many patients who have n ot been suited to these abrasive approaches, and have exposed participants to the possibility of psychological damage at the hands of the often untrained, though drug knowledgeable, paraprofessionals who work with them. Thus, a need has appeared for a form of rehabilitative therapy which will enhance the ability of the addict to function flexibly and autonomously and which may be safely used by paraprofessionals.

In the present paper a training program for staff working with addicted patients is described, in which a number of behavior modification principles and techniques used in clinical practice - including relaxation, desensitization, self-image training, assertive training, rational thinking, behavior analysis and behavior control - were taught to staff members in a systematic fashion, so that they might in turn transmit them to patients and thus aid them in their rehabilitation and restoration to the community.

This program, emphasizing the development of self-control through this kind of training was developed in the course of a decade's experience at the Institute.

The work began in 1967 with a ten week training program in which fourteen families of convalescent young adult schizophrenic patients were taught how to handle the disturbed and disturbing behavior of their ill family member by the systematic application of rewards and punishments (Cheek et. al., 1967). Training techniques included lectures, movies, group discussions and role playing. The success of this program encouraged us to develop in 1969 a similar program for wives of convalescent alcoholics,

(Cheek et. al., 1971), aiming now at altering the destructive interaction we had previously observed in a study of the therapeutic use of LSD with alcoholics.

In this program it quickly became evident that the tension, bitterness and resentfulness of the wives made it impossible for them to examine the consequences of their own behavior. It was, therefore, decided to initiate procedures of relaxation and desensitization to aspects of their interaction with their husbands. These measures proved quite popular with the wives and also with their husbands, many of whom now began to attend the program.

This led to the development of a new program which included hospitalized alcoholics and their wives, (Cheek et.al., 1971) which was conducted for five weeks with husbands and wives separately while the men were still hospitalized, and for five weeks with both together in joint sessions after the husbands left the treatment unit. The program now included training in relaxation, desensitization, how behavior is influenced and how it may be controlled. However, self-image and assertive training were also added at this time as it was felt these would be appropriately useful for both husbands and wives. This program, after an encouraging experimental phase, became part of the regular program of the alcoholic unit.

At this time it became apparent that, quite unintentionally, we had shifted our attention from training participants in behavior modification techniques in order that they might develop better control of <u>others</u>, to training them to have greater control over <u>themselves</u>. It was now decided to try out the program with drug addicts hospitalized at the

Institute, while undergoing build-up for methadone maintenance. It was felt the program would help the addicts to cope with problems of tension, low self-image, poor future orientation and inappropriate assertiveness, which had been noted in a previous study. The training was revised to take place in four weeks, with two one-and-one-half hour sessions per week. The various materials - lectures, techniques, playlets, etc. were incorporated into a training manual to which pictures and poetry, some of which were contributed by the patients, were added to enhance its attractiveness as well as to clarify its message. Diplomas were offered for completion of the course. In a pilot program 43 addicts were trained, with remarkably encouraging findings in terms of highly significant changes in general level of tension, self-control, self-image and degree of assertiveness, and favorable though not statistically significant improvement over a comparison group at six month follow-up. Following the pilot program, regular training sessions were begun and since that time 421 addicts have received diplomas for attending a full sequence of sessions.

The initial program for drug addicts not only proved exceedingly popular with the patients but also aroused the interest of staff so that many requests from staff at the Institute, as well as staff in outlying methadone clinics, probation offices, etc. led to a revision of the manual for training staff, in which the training in techniques were mentioned as before but the material now was oriented to staff instead of patients. Also, a first meeting presenting a historical account of the area of Behavior Modification and a last meeting offering instructions in how to set up and run staff and patient behavior modification training programs were added.

By the training of staff members in behavior modification theory and techniques in this area it was hoped to accomplish the following aims:

a). To help staff members to relate better to, and guide patients participating in the patient behavior modification programs.

b). To teach them how to use these principles and techniques in the conduct of their own professional roles.

c). To train them to conduct behavior modification programs themselves, if they so wished.

To date, 3 intramural staff training programs for staff of the Drug Addiction Treatment Center at the Institute (training 35 persons); and 7 extramural staff training programs for staff working with addicts in various facilities throughout the State 261 persons trained), have been conducted. Relevant pre- and post- measures such as level of anxiety and degree of inner control were obtained for the participants in the first 2 intramural and the first and fifth extramural programs, as well as subjective reactions to the program and follow-up accounts immediately following and at three months following completion of all programs. While all the evaluation material has not been returned on all programs, it is felt that sufficient data has presently been collected to report in a preliminary way on the effectiveness of this approach.

Method of Procedure

Setting of the Study

The New Jersey Neuropsychiatric Institute is a 862 bed state facility located 6 miles north of Princeton, New Jersey. At the time of the training program, its facilities included a 73 bed Regional

Mental Health Center serving adjacent Somerset County, a 52 bed male and 12 bed female Alcoholic Treatment Center, a 64 bed male and 12 bed female Drug Addiction Treatment Center featuring methadone maintenance, a 92 bed Children's Unit, a 369 bed Chronic Treatment Unit, a 62 bed Clinical Investigative Unit, and a 126 bed Medical-Surgical-Geriatric Section. An out-patient clinic serving Somerset County was also operative. The staff of 26 included 15 psychiatrists. Treatment modalities included drug, ECT, one-to-one and group psycho-therapy, pastoral counselling, recreational, music, occupational and Erg therapy.

The methadone maintenance program at the New Jersey Neuropsychiatric Institute (NJNPI), at the time of the training program, was operating on an experimental basis under approval of the Federal Bureau of Drug Abuse and Narcotic Addiction and the Food and Drug Administration. As mentioned above, it included 64 male and 12 female beds.

At the time the intramural staff training programs were conducted the drug unit staff included 5 physicaians, 2 psychologists, 5 social workers, 13 nurses, 37 aides and 1 school teacher.

Project Personnel

The behavior modification training programs were conducted by members of the Experimental Sociology Section of the Bureau of Research in Neurology and Psychiatry. The Section consisted of two research scientists, four project specialists, one clerk-typist and 12 volunteers. Mr. Harold Moss, Supervisor of Nurses at the Institute, acted as a consultant while Mr. Donald McConnell of Discovery House, Marlboro, New Jersey, acted as co-group leader for some programs.

Program Description

Schedule

Intramural programs were conducted with intervals of 3 or 4 weeks in between. Each program consisted of 9 1-1/2 hour sessions, one session per day, twice per week, over a 5 week period. Private sessions were also included at the request and convenience of participants.

The extramural programs were conducted with roughly two month intervals in between. Each program consisted of 10 sessions, 2 sessions per day, one day per week, over a five week period. A final session of discussion, criticism and evaluation was added in this program. The groups met at 9:30 a.m. for coffee and cake and met in session from 10:00 a.m. to 12:00 noon. From 12:30 p.m. - 1:30 p.m. a homework session was held and there was also an opportunity for make-up sessions for missed meetings and private sessions for those who wished to discuss the material further or to discuss professional or personal problems. The afternoon session ran from 1:30 - 3:30 p.m.

Location

The intramural staff-training programs were held in an unused dining room off the main hall of the treatment unit. This room suffered from some disadvantages, such as inadequate sound-proofing which tended to interfere with relaxation procedures, and uncomfortable chairs which impeded the effectiveness of the relaxation practice.

The extramural staff training programs were held in an unused building which provided adequate space for the large numbers involved, and which was relatively free of sound interference. Arrangements were made for comfortable seating, and refreshments and flowers were regularly

supplied by the Institute.

Program Content

The content of the intramural program, is presented in Chart 1.

(Insert Chart 1 about here)

The extramural sessions, as noted above, added a tenth meeting of discussion, criticism and evaluation.

In the first session an overview of behavior modification was given. The following three sessions dealt with the inner experience of the participant. A rationale for training in relaxation was initially presented, followed by a description of the use of the "calm scene" to facilitate relaxation, and practice in the muscle-relaxant method of relaxation. In the next session participants were introduced to two more methods of relaxation, using imagery based on feelings of lightness and heaviness respectively. Also, at this session, the principles of desensitization were presented, and practice was given in this technique, moving from less anxiety-arousing to more anxiety-arousing scenes. In the fourth session, participants were given a rationale for self-image training, together with a description of Susskind's Idealized Self-Image technique (Susskind, 1970) and practice in the use of this technique. All meetings included practice in relaxation, finally combining all three methods in one sequence.

The following three sessions of the program emphasized external experience. Session 5 covered the shaping and maintenance of social behavior by means of rewards and punishments, Session 6, specific techniques of behavior change in others. Playlets were presented to give emphasis to the points made in the lecture. The seventh session was devoted to a lecture and demonstration on assertive training (Wolpe & Lazarus, 1966, Alberti &

Emmons, 1970), with examples of over-assertive, under-assertive, and correctly assertive behavior which the group was asked to classify. The eighth session provided training in "Rational Thinking" (Ellis & Harper, 1961). The ninth session offered suggestions for the organizing and conducting of group behavior modification programs for patient and staff training, as well as a chance to discuss the program with Institute patients who were undergoing the training as well as staff from the Drug Unit, who had been able to witness their patients' response to the program. The tenth meeting, as noted above, offered a chance for criticism and evaluation by participants.

All meetings provided opportunities for discussion of the material, and assignments were regularly given. Extra practice in relaxation was available to members of the intramural program. Participants in the extramural program were asked to practice either alone with someone else or with a specially made tape. Participants were instructed that after each day of training that they should try out the techniques learned on a "victim" so that they could report any difficulties at the noon-hour homework sessions. In this way, by the time they had finished the program participants had tried out all the techniques and received supervision in their administration.

Training Manual

As with all other behavior modification programs developed at the Institute, a training manual was prepared for use by participants. All material used in the program was set out in this compilation, including lectures and descriptions of the techniques, as well as assignment worksheets. As in the patient manual, illustrations by the drug addicts and poems either selected or written by the addicts were added to enliven the material.

Diplomas

For attending at least four full-day sessions of the Behavior Modification Training Program (eight out of ten sessions), participants were issued a diploma by the New Jersey Neuropsychiatric Institute. Additionally, a diploma was available from the New Jersey Department of Health upon completion of the following requirements:

1). Attendance at 4 out of 5 full day training sessions (8 out of 10 sessions). (Missed meetings to be made up in private sessions.)

2). Attendance at at least 3 full day monthly review sessions at NJNPI; 3). Attendance at one female and one male drug patient session at NJNPI; 4). Observation of trainees using Behavior Modification Techniques either in a) a staff training program or b) a patient training program at their own agency. This condition may be fulfilled also by using parts of the program with staff or patients. Members of the Experimental Sociology Section, NJNPI, are responsible for observing and reporting on the running of each new program.

To date 64 Department of Health Diplomas have been issued.

Monthly Review Sessions

In order to provide further consultation and supervision to participants, all former trainees were invited to attend review sessions held at the Institute one day each month. In the morning, each participant would report on his or her activities, experiences and problems with behavior modification, receive advice and consultation and participation in further practicums. In the afternoon session, distinguished contributors to the area of behavior modification would lecture and thus provide further training for participants.

The Newsletter

Shortly after the first program ended a monthly newsletter was initiated which was issued monthly for 3 months and then became bi-monthly.

The newsletter was seen as fulfilling the following purposes:

1. To keep former trainees in touch with developments at the Institute in-patient, family, intramural and extramural staff training programs in drugs, alcoholism and mental illness, including schedules of training meetings, monthly review sessions, new programs developed, etc.
2. To present case histories and other materials from our own experiences and those of our trainees in carrying out behavior modification training programs.
3. To bring to the attention of former trainees books and articles on behavior modification that might be of interest to them as well as notices of scientific meetings and other local sources of training (seminars, etc.) in behavior modification.

Participants

The Intramural Programs. As noted above, three intramural training programs were conducted for staff of the Institute DATC. Thirty persons completed the programs and received diplomas (11 additional persons attended at least one session but did not complete the program), whose sex, age and educational background, job title and facility are shown in Table I.

(Insert Table I about here)

The Extramural Programs. At the time this paper was written seven extramural training programs had also been conducted for staff of various New Jersey facilities dealing with drug addicts. Two-hundred-and sixty-one

persons in all were trained and received diplomas (39 additional persons attended at least one session but did not complete the program) whose characteristics also appear in Table I.**

More females were trained in the intramural and more males in the extramural programs. The age ranges and medians (both intramural 21-53, and extramural 15-63) were similar for both programs though only the extramural program trained a few persons under the age of 21. In both programs, college graduation was the major educational category represented. However, the educational range in the extramural program at both ends was greater.

** For extramural programs 2 and 3, sex, job title and facility only were available.

Nursing personnel and social workers, in that order, were most heavily represented in the intramural programs, while supervisory personnel, counsellors, social workers, corrections officers, and psychologists comprised a large proportion of participants in the extramural programs.

The facilities most represented in the extramural programs were corrections facilities (N=71) including prisons, parole and probation offices. Next came non-residential drug-free counselling and referral services (N=63). Methadone Maintenance Clinics were next (N=22) followed by mental hospitals (N=22), and teenage rehabilitation and youth development programs (N=20). Educational facilities (N=15), Multi-modality Centers (N=11), residential drug-free programs (N=11), non-residential drug-free and non-residential methadone maintenance facilities (N=9), U.S. Army & Naval Installations (N=8), State Department of Health & school staff (N=6) and mental health clinics (N=3) comprised the remainder.

Evaluation of the Program

Pre- and post- program measures of relevant characteristics such as general level of anxiety, degree of assertiveness, etc. were obtained from participants in the first two intramural programs, and for participants in the first and fifth extramural programs. Subjective evaluations and reactions to the program were obtained for all participants in the three intramural and seven extramural programs immediately following their training.

Pre-Treatment

1. Data sheet -- demographic data and information relating to education and professional training and experience
2. Taylor Manifest Anxiety Scale (Taylor, 1953)
3. Rotter I - E Scale (Rotter, 1966)

4. Adjective Check List
5. Level of Assertiveness (developed from a series of questions regarding assertiveness in Behavior Therapy Techniques (Wolpe and Lazarus, 1966)
6. Imagery Scale (specially developed for this study from Galton's work)
7. Custodial Mental Illness Scale (Gilbert & Levinson, 1957)

Post-Treatment

1. Taylor Manifest Anxiety Scale
2. Rotter I - E Scale
3. Adjective Check List
4. Level of Assertiveness
5. Custodial Mental Illness Scale
6. Imagery Scale
7. Program Evaluation Questionnaire, examining reactions to the program and techniques.

Three and Six Month Follow-Ups

Program evaluation questionnaires, examining continuing use of the techniques and reactions to the program were mailed to all participants in all programs. However, the response was meager and the data are, therefore not reported here.

Quarterly Report Forms

Four times per year participants in former extramural programs were requested to fill in forms reporting on their use of the behavior modification training they had received in terms of setting up their own patient or staff training groups or using the techniques in a less structured way in group or

private sessions. This data provides another means of evaluating the effectiveness of the program.

Analysis of the Data

All standardized tests were scored and frequency counts derived on items or the evaluation questionnaires preparatory to the application of the Wilcoxon Matched Pairs Signed Ranks Test.

RESULTS

As noted earlier, evaluation data were not obtained for all programs. The data reported here are those of the first Intramural and first and fifth Extramural program participants. The fifth extramural program data are especially interesting in that they reflect the effects of training after the program had been conducted several times and had undergone revision as a consequence of more extensive experience.

A. Psychological Test Battery

The results of the pre- and post- program testing for our three groups (Intramural 1, Extramural 1, and Extramural 5) on relevant measures including level of anxiety, self-acceptance, degree of assertiveness, degree of inner control, ability to image, and therapeutic attitudes, appear in Table 2. The significance of changes was measured by the Wilcoxon Matched Pairs, Signed-Ranks Test.

(Insert Table 2 about here)

For Intramural 1 participants, only the Custodial Mental Illness Scores changed significantly in the expected direction, towards more therapeutic attitudes, though there was a tendency for self-acceptance to rise and level of assertiveness to fall. The Imagery Scale actually showed a movement in the reverse direction. This may have resulted from inadequate explanation to participants about how to fill in the test when it was first used.

For Extramural 1 participants, the level of self-acceptance rose significantly, while susceptibility to external control declined significantly. There were no marked trends on the other tests.

For Extramural 5 participants, when, presumably, greater experience had improved the training, all scores changed significantly in the predicted

direction. Thus, level of anxiety fell, self-acceptance rose, level of assertiveness declined, susceptibility to external control declined, ability to image improved and attitudes with regard to mental illness became more therapeutic.

B. Patient-Therapist Attitudes

A 36-item question was included in the pre-measure and post-program evaluation to examine changes in patient-therapist interaction and attitudes. The Wilcoxon Matched-Pairs, Signed-Ranks Test showed significant changes in the direction of improved interaction with patients for all three groups: at the .001 level for Intramural 1 and at the .005 level for both Extramural 1 and Extramural 5. For each group the eight items on which most change occurred are listed below:

Intramural 1 participants improved most in terms of ability to help patients restore their self-respect, to identify irrational thinking in themselves, to exercise authority over patients, to assert themselves appropriately with patients, to accept constructive criticism and to complement and praise patients. For this group, two items changed substantially in a negative direction - ability to correct irrational thinking in other staff members and to assert themselves with supervisors.

For Extramural 1 participants, the eight major changes were appropriately positive. They showed most improvement in terms of ability to plan ahead, to compliment and praise patients, to feel self-confident in their dealings with patients, to exercise authority over patients, to correct irrational thinking in themselves and in their patients, to remain calm in uptight situations and to correct irrational thinking in other staff members.

For Extramural 5 participants, all eight major changes were also appropriately positive. They showed most improvement in terms of increased ability to plan ahead, to exercise authority over patients, to identify irrational thinking in themselves and other staff members, to accept and give constructive criticism, to correct irrational thinking in other staff members and to communicate with patients.

In general the effects of training in behavior control, correct assertiveness, rational thinking, self-image, relaxation and desensitization appear in these responses. The increased ability to plan ahead may result from the training in behavior analysis which is presented in the context of examining the consequences of behavior and thus learning to plan ahead. This is of great importance for drug addicts who tend to be very present oriented (Cheek & Laucius, 1969) and perhaps for the staff working with them, some of whom may be former addicts.

C. Post-Program Evaluation

As noted earlier, evaluation questionnaires examining reactions to the various parts of the program and to the program as a whole, were filled out by all trainees, intramural and extramural, immediately after the period of training.

Table 3 presents the data on selected items of the questionnaire which relate to subjective experience of the training program, and its assessed potential for use in personal and professional contexts for participants in Intramural 1 and Extramural 1 and 5.

(Insert Table 3 about here)

For Intramural 1 participants, the meetings most enjoyed are those on assertive training, behavior control and guidelines and behavior analysis.

in that order. Extramural 1 participants also rank assertive training highest. Also, for this group, behavior control and the meeting on guidelines are included in the three most enjoyed meetings. Extramural 5 participants see the meeting on relaxation as most enjoyable, then the meeting on desensitization, and third the meeting presenting an overview of behavior modification. Enjoyment of the program as a whole has risen from an average of 3.5 for Intramural 1 to 3.9 for Extramural 1 and 4.6 for Extramural 5. (The average enjoyment for Extramural 2 and Extramural 3, whose evaluation questionnaires are not summarized here, was 3.9 and 4.2 respectively, confirming this rising trend of enjoyment of the program).

For each program, most participants report that their attitudes become more favorable as the program went along. Extramural 2 participants show the most positive shift in this regard. Few participants in any program report negative shifts of attitude over time.

Following Intramural 1, the sessions dealing with inner experience (relaxation, desensitization and self-image training) were felt to be of more interest to participants.

More people in Extramural 1 reported that they were unsure as to how to carry out the techniques. However, this number had dropped by Extramural 5. By then, we had begun to insist that participants practice every technique immediately after it was taught them, while homework practicums reviewing their progress were instituted at noon-hour sessions.

Asked about the most helpful parts of the program to them, Intramural 1 participants checked relaxation practice, private talks with group leaders and relaxation in group sessions in that order. For Extramural 1, the most helpful parts were relaxation in the group sessions, relaxation practice and the workbooks. For Extramural 5, the most helpful parts were again relaxation

practice, private talks with group leaders and relaxation in the group sessions. Thus, from the beginning the relaxation was seen as extremely useful.

Intramural 1 participants found the program most helpful in their professional life, while Extramural 1 and 5 participants reported it was more helpful in their personal life. Its future helpfulness was seen by most, [illegible] personal life though for Extramural 5, projected helpfulness in professional and personal life were tied.

Relaxation, improvement of self-image and self-assertion were seen as most likely techniques to be practiced by Intramural 1 participants. Extramural 1 participants felt they were most likely to practice relaxation and desensitization, rational thinking and relaxation in that order, while rational thinking, relaxation and self-image improvement were selected by Extramural 5 trainees. Thus, again, relaxation was seen as a very important part of the training.

D. Quarterly Reports

As noted above, participants were lax in response to our request for 3 and 6 month follow-up evaluation reports. However, a number responded to our request for quarterly reports on their use of the techniques in their individual agencies. These provide a measure of the effectiveness of the training in terms of its use by the trainees.

The quarterly reports summarized here represent returns from 6 extramural drug staff training programs (225 persons). Additionally, returns from 2 alcoholic staff (89) persons) and 1 mental illness staff training program (45 persons) are also included. While initially only staff training in the area of drug addiction was carried out, later similar programs were introduced for staff working with alcoholics and staff working with mentally ill.

For convenience, the quarterly reports were summarized jointly.

Thus, the following summarizes the data submitted by 51 participants in extramural programs (roughly 15% of the participants), in respect of 36 agencies (in some agencies, several sections ran programs.)

We did not expect that all trainees would run full patient and staff training programs, using the manuals, as we had done. Some, we thought might simply use the techniques in their regular group or individual sessions with patients.

The quarterly reports confirmed this expectation. At eleven facilities, full patient training programs like our own, had been carried out, training 200 patients. Five facilities reported on-going patient training programs while 17 were planning future programs of this kind.

More had completed full staff training programs. Twenty facilities reported having completed such programs, training 77 staff members. 7 had staff training programs in progress while 20 were planning these programs.

At 22 facilities, our trainees had worked with some of the techniques in their group sessions, training 138 patients. Five such programs were in progress and 29 more planned.

At 15 facilities, it was reported the techniques had been used in individual sessions, training 25 patients. At 19 such use was in progress and at 25 it was planned for the future.

Thus, for the 36 agencies reporting, 31 had completed programs using the techniques in these programs, 470 individuals had been trained, 27 facilities had programs in progress and 36 planned future programs.

Categories of participants in the behavior modification training programs reported for past, present and future programs were as follows:

	PAST	PRESENT	FUTURE
Staff only	14	11	13
Coed Groups	9	7	15
Males separately	4	11	9
Females separately	5	6	9
Relatives alone	1	1	6
Combinations of staff, patients &/or relatives	12	7	17

Stages of treatment for the drug patient groups were: drug free (14), on stabilized doses of methadone (6), being built up on methadone (2), and detoxification from heroin (4). Drug free settings included in-patient, out-patient, day care and correctional programs.

Problems in using the program varied. Some mentioned difficulties in selling hospital administrations on the idea, others the problem of selling it to patients. Difficulties with getting cooperation from individuals with regard to particular techniques were also reported. Some complained that the 8 sessions of the program were too long. Need for more training was also expressed.

Additional training was most desired in the technique of leading a full behavior modification training group as presented in the training manuals (13). Further training in self-image improvement (10), behavior control (10), behavior analysis (9), evaluation procedures (9) and how to help clients relate their personal problems to the techniques of the program (9) was also requested by many.

Participants were asked about any changes they had made in the program in order to adapt it to their own facilities or client groups. Some

reported that they used only the relaxation or just the first 3 meetings focussing on inner experience. Others had blended the program with encounter, sensitivity and role-playing techniques. Some mentioned they encouraged more verbalization than in our own training program, others that they had changed the examples in the workbook to gear them more toward personal rather than drug-related programs.

D. Case Reports

Finally, we asked some of the participants from our staff training program to write brief descriptions of kinds of participants they were working with or plan to work with and to describe any use they have made or plan to make of the behavior modification in their facility. The following comments were received:

1. From Discovery House, Marlboro Narcotic Addiction Rehabilitation Project, comes the following report:

"Twenty-three re-entry candidates in our therapeutic community have been trained in the techniques. Fifteen of these people re-entered society within the past six months. Their behavior has been an improvement over the clients who have preceded them. There has been, according to our tracking system, no reversal to drugs or crime with this group. However, the time span is too short for any significant evaluation of success or failure. All we can say now is, so far so good.

Eleven staff members have been trained by me and they in turn are now using the techniques both personally and professionally.

We are now using the techniques in our Education and Outreach Center (day-care) programs. The staff as well as the clients have

been pleased with the techniques. It seems to be lowering anxiety levels and creating an atmosphere for deeper trust and communications.

The learning and applications of the techniques is relatively simple. It can be taught in a short period of time (5 to 8 weeks). And its power seems to lie in its simplicity. NJNPI, in my estimation, has "packaged" a very powerful self-help program. Aggression is controlled and with the lessening of anxiety, alternatives to drugs and alcohol have opened up to the patients.

I am presently involved in research to validate the results of the NJNPI program with Methadone Maintenance patients. I will test twenty patients with the series before and after Behavior Modification training to find whether there is any significant change in their anxiety level, self-perception, etc. Then, using twenty people from a Bare-bones Methadone Program, I will run the same battery of tests. I will then use this second population as a control group and do a comparative analysis

Let me add that throughout the state I have heard only good things said about the NJNPI Behavior Modification Program and these remarks came from drug staff, nurses, alcoholic staff, correction officers, and both parole and probation officers."

2. The Mercer County Drug Clinic reports as follows:

"Our first behavior modification program was implemented at the Mercer County Drug Program on 6/30/72 with a group of 10 methadone maintenance patients. Eight were being built up

through ambulatory build-up and two were staff members, stablized on methadone.

Seven sessions were conducted during the 4-week build-up and the eight the week after. Only one patient failed to come to the last session because he didn't want to.

All patients felt the sessions beneficial even thcugh they admitted to not practicing outside the group setting. They best liked the playlets, poetry and discussions. As this group of patients were only involved with this program during the day, a lot of outside personal problems could be brought to the group and dealt with.

The problems with these sessions centered on (1) outside distractions from the street and within the building, (2) inability to hold daily practice sessions because of the structure of the whole day care program, (3) patients were not stabilized and because of the time factor we began the sessions while quite a few patients were nodding a lot.

Upon completion of the eight sessions the patients expressed an interest in follow-up groups to be held twice a month. Our first session was held 3/10/72. Four of the original ten members came, but two more will be coming. To this group we will admit others who have been through the program at NJNPI. At this time, we discuss problems in everyday situations and how to deal with them; and also review techniques.

We also hope to begin the program in the fall with our already stabilized methadone maintenance patients, as soon as we get the necessary workbooks. The general group feeling is that behavior modification is beneficial and gives them something to think about besides just being free of drugs."

3. From Fort Dix, U.S. Army Base:

"The techniques have been quite successful and are especially adaptable to our program which offers short term treatment over an average 8 week period.

In groups we apply the entire drug patient program as outlined in the New Jersey Neuropsychiatric Institute Patient Workbook. Certain phases have to be changed to fit our particular situation in treating servicemen, but the basic outline and techniques remain unchanged.

The more frequently groups can be run and practice session scheduled, the greater the percentage of success which will be realized.

Our sessions have given many basic trainees the ability to successfully cope with a high anxiety producing environment. We do not have a success percentage based on the use of Behavior Modification techniques alone; however, to date 97% to 98% of the people entering our program have been able to remain in the service and appropriately function at their jobs. Behavior Modification techniques of course are not totally responsible for this percentage factor, but they do significantly contribute to our success.

The techniques are very easy to learn and easy to apply. The more they are practiced and used the greater the benefit to the patient and the therapist conducting the groups.

Perhaps one of the greatest strong points of the entire program is that it can benefit most people to some extent, but for the most part people with social problems, poor self-images, poor rational thinking, etc.

The program works especially well with the young clients we see because for many of them it is the first time they have been given tools to enjoy life (get high on life) as opposed to relying on alcohol or drugs to enjoy the world around them.

The majority of our patients are the young men entering the service, who were identified from urine test results and the volunteers seeking help. Most are drug experimenters as opposed to addicts."

4. From the Nowark Defendants Employment Project:

"Recently, I completed all phases of the program and I am teaching the course to our counseling staff here at the Newark Defendants' Employment Project.

I have found the Behavior Modification Course quite interesting, and very helpful in dealing with participants, i.e. ex-offenders and individuals who are currently awaiting trial for various offenses.

Our Staff Counseling Unit and Executive Staff have utilized the NJNPI Behavior Modification Program and techniques extensively during our counseling sessions along with our individual plans of counseling, and have found the Behavior Modification techniques very helpful when dealing with the offender.

We have been very successful in rehabilitating individuals in many areas including drug, alcohol, and crimes committed upon impulse. The newly acquired knowledge gained by these individuals, <u>if and when</u> applied, will definitely help to curtail the individual when faced with a similar experience in the future.

We, the personnel of the N.D.E.P., have set up a Behavior Modification Training Program, designed to increase the effectiveness and general awareness of our staff. This will also serve to determine exactly how well the program works, before introducing it to the participants we are servicing.

We have received many favorable responses from the participants and request for the manual along with any additional information on the subject.

The course enables the participants to get involved, excites their interest, and allows them to see results in themselves, once they become aware of the necessity of the objective criticism.

I personally recommend the Behavior Modification Program not only for individuals who are in trouble, such as the people we service here at N.D.E.P., but for all people concerned with self-help and for the people who are dealing with the public in their daily job functions.

E. Participants in Behavior Modification Training Programs

As noted previously, we have to date conducted at the Institute 3 drug, 1 alcoholism and 1 mental health intramural staff training programs and 7 drug, 3 alcoholism and 2 mental health extramural statewide staff training programs. Including both intramural and extramural programs, a total of 563 staff members have attended two or more meetings of staff training programs. These include 371 in staff training in drug addiction, 101 in staff training in alcoholism and 91 in staff training in mental health. A total of 500 diplomas have been granted for attendance at a complete sequence of meetings, including 321 in drug addiction, 88 in alcoholism and 91 in mental health.

As noted above, we award Group Leader Certificates to participants in our staff training programs who have completed the training program and to

on to meet additional certification requirements including attendance at supplementary review training sessions, and being observed acting as a group leader in their own facility. The drug and alcohol certificates are given by the New Jersey Department of Health, and those in mental health are given by the NJNPI. Since the training programs began a total of 82 group leader certificates have been awarded, 64 in drug addiction, 11 in alcoholism, and 7 in mental health.

The Section also recently conducted its first national training program in behavior modification techniques for staff working with the mentally ill. The program was attended by 31 participants from 10 states, all of whom were granted diplomas for attendance at the complete program.

Also, since the patient training programs were initiated in November, 197[illegible] a total of 1,368 patients at the Institute have attended two or more meetings of behavior modification training programs - 653 drug addicts, 615 alcoholics, 53 mentally ill patients and 53 inmates. A total of 861 diplomas have been granted for attendance at a complete sequence of meetings including 406 drug addicts, 403 alcoholics, 18 mentally ill patients and 34 inmates.

Both staff and patient training sessions have been conducted mostly by paraprofessionals, a large percentage of whom are volunteers.

DISCUSSION

Certainly, one measure of the success of a program is its survival.

The continued interest of participants in both our staff and patient training programs is suggested by the attendance figures reported above. The enjoyment and perceived helpfulness of the staff training program in drug addiction reflected in the rising averaged ratings in the post-program evaluation questionnaires also testifies to its success. While our quarterly report forms show a small percentage of the participants actually using the techniques either in full programs or in combination with other group or individual techniques, the individual reports are enthusiastic. Moreover, almost all participants report in the post-program evaluation that they have enjoyed the program very much and found it useful both in their personal and professional roles.

One explanation of the positive response of staff working with addicts to the NJNPI program is the gap which exists in appropriate in-service training for the many paraprofessionals who function in this area. The NJNPI program is primarily oriented toward the training of paraprofessionals, rather than persons highly trained in behavior modification, though most training seminars have included a few Ph.D.'s in psychology or psychiatrists. However, our experience suggests that in-service training for all staff, and not only paraprofessionals, working in the area of drug addiction is badly needed.

The NJNPI program has the advantages of extreme simplicity, so that it is acceptable to all levels; a focus upon and practice in specific techniques, so that the participant emerges with something he may immediately put to use in his dealings with addicts; brevity and compactness so that it can be quickly transmitted; and structure so that the well-trained possesor of the training

manual may readily replicate the program. Essentially, this is an educational approach to therapy and, therapy as education is a new direction in which behavior modification techniques and ideas now make it possible to move. Thus, rather than the therapist programming a solution to the patient's problems for him the therapist may teach his patient a repertoire of simple but powerful techniques, and show him how to analyze his problem and choose the appropriate technique to deal with it by himself. In this way the self-control of the patient is enhanced.

It is hoped that in the future, further and more systematic evaluations of both the patient and staff training programs developed at NJNPI may give us more information about their utility and effectiveness.

TABLE 1

CHARACTERISTICS OF PARTICIPANTS TRAINED IN 3 INTRAMURAL AND 7 EXTRAMURAL STAFF TRAINING PROGRAMS*

			INTRAMURAL		EXTRAMURAL	
			No.	%	No.	%
A.	Sex (all programs)	M	9	30	186	71.3
		F	21	70	75	28.7
B.	Age Distribution					
	40 years +		2	13.3	20	13.9
	36-40		2	13.3	17	11.8
	31-35		2	13.3	16	11.1
	26-30		3	20	37	25.7
	21-25		6	40	50	34.7
	Under 20		6	40	4	2.8
	Range 21-53				Range 15-63	
C.	Educational Level (Hollingshead Scale)					
	1. Graduate Prof. Train.				26	17.9
	2. Standard college or university grad.		8	50	72	49.7
	3. Partial college		4	25	20	13.8
	4. High school grad.		2	12.5	20	13.8
	5. Partial high school		2	12.5	5	3.4
	6. Junior high school				2	1.4
D.	Job Titles (all programs)					
	1. Directors, superintendents asst. directors, asst. supt. coordinators & supervisors				56	21.4
	2. Counsellor supervisors, Ind. counsellors, counsellors, therapists, case expeditors		4	13.4	56	21.4

TABLE 1 (Continued)

Job Titles (continued)	No.	%	No.	%
5. Psychiatrists psychologists, asst. prof., psychol., psychol. tech., students, etc.			14	5.1
6. Drug Abuse aides Drug abuse asst.	1	3.3	14	5.1
7. TPI Grp. Ldrs, Beh. Mod.			14	5.1
8. Youth Workers (4-H, "Y")			9	3.4
9. Nursing Supv. Asst. supv., R.N.'s LPN's, psy. tech., attendants	17	56.7	7	2.7
10. Teachers & Human Rel. Instructors	1	3.3	7	2.7
11. Other: Program Spec., res. asst., students			8	3.1

* Types of Facilities of Participants in all extramural training programs.

Type of Facility	Individual Representation from Each Type No.	%
1. Corrections	71	27.2
2. Non-Residential Drug Free (counselling & Referral)	63	24.1
3. Methadone Maintenance Clinic	22	8.4
4. Mental Hospitals (In-patient)	22	8.4
5. Teenage Rehab. & Youth Develop. Pro.	20	7.7
6. Educational (Universities)	15	5.8
7. Multi-Modality Center	11	4.2
8. Residential Drug-Free	11	4.2
9. Non-Residential Drug-Free & Meth. Maint.	9	3.5
10. U.S. Army Complex - drug free V.A. Hosp. (in-patient) U.S. Naval Training Center	6	2.3
11. State Dept. Health School Staff Staff Develop. & Training Center	8	3.1
12. Mental Health Clinics, O.T. Cntrs.	3	1.1

(Table represents individuals, not facilities)

* Information not available for extramural programs 2 and 3 and intramural programs 2 and 3.

TABLE 2

CHANGES IN TEST SCORES OF PARTICIPANTS
(pre-Program vs Post Program)

	INTRAMURAL (1)					EXTRAMURAL (1)					(5)				
	+	o	-	Total	Level of Sig	+	o	-	Total	Level of Sig	+	o	-	Total	Level of Sig
Taylor Manifest Anxiety Scale	4	1	5	10	ns	9	6	9	24	ns	3	1	13	17	.005
Self-Acceptance (Adjective Check List)	8	1	3	12	ns	18	1	5	24	.005	14	0	4	18	.005
Level of Assertiveness	4	0	9	13	ns	13	1	9	23	ns	14	1	3	18	.005
Rotter I-E Scale	4	3	4	11	ns	4	5	14	23	.001	5	2	10	17	.005
Imagery Scale	2	1	8	11	.01	8	2	9	19	ns	16	0	2	18	.005
Custodial Mental Illness Scale	3	0	9	12	.005	8	3	11	22	ns	6	1	11	18	.05

TABLE 3

Post-Training Evaluation By Intramural and Extramural Participants

Enjoyment of Meetings Meeting		INTRAMURAL Av. Rating	EXTRAMURAL 1 Av. Rating	EXTRAMURAL 5 Av. Rating
1	Overview of Behavior Mod	3.5	3.9	4.4
2	Introduction to Muscle-Relaxant	3.3	3.7	4.8
3	Lightness Heaviness Desensitization	3.4	3.7	4.5
4.	Idealized Self-Image	3.3	3.6	4.1
5	Behavior Analysis	3.6	4.0	4.3
6	Behavior Control	3.7	4.0	4.3
7	Assertive Training	3.8	4.4	4.3
8	Rational Thinking	3.1	3.6	3.9
9	Guidelines	3.6	4.0	4.3
	Average rating on 5-point scale	3.5	3.9	4.6

Change of Attitude During Training

	Frequency	Frequency	Frequency
More Positive	8	22	12
More Negative	0	1	1
No Change	5	3	6

UNDERSTANDING OF THE PROGRAM	Frequency			Frequency			Frequency		
	Yes	No	Not Sure	Yes	No	Not Sure	Yes	No	Not Sure
Goals and Aims of the Program	11	0	2	23	0	0	19	0	0
How Techniques are Related to Program Aims	13	0	0	22	0	1	18	0	1
How to Carry Out Techniques	12	0	1	16	0	7	18	0	1

TABLE 3 (continued)

HELPFULNESS OF DIFFERENT PARTS OF PROGRAM	INTRAMURAL 1 Ave. Rating	EXTRAMURAL 1 Ave. Rating	EXTRAMURAL 5 Ave. Rating
Relaxation (Sessions)	4.3	4.7	4.7
Relaxation (Practice)	4.5	4.5	4.8
Desensitization (Sessions)	3.9	3.7	3.9
Desensitization (Practice)	3.4	3.7	4.1
ISI (Sessions)	3.5	3.7	3.6
ISI (Practice)	3.3	3.5	3.7
Lectures	3.7	3.3	3.9
Group Discussions	3.7	4.1	4.2
Workbook	3.6	4.2	4.3
Playlets	3.6	3.4	3.5
Private talks with group leaders	4.3	4.1	4.8
Mean rating on 5-point scale	3.7	3.9	4.2

HELPFULNESS OF PROGRAM SO FAR	Ave. Rating	Ave. Rating	Ave. Rating
In Professional Life	3.5	3.6	3.7
In Personal Life	3.4	3.7	3.9

FUTURE HELPFULNESS OF PROGRAM	Ave. Rating	Ave. rating	Ave. Rating
In Professional Life	3.8	4.4	4.4
In Personal Life	3.6	4.2	4.4

TECHNIQUES THAT WILL BE PRACTICED	Frequency	Frequency	Frequency
Relaxation	10	18	15
Relaxation and Desensitization	6	20	13
Improvement of Self-Image by own Effort	9	17	14
Rewarding of Others	6	16	13
Self-Assertion	8	17	13
Rational Thinking	4	19	16

TABLE 3 (Continued)

MOST INTERESTING PART OF PROGRAM	Frequency	Frequency	Frequency
Sessions dealingwith Inner Experience	6	19	15
Sessions dealing with Outer Experience	6	8	7

NOTE: Some participants marked both

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