THE CATHOLIC UNIVERSITY OF AMERICA

The Impact of Perceived Self-Control Over Treatment Access, Appraisal of the
Consequences of Substance Use, Self-Reliant Attitude Against Help-Seeking and Perception
of Workplace Culture on the Behavioral Intention to Seek Treatment for Substance Abuse
Among Union Construction Workers

A DISSERTATION

Submitted to the Faculty of the

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Doctor of Philosophy

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By

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Karen L. Grear

More than 95 percent of adults who suffer from substance use disorders fail to

connect either with professional treatment services or support groups such as Alcoholics

Anonymous (AA) (McCoy, C.B., Metsch, L.R., Chitwood, D.D., & Miles, C., 2001; Tighe &

Saxe, 2006). When compared to any other occupation, adult construction workers (including

union members) demonstrate among *the highest heavy alcohol and illicit drug use* (Office of

Applied Studies, 2007; Popp & Swora, 2001). Research indicates a variety of psychological

and environmental barriers likely impede treatment access (Clay, 2007). Less understood is

the role of individual attitudes towards seeking professional treatment and appraisal of the

consequences of substance use in negatively impacting help-seeking behaviors (Kleinman,

Millery, Scimeca, & Polissar, 2002). In addition, union construction workers hold

membership in a centuries-old, organizational culture that promotes substance abuse

(Sonnenstuhl, 1996). 'Union brotherhood' includes gender role indoctrination into a

hypermasculine workplace culture that fosters substance use while discouraging treatment

(Taillon, 2002). Union members are expected to demonstrate masculine self-reliance in

'holding their liquor' and managing their substance use without requiring professional help

(Bacharach, Bamberger, & Sonnenstuhl, 1994). Social workers and others in union MAPs

need to develop a better understanding of factors that impact members' intention to seek

treatment for substance use disorders in order to facilitate treatment entry.

This study utilized a cross-sectional survey design to test the relationship between union construction workers' behavioral intention to seek help along three stages of a continuum ranging from ambivalence, to recognition to taking steps, and multiple psychological and environmental predictors. MRA analyses demonstrated that union construction workers' behavioral intention is predicted by their appraisal of negative consequences and adverse effects of their substance use in the workplace, their attitude about masculine self-reliance towards help-seeking, their concern about emotional self-control, and their perception of workplace support of consumption.

This dissertation by Karen L. Grear fulfills the dissertation requirement for the doctoral degree in Social Work approved by Barbara P. Early, Ph.D., as Director, and by Joseph J. Shields, Ph.D., and Marie J. Raber, Ph.D., as Readers.

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Barbara P. Early, Ph.D., Director

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Joseph J. Shields, Ph.D., Reader

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Dedication

To Harry Krause, my husband of 20 years, my best friend in the entire world, and the love of my life, I thank you. This achievement would not have been possible without your endless emotional support, unfailing confidence in my ability to succeed, and constant encouragement to pursue my hopes and dreams. I appreciate the countless sacrifices of your time, energy and effort, and for making my priorities your own. You have been my coach, mentor and protector these many years. You have dried my tears, listened empathetically, made me laugh, and always urged me gently forward with the mantra, "Now, get back to work."

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Dedication (cont.)

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Chapter One: Introduction to the Study

Social workers are well familiar with the personal, familial and societal costs of untreated substance abuse (Hanson, 2001). However, more than 95 percent of adults who suffer from substance use disorders fail to connect either with professional treatment services or support groups such as Alcoholics Anonymous (AA) (McCoy, Metsch, Chitwood, & Miles, 2001; Tighe & Saxe, 2006). For reasons not yet fully understood, despite the prevalence and severity of substance abuse problems among union construction workers, they rarely connect with treatment services. The sad irony is that these worst occupational offenders are among the least likely to seek help.

Researcher's Interest in the Problem

I am the director of a union Member Assistance Program (MAP) that provides crisis intervention and referral services to union members and their families throughout the United States and Canada. Years of experience working in the addictions field could not *and did not* adequately prepare me for the enormity and gravity of substance use dependency among male union members in the construction industry. In my work over the past 12 years, I have encountered hundreds of *construction* workers who present with serious substance use disorders and yet are extremely resistant to commencing treatment. These union members often begin abusing drugs and alcohol in childhood, so that by the time they are young adults, they have developed life-threatening substance use dependencies. Members are also exposed to a pervasive, centuries-old permissive workplace culture that not only openly encourages substance use, but promotes a strong sense of masculine pride, or hypermasculinity that

discourages help-seeking.   Finding a way to help these difficult-to-reach members became my professional goal.

Throughout my career, I have noticed a tendency of many addictions professionals and program ideologies to focus more on the *provision* of treatment services than the solicitation of treatment *access*. Our existing health systems appear overloaded, so that there is little time, energy or funding to focus on the more than 95 percent of adults who do not access treatment (McCoy, , Metsch, , Chitwood, , & Miles, 2001; Tighe & Saxe, 2006). Yet, this alarming situation fails to bring about a collective gasp of alarm from professionals. Instead, the prevailing reaction appears to be an apathetic shrug, and repetition of the long over-parroted phrase, 'Until the client comes out of his denial, nothing can be done.' Ironically, however, denial is a *symptom* of addiction and should not be viewed as a *predictor* of treatment entry or outcome. *As with* any other barrier to treatment, denial is an obstacle to be addressed and overcome.

My personal work experience entirely supported the SAMSHA's proclamation that male construction workers were not only among the heaviest abusers, but also the least likely to pursue treatment (SAMHSA, 2007). I realized that my role as a MAP director afforded me a unique vantage point from which to understand union culture as well as the opportunity to intervene as a trusted union 'insider.' I felt determined that if union members' substance abuse problems were approached from the tried and true social work 'person-in-environment' perspective, new and successful interventions could be designed.

My belief is that a MAP can be an effective intervention tool to combat detrimental aspects of union culture. MAP directors must be cognizant of the fact that union members tend to be distrustful of outsiders, and that it sometimes takes years to develop rapport. However, by joining with union members and becoming a part of the culture, MAP directors are in a better position to bring about internal changes. MAPs can play a vital role in educating the membership and leadership regarding substance abuse, as well as the benefits of a drug-free workplace. MAPs can challenge outdated perspectives that overly focus on denial by helping members identify and remedy practical and psychological barriers that interfere with treatment access. MAPs can promote a view of help-seeking as a strength, *not* a weakness. And, MAPs can identify treatment entry as a chief program goal – one that shares equal *import* with assisting those clients who are treatment ready.

This study sought to understand the factors contributing to the failure of union construction workers with substance use disorders to seek treatment. Specifically, the purpose of the study was to test a conceptual model based upon social cognitive theory and the theory of planned behavior to explain behavioral intention to seek treatment for substance use disorders in male union construction workers.

This chapter will explore the problem of alcohol and illicit drug use among union construction workers. It will describe a connection between masculine self-reliant attitudes and a tendency to associate alcohol use as an indication of one's masculinity and union solidarity. It will further trace the history of a centuries-old permissive workplace culture that tolerates and promotes the use of alcohol and drugs. Recent attempts by the union to

change workplace culture will be highlighted, including the historical underpinnings to the development of contemporary union MAPs. Social Work's collaboration with the labor union movement and administration of MAPs will be reviewed, along with a discussion of key barriers that impede union member's behavioral intention to seek substance abuse treatment. This chapter will conclude with implications for social work practice, education, research, ethics and social policy.

Alcohol and Illicit Drug Use Among Construction Workers

When compared to any other occupation, adult construction workers (including union members in the building trades) demonstrate among the highest heavy alcohol and illicit drug use (Office of Applied Studies, 2007; Popp & Swora, 2001). For example, with respect to alcohol abuse, an astonishing 15.9 percent of construction workers admit to drinking five or more drinks daily, placing them in the lead occupational category of "heavy drinking." This level of alcohol abuse is nearly twice the average rate for all other professional industries (Larson, Eyerman, Foster, & Gfroerer, 2007; SAMHSA, 2007). The prevalence of illicit drug use among adult construction workers is 13.7 percent, the second highest ranking among all professional occupations (SAMHSA, 2007). Heavy illicit drug use includes abuse of marijuana; cocaine and crack; inhalants; hallucinogens, such as PCP, LSD, and Ecstacy; heroin and abuse of prescription sedatives, tranquilizers and pain relievers.

The tendency to abuse drugs and alcohol is more common among blue-collar workers than their white-collar counterparts (Gleason, Veum, & Pergamit, 1991). In fact, two of the most widely known risk factors associated with addiction exemplify a majority of

construction workers: these include being male, and possessing an educational degree no further than a high school diploma or GED (Larson, Eyerman, Foster, & Gfroerer, 2007).

The connection between certain types of substance abuse and blue-collar workers is well known. For example, Methamphetamine is widely used among male, blue-collar workers on construction job sites; it is believed that workers are attracted to the stimulant properties of the drug which enables them to maintain the energy required to perform physically arduous tasks and to work double shifts when required (NIDA Notes, 2007). Similarly, prescription drug abuse, and especially opiate abuse, are strongly associated with construction workers. It is believed that workers tend to abuse prescription opiates to manage the chronic severe pain that often accompanies construction work. Typically, workers who have suffered joint deterioration caused by years of repetitive motion are at higher risk, along with workers with previous workplace injuries. These workers are prone to abuse opiate medications to alleviate their pain, in order to allow them to continue to work at their jobs.

The construction industry is comprised of union and nonunion employees. Estimates are that nearly one in four construction workers are union members (DOL, 2009). While the percentage of union construction workers who suffer from substance use disorders is not known, union construction workers in the building trades are notorious for exhibiting substance use disorders (Popp, 2001). Further, union construction workers have a centuries-old history of membership in an organizational culture that promotes substance abuse (Sonnenstuhl, 1996). In fact, heavy alcohol use is considered to be an occupational norm,

and "part of the identity of being a good tradesman" (Popp, 2001, p. 1). There is also a strong connection between substance use by union workers and increased injury while on the job (Raglans, Krause, Greiner, Holman, Fisher, & Cunradi, 2002).

Recent changes in union demographics may potentially exacerbate the already high incidence of substance abuse due to an influx of minority workers and younger workers. In the past decade, for example, union membership has dramatically changed from a mostly Caucasian-dominated occupation, to one that includes a variety of racial minorities. Minorities, including African-American, Native American and Hispanic adults, among others, are four times less likely to receive treatment services (Duran, Oetzel. Lucero & Jiang, 2005; MacMaster, 2005; Schoeneberger, Leukefeld, Hiller, & Godlaski, 2006; Tighe & Saxe, 2006; Verdurmen, Smit, Toet, VanDriel, & VanAmeijden, 2004). This dual combination of some minorities' susceptibility to substance abuse, and difficulties in seeking treatment, undoubtedly will play a role in further complicating substance abuse problems among union construction workers.

An influx of younger male workers may lead to increased substance use and substance-related problems among union members. Young men aged 25-34 are not only among the heavier substance abusers, but they also demonstrate a higher risk for occupational injury; reports indicate the risk is nearly double (Pollack, Franklin, Fulton-Kehoe, & Chowdhury, 1998).

Substance abuse among union construction workers is especially concerning, given the highly dangerous nature of their work. Construction work is an inherently risky

profession (Gillen, Kools, Sum, McCall, & Moulden, 2003). It routinely involves operating heavy equipment such as high-speed electric saws and forklifts; working on open scaffolding at great heights; wielding sharp tools; lifting and positioning heavy building materials such as block and stone; handling and mixing perilous chemicals, exposure to lead, asbestos and silica dusts, and working outside in temperature and weather extremes (APHA, 2005; Burkhart, Schulte, Robinson, Sieber, Vossenas, et al. 2007; OSHA, 2009).

Workers who are physically or mentally impaired by the effects of alcohol and drug abuse are unfit to perform their job duties in a safe manner, and are a hazard to themselves and their coworkers (Building Trades, 2009; Pollack, Franklin, Fulton-Kehoe, & Chowdhury, 1998). Workers employed in high risk occupations, including union construction, demonstrate significantly higher rates of substance abuse and increased risk of injury on the job (Lehman, 2002). Ironically, the higher the inherent safety risks of the job, the more workers are at risk for substance abuse (Bennett & Lehman, 1999; Lehman, Farabee, Holcom, & Simpson, 1995). Further, workers often use alcohol or drugs on the job site, or report to work high or with a hangover. When compared to other workers, these high risk workers are also less likely to report incidents of substance abuse among coworkers or to management (Bennett & Lehman, 1998).

Historically, the construction industry has ranked uppermost in the number of work-related deaths (Herbert & Landrigan, 2000). "Few industries are plagued by more workplace injuries than the construction industry, which had the highest death rate in 2004 when compared to other occupations" (Chen, Rosecrance, & Hammer, 2009, p. 1). In 2007, for

example, the fatality rate among construction workers was 13.3 per 100,000 employed

workers - topping the occupational chart for the industry with the most workplace fatalities

(DOL, 2009). In 2008, the construction industry continued to hold the highest number of

occupational fatal injuries (CFOI, 2008).

"Substance abuse continues to plague the construction industry, threatening lives and

safety, increasing workers' compensation insurance premiums and reducing worker

productivity" (Winston, 2004, p. 32). While construction unions have implemented safety

procedures, on-the-job injuries continue to plague the industry and contribute to unusually

high mortality rates (Gillen, Kools, McCall, Sum, & Moulden, 2004). Research suggests a

strong casual connection between illicit drug use and accidents in the construction industry

(Melia & Becerril, 2008). Union members who are addicted to drugs and alcohol are

especially prone to cause accidents that can lead to serious injury and death (DOL, 2009;

Gleason, Veum, & Pergamit, 1991; Larson, Eyerman, Foster, & Gfroerer, 2007). Further,

there is a strong association between holding a physically demanding job such as a union

construction worker, abusing alcohol and subsequent premature death (Bourgkard, Wild,

Massin, Meyer, Sierra, et al., 2008).

A Workplace Culture of Permissibility of Substance Use

There are a number of factors that contribute to the problem of substance abuse

among construction workers. Of particular importance is a culture of permissibility of

substance abuse. The foundation of workplace culture is social norms. These norms inform

workers regarding mutual understandings of what is customary and appropriate behavior

(Michela & Burke, 2000). A permissive workplace culture is based upon "an organized set of understandings that participants within a work setting share regarding behavioral comportment … and what behaviors constitute appropriate drinking (or drug use)" (Bacharach, Bamberger, & Sonnenstuhl, 2002, p. 638). Permissive workplace cultural norms convey the permissibility of substance use based upon workplace expectations, social supports and traditions, as well as a tendency to tolerate and cover up binge use (Fine, Akabas, & Bellinger, 1982).

Union Historical Ties to Permissive Drinking Culture

"Work-related [workplace] drinking refers to drinking patterns in work-related circumstances, such as on the job, on work premises, during lunch and breaks, on the way to work, and during work or union-sponsored meetings" (Ames & Janes, 1992, p. 116). Labor unions in the construction industry have developed a unique, centuries-old, permissive workplace drinking culture. This culture is comprised of common beliefs, values, and behavioral norms that create a "shared way of life" (p. 64) regarding the acceptability of alcohol abuse (Bacharach, Bamberger, & Sonnenstuhl, 2001).

Permissive drinking culture has long been associated with union membership. Union members affiliated with the Bricklayers Union, called masons, for example, have a strong connection with a permissive drinking culture that dates back to the Middle Ages. The European masons, who brought their craft with them to Colonial America, also passed on the habit of rewarding hard work with wine and other alcohol 'incentives.' "The accepted

principle here is that drinking motivates work and is tied directly to the reward structure" (Sonnenstuhl, 1996, p. 14).

Throughout the 17th, 18th and 19th Centuries, drinking rituals continued to be an integral part of union workplace culture. An early documented example of the predominant work-based alcohol reward system dates to 1656 and the construction of a government building in Albany, New York. Government records indicate that every union tradesman who worked on the project was given alcohol incentives in the form of daily kegs of brandy and barrels of beer (Sonnenstuhl, 1996). "Workers not only received alcohol as part of their wages, they were also provided with alcohol on the job and were allowed to drink it openly while working and during breaks and meals" (Sonnenstuhl, 1996, p. 96). In addition, workplace drinking camaraderie continued after work when construction workers joined to drink during their leisure time.

In the 1800's, union student apprentices were indoctrinated to permissive drinking workplace norms as part of their learning experience. Apprentices were expected to drink regularly with their co-workers, job supervisors and employer contractors throughout their training day and after work hours. Further, when apprentices graduated to become unsupervised 'journeyman' members, they were asked on their first day of employment to participate in a ritual ceremony of making a 'payment' of whiskey to the union (Sonnenstuhl, 1996).

Throughout the 20th Century, indoctrination of apprentices to permissive drinking culture continued to be a common practice among many unions. For example, in his

qualitative research with railroad unions, Sonnenstuhl (1996) captured union members' firsthand experiences with permissive drinking culture:

> When newcomers first began working within the old culture, the first thing they learned was their responsibilities about drinking. For instance, they were often told that it was their responsibility to keep a bottle under a particular switch in the yard or to hop off the train at a particular crossing to pick up a six pack or a bottle. (p. 75)

> In addition, they learned that "in order to be accepted, you had to drink" and "drink like a man." (p. 75)

Similarly, in their research with blue collar, assembly line workers, Ames & Janes (1990) describe the union workplace as an "enabling environment," (p. 101) that encourages permissive drinking. Workers admitted that on-the-job drinking was a daily occurrence. In addition, workers frequently socialized by drinking together after work.

The union permissive drinking culture persists to modern times; the culture remains especially strong among the construction labor unions. Union apprentices continue to be exposed to drinking rituals both on and off the job (Sonnenstuhl, 1996). Apprentices face enormous pressures to participate in the culture under the fear of being ousted from their work group. For instance, apprentices and journeyman union members who refuse to drink often are ostracized and taunted by their peers, distrusted, and passed over for the best jobs (Iacuone, 2005). Therefore, there exists considerable pressure to spend time thinking and talking about alcohol, as well as to consume alcohol heavily in order to fit in with peer

culture. "When tradesmen were not planning the next occasion when they would drink beer to the point of paralysis, *alcohol* would arise as a topic in other ways" (Iacuone, 2005, p. 254).

Heavy substance abuse continues to be associated with blue collar workers employed at industrial jobsites, many of whom are union workers (Webb, Redman, Hennrikus, Rostas, & Sanson-Fisher, 1990). The underlying values of this culture associates drinking with positive consequences (Ames & Janes, 1992). For example, labor unions often offer 'open bar' service at many union functions, including officer meetings and retiree dinners, to reward members, and as a symbol of union camaraderie (Janes & Ames, 1989). These centuries-old union values favoring a workplace permissive drinking culture serve as a generational, cultural "bridge linking the past, present and the future" (Bacharach, Bamberger, & Sonnenstuhl, 2001, p. 62. Sadly, newer generations of union members are expanding that culture to include illicit drug as well as alcohol abuse.

Substance Use as Solidarity

Dating back to the Middle Ages, union culture has been centered on the concept of 'brotherhood' in that the union is envisioned not as a collection of individual, autonomous members, but as a single, communal family comprised of 'brother' and 'sister' members (Sonnenstuhl, 2001; Trice, 1993). "According to guild statutes, members were required to demonstrate brotherly and sisterly feelings toward one another, to bring their quarrels to the guild's tribunal and abide by its decisions, and to support one another in times of adversity"

(Bacharach, Bamberger, & Sonnenstuhl, 2001, p. 28). This solidarity creates a family atmosphere of intense loyalty.

This sense of union brotherhood and solidarity continues to be an integral part of the identity of union tradesmen. Union workers perceive their membership in their union as being part of a brotherhood – a family. Unlike the general public, which identifies immediate biological and spousal family members as 'significant others,' among union members, "the shop steward, union officers, and workers are significant others" (Trice, 1977, p. 103).

Over the centuries, union permissive drinking culture appears to have blended with other cultural aspects of the union, including solidarity (Delaney & Ames, 1998). Conceptualizing substance use as union solidarity likely further entrenches permissive drinking norms in union culture. Generations of union families have 'inherited' permissive substance use cultures from their predecessors (Roman, 1990). Drinking, in particular, has evolved into a "ritual that generates feelings of solidarity and highlights members' obligations to protect one another" (Bacharach, Bamberger, & Sonnenstuhl, 2001, p. 140). For example, among unionized railroad workers, drinking "became a symbol signifying who was a trusted community member. In order to be accepted into the group, members drank and were expected to protect one's coworker who drank on the job" (Bacharach, Bamberger, & Sonnenstuhl, 2001, p. 140).

"In certain occupational subcultures, drinking, rather than being viewed as pathological, may be seen as communicative behavior symbolizing social *solidarity*" (Ames

& Janes, 1992, p. 117). Prior to the advent of modern drug-free workplace rules, union members had a tradition of meeting in bars during their lunch breaks and after work. Union members continue to uphold the tradition of drinking together after work "... to soothe their grievances and demonstrate mutual support" (Bacharach, Bamberger, & Sonnenstuhl, p. 58. In addition, it was not uncommon for workers and management to connect in bars so that "drinking was manifestly expressive of the relationship between union and management...an assertion of solidarity" (Ames & Janes, 1990, p. 101).

The Role of Permissive Workplace Culture in Facilitating Substance Use

"The workplace culture perspective postulates that administrative and occupational subcultures establish norms for alcohol [and drug] consumption" (Trice, & Sonnenstuhl, 1988, p. 327. Relatively few studies have investigated the impact of occupational social support systems as an explanatory factor in employee problem drinking or drug use (Martin, Roman, & Blum, 1996). "Occupational factors are rarely used to explain drinking patterns" (Fillmore, 1990, p. 77). However, preliminary research shows that participation in work-based drinking networks has the potential to dramatically impact worker substance abuse (Martin, Roman, & Blum 1996). Workplace subcultures are likely a significant factor in predicting substance abuse (Macdonald, Wells, & Wild, 1999). This early research has contributed to a growing awareness that workplace culture can contribute to an atmosphere that facilitates substance use among workers (Delaney & Ames, 1995; Mack, Kahn, & Frances, 2001; Yang, Yang, & Kawachi, 2001).

Whereas in the past, substance abuse often has been evaluated purely on an individual level, there is a growing call to include the workplace environment as a key risk factor for substance abuse. Even when controlling for individual factors commonly associated with substance abuse, such as family history and prior personal use, workplace factors show significance as risk factors (Bennett & Lehman, 1999). Trice (1992) suggests that workplace cultural factors should be given as much importance as other risk factors, including genetics, family dynamics, social class, economic forces and mental health issues. Bennett & Lehman (1998) identified workplace drinking climates as powerful predictors of individual substance use. Interestingly, certain work settings, including union construction, are especially prone to substance abuse. The belief is that permissive work cultures often develop as a maladaptive coping mechanism to manage the stress associated with performing particularly dangerous work (Bennett & Lehman, 1999; Berger, 2006; Blum & Roman, 2002).

Permissive workplace cultures are believed to contribute to addiction because substance abuse problems "exist within a communal context" (Roman, 1990, p. 238) based upon the social support individuals receive. "Individuals drinking behavior may be influenced by their interpretation of the drinking norms, behaviors, and rationalizations suggested by members of their occupation or by proximate coworkers" (Bennett & Lehman, 1999, p. 638). "Members of occupations come to share beliefs, values and norms" (Trice & Beyer, 1993, p. 182). They also "develop shared ideologies by using one another as reference points. Members look to one another for support and confirmation of meanings

they ascribe to events around them and for approval and disapproval of patterns of

behaviors" (p. 182).

Workplaces that foster opportunities for ritualized substance abuse promote

workplace substance abuse cultures (Ames, 2005). Blue collar workers, such as those in the

labor union construction industry, are especially vulnerable to the effects of pervasive

permissive workplace cultures (Edid, 2001). Active participation in permissive work

cultures promotes substance abuse (Ahern, Galea, Hubbard, Midanik, & Syme, 2008; Ames

& Cunradi, 2004; Martin, Roman & Blum, 1996). Workplace cultures that condone heavy

substance use seem to promote binge drinking and drug use (Jacobs & Shain, 2008;

Macdonald, Wells, & Wild, 1999). In male-dominated work settings, men "may be

motivated to adopt behaviors consistent with referents' norms" (p. 236) to garner the

approval of coworkers and solidify their work relationships (Bacharach, Bamberger, &

McKinney, 2007). Further, the more "embedded these permissive workplace norms are, the

more likely are workers to abuse substances on the job" (p. 236). Permissive workplace

cultures also contribute to the tendency of workers to extend their communal substance use

from during work to after work activities (Martin, Roman, & Blum, 1996).

Permissive work cultures are especially predominant in "close-knit occupational

communities" (p. 344) such as labor unions (Trice & Beyer, 1993). Within many union

subcultures, "on-the-job drinking becomes normative, accepted, and even integrated into

work group management" (Roman, 1990, p. 381). Emerging research points to the fact that

workplace norms are the "strongest predictor" of substance abuse because "norms both

mediate and moderate the effects of other work-related risk factors" for substance use (Bennett & Lehman, 1999, p. 652). With respect to alcohol use, for instance, in workplace settings in which substance abuse is discouraged, "workers were 45 percent less likely to be heavy drinkers, 54 percent less likely to be frequent drinkers, and 69 percent less likely to drink at work than their counterparts in workplaces with the most relaxed attitudes toward drinking" (Barrientos-Gutierrez, Gimeno, Mangione, Harrist, & Amick, 2006, p. 607).

The Connection between Workplace Culture and Workplace Injury and Death

Workplace cultures that promote substance abuse or exercise permissive attitudes towards substance abuse are associated with higher levels of worker stress, low morale, increased substance use among workers, and increased risk of accidents on the job (Bennett & Lehman, 1998; Frone, 2009). In addition, workplace cultures that promote an exaggerated masculinity also are connected with increased risk of substance abuse, accidental injury and death. It is believed that hypermasculine work cultures, such as those dominant in union construction trades, emphasize risk-taking and bravado as a show of manliness, contributing to an increased propensity toward accidents (Iacuone, 2005). Workers may forego wearing safety goggles and hats, for example, for fear of being taunted by co-workers. Similarly, workers may fail to use safety harnesses or abide by Occupational Safety and Health Administration (OSHA) standards in order to uphold exaggerated masculine gender roles that "prescribe that men should be tough, dominate over others, and should not be afraid of danger" (Iacuone, 2005, p. 262).

Permissive Workplace Culture as a Barrier to Help-Seeking

Union permissive workplace culture can act as a significant barrier to help-seeking. Not only does permissive culture encourage substance use, but it likely prohibits actions associated with help-seeking behaviors. For example, union members are keenly aware of longstanding norms against 'turning in' their union brothers by reporting substance abuse. Further, union members tend to be highly skeptical of outsiders, including white collar professional social workers and other mental health professionals, who do not 'belong' to the blue collar union family. In addition, job supervisors are often reluctant to uphold substance abuse workplace policies by referring impaired workers for professional help. Instead, union norms support members' colluding against authorities by ignoring or hiding substance abuse among work peers. Sadly, union members mistakenly view such enabling actions as upholding the concept of 'union mutual aid' and 'taking care of one's own' (Bacharach, Bamberger & Sonnenstuhl, 2001).

Workplace drinking climates sanction substance use by discouraging workers from reporting alcohol and drug-related incidents on the job. "Workers in close-knit working relationships are prevented from reporting substance use to management because of their fears about being scapegoated, shunned, or overlooked when hiring workers for the next job" (Bennett & Lehman, 1999, p. 310). Unionized workers at CSX, for example, are known to have belonged to a "deeply embedded drinking culture" (p. 75) that encouraged enabling behaviors, such as hiding substance abuse (Bacharach, Bamberger & Sonnenstuhl, 2001).

Because of the camaraderie of the brotherhood, there was an unwritten rule that you don't snitch on your fellow worker. In cases where you knew about somebody who was drinking or came to work that way [drunk], or asked you to get them something [alcohol or drugs], you just didn't say anything about it. You did everything you could to cover up for them. (Bamberger & Sonnenstuhl, 2001, p. 75)

Further, workers who report substance abuse by 'snitching' on fellow union members are often labeled by union peers and leaders as untrustworthy and targeted for termination. "Transit workers learned early on in their careers that their continued employment was dependent on complying with the norm of covering up for one another" (Bamberger & Sonnenstuhl, 2001, p. 141).

Permissive workplace cultures promulgate laissez-faire attitudes that infiltrate work culture to encourage substance abuse and discourage help-seeking in spite of having written substance abuse policies to the contrary (Mack, Kahn, & Frances, 2001). An integral part of the workplace laissez-fair attitude is a tendency by management to unwittingly endorse substance abuse either by denying the problem or helping members to cover up evidence (Bacharach, Bamberger, & Sonnenstuhl, 1994). Union officers often feel

compelled to cover up for workers. In its efforts to help members charged with drinking violations, the union would attempt to keep one step ahead of management, by arranging for members to be transferred to another location or shift. If that failed, they would take the worker's case to grievance. (Bamberger & Sonnenstuhl, 2001, p. 141)

Union leaders typically challenge disciplinary actions against substance-impaired workers (Ames, Delaney, & Janes, 1992). And, although unions 'technically' support abstinence, the reality is that they seldom intervene because "union leaders recognize that drinking continues to *symbolize* camaraderie to their members" (Bamberger & Sonnenstuhl, 2001, p. 60.

Permissive workplace norms also prevent the recognition of the seriousness of substance abuse problems by minimizing and denying problem severity. Heavy alcohol and drug use are more common in permissive workplace cultures; therefore, substance abuse behaviors do not appear as anything unusual or out of the norm. "Alcohol [and drug] problems exist within a communal context. Individuals receive social support for their drinking [and drug] behavior," (p. 238) and union members "will not seek help unless these social supports can be overcome and they recognize that their drinking behavior is problem" (Sonnenstuhl, 1990, p. 237).

The historic union distrust of outsiders often interferes with members' willingness to seek help from mental health professionals, including their internal union MAPs. For example, in talking about the idea of creating a MAP, the founder of the Tunnel and Construction Workers union commented that, "If we brought in what they call a 'professional' person...an outside social worker to run the program, you might as well not have a program" (p. 52) because of the perceived inability of members to "have a sense of trust and camaraderie" (p. 53) with a nonunion member (Bacharach, Bamberger & Sonnenstuhl, 2001).

Masculine Self-Reliance Against Help-Seeking Among Construction Workers

The workplace culture that encourages permissive substance use among union construction workers also promotes a masculine self-reliance that deters members from seeking help. There appears to be a strong connection between masculine self-reliance and the intention to seek treatment for substance abuse services (Pederson & Vogel, 2007). Masculine self-reliance is likely connected to perceptions about the acceptability of heavy substance use, particularly with regard to alcohol. Self-reliant attitudes may also contribute to lack of problem recognition and denial, as well as beliefs supporting the idea that substance abuse problems are best handled on one's own. Masculine self-reliance may also promote the view that talking about problems in psychotherapy is a feminine pursuit unworthy of a traditionally masculine male.

Masculine Self-Reliance, Gender Role Conflict and Help Seeking

Masculine gender roles are a social construction. These norms develop within the context of interacting with people in one's social environment, including the workplace. Masculine gender role norms involve more than internal psychological conceptions, but also relate to the acceptability of behaviors in men's social groups. Essentially, gender is not simply something that "we 'are,' rather something we 'do' in social interactions" (McCaughan & McKenna, 2007, p. 2106).

Male gender role norms influence whether a man will engage in a specific behavior by stipulating those rules or standards by which the behavior is considered appropriate for men (Mahalik, Locke, Ludlow, Diemer, Scott, Gottfried, & Freitas, 2003). "The 'traditional'

male gender role emphasizes a variety of characteristics, including success and achievement, emotional stoicism, avoidance of the feminine, independence, and masculine self-reliance" (Lane & Addis, 2005, p. 155). Strict masculine gender roles promote the idea of men who maintain their independence, invulnerability and self-control. It is not surprising; therefore, that many men experience gender role conflict in admitting substance abuse problems and seeking help.

Regardless of age, ethnicity or social status, men seek professional psychotherapy services far less often than do women (Bamberger, 2009). Men tend to delay seeking health care longer and use health care services less often (Noone & Stephens, 2008). Much research suggests that traditional masculine gender roles discourage help seeking among men, particularly with regard to substance abuse treatment services (Addis & Mahalik, 2003, Isenhart, 2005).

Commencing treatment presents a dilemma for men in that it is "in direct conflict with the culture of masculinity" (Rochlen & Hoyer, 2005, p. 675). Men often see engaging in psychotherapy or professional treatment services as 'feminine' activities (Isenhart, 1993). Self-sufficiency is tightly woven into men's conceptions about appropriate male gender roles so that admitting problems and seeking help is often interpreted as a feminine display of weakness (Addis & Mahalik, 2003). Talking about problems risks exposing vulnerabilities and portends a potential loss of self-control in 'feminine' displays of emotion (Bamberger, 2009).

Commencing treatment also risks sacrificing masculine self-reliance in that psychotherapy is traditionally an interdependent process between client and therapist, as well as client and group peers. Relying on others for suggestions, advice and feedback moves men dramatically away from the emotional self-containment and masculine self-reliance so strongly attached to traditional masculine gender roles. "Men's difficulty with accessing health services is thus attributed to a mismatch between available services and traditional masculine roles emphasizing masculine self-reliance, emotional control, and power" (Addis & Mahalik, 2003, p. 12).

The tendency to avoid or procrastinate seeking help is particularly pronounced for men with an exaggerated sense of masculinity(Addis & Mahalik, 2003; Galdas, Cheater, & Marshall, 2005). These men tend to proscribe healthcare services in general, but particularly stigma-laden substance abuse treatment services (McCoy, Metsch, Chitwood, & Miles, 2001). Men who adhere to strict masculine gender roles are often extremely reluctant to pursue counseling. For these men, admitting the need for help is akin to admitting failure. They experience a strong sense of shame and self-stigma that interferes with the help seeking process (Pederson & Vogel, 2007). Hypermasculine men perceive giving up alcohol as giving up a part of themselves – their masculinity (Isenhart, 2005).

Masculine gender role stress also "contributes to a man's denial of problem severity and exacerbates his guardedness and defensiveness during substance abuse treatment" (Isenhart, 1993, p. 177). Therefore, men who affiliate strongly with stereotypical masculine gender roles often face a 'double whammy" in seeking substance abuse treatment services.

Essentially, the man must overcome two tiers of psychological hurdles before he can engage in treatment. The first obstacle involves overcoming gender role perceptions that cause him to associate psychotherapy with femininity. A second barrier concerns lowering his psychological guard sufficiently to trust in the process of psychotherapy so that therapy can be effective in properly evaluating, diagnosing and treating him.

Union Hypermasculinity and Help-Seeking

Union members belong to a centuries-old culture that promotes an exaggerated masculinity (Williams, 2002). For the majority of their history, unions were comprised solely of male workers, who prided themselves on being 'tough men' (Tailion, 2002). Hypermasculinity emphasizes qualities such as "bravery, strength, bravado, responsibility, male dominance," as well as "excessive use of alcohol, stoicism, lack of emotion and aloofness" (Casas, Turner, & Ruiz de Esparza, 2005, p. 340). The result is that hypermasculinity, masculine self-reliance and a culture of permissive drinking have long been considered central components of many trade unions (Taillon, 2002).

Masculine Symbolism

The hardhat worn by every union construction worker has traditionally been recognized as a symbol of manliness. While union tradesmen perform different job functions and carry various tools, the hardhat is a unifying professional emblem that is associated with masculinity. Ironically, the image of the hardhat-clad man has been used by the alcohol sales industry to promote the association between drinking and masculinity (Freeman, 1993).

Despite the influx of women into the trades and the fact that women are now donning hardhats, unions continue to label themselves as 'macho' (Sun-times, 2007).

Hypermasculinity and Alcohol Use

There is a longstanding association between alcohol use and masculinity (Isenhart, 2005). Alcohol use symbolizes masculine traits such as behaving in an uninhibited manner and rebelling against authority. Among union construction workers, the connection between their sense of masculinity and alcohol dates back to the Middle Ages, when union workers were paid part of their salaries in alcohol, and given performance-related alcohol bonuses for the toughest jobs (Sonnenstuhl, 1996).   Since its inception, 'union brotherhood' has included indoctrination into a hypermasculine workplace culture that fosters an association between "aggressive celebration of physical strength and consumption of alcohol as badges of masculinity" (Taillon, 2002, p. 4). Union members are expected to demonstrate masculine self-reliance in 'holding their liquor' and managing their substance use without requiring professional help (Bacharach, Bamberger, & Sonnenstuhl, 1994; Bamberger, & Sonnenstuhl, 1995). To this day, "alcohol consumption is an important aspect of the masculine culture found in the building industry. According to many construction workers, 'real men' look forward to occasions when they can drink beer, and men who do not are considered effeminate" (Iacuone, 2005, p. 253). Thus, union members face considerable pressures not only to use alcohol but also to avoid seeking help should their alcohol use present a problem.

Masculine Strength and Masculine Self-Reliance as Solidarity

Construction work is an inherently dangerous profession in which union members must demonstrate strength, speed and skill. While performing physically strenuous and mentally demanding activities, workers must maintain constant vigilance to guard against accidental injury and death. The heavy and dangerous nature of the work "came to be associated with toughness and hardness in the men themselves" (Williams, 2002, p. 307). Union members are expected to "present a persona of emotional self-containment" (p. 294) as a show of masculinity and union solidarity (Williams, 2002). Men's masculinity is strongly "policed by other men," (p. 294) to reinforce the "anti-emotions agenda of trade union men" (p. 297).

This exaggerated sense of masculinity pervades union culture; it extends from the union construction worker, to the job supervisor, and through the upper echelon of union leadership. Elected and appointed union leaders are often selected based upon the degree to which their sense of masculinity reflects that of the rank and file members. "The profile of an 'acceptable' union leader is a hard-headed macho person" (Williams, 2002, p. 300). Union leaders model masculine self-reliance by demonstrating emotional detachment in their social interactions with members. Leaders are prohibited from "identifying with other people's emotions," and "displaying empathy to union members is regarded as unacceptable" (p. 300). It is paramount, therefore, that union members maintain the emotional control and masculine self-reliance that is expected of them as an integral component to union work culture.

Union hypermasculinity most likely negatively impacts union members' readiness to make changes with respect to their substance abuse problems. When it comes to decision-making and readiness to change, these union men are "thought to be motivated by different kinds of goals and ideals than are his [their] contemporaries (Valley, 1995, dissertation)."

Interestingly, male construction workers aged 18 to 25, who are known to be at highest risk for substance abuse are also especially reluctant to seek professional help because of fears of displaying vulnerability (Richardson, 2001). It appears that these younger men are more sensitive to the effects of workplace hypermasculine culture.

Masculine self-reliant attitudes further impact union supervisors' willingness to refer workers for professional substance abuse treatment services. Job supervisors who are members of hypermasculine workplace climates tend to demonstrate greater tolerance for substance abuse among their workers, decreased responsiveness, and outright failure to refer addicted workers to their union MAP (Bennett & Lehman, 2002).

Barriers to Treatment

Perceived Control

Perceived control is conceptually defined as individuals' beliefs about whether they possess the resources and opportunities necessary to access substance abuse treatment. Perceived control also involves individuals' perceptions of existent barriers that act as obstacles to treatment access. These barriers may be psychological in nature, such as an individual's concerns about talking about uncomfortable feelings and distrust of social workers and other addictions professionals, or related to realistic, practical concerns that

interfere with treatment entry. Psychological barriers often include failure to recognize the problem, lack of motivation to commence treatment and social networks that discourage treatment access (Marlatt, Tucker, Donovan, & Vuchinich, Xu, Wang, Rapp, & Carlson, 2007). Practical problems typically include concrete barriers such as inadequate health coverage, no transportation, lack of suitable programs, and concerns about the time, effort and financial cost involved in seeking help (Clay, 2007; Marlatt, Tucker, Donovan & Vuchinich, 1997; Wechsberg, Zule, Riehman, Luseno & Lam, 2007).

While construction workers top the charts of the heaviest substance abusers, little research has been done to determine what barriers interfere with their treatment access. As a group, construction workers are not easily accessible to researchers. Not only do construction workers frequently move from job to job, but they also tend to be leery of white-collared outsiders asking questions about their use of addiction treatment services. Therefore, the specific barriers that impede union construction workers' perceived control over treatment access are not known. However, it stands to reason that union members, like members of the general public, experience a host of barriers. Each of these common impediments will be reviewed in turn.

Denial and Lack of Problem Recognition as Key Internal Barriers

Thwarting efforts towards a drug-free workplace through MAP's and other means, are continuing barriers to seeking help. One of the most commonly cited reasons for not seeking substance abuse treatment services is that clients simply do not recognize the need (NSDUH, 2003). This all too common desire to handle problems 'on their own' is

considered among the chief obstacles to help seeking among substance abusers (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993). Clients' lack of recognition of problem severity, despite encountering numerous negative consequences as a result of their substance abuse, is a hallmark symptom of addiction as well as a common barrier (APA, 2000).

Clients' belief that their substance abuse problems are minor and do not require professional help to resolve is often a key factor in predicting help-seeking behavior (Tucker, Vuchinich, & Rippens, 2004). The failure of alcoholics and addicts to recognize their problem - often labeled as *denial*, has been categorized as one of the most common and difficult obstacles to treatment access (Saunders, Zygowicz, & D'Angelo, 2006). In fact, addiction is often labeled as a 'disease of denial' (APA, 2000; Taleff, 1994).

Client motivation has been described as a three-stage process involving problem recognition, desire for help, and readiness for treatment (Wechsberg, Zule, Riehman, Luseno, & Lam, 2007). Clients' subjective perception about the need for treatment, therefore, is considered a powerful motivator for treatment entry, as well as a potentially significant barrier (Lo & Stephens, 2002). Sadly, misconceptions abound regarding the "causes and cures" (p. 166) of substance abuse (Cunnigham, Blomqvist, & Cordingley, 2007). Among the beliefs promulgated by the public and substance abusers alike is the idea that untreated recovery is simply a matter of personal will power - a feat that can be accomplished easily on one's own. The result is that lack of problem recognition and the need for help translates to a

virtually insurmountable barrier to substance abuse treatment access (Nwakeze, Magura, &

Rosenblum, 2002).

Common Barriers

Even for those clients who do overcome denial, many will face additional hurdles in

the form of barriers that limit treatment access. These include: (1) the belief that the cost of

treatment is too high, (2) insurance barriers, (3) stigma, and (4) not knowing where to receive

help (NSDUH, 2003; NSDUH, 2009). Additional barriers include lengthy admissions

processes and waiting lists, lack of childcare and transportation, homelessness, family

conflicts and an aversion to or distrust of mental health professionals (Appel, Ellison, Jansky,

& Oldak, 2004). For clients who were involuntarily-referred for treatment by their employer,

union MAP, or the legal system, the feeling of being 'coerced' into treatment can also act as

a barrier (Marlowe, Merikle, Kirby, Festinger, & McLellan, 2001). For racial and ethnic

minorities, lack of access to culturally appropriate treatment programs staffed with bilingual

social workers may also act as significant barriers (Documét & Sharma, 2004). Clients of

male gender are far less likely than women to seek help from their employee assistance

programs or from substance abuse treatment services (Blum & Roman, 1992).

Stigma as a Barrier

Stigma is considered a chief problem in discouraging early treatment entry and help-

seeking behaviors (CQ Researcher, 2007). Social stigma, and client fears about being

labeled a 'drug addict' or 'alcoholic,' often serves as a major barrier to treatment entry

(Semple, Grant, & Patterson, 2005). Self-stigma, which relates to clients' self-appraisals of

shame, is also a significant barrier. Self-stigma may be based upon a combination of

irrational fears, as well as realistic concerns, including facing discrimination in employment,

housing and social relationships as a result of being labeled an alcoholic or drug addict

(Luoma, Kohlenberg, Hays, Bunting, & Rye, 2008).

From a client perspective, the stigma of substance abuse problems often far

outweighs that of mental health concerns such as anxiety and depression. The simple status

of acknowledging that one is a substance abuser is experienced by many as an overwhelming

barrier. Workers with substance abuse problems are, in fact, far less likely to use their EAP

(or union MAP) than are employees with mental health concerns (Reynolds & Lehman,

2003).

Economic Cost as a Barrier

Economic obstacles continue to represent significant barriers for both the insured and

uninsured. More than 11 percent of clients seeking substance abuse treatment encounter

economic-related barriers that prevent treatment access (Sturm & Sherbourne, 2001).

Concerns include the cost of treatment in terms of payment for treatment or insurance co-

pays, lost time from work, transportation fees and other costs (Sturm & Sherbourne, 2001;

McCollister, French, Pyne, Booth, Rapp, & Carr, 2009). One in ten insured clients ends up

having to shoulder the full cost of treatment (Schmidt & Weisner, 2005). Uninsured clients

often forego treatment altogether because they cannot afford it. Many uninsured clients first

attempt to seek help through their local hospital emergency room, only to give up when they

are referred elsewhere and cannot afford services (Rockett, Putnam, Jia, Chang, & Smith,

2005). Low income clients (whether publicly or privately insured) report an inability to afford treatment (Weinick, Byron, & Berman, 2005).

Treatment Delays as a Barrier

Treatment delays, defined as problems gaining immediate or timely access to substance abuse treatment services, has often been cited as a common barrier. Substance abusers are especially prone to delaying seeking help, and if help is not readily available, they may give up the idea that treatment is necessary (Booth, Staton, & Leukefeld, 2001). Further, substance abusers often change their minds about commencing treatment during the waiting period. Ethnographic research suggests that lengthy waiting lists are far more problematic to clients than previously realized (Redko, Rapp, & Carlson, 2008).

Lengthy waiting lists for treatment access are increasingly common; they discourage treatment because if treatment is not readily available when the client is ready, the client may change his mind, losing a rare 'window of opportunity' (Chun, Guydish, Silber, & Gleghorn, 2008; Merrick, Horgan, Garnick, Reif, & Stewart, 2009). The lack of available 'bed space' in detoxification centers is particularly problematic for injecting drug abusers and alcoholics, who may be forced to postpone the recovery process until they can be formally admitted (Appel, Ellison, Jansky, & Oldak, 2004).

Transportation as a Barrier

Clients who must travel long distances to access treatment report transportation as a major obstacle (Schmitt, Phibbs, & Piette, 2003). Clients in rural areas may have few treatment options from which to choose (Clay, 2007). Poor clients in urban areas report

barriers that include a lack of information about free or discounted treatment services, childcare and transportation concerns (Ahmed, Lemkau, Nealeigh, & Mann, 2002).

Ironically, many substance abusers have lost their driving privileges; This is particularly true for clients who have incurred legal charges for driving under the influence (DUI) or driving while intoxicated (DWI).

Homelessness as a Barrier

Homelessness is a serious barrier to treatment in that the client often lacks health insurance coverage, transportation and other basic requirements necessary to comfortably pursue treatment (Freund & Hawkins, 2004; Kertesz et al., 2006).

Male Gender as a Barrier

Men's tendency to avoid seeking medical help has often been highlighted as a chief obstacle in men's health care (O'Brien, Hunt, & Hart, 2005). Beginning in childhood, men learn that 'boys don't cry,' and this philosophy of emotional stoicism affects their use of health care in later life (Moller-Leimkuhler, 2002). The rigid gender roles to which men are indoctrinated likely "contribute to a non-perception, underevaluation and denial of symptoms, thus producing barriers to help-seeking" (p. 5). Essentially, men view help-seeking as suggesting a "loss of status, loss of control and autonomy, incompetence, dependence, and damage of identity" (p. 6).

Treatment underutilization by alcoholic men is well researched. These men experience significant barriers to treatment that may be a reflection of a combination of barriers, including the negative effects of male gender roles. While alcoholic men identify

cost barriers as significant, they also report problems with stigma-related concerns and a desire to handle the problem on their own (Saunders, Zygowicz, & D'Angelo, 2006). Caucasian men often hold fears about being stigmatized as well as doubts about whether treatment will be effective (Schmidt, Greenfield, & Mulia, 2006).

Still, while there is solid evidence that men seek medical help far less often than women, there is a paucity of research in gender-related, help-seeking studies (Moller-Leimkuhler, 2002; Schober & Annis, 1996). Other researchers have reported conflicting results and confusion as to the significance of male gender roles. "It is not clear if gender plays an important role in treatment initiation …to date, research results have been contradictory" (Green, Polen, Dickinson, Lynch, & Bennett, 2002, p. 286).

Distrust as a Barrier

As a barrier, distrust can take many forms. Examples include fears about the treatment process, lack of information and misunderstandings about the availability of and requirements for treatment, negative attitudes regarding treatment, and a reluctance to allow an outsider to intervene with private concerns Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; Rapp, Xu, Carr, Lane, Wang, & Carlson, 2006; Saunders, Zygowicz, & D'Angelo, 2006).

Client ambivalence, especially with respect to entering long-term treatment, has been identified as a barrier (Raven, Carrier, Lee, Billings, Marr, & Gourevitch, 2010). Client uncertainty appears to become more ingrained in situations in which mental health

professionals fail to provide the necessary emotional support and encouragement to begin treatment.

Prior negative experiences with substance abuse treatment acts as a barrier (Weiss, McCoy, Kluger, & Finklestein, 2004). Clients' negative preconceptions are further heightened by perceptions that admissions staff is uncaring or unhelpful.

Union members report reluctance to use their MAPs because of unfamiliarity with the program, stigma, reluctance to self-refer and concerns about internal referral procedures (Reynolds & Lehman, 2003). Unhealthy work climates, stigma and fears about confidentiality often contribute to workers' failure to seek help (Bennett & Lehman, 2001).

Ethnicity as a Barrier

Perhaps one of the most researched and documented barriers involves the difficulties faced by non-Caucasian clients. When compared to their Caucasian counterparts, minorities report significant problems with access to substance abuse treatment (Wells, Klap, Koike, & Sherbourne, 2001). Ethnic clients, and especially cultural minorities who speak limited English, encounter significant barriers to seeking substance abuse treatment services (Wong, Marshall, Schell, Elliott, Hambarsoomians, Chun & Berthold, 2006). Language and the ability to communicate and understand treatment options is a considerable barrier. In addition, minorities also face the same practical barriers to treatment as their non-minority counterparts. Native Americans, for example, not only face obstacles to locating and affording quality treatment within a reasonable proximity, but must also cope with ethnic

cultural values that discourage help-seeking (Duran, Oetzel, Lucero, Jiang, Novins, Manson, & Beals, 2005).

"Racial and ethnic differences in utilization of alcohol services may result from underlying differences in barriers to care" (Schmidt, Greenfield, & Mulia, 2006, p. 3). For example, African American men are more likely to perceive material concerns that act as barriers to treatment access. These include uncertainty about how to locate services as well as how to afford them (Schmidt, Greenfield, & Mulia, 2006). Further, African American men often encounter multiple ethnicity-related barriers to treatment, including "socioeconomic status, masculinity, racism, lack of awareness of the need for primary care [and other treatments], religious beliefs, and peer influences" (Cheatham, Barksdale, & Rodgers, 2008, p. 555).

Asian Americans experience cultural and language barriers that interfere with treatment access (Yu, Clark, Chandra, Dias, & Lai, 2009). Cultural values that emphasize sobriety and abstinence are thought to contribute to stigma that is further heightened when seeking services from agencies outside the Asian community.

Ethnic minority populations experience more negative consequences of drinking than Whites and therefore have greater treatment needs. Whether access to treatment is more compromised for minority clients than for Whites is a matter of debate. It is clear, however, that ethnic disparities in the quality and appropriateness of treatment are ubiquitous. (Schmidt, Greenfield, & Mulia, 2006, p. 1)

Incidental Barriers

Illicit drug users are particularly prone to underutilize substance abuse treatment services (McCoy, Metsch, Chitwood, & Miles, 2001). Common barriers to treatment access include not wanting treatment, believing in 'self-treatment,' procrastination and lack of insurance coverage (McCoy, et al., 2001).

Historically, single, older men who are unemployed tend to be overrepresented in substance abuse treatment programs (Weisner, Matzger, Tam & Schmidt, 2002). Age and marital status are often associated as potential barriers, with some studies indicating that young, unmarried men under age 35 seek help less; while other research suggests the opposite (Kirchner, Booth, Owen, Lancaster, & Smith, 2000).

While lower levels of education, lack of health insurance and homelessness are often associated as common barriers, other research suggests the opposite for clients entering detoxification programs (Green, Polen, Dickinson, Lynch, & Bennett, 2002; Lundgren, Schilling, Ferguson, Davis, & Amodeo, 2003). This contradictory research further highlights the complexities in understanding access barriers, and suggests variability in the factors that impede access when linked to specific types of substance abuse treatment programs.

Attempts to Change Permissive Workplace Culture:

Worker, Employer and Union Resistance to Drug-Free Workplace Programs

Given the history of a workplace culture of permissibility towards substance use, the predominant attitude of masculine self-reliance against help-seeking, and the many additional barriers to treatment; attempts have been made recently to promote a drug-free workplace

culture. Beginning in the Middle Ages, during the formation of skilled labor union guilds, and continuing until modern times, construction unions have overlooked substance abuse among their membership. As recently as the 1960s and 1970s, members typically consumed alcohol openly on the job throughout the work day, and many considered alcohol abuse a normal part of their daily work routine (Heffernan, 2007). Further, at the end of the work week, many employers 'rewarded' their workers with kegs of beer and other alcohol by bringing it to the job site and encouraging workers to imbibe. While illicit drug use was viewed less favorably, it also was viewed with an eye towards leniency, particularly if the substance use occurred after work hours.

Starting in the 1980s and continuing to the present time, construction unions began to initiate industry-wide changes to curtail substance use. Substance use on the job site officially became prohibited; however, many workers and employers continued their decades-old practices of allowing substance use. The official intervention process adopted by construction unions primarily consisted of a three-tier strategy: (1) development of formal workplace substance abuse policies, (2) implementation of drug testing programs, and (3) use of Member Assistance Programs (Cook, R.F., Hersch, R.K., Back, A.S., & McPherson, T.L., 2004). In addition, union employers have been given incentives to maintain drug-free workplaces. Those who participate in the drug-free workplace programs receive significant discounts on their workers' compensation insurance. Employers are also increasingly savvy about the risks to company liability should they promote substance abuse

among their workers. Company-sponsored 'keg parties' at the end of the work week are a

relic of the past.

From the 1990s through recent years, construction unions have participated in the

development of drug-free workplaces to promote substance abuse education and prevention.

An essential component of the drug-free workplace involves mandatory drug testing in

certain situations. Prior to 1980, drug testing in the construction industry was virtually

unknown, but has since become increasingly widespread (Gerber & Yacoubian, 2002).   The

Department of Labor reports that "workers increasingly face the prospect of applicant,

reasonable-cause, post-accident, return-to-work, or random drug testing" (Oleson, 2004, p.

67). Despite changes in state and federal laws that increasingly require workplace drug

testing, the issue remains controversial among union members and union leaders (Oleson,

2004). "Attitudes towards the use of drugs from marijuana to spousal prescriptions, indeed

the very definition of a drug – for example, the commonplace separation of alcohol from

other drugs – vary widely" (p. 69). Further, union leaders remain divided about the necessity

to enforce drug testing policies. Common concerns include uneasiness about infringing upon

members' off-duty recreational activities, confusion over drug testing technologies and the

accuracy of results, stigma encountered by members who test positive, and fears about the

ability to maintain the confidentiality of members' medical records (Oleson, 2004).

Inconsistent enforcement of substance abuse policies. Despite growing awareness

of the need to maintain drug-free workplaces, and added incentives for union employers to

uphold policies, in practice, enforcement varies widely (Olesen, 2004). Unlike state and

federal job sites, on which policies are held firm by local, state and federal government oversight and enforcement, individual private employers are often far less stringent. Even worse, many employers have responded to union attempts to implement drug-free workplaces with direct or indirect sabotage. Many union supervisors often deliberately 'look the other way' by ignoring substance abuse among workers (Ames & Delaney, 2006). Other supervisors may indirectly encourage substance abuse because even though they notice and respond to worker infractions, they fail to follow any clear decision-making paths for handling policy violations. In both of these all too common scenarios, workplace policies are thereby undermined (Ames & Delaney, 2006). Another common practice is for union employers to 'go through the motions' of establishing a drug-free workplace policy by negotiating a 'watered down' version through their collective bargaining process with the union. Employers are often motivated to limit their policies for two vital reasons: (1) to avoid incurring cost-sharing for expensive insurance coverage to treat substance-impaired workers, and (2) to avoid construction delays that occur when multiple workers are drug tested on the same day and later face mandatory layoffs for infractions (Seeber & Lehman, 2005).

Outright resistance to substance use policies. Many local unions demonstrate subtle or outright resistance to enrolling in drug testing programs. Union leaders often avoid establishing drug testing policies themselves, and, instead, rely upon the contractors to initiate and develop protocol for the members whom they employ (Oleson, 2004). When drug testing policies are negotiated, unions frequently raise a variety of concerns that have

the impact of softening the proposed policy. Union membership is often "heavily divided on

the need for a drug testing policy," (p. 69) and frequently disagrees over the definition of

which substances are harmful (Oleson, 2004). For example, many members see no harm in

the recreational use of alcohol and Marijuana, and believe that drug testing encroaches on

members' off-duty privacy when members test positive for drugs used outside of the

workplace (Oleson, 2004). The result is that "the union can easily find itself on the

defensive, concerned that it appears to be 'defending substance abuse'" (Olesen, 2004, p. 69).

While state and federal jobsites require strict adherence to established drug testing policies,

individual contractor policies often vary widely. The outcome is often a hodgepodge of drug

testing policies and procedures. Substance-impaired union members quickly ascertain which

jobsites enforce drug testing, allowing them to 'shop' for jobs with contractors with lax drug

testing enforcement.

More than 73 percent of construction workers are aware that their employers have

written policies prohibiting substance abuse. An estimated 37 percent of employers provide

educational literature about substance abuse to increase awareness and understanding of its

harmful effects, as well as to encourage prevention and treatment efforts (SAMHSA, 2007).

However, negative attitudes held by workers and job supervisors towards substance abuse

policies can detract from their relevance and effectiveness (Bennett, Lehman, & Reynolds,

2000). This lack of awareness and understanding of the impetus behind substance abuse

prevention policies contributes to its failure (SAMHSA, 2009). The fact is that although

sometimes considered coercive, workplace enforcement of substance abuse policies are known to facilitate treatment entry for resistant workers (Wu, 2002).

Another challenge to union support of the drug-free workplace program involves the union's own grievance resolution processes for its workers. Workers who have been accused of policy violations are well within their rights to request the assistance of free, professional arbitration. Bolstered by their union rights, workers often opt to fight charges leveled against them. The end result is that many workers are able to successfully challenge drug testing policy infractions to avoid intervention (Seeber & Lehman, 2005).

The Development of Union MAPs

'Don't notice, don't tell' practices prior to MAPs. Prior to the relatively recent introduction of MAPs, union members' problems with substance abuse were virtually ignored (Bacharach, Bamberger, & Sonnenstuhl, 2001). Union peers and job supervisors maintained an attitude of complacency regarding members' substance abuse problems. Union members tended to uphold an unspoken policy of 'don't notice, don't tell' with respect to coworker substance abuse problems. Ironically, however, members whose substance abuse problems became severe enough to interfere dramatically with their work were often summarily fired without being offered referrals to treatment (Bacharach, et al., 2001).

The history of union MAPs. This history of the development of union MAPs is closely connected to the concept of union solidarity and brotherhood. A central doctrine of the union brotherhood has always involved an intrinsic obligation to help fellow union members. In the early 18th Century, American union craft guilds operated as 'mutual aid'

societies by ensuring that members and their families received union-sponsored social

services (Bamberger & Sonnenstuhl, 1995). In the late 18th and early 19th Centuries, before

the advent of workers compensation and readily available healthcare, workers who were

injured on the job relied on their union peers to assist and support them (Bacharach,

Bamberger, & Sonnenstuhl, 2001). Union members tended to live in the same communities,

attend the same church and socialize together. Thus, the term, 'brotherhood,' was coined to

describe the very real sense of family camaraderie felt by one union member towards

another. The brotherhood sentiment likely was also encouraged by ethnic similarities among

union members, and a shared ethnic heritage.

In the 1980s, the labor movement created the forerunner to the modern, Member

Assistance Program by establishing Mutual Assistance Programs (Bacharach, Bamberger, &

Sonnenstuhl, 2001). Union mutual aide programs are based upon the union values of

solidarity and 'brothers helping brothers.' Mutual Assistance Programs were created by

recovering alcoholic and addict union members, who wished to encourage fellow union

members to seek help for substance abuse. Similar to support groups such as Alcoholics

Anonymous, mutual aid programs offer coaching and mentor services by union members for

union peers new to the recovery process. Older members who have successfully achieved

years of abstinence from alcohol and drug abuse serve as role models for younger members

who are initiating recovery. Mutual Assistance Programs continue to be a mainstay of many

union volunteer self-help programs. For example, the highly touted Steamfitters Union'

Mutual Assistance Program was featured in the 2007 HBO "Addiction" film documentary

series (Kopple, 2007). Mutual Assistance Programs are considered especially effective because of union member' trust in working with peers as opposed to outsiders.

The impetus behind union Mutual Assistance Programs centered on two key issues: (1) union support for mutual self-help in keeping with a centuries' old communal culture, and (2) a distinct distrust of outsiders and recognition that members would not easily turn to an external mental health professional for assistance regardless of the severity of need (Bacharach, Bamberger, & Sonnenstuhl, 2001). Essentially, Mutual Assistance Programs fit with an entrenched union culture of mutual aide. "Culturally, the MAP is framed around the belief that peer counselors, because they share many of the same experiences of their troubled coworkers, are best equipped to help them" (Bacharach, Bamberger, & Sonnenstuhl, 2001, p. 148).

The emergence of contemporary MAPs. The emergence of contemporary MAPs is connected to the implementation of federal drug-free workplace programs and policies. Whereas in the past, MAPs were informal, union self-help groups known as Mutual Assistance Programs, modern MAPs, called Member Assistance Programs, are often staffed by professional social workers. The utilization and success of MAPs depends upon active involvement and support of the program by workers, supervisors, employers and local unions. However, MAPs often have been received with mixed reactions, further complicating union efforts towards achieving a drug-free workplace. To understand the response of labor unions to MAPs, it is important to review its history and development. The creation of modern MAPs involves centuries of common goals surrounding community

development and mutual aid societies, with social workers working side-by-side with labor unions. The path to modern MAPs has also encountered twists and turns connected with union solidarity and distrust of outsiders – a path which has at times embraced social work involvement, and alternately, led to distance between the two.

The movement to create professionally staffed Employee Assistance Programs (EAPs) began in the 1970s, as an offshoot of alcoholism prevention programs first developed by industry in the 1930s (Masi, Altman, Benayon, Healy, Jorgensen, Kennish, et al. (2002). While alcoholism was the primary focus of the early programs, modern EAPs assist workers with the gamut of mental health and substance abuse problems (Jacobs & Shain, 2008). "Many of the pioneering EAPs, in fact, were housed within corporate medical departments or the welfare offices of labor organizations" (Beidel & Brennan, 2005, p. 7).

While Mutual Assistance Programs began as a peer-based movement, since the early 1990s, many Member Assistance Programs have transitioned to hiring professional social workers to staff these programs (Akabus, & Kurzman, 2005). It is estimated that some 3,000 to 5,000 union MAPs are currently in operation, and that the number of professional social work MAP directors has grown from a few hundred to nearly a thousand (Bacharach, Bamberger, & Sonnenstuhl, 2001). More than 45 percent of construction workers are now offered confidential professional assistance for substance abuse problems through their company employee assistance program or union member assistance program.   MAP professionals act as union members' case managers to help them evaluate treatment options,

select appropriate treatment providers and to identify and resolve barriers that prevent treatment access.

Continued ambivalence regarding MAPs. In keeping with its mission to promote the safety and well-being of its members, the labor union movement has shifted from its former stance of unwittingly endorsing a culture of substance abuse to promoting prevention and intervention. Labor unions' strategies include tougher enforcement of drug testing policy and the development of union Member Assistance Programs (MAPs) (Donovan, 1993). While MAPs hold enormous potential to assist union members in recovery from substance abuse, the general belief is that MAPs currently are being underutilized (AFL-CIO, 2008). Underutilization may be linked to the fact that labor unions have a varied and conflicted history with respect to MAPs.

Labor unions tend to support the development of MAPs while also being strongly suspicious of them (Bacharach, Bamberger, & Sonnenstuhl, 1994). While unions historically have strongly support the concept of 'mutual aid,' they also have been especially wary of *outside* intervention, particularly in the areas of mental health and substance abuse. Unions encounter unique problems and conflicts when developing and implementing MAPs (Sonnenstuhl & Trice, 1995).

> Historically, union leaders have had mixed reactions to management programs to assist employees. On the one hand, they want the services for their members; on the other, they perceive such services as attempts to undermine the union's authority and its traditional role as help to union members. (Sonnenstuhl & Trice, 1995, p. 7)

Union-management conflicts regarding how best to develop a joint substance abuse policy have often had a crippling effect on intervention efforts and use of MAPs (Trice, 1992). However, when union support can be garnered, utilization of union MAPs is dramatically improved (Sonnenstuhl & Trice, 1995).

Social Work's collaboration with the labor union movement. It is also critical to understand social work's role in supporting values and ideologies shared by both professional social work and the labor union movement. Social work has a lengthy history of alliance with the labor union movement stemming back to the era of Jane Addams and work in settlement houses (Scanlon & Harding, 2005). At that time, social workers and labor unions shared the common goals of "support of legislation beneficial to labor, reduction of working hours, and improvement of working conditions" (Sonnenstuhl & Trice, 1995, p. 4). However, "prior to World War II, only a handful of psychiatrists, psychologists and psychiatric social workers were employed in industry" (p. 4). In the 1940s, several key unions, including the United Mine Workers, International Ladies Garment Workers, and the Teamsters Union initiated mental health programs for their members (Bamberger & Sonnenstuhl, 1995). Around this same time, the AFL-CIO created its first peer counseling program, which has been credited as "the oldest existing EAP in the United States" (p. 292).

Lack of research on effectiveness of union MAPs. MAPs are relatively new to the American labor union movement; therefore, little to no research has been compiled on their utilization or effectiveness (Bacharach, Bamberger, & Sonnenstuhl, 1996; Bamberger, Bacharach, & Sonnenstuhl, 2001; Roman & Blum, 2002). To date, researchers at Cornell

University, including William Sonnenstuhl, are among the few to have explored the role of union MAPs in impacting substance abuse among union members. There is growing evidence to suggest that MAPs' provision of case management to individual union members facilitates substance abuse treatment entry (Jessup, 2006; Mejta, Bokos, Mickenberg, Maslar, & Senay, 1997). MAPs are also able to act as overall change agents by using education, training and intervention to help transform unhealthy, permissive workplace cultures (Bacharach, Bamberger, & Sonnenstuhl, 1994). While research is limited, the general belief is that MAPs hold enormous potential not only to expedite treatment entry, but to assist in "a gradual transformation of the workplace drinking culture (...) and diminution of the near-universal pressure to drink with work peers both on and off the job" (Roman & Blum, 1999, p. 313). To date, more than 45 percent of construction workers are offered confidential professional assistance for substance abuse problems through their company employee assistance program or union member assistance program.

Purpose of the Study

It is important that social workers employed by MAP's understand the factors that promote substance abuse among union construction workers and those that impact the decision to seek treatment. The purpose of this study is to test a conceptual model based upon social cognitive theory and the theory of planned behavior to explain behavioral intention to seek treatment for substance use disorders in male union construction workers. The study hypotheses:

H1: It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **ambivalence** towards seeking help on the behavioral intention of readiness continuum of change.

H2: It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **recognition** towards seeking help on the behavioral intention of readiness continuum of change.

H3: It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional*

self-control, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **taking steps** towards seeking help on the behavioral intention of readiness continuum of change.

Reconceptualizing Substance Abuse as a Multidimensional, Psychosocial Problem

Professional understandings of substance abuse have been influenced by and are a reflection of societal stereotypes. "Across three centuries of American history there has been a common thread in the belief that problem drinking and alcoholism are related to individual deviance" (Ames & Janes, 1990, p. 95). While there are varying ideological approaches to substance abuse treatment, a majority focus on the individual client. For example, the medical model views substance abuse as a biological disease within the individual person as does Alcoholics Anonymous and other 12-step based support groups (Burke & Clapp, 1997). Recent research in the genetic underpinnings to addiction continue to highlight individual conceptions of substance abuse. It reflects a general historical thrust in the health sciences to search out single underlying causes of disease and illness at the level of the organism and thereby to ignore levels of causality which involve the relationship of an individual to his or her natural and social environment. (Ames & Janes, 1990, p. 95)

While the social work profession has always emphasized the need to view client problems from an expansive, person-in-environment perspective, in reality, much of the professional

literature in the substance abuse treatment field conceptualizes substance abuse as an individual problem (Burke & Clapp, 1997). Further, many of the predominant social work theories distinguish the *individual* as the area of focus; including cognitive and cognitive-behavioral, client centered, psychoanalytic, ego psychology, problem-solving, empowerment, and task-oriented (Turner, 1996). Although social workers are well familiar with psychosocial models that view substance abuse from psychological and social constructs, the fact is that *interventions* often continue to be primarily focused on the individual. The result is an overly simplistic, reductionist understanding of the complexities involved in addiction (Barber, 1994).

Construction workers have long topped the charts as being among the heaviest substance abusers (NIDA, 2009). If social workers are to intervene with this vulnerable population that includes union tradesman, it is critical to shift our professional acumen from the individual person and a return to a person-in-environment perspective.

> When we focus on the role of environmental factors in workplace drinking, we gain new understandings of how such drinking may be an outcome of a complex set of interrelationships between the work environment, the social organization of work, and the evolution of informal groupings at work. (Ames & Janes, 1990, p. 108)

"The view that addiction resides solely within the individual continues to foster significant limitations across addiction theorizing, research, and treatment" (Graham, Young, Valcach, & Wood, 2008, p. 121). "We argue for the need to conceive of addiction from a social/relational level of analysis" (Graham, Young, Valcach, & Wood, 2008, p. 130).

Implications of the Study

Implications for Social Work Practice

Masculine gender roles that encourage masculine self-reliance and discourage help seeking behaviors appear to be deeply ingrained among union construction workers. However, it is important that social work professionals recognize the need for health education among men to support healthier concepts about help-seeking. For example, recent media campaigns that have focused on the need for men to pursue routine colonoscopy and prostate screenings show promise in helping men to adopt new healthcare behaviors (Noone & Stephens, 2008). While masculine gender roles are often firmly entrenched, they are capable of being changed. Social workers can perform an invaluable role in recognizing the cultural underpinnings to men's reluctance to seek help and educating them about "manly" alternatives. For example, social workers might help dispel the idea that help-seeking portrays weakness by emphasizing help-seeking as an act of courage. Social workers should be adept at recognizing all too common, traditional masculine 'scripts,' or 'negative self-talk" that act as barriers to prohibit help seeking (Mahalik, Good, & Englar-Carlson, 2003). These masculine scripts might be amenable to cognitive behavioral therapy techniques aimed at altering thinking processes, which in turn, might lead to new, positive behaviors such as help seeking.

Young construction workers aged 18-25 are among the heaviest substance abuse users; They are also at higher risk for substance-related workplace injuries (Pollack, Franklin,

Fulton-Kehoe, & Chowdhury, 1998.) Therefore, prevention efforts might especially target

younger workers who are at the highest risk for both substance abuse and injury.

Social workers might also work to enhance case management to assist union

construction workers in alleviating barriers that block access to treatment. Rather than

assuming that clients are in denial and that 'nothing can be done until the client is ready,'

social workers might best 'start where their client is' by accepting clients' perspectives about

what will help or impede treatment entry. Indications are that intensive case management

may facilitate resolution of barriers that interfere with treatment entry among substance

abusers (Morgenstern, Riordan, McCracy, McVeight, Blanchard, & Irwin, 2001). If such

case management is found to be effective, union MAPs are in a prime situation to provide

such services.

Implications for Education

"Increasingly, the workplace (construction sector) is viewed as an appropriate context

for the development, maintenance and promotion of employees' health behaviors" (Melia

and Becerril, 2009, p. 427). Educational efforts aimed at increasing worker awareness of

EAP services and the reasons for its policies is connected to an increased use of the EAP

(Reynolds & Lehman, 2003). Miller, Zaloshnja, & Spicer (2006) found that when peer based

education regarding substance abuse prevention is combined with drug testing programs

there is a one-third reduction in workplace injury.

Implications for Research

While the reluctance of men to seek substance abuse treatment services is well known, there is a scarcity of research regarding how to market treatment services specifically to men (Rochlen & Hoyer, 2005). However, recent marketing campaigns by the National Institutes of Health (NIH) demonstrate that targeted marketing to men can be effective in helping to reduce the barrier of stigma. For example, the NIH "Real Men, Real Depression" campaign is exemplary in its choice of marketing materials that display images of racially diverse men on its cover brochure (NIH, 2011; Schmidt, Greenfield, & Mulia, 2006). Additional research might go on to specifically target the impact of such educational brochures in marketing treatment services to men in the construction trades.

Further study is needed in trying to better understand the specific client characteristics that predict substance abuse treatment entry as there is a paucity of research (Cohen, Feinn, Arias, & Kranzler, 2007).

Meyer (2001) points to inadequacies in the diagnostic categories of the DSM-IV (and ICD-10) to serve as a foundation for research. Instead, Meyer suggests that psychosocial factors be given greater predominance to increase our understanding of substance abuse and to generate more worthwhile research.

Another area of research involves targeting intervention strategies to match with a client's stage of readiness to change, using the model developed by DiClemente and Proschaska (Schmidt, Greenfield, & Mulia, 2006). Essentially, the belief is that treatment

can be 'marketed' to substance-impaired clients by designing interventions specifically for the stage of change clients are currently in (Noar, Benac, & Harris, 2007).

Implications for Social Work Ethics

Social work has always been at the forefront of working to empower disenfranchised clients, including cultural minorities. Social workers could play a vital role in improving treatment access by attending to and helping to resolve language and other programmatic problems that serve as barriers to ethnic minorities. Further, social workers must be adept at how client ethnicity interferes with clients' behavioral intention to commence treatment. For it is only though shared, collaborative understanding that social workers can work to educate clients to ameliorate their concerns. For example, Sobralske (2006) found in her ethnographic study that Mexican-American men perceive illness as "not being able to be a man" (p. 129). However, it is possible to reframe Mexican-American men's hypermasculinity by educating them to perceive help-seeking as a means to enable them to fulfill their familial and work obligations.

Implications for Policy

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) identifies workplace acceptance of drinking, including lack of adequate supervision and reticence to uphold substance abuse policies as critical factors that contribute to employee substance abuse problems (Jacobs & Shain, 2008). Inconsistent workplace substance abuse policies contribute to the development of workplace subcultures that promote substance abuse (Ames,

2005). Further, "effective substance use policy requires a focus on changing workplace norms" (Bennett & Lehman, 1998, p. 608).

Social workers are in a prime position to influence the development of workplace substance abuse policies. Social workers employed as EAP or MAP directors can combat each of these workplace problems by spearheading policies designed to address these concerns. For example, social workers should insist that substance abuse policies specify the need for ongoing, mandatory substance abuse education for workers and job supervisors. Further social workers can act as a liaison between management and workers to educate reluctant supervisors on ways to refer workers to their EAP or MAP.

Ames, Delaney & Janes (1992) discovered a tendency for union substance abuse policies to be divided into two, divergent tiers comprised of a union MAP component and a supervisory component, with the absence of a clearly identified, unified policy. The MAP component highlights the clinical conception of alcoholism as a disease, and the corresponding need for referral to treatment, while the union leadership component focused on control of alcohol impairment on the job. Ames's findings call attention to "competing priorities" (p. 1068), in which management focuses on

> quality, production and political considerations overshadow and add to the
> implementation problems by devaluing the importance of alcohol issues. Managers,
> union leaders and the employee population have lost grasp of the essentials of their
> policy because the policy is no longer integrated in its essentials. (p. 1068)

Further, a qualitative inquiry showed that union members held "misconceptions, confusion and ambivalence around drinking practices and alcohol policy" (p. 1056).

Substance abuse policies might also target improving access to treatment, particularly with regard to racial and ethnic minorities, who report serious problems with barriers (Schmidt, Greenfield, & Mulia, 2006). Suggestions include targeting funding to locate treatment facilities in geographic areas familiar to minority populations and easily accessible by public transportation.

Limited previous research suggests that in order to increase treatment utilization among construction workers, that specific policy be developed that targets prevention efforts to union members (Lipscomb, & Dement, 2003). Because of the highly mobile nature of the union workforce, which travels from job to job, prevention efforts might best be accomplished by providing services through a centralized union MAP. Union MAPs are in an ideal situation to coordinate preventive education efforts as well as to offer treatment referrals and information.

Summary and Plan of the Chapters

This chapter has discussed factors that promote alcohol and illicit drug use among union construction workers and impede their behavioral intention to seek substance abuse treatment. Chapter Two will review the theoretical and empirical literature regarding the decision-making processes by which individuals initiate help-seeking behaviors. It will examine the connection between social cognitive theory, the theory of planned behavior and the transtheoretical model of change and behavioral intention. The third chapter will describe

the methodology used for the study. The fourth chapter will report the findings and the last

chapter will further interpret the findings and discuss the implications of the study.

Chapter Two: Review of the Literature

This study sought to understand the factors that influence the readiness to seek treatment among substance-impaired union construction workers. In the field of addictions, behavioral intention of readiness for treatment is one of the least understood aspects of addiction recovery (McCoy, Metsch, Chitwood, & Miles, 2001). Although it is well known that more than 95 percent of substance users fail either to connect with professional addiction treatment services or to support groups such as Alcoholics Anonymous - the reasons why not are an enigma (McCoy, Metsch, Chitwood, & Miles, 2001; Tigh & Saxe, 2006). Previous research has connected behavioral intention to client motivational stages conducive to treatment entry. However, many questions remain as to the factors that facilitate movement along the motivational stage continuum.

Chapter One explored the problem of alcohol and illicit drug use among union construction workers. It reviewed literature that suggested a number of psychological factors that impact construction worker's thoughts, attitudes and beliefs, as well as the environmental influence of workplace social norms that are involved in this decision. Chapter Two will utilize Bandura's social cognitive theory, Ajzen's theory of planned behavior, and Prochaska and DiClemente's transtheoretical model as the conceptual framework that integrates both psychological and environmental factors to develop a comprehensive explanatory model for behavioral intention of readiness for treatment.   The model is articulated in the study hypotheses:

H1: It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **ambivalence** towards seeking help on the behavioral intention of readiness continuum of change.

H2: It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **recognition** towards seeking help on the behavioral intention of readiness continuum of change.

H3: It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional*

self-control, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **taking steps** towards seeking help on the behavioral intention of readiness continuum of change.

Conceptual Framework for Behavioral Intention of Readiness for Treatment

The study sought to explain the decision to seek treatment among substance-impaired union construction workers. The decision was conceptualized in this study from the Prochaska and DiClemente's transtheoretical model of intentional behavioral change (TTM) as a construction worker's *behavioral intention of readiness for change*. It is defined as an individual's "motivation to seek help and preparedness to engage in treatment activities" (DiClemente, Schlundt, & Gemmell, 2004, p. 105) as evidenced by movement along a behavioral continuum that culminates in the individual's stated intention to begin treatment. Behavioral intention will be further explained within three conceptual frameworks: The transtheoretical model itself, Bandura's social cognitive theory, and Ajzen's theory of planned behavior.

The Transtheoretical Model

Prochaska and DiClemente (1986) developed the transtheoretical model to describe and identify a behavioral continuum of particular processes whereby individuals move through stages of change from addiction towards abstinence and recovery. The TTM is used to assess

an individual's readiness for change by assigning the person to a particular stage on a continuum of change that ranges from precontemplation, contemplation, preparation, action and maintenance. DiClemente (2003) points out that patterns of behavior are not usually created, modified or stopped in a single moment or with a single flick of a switch. There are steps or segments in the process that the TTM labels *stages of change*. These stages depict the motivational and dynamic fluctuations of the process of change over time. Each stage represents specific tasks that must be completed and goals that need to be achieved if the individual is to move forward from one stage to the next (DiClemente, 2003).

Prochaska and DiClimente developed TTM after conducting research on smoking cessation, and attempting to identify and track elements of the change process (Prochaska & Velicer, 1997). TTM is 'transtheoretical' in that it was created to integrate various theories to develop a more unified biopsychosocial approach to understanding and treating substance abuse. The authors reviewed a variety of theories, including psychodynamic, psychosocial, behavioral and humanistic to borrow concepts generic to the change processes in addiction recovery. The idea is that there is a "common pathway" (DiClemente, 2003, p. 23) that every substance abuser typically follows in help-seeking, and that an individual's progress towards recovery can be followed.

TTM was created as a helpful guide to assist social workers and other professionals to design interventions that facilitate an individual's movement along the behavioral continuum of change (Prochaska, DiClemente, & Norcross, 1992). TTM enables professionals to target the specific tasks and goals that an individual must master to progress along the path to

recovery. While TTM is world renowned for its applications to addictions recovery, it has

also been applied to other health interventions, such as safe sexual practices; nutrition,

exercise and diet; adolescent delinquent behavior, and management of HIV (Bridle,

Riemsma, Pattenden, Sowden & Mather, et al, 2005; Prochaska, Velicer, Rossi, Goldstein,

Marcus, et al, 1994).

Each of the stages of change will be described in turn:

Precontemplation: Individuals in the precontemplation stage are not yet ready to change

their addictive behavior. They have no plans to change their behavior within the foreseeable

future, generally defined as within the following six month period. Basically,

precontemplation "represents a status quo" in which "change is seen as irrelevant, unwanted,

not needed, or impossible to achieve" (DiClemente, 2003, p. 26).

An important task for individuals in the precontemplation stage is to increase their

awareness about their addictive behaviors and the possibility to make positive changes. The

overall goal is for individuals to give serious consideration to the need to change.

Contemplation: Individuals in the contemplation stage are beginning to consider the need

to make changes in their addictive behavior. The general task of this stage involves

individuals' conducting a "risk-reward analysis" (DiClemente, 2003, p. 27) to evaluate the

pros and cons and costs and benefits of their behavior. The overall goal is for individuals to

undergo a serious, thoughtful, self-analytic process that ultimately leads to a definite decision

to change. Successful completion of the contemplation stage results in individuals

acknowledging their decision to "*seriously considering* stopping the addictive behavior in the next six months" (p. 140).

Individuals in the contemplation stage often continue to struggle with weighing the pros and cons of quitting their addictive behavior to arrive at a decision to change. Unfortunately, individuals can remain stuck in the contemplation stage for years (Prochaska, DiClemente, & Norcross, 1992). The problem is that for many substance abusers, "their view of the pros and cons of the behavior can be rather balanced but is still tipped in the favor of continuing the addiction" (DiClemente, 2003, p. 140). Contemplators differ from Precontemplators in that "they are beginning to engage in cognitive and experiential change process activities and are actively and seriously considering change in the foreseeable future" (p. 140).

Preparation: The preparation stage follows successful completion of the decision making phase. The individual recognizes that "changing addictive behaviors takes more than simple willpower; it takes commitment and planning specific to the individual and the behavior" (DiClemente, 2003, p. 157). An individual embarks upon the preparation stage when he makes a commitment to change addictive behavioral patterns by developing a concrete action plan. Whereas the decisional balance phase involves a mental and emotional weighing of pros and cons, the preparation stage occurs when the individual demonstrates a willingness to make thoughtful, planned behavioral changes. The individual's action plan must be "acceptable, accessible, and effective" (p. 156).

Essentially, the individual goes beyond thinking about the problem to doing something about it. He or she makes a firm commitment to change based upon a realistic understanding of the commitment required. "Commitment represents the individual's readiness to place a particular change at the top of his or her personal agenda, to allocate personal time, energy, and resources to do the work needed to make the change" (p. 156). Steps that might be taken during the preparation stage include making a plan to contact an agency to commence treatment, to change substance use behaviors, to modify one's environment to remove substances and substance-related paraphernalia, and to identify recreational and other activities as alternatives to substance abuse.

"The main tasks of the preparation stage are (1) making and strengthening a commitment adequate to support the attempt to change, and (2) developing a plan for action that is sound, reasonable, and feasible for the individual to implement" (p. 154). The overall goal of the preparation stage is for the individual to implement the action plan in the near future.

Taking Action: The action stage begins when an individual begins taking steps to implement his action plan to change addictive behaviors. Whereas previous TTM stages involve changing thoughts, feelings and attitudes, the action stage is focused on quitting addictive behaviors and developing healthier behavioral patterns.

During the action stage, addicted individuals begin to break the physiological, psychological and social ties that bind them to the addictive behavior. They separate themselves from the old pattern and begin to create a new one. This stage requires

commitment and active use of the behavioral processes of change. The four main tasks of the action stage are (1) breaking free of addiction by utilizing behavioral change processes and the strategies of the plan, (2) commitment, (3) revising the plan in the face of difficulties, and (4) managing temptations and slips that can provoke relapse. The goal is to establish a new pattern of behavior. (DiClemente, 2003, pp. 169-170)

The overall goal of the action stage is to successfully change behavioral patterns, and to maintain a healthy, abstinent lifestyle for a minimum of a three to six month time period. In order to implement the action stage successfully, the individual must possess the *self-efficacy* required to endure the trials and tribulations that coincide with the recovery process.

Maintenance: During the maintenance stage, the individual has achieved sustained behavioral change to quit addictive behaviors. The individual has also adopted new, healthy behavioral patterns to replace maladaptive addictive behaviors.

The primary tasks of the maintenance stage are to maintain the behavioral changes associated with an abstinent lifestyle, and to avoid regressing to old behaviors that could signal relapse. The overall goal of this stage is "long-term sustained change of the old pattern and establishment of a new pattern of behavior" (DiClemente, 2003, p. 27).

Use of the transtheoretical model in substance abuse studies. The TTM has been widely used in the field of addictions to explore the utility of TTM-based assessments, tailored (matched) clinical interventions and to predict movement along the continuum of change. The results of an empirical review highlight the mostly favorable, yet mixed support

for the model. Petry (2005) evaluated 234 pathological gamblers using a cluster analysis

formula of the TTM and found validity for the model. In contrast, Aveyard, Massey,

Parsons, Manaseki, & Griffin (2008) found no evidence of effectiveness of using stage-based

interventions in their work with nearly 2500 smokers. In a large-scale randomized,

controlled study of the TTM by Heather, Honekopp, and Smailes (2009) in which the authors

assessed 742 adults who abuse alcohol, the authors found significant support for use of the

model in terms of understanding the recovery process. Velasquez and von Sternberg (2005)

evaluated multiple substance abuse treatment programs based upon the TTM model to find

that it supports effective motivational interviewing with clients. McWhirter (2008) found

that the TTM assisted clinicians to enhance adolescents' participation in substance abuse

treatment, and improve treatment success rates. Callaghan, Hathaway, and Cunningham

(2005) examined a culturally diverse group of adolescents to find that the TTM accurately

predicts client discharges from an inpatient substance abuse treatment program and is able to

accommodate client ethnicity and culture. In their work with 458 Driving Under the

Influence (DUI) offenders, Nochajski and Stasiewicz (2005) report that the TTM failed to

predict motivation to change.

  The TTM has its critics. Adams and White (2005) argued against stage-based

interventions as being unhelpful and ineffective. The authors cite a variety of problems with

the model including: (1) the inability of the model to address the myriad of complexity

involved in multiple actions that comprise a behavior, (2) weak statistical standards to

address the validity of staging algorithms, (3) the absence of longitudinal data, and (4)

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concerns that stage progression is not necessarily the equivalent of behavioral change. West (2006) decries the TTM as unscientific because of his view that the model, among other deficiencies, fails to adequately predict human behavior or to promote new intervention technologies. Whitelaw, Baldwin, Button, & Flynn (2000) "expressed reservations about the tendency of some investigators to accept the value of the model on intuitive grounds alone" (Brug, Conner, Harre, Kremers, McKellar et al., 2005, p. 254). The authors also express concern that many behaviors can be anticipated to change simply with the passage of time, thus invalidating the sanctity of the model. Some authors suggest that due to the intuitive appeal of the TTM, that too much attention has been "focused on its conceptual utility, and inadequate work conducted on the measurement of its core constructs and the empirical testing of basic model concepts" (Migneault, Adams, & Read, 2005, p. 445). In a meta-analysis, Bridle, Riemsma, Pattenden, Sowden, & Mather (2005) examined 37 randomized controlled trials of the TTM to report that despite the popularity of the model, its effectiveness remains in question. The authors state that for a majority of studies on the TTM, researchers used inadequate methodological standards. They further suggest using caution in the application of the model. At the same time, however, the authors note that because the TTM was originally created to evaluate *addiction-related behaviors*, it may be more suitable for this purpose than examining other health behaviors less amenable to the model.

Application of the transtheoretical model to understanding behavioral intention of readiness for treatment. The purpose of this study was to enhance understanding of

union construction workers' behavioral intention to seek substance abuse treatment services. This investigation involved assessing union members with a variety of substance use disorders who were in various stages of the process of change. The TTM is well matched to understanding help-seeking because the model helps us to evaluate behavioral intention as a process, rather than a single 'yes' or 'no' decision. Whereas in the past, social workers and other mental health professionals tended to label clients as being 'treatment resistant' or 'in denial,' the TTM expands knowledge of behavioral intention by breaking down the process step-by-step for a more incremental assessment of change (DiClemente, Bellino, & Neavins, 1999). The model also supports social work ethics of a maintaining a nonjudgmental attitude and starting where the client is by understanding behavioral intention from the client's perspective (Workers, 2008).

In many respects, the transtheoretical model appears to offer a promising approach to the problem of substance abuse. Interventions for substance abuse have moved away from confrontational approaches, and have focused instead on working within the parameters of an individual's own readiness to make a behavioral change. Stage-based approaches to substance abuse treatment may facilitate therapeutic alliance and increase likelihood of treatment progress. Indeed, the TTM offers an alternative way of conceptualizing denial and resistance. (Migneault, Adams, & Read, 2005, p. 444)

The specific areas of research in which the TTM demonstrates the highest level of empirical backing are connected to the variables chosen for this study. The TTM "helps us understand when shifts in attitudes, intentions and behavior will occur" (Armitage & Connor,

2000, p. 183). While the TTM may not yet be proven effective for stage-related intervention design, it is a useful framework to enhance understanding of the role of decisional balance, attitudes, perceived control and social norms in relationship to behavioral intention.

Despite mixed reviews of the TTM, its use remains ongoing and frequent, particularly with respect to its use in the emerging area of improving understanding of behavioral intention in seeking substance abuse treatment (Armitage & Conner, 2000). Further, it is important to remember that TTM "has had a profound impact on health promotion, becoming one of the most prominent and popular resources in the field" (Whitelaw, Baldwin, Bunton & Flynn (2000, p. 709).

One of the more promising applications of the TTM involves research aimed at help-seeking for substance abuse treatment. A brief empirical review suggests recent and emerging areas of research. Freyer, Tonigan, Keller, Rumpf, & John et al. (2005) employed the TTM to assess readiness for change and help-seeking among 549 non-treatment seeking alcohol-dependent clients. In a National Institute on Alcohol Abuse and Alcoholism NIAAA sponsored study, LoCastro, Potter, Donovan, Couper & Pope (2008) evaluated characteristics of first-time alcohol treatment seekers among 1,362 alcoholic adults using the TTM. Jakobsson, Hensing, & Spak (2005) conducted a qualitative study to assess the differences between men and women in their help-seeking processes for seeking treatment of alcohol problems based upon constructs from the TTM. Carroll, Ball, Nich, Martino, & Frankforter (2006) used the TTM in their study to evaluate the effectiveness of motivational interviewing to improve treatment engagement. In their randomized controlled study, the authors assessed

423 adult substance abusers entering outpatient treatment across five community-based treatment settings. The authors recommend that the TTM be employed to enhance motivational interviewing techniques and to facilitate treatment entry. Longshore & Teruya (2006) incorporated elements of the TTM to assess treatment motivation in drug users. The authors note that the TTM is helpful in evaluating client readiness and resistance for substance abuse treatment. Freyer, Coder, Bischof, Baumeister, and Rumpf et al. (2007) utilized TTM concepts to evaluate the behavioral intention of adult alcoholics to seek formal treatment. The authors found that negative consequences from substance use and prior experience with help-seeking were significant predictors of behavioral intention.

Collins, Eck, Torchalla, Schroter, & Batra (2009) used components of the TTM to quantify qualitative data representing motivation to change among treatment-seeking smokers. The authors emphasize the validity of the decisional balance component of the TTM in particular. In their randomized trial of case management interventions to facilitate treatment entry among injection drug users, Strathdee, Ricketts, Huettner, Cornelius, & Bishai, et al. (2006) assessed 245 clients using a modified version of the TTM and found the constructs of the model to be valid. Hughes, Keely, Fagerstrom, & Callas (2005) studied 115 U.S. and Swedish smokers to evaluate their intention to quit smoking over time. The authors found that as a variable, behavioral intention is subject to continual fluctuation. The authors identified two concerns regarding their use of TTM: (1) Confusion regarding whether observed changes in behavioral intention were a true change or due to measurement unreliability, and (2) The inability, in their view, of the TTM to fully capture behavioral

intention in a single snapshot application of the model because of the rapid changeability of the variable.

Social Cognitive Theory

Bandura (1986) developed social cognitive theory to explain the multifaceted processes by which individuals learn and adopt new behaviors. He emphasized that learning a new, complex behavior is generally a unique product of the interaction between an individual's personal preferences and his/her exposure and response to environmental influences. Bandura coined the term, "reciprocal determinism" to describe the triadic relationship involved in the acquisition of new behaviors. Reciprocal determinism suggests that all human behavior is the product of a continuous, evolving, reciprocal feedback loop interaction between an individual's unique response to cognitive, behavioral and environmental determinants (Bandura, 1977).

Bandura avoided simplistic explanations of human behavior that portrayed individuals as either robots who mindlessly responded to the external stimuli of positive and negative reinforcement, or alternately, as unknowing captives of the inner forces of unconscious psychological drives. In devising social cognitive theory, Bandura (1986) sought to correct what he perceived were deficiencies in the traditional psychodynamic and behavioral theories of human behavior. Bandura held that psychodynamic theories minimized environmental influences, while behavioral theories often overlooked individual psychological factors. Social cognitive theory was designed to bridge the gap between psychodynamic and

behavioral theories by providing a more comprehensive and dynamic analysis of human behavior.

Bandura described human behavior as an active, goal-directed process in which individuals produce actions of their own volition. Bandura (1986) acknowledged, however, that human beings do not always make the best behavioral choices, such as when they abuse alcohol or drugs. While self-destructive behaviors are particularly hard to understand, Bandura held that they can be sorted out, assessed and analyzed with the goal of promoting healthy behavioral change. A first step to understanding complex behaviors such as help-seeking is to recognize that the relative influence of psychological and environmental factors often varies tremendously according to each individual's unique life circumstances (Bandura, 1977). Further, even in situations in which human behavior has remained static, changes to any of the components involved in reciprocal determinism hold the potential to bring about dramatic behavioral change.

Bandura (2005) was among the first to call for a professional paradigm shift from disease management to health promotion, especially in the field of addiction recovery. Bandura's theories have been used widely throughout the health professions to further health promotion interventions, such as diet, nutrition and exercise, safe sexual practices, smoking cessation, and substance use abstinence (Bandura, 1999; Bandura, 2004, Bandura, 2005; Brandon, Herzog, Irvin, & Gwaltney, 2004; Dolan, Martin, & Rohsenow, 2008).

Application of Social Cognitive Theory to understanding behavioral intention of readiness for treatment. One of the least understood aspects of human behavior in the field

of addictions is clients' behavioral intention of readiness. As discussed above, previous research has connected behavioral intention to client motivational stages conducive to treatment entry (Prochaska & DiClemente, 1986). However, many questions remain as to the factors that facilitate movement along the motivational stage continuum. Bandura's SCT holds one key in that the theory differentiates between willpower, a simple desire to change, and actual behavioral performance (Bandura, 1986; Bandura, 2005; Cho, 2007).

Bandura's SCT helps to elucidate the continuum of behavioral intention because the theory encompasses the cognitive, psychological and social mechanisms by which change is possible. SCT highlights the purposeful nature of human behavior and helps to demystify behavioral intention. Bandura (1991) was quick to point out that "neither intention nor desire alone has much effect if people lack the capability for exercising influence over their motivation and behavior" (p. 249). Among these critical capabilities are forethought and self-regulation:

Forethought and behavioral intention. Bandura described human behavior as an active, goal-directed process in which individuals produce actions on their own volition. Bandura envisioned *forethought* as a necessary prerequisite to purposeful behavior (Bandura, 1986; Bandura, 2005; Maisto, Carey, & Bradizza, 1999). Forethought enables individuals to visualize, anticipate and plan certain actions. "There are two distinctive but closely linked categories of forethought: (1) task analysis, and (2) self-motivational beliefs. A key form of task analysis involves the setting of goals" (Zimmerman, 2000, p. 16). It is this ability to identify and establish goals for action that is a hallmark of behavioral intention.

Bandura believed that forethought leads to behavioral intention, that individuals must establish goals and develop realistic actions plans prior to successful behavioral enactment. Forethought also involves an individual's ability to break down complex behavioral goals into smaller, more manageable tasks.   Individuals who fail to exercise adequate forethought are prone to become disorganized, aimless and unmotivated (Zimmerman, 2000).

Much research documents the connection of forethought to behavioral intention. For example, Webb & Sheeran (2006) conducted a meta-analysis of 47 experimental studies to determine that behavioral intention correlates with the goal-directed behaviors associated with forethought.   With respect to the behavioral intention of readiness, a union member would first exercise forethought by establishing help-seeking as a goal. Next, the member would need to identify the tasks relevant to commencing treatment. For example, typical tasks might include ascertaining health insurance information, identifying a funding source for self-pay or co-pay, making arrangements for time off from work, childcare and transportation, locating a suitable treatment facility and contacting his union MAP. Members who fail to exercise forethought would be less likely to satisfy the prerequisite steps to achieve a successful state of readiness.

Self-regulatory capability and behavioral intention. Closely connected to forethought and behavioral intention is Bandura's concept of *self-regulation*. Bandura (1977) identified the capability to self-regulate as a core component of all human behavior. Bandura (1994) defined self-regulation as a multifaceted construct that involves the "exercise

of influence over one's own motivation, thought processes, emotional states and patterns of behavior" (p. 71).

Self-regulation pertains to internal psychological processes by which an individual evaluates his behavior and consciously decides to change. Self-regulation serves as an internal compass that helps to regulate and shape behavioral intention. Self-regulation is not automatic, however, but occurs as a result of an individual's experience with respect to sanctions that prohibit certain behaviors while promoting others (Bandura, 1986).

An important aspect to self-regulation is an individual's ability to maintain his or her commitment to behavioral intention in the face of adversity (Brown, 1998). To some degree, individuals must be able to fortify themselves during times when there is an absence of intrinsic rewards and external social supports to stay on course with their goal. A particular challenge, however, is that, by definition, substance abuse involves an inherent loss of control and inability to self-regulate (American Psychiatric Association, 2000; Bandura, 1999; Miller & Heather, 1998).

In keeping with Bandura's concept, union members' self-regulatory capacity would be impacted by the internal psychological and external environmental endorsements and prohibitions of these behaviors. In order for members' self-regulatory capacities to be fully realized, they would need to develop the requisite skills associated with readiness. Typical self-regulatory skills include the ability to establish a goal, to evaluate the tasks necessary to accomplish that goal, and to maintain sufficient motivation despite encountering practical

difficulties and psychological stress associated with the change process (Bandura, Caprara, Barbaranelli, Pastorelli, & Regalia, 2001).

Theory of Planned Behavior

The theory of planned behavior (TPB) grew from the theory of reasoned action (TRA) developed by Fishbein and Ajzen (1975) to explain and predict an individual's behavioral intention to perform a given behavior based upon the person's attitude about the behavior and subjective norms. Social norms involve an individual's perception of whether he or she should perform a given behavior based upon the approval or disapproval of one's social referent group (Ajzen, 1991). Ajzen & Fishbein (1980) report that their theory is predicated upon the belief that individuals are rational and systematic in their choice of selecting the most appropriate behavior for themselves based upon their unique circumstances.

Similar to Bandura, Ajzen and Fishbein's (1975) TRA demonstrated a departure from traditional psychoanalytic and behavior theories, and assigned a greater role to subjective decision-making in human behavior (see Appendix A). The formula for TRA is: Behavioral Intention (BI) = Attitude (A) + Subjective Norm (SN), or BI = A + SN. Ajzen and Fishbein were careful to stipulate that the impact of the variables are not necessarily evenly dispersed, but can vary based upon each person's unique situation and the specific behavior in question. For some individuals, with respect to certain behaviors, attitudinal factors may prevail, while for others, subjective norms may take priority.

In 1985, Ajzen developed the theory of planned behavior (TPB) to improve upon the TRA by adding what Ajzen considered to be a critical missing link – perceived behavioral control (see Appendix B). The TPB contains all of the original elements of TRA with the added element of perceived behavior control.

> A central determinant of behavior is the individual's *intention* to
> perform the behavior in question. As they formulate their intentions, people
> are assumed to take into account three conceptually independent types of
> considerations. The first are readily accessible or salient beliefs about the
> likely consequences of a contemplated course of action, beliefs which, in
> aggregate, result in a favorable or unfavorable *attitude toward the behavior*.
> A second type of consideration has to do with the perceived normative
> expectations of relevant referent groups or individuals. Such salient
> normative beliefs lead to the formation of a *subjective norm* – the perceived
> social pressure to perform or not to perform the behavior. Finally, people are
> assumed to take into account factors that may further or hinder their ability to
> perform the behavior, and these salient control beliefs lead to the formation of
> *perceived behavioral control*, which refers to the perceived capability of
> performing the behavior. (Ajzen, Albarracin, & Hornik, 2007, p.5)

The TPB has been shown to predict human behavior, especially in the area of promoting healthy behavior (Gorn, 2007). TPB has been successfully applied, for example, to understanding and promoting health behaviors such as safe sexual practices, as well as

maintaining diet and exercise health regimens for illnesses such as diabetes. The TPB has

assisted researchers to better understand the motivations behind behavioral change processes.

The theory has also helped social workers to better design interventions with the aim of

promoting healthy behaviors among clients (Ajzen, Albarracin, & Hornik, 2007). For

example, educational efforts can be geared towards identifying and modifying belief systems

that interfere with the behavioral intention to change. In addition, community action

campaigns can help educate clients while also addressing detrimental social norms.

Application of the Theory of Planned Behavior to understanding behavioral

intention of readiness for treatment. Fishbein & Ajzen (2010) define behavioral intention

as a client's readiness to perform a given behavior.

> Intentions are assumed to capture the motivational factors that influence a behavior;
>
> they are indications of how hard people are willing to try, and how much of an effort they
>
> are planning to exert, in order to perform the behavior. As a general rule, the stronger the
>
> intention to engage in a behavior, the more likely should be its performance. (Ajzen,
>
> 1991, p.181)

The TPB helps elucidate the components to behavioral intention. The TPB holds that

Behavioral Intention (BI) = Attitude (A) + Subjective Norms (SN) + Perceived Control (PC).

The TPB acknowledges a wide variation in human behavior by explaining behavioral

intention in terms of each individual's unique *set* of attitudes, beliefs and perceptions. Thus,

two individuals may arrive at the same behavioral intention despite having divergent views.

In one individual, subjective norms may predominate, while in another individual attitudes

may prevail. The individual assigns the relative strength of each component to arrive at his or her unique determination of behavioral intention. A strength or deficit in any one element may tip the scales for or against the enactment of a behavior.

The TPB applies to union members' behavioral intention of readiness. Again, while the individual components likely vary, the TPB suggests a prototype of a union member with a favorable behavioral intention of readiness. This union member would experience a combination of attitudes, beliefs and perceptions in favor of help seeking. For example, he might harbor positive attitudes about abstinence and sobriety (A), anticipate emotional support and approval from union peers, job supervisors and union leaders that comprise his workplace culture (SN), and believe that he is capable of overcoming obstacles to locate, afford and access treatment services (PC).

To date, there appears to be no research specifically addressing behavioral intention among construction workers to seek substance abuse treatment services or other mental health services. There are, however, a number of studies that have incorporated the TPB to assess the behavioral intention of adolescents and adults to seek substance abuse treatment. For example, Neff & Zule (2000) utilized the TPB to develop a brief instrument designed to assess adult substance abusers' attitudes towards treatment and to predict treatment-seeking behavior. Kleinman, Millery, Scimeca, & Polissar (2002) employed Ajzen's concepts in their study to predict long-term treatment utilization among addicts entering detoxification. Codd & Cohen (2003) demonstrated the effectiveness of TRA to predict college students' intention to seek help for alcohol abuse. Matto, Miller, & Spera (2005) pilot tested an

instrument based upon the TPB to accurately assess adult clients' behavioral intention towards admitting themselves to outpatient and residential substance abuse treatment programs throughout the East Coast. In addition, meta-analyses have shown considerable support for the efficacy of the TPB. For example, Armitage and Connor (2001) reviewed 185 research studies to find that empirical research backs up the central constructs of the TPB. While crediting the usefulness of the TPB, Pomery, Gibbons, Reis-Bergen & Gerrard (2009) suggest expanding the model to include a new concept of behavioral willingness.

Psychological Factors Influencing Behavioral Intention

This study examined the effect of psychological and environmental factors on behavioral intention of readiness for treatment. Among the psychological factors influencing behavioral intention to seek treatment are appraisal of consequences of substance use, perceived control over treatment access, and a self-reliant attitude against help seeking.

Appraisal of Consequences/Decisional Balance

How the Transtheoretical Model conceptualizes the relationship of Decisional Balance to Behavioral Intention. Appraisal of consequences is defined as the process an individual goes through in weighing the pros and cons of continuing his or her substance use. The transtheoretical model (TTM) suggests that the appraisal of the decisional balance of con to pro towards the consequences of the behavioral intention to continue the behavior tips at the contemplation stage. Ideally, the decisional balance process that takes place primarily during the contemplation stage involves intensive self-analysis that encompasses cognitive and emotional realms. While there are some commonalities in weighing pros and cons, each

individual's decision-making process is unique based upon his or her personal, familial and social factors.

This makes understanding anyone's decisional balance tricky, because an observer would have to gain access to the personally relevant considerations and their significance. An evaluation of the pros and cons is not simply an intellectual, rational experience. That is why both cognitive processes, like consciousness raising, and experiential processes like emotional arousal and self-evaluation, are important in shifting the decisional balance. (DiClemente, 2003, p. 141)

How Social Cognitive Theory conceptualizes the relationship of Decisional Balance to Behavioral Intention. Decisional balance is important to understanding several key components regarding substance abuse among union members. First, decisional balance helps to demonstrate the mechanisms by which union members decide whether to abuse substances. Second, decisional balance contributes to union members' appraisal of their substance use as problematic. And, third, decisional balance is likely a critical aspect of members' decisions regarding whether to pursue substance abuse treatment. Bandura's SCT explains decisional balance in terms of operant conditioning, forethought, and self-reflection.

Operant conditioning. Bandura describes the decisional balance process, in part, in keeping with operant behavioral theories of reinforcement. The processs is that an individual's decision about whether to engage in a specific, goal-directed behavior is dramatically impacted by his or her unique psychological response to positive and negative reinforcers. Positive reinforcers act as "anticipatory incentives" (p. 18) to promote the

behavior while negative reinforcers serve to discourage behavioral enactment (Bandura, 1986). For example, given that substance use acts as a potent chemical and psychological reinforcer, a hallmark anticipatory incentive is the euphoria of a drug 'high.' Sadly, in weighing the decisional balance, many substance users will not be able to overcome this single anticipatory incentive to decide in favor of readiness.

It is important to recognize, however, that decisional balance involves more than a simple weighing of pros and cons. Individuals with similar sets of circumstances may evaluate their situations differently to arrive at different states of readiness. In addition, any one positive or negative consequence may tip the scales for or against. Bandura's SCT helps to explain the wide variation in how individuals approach decisional balance by emphasizing that human behavior is a uniquely individual reciprocal process that goes beyond mere stimulus-response (Bandura, 1977). To understand union members' decisional balance process, therefore, one would need to identify and evaluate psychological and environmental characteristics unique to construction workers that serve as prominent anticipatory incentives.

Forethought. As previously described, Bandura's (1986) concept of forethought describes how individuals pursue the goal-directed behavior required for behavioral intention of readiness. However, certain aspects of forethought also relate to decisional balance in that individuals anticipate and weigh the pros and cons prior to behavioral enactment. Bandura (1986) describes forethought as an advanced mental capacity that guides human behavior above and beyond that of instinctual lower animals. "Through exercise of forethought,

people motivate themselves and guide their actions anticipatorily" (Bandura, 1986, p. 19).

Essentially, an individual's use of forethought enables him or her to anticipate potential

consequences of a given behavior to negotiate the decisional balance process effectively.

"Anticipatory capacities enable humans to be motivated by prospective consequences. Past

experiences create expectations that certain actions will bring valued benefits, that others will

have no appreciable effects, and that still others will avert future trouble" (Bandura, 1986, p.

18).

Yet, despite their advanced capacity for thought, humans do not always choose

wisely. Human behavior is often self-destructive. "People anticipate the likely consequences

of their prospective actions, they set goals for themselves, and they otherwise plan courses of

action for cognized futures, for many of which established ways are not only ineffective but

may also be detrimental" (Bandura, 1986, p. 19).

Self-reflective capability. Bandura (1986) defines self-reflection as a process by

which individuals monitor and appraise their thoughts, feelings and beliefs, as well as the

short and long-term consequences of their behavior. Similar to the psychodynamic concept

of 'insight,' self-reflection enhances an individual's awareness of the motivation behind his

behavior. Self-reflection also portends the likely consequences should a behavior be

continued as well as suggesting alternative actions that might lead to better outcomes for the

individual.

Self-reflection is akin to decisional balance in that it presents an opportunity for

personal growth and change. "People not only gain understanding through reflection, they

evaluate and alter their own thinking. In verifying thought through self-reflective means, they monitor their ideas, act on them or predict occurrences from them, judge the adequacy of their thoughts and the results, and change them accordingly" (Bandura, 1986, p. 21).

Decisional balance involves an individual's ability to weigh the pros and cons of behavior, including decisions about substance use and behavioral intention. Interwoven with the concept of decisional balance is Bandura's construct of self-regulation. "The social cognitive theory (SCT; Bandura, 1986) states that individuals are aware of their own behavior and its *consequences*, and that these capabilities allow them to plan their future behavior. Therefore, addictive behavior can be modified when individuals undertake and accomplish self-regulation" (Cho, 2007, p. 55).

Two important subfunctions of self-regulation include self-observation and a judgmental process (Cho, 2007). Self-observation is an individual's ability to monitor his own behavior and to assess its positive and negative outcomes.

> A social cognitive perspective is distinctive in viewing self-regulation as an interaction of *personal, behavioral,* and *environmental* triadic processes (Bandura, 1986). More specifically, it entails not only behavioral skill in self-managing environmental contingencies, but also the knowledge and sense of personal agency to enact this skill in relevant contexts. (Zimmerman, 2000, p. 13)

When individuals exercise self-regulation in performing the functions of decisional balance, they are "regulating their thoughts, emotions, impulses or appetites, and task performances" in a "conscious, deliberate action" (Vohst & Baumeister, 2004, p. 2). Human

behavior is such, however, that individuals may or may not exercise good judgment about behavioral intentions.

How the Theory of Planned Behavior conceptualizes the relationship of Decisional Balance to Behavioral Intention. For the purpose of this research, decisional balance is defined as a union member's appraisal of the positive and negative consequences of entering substance abuse treatment. Azjen & Fishbein (1980) define decisional balance as related to an individual's attitudes about the intention and his "judgment that performing the behavior is good or bad" (p. 6).

Several researchers have used the TPB to examine the role of decisional balance in impacting substance use behaviors and the motivation to seek help. For example, Van Hulten, Lodder, Teeuw, Bakker, & Leufkens, et al. (2004) found that perceived norms and weighing of perceived health benefits of substance use (decisional balance) were chief factors in clients' intention to use benzodiazepines. Schlegel, Davernas, Zanna, DeCourville, & Manske (2006) used the TPB in a 12-year longitudinal study of adult problem drinkers to find that the model does accurately predict behavioral intention based upon attitudinal and other factors associated with decisional balance. Freyer, Coder, Bischof, Baumeister, & Rumpf, et al. (2007) studied adults' intentions to utilize formal help for alcohol problems using decisional balance. The authors note that behavioral intention is related to clients' evaluation of the positive and negative consequences of alcohol use. In addition, the authors speculate that factors related to behavioral intention likely change depending on the 'stage of

change' clients are in. The authors further note that adults who had previously sought treatment were 10 times more likely to do so again.

While more research is needed to understand the role of decisional balance factors in adults' decision-making processes, a variety of research emphasizes the importance of decisional balance in adolescents' behavioral intention to modify substance use behaviors. For instance, in their study evaluating the use of motivational interviewing techniques to impact adolescents' readiness to change smoking behaviors, Apodaca, Abrantes, Strong, Ramsey & Brown (2007) found that while adolescents' decisional balance impacts behavioral intention to smoke, that motivational interviewing should avoid focusing too much on the negative consequences of smoking. The authors further identified peer and parental influences as the strongest predictors of adolescent smoking initiation, and that these social norm factors weigh more heavily upon behavioral intention than do negative consequences. Similarly, Halpern-Feisher, Biehl, Kropp, & Rubinstein (2004) examined the role of adolescents' appraisal of the perceived risks and benefits of smoking to find that while adolescents do exercise a form of decisional balance, that social pros and cons were more influential in predicting use.

Kuther & Higgins-D-Alessandro (2003) examined attitudinal factors that predict alcohol use among older adolescents and young adults. The authors found that adolescents use a rational process to weigh the positive and negative consequences of drinking as explained by the TPB. In addition, social norms were a strong predictor of alcohol use among all age groups.

Perceived Control Over Treatment Access

The second psychological factor affecting behavioral intention of readiness for treatment is perceived control over treatment access. This is conceptualized as individuals' belief about whether they possess the resources and opportunities necessary to access treatment. Specifically, the elements of perceived control that relate to treatment access include issues such as perceived control over emotions, privacy/trust and concrete barriers. Perceived control over emotions involves an individual's comfort level with discussing feelings, disclosing substance abuse problems and coping with self-revelations regarding embarrassing and potentially stigmatizing concerns. Perceived control over privacy/trust concerns an individual's willingness to talk to and trust social workers and other addictions professionals with personal, private issues. And, perceived control over concrete barriers relates to an individual's confidence in being able to negotiate practical concerns, such as insurance coverage and transportation, to connect with treatment.

How the Transtheoretical Model conceptualizes the relationship of Perceived Control to Behavioral Intention. A particular strength of the TTM is that it was among the first conceptual models to suggest that problems with perceived control be linked with the stage of change in which the client currently is (Bridle, Riemsma, Pattenden, Sowden, & Mather, 2005). The idea is that practical and emotional constraints vary as individuals progress through the stages of change. By identifying and anticipating these obstacles, individuals can be helped to enhance their perceived control to facilitate readiness.

The TTM also emphasizes the importance of self-efficacy in movement through the behavioral continuum. Self-efficacy involves "an individual's self-reported confidence to abstain from a problematic behavior as well as to perform a desired one" (DiClemente, 2003). The TTM posits that individuals with low self-efficacy (perceived control) are less likely to demonstrate readiness because they are unwilling to discontinue their substance use. This loss of perceived control impacts individuals from a cognitive-behavioral perspective in that they harbor negative thoughts and feelings that lead to hopelessness about their ability to change, and often fail to pursue actions that would facilitate readiness (DiClemente, 2003).

How Social Cognitive Theory conceptualizes the relationship of Perceived Control to Behavioral Intention. Perceived control impacts behavioral intention in that individuals must possess a degree of confidence in their ability to carry out the practical and psychological tasks necessary to ready themselves for treatment. Perceived control is closely connected to Bandura's (1994) SCT concept of self-efficacy, which he defines as individuals' beliefs about whether they are capable of performing a particular behavioral goal. Bandura points out that self-efficacy beliefs affect an individual's thoughts, emotions, and motivation to succeed. Bandura's concept of self-efficacy highlights the multifaceted process by which clients enact behavioral change. Bandura's definition of self-efficacy also reveals how problems in any one sphere (cognitive, emotional, social, behavioral) could undermine union members' perceived control over treatment readiness.

Bandura (1994) postulated that ultimately, self-efficacy determines behavioral outcomes. Individuals with low self-efficacy tend to give up easily in the face of adversity. They often

avoid challenging tasks and ruminate about perceived inadequacies rather than searching for solutions. They also suffer from low aspirations and a weak commitment to their goal. "Self-doubters are quick to abort … if their initial efforts prove deficient" (Bandura, 1986, p. 391). In contrast, individuals with high self-efficacy tend to be more self-assured, and are more likely to accomplish their goal. They demonstrate a willingness to weather difficulties and redouble their efforts when challenges are encountered on the path to success.

Bandura held that self-efficacy was especially important in the arena of substance abuse treatment readiness and recovery. "Perceived self-efficacy exerts its effects on every phase of personal change – the initiation of efforts to overcome substance abuse, achievement of desired changes, recovery from relapses, and long-term maintenance of a drug-free life" (Bandura, 1999, p. 214). And, problems with low self-efficacy can undermine behavioral intention regardless of whether the individual strongly desires addiction treatment and recovery.

Self-efficacy is a concept that has been widely applied to a variety of aspects of substance use behaviors in the field of addictions recovery. Bandura's portrayal of the role of self-efficacy in addiction has been widely used in research and his original conceptualization remains relatively unchanged. While some integrative models (e.g., Marlatt & Gordon 1985; Niaura et al. 1988) describe the interactive and predictive values of self-efficacy differently, the usefulness of this construct has stood the test of time (Brandon, Herzog, Irvin, & Gwaltney, 2004).

Confusion arises, however, in that self-efficacy is believed to impact a variety of substance use behaviors and aspects along the continuum of readiness. In addition, self-efficacy can both support *addiction behaviors* and *addiction recovery behaviors*.

Perceived self-efficacy plays a unique role in the addictive behaviors field. Such beliefs influence both the initial development of addictive habits and the behavior change process involving the cessation of such habits and maintenance of abstinence. It is important to note, however, that perceived self-efficacy can cut both ways at the choice point: In addition to resistance self-efficacy, self-efficacy is also involved in attempts to initiate an addictive habit. (Marlatt, Baer, & Quigley, 1997, p. 289)

Simoneau & Bergeron (2003) report that with respect to research on client motivation to stop substance use behaviors that "despite a fair amount of empirical support for the utility of self-efficacy in the treatment of substance-related disorders, several problems remain unsolved: the conceptual and definitional heterogeneity of the construct, the existence of factors moderating the influence of self-efficacy, and the enhancement of self-efficacy by participation in treatment" (p. 1221). The authors point to discrepancies in research findings, for example, in which self-efficacy has been linked to overconfidence and premature dropout from treatment rather than the hypothesized ideal of high self-efficacy increasing motivation. For example, Jackson, Wernicke, & Haaga (2003) found that increased levels of self-efficacy in terms of hopefulness about substance abuse treatment correlated with a lower probability

of clients entering treatment. They speculate that clients who are overly confident may ultimately avoid treatment access.

Bandura's SCT construct of self-efficacy has been widely researched in connection with understanding how substance abuse develops, treatment outcomes, relapse and abstinence (Maisto, Carey, & Bradizza, 1999). There is little research, however, specifically concerning the relationship between self-efficacy and individual's behavioral intention to access substance abuse treatment (Dolan, Martin, & Rohsenow, 2008). For example, Young and Oei (2000) examined the predictive value of self-efficacy in determining clients' ability to refuse alcohol, and Connor, Gudgeon, Young & Saunders (2007) similarly explored the relationship between self-efficacy and drinking restraint. Larose, Mastro, & Eastin (2001) showed that deficiencies in self-efficacy contribute to internet addiction. In their work Dolan, Martin & Rohsenow (2008) found that self-efficacy can be a powerful predictor of cocaine abstinence. Warnecke, Morera, Turner, Mermelstein, & Johnson, et al. (2001) identified self-efficacy as a critical construct in treatment readiness for smoking cessation. Demmel, Beck, Richter, & Reker (2004) conducted research with adult problem drinkers to show that self-efficacy was positively related to client readiness to change and treatment outcomes.

Much research suggests that for substance abusers, self-efficacy improves with the *completion* of treatment, however, self-efficacy is also believed to be an essential component of the behavioral intention for *initiation* of treatment (Maistro, Carey, & Bradizza, 1999). This creates a vicious circle in which substance abusers often lack the self-efficacy required

to initiate treatment, but may not bolster their self-efficacy until they have completed a significant portion of treatment. This helps to explain why behavioral intention to seek substance abuse treatment is a confounding aspect which requires much further research to enhance understanding.

While some researchers have found a connection between self-efficacy and future substance use behaviors, others have not. For example, in their study with 100 male alcoholics, Solomon & Annis (1990) found that self-efficacy towards abstinence strongly predicted future drinking patterns. In their research regarding alcoholic clients' readiness for change and help-seeking, Freyer, Tonigan, Keller, Rumpf, John, et al (2005) suggest that self-efficacy variables related to help-seeking might be predictive when paired to other motivational factors. For example, low self-efficacy might help to explain a combination of low behavior change motivation coupled with high help-seeking motivation, while high self-efficacy might be associated with the reverse.

How the Theory of Planned Behavior conceptualizes the relationship of Perceived Control to Behavioral Intention. Ajzen describes perceived control as equivalent to Bandura's concept of self-efficacy in that it describes an individual's perceptions about the degree of capability he possesses to perform a particular behavior. Perceived control is defined as an individual's "perception of the degree to which he is capable of, or has control over, performing a given behavior" (Fishbein & Ajzen, 2010, p. 64). Perceived control acts as a moderator over behavioral intention in that the more confidence an individual possesses that he has control over practical and psychological

obstacles that interfere with treatment, the more apt he will be to hold a positive behavioral intention of readiness. "It is well recognized, however, that lack of requisite skills and abilities, or presence of environmental constraints, can prevent people from acting on their intentions" (Fishbein & Ajzen, 2010, p. 21). Perceived control helps to explain why individuals who profess readiness often do not act upon their intentions, because they lack sufficient confidence.

In their qualitative study of methadone-maintained clients, Nyamathi, de Castro, McNeese-Smith, Nyamathi, & Shoptaw, et al. (2008) identified perceived control over treatment access as a significant barrier to predict client willingness to seek help for alcohol abuse and dependency. Marcil, Bergeron, & Audet (2001) studied the decision-making processes behind young adult males' behavioral intention to drink and drive. The authors found that corresponding with the TPB, clients' attitudes about drinking and perceived behavioral control over drinking were significant predictive factors. Interestingly, however, in contrast to other research, the authors found that subjective norms were less significant in influencing young men's behavioral intention to drink and drive. This study highlights the predictive value of the TPB in helping to enhance our understanding of the complexities involved in behavioral intention among various client populations and behaviors.

Masculine Self-Reliant Attitude Against Help-Seeking

How the Transtheoretical Model conceptualizes the relationship of Masculine Self-Reliant Attitude to Behavioral Intention. The third psychological factor influencing behavioral intention is a masculine self-reliant attitude against help-seeking. While the TTM

does not specifically address masculine self-reliant attitudes and hypermasculinity, it does acknowledge the tremendous impact of attitudes, beliefs and values on behavioral intention (DiClemente, 2003). "Beliefs and expectancies act as facilitative and inhibitory factors during the precontemplation stage" (DiClemente, 2003, p.84) at the critical juncture when individuals are contemplating behavioral intention. TTM also suggests cognitive-behavioral interventions designed to combat unhealthy and unproductive attitudes. For example, similar to AA, TTM warns against 'stinkin thinkin,' or minimization and denial-laced thoughts that often contribute to masculine self-reliant attitudes that minimize the need for treatment.

How Social Cognitive Theory conceptualizes the relationship of Masculine Self-Reliant Attitude Against Help-Seeking. Masculine self-reliance is comprised of a set of hypermasculine attitudes, beliefs and behaviors. An example of early sociological research on hypermasculinity is Brannon's (1976) work, in which he described men as 'sturdy oaks' who were preoccupied with social gender roles connected with confidence and self-reliance (Brannon, 1976; Bennett, 2007). While male gender roles have evolved significantly since the 1970s, and continue evolving over time and culture, men in certain cultural contexts continue to experience pressure to conform to hypermasculine social norms that endorse masculine self-reliance (Bennett, 2007). Recent research in health, mental health and addictions fields suggests that the hypermasculinity associated with masculine self-reliance, and the pressure to uphold hypermasculine social gender roles may help to explain why a majority of men seek medical help far less than women (Bamberger, 2009; Garfield, Isacco & Rogers, 2008; Rochlen, Paterniti, Epstein, Duberstein, Willeford, et. al, 2010). For

example, with respect to hypermasculinity in the prison culture, in their work with 418 adult

male inmates Morgan, Steffan, Shaw, & Wilson (2007) found that masculine self-reliance

acts as a barrier to men's seeking mental health services. Older men who may have been

exposed to more traditional or hypermasculine gender roles are often far less likely to seek

help than women or younger men (Mansfield, Syzdek, Green, & Addis, 2008). Wade (2008)

points to "a growing body of research that indicates that men who endorse traditional

masculinity are less likely to engage in health-promoting behaviors (p. 6)," particularly if

they belong to a social referent group that endorses traditional or hypermasculine social

gender roles. Union members are indoctrinated to an unusually masculine self-reliant peer

work culture. Masculine self-reliant members are hypothesized to demonstrate a lower

behavioral intention of readiness because of their unwillingness to admit substance abuse

problems and to seek help (Addis & Mahalik, 2003; Galdas, Cheater, & Marshall, 2005).

Bandura's SCT portrays modeling as an unusually compelling force with the potential

to transform an individual's attitudes, beliefs and behaviors to align with those of his social

referent group (Bandura, 1969). Beginning with his famous Bobo doll study in which

children became unusually aggressive after watching a role model, Bandura (1963) was

among the first theorists to demonstrate the strength of modeling (Hart & Kritsonis, 2006).

Bandura's SCT would portray masculine self-reliance as a product of modeling of workplace

gender role norms. A description of modeling in general, and modeling of gender roles

specifically follows:

Modeling.   Modeling involves observational learning within a social context (Bandura, 1971). It is considered to be a universal phenomenon whereby individuals observe role models to incorporate socially acceptable behaviors into their own behavioral repertoire (Bandura, 1986). Modeling is more than mere imitation, however, and involves a complex process of learning socially sanctioned rules and structures for behavior. "Modeling is one of the most pervasive and powerful means of transmitting values, attitudes, and patterns of thought and behavior" (Bussey & Bandura, 1999, p. 16).

Modeling gender roles.   Masculine self-reliance against help-seeking can be conceptualized as an exaggerated, hypermasculine gender role. SCT postulates that gender roles are heavily influenced by modeling (Bandura, 1986). The socialization to gender roles begins in infancy when male newborns are clothed, handled and held differently than females (Bussey & Bandura, 1999). Reinforcement for men to adhere to traditional masculine gender roles continues in early childhood, and throughout adolescence and adulthood. And, although gender roles are evolving in Western culture, historically, strict rules have applied for gender-appropriate behavior. Friends, family, peers and social norms continue the process of gender role socialization

In certain ethnic groups and cultures, traditional male gender roles have become overstated to the extent that they are labeled hypermasculine. For example, hypermasculinity is often deeply rooted in many Hispanic cultures (Mayo, 1997; Torres, 1998). Similarly, hypermasculinity has long been ingrained as an integral part of the occupational culture of union construction workers (Iacuone, 2007). Occupational modeling is especially prevalent

given that adults spend considerable time on their jobs (Bussey & Bandura, 1999). In addition, the longer the exposure to occupational norms, the greater the likelihood that these attitudes, beliefs and behaviors will be absorbed through modeling.

How the Theory of Planned Behavior conceptualizes the relationship of Masculine Self-Reliant Attitude to Behavioral Intention. For the purpose of this research, masculine self-reliant attitude against help-seeking is defined as a union member's favor towards displaying hypermasculine, self-reliant attitudes against behavioral intention of readiness. The TPB defines an attitude as "the evaluation of an object, concept, or behavior along a dimension of favor or disfavor, good or bad, like or dislike" (Fishbein & Azjen, 2010, p. 78). The TPB purports that an individual's attitudes towards a behavior ultimately predict his or her behavioral intention (Fishbein & Azjen, 1975).

Historically, attitudes have not been considered a valid measure of behavioral intention (Ajzen, 1991). Problems with using attitude to predict behavior include several concerns: (1) attitude is a complex, multidimensional construct that may not be amenable to reduction to a single behavioral intention, (2) the level and intensity of an attitude varies and is often inconsistent with behavioral outcomes, and (3) response biases often interfere with accurate representation of an individual's actual attitude (Ajzen & Fishbein, 2005). While acknowledging these concerns, Ajzen's TPB suggests that validity of attitudinal measurements and behavioral outcomes can be improved through precise variable definition and measurement (Ajzen & Fishbein, 2005). The idea is that "measures of attitude and

behavior involve exactly the same action, target, context, and time elements" so that measurement is as accurate and specific as possible. (p. 183)

The TPB also attempts to capture the complexities of attitude by also incorporating elements of perceived control to achieve a more multidimensional aspect to behavioral intention. Much research documents the utility of the TPB in using attitudinal constructs to predict behavior, especially with regard to help-seeking (Vogel, Wester, Wei, & Boysen, 2005). Schomerus, Matschinger, & Angermeyer (2009) used the TPB to find that attitudes are a key construct in determining adult clients' willingness to pursue psychiatric treatment for depression. Similarly, Schomerus & Angermeyer used the TPB to connect attitudes regarding the stigma clients anticipate for seeking psychiatric services and a subsequent reduction in their behavioral intention. Cusack, Deane, Wilson, & Ciarrochi (2006) explored the role of male gender roles and restricted emotional expression as promoting a reluctance to seek help among men.

Environmental Factors Affecting Behavioral Intention of Readiness for Treatment: Perception of Workplace Culture.

Union members' perceptions regarding the permissibility of substance use in the workplace is a critical, environmental factor impacting behavioral intention.

How the Transtheoretical Model Conceptualizes the Relationship of Masculine Self-Reliant Attitude to Behavioral Intention. The TTM does not specifically focus on permissive workplace culture, however, it clearly acknowledges environmental social influences as contributors to addiction and ambivalence with regard to behavioral intention.

DiClemente (2003) recommends stage-specific interventions to help offset the impact of permissive cultural norms. For example, he suggests a cognitive-experiential technique that he calls 'social liberation.' The goal is for individuals in recovery to be more cognizant of social norms that promote or detract from abstinence (DiClemente, 2003). At the same time, DiClemente (2003) also recommends that individuals enhance their recovery skills by developing helping relationships that provide positive, recovery-oriented social supports.

How Social Cognitive Theory Conceptualizes the Relationship of Workplace Culture to Behavioral Intention. SCT has long characterized substance use as more than a mere personal problem, but as a social malady (Bandura, 1999). Permissive workplace culture is conceptualized as the level of social support among union members in the workplace that would either facilitate or deter substance use, as suggested by Beattie, Longabaugh, & Fava (1992). Specifically, permissive workplace culture relates to the degree of workplace support for abstinence, consumption and positive or negative workplace peer' reactions to adverse effects of substance use on the job.

Permissive workplace culture is often conveyed through workplace traditions and sanctions, as well as a tendency to tolerate and cover up substance use (Bennett & Lehman, 1998). SCT postulates that workplace norms are learned by modeling. It is hypothesized that union permissive workplace culture reduces the behavioral intention of readiness.

Common workplace factors that influence permissive workplace norms include the type of work setting, attitudes and behaviors of coworkers, and whether substances are typically used on the jobsite during the work day, at workplace social events and at informal,

after-hours gatherings of work peers. In addition, individuals whose identities are closely

intertwined with their status as a member of their work group are more susceptible to

modeling permissive norms (Bandura, 1986).

>   At the workplace, dynamic sociological and psychological forces are at work:
>   the need to be accepted, rewarded, attached to a group, fully understanding the social
>   structure within the organization, that is, subordination and superordination; There is
>   also the anticipation of self-actualization, that is, becoming "someone" within the
>   organization and reaching the top. All these factors impact on workplace behavior
>   and they can lead to drinking. (Marshall, 2001, p. 114)

Permissive workplace culture is increasingly recognized as a highly influential social

norm. Emerging research suggests that permissive workplace cultures negatively impact

behavioral intention of readiness on two fronts: First, these norms contribute to a tendency

for individuals to abuse alcohol and drugs making it harder for them to contemplate seeking

help to quit, and second, norms propagate the myth that substance abuse is a normal behavior

that does not require treatment (Maisto, Carey, & Bradizza, 1999). Empirical research

documents this double impact of permissive workplace culture on modeling increased

substance use behaviors and reduced behavioral intention:

A growing body of research demonstrates that the social norms of permissive workplace

cultures that encourage substance use affects individuals through modeling.   Social

modeling has long been associated with addictive behaviors such as smoking, but alcohol and

illicit drug use is also increasingly becoming a part of permissive workplace cultures

(Bandura, 1998). For example, Yang & Kawach (2001) found that workplace drinking subcultures dramatically increase individual alcohol use. Quigley & Collins (1999) determined that social modeling showed a significant effect on the amount of alcohol consumed, especially when individuals were exposed to heavy drinking partners. Leatherdale, McDonald, Cameron, & Brown (2005) found that social influences factored predominately in youths' early onset smoking and smoking dependency. Neaigus, Gyarmathy, Miller, Frajzyngier, & Friedman, et al. (2006) discovered that social networks dramatically and negatively impact heroin users in contributing to their decision to become injecting users despite the risk of contracting HIV. Walters, Bennett, & Noto (2000) studied the role of college campus culture in promoting alcohol abuse among young people to find that students exposed to permissive peer culture were more likely to drink heavily. Caudill & Kong (2001) identified modeling effects and social approval as key factors in encouraging alcohol abuse. Ahern, Galea, Hubbard, Midanik, & Syme (2008) demonstrated that in certain communities, predominant permissive cultures exert strong social norms to pressure individuals to model excessive drinking behavior.

The influence of workplace culture through modeling is believed to be more powerful in workplace settings in which employees are members of a collective group, such as active duty and retired members of the military and members of unions. For instance, Ames' (2009) research pointed to a predominant occupational drinking culture among young adults in the U.S. Navy as strongly contributing individuals' drinking behaviors. Ames, Grube, & Moore (2000) found that union workers exposed to workplace drinking norms abused alcohol

much more heavily than did their counterparts working in industry in which such norms were not present. Valente, Gallaher, & Mouttapa, (2004) concluded that adolescents tend to model peer social networks in their substance use habits. Verney & Kipp (2008) studied the impact of acculturation and modeling on encouraging veterans to abuse substances, and found a positive association, with minority Veterans showing an especial vulnerability. Rimal & Real (2003) point out that while researchers are beginning to understand the role of social norms on substance use behaviors, there is little information regarding how the social modeling process maintains such a strong influence.

There is a paucity of research regarding workplace culture and its role on the behavioral intention to seek substance abuse treatment services. However, there is a general understanding and acknowledgement among social workers and other addictions professionals of the fact that substance abusers who identify heavily with permissive peer cultures are often less likely to seek treatment (Hanson, 2001). Individuals in such cultures likely model attitudes and social norms that reduce behavioral intention.

> Perhaps the most common motivational obstacles to early behavior change or help seeking is the perception that 'one does not have a problem' serious enough to warrant change…People compare their own substance use to that of people around them, or to perceived norms. If they find no discrepancy - for example, if heavy drinking is normative rather than sanctioned in the person's reference group – change is unlikely to occur. (Miller, 2006, p. 140)

Recent research supports the role of modeling of permissive culture and reduced behavioral intention. For example, Davey, Latkin, Hua, Tobin, & Strathdee (2007) examined the role of social network factors in predicting entry into substance abuse treatment to find that illicit drug users were much more likely to initiate treatment if their peers had modeled treatment-seeking behaviors. To date, research on the behavioral intention to seek substance abuse treatment among construction workers has not been done despite the fact that this client population is among the heaviest substance abusers.

How the Theory of Planned Change Conceptualizes the Relationship of Masculine Self-Reliant Attitude to Behavioral Intention. Fishbein & Azjen (2010) indicate that an individual's behavioral intention is strongly impacted by social norms that advise permissible behavior. Social norms can also be conceptualized as "social pressure" (p. 130) based upon social rewards and coercion to conform. Workplace cultural norms also serve as a powerful influence upon an individual regarding socially acceptable behaviors, including substance use behaviors and the behavioral intention of readiness.

Several researchers have shown support for the TPB in understanding substance abuse and recovery processes, including behavioral intention. Neff & MacMaster (2005) identified peer influence, role modeling and social reinforcement as vital to clients' decisions about incorporating spirituality in the recovery process in keeping with the TPB. Campo, Brossard, Frazer, Marchell, & Lewis, et al. (2003) found that among college students, drinking behavior is positively related to social norms as suggested by the TPB. Hillebrand, Marsden, & Finch (2001) identified social norms and perceived functions of alcohol use as

significant to predicting alcohol abuse among clients in methadone maintenance. Little research has been done involving the TPB as it applies to the client population of construction workers. However, in a rare study, Mayze & Bradley (2008) used the TPB to demonstrate that Australian construction workers were influenced by permissive workplace cultures that promote drinking while discouraging help seeking.

Conclusion

Chapter Two reviewed aspects of Prochaska and DiClemente's TTM, Bandura's SCT and Ajzen's TPB as they explain the psychological and social-environmental variables in this study. The hypothesized relationship between these psychological and social-environmental variables and behavioral intention that was suggested by these theories and models was discussed in detail, along with the appropriateness of their use for this study. A review of the empirical literature highlighted the most recent relevant research and gaps in the professional knowledge base.

Chapter Three will discuss the methodology used for this study, including a presentation of the study design and methodology, description of client population, instruments, and data collection used to test the hypothesis.

Chapter Three: Methodology

This chapter explains the methodology used for the study. It presents the study design, including the client population, sampling strategy and procedures. The hypotheses and study variables will be described in detail, along with data collection methods. The chapter will conclude with a review of the statistical analysis plan chosen for the study.

Study Design

Purpose of the Study

The purpose of this study was to test a conceptual model based upon social cognitive theory, the theory of planned behavior and the transtheoretical model to explain the behavioral intention to seek treatment for substance use disorders in male union construction workers. This study explores the relationship between stages along the continuum of behavioral intention and perceived control over treatment access, appraisal of the consequences of substance use, masculine self-reliant attitude toward help-seeking and perception of workplace culture of permissibility.

The Role of the Researcher

The researcher is an employee of a union of construction workers. She is the director of a union Member Assistance Program (MAP). Her role is to provide telephone crisis intervention and referral services for union members who contact a toll-free telephone hotline. Members telephone from throughout the United States for help for a variety of problems including mental illness, substance abuse problems, domestic violence, joblessness, and other issues.   All services are provided over the telephone. Members are provided with

information and referral services, and members are directed to therapists, programs and services in the community in which they live.

During their initial crisis call to MAP, all clients are routinely screened for substance use disorders regardless of the stated purpose of their call. For example, some study participants initially called for assistance as perpetrators of domestic violence, or for help with anxiety or depression, but were included in the study because they were identified as having a likely substance use disorder. The researcher administers the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST) to callers verbally over the telephone according to the standard MAP protocol.

Based upon the telephone screening, union members who appear to be at risk for having a substance use disorder are referred to the appropriate level of care, ranging from inpatient medical detoxification, inpatient residential treatment, and day treatment to outpatient services. Referrals are tailored to the specific needs of the union member given the member's substance use diagnosis, insurance coverage status, prior treatment experience and any special needs (e.g., transportation issues, childcare concerns, bilingual requirements, etc).

Members who contact the hotline receive a confidential referral packet delivered to them via overnight UPS. Service provision response time is generally 24-48 hours, from the time the member first contacts the hotline, until he receives a referral packet. Follow-up with members is provided by telephone and in writing within one week of the member's receiving services to ensure the referrals are suitable and helpful.

Hypotheses

A cross-sectional, correlational survey design was utilized to test the following hypotheses:

H1: It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **ambivalence** towards seeking help on the behavioral intention of readiness continuum of change.

H2: It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **recognition** towards seeking help on the behavioral intention of readiness continuum of change.

H3: It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of *taking steps* towards seeking help on the behavioral intention of readiness continuum of change.

Sampling Strategy and Procedures

Human Subjects Concerns

A primary human subjects concern for this study involved the need to guard against coercing participation. This concern arose because of the dual role of the researcher in providing direct intervention services to clients while also soliciting their participation in this research study. In an effort to minimize any perception of coercion, the researcher refrained from verbal entreaties to solicit participation. Instead, union members received a confidential letter (See Appendix C) soliciting their participation after the conclusion of their receipt of crisis intervention services and the closing of their case file. Union members were advised in the introductory letter of the purpose of the study and the fact that their decision to participate was a confidential, voluntary choice. In addition, potential participants were advised that the researcher would not know whether they had decided to participate or not, and that their decision would not impact their union standing or ability to receive services in the future

from their union MAP. Another consideration worth noting is the fact that union members are routinely surveyed by their union on sensitive topics such as politics, and are aware of the union's policies regarding voluntary participation in all survey research.

IRB Approval

In February 2009, the researcher attained approval from the Internal Review Board (IRB) of the Office of Sponsored Programs and Research Services at The Catholic University of America for the study project titled, "The Behavioral Intention to Seek Treatment for Substance Abuse among Union Construction Workers. The researcher also received the approval of the Secretary-Treasurer of the International Union of Bricklayers and Allied Craftworkers in Washington, D.C. to conduct the research study.

Data Collection

In April 2009, the researcher conducted a pilot study of the instrument by asking nine local union leaders to complete the questionnaire and assess the ease with which they understood and could answer the questions, as well as the appropriateness of the survey for union construction workers. The pilot study suggested that while the questions were appropriate and understandable, that the length of the survey might be tedious for the average worker. The offering of a $20 incentive was believed to increase the likelihood of a greater response rate.

In May 2009, the researcher began screening union construction workers for the study by identifying potential participants who had called their union MAP for assistance. During their initial crisis call to MAP, the researcher administered the Alcohol Use Disorders

Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST) to callers verbally over the telephone according to the standard MAP protocol.

Participants who had received services from MAP from May 2009 to May 2010 and whose cases had been completed and closed were sent confidential, written invitations explaining the purpose of the study, and seeking their informed consent and participation (See Appendix D). In an effort to capture union members' frame of mind regarding their stage of change at the time of their crisis call, survey kits were mailed to potential participants on a case-by-case basis within one week of case closing.

Participants were asked to provide their signed informed consent for participation in the study, and were offered a $20 gift certificate in consideration of their time. Participants also received a self-administered survey questionnaire to be returned in a separate, unmarked envelope to protect anonymity and confidentiality. It is important to note that the AUDIT and DAST were repeated within the body of the study questionnaire so that participants would be able to give their written, informed consent prior to completing these instruments for the purpose of the study.

The researcher sent surveys to 223 potential respondents, and received 125 completed surveys for a response rate of 56 percent.

Sample

A non-probability, purposive convenience sample consisted of 125 male adult union construction workers who contacted their union MAP by telephone for intervention and referral, and were screened as having a substance use disorder. The study participants ranged from age categories of 18-25, 26-45, 46-61, and 62 and older. Some participants called MAP

voluntarily while others were mandated to call either because of legal problems such as having been charged with driving under the influence (DUI) or driving while intoxicated (DWI), having tested positive for substances on the job, or having been referred by their job supervisors, local union leaders or union contractors. Some participants originally called MAP for problems other than substance abuse, but consented to participate in the study after being screened as having an apparent substance use disorder.

Screening Instruments

Table 3.1 presents each of the study variables, and their conceptual and operational definitions. The table also clarifies which scales and subscales are utilized for each variable used in the study.

Alcohol Use Disorders Identification Test (AUDIT). As shown in Section Five, Appendix E, The Alcohol Use Disorders Identification Test (AUDIT) is a 10-question, Likert-style screening instrument that was designed in 1992 by the World Health Organization (WHO) as a brief assessment measure to screen for alcohol abuse (Babor, DeLaFuente, Saunders, & Grant, 1992). The AUDIT was developed and analyzed internationally over a 20-year period to become a recognized reliable and valid measure (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001).   The AUDIT is appropriate for use with clients of varying ages and cultures. Among its intended uses, the AUDIT was specifically designed for use by employee assistance program professionals to screen the alcohol risk of employees with whom they come into contact. The AUDIT is often used as a self-report questionnaire. Responses to each question range from 0 to 4. Total scores of 8 or more represent harmful drinking, while scores of 15 or more suggest likely alcohol

dependency (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). The AUDIT has demonstrated concurrent, construct and discriminant validities (Allen, Litten, Fertig, & Babor, 1997). The instrument is helpful in distinguishing between harmful and hazardous alcohol use. Several studies report high reliability for the instrument with a Chronbach's alpha of .86. (deMeneses-Gaya, Zuardi, Loureiro, & Crippa, 2009; Reinert & Allen, 2002). The AUDIT was also chosen for this study because of its suitability and versatility in being administered as a self-report questionnaire.

Drug Abuse Screening Test (DAST). As shown in Section Six, Appendix E, the DAST is a 20-question, yes-no response screening instrument that was designed as a brief instrument to detect drug abuse and dependency (Skinner, 1982). The DAST screens for non-medical use of prescription medications, as well as marijuana, hash, solvents, tranquilizers, barbiturates, cocaine, stimulants, hallucinogens and narcotics. The DAST does not screen for alcohol abuse or dependency. The DAST was deemed appropriate for this study given its frequent use in settings in which individuals are in the process of seeking treatment for substance abuse. The 20-question DAST is considered comparable to the original 28-item instrument in terms of its validity and reliability. Standardized cut-off scores were used for the DAST, i.e., scores of ≥ 6 reflect a substance abuse problem while scores of ≥ 15 represent a likely severe substance abuse problem. After more than two and a half decades of use, the DAST is considered a reputable, highly valid instrument with good concurrent and discriminant validity (Gavin, Ross & Skinner, 1989). The DAST also demonstrates good reliability with a reported Chronbach's alphas of .86 to .94 (Yudko, Lozhkina, & Fouts, 2006).

Dependent Variable

Behavioral intention was conceptualized as an individual's "motivation to seek help and preparedness to engage in treatment activities" (DiClemente, Schlundt, & Gemmell, 2004, p. 105) as evidenced by movement along a behavioral continuum that culminates in the individual's stated intention to begin treatment.

Behavioral intention was operationalized by the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8D, 1990) (Miller & Tonigan, 1996). As shown in Section 1, Appendix E, this 19-item drug and alcohol questionnaire reflects behavioral intention of readiness based upon three factorially-derived subscales related to an individual's (1) ambivalence or uncertainty about the deleterious effects of substance use habits, (2) recognition of substance use problems, and (3) ability to take concrete, behavioral steps towards making positive changes in substance use habits. While there are multiple scales available for use in measuring stages of change, and no established 'gold standard,' the SOCRATES is considered a reputable instrument with respect to validity and reliability (Napper, Wood, Jaffe, Fisher, Reynolds & Klahn, 2008). The SOCRATES subscales report a Cronbach Alpha of .83 to .96 (Miller & Tonigan, 1996; Nidecker, DiClimente, Bennett, & Bellack, 2008).

Independent Variables

Appraisal of Consequences of Substance Use. Appraisal of consequences of substance use was conceptualized as individuals' evaluation of the positive and negative consequences of their substance use. Appraisal was operationalized as one overall score measured by the Decisional Balance Inventory (DBI) (Velicer, DiClemente, Prochaska, &

Brandenburg, 1985). As shown in Section Three, Appendix E, the DBI is a 20-item Likert

scale that assesses the pros and cons of changing alcohol or drug use behaviors. The DBI

reports a Cronbach's alpha of .87 for the pros subscale and .90 for the cons subscale,

although the final scale results involves one consolidated, summated score (Nidecker,

DiClimente, Bennett, & Bellack, 2008; Velicer, DiClemente, Prochaska, & Brandenburg,

1985). While some reviews of the DBI are mixed, it continues to show success in the

literature as an indicator of readiness to change (Morgen & Gunneson, 2008).

   Masculine Self-Reliant Attitude against Help-Seeking. Masculine self-reliance

was conceptualized as individuals' adherence to masculine gender role stereotypes that

promote self-sufficiency in handling problems on one's own without seeking professional

help (Mansifeld, Addis & Coutenay, 2005). As indicated in Section Two of Appendix E, it

was operationalized by a subscale that included questions 1-10 of the Barriers to Help-

Seeking Scale (BHSS) (Masculine Self-Reliance) that reports a Cronbach alpha of .85

(Mansfield, Addis & Coutenay, 2005). Again, while the authors of the scale report adequate

convergent and criterion validity and good reliability, no additional reviews are yet available

in the literature.

   Perceived Control. Perceived control over treatment access is conceptualized as an

individual's belief about whether he or she possesses the resources and opportunities

necessary to access treatment. As listed in Section Two, Appendix E, it was operationalized

by scores on three subscales of the Barriers to Help-Seeking Scale (BHSS) modified by the

researcher: concern about emotional self-control (questions 19-22), concern about

privacy/trust (questions 15-18), and perceived control of concrete barriers to treatment access

(questions 11-14) (Mansfield, Addis & Coutenay, 2005). The BHSS subscales, "Concrete Barriers," "Distrust of Caregivers/Privacy," and "Emotional Control" report Cronbach's alpha scores of .79, .83 and .89 respectively (Mansfield, Addis & Coutenay, 2005). The authors of the scale report good convergent and criterion validity for the BHSS; however, the scale has not yet been widely used and there are no further reports of its psychometric properties in the literature. For the purposes of this study, the subscales were slightly modified. A separate subscale was created for concrete barriers. The distrust of caregivers and privacy questions were combined to create one subscale.

Perception of workplace permissibility. Perception of workplace culture of permissibility of substance use was conceptualized overall as the level of social support among union members in the workplace that would either facilitate or deter substance use, as suggested by Beattie, Longabaugh, & Fava (1992). Beattie, Longabaugh, and Fava (1992) developed the 13-item, self-report, Your Workplace Scale (YWP) to assess the impact of workplace substance use rituals on adults' work performance, and support for substance use or abstinence.

As shown in Section 4, Appendix E, this study used three subscales of the YWP to operationalize the following permissive workplace variables: (1) perception of workplace support of substance use consumption, (2) perception of workplace support of abstinence, and (3) awareness of adverse effects of substance use in the workplace. The YWP has been shown to determine the degree of social supports in the workplace that either promote recovery or increase the risk of relapse (Donovan, 1995). With respect to validity, the YWP has demonstrated face validity, discriminant and convergent validity, construct and criterion-

related validity; The scale also has established internal reliability (Donovan, 1995; Rice, Longabaugh, & Stout, 1998).

Control Variables. Control variables for this study include (1) age, (2) race, and (3) severity of the primary drug of choice. The age categories for the study were chosen in keeping with the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines for its national surveys on drug use and health (NSDUH 2008); the age categories identified were 18-25, 26-45, 46-61, 62 or older. Race was chosen as a control variable to isolate the effects of ethnicity as a potential barrier to help-seeking. The race categories used for this study were White, White, non-Hispanic, Hispanic, African-American, Asian or Pacific Islander, Native American, and other. Severity of primary drug of choice was chosen as a control variable, and was operationalized using the cut-off scores recommended by the AUDIT, i.e., harmful substance abuse is reflected by scores ≥ 8, and probable substance dependence is indicated by scores ≥ 15.

Statistical Analysis Plan

The Statistical Package for Social Sciences (SPSS) was used to enter the data, checked for errors and cleaned. Client demographics were analyzed by descriptive statistics. A multiple regression analysis was used to test the hypothesis. The level of significance used for this study for all statistical analyses was $p \leq .01$ and ≤ 05.

Strengths and Weaknesses of the Study Design

It was not feasible to use random sampling strategies with this client population. Instead, convenience sampling was utilized; however, it detracts from the generalizability of study findings in that the sample reflects only those union members who chose to participate

(Sapsford, 1999). Another study limitation involves the ability of the researcher to fully capture union members' frame of mind along the continuum of the behavioral intention to change given the fact that union members received surveys after they had recently received crisis intervention services. While every attempt was made to issue surveys promptly, by the time surveys were received, completed and returned, union members' may have already entered a new stage of change on the continuum as a result of having received intervention services. A study strength is that the reliability measures for the scales utilized in the study reported Cronbach's alpha scores ranging from .85 to .93 (See reliability analyses of scales and tests in Chapter Four).

Summary

This chapter reviewed the methodology for the study. Study design and protocol were presented, including a review of the study purpose, design, hypothesis, sampling strategy and data collection procedures. Study variables were defined conceptually and operationally, as well as instrumentation. Finally, the method of statistical analysis was discussed.

Chapter Four will review data analysis. The data will be interpreted to reveal its support for the study hypothesis.

Table 3.1 Variable list with conceptual and operational definitions

Variable	Conceptual	Operational
Control 1. Age 2. Race 3. Severity of substance abuse		 3. Cut off score on AUDIT and DAST
Independent 1. Appraisal of consequences of substance use (more negative) (lower) ↓ 2. Masculine self-reliance against help-seeking (lower) ↓ 3. Emotional self-control concerns (lower) ↓ 4. Privacy and trust concerns (lower) ↓ 5. Perceived control over concrete barriers (higher) ↑ 6. Perception of workplace support of abstinence (increased) ↑ 7. Perception of workplace support of consumption (decreased) ↓ 8. Awareness of adverse effects of use in workplace (increased) ↑	1. Evaluation of positive v. negative consequences of substance use. 2. Adherence to masculine gender role stereotypes that promote self-sufficiency in handling problems on one's own without seeking professional help. 3. Need to maintain emotional stoicism and to avoid discussions that provoke feelings. 4. Concerns about one's ability to trust professional therapists, and to reveal embarrassing personal problems. 5. Belief that one possesses resources & opportunities to access treatment. 6. Perception of workplace peer and supervisory norms and activities that encourage abstinence. 7. Perception of workplace peer and supervisory norms and activities that sanction substance abuse. 8. Awareness that substance abuse is negatively impacting one's job performance and work standing.	1. Decisional Balance Inventory (DBI) 2. Masculine self reliance subscale of Barriers to Help-Seeking Scale (BHSS) 3. Subscale of Barriers to Help-Seeking Scale (BHSS) 4. Modified subscale of Barriers to Help-Seeking Scale (BHSS) 5. Modified subscale of Barriers to Help-Seeking Scale (BHSS) 6. Subscale of Your Workplace Scale (YWP) 7. Subscale of Your Workplace Scale (YWP) 8. Subscale of Your Workplace Scale (YWP)
Dependent 1. Ambivalence to seeking help (increases) 2. Recognition of problem and need for help (increases) 3. Taking steps towards help (increases)		1. Ambivalence subscale of Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) 2. Recognition of substance use problems subscale SOCRATES 3. Ability to take steps towards change in substance use subscale of SOCRATES

Chapter Four: Findings

Chapter Four presents the findings of the study which tested the effects of a set of internalized values and environmental social norms on the stages of change toward seeking help for substance abuse among male union construction workers. Socio-demographic data will be presented, followed by a summary of each scale and reliability analysis. Bivariate analyses will highlight correlations between the dependent and independent, control and other dependent variables. The results of multiple regression analyses will be compared and contrasted with the study hypotheses. Finally, the implications of these findings will be discussed in detail.

Socio-Demographic Data

The participants for this study consisted of 125 adult, male union construction workers who were screened as having a probable substance use disorder after having contacted their union Member Assistance Program (MAP) telephone crisis center for information and referral. Members were categorized in age groups ranging from 18-25, 26-45 and 46-61. The study included 18 men aged 18-25 (14 percent), 70 men (56 percent) age 26-45, and 37 men (30 percent) aged 46-61. Participants' race was 77 percent Caucasian and 23 percent non-Caucasian. Specifically, participants consisted of 96 Caucasian, 4 Caucasian/Non-Hispanic, 10 Hispanic, 11 African-Americans, 1 Asian/Pacific Islander, and 3 Other. Among the 125 participants, 81 (65 percent) grew up in union families in which their parent, grandparent or close relative were also union members. Demographic data is detailed in Table 4.1.

Additional demographic information concerned participants' history of having received a driving under the influence (DUI) or driving while intoxicated (DWI) charge. Participants' responses indicated that 43 (34 percent) had never received a DUI/DWI, 29 (23 percent) had been charged one time, 26 (21 percent) had received two charges, and 27 (22 percent had incurred three or more charges.

A majority of study participants admitted to having prior experience with substance abuse treatment or support group involvement. For example, 79 (63 percent) of participants had attended Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) support groups in the past. In addition, 73 percent of participants had attended professional treatment programs for substance use problems. Among these, 22 (18 percent) were voluntary clients, 68 (55 percent) were involuntary clients who were mandated to treatment by their employer or the court. Nearly one-third of participants, 34 (27 percent) had no prior exposure to professional treatment. With regard to serious substance use disorders requiring hospitalization, 59 (47 percent) admitted to prior hospitalizations, while 66 (53 percent) reported no hospitalizations.

Table 4.1 Demographics Table

	Frequency N	Percentage %
AGE (N = 125 adult males)		
18-25	18	14
26-45	70	56
46-61	37	30
RACE		
White	96	77
White, Non-Hispanic	4	3
Hispanic	10	8
African-American	11	9
Asian or Pacific Islander	1	1
Other	3	2
DUI or DWI HISTORY		
Never	43	34
One time	29	23
Two times	26	21
Three or more times	27	22
GREW UP UNION FAMILY		
Yes	81	65
No	44	35
PRIOR ATTENDANCE AA, NA		
Yes	79	63
No	46	37
PRIOR PROFESSIONAL TX		
Yes, voluntary	22	18
Yes, involuntary (court or employer)	68	55
No, never	34	27
PRIOR HOSPITALIZATION **(substance abuse)**		
Yes	59	47
No	66	53

Summary Statistics

Summary of the Scales

Table 4.2 illustrates the summary of the scales used for this study. The summary includes the mean, standard deviation, potential and actual range for the scales. The Alcohol Use Disorders Test (AUDIT) scores, used to measure the control variable of alcohol abuse, were in the middle of the range with a mean of 15.8. The three stages of change (ambivalence, recognition, and taking steps) were identified as dependent variables and were measured by the subscales of the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). The mean scores for all of the dependent variables were relatively high given the actual ranges. For example, the mean for ambivalence was 14.0 with an actual range of 4-20, the mean score for Recognition was 24.5 with an actual range of 7-35, and the mean score for taking steps was 25.5 with an actual range of 8-39.

Among the independent variables, the mean score for appraisal of consequences was -.3 with an actual range of -2.4-+2.4. Masculine self-reliant attitude against help-seeking scores were especially high overall, with an actual range of 23-50 of a potential 10-50 range. The mean score for masculine self-reliant attitude was also relatively high at 39. Scores for perception of workplace support of abstinence were low, with an actual range of 0-17 compared to a potential range of 0-24. The mean score of 1.9 for workplace support of abstinence was extremely low. The mean score for perception of workplace support of consumption was also remarkably high at 18.7 with an actual range of 5-28. The mean score for awareness of adverse workplace effects was 6.1, with an actual range of 0-23. Union

members' concerns about perceived control over concrete barriers, emotional self-control, and privacy/ trust were elevated: The mean scores for perceived control over concrete barriers was 14.9 of an actual range of 8-20; 16.3 for concern about emotional self-control with an actual range of 11-20; and 13.5 for concern about privacy and trust with an actual range of 9-20.

Table 4.2   Summary of the Scales (N = 125)

Scale	Mean	Actual Range	SD	Potential Range
AUDIT	15.8	1-30	9.7	1-37
DAST	10.5	2-22	5.0	0-20
Ambivalence	14.0	6-20	2.9	4-20
Recognition	24.5	7-35	6.2	7-35
Taking Steps	25.5	8-39	6.2	8-40
Appraisal of Consequences	-.3	-2.4-+2.5	.9	-4-+4
Masculine Self-Reliant Attitude against Help-Seeking	39.0	23-50	5.5	10-50
Concern about Emotional Self-Control	16.3	11-20	2.2	4-20
Concern about Privacy/Trust	7.6	9-21	1.3	4-20
Perceived Control over Concrete Barriers	20.8	8-20	3.5	4-20
Perception of Workplace Support of Abstinence	1.9	0-17	3.1	0-24
Perception of Workplace Support of Consumption	18.7	5-28	4.9	0-31
Awareness of Workplace Adverse Effects	6.1	0-23	5.0	0-30

Reliability Analyses

Reliability analyses were run on SPSS for all of the scales used in the study.

Cronbach's Alpha for each scale and subscale is listed in Table 4.3.

Table 4.3   Reliability Analyses of Scales and Tests

Scale	No. of Items	Cronbach's Alpha
Alcohol Use Disorders Identification Test (AUDIT)	10	.93
Drug Abuse Screening Test (DAST)	20	.81
Barriers to Help Seeking Scale (BHSS)	22	.87
Decisional Balance Inventory (DBI) (Appraisal of Consequences)	20	.88
Your Workplace Scale (YWP)	15	.85

Bivariate Analyses

A number of variables demonstrated a significant correlation with the dependent

variables of ambivalence, recognition and taking steps. In general, multicollinearity between

the predictor variables was moderate to weak with the exception of masculine self-reliance

and concern about privacy/trust (r=.55, p. $\leq$ .01), and perception of workplace support of

abstinence and awareness of adverse effects in the workplace (r=.62, p. $\leq$ .01). Table 4.4

summarizes the findings of a correlation matrix of variables using bivariate analyses.

Bivariate Analysis
Table 4.4 Correlation Matrix of Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	1	.028	-.020	-.303**	.008	-.093	-.064	.094	-.142	.029	-.204*	-.105	-.096	-.065	-.054
2		1	-.068	-.022	-.097	-.043	.129	.032	-.034	-.111	-.084	.026	.035	.077	.037
3			1	.060	-.181*	-.049	.189*	-.026	.259**	.274**	.396**	.212*	.434**	.398**	.005
4				1	-.138	-.071	-.002	.086	.145	.164	.149	302**	.259**	.219*	.058
5					1	.448**	-.211*	.330**	-.066	.111	.082	.129	-.550**	-.660**	-.247**
6						1	.343**	.549**	.426**	.001	.265**	.023	-.221*	-.343**	-.052
7							1	.362**	.373**	-.014	228*	.002	.286**	.269**	.148
8								1	.289**	.205*	.263**	.396**	-.100	-.166	.030
9									1	-.138	.423**	.034	.233**	.144	.137
10										1	.019	.622**	.003	-.010	-.051
11											1	.207*	.187*	.190*	.058
12												1	.128	.114	-.054
13													1	.842**	.226*
14														1	.350**
15															1

Key to Variables

1. Age
2. Race
3. AUDIT
4. DAST
5. Appraisal of Consequences
6. Masculine Self-Reliant Attitude
7. Emotional Self-Control
8. Privacy/Trust
9. Perceived Control over Concrete Barriers
10. Workplace Support of Abstinence
11. Workplace Support of Consumption
12. Workplace Adverse Effects
13. Ambivalence
14. Recognition
15. Taking Steps

Ambivalence. The dependent variable of ambivalence towards seeking help correlates with the dependent variables of recognition and taking steps. For example, there is a significant positive linear relationship between ambivalence and recognition ($r=.84$, p. $\leq$ .01) and ambivalence and taking steps ($r=.23$, p. $\leq$ .05), indicating that along the continuum of behavioral intention of change, as union members' scores on ambivalence increase, their scores for problem recognition and taking steps towards treatment also increase. There is a significant negative linear relationship between ambivalence and appraisal of consequences ($r= -.55$, p. $\leq$ .01). As union members' ambivalence increases, they also report experiencing increased awareness of the negative consequences of their substance use. There is a significant negative linear relationship between ambivalence and masculine self-reliant against help-seeking ($r=-.22$, p. $\leq$ .05). As union members' ambivalence increases moving them along the behavioral continuum towards seeking help, they report reduced levels of masculine self-reliant attitudes against help-seeking. There is a positive significant relationship between ambivalence and perception of workplace support of consumption ($r=.19$, p. $\leq$ .05). This suggests that as union members' ambivalence increases and moves them along the behavioral intention continuum towards seeking help, they also report increased recognition of workplace support of consumption. A significant positive linear relationship exists between ambivalence and concern about emotional self-control ($r=.29$, p. $\leq$.01). As union members' ambivalence increases and they move towards help-seeking, their concern about emotional self-control also increases. There is a significant positive linear relationship between ambivalence and perceived control over concrete barriers ($r=.23$, p. $\leq$ .01). As union members' ambivalence increases, their perceived control over concrete

barriers also increases. Union members report that as their ambivalence increases, they are more aware of the negative effects of their substance use in the workplace and upon their work standing.

   Recognition. There is a significant positive linear relationship between recognition of the problem and the need for help and taking steps (r=.35, p. ≤.01). As recognition increases, clients also increase their behavior towards taking steps along the continuum of change. A significant negative linear relationship also exists between recognition and appraisal of consequences. As union members' recognition of the need for help-seeking increases, their awareness of the negative consequences of their substance use also increases (r= -.66, p. ≤ .01). There is a significant negative linear relationship between recognition and masculine self-reliant attitude against help-seeking (r=-.34, p. ≤.01). As recognition of the need for treatment increases, masculine self-reliant attitude decreases. A significant positive linear relationship exists between recognition and perception of workplace support of consumption (r=.19; p. ≤ .05). As problem recognition increases, union members report increased recognition of workplace support of consumption. A significant positive linear relationship was identified between recognition and concern about emotional self-control (r=.27, p. ≤ .01). As union members' problem recognition increases, their concern about emotional self-control also increases.

   Taking Steps. There is a significant negative linear relationship between taking steps and appraisal of consequences (r = -.25, p. ≤ .01). The more aware union members are of the negative consequences of their substance use, the more likely they are to take steps towards change.

Control Variables

Age. There is a significant negative linear relationship between age and perception of workplace support of consumption (r=-.20, p. ≤ .05). The older the worker, the less likely he is to perceive support for consumption of substances in the workplace. There is a significant negative linear relationship between age and DAST scores (r=-.30, p. ≤ .01). As age increases, scores on the DAST decrease, suggesting that older union members have less severe substance use problems.

Race. No significant relationships were found between race and any of the variables used in the study. This finding may be related to the fact that 77 percent of the participants were Caucasian, and only 23 percent were racial minorities, providing little variance to see a correlation effect.

AUDIT. Several significant relationships were found between severity of use as determined by union members' score on the AUDIT and study variables. For example, there is a positive linear relationship between AUDIT and Ambivalence (r=.43, p. ≤ .01). As union members' severity of substance use increases, their ambivalence also increases along the behavioral intention of help-seeking continuum. There also appears to be a significant positive linear relationship between AUDIT and Recognition (r=.40, p. ≤ .01). As union members' severity of substance use increases, their recognition of their substance abuse problem and the need to seek help also increases. There is a positive linear relationship between AUDIT and perception of workplace support of abstinence (r=.27, p. ≤.01). As union members' severity of substance use increases, their perception of workplace support of abstinence also increases. Ironically, at the same time, a positive linear relationship also

exists between AUDIT and perception of workplace support of consumption (r=.40, p. ≤ .01). As severity of substance use increases, clients also report increased perception of workplace support of consumption as well. It would appear, therefore, that clients with more severe substance use problems show greater sensitivity to the tug of war between workplace support of abstinence and consumption. There is a significant positive linear relationship between AUDIT and awareness of adverse effects in the workplace (r=.21, p. ≤ .05). As union members' severity of substance use increases, they report increased awareness of adverse effects in the workplace with respect to their work standing and employment. There is a positive linear relationship between AUDIT and concern about emotional self-control (r=.19, p. ≤ .05). As union members' severity of substance use increases, their concern about emotional self-control also increases.   There is a significant positive linear relationship between AUDIT and perceived control over concrete barriers (r=.26, p. ≤.01). As union members' substance use increases, they report higher levels of perceived control over concrete barriers.

DAST. There is a significant positive linear relationship between the DAST and adverse effects in the workplace (r=.30, p. ≤ .01). As union members' DAST scores increase to reflect worsening substance abuse problems, they also report increased awareness of the adverse effects of their substance abuse in the workplace and their work standing. DAST is also correlated with two dependent variables: ambivalence and problem recognition. As union members' DAST scores increase, they also experience higher levels of ambivalence (r=.26, p. ≤ .01) and problem recognition (r=.22, p. ≤ .05) along the continuum of behavioral intention to seek help.

Findings Related to the Hypotheses

Multiple regression analyses were performed to test the effects of the independent variables on three, separate stages along the continuum of the behavioral intention to commence treatment: ambivalence towards seeking help, recognition of the problem and the need for help, and taking steps towards seeking help. The independent variables included appraisal of consequences, masculine self-reliant attitude against help-seeking, concern about emotional self-control, concern about privacy and trust, and perceived control over concrete barriers, as well as perception of workplace support of abstinence, perception of workplace support of consumption, and awareness of adverse effects in the workplace. In Model 1 (Complete), the hypotheses were tested for each of the dependent variables using all of the predictor variables. In Model 2 (Reduced), the hypotheses were tested for each of the dependent variables using only the significant predictor variables. Tables 4.5, 4.6 and 4.7 depict the results of a multivariate analysis run on SPSS for Models 1 and 2.

Hypothesis 1

It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **ambivalence** towards seeking help on the behavioral intention of readiness continuum of

change. Ambivalence is an early stage along the path towards the behavioral intention to seek help for substance use problems. It is characterized by a beginning awareness of the negative consequences associated with substance abuse. At the same time, however, persons in this stage are in a state of flux. They may exhibit momentary glimpses of insight and awareness of the need to seek help, followed by rapid retreats into minimization and denial.

The findings, which are listed in Table 4.5, provide partial support of the hypothesis. The complete model is significant at the .01 level, and the overall set of predictors explains 43 percent of the variance in ambivalence towards seeking help. The reduced model is significant at the .01 level, and the significant set of predictors explains 37 percent of the variance in ambivalence towards seeking help. Study results suggest that three predictors were key to union construction workers' decision-making processes during the ambivalence stage. These include: negative appraisal of consequences (Beta = -.54, $p \leq .01$), concern about emotional self-control (Beta = .17, p. $\leq .05$), and awareness of adverse effects in the workplace (Beta = .20, p. $\leq .05$).

Table 4.5 Regression of *Ambivalence* and Appraisal of Consequences of Substance Abuse, Masculine Self-Reliant Attitude against help-seeking, Concern about Emotional Self-Control, Concern about Privacy and Trust, Perceived Control over Concrete Barriers, Perceived Support of Workplace Abstinence, Perceived Support of Workplace Consumption, and Awareness of Workplace Adverse Effects.

Variables	Model 1 (Complete)			Model 2 (Reduced)		
	B	Beta	T	B	Beta	T
Appraisal of Consequences	-1.30	-.44	-4.70**	-1.61	-.54	-7.25**
Masculine Self-Reliant Attitude against Help-Seeking	-.07	-.14	-1.29			
Concern about Emotional Self-Control	.26	.19	2.16*	.23	.17	2.33*
Concern about Privacy/Trust	-.14	-.11	-1.10			
Perceived Control over Concrete Barriers	.16	.15	1.69			
Perception of Workplace Support of Abstinence	-.04	-.05	-.49			
Perception of Workplace Support of Consumption	.08	.13	1.66			
Awareness of Workplace Adverse Effects	.13	.27	2.22*	.12	.20	2.71*
	R^2	.43		R^2	.37	
	F	10.75**		F	23.78**	

*	$p \leq .05$
**	$p \leq .01$

Hypothesis 2

It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **recognition** towards seeking help on the behavioral intention of readiness continuum of change. Recognition pertains to the ability to recognize one's substance abuse problem and a willingness to change. Recognition is a critical stage in the process of change in that it involves the end of chronic minimization and denial, and the beginning of an acknowledgement of the seriousness of one's substance abuse problem (Miller, & Tonigan, 1996). Recognition is also the starting point in which the client understands and admits to the necessity of treatment. The findings, which are listed in Table 4.6, provide partial support of the hypothesis. The complete model is significant at the .01 level, and the overall set of predictors explains 56 percent of the variance in ambivalence towards seeking help. The reduced model is significant at the .01 level, and the significant set of predictors explains 55 percent of the variance in ambivalence towards seeking help. As hypothesized, union construction workers who acknowledge greater awareness of an appraisal of the negative consequences of their substance use report higher scores on recognition (Beta = -.57, p. ≤ .01). Also, the variables that were significant during the ambivalence phase, concern about

emotional self control (Beta = .17, p. ≤ .05) and awareness of adverse effects in the

workplace (Beta = .15, p. ≤ .05) continue to exert their influence during the recognition

phase. During the recognition phase, however, two additional predictors appear significant.

These include masculine self-reliant attitudes against help-seeking (Beta = -.21, p. ≤ .05) and

perception of workplace support of consumption (Beta = .22, p. ≤ .01).

Table 4.6 Regression of *Recognition* and Appraisal of Consequences of Substance Abuse, Masculine Self-Reliant Attitude against help-seeking, Concern about Emotional Self-Control, Concern about Privacy and Trust, Perceived Control over Concrete Barriers, Perceived Support of Workplace Abstinence, Perceived Support of Workplace Consumption, and Awareness of Workplace Adverse Effects.

Variables	Model 1 (Complete)			Model 2 (Reduced)		
	B	**Beta**	**T**	**B**	**Beta**	**T**
Appraisal of Consequences	-3.34	-.54	-6.58**	-3.53	-.57	-7.36**
Masculine Self- against Help-Seeking	-.22	-.20	-2.12*	-.24	-.21	-2.61*
Concern about Emotional Self-Control	.54	.19	2.46*	.48	.17	2.32*
Concern about Privacy/Trust	-.23	-.09	-1.02			
Perceived Control over Concrete Barriers	.10	.04	.56			
Perception of Workplace Support of Abstinence	-.12	-.06	-.76			
Perception of Workplace Support of Consumption	.26	.20	2.89*	.28	.22	3.40**
Awareness of Workplace Adverse Effects	.27	.22	2.44*	.18	.15	2.28*
	R^2	.56		R^2	.55	
	F	18.38**		F	29.26**	

* p $\leq$ .05

** p $\leq$ .01

Hypothesis 3

It was hypothesized that controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of ***taking steps*** towards seeking help on the behavioral intention of readiness continuum of change. Taking steps is the final stage of behavioral intention to seek change. Following a resolution of ambivalence and recognizing that a problem exists, the person is ready to take concrete, behavioral steps towards making positive changes in substance use habits.

As shown in Table 4.7, the findings do not provide adequate support of the hypothesis. While multiple regression demonstrated that as with the ambivalence and recognition stages, appraisal of consequences remained a significant predictor for taking steps (Beta = -.25, p. ≤ .05), it was the only significant predictor. The variables that were significant in earlier stages of the help-seeking continuum do not exert their influence in the final stage of the behavioral intention to seek help. In addition, the complete model was not significant at the .01 or .05 levels and accounted for only nine percent of the variance. Neither was the reduced model significant at the .01 or .05 levels, and accounted for a mere six percent of the variance in taking steps.

Table 4.7 Regression of *Taking Steps* and Appraisal of Consequences of Substance Abuse, Masculine Self-Reliant Attitude against help-seeking, Concern about Emotional Self-Control, Concern about Privacy and Trust, Perceived Control over Concrete Barriers, Perceived Support of Workplace Abstinence, Perceived Support of Workplace Consumption, and Awareness of Workplace Adverse Effects.

Variables	Model 1 (Complete)			Model 2 (Reduced)		
	B	Beta	T	B	Beta	T
Appraisal of Consequences	-1.46	-.24	-2.01*	-1.54	-.25	-2.83*
Masculine Self- against Help-Seeking	-.09	-.08	-.61			
Concern about Emotional Self-Control	.09	.03	.30			
Concern about Privacy/Trust	.36	.14	1.11			
Perceived Control over Concrete Barriers	.21	.10	.85			
Perception of Workplace Support of Abstinence	.05	.02	.20			
Perception of Workplace Support of Consumption	.04	.04	.34			
Awareness of Workplace Adverse Effects	-.13	-.10	-.80			
	R^2	.09		R^2	.06	
	F	1.45		F	8.01	

* $p \leq .05$

Summary of Findings

This study evaluated the impact of multiple predictors upon the stages of behavioral intention to seek help for substance abuse problems. The stages along the continuum consisted of ambivalence, recognition and taking steps. The strongest findings identified multiple predictors in the early and middle phases of help-seeking, ambivalence and recognition. The models for predicting ambivalence and recognition were both significant at the .01 level. The model for the final stage of the behavioral continuum, taking steps, identified only one significant predictor variable.

One predictor, appraisal of consequences, was consistently identified as being significant across all three stages of the continuum. Further, two additional predictor variables, concern about emotional self control and awareness of workplace adverse effects, were found to impact the ambivalence and recognition stages. Further, the study found that two additional variables relating to internalized values and environmental norms connected to workplace culture, masculine self control and perception of workplace support of consumption affected the key recognition phase.

Summary

This chapter reviewed the findings of statistical analyses to demonstrate partial support for the study hypotheses. Congruence with some of the findings increases our understanding of union members' behavioral intention to seek help, while discrepancies also recommend the need for additional research.

Chapter Five will provide a brief overall summary of the study, discuss the significance of the findings for contributions to the social work knowledge base, and interpret the study findings from a theoretical perspective.

Chapter Five: Summary and Conclusions

This chapter provides a review and conclusion to the study. It summarizes the literature that describes and explains the problem, and grounds the purpose of the study. It will present the methodology and review the study's overall findings as well as provide an analysis by stage of behavioral intention to change. Further, it will interpret the findings from the theoretical foundations of the study.   Finally, it will explore the limitations of this study, suggest its contributions to social work practice and theory, and will make recommendations for future research.

Summary of the Literature

When compared to any other occupation, adult construction workers (including union construction workers) demonstrate among the highest heavy alcohol and illicit drug use (Office of Applied Studies, 2007; Popp & Swora, 2001).   With respect to alcohol abuse, an astonishing 15.9 percent of construction workers admit to drinking five or more drinks daily, placing them in the lead occupational category of "heavy drinking." This level of alcohol abuse is nearly twice the average rate for all other professional industries (Larson, Eyerman, Foster, & Gfroerer, 2007; SAMHSA, 2007). The prevalence of illicit drug use among adult construction workers is 13.7 percent, the second highest ranking among all professional occupations (SAMHSA, 2007). For reasons not yet fully understood, despite the prevalence and severity of substance abuse problems among union construction workers, they rarely connect with treatment services (Tighe & Saxe, 2006). The sad irony is that these worst occupational offenders are among the least likely to seek help.

Union members often begin abusing drugs and alcohol in early adolescence, so that by the time they are young adults, they have developed life-threatening substance use dependencies. Members are also exposed to a pervasive, centuries-old permissive workplace culture that not only openly encourages substance use, but promotes a strong sense of masculine pride, or hypermasculinity that discourages help-seeking. As the director of a union Member Assistance Programs (MAP) that provides crisis intervention and referral services to union members and their families, the researcher encountered hundreds of construction workers who presented with serious substance use disorders and yet are extremely resistant to commencing treatment.

MAP directors are aware that union members tend to be distrustful of outsiders, and that it sometimes takes years to develop rapport. However, by joining with union members and becoming a part of the culture, MAP directors are in a better position to bring about internal changes. MAPs can play a vital role in educating the membership and leadership regarding substance abuse, as well as the benefits of a drug-free workplace. MAPs can challenge outdated perspectives that overly focus on denial by helping members identify and remedy practical and psychological barriers that interfere with treatment access. MAPs can promote a view of help-seeking as strength, not a weakness. And, MAPs can identify treatment entry as a chief program goal – one that shares equal import with assisting those clients who are treatment ready.

Theoretical Framework

The theoretical framework for this study consisted of Prochaska and DiClemente's (1986) transtheoretical model of behavioral change (TTM), Bandura's (1986) social

cognitive theory (SCT) and Ajzen's (1985) theory of planned behavior (TPB). These conceptual frameworks addressed the processes by which individuals engage in purposeful, goal-directed behavioral change. Central to these frameworks is the unique contribution of individual thoughts, attitudes and belief systems, as well as social norms in contributing to the acquisition of new behaviors. The overall perspective of the model and theories is that behavioral change should be viewed from a holistic, person-in-environment vantage point that includes the relevancy of social norms in influencing behavior

The decision to seek treatment was conceptualized from the Prochaska and DiClemente's transtheoretical model of intentional behavioral change (TTM) as a construction worker's *behavioral intention of readiness for change*. Behavioral intention is defined as an individual's "motivation to seek help and preparedness to engage in treatment activities" (DiClemente, Schlundt, & Gemmell, 2004, p. 105) as evidenced by movement along a behavioral continuum from ambivalence to seeking help, to recognition of the problem and need for help, and culminating in taking steps towards help. The environmental and psychological influences on behavioral intention were further explained by Bandura's social cognitive theory, and Ajzen's theory of planned behavior.

Purpose

Specifically, the purpose of the study was to test this conceptual model that integrates both environmental and psychological factors in a comprehensive model to explain behavioral intention to seek treatment for substance use disorders in male union construction workers.

Study Hypotheses

Empirical and theoretical literature suggested that multiple factors influence union members' behavioral intention to seek substance abuse treatment From the literature, key factors were identified and hypothesized to have an effect on behavioral intention. These factors included the role of an attitude of masculine self-reliance and perceptions about a permissive workplace culture, along with a tendency to minimize the consequences of substance use and concerns about perceived control over treatment access. The study hypotheses were:

H1: Controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of ***ambivalence*** towards seeking help on the behavioral intention of readiness continuum of change.

H2: Controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the*

workplace, will be associated with a higher level of **recognition** towards seeking help on the behavioral intention of readiness continuum of change.

H3: Controlling for age, race and level of severity of substance use, a more negative *appraisal of consequences* of substance abuse, a less *masculine self-reliant attitude* against help-seeking, a lower level of *concern about emotional self-control*, a lower level of *concern about privacy and trust*, a higher level of *perceived control over concrete barriers*, a higher *perception of workplace support of abstinence*, a lower *perception of workplace support of consumption*, and an increased *awareness of the adverse effects of substance abuse in the workplace*, will be associated with a higher level of **taking steps** towards seeking help on the behavioral intention of readiness continuum of change.

Methodology

This study utilized a cross-sectional survey design to test the relationship between union construction workers' tendencies to minimize the negative consequences of substance use, attitudes of masculine self-reliance, perceptions of a permissive workplace culture towards substance use, and their concerns about perceived control to access treatment and three stages of the behavioral intention to seek substance abuse treatment (ambivalence, recognition and taking steps). The study sample consisted of 125 adult, male union construction workers who were screened as having a probable substance use disorder after having contacted their union Member Assistance Program (MAP) telephone crisis center for information and referral. Data from a mailed survey were entered into an SPSS data file, and checked for errors. Descriptive statistics were employed to establish frequency distributions for demographic characteristics of the participants. Bivariate analyses highlighted

correlations between the dependent and independent, control and other dependent variables at the $p \leq .01$ and $p \leq .05$ levels. Multiple regression analyses were used to test the study hypotheses.

Summary of Findings

The results of the testing of the hypotheses will be reported. These findings will first be described from the perspective of the continuum of behavioral intention overall. A schema chart in Table 5.1 will review key predictors that influence union construction members' decision-making processes as they transition along the behavioral continuum. Then, the results of the testing of the hypotheses will be reviewed and theory will be applied to explain the resulting models by stage.

Overall Perspective of Study Findings Related to the Continuum of Behavioral Intention

Multiple regression analyses were performed to test the hypotheses. In Model 1 (Complete), the hypotheses were tested for each of the three stages of change using all of the predictor variables. In Model 2 (Reduced), the hypotheses were tested for each of the dependent variables using only the significant predictor variables.

At the end of this section, Table 5.1 provides a visual representation or schema of significant predictors in union construction workers' behavioral intention to seek help for substance abuse. The table illustrates the continuity of several significant variables. For example, as union members move from the ambivalence stage, through the recognition stage to the final, taking steps stage, along this path, appraisal of negative consequences of substance abuse maintains its significance. This indicates that union members who are in the

process of seeking help focus primarily on negative appraisal of consequences, and retain this acumen throughout the help-seeking process. Similarly, awareness of adverse effects of substance use in the workplace (another negative consequence), becomes important in the early ambivalence stage and continues to exert its influence for union members during the middle recognition phase.

The schema also reveals that union members who enter the behavioral intention continuum to harbor fewer concerns about the need to maintain emotional self-control. These union members report feeling more comfortable talking about emotionally laden issues and displaying feelings. They also are not overly concerned about becoming embarrassed by talking about their substance abuse problem. During the middle recognition stage, union members who are able to acknowledge their substance abuse problem and the need for help are also less likely to demonstrate a masculine self-reliant attitude against help-seeking. This finding suggests that such a masculine self-reliant attitude may act as a barrier to behavioral intention, because union construction workers who score high on this attitude scale refrain from seeking help.

Interestingly, during the middle recognition phase of help-seeking, union members report a growing perception of workplace permissive culture that promotes substance abuse. Union members have greater insight and awareness of the negative influence of social norms that promote consumption.

The schema indicates a remarkable consistency in the predictor variables that impact behavioral intention. It also highlights the fact that different predictors are important to union construction workers at different stages along the continuum. It is also important to

note that in keeping with the social work person-in-environment perspective, that these

predictors are a mixture of individual and environmental concerns.

Table 5.1 Schema of Statistically Significant Predictors in Union Construction Workers' Behavioral Intention

```
                          ┌──────────────────────┐
                          │ Behavioral Intention │
                          └──────────┬───────────┘
              ┌──────────────────────┼──────────────────────┐
      ┌───────────────┐      ┌───────────────┐      ┌───────────────┐
      │  Ambivalence  │      │  Recognition  │      │  Taking Steps │
      └───────┬───────┘      └───────┬───────┘      └───────┬───────┘
      ┌───────────────┐      ┌───────────────┐      ┌───────────────┐
      │  Appraisal of │      │  Appraisal of │      │  Appraisal of │
      │    Negative   │      │    Negative   │      │    Negative   │
      │  Consequences │      │  Consequences │      │  Consequences │
      └───────┬───────┘      └───────┬───────┘      └───────────────┘
      ┌───────────────┐      ┌───────────────┐
      │  Awareness of │      │  Awareness of │
      │    Adverse    │      │    Adverse    │
      │  Work Effects │      │  Work Effects │
      └───────┬───────┘      └───────┬───────┘
      ┌───────────────┐      ┌───────────────┐
      │ Concern about │      │ Concern about │
      │   Emotional   │      │   Emotional   │
      │  Self-Control │      │  Self-Control │
      └───────────────┘      └───────┬───────┘
                             ┌───────────────┐
                             │   Masculine   │
                             │  Self-Reliant │
                             │    Attitude   │
                             └───────┬───────┘
                             ┌───────────────┐
                             │ Perception of │
                             │   Workplace   │
                             │   Support of  │
                             │  Consumption  │
                             └───────────────┘
```
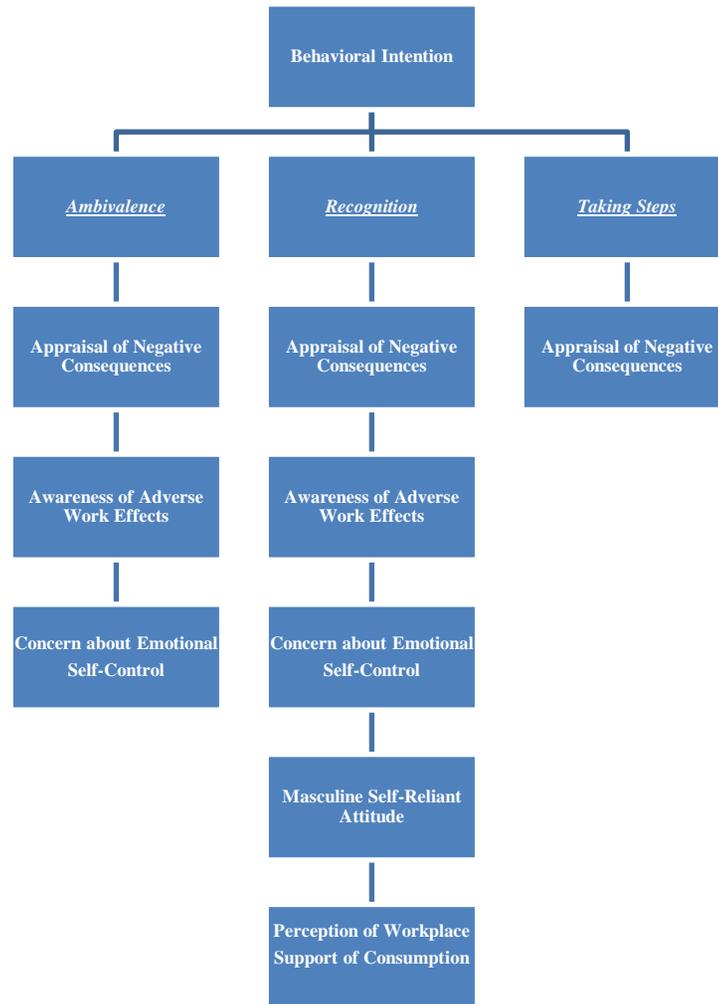
Findings on the Ambivalence Stage

Ambivalence is an early stage along the path towards the behavioral intention to seek help for substance use problems. It marks a firm entrance into the behavioral intention to seek help. Ambivalence is characterized by a beginning awareness of the negative consequences associated with substance abuse. At the same time, however, persons in this stage are in a state of flux. They may exhibit momentary glimpses of insight and awareness of the need to seek help, followed by rapid retreats into minimization and denial (Miller & Tonigan, 1996; Nace & Tinsley, 2007)..

The reduced model for ambivalence was significant at the .01 level and the predictors accounted for 37 percent of the variance. Study results suggest that three predictors were key to union construction workers' decision-making processes during the ambivalence stage. These include: negative appraisal of consequences (Beta = -.54, p ≤ .01), concern about emotional self-control (Beta = .17, p. ≤ .05), and awareness of adverse effects in the workplace (Beta= .20, p. ≤ .05).

The strongest predictor of ambivalence was appraisal of consequences. As union construction workers' appraisal of the negative consequences of their substance use, their scores on ambivalence also increase. This finding makes sense intrinsically in that appraisal of consequences is a process by which the union construction member conducts a cost-benefit analysis of his substance use. In order to achieve the milestones necessary to transition through this stage, the union member must evaluate the harm caused by his substance use, without falling into the well worn tendency to minimize and deny. This process involves a serious, sober reckoning of the myriad of ill effects of substance abuse

upon one's life. These negative effects might include life-threatening health problems, such as liver and heart damage; the risk of contracting Hepatitis, HIV and other diseases that often accompany unsafe sexual practices while under the influence of alcohol and drugs, or through shared needle exchange; emotional problems such as anxiety and depression; family conflicts including neglecting one's responsibilities to the family, child abuse and neglect and domestic violence; workplace difficulties that stem from tardiness, absenteeism, substance-related workplace injuries or violence; and legal problems that include driving while under the influence or while intoxicated, possession and/or sale of illegal substances, and theft to support one's substance abuse (Hanson, 2001).

In conducting a cost-benefit analysis of substance abuse, union construction workers would also attend to the positive benefits they associate with their substance use. Common pros to substance use often include the physical and psychological pleasure of a substance-induced 'high' (Hanson, 2001). Another typical perceived benefit involves using substances as a psychological outlet or 'release' from life pressures, anxiety and depression. Perhaps one of the most tenacious perceived benefits is the camaraderie many substance abusers experience in socializing with other substance abusers. Some substance abusers' social lives are centered completely around substance use, so that considerations of abstinence and sobriety seem an overwhelming, daunting task. The substance abuser must let go of friends who continue abusing drugs and alcohol, and design an entirely new social life that does not revolve around substance-related activities.

Study results indicate that union members in the ambivalence stage of behavioral intention are able to appraise the positive and negative consequences of their substance use to

arrive at a focus in which the costs outweigh the benefits. As hypothesized, union construction workers with higher scores on ambivalence also report greater attention to the negative consequences attached to their substance use (Beta = -.54, p. ≤ .01).

A second significant predictor of ambivalence in the model was the impact of adverse workplace effects. This study provided evidence that substance use is an integral part of union construction work culture. Thus, giving up substance abuse might compromise a union member's workplace social standing by preventing his conformity to workplace social norms that sanction substance abuse. At the same time, however, union workplace cultural norms are not static. Union construction workers are employed in an industry in which safety is paramount. The recent advent of routine and reasonable suspicion workplace drug testing has the potential to bring about a shift in union culture. No longer can supervisors openly condone or ignore substance abuse. Nor can supervisors arbitrarily refrain from reprimanding union members who test positive on workplace drug screens or attempt to work while under the influence.

Study results indicate that as hypothesized, as union construction workers move into the ambivalence stage along the continuum of help-seeking, those with higher scores of ambivalence also demonstrate greater awareness of the adverse effects of their substance use in the workplace (Beta = .20, p ≤ .05). Ostensibly, union members are unwilling to participate in a workplace culture that promotes substance abuse if such involvement might compromise their ability to earn a living. Anecdotal evidence from the researcher's experience as a MAP director also supports this conclusion. Many union workers who contact their MAP for help emphasize that their primary motivation is to maintain their

employment in order to take care of their families. In addition, these union members also report that while their spouses or partners may have tolerated some recreational substance use in the past, that they did not condone substance use if it interfered with the member's ability to earn a living.

The important outcome for this study is that union construction workers who enter the ambivalence stage of the helping-seeking are able to focus their attention to the negative consequences of their substance abuse. This finding recommends that an effective intervention strategy is to help union construction workers identify and consider the extent of the negative consequences associated with their substance use. Using the classic social work' person-in-environment perspective, social workers might better intervene with union construction workers by helping them to evaluate the full spectrum of the ill effects of their substance abuse. Essentially, social workers might assist union members to be more cognizant of the fact that their substance abuse cuts across multiple levels to include damaging individual, familial, occupational and social outcomes.

Concern about emotional self-control was a third significant predictor in the model. It relates to union members' comfort level in revealing and discussing substance abuse problems that might evoke a public display of emotions. The challenge for union members who are preoccupied with maintaining emotional self-control is to manage their emotions while discussing embarrassing, stigma-laden problems, and answering the emotionally provocative questions that typically accompany a substance abuse evaluation by a social worker.

As predicted by the hypothesis, union members with higher scores on ambivalence reported fewer concerns with emotional self-control as a barrier to help-seeking. This study confirmed that historically, union construction workers are 'tough, manly men' who refrain from displays of emotion that might make them appear weak or feminine (Sonnenstuhl, 1995; Tailion, 2002; Williams, 2002). While it appears that current union work culture continues to espouse emotional self-containment, the results of this study strongly suggests that in order for members to seek help, they must distance themselves from a preoccupation with emotional self-control. Social workers might assist union members towards this goal by using a strengths-based approach that emphasizes the courage in admitting problems and seeking help. Social workers could play a pivotal role in helping to reframe emotional self-expression as a positive symbol of masculinity.

Analysis of the Ambivalence Stage by Theory

The results of the MRA of the reduced model will be analyzed by theory. First Bandura's social cognitive theory (SCT) will be applied. The transtheoretical model (TTM) will further explain the effects on ambivalence. Finally, the effects on ambivalence will be analyzed via the theory of planned behavior (TPB).

The effects on ambivalence from the perspective of SCT. During the ambivalence stage, union members are chiefly concerned with appraisal of the negative consequences of their substance abuse, as well as its adverse effects in their workplace standing. Bandura's social cognitive theory (SCT) describes the decisional balance process as a function of operant behavioral theories of reinforcement (Bandura, 1986). Union members' decisions about whether to seek treatment for substance abuse would be impacted by their unique,

individual psychological response to positive and negative reinforcers related to their substance use and help-seeking attitudes and beliefs. Study results confirm that for union members, a primary motivation in help-seeking relates to anticipated negative reinforcers which serve to discourage ongoing substance abuse and encourage behavioral intention.

According to Bandura, behavioral change is a self-reflective process by which an individual monitors his or her thoughts, feelings and beliefs, as well as the short and long-term consequences of a given behavior. Bandura also held, however, that behavioral enactment involves more in-depth psychological processes than mere positive and negative reinforcers. Bandura (1986) emphasized the value of self-reflection, or what psychodynamic theories deem 'insight.' Study results indicate that one important aspect of self-reflection involves concern about emotional self-control and the need to lessen fears about talking about emotional issues. Study results suggest that in the ambivalence stage union members are undergoing a self-reflective, analytical process of change that causes them to question what would be the outcome of their unremitting substance use, as well as emotional changes necessary as prerequisites for change.

The effects on ambivalence from the perspective of the TTM. The TTM characterizes behavioral intention of readiness as a process rather than a single event. The model focuses attention on a compilation of behaviors to suggest that the interplay between multiple, internal psychological processes and external environmental factors come together to develop behavioral intention. While this complex change process is unique for each individual, Prochaska and DiClemente (1986) advise that there are common, identifiable tasks and goals associated with particular stages of change.

The ambivalence stage as measured by the SOCRATES is associated with the contemplation phase of the TTM. During this early stage of change, an important goal is for the individual to conduct a risk-reward analysis of his or her substance abuse to determine that the negative consequences eclipse any positive benefits. At the same time, an individual must also enhance self-confidence in his or her ability to change.

In keeping with the TTM framework, study results indicate that union members in the early stages of behavioral intention of change are primarily concerned with evaluating the pros and cons of their substance use. Union members in this stage are beginning to recognize that the risks of their substance use far outweigh the rewards. Union members are able to admit and focus on a host of negative consequences that relate to myriad of substance-related concerns, including health problems, anxiety and depression, family conflicts, and legal troubles. Union members are particularly aware of the adverse effects of their substance use in the workplace in contributing to absenteeism, tardiness, and disciplinary actions that might lead up to work suspension or termination.

In conjunction with their focus on appraisal of negative consequences, study results also indicate that union members are undergoing internal, psychological changes to enhance their behavioral intention. As predicted by the TTM, union members appear to be relinquishing concerns about maintaining emotional self-control. They are less focused on worries about becoming embarrassed by public displays of emotion, and more attentive to the tasks necessary to bolster behavioral intention.

The effects on ambivalence from the view of the theory of planned behavior.

The TPB acknowledges a wide variation in human behaviors such as help-seeking for substance abuse, by explaining behavioral intention in terms of each individual's unique set of attitudes, beliefs and perceptions. The TPB holds that the behavioral intention of readiness is a product of an individual's attitudes, subjective norms and perceived control over help-seeking. Therefore, in assessing the ambivalence stage, the TPB would recommend assessing union members' beliefs and social norms with respect to help-seeking, including any problems with perceived control (Ajzen, Albarracin, & Hornik, 2007).

Study results fit with the TPB's explanation of behavioral intention. During the ambivalence stage, union members are concerned with a mix that comprises the integral components of the TPB. For example, union members' attitudes towards their substance use are shifting to assess the negative aspects of this behavior. They are reappraising their subjective norms regarding their beliefs about whether substance use is wise given its adverse effects in the workplace. Further, union members are concerned with elements of perceived control with respect to shifting their attitudes regarding the importance of maintaining emotional stoicism.

Findings on the Recognition Stage

Recognition pertains to the ability to recognize one's substance abuse problem and a willingness to change. Recognition is a critical stage in the process of change in that it involves the end of chronic minimization and denial, and the beginning of an acknowledgement of the seriousness of one's substance abuse problem (Miller, & Tonigan,

1996). Recognition is also the starting point in which the client understands and admits to the necessity of treatment.

The model for the recognition stage was significant at the .01 level. As hypothesized, union construction workers who acknowledge greater awareness of an appraisal of the negative consequences of their substance use , also report higher scores on recognition. And, importantly, the variables that were significant during the ambivalence phase continue to exert their influence during the recognition phase. For example, union construction workers who are progressing through the recognition phase continue to report fewer concerns about maintaining emotional self-control and greater awareness of the adverse effects of their substance abuse in the workplace. During the recognition phase, however, two additional predictors appear significant. These include masculine self-reliant attitudes against help-seeking and perception of workplace support of consumption. These will be discussed in turn.

Masculine self-reliant attitude against help-seeking concerns a tendency to associate help-seeking with emotional vulnerability (Addis & Mahalik, 2003). It also involves the belief that sharing personal problems is a sign of weakness. As hypothesized, union construction workers who report less affiliation with masculine self-reliant attitude against help-seeking (Beta = -.21, $p \leq .05$) score higher on the recognition stage This result suggests that union members who refrain from adopting a masculine self-reliant attitude associated with union work culture are more likely to seek help. Or, conversely, this result might also indicate that as union members' recognition of their substance abuse problem increases, that

they distance themselves from the prevailing masculine self-reliant attitudes associated with their work culture.

This study provided data to support the idea that union construction workers are exposed to a workplace culture that promotes support of consumption of substances (Iacuone, 2005). It was originally hypothesized that as union members gained greater insight into their substance use problems they would report less perception of workplace support of consumption due to its dwindling influence. Dramatically, and contrary to the hypothesis, however, as union members' perception of workplace support of consumption increases (Beta = .15, p ≤ .01), recognition of their problem increases. While unanticipated, this finding makes sense intuitively; it suggests that as union members move along the path towards seeking help, they become more sensitized and aware of the negative influence of workplace culture that promotes consumption. Whereas during the ambivalence phase, union members do not appear to perceive permissive workplace norms as unusual, during the recognition phase, union members are well aware of peer social norms that promote unhealthy substance use.

This study finding is important in that it provides insight into the social mechanisms that impact union construction workers during the recognition phase of help-seeking. As union members report greater understanding of their substance abuse problems, and a willingness to admit the need for help, they also appear to recognize the negative influence of peer workplace culture that promotes substance use. This finding provides an avenue for social work interventions aimed at helping union members to rethink their participation in workplace peer culture. For example, the National Institute of Health (NIH) has launched a

successful education campaign to destigmatize depression in men and encourage men to actively seek help (NIH, 2011). The NIH educational brochure, "Real Men, Real Depression," helps to demystify depression while also discrediting stereotypes that suggest that depression is a 'women's-only' illness (NIH, 2011). Similar educational campaigns might also help union construction workers to rethink their participation in permissive work culture.

Analysis of the Recognition Stage by Theory

The results of the MRA of the reduced model will be analyzed by theory. First Bandura's social cognitive theory (SCT) will be applied. The transtheoretical model (TTM) will further explain the effects on recognition. Finally, the effects on recognition will be analyzed via the theory of planned behavior (TPB).

Analyzing the recognition stage from the view of Bandura's SCT. Study results indicate that during the recognition stage, union members continue their appraisal of negative consequences in keeping with Bandura's concept of operant conditioning. Union members also maintain their self-reflective analysis to become less concerned about issues related to maintaining emotional self-control. Union members become more willing to talk about their problems and to let go of fears about becoming embarrassed or being seen in a negative light.

Two additional factors that become relevant during the recognition phase include an attitude of masculine self-reliance against help-seeking, and perception of workplace support of substance use. Two concepts of Bandura's SCT, self efficacy and modeling, address these important predictors of behavioral intention.

Bandura (1994) postulated that self-efficacy is closely tied to behavioral intention because individuals who lack it are prone to give up too easily, especially in the face of adversity. Bandura's SCT suggests that masculine self-reliant union members, while seemingly over-confident, actually lack the self-efficacy required to perform help-seeking. The false bravado associated with masculine self-reliant attitudes suggests an underlying insecurity regarding help-seeking and fears about being labeled weak or inadequate for seeking help. As predicted, union members who progress through the recognition phase appear to withdraw from the prevailing masculine self-reliant attitudes in their work culture that lower help-seeking self-efficacy.

Further, Bandura (1999) held that modeling is an extraordinarily powerful method of learning values, attitudes, thinking patterns and behaviors (Bussey & Bandura, 1999). Among the most prevalent mechanisms for modeling is adoption of social gender roles. Bandura's SCT would portray masculine self-reliant attitudes against help-seeking as an exaggerated, hypermasculine male gender role that union members learn through workplace social norms. Bandura's theories also suggest that perception of workplace support of consumption is another form of modeling of social norms – a model which must be disavowed in order for union members to change their behavior.

Study results demonstrate that union members who successfully enter the problem recognition phase of behavioral intention are highly cognizant of the thoughts, feelings and attitudes associate with gender role and social norm expectations in their work environment, and that they shift their behaviors accordingly when initiating movement along the behavioral continuum.

Analyzing the recognition stage from the perspective of the TTM. The recognition stage as measured by the SOCRATES roughly corresponds to the preparation phase of the TTM. The tasks in this stage of help-seeking involve continuing a serious appraisal of negative consequences of substance use; identifying, challenging and changing cognitions and beliefs that interfere with behavioral intention, and strengthening familial and social alliances that support recovery. Study results suggest that as outlined by the TTM, union members are actively engaged in these tasks.

During the recognition stage, union members continue to concentrate on their appraisal of negative consequences of their substance use. They retain this focus as a primary consideration of change. At the same time, however, union members are maintaining their attention to the ill effects of their substance use in the workplace. In addition, union members also appear to be letting go of concerns about emotional self-control that might interfere with help-seeking.

As union members progress through the recognition stage, they continue working to reevaluate internal attitudes and beliefs, and perceptions of environmental constraints that might detract from their behavioral intention of readiness. For example, an important task during this phase appears to involve union members' ability to detach from workplace cultural values that promote masculine self-reliance against help-seeking. In order for union members to move forward, they must modify their views about masculinity and self-reliance to envision help-seeking as a strength rather than a weakness. Union members also become more aware, perhaps for the first time, of the negative impact of workplace support of consumption, and begin to distance themselves from this element of workplace culture.

Understanding the recognition stage from the view of the TPB. The formula for the TPB holds that behavioral intention is a product of attitudes, subjective norms and elements of perceived control. The study results for the recognition stage align with the fundamental elements of the TPB. During the recognition phase, union members continue the attitudinal shifts and gains made during the ambivalence phase. They also appear less concerned about maintaining emotional self-control that might interfere with behavioral intention of readiness.

In keeping with the TPB, union members also extend their focus from individual attitudes and beliefs to social norms within the workplace setting. Union members demonstrate a growing awareness of social pressures among their workplace peers that promote substance use. They also appear less susceptible to the need to adhere to masculine self-reliant attitudes against help-seeking prevalent among their work culture.

Findings on the Stage of Taking Steps

The taking steps stage of behavioral intention involves attempts to implement a plan for commencing treatment and to maintain commitment in the face of adversity. Part of this commitment includes retaining a focus on the awareness of negative consequences associated with substance abuse.

The model for taking steps was not significant. The only variable that remained statistically significant was appraisal of consequences (Beta = -.25, p. ≤ .05). However, this variable is substantively significant in that it retains its importance to union members throughout the continuum of change. While this predictor accounts for a mere six percent of the variance, it remains clear that the other variables that were significant in earlier stages of

the help-seeking continuum do not exert their influence in the final stage of the behavioral intention to seek help. This finding is important in that it simultaneously suggests some continuity, while also highlighting the uncertainty regarding what motivates union members during this final stage of help-seeking.

Analysis of the Taking Steps Stage by Theory

The results of the MRA of the reduced model will be analyzed by theory. First Bandura's social cognitive theory (SCT) will be applied. The transtheoretical model (TTM) will further explain the effects on taking steps. Finally, the effects on taking steps will be analyzed via the theory of planned behavior (TPB)

Analyzing the taking steps stage from the view of Bandura's SCT.

Bandura (1991) was quick to point out that "neither intention nor desire alone has much effect if people lack the capability for exercising influence over their motivation and behavior" (p. 249). While union members' progression through the ambivalence and recognition phases of help-seeking suggest that they are working towards attitudinal shifts, making changes in their values with respect to workplace social norms, and improving their self-efficacy, it remains unclear what additional elements are required to transition from intention to behavioral enactment. Because union members were surveyed early on in the helping process, however, it could be that they had not yet had time to sufficiently work through these issues to arrive fully at the taking steps stage.

Analyzing the taking steps stage from the perspective of the TTM. Union members who enter the taking steps stage continue to attend to the negative consequences associated with substance abuse. However, study results indicate that no other predictors

were identified as significant. These results could be a reflection of the fact that union

members included in this study were captured during the early phases of change. Not enough

time had passed to allow union members to further progress towards implementing an action

plan, and taking steps towards change.

Understanding the taking steps stage from the view of the TPB. The TPB

predicts that behavioral outcomes are strongly related to self-efficacy issues of perceived

control, as well as beliefs about anticipated outcomes. Union members' continued focus on

appraisal of negative consequences of their substance use speaks to their concerns about a

negative outcome of ongoing, untreated substance abuse. However, because no other

variables surfaced as being significant during this stage, the TPB can provide little more

information. There may be other outcome measures applicable to the taking steps phase that

were not included as part of this study. The previous ambivalence and recognition stages;

however, are aligned with the central components of the TPB.

Recommendations for Future Research

Historically, much research has focused on enhancing treatment processes for those

substance abusers who have *already* initiated treatment. Areas of research have included

improving quality of care, client retention and follow-through with aftercare. Far less

attention has been focused on furthering our understanding of what promotes or impedes

treatment entry for the 95 percent of substance abusers who fail to commence treatment.

Additional work is needed to understand why some occupational groups, including

construction workers, appear at risk for becoming heavy substance users while also being

least likely to seek treatment. As researchers become more familiar with the risk factors

involved, social workers and other professionals can better design targeted intervention

strategies aimed at promoting problem recognition and the need for professional help.

Recommendations for Social Work Theory and Practice

Social workers should remain vigilant to certain client populations who may be at risk

for minimizing and denying their problems. This vigilance is particularly critical for work in

Member Assistance Programs with construction workers who are in need of substance abuse

treatment. Social workers can play a pivotal role in helping them to identify and resolve

internal, psychological and external, environmental barriers that impede treatment access.

Further, social workers must recognize that many clients will need help to overcome

occupational peer pressures that negatively influence their outlook about treatment. Social

workers can help alleviate stigma by educating clients about substance abuse problems and

by characterizing help-seeking as a strength rather than a weakness. Finally, social workers

must be alert to gender differences in how clients communicate regarding a willingness to

admit to problems and the need for help. Social workers must be adept at using intervention

strategies, such as cognitive behavioral techniques, to target hypermasculine thoughts,

feelings, beliefs and attitudes that interfere with treatment access. At the same time, social

workers might utilize a strengths perspective that emphasizes the courage required in help-

seeking, along with helping the client to recognize that treatment may prevent his losing his

employment and ability to care for his family.

Education

While social workers receive advanced training in adversity, including understanding

the differences in various racial and cultural minorities, they might also benefit from

education regarding hypermasculine gender culture. Armed with such education, social workers will be in a better position to intervene with this difficult to reach client population.

Ethics

Social workers have an ethical, professional and moral obligation to intervene with difficult to reach, vulnerable client populations – including substance-impaired, blue collar men. Rather than join the professional band wagon that often labels hypermasculine construction workers as being untenably 'in denial,' and 'unreachable,' social workers might lead the way in targeting interventions that solicit movement along the behavioral continuum. From the start, denial should be construed as a *symptom* of the problem, not as an excuse for professional inaction.

<div align="center">

Study Limitations

</div>

Important limitations to this study involved its use of a convenience sample rather than a random sample, and a limited sample size. Therefore, the results may not be generalized to the overall union population, but instead, are indicative of union members who contacted their union MAP. Further, because the sample was drawn from union members who telephoned their MAP crisis hotline, it could be argued that these members were already taking some preliminary steps along the continuum of behavioral change towards commencing treatment. While it would have been more desirable to conduct random sampling, such data collection was not feasible given the fact that union members reside throughout the United States and work on hundreds of varying and often-isolated work sites. Further, union members are often weary of outsiders and fearful of answering substance-related questions that might lead to disciplinary action or job termination

(Sonnenstuhl,1986).   A larger sample size would have helped to strengthen the significance of study results given its large number of predictor variables. The inherent difficulties in connecting with this client population may help to explain why it is so under-researched despite being among the heaviest occupational substance use offenders.

Social Work's Collaboration with the Labor Union Movement through MAPs

Social work has a lengthy history of alliance with the labor union movement stemming back to the era of Jane Addams and work in settlement houses (Scanlon & Harding, 2005).   In recent years, labor unions are collaborating with social workers to develop and enhance employee assistance services offered through MAPs. Social workers can play a vital role in their partnership with labor, by establishing service delivery protocols that enhance worker participation and encourage behavioral intention to seek help.

MAPs are relatively new to the American labor union movement; therefore, little to no research has been compiled on their utilization or effectiveness (Bacharach, Bamberger, & Sonnenstuhl, 1996; Bamberger, Bacharach, & Sonnenstuhl, 2001; Roman & Blum, 2002). However, there is growing evidence to suggest that social work's provision of professional services through union MAPs hold tremendous potential to facilitate substance abuse treatment entry (Jessup, 2006; Mejta, Bokos, Mickenberg, Maslar, & Senay, 1997; Roman & Blum, 1999). Further, MAPs are also able to act as overall change agents by using education, training and intervention to help transform unhealthy, permissive workplace cultures (Bacharach, Bamberger, & Sonnenstuhl, 1994).

Conclusion

Chapter Five provided an overview of the study and its findings. Study results were assessed from the perspective of overall results as well as an analysis by stage. A review of relevant theories helped to further elucidate study results. Finally, implications for social work practice and theory were discussed.

Appendix A

Formula for the Theory of Reasoned Action (TRA)

Reasoned Action Model - Azjen&Fishbein, 1975
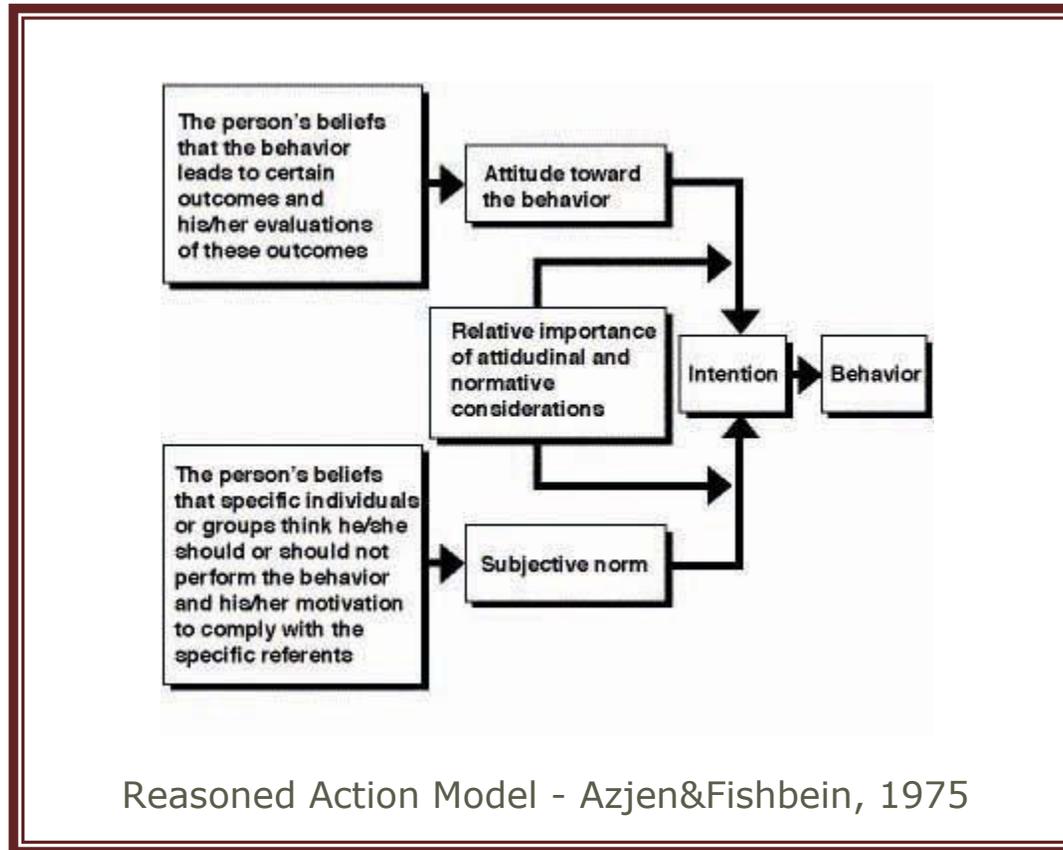
Appendix B

Formula for the Theory of Planned Behavior
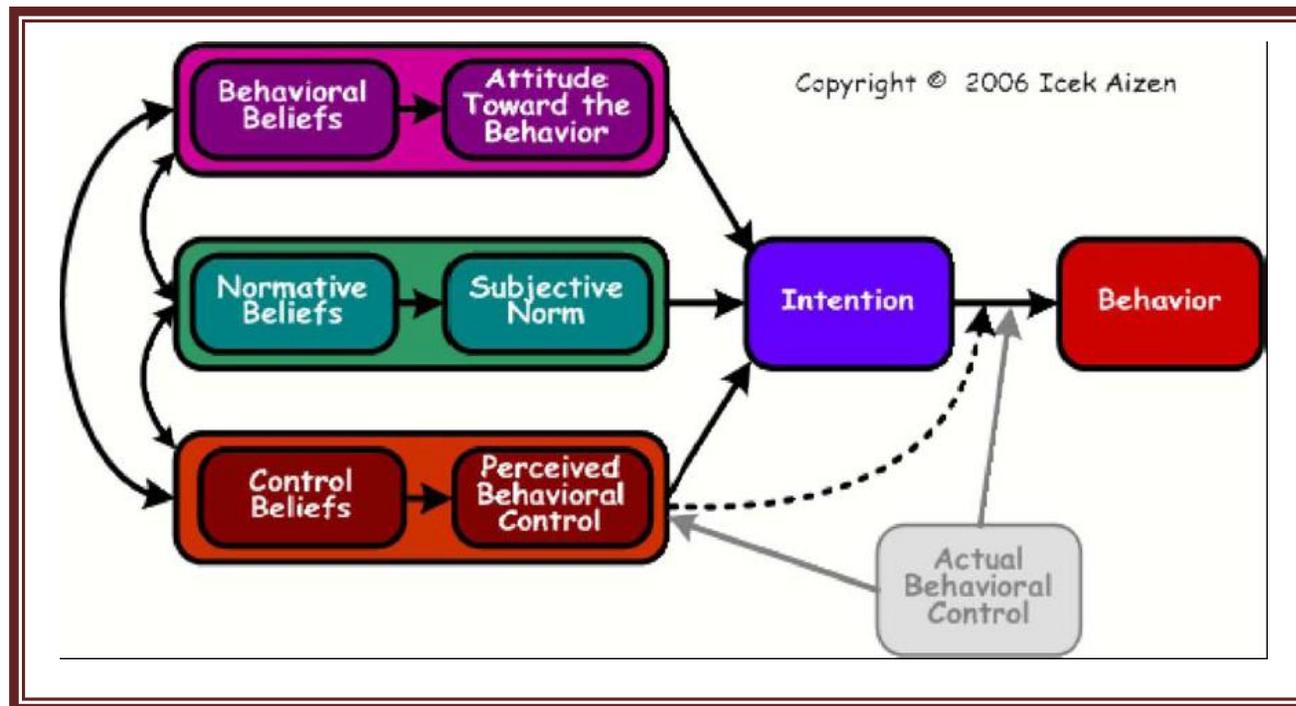
Appendix C

Letter to Invite Participation in Research Study

CUA

THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service
Washington, DC 20064
202-319-5458
Fax 202-319-5093

Dear Union Member:

I am inviting you to participate in a confidential, anonymous research project to study the thoughts and feelings of union construction workers in seeking treatment for substance abuse. You have sought and received assistance through your union's Member Assistance Program (MAP) where I am employed, but I am doing this study as a partial fulfillment to satisfy the requirements for a doctorate degree in social work at the Catholic University of America. The survey should take 20 minutes to complete, and you will be sent a $20 gift certificate in consideration of your time.

Your privacy and confidentiality are fully protected in that no one will know about your participation in this research project. Your name will not be on the survey, and neither I, nor anyone else, will know your answers to survey questions. I will not be contacting you by telephone or mail regarding your decision to participate, nor will I discuss your participation with your job supervisor or anyone else. I am not keeping a list of names of members who have been invited to participate in this study. In addition, The Catholic University of America will not have access to your name or any information about you so that your confidentiality is fully protected.

Through your participation I hope to better understand the experiences of union construction workers who seek substance abuse treatment services. If you decide to complete the enclosed survey, please do not write your name or any identifying information on the survey, so that it can remain completely anonymous. I have provided a separate, confidential envelope for return of the survey. I will destroy all surveys once the anonymous information has been entered into a computer software program designed to analyze the information.

There are no known risks to you or to your privacy if you decide to join my study by filling out this survey. But if you choose not to participate that is fine. If you do decide to participate, please sign the consent form and return it in the enclosed, confidential, pre-paid, envelope. Upon receipt of your signed consent, I will send you a $20 gift certificate in consideration of your time.

If you have any questions about the survey questionnaire, or about being in this study, you may contact me collect at (301) 855-9512. The Institutional Review Board (IRB) at The Catholic University of America has approved this study. If you have any have any questions about the conduct of this study or your rights as a participant in the study, you may contact The Catholic University of America Office of Sponsored Programs at (202) 319-5218.

Sincerely,

Karen Grear
301-855-9512

Consent for Participation in Research

CUA

THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service
Washington, DC 20064
202-319-5458
Fax 202-319-5093

Consent for Participation in Research

Title of Study: The Behavioral Intention to Seek Treatment for Substance Abuse Among Union Construction Workers

Responsible Researcher: Karen Grear, LICSW

Responsible Supervisors: Barbara Early, Ph.D., Marie Raber, Ph.D., and Joseph Shields, Ph.D.

Purpose: I understand that the purpose of this study is to learn about my thoughts and feelings related to how I would decide when professional treatment is needed for alcohol and drug use. The study will also ask questions about my opinions about how alcohol and drug use is perceived in the workplace. This study is being carried out in partial fulfillment for the requirements of a Ph.D. in social work.

Procedure: I agree to participate in this study on a voluntary basis. I further agree to complete an anonymous questionnaire. I understand that I can stop and end my participation at any time, can decline to answer any question, or change my mind about starting, all without any penalty or loss of benefits otherwise available to me. I understand that my name and personal information will <u>not</u> be on the questionnaire, and that neither the researcher, my employer, nor anyone else will be able to identify me as the person who completed the questionnaire. The questionnaire will take approximately 20 minutes to complete, and I will receive a $20 gift certificate in consideration for my time. I understand that this consent form with my name and address will not be connected to the answers I provide on the separate, anonymous study questionnaire.I understand that all surveys will be destroyed once the anonymous information has been entered into a computer software program designed to analyze the information.

Benefits: I understand there are no known benefits for me from participating in this study. However, the study will help social workers better understand ways to assist union construction workers who are seeking help for alcohol or drug abuse.

Risks, Inconvenience, and/or discomforts: I understand that there are no known risks for participating in this anonymous study other than the inconvenience of the time in completing the questionnaire. I understand that my involvement in this research is completely my choice. I also understand that I am free to discuss any questions or concerns with the researcher or the university's Office of Sponsored Programs, and that I can choose not to participate without any penalty.

Confidentiality: I understand that confidentiality will be maintained, and that no study participants, including me, will be identified by name. I understand that findings generated by the study will be reported as group findings.

Phone Number if questions arise: If I have any questions about this study, I may contact the study researcher, Karen Grear, via collect call to (301) 855-9512. If I have any questions about the conduct of this study or my rights as a participant in this study, I have been told that I can call The Catholic University of America's Office of Sponsored Programs at 202-319-5218.

I volunteer to participate in this study.

_____

Signature of participant   Date

Please print your name and address below so that we may send you a $20 gift certificate in consideration of your time:

_____

Name (PLEASE PRINT)

_____

Street Address

_____

City, State   Zip Code

_____

Researcher's signature   Date

Study Questionnaire

CUA

THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service
Washington, DC 20064
202-319-5458
Fax 202-319-5093

The behavioral intention to seek treatment for substance abuse
among union construction workers

QUESTIONNAIRE

The purpose of this study is to learn about your thoughts and feelings related to how you would decide when professional treatment is needed for alcohol and drug use. It also asks your opinions about how alcohol and drug use is perceived in the workplace.

Please be assured that your answers will be kept completely confidential and anonymous. No one at the union, including the researcher, Ms. Grear, will be able to identify you as the person who completed the questionnaire. The questionnaire, which consists of seven sections, should take 20 minutes to complete.

Please answer each question honestly, and return the completed questionnaire in the enclosed, confidential envelope by placing it in the <u>anonymous return box at the MAP conference table</u>.

If you have any questions regarding this study or the questionnaire, please contact Karen Grear, Licensed Clinical Social Worker, doctoral student at The Catholic University of America School of Social Services, by calling collect to her private, confidential phone at (301) 855-9512. If you have any questions about the conduct of this study or your rights as a participant in this study, please call The Catholic University of America's Office of Sponsored Programs at 202-319-5218.

QUESTIONNAIRE

Section 1

Please read the following statements carefully. Each one describes a way that you might or might not feel about your drug use. For each statement, please **check √ only one answer** to indicate how much you agree or disagree with it right now.

How much do I agree with each statement?	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
1. I really want to make changes in my use of alcohol or drugs.					
2. Sometimes I wonder if I am an addict or alcoholic.					
4. I have already started making some changes in my use of alcohol or drugs.					
5. I was using alcohol or drugs too much at one time, but I've managed to change that.					
6. Sometimes I wonder if my alcohol or drug use is hurting other people.					
7. I have an alcohol or drug problem.					
8. I'm not just thinking about changing my alcohol or drug use, I'm already doing something about it.					

Section 1 (cont.)

How much do I agree with each statement?	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
9. I have already changed my alcohol or drug use, and I am looking for ways to keep from slipping back to my old pattern.					
10. I have serious problems with alcohol or drugs.					
11. Sometimes I wonder if I am in control of my alcohol or drug use.					
12. My alcohol or drug use is causing a lot of harm.					
13. I am actively doing things now to cut down or stop my use of alcohol or drugs.					
14. I want help to keep from going back to the alcohol or drug problems that I had before.					
15. I know that I have an alcohol or drug problem.					

Section 1 (cont.)

How much do I agree with each statement?	NO! Strongly Disagree	No Disagree	? Undecided or Unsure	Yes Agree	YES! Strongly Agree
16. There are times when I wonder if I use alcohol or drugs too much.					
17. I am an alcoholic or drug addict.					
18. I am working hard to change my alcohol or drug use.					
19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.					

Section 2

The questions below refer to your thoughts and feelings about seeking help for an alcohol or drug problem. There are no right or wrong answers. For each statement, please **check √ only one answer** to indicate how much you agree or disagree with it right now.

How much do I agree with each statement?	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1. I would think less of myself for needing help.					
2. I don't like other people telling me what to do.					
3. Nobody knows more about my problems than I do.					
4. I'd feel better about myself knowing I didn't need help from others.					
5. I don't like feeling controlled by other people.					
6. It would seem weak to ask for help.					
7. I like to make my own decisions and not be too influenced by others.					
8. I like to be in charge of everything in my life.					

Section 2 (cont.)

How much do I agree with each statement?	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
9. Asking for help is like surrendering authority over my life.					
10. I do not want to appear weaker than other people.					
11. People typically expect something in return when they provide help.					
12. I would have real difficulty finding transportation to a place where I can get help.					
13. I wouldn't know what sort of help was available.					
14. Financial difficulties would be an obstacle to getting help.					
15. I don't trust doctors and counselors.					

Section 2 (cont.)

How much do I agree with each statement?	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
16. A lack of health insurance would prevent me from asking for help.					
17. Privacy is important to me, and I don't want other people to know about my problems.					
18. This problem is embarrassing.					
19. I don't like to get emotional about things.					
20. I don't like to talk about feelings.					
21. I'd rather not show people what I'm feeling.					
22. I wouldn't want to look stupid for not knowing how to figure this problem out.					

Section 3

Please read each statement and check √ only one answer that best indicates how you would rate the level of importance concerning your decision about whether to drink or use drugs at the present time.

How important is this to you?	Not At All	Slightly	Moderately	Very	Extremely
1. My drinking (drug use) causes problems with others.					
2. I like myself better when I am drinking (using drugs).					
3. Because I continue to drink (use drugs) some people think I lack the character to quit.					
4. Drinking (drug use) helps me deal with problems.					
5. Having to lie to others about my drinking (drug use) bothers me.					
6. Some people try to avoid me when I drink (use drugs).					
7. Drinking (drug use) helps me to have fun and socialize.					
8. Drinking (drug use) interferes with my functioning at home.					
9. Drinking (drug use) makes me more of a fun person.					
10. Some people close to me are disappointed in me because of my drinking (drug use).					

Section 3 (cont.)

How important is this to you?	Not At All	Slightly	Moderately	Very	Extremely
11. Drinking (drug use) helps me to loosen up and express myself.					
12. I seem to get myself into trouble when drinking (using drugs).					
13. I could accidentally hurt someone because of my drinking (drug use).					
14. Not drinking (using drugs) at a social gathering would make me feel too different.					
15. I am losing the trust and respect of my spouse/partner because of my drinking (drug use).					
16. My drinking (drug use) helps give me energy and keeps me going.					
17. I am more sure of myself when I am drinking (using drugs).					
18. I am setting a bad example for others with my drinking (drug use).					
19. Without alcohol (drugs), my life would be dull and boring.					

Section 3 (cont.)

How important is this to you?	Not At All	Slightly	Moderately	Very	Extremely
20. People seem to like me better when I am drinking (using drugs).					

Section 4

Please check √ only one answer that best describes your overall experiences working on union jobsites for the past six months.

In the past 6 months:	Daily	Several times a week	Once a week	Every few weeks	Once a month	Less than once a month	Never
1. How many times have your coworkers used alcohol or drugs during working hours, on breaks or at lunchtime?							
2. On some jobs, you might be expected to drink, for example, to celebrate something. How many times has this happened?							
3. How many times were you absent from work or called in sick because of your alcohol or drug use?							

In the past 6 months:	Daily	Several times a week	Once a week	Every few weeks	Once a month	Less than once a month	Never
4. How many times have your come in late or left early from work because of your alcohol or drug use?							
5. How many times did you not come in to work because of your alcohol or drug use even when you knew it was very important for you to be there?							
6. How many times have you taken longer lunch breaks than you usually do because of your alcohol or drug use?							
7. How many times have people at work suggested you get treatment for your alcohol or drug use?							
8. How many times have people at work commented positively when you had <u>not</u> been drinking or using drugs recently?							

Section 4 (cont.)

In the past 6 months:	Daily	Several times a week	Once a week	Every few weeks	Once a month	Less than once a month	Never
9. How many times have people at work done something for you to show they approve when you have <u>not</u> been drinking our using drug?							
10. How many times have you not done your work as well as usual because of your alcohol or drug use?							
11. How many times have some of your coworkers (such as other union members, foreman or contractors) used alcohol or drugs together off the job?							

check √ only one answer	Always	Usually	Sometimes	Rarely	Never
11 (a). How many times have you gone with your coworkers **and** used alcohol or drugs together off the job?					

Section 4 (cont.)

In the past 6 months...

12. How much of the talk at work is about drinking or drugs, or activities involving drinking or drugs?
Please circle ( ) the number that best represents your response below:

0	1	2	3	4	5

$\longleftrightarrow$

None	A Little	Some	About Half	A Good Amount	A Lot

12 a. How much do you become part of the talk at work that is about drinking or drugs or such   activities?
Please circle ( ) your best response below:

0	1	2	3	4	5

$\longleftrightarrow$

Never	A little	Some	About half the time	Often	Almost Always

12b. How much pressure do you feel to become involved in talking about or taking part in   activities that involve drinking or drugs? Please circle ( ) your best response below:

0	1	2	3	4	5

$\longleftrightarrow$

No Pressure   A lot of Pressure

Section 5

Please check √ the box that contains the answer that best applies to you:	**2-3 times per week**	**4 or more times per week**	**2-4 times per month**	**1 time per month (or less)**	**Never**
1. How often do you have a drink containing alcohol?					

Please check √ the box that contains the answer that best applies to you:	10 or more	7 to 9	5 or 6	3 or 4	1 or 2
2. How many drinks containing alcohol do you have on a typical day when you are drinking?					

Please check √ the box that contains the answer that best applies to you:	**Daily** (or almost daily)	**Weekly**	**Monthly**	**Less than monthly**	**Never**
3. How often do you have six or more drinks on one occasion?					
4. How often during the last year have you found that you were not able to stop drinking once you had started?					
5. How often in the last year have you failed to do what was normally expected of you because you were drinking?					
6. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?					

Section 5 (cont.)

Please check √ the box that contains the answer that best applies to you:	**Daily** (or almost daily)	**Weekly**	**Monthly**	**Less than monthly**	**Never**
7. How often during the last year have you had a feeling of guilt or remorse about your drinking?					
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?					

Please check √ the box that contains the answer that best applies to you:	**No**	**Yes, but not in the last year**	**Yes, during the last year**
9. Have you or someone else been injured as a result of your drinking?			
10. Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested that you cut down?			

Section 6

Please check the box to the right that best applies to you in answering the questions listed below. These questions refer to the past year, and the term "spouse" refers to marital partner or significant other.	YES	NO
1. Have you used drugs other than those required for medical reasons?		
2. Have you abused prescription drugs?		
3. Do you abuse more than one drug at a time?		
4. Can you get through the week without using drugs?		
5. Are you always able to stop using drugs when you want to?		
6. Have you had "blackouts" or "flashbacks" as a result of drug use?		
7. Do you ever feel bad or guilty about your drug use?		
8. Does your spouse (or parents) ever complain about your involvement with drugs?		
9. Has drug abuse created problems between you and your spouse or your parents?		
10. Have you lost friends because of your use of drugs?		
11. Have you neglected your family because of your use of drugs?		
12. Have you been in trouble at work because of drug use?		
13. Have you lost a job because of drug use?		
14. Have you gotten into fights when under the influence of drugs?		
15. Have you engaged in illegal activities in order to obtain drugs?		
16. Have you been arrested for possession of illegal drugs?		
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		

Section 6 (cont.)

Please check the box to the right that best applies to you in answering the questions listed below. These questions refer to the past year, and the term "spouse" refers to marital partner or significant other.	YES	NO
18. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?		
19. Have you gone to anyone for help for a drug problem?		
20. Have you been involved in a treatment program specifically related to drug use?		

Section 7

Please check √ the best answer that applies to you:

1. How old are you?

_____18-25
_____26-45
_____46-61
_____62 or older

2. What race are you?

_____White
_____White, Non-Hispanic
_____ Hispanic
_____ African-American
_____ Asian or Pacific Islander
_____ Native American
_____ Other: Please write in your answer:

_____

3. Have you ever received a DUI or DWI?

_____ Never
_____ 1 time
_____ 2 times
_____ 3 or more times

4. Did you grow up in a union family (having family members who are also union members)?

_____ Yes   _____ No

5. Have you ever attended alcohol or drug support groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) or 12-step meetings?

_____ Yes   _____ No

_____ No, never

Section 7 (cont.)

Please check √ the best answer that applies to you:

6. Have you ever attended any classes or treatment programs for alcohol or drug use?

_____ Yes, voluntarily (I made the decision)
_____ Yes, but involuntarily (court-ordered or employer-mandated)

7. Have you ever been hospitalized for an alcohol or drug problem?

_____ Yes   _____ No

THANK YOU. PLEASE PLACE IN THE ENCLOSED ADDRESSED AND STAMPED ENVELOPE.

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