

CINEMATHERAPY FOR ALCOHOL DEPENDENT PATIENTS

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ABSTRACT

CINEMATHERAPY FOR ALCOHOL DEPENDENT PATIENTS

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The aim of the present study was to examine the effects of the cinematherapy technique on the treatment of alcohol dependent patients. In terms of change, self-efficacy, decisional balance and motivation levels of participants were examined. 94 alcoholic patients from a state hospital, and 14 members of Alcoholics Anonymous' Istanbul groups participated in the study. Participants were either inpatients in the dependence treatment center, or alcohol dependent patients who had been clean and sober for various periods of time. The cinematherapy technique was applied as an adjunct to alcohol dependence treatment. It included the presentation of a movie with an alcohol dependence theme followed by an elaboration session. Participants in the experimental group received two sessions of cinematherapy. On the other hand, control group A participants watched one movie unrelated with alcohol dependence. It was followed by an elaboration session with a non-alcoholic theme. Control group B participants watched two movies unrelated with alcohol dependence. Any elaboration session was not made with control group B participants. Decisional balance, self-efficacy, treatment motivation and stages of change were used as the main outcome measures in the pre-treatment and post-treatment assessments. Since the experimental and control groups sample sizes were small, non-parametric tests were used in data analysis. According to results, cons

of alcohol and self-efficacy increased for the overall sample after cinematherapy sessions. In addition, the cinematherapy group showed higher identification than the control groups. Stages of change differences were gained for pros of alcohol use and self-efficacy in line with literature.

Keywords: Cinematherapy, alcohol dependence, stages of change, decisional balance, self-efficacy, treatment motivation, transtheoretical model of change.

ÖZ

ALKOL BAĞIMLILARI İÇİN SİNEMATERAPİ

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Bu çalışmada sinematerapinin alkol bağımlıları üzerindeki etkilerinin incelenmesi amaçlanmıştır. Katılımcıların öz-yetkinlik, karar dengesi, tedavi motivasyonu ve film özdeşleşmelerindeki değişimler incelenmiştir. Çalışmaya bir devlet hastanesinden 94 alkol bağımlısı hasta ve Adsız Alkolikler İstanbul gruplarından 14 üye katılmıştır. Örneklem, alkol bağımlılığı tedavisi görmekte olan ya da önceden görmüş ve uzun zamandır alkol kullanmamış kişilerden oluşmuştur. Deney grubuna iki seanslık alkol bağımlıları için sinematerapi tekniği (film izleme ve film üzerine yapılan tartışma seansları) uygulanmıştır. Kontrol A grubundaki katılımcılara alkol ile ilgisi olmayan bir film izletilmiş ve üzerine filmin konusu üzerinden tartışma seansı yapılmış; kontrol B grubu katılımcılarına ise iki alkol ile alakasız film izletilmiş ve tartışma seansı yapılmamıştır. Sinematerapiden önce ve sonra yapılan ölçümler, değişimler karar dengesi, öz-yetkinlik, tedavi motivasyonu ve film özdeşleşme ölçekleri ile değişim aşamaları soruları esas alınarak yapılmıştır. Veri analizinde deney ve kontrol gruplarındaki katılımcı sayıları küçük olduğundan parametrik olmayan veri analizi yöntemleri kullanılmıştır. Bulgulara göre alkolün devavantajları algısının sinematerapiden sonra arttığı ve avantajları algısının aynı kaldığı; alkolü bırakmaya dair öz-yetkinliğin sinematerapiden sonra arttığı bulunmuştur. Bir başka bulgu ise alkol ile ilgili filmler izletilen sinematerapi

grubunda film karakterleri ile özdeşleşmenin alkol ile ilgisiz filmler izletilen gruplara göre daha yüksek olduğu bulunmasıdır. Değişim aşamalarına göre alkolün avantajları ve öz-yetkinlikte literatür ile aynı yönde farklar gözlenmiştir fakat alkolün getirdiği dezavantajlar ve tedavi motivasyonunda anlamlı aşama farkları bulunmamıştır. Tedavi motivasyonunda beklenen değişim aşamaları farkları gözlenmemiştir.

Anahtar kelimeler: Sinematerapi, alkol bağımlılığı, değişim aşamaları, karar dengesi, öz-yetkinlik, kuramlar üstü değişim modeli.

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CHAPTER 1

INTRODUCTION

1.1 Addiction

Addiction has been evaluated in many different ways in terms of its reasons and consequences throughout history. At the beginning of addiction literature, the responsibility of an individual's addiction was given mostly to the society. The most common beliefs were that addiction was a "breakdown in moral standards" or a consequence of societal problems like inequities (Keller, 1976, Fishbein and Pease, 1996). Later addiction's responsibility was put on the individual rather than the society. Experiences, learning, and individual choice were taken into account. These theories took the blame from society and put it on the individual. The individual focus was replaced by biological paradigms which put the blame on genetics and involuntary responses of human body. As the researches continued not only in the fields of biology and psychology but also in the field of sociology, many theories were proposed. Today, it has become obvious that the responsibility of being an addict is like a point on a continuum from societal conditions to individual characteristics, and the person's vulnerability to effects of drug use is in relation with that point (Fishbein et. al, 1996).

The Diagnostic and Statistical Manual of Mental Disorders - Text Revision (DSM-IV-TR) (American Psychiatric Association [APA], 2000, p. 197) defines a person "dependent" on a psychoactive substance if the person meets three of the following criteria: 1) tolerance, 2) withdrawal, 3) the substance is often taken in larger amounts or over a longer period of time than was intended, 4) there is a persistent desire or unsuccessful efforts to cut down or control substance use, 5) a great deal of time is spent in activities necessary to obtain the substance, use the

substance, or recover from its effects, 6) important social, occupational, or recreational activities are given up or reduced because of substance use, 7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. Dependence is further specified according to the existence of tolerance or withdrawal which are physiological states as “with physiological dependence” or “without physiological dependence” (APA, 2000, p. 198). The diagnosis of dependence can be made without tolerance or withdrawal but these specifications help to describe a dependent person better in addition to the diagnosis according to APA.

Recent literature proposed many theories which combine different approaches in themselves, therefore biopsychosocial theories gained importance.

According to West (2001), a classification of addiction theories could be made under five headings. First heading included broad theories on addiction conceptualization which include biological, social, psychological processes and combinations of these. West (2001) gave forty three article references published till 1980 for this category. Second heading included theories which examined the effects of certain stimulus that may be triggering addiction and this cluster was more related with experimental psychology and neurobiology. Third heading included theories focused on individual characteristics that made the person vulnerable to addiction. Fourth set of theories focused on environmental and social conditions that increase the risk for addiction for members of the society. Fifth group of theories involved on treatment and relapse issues which had links with the other four headings.

Theories of addiction will be discussed in a similar manner with West’s clustering.

1.2 Psychological Theories

1.2.1 Psychodynamic Perspective

At the beginning of psychoanalytic literature, addiction was labeled as an “oral fixation” by Freud (1905) which is experienced because of a traumatic event in the oral stage of development corresponding to 0-18 months (Ramos, 2006). Chafetz (1959) called it an “oral perversion”. Later prospective studies showed that oral overactivity in children did not precede alcoholism in adulthood rather accompanied

it (Ramos, 2004). When oral fixations occur, psychological disorders related with the mouth area are expected. For example, smoking, alcohol dependence or overeating can be because of oral fixation.

On the other hand, Rado (1933) stated that it is the person's way of adaptation which is destructive to himself. Addiction is a way of aggressive acting-out behavior. Ego psychologists emerged in 1970s. They argued that addiction is a defect in the ego functions. This defect is thought to be rooted in unresolved conflicts or failures to internalize parental functions in childhood (Yalisove, 1997).

Freud was the first psychoanalyst who examined the roots of addiction in his writings. In his paper "From Civilization and Its Discontents" (1929), he stated the associations between happiness, pleasure, reality principle, and religion. Meanwhile he also mentioned addiction as a way which supplied happiness and avoiding unhappiness at the same time. As the person is liberated from the external world, immediate rush of pleasure captures him/her. For Freud, while the person reaches an ultimate happy state far from the external destructive mechanisms like society and human relations, this state consumes too much of the person's energy which could have been used for other purposes to improve himself/herself (Yalisove, 1997).

On the other hand, Freud, himself, was an antiquities collector and Subkowski (2006) thought that "collecting" was similar to addiction in terms of finding and taking something for oneself to feel more complete in a systematic way regularly and passionately. Additionally, the object of interest should be something that has a depth or a culture behind it like alcohol culture (p. 26). Collecting and addiction according to Abraham (1917) are symbolical gratifications of repressed desires which occur because of transferring libido to an unlimited number of objects (as cited in Subkowski, 2006).

According to the psychoanalytical approach, addiction can also be a result of "sublimation". Sublimation is drawing the sexual energy, libido, from the id to the ego, hence that the sexual energy is turned from inside onto an external, independent object like alcohol (Subkowski, 2006).

Gürol (2004) argued that addiction is a process of gaining and losing the object of love. Hence, addiction occurs as a result of faulty object relations. The dependent person seeks the drug or alcohol. He is relieved for a short period of time after consuming it. Subsequently, the drug's effect diminishes. The dependent person

feels insecure and ambivalent when the relief is lost. This kind of relation with the drug is experienced as a result of severe infantile trauma according to the psychoanalysts. As a child, the dependent person may have come face to face with an uncontrollable external object (probably an inadequate care-taker). The child can not internalize the mother's love. Accordingly child decides to externalize his mother's love which is defined as "externalization of idealized object". The child starts to fantasize that someone loves him/her but she/he is not there at that moment. Since the inadequate mother takes care of the child from time to time, the child tries to internalize his mother's love. However he can not because the care of the mother is not permanent. This type of relation with the mother is unsatisfying for the child's love needs. It is similar to the dependent's relation with the drug in terms of the vicious circle going around losing and gaining the object of love.

Another characteristic observed in dependent individuals is that their mothers are either extremely empathetic or lacking empathy totally (Gürol, 2004). Winnicott (1960) calls it "good enough mother" for the woman who is empathetic enough and not in an extreme way. While the mother satisfies the needs of her child, the only tool in her hand is her empathy because the baby can not express his feelings or needs verbally. If she is overly empathetic, the child can not learn how to satisfy his needs by himself. If the mother is not empathetic at all, repetitive traumatic experiences may occur for the child. Self-care capacity of a person is a determinant in addiction because if the person did not learn how to do it in his/her childhood, she/he starts seeking external ways to do it in adulthood. Ramos (2004) argued that the mother's incapability to satisfy the baby to an optimum degree leads to problems about narcissistic gratification in the baby which goes on to the baby's adulthood. However studies about the mothers of alcoholics did not show an extreme rate of problems between alcoholic patients in therapy and their mothers retrospectively, rather a rate of problems similar to other patient populations was found. In alcohol dependence, it was found in most of the studies on the etiology of addiction that a father figure was missing which was thought be causing a weak and fragile ego in alcoholics (Ramos, 2004).

As a result, many psychodynamic theories converge in some points. These points are related with a dysfunctional ego and problems in gratification of desires.

1.2.2 Behavioral Perspective

Behavioral theories of psychology are based on the overt behavior which is observable and measurable. One of the first theoreticians in behavioral psychology was Skinner who considered addiction as the flaw of the society because the society can not teach its members appropriate ways of behaving and individuals do not learn alternative functional behaviors because of lacking reinforcement (1975, as cited in Thombs, 2006, p. 136).

There are two types of conditioning which leads to learning. The first one is *classical (respondent/Pavlovian) conditioning*. In this type of conditioning, the reflexive respondent behavior is changed by pairing an unconditional stimulus with a conditional stimulus. For example, the environment may be the conditioned stimulus for the positive effects of alcohol like inhibition of introversion. The dependent person thinks he/she can socialize or feel euphoric only in the place that she/he is used to drink. The person forgets how to socialize without alcohol, or during occasions that no one drinks alcohol. Consequently, social skills are impaired.

The second type of conditioning is *operant conditioning* theory which was established by Skinner. In operant conditioning, the behavior is not reflexive, rather it is voluntary. The behavior is learnt by *reinforcement* or *punishment* occurring subsequently to it. Reinforcements are any event that occurs after the behavior so that the behavior's occurrence increases in rate. In opposition to reinforcement, punishment decreases the rate of the behavior (Thombs, 2006). For example, the positive consequences of drinking alcohol like euphoria or increasing sociability are positive reinforcements. There are also *negative reinforcements* which again increase the rate of the behavior but by the disappearance of a negative event supplying "relief". For example, when the person quits alcohol, *withdrawal symptoms* occur. The withdrawal symptoms are tremors, anxiety or craving for alcohol (p. 28). Starting to drink again supplies relief from the withdrawal symptoms, hence it is negatively reinforcing. If the person quits drinking alcohol for a long period like one month, the body is detoxified. When the person starts to drink again, the body can not process large amounts of alcohol that it did previously to quitting. Therefore alcohol intoxication occurs. In terms of punishment, the negative events occurring after alcohol intake like intoxication, getting sick in the stomach or being bullied by friends decrease the probability of drinking one more time.

Relapse could be explained by operant conditioning too (Thombs, 2006). When the reinforcement is removed from the environment, the behavior's rate of occurrence declines. When the behavior totally ceases, it is called *extinction*. Relapse is starting alcohol intake after the behavior had ceased because of treatment and it could mean that the problem behavior did not successfully and totally become extinct.

1.2.3 Cognitive Perspective

Cognitive models refer to the link between our emotional states and our thoughts which includes “expectancies”, “beliefs”, “schemas”, “automatic thoughts” and “thinking errors”.

In terms of cognitive theories, Bandura's “*social learning theory*”, (Bandura, 1986) which is also called “social cognitive theory” or “*self-efficacy theory*”, or “*alcohol-expectancy theory*” (Goldman, Brown & Christiansen, 1987) explained addiction. Until the appearance of social cognitive theory, in psychology it is believed that the human being can not control his/her own thoughts or desires because psychoanalysts argued that the personality is shaped in childhood. It is very difficult to change after childhood; additionally desires are controlled by the unconscious. Behaviorists argued that learning occurred by external stimulus-stimulus interactions. On the contrary, social cognitive theorists found that a person can learn a behavior just by observation which is called *vicarious learning* (Bandura, 1961). According to the vicarious learning paradigm, the person does not need to receive direct reinforcement to learn a behavior; observing someone being reinforced is enough. According to Bandura (1986), vicarious learning which is also called “modeling” can occur in three ways. Firstly, it can be a result of “observational learning effects” on behaviors that does not exist in the individual's repertoire. Secondly, it can be a result of “inhibitory-disinhibitory effects” that individual wants to increase or decrease the rate of occurrence. Thirdly, it can be a result of “response facilitation effects” on behaviors which existed in the individual's repertoire but have not been used until the observation of others doing it (Thombs, 2006).

Bandura (1986) defined self-efficacy as “the conviction that one can successfully execute the behavior required to produce the outcomes”. In terms of self-efficacy, it was found that efficacy beliefs of a person determined whether a

person evaluates a problem as a *challenge* that he/she can transcend or as an obstacle on the way to happiness. When perceived self-efficacy is high, the person deals with the problem better and when the problem is over, the person becomes even stronger. High perceived self-efficacy was found to be more prevalent in successful quitters in alcohol or drug dependence and in eating disorders as well (Bandura, 1999). In terms of addiction, self-efficacy is especially important when physical dependence has been overcome. It can be said that the craving that occurs after the physical dependence has diminished is purely psychological. These psychological urges that induce relapse can be dealt with cognitive and behavioral self-regulatory strategies only if the person evaluates these urges as under his/her own control (Bandura, 1999). For example, 40 million people have quit smoking and did not relapse. It does not mean that they are living lives free of unhappiness; rather they are living lives that they view as manageable and under control which is a result of high self-efficacy.

According to Bandura et. al (1986), there are four sources of self-efficacy in daily life. Firstly, *performance accomplishments* which are direct experiences to gain personal mastery are effective on self-efficacy. Successes increase self-efficacy as much as failures decrease it. It is the most powerful way of changing self-efficacy and it can be established by *participant modeling* technique in therapy. Secondly, *vicarious experiences* influence self-efficacy which is a result of seeing another person perform an act and watch the results of his/her behavior. It can be achieved by *modeling* technique in therapy. Thirdly, *verbal persuasion* is a source of self-efficacy development because suggestion is the most prevalent and easily available technique but its effect ends when the person behaves accordingly and sees the results; it turns into performance accomplishment. Fourth source is *emotional arousal* which affects the efficacy perceptions in anxiety provoking situations; hence some methods aim to decrease emotional arousal to overcome problem situations.

In a study, Bandura et. al (1986) investigated perceived self-efficacy of patients who had snake phobia. Three treatment conditions were compared in terms of initiation and persistence for treatment. The three conditions were *participant modeling*, *modeling* and *control*. Participant modeling subjects firstly watched the therapist performing the feared behaviors with the snake and then they performed the same acts in a gradual manner. In the modeling condition, subjects only watched the

therapist perform the same feared graduated activities with the snake. The control subjects did not receive any treatment; they only waited till the same time period with the treatment conditions elapsed. As a result, self-efficacy was found to be a predictor of successful task accomplishment in specific phobia treatment. Participant modeling subjects as expected had highest self-efficacy expectations among three conditions, and they had the best treatment outcome in three conditions. In addition, modeling condition which corresponds to “vicarious experience” in social cognitive theory was found to be highly predictive of approach behavior in phobic situations as much as subjects in the condition of participant modeling.

Recently, self-efficacy has been studied in addiction studies as Prochaska and Norcross (2003) embedded it into their model as a construct which was found to be related with the stages of change (p. 11). A study on self-efficacy of socially anxious college students showed that those socially anxious participants with low self-efficacy reported more alcohol consumption than the socially anxious individuals with higher self-efficacies. A recent study concluded that after one year passed over the treatment, individuals with higher self-efficacies showed greater improvements in frequency of heavy drinking and drinking problems; in treatment of depression, impulsivity, avoidance coping; in receiving social support; and they were attending AA meetings for longer durations than those with low self-efficacies (McKellar, Ilgen, Moos, Moos, 2008). Another study focusing on self-efficacy in alcohol dependence found that the participants who had higher self-efficacy resisted drinking regardless of the extent of risk situation they were faced with for six months (Vielva and Iraurgi, 2001). In a study made with Turkish university students, Sönmez (2008) found that self-efficacy of the participants that attended the smoking-cessation program significantly increased. On the other hand, the control group that did not attend the program had significantly lower self-efficacy in the second assessment which was in line with literature as in the time period between the first assessment and second assessment, the control group participants may have lived unsuccessful occasions in resisting smoking which is known to decrease smoking related self-efficacy.

1.2.4 The Transtheoretical Model of Change (TTM)

Prochaska and Norcross (2003) argue that most of the theories of psychotherapy lack empirical support although they are rational, and findings show consistency for the placebo effect caused by the researcher attention. In addition, the theories have usually focused on the content of problem behaviors or personalities rather than the processes of change. The eclectic approaches lack empiricism too because psychologists take some parts that “they” think that are useful but they do not have a model when choosing what to apply from different models of treatment (Prochaska & Norcross, 2003).

Prochaska and Norcross (2003) built up a model of psychotherapy and behavior change that would go beyond “the relativism of eclecticism through a commitment to creating a higher order theory of psychotherapy that, in Werner’s terms, appreciates the unity *and* the complexity of the enterprise”. In that sense, their theory is called the “transtheoretical model of change”. This theory had three core dimensions: Processes, stages and levels of change.

Processes of Change

The processes of change are the activities that people do to change their emotions, thoughts, behaviors, or relationships related to problems or patterns that become obstacles to their lives. These are decided upon previous studies especially on addictive behaviors therefore they are empirically supported processes (Prochaska and Norcross, 2003). The processes of change are consciousness raising, catharsis/dramatic relief, self-reevaluation, environmental reevaluation, self-liberation, social liberation, counterconditioning, and stimulus control, contingency management, and helping relationship.

The object of this study is cinematherapy and movies are used in this perspective may involve consciousness raising, catharsis/dramatic relief, and self-liberation. Consciousness raising is informing the patient about the nature of the problem. Chosen movies for the cinematherapy application are about a protagonist who experiences almost the same experiences that every alcoholic experiences. The protagonist gets into treatment, quits drinking alcohol with success, or experiences relapse. As a result, it was expected that these movies would create *feedback* and *education* that Prochaska et. al (2003) stated as components of consciousness raising.

Catharsis is another component of cinematherapy as until the Greek tragedy, catharsis was one of the aims of stage arts (p. 38). Self-liberation is in line with increasing self-efficacy as a person has to believe that he/she has the power to change his/her life before taking action (p. 7). People's self-efficacies have been found to get higher as they get from a stage to a further stage of change in the TTM.

Consciousness raising is a process that is common in many psychotherapies. For example, Psychoanalysis, Adlerian therapy, Existential therapy, Person-centered therapy, Gestalt therapy, Cognitive therapy and Rational-emotive therapy uses consciousness raising although their roots are very different. Catharsis/dramatic relief is a process of change in psychotherapies like Psychoanalytic therapy, Gestalt therapy, Person-centered therapy or Satir's family therapy. Self-liberation is a component that Adlerian, Existential, Behavior or Bowenian therapy aims to take as a target.

Treatment Motivation and Stages of Change

The transtheoretical model is a developmental theory which includes five stages of change inspired by previous developmental theories of Perry (1970) and Werner (1948). These theories can be applied both to individuals and to psychotherapists' ideas about which psychotherapeutic approach to adopt.

Perry's model is a cognitive stage theory of intellectual and ethical development (Prochaska et. al, 2003). This theory argues that young people are *true believers* who evaluate the world in dualistic terms like good or bad, true or false, at the beginning of their intellectual development. Then, they go through stages of being multiplists who do not know which idea to adopt; then being relativists who are true eclectics as therapists that do not believe there is any absolute truth; and finally being committed to one idea although knowing that empirical evidence is not always convincing but it is ethical to be committed because of having values of humanity. In addition to Perry's stage theory, Werner proposed an organismic-developmental theory which argues similarly to Perry that individuals go through stages of seeing the world (or psychotherapy) as a global whole at the beginning, then as multiple components therefore loses the "big picture", and finally as an organized and integrated whole with valuable different components but with a complex unity. As a result, the psychotherapist adopts an integrative, organized

model of psychotherapeutic change by adopting TTM after knowing all the valuable common components of different approaches to therapy.

Prochaska (2004) stated that in one of the biggest studies on alcoholism, Project MATCH, outcomes of different treatment approaches like cognitive-behavior therapy or 12-step treatment were compared, and similar outcomes were found; hence the maintainers and relapsers' pathways of change did not differ from approach to approach, the most important aspect that affected outcome was found to be clients' "*readiness to change*" before therapy; hence the more a person thinks about or behaves in order to change himself the more successful is the outcome of therapy (Prochaska & DiClemente, 1992). Ryan, Plant, and O'Malley (1995) found that outpatients with high intrinsic and extrinsic motivations for treatment had the best treatment attendance and retention outcomes. On the opposite side, outpatients with low treatment motivation had the worst treatment outcomes. The motivation level before the study was categorized by "*stages of change*", and it was indicated that the prognosis of a patient was significantly affected by pre-treatment stage of change (DiClemente, Bellino, Neavins, 1999). When the patient is in a further stage of change, he/she is expected to benefit from treatment in a quicker manner. In addition, dropouts have been found to decrease in line with the stage of the client, therefore the more action the person takes the less the person terminates therapy early.

Prochaska & Norcross' (2003) *stages of change* are as follows:

1. *Precontemplation*: The person does not intend to change in a near future. This is a stage of unawareness of problems. The important characteristic of a precontemplator is "resistance", and they usually come to treatment because they are forced to by a significant other or not to lose their job.
2. *Contemplation*: The person is aware that there is a serious problem which needs to be changed and thinking seriously on it as Prochaska & Norcross (2003) states beautifully: "Knowing where you want to go, but not being quite ready to go there".
3. *Preparation*: The person is ready to change and has fulfilled some small behavioral changes like decreasing the frequency of the problem behavior although it is small. It is like being on the edge of some big changes in an individual's life.

4. *Action*: If the person has altered the problem behavior and it has been at least one day up to six months, it can be said that the person is in the action stage. Being in the action stage requires fulfilling a specific criterion about the problem behavior like staying clean for at least one day in alcohol dependence. They actively learn the processes of change day by day, and apply them to their lives.
5. *Maintenance*: It is a continuation of change stage, and the main aim is to prevent relapses by supporting the person to continue applying the skills and other gains from therapy to his/her life. The criterion to be in maintenance stage is staying free of the chronic problem for at least six months.

Prochaska & Norcross (2003) emphasized that chronic disorders like addictions do not follow a linear pattern of change rather follow a *spiral pattern* as relapses occur frequently. Relapse prevention has been an important part of therapy because 85 % of patients that relapsed were found to get back to contemplation and preparation stage (Prochaska & DiClemente, 1984). In the present study, relapse prevention was dealt with during cinematherapy sessions as there were many patients that experiences relapse in cinematherapy sessions. The movies (28 Days, When a Man Loves a Woman) included relapse as a theme too.

“*Decisional balance*” construct has its roots in the decision making model of Mann (1977), and has been found to be related with the stages of change. Studies showed that it has two constructs, namely “pros of change” and “cons of change” (Velicer, DiClementi, Prochaska, and Bandenburg, 1985, Schumann et. al, 2005, Yalçinkaya and Karancı, 2007). These two constructs have been named differently in some studies although they meant the same; some researchers called the disadvantages of problem behavior as “pros of changing” (Prochaska, 1994, Berry, Naylor, and Wharf-Higgings, 2005). However some studies called it “cons of the problem behavior” (Velicer, Norman, Fava, Prochaska, 1999, Yalçinkaya, 2001, Yalçinkaya and Karancı, 2007, Plummer, Velicer, Redding, Prochaska, Rossi, Pallonen, Meier, 2001, Font-Mayolas, Planes, Gras, Sullman, 2006). In the present study (p.55), the disadvantages of drinking is called “cons of drinking”, advantages of drinking is called “pros of drinking”.

It has been argued that cons of the problem behavior which may be smoking, drinking, or overeating increased from precontemplation to contemplation

(Prochaska, 1994, Velicer et. al, 1999, Plummer et. al, 2001), and from contemplation to action (Share, McCrady, Epstein, 2003).

The pros of the problem behavior have been found to be decreasing consistently from contemplation to action (Prochaska, Rossi, Goldstein, Marcus, Rakowski, Fiore, Harlow, Redding, Rosenbloom, & Rossi, 1994). In a Turkish sample, Yalçinkaya and Karancı (2007) found that pros of smoking decreased in contemplation and in preparation but then increased in the action stage which may be due to experiencing difficulties during action or due to small sample size of action group in the study. It was also reported that in the Turkish sample, cons of smoking increased steadily from precontemplation to preparation, and received the highest score at action stage in line with literature (Yalçinkaya & Karancı, 2007).

Self-efficacy is another key construct that the transtheoretical model takes into account. As mentioned previously (p. 7), the theory of self-efficacy was developed by Bandura, and recently it is widely studied in addiction and TTM studies. “Self-efficacy is the confidence to change in challenging situations” (Prochaska, J. M, Prochaska, J. O., Cohen, Gomes, Laforge, and Eastwood, 2004), and it was found to increase as the person moves through the further stages. Berry et. al (2005) found that among the constructs of the transtheoretical model, self-efficacy was the strongest one predicting change as it discriminated the stages of precontemplation and maintenance stages from other stages significantly. Many studies concluded that self-efficacy is higher in preparation and action stages than precontemplators and contemplators (Berry et. al, 2005, Yalçinkaya and Karancı, 2007). In this study, self-efficacy was analyzed in terms of stages of change.

Levels of Change

Levels of change are the points that different types of psychotherapies focus during the process of change. These levels are symptom/situational problems, maladaptive cognitions, current interpersonal conflicts, family/systems conflicts, and intrapersonal conflicts. Psychodynamic therapies intervene at the intrapersonal conflicts level, cognitive therapy at the maladaptive cognitions level, behavior therapy at the symptom/situational problems level, and family therapy at the family/systems level (Prochaska et. al, 2003).

The decision to intervene at which level depends upon both the therapist's choice of theory, and also upon the patient's characteristics of problems. Usually therapy starts at the symptom/situational level, and go further with getting deeper down to intrapersonal conflicts but deeper levels require longer time and a more complex psychotherapy. Another characteristic of levels of change is that a change at one level produces changes at other levels too, hence they are not independent from each other; they affect each other simultaneously (Prochaska, 2003).

In cinematherapy, applications can be expected that the discussion on movies would intervene at various levels of change according to the specific group's dynamics in every session.

1.3 Sociological Theories

Alcohol dependence has been evaluated in literature at various levels from the individual level to international level. The first psychological theories on addiction focused on the societal breakdown and deviation side of addiction and recent theories focused on the individual side more. In 1950s, alcohol dependence was viewed as "losing control" over one's being which was evaluated then differently by Alcoholics Anonymous' (AA) when the organization was first established (Room, 1985). AA members had to admit that they were powerless over alcohol and they had lost the control of their lives as the first step in the *twelve step* treatment (Alcoholics Anonymous World Services, 1994); they argued that alcohol dependence was a flaw of the individual.

On the other hand, Lemert (1954) acknowledged that alcoholism occurred in cultures with severe disapproval of addiction because the disapproval caused depression and guilt in the addicted individual as the person could not control it after a while. Some other merging data showed that in Mormon or Muslim cultures, addiction rates were low because of religious limitations (Öncü, Ögel, Çakmak, 2002) and alcohol dependence was rare in tribal and village societies (Room, 1985). From the opposite side, although some cultures support consumption of alcohol at the social level very much, they can't stop the development of a negative view towards addiction. In a study conducted in Britain (Luty and Grewal, 2002), it was found that a significant proportion of the attendants found "addicts" untrustworthy and unreliable. In addition, drug addiction was thought to be one of the main causes

of crimes and a threat for the society. The conclusion of the study was pretty though for the addicts because they were a stigmatized outcast although the social norm was to go to the pub for “a drink” after work and they had obeyed it.

In linguistic studies, it was observed that even the name of “alcohol” which is “alkol” in Turkish was derived from “el küül / al kihl / el kuhl” in Arabic meaning a substance’s core, abstract or origin. In English, “spirit” is used as a word for drinks containing alcohol which is similar to “ispirto” in Turkish and both words have Latin origins coming from the word “spiriitus” meaning soul, breath, life’s origin, brave, or strong (Öncü et. al, 2002). From the origin of the word “alcohol” or “spirit”, the heavy meaning assigned to them could be understood. It has been taken as something that makes a person “lively”, or something that gives life a meaning among both the eastern and western cultures.

Öncü et. al (2002) focused on the mythological and historical basis of alcohol culture and it was implicated from the study that in today’s globalized modern culture, various rituals and status determinants related with alcohol belonging to different geographic zones have merged into a new one by mass media and communication technologies. These sociological theories which took addiction as a deviance and as a result of differences in cultures were called “*cultural relativists*” (Adrian, 2003). In time, anthropologists focused on the functional uses of psychoactive drugs in different cultures and supported the view of cultural collectivists with empirical data.

Another theory about deviance related to addiction was *Merton’s theory of deviance*, also called *the Strain Theory* which emerged from the early *structural functionalists*. Structural functionalists argued that deviance could be caused by an individual or the society but the deviance was always embedded in the society. Later Merton’s theory took it to a further level and proposed that anomie occurred in times of rapid social change in societies which caused deviance because of losing motivation to conform to the new regulations (Adrian, 2003). According to Merton, four types of possible adaptations to the rapid social change were as follows:

Innovation was accepting the ends but not the legitimate means to reach those ends which could be drug dealing in terms of addiction, as the dealer gets rich which is a new value of the modern society and in what way he/she gets rich is not important.

Ritualism was accepting the means to adapt to the society but rejecting the ends, hence the person did not care the money he/she earn but had to work till late everyday and then go home and use a drug to relieve his/her stress.

Retreatism was rejecting both the ends and means of the society. An alcohol addict or drug abuser without any job or appropriate housing was labeled a retreat and became an outcast.

Rebellion was both rejecting the means and ends of the society and trying to change them. Individuals in the hippie culture or in new popular trends arguing that illegal drug use should become legal and trying to change the laws according to it are rebellions (Adrian, 2003).

When socioeconomic status was taken into account, it was found that it had an indirect relationship with addiction as perceived unfair socioeconomic status was a reason for depression which was related with addiction (Levy, 2008). This indirect link occurred when people sought treatment from depression by using legal drugs but these drugs caused addiction which led to more economical deprivation as the addicted person's performance declined and stigmatization occurred towards him/her in the society. Levy's finding was in line with Merton's theory of deviance too because it was also about the individual's perception of the society and his/her role in it.

The theory of *Dialectical Analysis* of Marx and other oppositional theories like *conflict* or *critical theories* evaluated addiction different from labeling it as "deviance" (Adrian, 2003). According to Marx, it was a result of alienation of working class; hence the addicts were the "social scum" of the society who were usually from the low socio-economic status. Other critical theorists defended that the social system worked against the lower classes therefore that either the laws or the health system caused the lower social class to become outcasts, addicts or criminals, and did not help them to heal and develop themselves.

After structural functionalists, *symbolic interactionists* appeared arguing that culture is learnt. It is learnt by modeling (Bandura, 1986) or language (Chomsky, 1968). In a language, the meaning attached to words related to addiction like "drunkard" or "alcoholic" passes through generations like a label, hence the drug addict internalizes the label, and it gets harder to change himself / herself (Adrian, 2003). Symbolic interactionists' theory is known as "the *Labeling Theory*" (Fishbein

& Pease, 1996). It evaluates addiction from a less collective and more individualistic perspective.

In conclusion, addiction in general and especially alcohol abuse have been triggered by cultural norms and regulations in some societies. On the contrary, alcohol use is prohibited in some others. In addition, after accepting alcohol abuse as a problem, ways of seeking treatment for the problem are influenced by societies' perspectives towards addiction as well.

In elaboration sessions of cinematherapy application, especially cultural norms and customs of drinking can be discussion topics. It may be useful to discuss the society's role on the patients' feelings and experiences before and after they decided to quit drinking. Many patients complain about the coercion of the society to drink "at least half a glass" of alcohol because the society is not informed about the treatment of dependence in Turkey. In big cities of USA or Europe, educated people may know how to behave in a dinner or wedding beside an alcohol dependent patient. However uneducated people about dependence may not know that their insistence on offering a drink may end months or years of clean and sober life of a dependent person. Hence the elaboration sessions may be appropriate for dealing with relapse to a great extend.

1.4 Biological Theories

First theories on biological mechanisms focused on commonalities of human beings but findings showed vulnerability to drugs' effects differed from person to person (Fishbein et. al, 1996).

Wise's first neurobiological theory of addiction was (1980) related to the *mesolimbic dopaminergic reward pathway*. It was found that the specific reward system in central nervous system (CNS) was stimulated by certain receptors (esp. dopamine, aminobutyric acid [GABA], endogenous opioids including enkephalin, endorphins, and glutamate). Some researchers suggested that intake of alcohol indirectly activates the dopaminergic reward pathway by stimulating the opioid system to release endogenous opioid peptides (endorphins) (Benjamin and Pohorecky, 1993) but there is controversy in literature about the role of opioids on the alcohol dependence (Yeomans and Gray, 2002). Yeomans et. al (2002) proposed that there was a difference between animal and human studies in terms of opioids'

relation with alcohol; animal studies showing a greater effect of opioids on alcohol intake than human studies.

Another neurobiological theory of addiction (Jentsch and Taylor, 1999) was about the “*inhibitory control mechanism*” in the frontal striatal systems. This control mechanism inhibits the impulsivity of organism in terms of instant motivational states, reflexes and conditioned responses therefore that slower higher order cognitive processes can be made. It was found that lesions in the frontal striatal area (esp. corticostriatal projections from the medial frontal cortex to the caudate nucleus, nucleus accumbens core, and shell) caused disinhibition and problems in functions like delaying reward-seeking behavior. The problematic disinhibition in striatal areas causing addiction has been supported by extensive brain imagining studies (Li-ping Fu et. al, 2008, Torregrossa and Kalivas, 2008, Salas and Biasi, 2008, Belin, Everitt, 2008, Robbins et. al, 2007).

Foy (2007) offered a new biological model of addiction. According to the model, addiction occurs in a cycle of four elements biologically. These four elements are *acute intoxication and reinforcement; withdrawal and consequent dysphoria; craving; compulsive drug use*. Acute reinforcing occurs by the stimulation of reward pathway in the brain which is in the mesolimbic system. It incorporates the ventral tegmental area, the nucleus accumbens and the extended amygdala. Next, withdrawal dysphoria which is the result of cessation of drug use and the unpleasant sensation afterwards occurs; the addict starts to crave for the drug. As a cycle these lead to the compulsive use. The consecutive occurrence of craving is thought to be the result of deficits in cognitive functioning, for example in memory or learning.

Alcaro, Huber and Panksepp (2007) have examined the recent neuroethological developments. They found that the mesolimbic dopaminergic (ML-DA) system evolved, hence the organisms could search for “life-supporting stimuli” to avoid harm by activating an “instinctual emotional appetitive state” (SEEKING). The SEEKING induced to the organism was thought to be related to addiction. The organisms showing low basal levels of ML-DA were found to be more eager to show drug-seeking behaviours (Torregrossa, Kalivas, 2008, Enoch, 2008, Volkow, Fowler, Wang, Telang, 2008, Barrett, Pihl, Benkelfat, Brunelle, Young, Leyton, 2008, Ferrario, Shov, Samaha, Watson, Kennedy, Robinson, 2008). This drug-seeking was explained by pharmacologically seeking an exogenous arousal of the ML-DA system

to reach an optimum level. In contrary to these findings, Barrett et. al (2008) found the issue of dopamine (DA) problematic because although DA increase was found to be related with the euphoric and craving responses to the abused substance when DA was diminished, the euphoric or craving responses did not. As a result, it was proposed that the hedonic effects of alcohol could be associated with changes in GABAergic and endogenous opioid transmission rather than DA (Barrett et. al, 2008).

In addition, ethanol's (pharmacological name of alcohol) effects seem to be related with many more neurotransmitters than dopamine and GABA. For example, as DA causes the positively reinforcing effects of ethanol, serotonin (5-HT) was found responsible for the behavioral and psychological changes like aggressive behavior or depressive symptoms followed by alcohol consumption (Badawy, 1996, Barrett, 2008), hence ethanol's effects are thought to be different than other abusable substances. This difference in working mechanism of ethanol causes debates in psychological grounds whether alcohol dependence should be diagnosed under a different heading and be separated from other substance abuse disorders. Kuo, Aggen, Prescott, Kendler, Neale (2008) even indicated that significantly different subgroups of alcoholics were found (non-problem drinking, severe drinking and moderate drinking problem groups) for alcohol-caused behavioral problems, comorbid disorders, age at onset for alcohol-related milestones, and personality. As a result, it was implicated that the Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association, 1994) classification could be improved for better prevention, diagnosis and treatment. When Badawy (1996) examined whether a deficiency in the serotonin mechanism could be causing alcohol consumption, it was found that different studies showed different results for different strains of rats and human studies were lacking evidence because of ethical reasons causing difficulty studying with human subjects. However it was known that amygdala is associated with memory storage, emotional and motivational aspects of human behavior and learning by reinforcement (McGaugh, 1996). Serotonin was found to be one of the main neurotransmitters in the brain's reward circuitry (Koob and Le Maul, 1997) and in relation with amygdala to a great extend. Yoshimoto et. al (1991, 1996) have found that the previously mentioned nucleus accumbens' dopaminergic neurotransmission was affected by serotonergic innervations from the

dorsal raphe nucleus. In addition, there is increasing evidence showing the effects of alcohol on the serotonin levels (Jenkins et. al, 1996, Lovinger and Zhou, 1998, Lovinger, 1999, Prosser, 2008). Another study on alcohols' effects on the serotonergic neurons showed a negative correlation between duration of heavy drinking and number of serotonergic neurons; meaning the longer the person has been an alcohol dependent, the more serotonergic neurons she/he has lost (Berggren, Ericksson, Fahlke, Balldin, 2002).

In genetics studies, the most convincing results were gained for alcohol among all types of addictive behaviors (Fishbein et. al, 1996). In general, addiction has not been reported to be stemming from a single gene, rather a cluster of personality or physiological traits which are inherited which make the person vulnerable to the effects of alcohol. For example, physiological features which are inherited could be the way the person's body metabolizes alcohol and tolerance level to alcohol. Personality factors inherited could be impulsivity, or psychopathological disorders like hyperactivity. It was also found that if family history of alcohol dependence existed, individuals were found to be more sensitive to alcohol's effects (Fishbein et. al, 1996). Twin studies clearly exhibited that genetic components of drug abuse vulnerability explained the 40 - 60% of the overall vulnerability (Fishbein, 1996, Tsuang, Bar, Harley, Lyons, 2001, Uhl, 2004). In the Harvard Twin Study of Substance Abuse (Tsuang et. al, 2001), 8000 male twin pairs born between 1937 and 1957 were taken into study. Results indicated that there was a genetic vulnerability common for substances like psychedelics, heroine, sedatives and marijuana. The genetic commonalities could be the results of personality factors like risk-taking, sensation-seeking behaviors, openness to new experiences, intolerance of boredom, or results of physiological vulnerabilities for substances like metabolism and absorption rates of substances which cause the positive or negative experiences after substance consumption that reinforce intake. In another study on genetic analysis of comorbidity in 438 twin pairs (Jang, Livesley, Vernon, 1995), it was found that additive genetic influences were moderate for all alcohol abuse items (21—46%) and frequency of drug use (32%). Hettema, Corey and Kendler (1999) stated that in their study of 774 monozygotic and 809 dizygotic twin pairs, *shared environmental factors* played a small role in substance abuse vulnerability. Additionally, underlying *genetic or environmental individual factors*

were more effective as risk factors to become an addict. Stallings, Hewitt, Beresford, Heath, Eaves (1999) found that initiation of substance use including the age of onset was related to environmental means rather than genetic factors but the patterns of dependency after initiation was more related with genetic factors.

Uhl (2004) stated that the most common finding in terms of genetics was about the allelic variations in alcohol and acetaldehyde dehydrogenase (ADH and ALDH) genes which cause the “flushing” when alcohol is consumed. These findings supported the ethnic/racial vulnerability of groups towards several substances. Another finding of the study was that comorbidities with depression, anti-social personality disorder/conduct disorder and specific personality characteristics like “neuroticism” were linked with genes of alcoholics. Furthermore, Uhl (2004) mentioned twenty chromosomal regions that could cause “reproducible substance abuse vulnerability” as a result of a review of previous genetic research articles.

Cardenas, Studholme, Meyerhoff, Song, Weiner (2005) examined the relationship between alcohol consumption and regional brain tissue volumes, it was concluded that alcohol drinking was associated with significant temporal, parietal and occipital gray matter loss; active heavy drinkers had more loss than light drinkers. Moreover, participants with a family history of alcohol dependence had smaller cerebrospinal fluid volumes than participants without a family history of alcohol dependence.

Although gene scanning has been in an ongoing development a novel area of research, several findings have shown good candidates of genes or regions of genes (Uhl et. al, 2002). Lusher, Ebersole and Ball (2000) reported that dopamine D4 receptor gene increased the severity of dependence but did not explain initiation of drug use. In the Collaborative Study on the Genetics of Alcoholism (COGA), a large sample of families with a high density of alcohol dependence was examined with linkage analysis for electrophysiological traits (EEG, ERP) that can potentially identify individuals at risk for alcoholism. As a result, GABA_A receptor gene was found to be associated with alcohol dependency (Geus, 2002). These genetic research findings were in line with literature on neurobiology of addiction.

In terms of biological theories, firstly specific brain reward pathways and inhibitory control mechanisms that have been found to be related with learning and memory have been examined. Next, specific neurotransmitters (e.g. dopamine,

GABA, endorphins, opioids, and serotonin) were found to be associated with addiction. Thirdly, genetics of addiction studies were investigated, and the results were promising especially for “initiation” of addiction. In addition, environmental effects were found to be related with the ongoing pattern of addiction after onset. Ethnic differences, comorbidities with other psychological disorders, and several gene regions which could be producing vulnerability to addiction were also found in genetic studies.

The results of pharmacological treatments (antidepressants, antabuse, anxiolytics etc.) present themselves as motivation differences towards quitting alcohol. When the person is less depressant and anxious, it is easier to motivate him/her for treatment and its difficulties. Additionally, many patients report that they have alcohol dependent parents in support of empirical findings. It is called being an “al-anon” by Alcoholics Anonymous World Services. Hence many patients of AA are also al-anons. During the cinematherapy application, the effects of pharmaceuticals, as well as the effects of drinking parents in terms of genetic vulnerabilities or patterns of child-rearing may be elaborated after watching the movies related with these issues.

1.5 Prevalence

The prevalence rates vary to a great extent according to age, gender and race. Usually surveys give different results because of differences in diagnostic criteria or sample characteristics (Overstreet and Kampov-Polevoy, 2000).

In a study, researchers examined the prevalence rates of drug abuse in Turkey (Ögel, Çorapçioğlu, Sır, Tamar, Tot, Doğan, Uğuz, Yenilmez, Bilici, Liman, 2004). It was found that the first time a person drinks alcohol was found to be at the age of 11.6 ± 1.1 in average, getting drunk for the first time was at the age of 11.9 ± 2.5 in average. Males were found to be at risk more than females in terms of alcohol, inhalants, and illicit drug abuse. In addition, the students whose families were members of a higher socioeconomic status were found to be in higher risk for alcohol use. In this study, when Turkey is compared with countries in Europe and America, drug use rates were found to be lower in Turkey.

When the lifetime prevalence rates were examined in Turkey, it was found that the prevalence rates had declined for tobacco (-11.9 %) and alcohol (-7 %) from

2001 to 2004 (Ögel, 2005). On the other hand, lifetime prevalence rates had increased for marijuana (2.5 5 %), inhalants (1.7 %9), ecstasy (2.3 %) and heroine (0.8 %). In a research conducted by Turkish Ministry of Health, the percentage of getting the diagnosis of alcohol dependence was found to be 0.8 % for the last 12 months (Ögel and Tamar, 2001). It was 1.7 % for males, 0.1 % for females. The average age of diagnosed participants with alcohol dependency was 41.1. It was reported that alcohol dependency was more prevalent in western regions of Turkey (73.8 %) than the east. The rate of alcohol dependency was more than two times prevalent in big cities (57.4 %) than small cities (24.6 %).

In a research made with homeless children in Istanbul (Turkey), it was found that the most widely abused drug was paint thinner and marijuana. Substance abuse rate was found to be 78% among them (Ögel and Tamar, 2001). In another recent research report (Ögel, Tamar, Aksoy, 2004), it was found that paint thinner (60%) and alcohol (56.45%) were the most commonly used substances of abuse among homeless children in Istanbul, Turkey. In the same study, males were found to be using these common substances more than females. In school children, again males were found to be using alcohol and tobacco more than females in Turkey (Ögel et. al, 2004) which was in line with the research finding showing that males start to abuse alcohol and tobacco more than females as they grow older in the United States compared with younger ages (Johnston et. al, 2007).

Özer (1998) stated that whereas alcohol and cigarette dependent individuals reported thinking of using an abusable substance at least once with a rate of 10.6%, non-dependent individuals reported thinking of using at least once with a rate of 3.3 %, hence it could be said that alcohol dependency made participants more eager to try using other abusable substances.

Another study focused on high school students in Turkey (Ögel, Tamar, Evren, Çakmak, 2001). The results showed that among fifteen cities in Turkey. Big cities and western regions of Turkey had higher rates of alcohol use than small cities and eastern regions of Turkey. Big cities' higher drug abuse rates may be explained by high population density which occurred in a recent American study too (Johnston et. al, 2007).

Among all abusable substances, alcohol is the most widely used one in the United States (Brachtesende, 2006). In the recent report of National Institute on Drug

Abuse of USA (Johnston et. al, 2007), it was stated that almost half of the American students in secondary school had used an illicit drug at least once by the time they graduated from high school. Some illicit drugs' usage rates have declined (e.g. marijuana, amphetamines, Ritalin), some of them have kept a steady rate (e.g. 2007 hallucinogens including LSD, cocaine, heroin), some of them have increased (e.g. ecstasy and inhalants). Among legal drugs, smoking has decreased until 1996. Similarly, alcohol showed a decline which could be explained by increase in perceived risks and disapproval of society for these substances.

1.6 Alcohol Dependence

Alcohol is a substance that has been shown acceptance for a degree so far in history similar to tobacco. It has been taken an object of fun; consumed in social gatherings for thousands of years. Although the developed societies have started to support a negative look for both tobacco and alcohol dependence in the recent years, treatment facilities or government-supported campaigns are lacking especially in terms of alcohol treatment in Turkey.

In Turkish culture, alcohol has its drinking customs. It has always been an object that gathers people in a place for an occasion (Öncü, Ögel, Çakmak, 2002). There are rules of how to order, or how to prepare the side dishes of alcohol. For example, there are rules of how to consume an alcoholic beverage called "Rakı" in Turkey; it is consumed in group settings and rarely when the person is alone. In these groups, alcohol dependence is seen as fulfilling customs, or performing rituals that bound the group members together therefore it is a social status symbol.

People's responses to alcohol vary to a great extent as the rate of how well a person's metabolism tolerates alcohol by the body's constitution and biochemical make-up. It is known that alcohol easily passes the blood-brain barrier, consequently influences its functioning. If a person wants to slow down the effects of alcohol, there are several things to do. For example, drinking when the stomach is not empty, and especially drinking it with high protein foods slows down the absorption speed (Fishbein and Pease, 1996). On the other hand, drinking alcohol mixed with carbonated drinks (e.g. coke, energy drinks) facilitates the absorption. Another important determinant of how alcohol affects the person is its concentration. The higher the concentration, the more rapid it is absorbed from the stomach. Distilled

liquors including vodka, whiskey, and gin have very highly concentrated alcohol levels (40-50 %). Body mass and gender are also effective in terms of speed of intoxication. The larger is the body, the slower it is intoxicated. Thence women are intoxicated in a more rapid way; they usually weigh less than men, have higher percentages of body fat and lower levels of water in their body (Fishbein and Pease, 1996).

Neurobehavioral effects of alcohol can be summarized as intoxication of the metabolism, reinforcement to use again, aggression (without the significance of amount of alcohol intake), negative effects on learning and memory, brain damage, and building up tolerance resulting in development of physical addiction (Overstreet, 2000).

Intoxication is the result of effects of alcohol occurring on a continuum from stimulatory to inhibitory. Firstly, alcohol is stimulating; it shuts down the inhibitory mechanisms of the societies' rules and regulations, in consequence making people talkative and active (Overstreet et. al, 2000). It is the effect that has made alcohol an object of "fun". The second effect on the continuum is both stimulating and inhibiting at the same time which causes slurred and disoriented speech although the person still wants to go on talking. The last effect is sedative and intoxicating. In fact, alcohol's pharmacological compound, "ethanol", is also a central nervous system depressant as the sedative-hypnotics which are barbiturates (Gessner, 1997).

Reinforcement occurs by the rewarding effects of alcohol which are caused by the stimulation of certain centers in the brain related to reward mechanisms mentioned in the biological theories section (p.19).

Negative effects of alcohol on memory and learning are found in many studies recently (Schrimsher et. al, 2007, Kameda et. al, 2007). Alcohol seems to affect working memory, implicit memory, attention, psychomotor speed, and association of learning with memory badly (Cairney et. al, 2007). These memory dysfunctions may be related with enlargement in the volume of cerebral ventricles which is associated with decreasing number of neurons and brain mass (Gessner, 1997).

Tolerance is another neurobehavioral effect of alcohol which occurs by chronic intake of large amounts of alcohol. As a result, metabolism produces more liver enzymes, larger amounts of alcohol start to create the same effects of smaller

doses of alcohol in time which is a neural adaptation (Overstreet, 2000). A metabolism that has developed tolerance for alcohol starts to show *withdrawal symptoms* when alcohol intake stops. The symptoms may start in a few hours of alcohol abstinence. They peak at about forty eight hours. The autonomic symptoms of withdrawal are sweating, gross tremor, vomiting, headache and sleeplessness; emotional symptoms are anxiety and agitation; perceptual dysfunctions are audio, visual (e.g. seeing bugs or rats) or tactile hallucinations, attention and orientation problems, epileptic seizures, hypothermia, tachycardia, arrhythmia (Ögel, 2001). It takes about five to ten days according to the person's severity of addiction to *detoxify*, and to get over the withdrawal symptoms. If the dependence is very severe, withdrawal may lead to a worse syndrome called "*delirium tremens*". It is characterized by profound confusion, agitation, hallucinations, delusions, sleep-awake cycle dysfunctions, memory deficits, attention problems, and over activity in the emotional states (Ögel, 2001). It is a crisis situation which is even in today's conditions may lead to death therefore needs special attention. Its treatment should be made in particularly empty, well lighted, small place filled with familiar furniture for the person. If the patient is supported with certain medications like central nervous system antidepressants, benzodiazepines and vitamins (esp. thiamine to avoid Wernicke encephalopathy), delirium tremens does not develop during detoxification (Gessner, 1997) so that the withdrawal symptoms are defeated in an easier way.

Alcohol abuse is defined as "a maladaptive pattern of substance use that occurs in the presence of physically hazardous situations, multiple legal problems, and recurrent social and interpersonal problems" (APA, 2000, p.182). The DSM-IV-TR (2000) characterized *alcohol dependence* as "tolerance, dependence, withdrawal, and compulsive use of alcohol even in the presence of negative life consequences" (p. 197). To receive a diagnosis of alcohol dependence, three or more of the following must occur within the same 12-month period: (a) tolerance, (b) withdrawal, (c) increased amounts over time, (d) inability to limit or cease use, (e) much time devoted to activity or obtaining the alcohol, (f) withdrawal from or inability to complete social, recreational, or occupational responsibilities, and (g) continuation of drinking despite psychological or physical problems that have been

caused or exacerbated by alcohol consumption.

Brachtesende states that if the person who is alcohol dependent is not treated, health problems -other than dependence- occur. Some of the diseases related with alcohol are diabetes, asthma, mental disorders like mood disorders, alcohol-related dementia (2006). Although the relation between alcohol and these diseases may not be direct, several studies showed that moderate consumption of alcohol correlates highly with these diseases in the population. In addition, alcohol causes interactions with medications which may even end up with liver damage or even sudden deaths.

College students have been the most extensively studied group among alcohol using populations because they were found to be inclined to become addicted. In a study, it was found that males were more likely to expect that alcohol would make dealing with stress and peer communications easier (Piane and Safer, 2008).

1.7 Alcohol Dependence Treatment

Alcohol dependence treatment was defined as activities to eliminate the patient's physical and psychological addiction to alcohol, also to eliminate behavioral problems related to alcohol abuse, and to prevent relapse (Fishbein and Pease, 1996).

A study was made with alcohol dependent individuals who quitted with or without treatment (Cunningham, Lin, Ross, Walsh, 2000). It was found that among 589 individuals, more than half of the sample had recovered without formal help. Most of the individuals that remitted were still drinking alcohol in a moderate but unproblematic way. The important finding was that the untreated group that still consumed alcohol at a moderate level used to have less severe problems about alcohol prior to quitting, and had been using for a shorter duration of time. On the contrary, the treated group which still used no alcohol at all used to have more severe problems, and had been drinking for a longer duration of time before quitting. The authors recommended an increase in health services delivery for alcohol dependent individuals because it appeared that the more costly population for the society was the part of the sample that was still drinking at a moderate level, and never sought treatment.

1.7.1 Medical Treatment

First step in the medical treatment of alcohol dependence is to deal with the biological dependence that ethanol created by a *detoxification program*. As mentioned previously (p. 28), withdrawal symptoms occur when alcohol use is stopped instantly because of the physical dependence on ethanol. The most severe version of withdrawal symptoms occurs with “delirium tremens”. Medical treatment starts with the pharmacological treatment which aims to supply the brain chemicals that are worn out by chronic alcohol use (Fishbein and Pease, 1996). The detoxification program usually changes in duration with a range of a few days to a few weeks. The pharmacological treatment during the detoxification includes the use of sedatives (e.g. Diazepam), vitamin-mineral combinations (especially tiamin [B₁], B₁₂, and folic acid, and potassium), anticonvulsants, antipsychotics and electrolytes for renewing the water-mineral balance of the body (Fishbein and Pease, 1996, Ögel, 2001).

In addition, the use of “antabuse” (e.g. Disulfiram) has been prevalent during detoxification as it produces a state of discomfort when alcohol is taken. Since the drinker may not want to live this unpleasant feeling in the next trial, antabuse helps to quit by associating the unpleasant feeling with alcohol.

Other psychotropic medications are antidepressants, tranquilizers, or neuroleptics which are used to decrease the problematic mental states which may have increased the frequency of alcohol drinking until treatment (Fishbein and Pease, 1996).

1.7.2 Psychosocial Treatment

Psychosocial treatment mainly consists of psychotherapy, self-help groups, and rehabilitation centers applying the Minnesota Model of treatment.

1.7.2.1 Psychotherapy

Psychotherapy for alcohol dependence could be categorized as individual, group, or family therapy.

In general, there are common points in addicts’ lives that need to be the focus in *individual therapy* (Miller, 2005). These are mostly facing the stigma of the society for being an alcoholic, and having flashbacks in a euphoric way about the times

under the effect of alcohol. The therapist should focus on the triggers and emotions of loneliness. Therefore the focus should be on getting into new social network; learning to cope with the emotions and conflicts experienced because of leaving a certain style of life and social network.

Individual therapy is applied by using one of the psychotherapy theories which changes according to the choice of the therapist. The widely used approaches in individual therapy for addiction are behavior therapy, cognitive-behavior therapy, and motivational interviewing (Ögel, 2001). In behavior therapy, the focus is on learning, hence the alcohol dependent person with the assistance of the therapist develops goals, and evaluates the process of change. The therapist is very active in this therapy. Techniques used in behavior therapy are relaxation, reinforcement, modeling, assertiveness, and social-skills training. In addition, making contracts with the patient, and giving homework assignments every week is a natural part of the therapy process (Miller, 2005). Behavior therapy elicits stimulus control (keeping the patient away from alcohol), instinct control (thoughts and emotions that trigger drinking), and social control (getting the family and social network to keep the person away from alcohol) (Ögel, 2001).

Another type of individual therapy is cognitive-behavior therapy (CBT) which focuses on the client's faulty thinking causing negative emotions and affects behavior in a negative way. The client is taught to catch his/her dysfunctional automatic thoughts. Subsequently the patient learns to respond rationally to these negative automatic thoughts. The dysfunctional thoughts are labeled as "cognitive distortions". Types of cognitive distortions are arbitrary inference, selective abstraction, overgeneralization, magnification/minimization, personalization, labeling/ mislabeling, and polarized thinking. Homework assignments are given to the patient to catch automatic thoughts, to write them down to discuss them later with the therapist, and also to learn how to respond to dysfunctional beliefs rationally. The skills learnt in CBT are problem-solving efficiently, identifying thoughts and situations that trigger drinking behavior, learning inappropriate decisions, relaxation, anger management, and social skills (Ögel, 2001, Edwards et. al, 2003). As alcohol dependent individuals have concrete irrational beliefs about change or about treatment of addiction, cognitive-behavior therapy works well with them (Miller, 2005).

An important issue in therapy is *relapse prevention* (Ögel, 2001, Edwards, Marshall and Cook, 2003). The reason for starting drinking can be because of various reasons. If the patient is a recent quitter, conflicts because of a new life style and alcoholic friends can be reasons for relapse. If the patient is depressed because of problems other than addiction, the patient may not have the efficient problem-solving skills (Edwards et. al, 2003). According to *Marlatt's cognitive-behavioral model of relapse prevention* (Marlatt and Gordon, 1985), firstly the patients identify risky situations for relapse, next they engage in “coping responses” either negatively or positively. If the result is positive, their self-efficacy increases; if the result is negative, self-efficacy decreases. The negative result causes the following “initial use” of alcohol.

Another model of relapse was made by the transtheoretical model of change (Prochaska, 1992). According to this model, there is “spiral pattern of change” through the stages. The patient may start to change but may have concerns about quitting at the contemplation and preparation stages. The patient may have concerns about relapse especially in action and maintenance stages, hence may revert to preparation stage. The important point in relapse prevention is that the therapist should inform the patient about relapse before it happens at the contemplation and preparation stages. It is important to note that relapse is neither the end of treatment nor a failure in treatment, rather it is a lesson to be learned. Relapse is just an obstacle in treatment which can be overcome by the support of therapy. It should be dealt with seriously in therapy by discussing the concerns of the patient about relapse, triggers for drinking, whether there is something that interferes with the therapy process, taking social support from family and support groups like Alcoholics Anonymous, changing life-style, developing self-control skills such as refusing drinking offers appropriately, and applying cognitive-behavior techniques like keeping records or role-playing to find the triggering behaviors and triggering thoughts for relapse (Ögel, 2001, Craig, 2004).

Group therapy is also a common psychotherapy form for alcohol dependent individuals. It is widely used in chemical dependency centers. In group therapy, the therapist may use behavior, cognitive, or interpersonal therapy in the group format. If

the patients seem to show maladaptive ways of coping, behavior therapy may be used. If the patients seem to show dysfunctional thoughts about addiction, cognitive therapy may be used. If family and friendship issues start to occur frequently, interpersonal therapy may be applied (Perkinson, 2002).

The group setting provides people ability to learn about their own problems from others, also provides social support, feedback, and hope for change (Kinney, 2003). Perkinson (2002) stated the benefits of group therapy. Firstly, hope is created by the help of healthy members who become models for healthy communication skills. In addition, it prevents the feeling of loneliness; creates an educational atmosphere, develops a feeling of acceptance, supplies a ground for expression of feelings and a ground for learning the interpersonal skills like listening.

Group therapy for addiction is under the category of structured groups that focus on a theme of recovery from addiction. In that case, cinematherapy technique applied for this study was similar to a group therapy. Group leaders set goals for the group. Subsequently, they seek ways to achieve these goals with the group. Usually group leaders do not have a chance to make a pre-group interview, hence the leader of the group (the therapist) make a small contact with the individuals just at the beginning of a session either by shaking hands and introducing the new person to the group which builds trust which gives comfort to the new member. Another important point in group therapy is building the norms of the group because the frequency of minimum attendance, out-of-group relations of group members (esp. sexual relations), and confidentiality issues are sensitive issues for the group dynamics (Miller, 2005).

There are types of groups in group therapy for addictions (Perkinson, 2002). The therapist can apply one of these group techniques whenever he/she feels it is the appropriate time. Some types of groups are applied every day or every night, some of them are applied whenever it is needed. The “honesty group” helps the patients to realize how they lie to themselves. Another group is the “euphoric recall group” in which the patients talk about their experiences under the effect of alcohol, and how it affected their real life. The “reading group” is another type which starts with reading a chapter, a paragraph or a sentence from the Big Book of Alcoholics Anonymous. Afterwards they elaborate on it. The “relapse prevention group” is a very important one in group therapies; it should be made once a week. It is used to find the triggers

and high-risk situations before the relapse occurs. Additionally, it is used to discuss the experiences to learn more effective coping skills. The “spirituality group” is another type that should be run once a week. It is moderated by a therapist and a clergy who is trained in the group process. It is similar to the “higher power” belief of AA. In the “childhood group”, the patients realize their beliefs about people’s reasons for loving them. The childhood group helps patients to realize that people that love them would still love them when they revealed their defects. In addition there are “men’s and women’s groups” for discussing problems specific to genders, “community group” for discussing actual problems inside the treatment facility with the staff or with friends, and the “inventory group” for discussing every night what they achieved or failed that day as a part of the treatment (Perkinson, 2002).

1.7.2.2 Self-help Groups

Self-help groups are mainly Alcoholics Anonymous (AA), Women for Sobriety, Self-Management and Recovery Training (SMART). In Turkey, only AA meetings are held in many cities. Alcoholics Anonymous was founded in 1935 by two alcoholics who were a doctor and a failed stock broker (Alcoholics Anonymous World Services, 1991). AA was founded with the guidance of several mental health professionals arguing that the alcoholics needed some spiritual guidance and insight to support their psychiatric treatments (Miller, 2005). AA proposes 12 steps for the personal development of each alcoholic. These twelve steps are discussed in group sessions which are held on a local basis. During the development through the steps, the members are expected to accept their disorder, start to believe in “a power greater than themselves”, make a moral inventory for the damages they have caused to other people because of alcohol dependence. Subsequently, they try to make amendments for those damages they have caused. They pray and meditate. Finally they are expected to experience a spiritual awakening (AA World Services, 1991).

The meetings are not moderated by any mental health professionals, rather a chairman chosen by the group members allows the members who request to talk. All of the attendees are “alcoholics” as they call themselves. Mental health professionals can only attend the open meetings; the closed meetings are only for members of AA. In addition, every new member finds a “sponsor” who is an experienced member and a role model. The sponsor gives his/her phone number in order that the new member

can call in crisis situations. This provides social support to new members. AA creates an atmosphere of trust and social support which helps new members of AA to leave their old lifestyles and old alcoholic friends to start a new lifestyle.

Some limitations of AA have been stated by Miller (2005). For example the rigidity of 12-step program may not be appropriate for every alcohol dependent individual, or the belief in “higher power” may not appeal to atheists or agnostics who do not fit into the normative religious thoughts (Miller, 2005).

“Women for Sobriety” is another self-help organization that has been developed by Kirkpatrick (1978). It is similar to AA because it is again a non-profit organization but the difference is that it is based on Emerson, Thoreau, and Unity Church Philosophies, and cognitive behavioral techniques. In addition, they believe that problems of alcoholic women are different from men. There are thirteen statements with the theme of acceptance of disorder, negative thoughts’ destructiveness, mutuality of love, and having the power against life challenges.

The therapists are advised to be in contact with at least one self-help organization for their alcoholic patients because these group meetings supply the social support and life style change which can not be supplied by the therapist alone. It has not been cleared yet whether it is valid or not because it fits to some patients, besides it does not work for some patients. The future studies need to focus on who benefits from AA (Fishbein and Pease, 1996).

1.7.2.3 The Minnesota Model of Treatment

The Minnesota model of treatment was established by three alcoholism rehabilitation centers firstly in late 1940s (Powell, 2004). It is an intensive inpatient rehabilitation program which usually takes four weeks (Myers and Salt, 2007). The treatment is based on the twelve-step treatment of AA but it is also a combination of medicine, psychotherapy, and education.

It starts with detoxification in which the patient is stabilized medically without experiencing severe withdrawal symptoms in an average of five days. It is traditionally based in inpatient clinics but in 1990s some outpatient detoxification programs appeared in USA too, however today detoxification is mostly applied at the beginning of a more complex treatment.

The treatment includes multi-professional staff, group therapy, lectures,

recovering addicts or alcoholics as therapists, therapeutic milieu, work assignments, family counseling, AA attendance, daily reading groups, life-history taking (diaries), twelve-step work, and recreational and physical activity (Powell, 2004). As a result, the person gets into psychotherapy (individual, group and family therapy), attends AA meetings, reads and attends seminars about alcoholism, receives social skills trainings, takes responsibilities of either domestic work or homework assignments in therapy for four weeks. It is a blended model of treatment which has been very common till 1950s in USA.

This model is the one that was applied in this study's selected movies for cinematherapy; "28 Days" and "When a Man Loves a Woman".

1.7.3 Current and Developing Techniques

1.7.3.1 Motivational Interviewing

Motivational interviewing is a new practical technique especially useful to use with reluctant patients that are ambivalent about change (Edwards et. al, 2005). It is based on strategies from client-centered therapy, cognitive therapy, systems theory, and the social psychology of persuasion (Miller and Rollnick, 2002). Its most functional side is that it takes short time, as well as leaving long lasting effects on the will to stop drinking (Ögel, 2001). It supplies the state of mind for the person by pointing out why and how change should occur. The basic principles of the motivational interview are using empathy, finding out the conflicts, avoiding confrontation, working with resistance, and enhancing self-efficacy. While applying these basic principles, the therapist may give advises, pointing out the obstacles on the way to change, creating alternatives, giving feedback, clearing out the goals, and giving active help by phone or getting into contact when the patient is reluctant to go on with therapy (Ögel, 2001). In addition, in motivational interviewing, the therapist does not play a confrontational or judgmental role (Miller and Rollnick, 2002).

A major point is to compare the positives and negatives of drinking. LaBrie, Pedersen, Earleywine, and Olsen (2006) analyzed the drinking behaviors of forty seven men after motivational interviewing. They argued that their motivation to stop drinking increased; there were severe decreases in numbers of drinks per day or per month. Another significant finding occurred in a very famous study called Project MATCH (1998). In this study, outcomes of cognitive-behavior therapy (CBT),

motivational enhancement (ME), and twelve - step facilitation were compared. The results indicated that all three approaches produced significant decreases in number of abstinent days from drinking and number of drinks per drinking day. On the long term follow-up, there was a significant difference between the therapies; the twelve-step facilitation patients remained abstinent over the first year of follow-up which was longer than CBT and ME (Roth and Fonagy, 2005). However, Roth and Fonagy (2005) reported that the effect sizes of studies over the effectiveness of motivational interviewing were ranging between .3 and .83. It was also found that across studies, the gains were found to be permanent but within studies the long term effects were questionable.

The common point in TTM (p. 8) and motivational interviewing is the motivation of patients before therapy about the success of treatment. In the study, treatment motivation was expected to increase after the cinematherapy application, additionally different stages of change were expected to have different levels of motivation (Prochaska & Norcross, 2003).

1.7.3.2 Cinematherapy

Roots and Recent Findings

Cinema is a means to not only entertain and relax ourselves but also to reach “catharsis”. Aristotle was the first person who used the term “catharsis”, in his book “Poetics”. It means “purification” or “cleansing” in Greek. He used the term for the release of emotions through watching drama, and identifying with the main character, the protagonist. According to Wedding and Boyd, “with the best films, the viewer experiences a sort of dissociative state in which ordinary existence is temporarily suspended”, and identification occurs. As a result, the defense mechanism of “projection” to a movie character is triggered (2005).

Cinematherapy has been named and defined differently by many theoreticians but the common idea is that cinematherapy is used as an “adjunct to good therapy”. It never substitutes for joining, assessment and conceptualization skills, rather it can be used to reframe, educate, create metaphors in order to provide a novel look at the problem situations (Dermer and Hutchings, 2000; Wedding and Niemec, 20003). One of the first definitions included the use of commercial movies in therapy by assigning them to be watched alone or with significant others (Berg-Cross, 1990).

Next, carefully selecting and assigning movies to clients to watch at home and do the follow-up in the sessions was another definition. (Sharp, Smith, and Cole, 2002). Calisch (2001) defined it as “the therapeutic process in which the clients and therapists discuss themes and characters in popular films that relate to core issues of ongoing therapy”. As it can be seen, first definitions focused on homework assignment role of cinematherapy technique.

The use of movies in therapy takes a variety of forms; movies can be used as stimulus for either discussion materials in therapy, or as metaphors in interventions. In addition, movies can be used as homework assignments. Mangin (1999) stated that cinematherapy is a technique that can be applied by offering carefully selected movies to patients to watch at home. In that sense, the follow-up of the patient’s reactions was done during the succeeding therapy session. It may take the form of homework assignment in cognitive-behavior therapy. Solomon (1995) argued that a movie is like a map so that it shows the patient where he/she is. The therapist’s remarks make the patient’s journey easier and safer in order to remind the patient where she/he is going. According to the transtheoretical model of change, patients in contemplation stage know they must go somewhere but not ready to go there yet (p. 12), similarly to Solomon’s emphasis on the cinematherapy technique.

Lampropoulos and Kazantzis (2004) argued that therapists should be very careful while choosing the appropriate patient, the right movie and right time for assigning this homework. Every patient may not like watching movies, or may not differentiate reality and fiction. If the therapist does not discuss the material in the movie in the following session, it could be more confusing for the patient than not watching it. Another point that is important in assigning movies as homework assignments is that the therapist should explain the rationale before doing it. A debriefing should be made after the patient watches the movie as well. In addition, the movies that will be assigned to patients should be chosen from an anthology of therapeutically useful movies (Calisch, 2001).

Bibliotherapy is known to be the root of cinematherapy (Hesley, 2001). According to Menninger (Calisch, 2001), literature provided both educative information and an interaction with the external world in order that patients could stay in contact with the external reality. In addition to education and turning the focus of the patient outside, cinematherapy has some further advantages (Sharp,

Smith and Cole, 2002). Lanza (1996) stated that it is easier to get a client to watch a movie than read a book, because it is easier to focus (Calisch, 2001). Additionally, it takes shorter time to be healed by experiencing the story in the film (Solomon, 1995). As it does not require high language skills like reading does, less educated people can benefit from movies (Calisch, 2001). Although the movies are easier to focus and easier in reaching the client, they also have greater potential to influence us than reading materials. Wedding and Boyd even argue that cinema is the most influential art form that affects our consciousness (2005). Marrs (1995) has found in a meta-analytic study that audiovisual materials were more affective than bibliotherapy as an intervention. Newton (1995) mentioned that cinematherapy makes processing the unconscious material accessible more easily as well as reducing resistance because it is indirect. It gives greater insight to patients about their dilemmas or personalities, and creates useful metaphors for patients' problems (Berg-Cross, Jennings and Baruch, 1990, Calisch, 2001). Furthermore, Berg-Cross et. al (1990) argued that cinematherapy helps building the therapeutic alliance by bonding therapist's empathy and client's fear about therapy. In spite of these arguments, the underlying mechanisms have not been examined empirically. In a study, Waitkus (2003) made a qualitative analysis of the ways movies may facilitate positive psychotherapy. The study firstly involved a semi-structured interview with a psychotherapist on cinematherapy. Secondly the meta-analysis of studies on cinematherapy was acquired. As a result, Waitkus (2003) argued that future studies should be made empirically in order that underlying mechanisms of cinematherapy may be found.

Another property of cinematherapy is that movies provide us models of behaviors, therefore consequences of certain behaviors become obvious for us. Solomon calls this, "paradoxical healing" which means learning what not to do after doing it (1995). According to the social learning theory of Bandura (1986), watching a person perform what we would like to do could may cause "vicarious learning" (p. 8). In that sense, the audience does not experience but just watch the results of modeled behaviors. For example, a person may watch a movie with a protagonist regularly taking risks with unsuccessful results. Consequently, the audience may learn what not to do in terms of decision making by the help of the movie.

Portadin (2006) criticized the studies on cinematherapy. He concluded that

the terms used were not defined in the studies. Cinematherapy is a new field, hence existing literature was mostly on case stories of therapists, empirical findings were lacking; generalizations were not possible. In addition, the training of the therapists in the cinematherapy technique was questionable. Accordingly, the selection of movies for patients to watch was not even an issue in most of the articles or books. On the other hand, although empirical data is lacking, movies are popularly used in therapy. Lampropoulos and Kazantzis (2004) investigated the psychotherapists' attitudes and patterns of movie usage in therapy. It was found consistent with the findings of Norcross et. al (2000) from 827 licensed practicing psychologists. Most of the psychologists (67 %) had used movies at some point in therapy. They found it helpful at least as much as self-help books for increasing therapy gains. Similar to the pattern of recommendation of self-help books to clients, eclectic-integrative, cognitive-behavioral, and humanistic therapists used movies in therapy more than psychodynamic-analytic therapists.

The most important problem has been lacking empirical research data especially from controlled trials (Portadin, 2006, Lampropoulos and Kazantzis, 2004). Solomon (1995) and Wedding et. al (2005) stated their ideas on cinematherapy according to their experiences with their patients and students. Dermer and Hutchings (2000) created a list of movies that can be used in family therapy by making a survey with thirty-seven participants. The participants were family therapists of Kansas Association of Marriage and Family Therapy, directors of accredited marriage and family therapy programs and other family therapists that expressed their interests in cinematic interventions. In addition, Lee (2005) conducted a research on cinematherapy with adolescents who had divorced parents. In the study, a group therapy manual was established including cinematherapy for adolescents. Nevertheless any statistical analysis was not made after the intervention. Similarly, researchers made guidelines about the use of cinematherapy for different disorders according to case studies (Christie and Mc Grath, 1989; Dole and McMahan, 2005; Neumeister, 2001; Bierman, Krieger, and Leifer, 2003; Hall, 2006).

In an empirical study, Powell, Newgent, and Lee (2006) argued that cinematherapy was especially useful with patient populations like youth because they required the therapists to use creative techniques and a metaphorical language in therapy. Powell et. al (2005) have found that the combination of cinematherapy with

coping-skills training had a more positive impact on self-esteem than coping skills training alone. In spite of these findings, the results were not significant because of small sample sizes. In another empirical study, Aka (2007) found that perfectionism scores of 34 participants decreased significantly after watching “The Remains of the Day” and a debriefing session. The gains from the application were still valid after ten days. However the experimental group who watched the movie and received a debriefing on perfectionism was not different from the control group who only watched the movie and did not receive any debriefing. Aka (2007) concluded that more cinematherapy sessions may even produce personality trait or schema changes.

In this study, cinematherapy was used as an adjunct to alcohol dependence treatment. It was made in a group format in order to fit into alcohol dependence treatment program as the patients were used to group sessions.

Media and Drug Abuse

Effects of media on drug abuse prevalence have been studied extensively. Roberts, Henriksen, Christenson, Kelly, Carbone, and Wilson (1999) examined the frequency and nature of substance use in movie rentals and songs in 1996 and 1997. They found that alcohol appeared in 93 percent of movies; only 9 percent contained an anti-use statement; only 14 percent included a refusal to an offer of alcohol. In addition, 43 percent of movies showed consequences of alcohol use. Kulick and Rosenberg (2001) have found that watching positive effects of alcohol, drug and tobacco use in a movie increased the level of alcohol consumption of young college students in one month after viewing the movie. In a study, Hersey (2005) analyzed Hollywood movies on addiction. Three of them which included treatment in detail were “Clean and Sober”, “When a Man Loves a Woman”, and “28 Days”. Ögel and Aksoy (Pur, 2008a) reported that “28 Days” is an appropriate movie to be prescribed to dependent patients. It involves the Minnesota Model of treatment. Additionally, it deals with relapse and relations of alcohol dependent individuals with their significant others (Pur, 2008b). It was also emphasized that “Requiem for a Dream”, “Spun”, “Trainspotting”, “Havoc”, “London, and “Nordkraft” are movies that professionals in the area of dependence treatment should watch (Pur, 2008a). These six movies are not proposed for cinematherapy applications because they include scenes of drug use. Hence they may cause craving in dependent individuals.

Additionally, several television shows include characters seeking recovery from drug dependence like “The Sopranos”, “Dawson’s Creek”, and “Law and Order”. Hersey (2005) argued that most of the protagonists were middle-class, white, and attractive, hence popular culture showed drug dependence treatment as an option for a certain class of people. Second argument was that the people that can afford treatment were overrepresented in these movies. In real life, such treatments in rehabilitation centers would be unavailable to most of the population who had little money and no insurance. The last and most important argument was that these three movies offered a limited view of addiction treatment; they did not give any information on the alternatives to the “disease-model” in treatment. As a result, the movies usually missed the self-help groups, spiritual parts of treatment or “harm reduction” programs (Hersey, 2005; Cape, 2003).

Robinson (2004) examined the portrayals of psychological disorders in movies. In terms of alcohol dependence, “Affliction”, “Hoosiers”, and “The Lost Weekend” were offered to be watched. Wedding and Boyd (2005) proposed that the movie, “The Lost Weekend” was appropriate to use in cinematherapy since it included denial, minimization of problems, hallucinations during delirium tremens, and possible difficulties during finding alcohol. Unfortunately, Turkish dubbing versions of these movies are not available.

Other movies that were successfully representing portrayals of alcohol dependence were stated as “When a Man Loves a Woman”, “Clean and Sober”, “Leaving Las Vegas”, “House of Sand and Fog”, “28 Days”, “Monster’s Ball” etc. (Wedding and Boyd, 2005). “When a Man Loves a Woman” was also offered for cinematherapy by Solomon (1995) arguing that “this movie may be the best entry to date with the real issues and emotions that go along with being an alcoholic and their families”.

In this current study, the selection of movies was made in the light of previous studies and proposals of psychotherapists.

1.8 Aims of The Study

The study aims to examine the effects of cinematherapy on alcoholics in terms of the transtheoretical model of change, hence the change in decisional balance, self-efficacy, treatment motivation, and movie identification of alcoholics were analyzed.

Self-efficacy concerning being able to stop drinking was expected to increase after the cinematherapy application (Time 2) for the experimental group. Any change in the control groups' self-efficacy was not expected. At the end of the treatment, experimental group was expected to have higher self-efficacy than the control groups. In addition, stage of change differences were expected to be found for self-efficacy in line with literature.

In terms of decisional balance, pros of alcohol drinking were expected to decrease, as cons of drinking were expected to increase in time 2. Experimental group was expected to have fewer pros and more cons than the control groups in time 2. In addition, stage differences were anticipated in time 1 and 2.

Treatment motivation was expected to increase in time 2. In addition, stage differences were expected to exist for treatment motivation. Action stage individuals were expected to have higher motivation than preparation and contemplation stages.

Finally, the experimental group was expected to show more movie identification than the control groups because the movies they had watched were especially chosen for alcohol dependence.

CHAPTER II

METHOD

2.1 Participants

In this study, 108 alcohol dependent individuals who were members of Istanbul Branches of Alcoholics Anonymous (AA) or in-patients in “Alcohol and Substance Dependence Research and Treatment Center” (AMATEM) of Bakırköy Prof. Dr. Mazhar Osman Mental Health and Neurological Disorders Hospital. The patients of AMATEM were in detoxification. They joined group therapy sessions, namely “good morning meetings” every day. In addition, their treatment included psychoeducation about alcohol dependence. The patients were presented “28 Days” once a week, however they did not have any elaboration on the movies with mental health professionals. The patients had to stay in one building the whole time (except the cigarette smoking breaks and morning walks). Their treatment did not involve any recreational activities like fine arts or different types of sports. All of the participants from Alcoholics Anonymous were either actually receiving individual psychotherapy, or received it at least once and now sober for a period. Some of the AA members had stayed in AMATEM previous to the current study. Members of AA were also joining AA meetings at least two times a week. As a result, both groups had received psychiatric treatment at least for once. The selection of participants was made according to practical reasons. All of the volunteering patients available in AMATEM and AA Istanbul Branches were invited to cinematherapy applications. Data from 108 patients was collected in seven months. Consequently, cinematherapy was an adjunct to their actual treatment condition.

There were 52 (48 %) participants in the experimental group (EG), 42

participants (39 %) in the control group A (CGA), and 14 participants (13 %) in the control group B (CGB) respectively. All of the participants ranged in age from 24 to 61 years, with a mean age of 43.86 ($SD = 8.98$) which was close to the mean age of 41.1 in Turkey (Ögel and Tamar, 2001). The mean age of EG was 44.23 ($SD = 3.22$), the mean age of CGA was 42.86 ($SD = 8.92$), and the mean age of CGB was 45.5 ($SD = 7.13$). In the total sample, 96 participants (88.9 %) were male and 12 participants (11.1 %) were female. Total years of education ranged from 3 to 20 years with a mean of 9.86 years ($SD = 4.03$). 30 participants (27.8 %) attended elementary school, 31 participants (28.7 %) attended secondary school, 28 participants (25.9 %) attended high school, 18 participants (16.7 %) attended university, and 1 participant (0.9 %) completed graduate education.

70 (64.8 %) participants were married, 19 (17.6 %) participants were single, 12 (11.1) participants had divorced, 2 (1.9 %) were engaged, 5 (4.6 %) of the participants' partners had died.

2.2 Materials

2.2.1 Baseline Measures

In time 1, a Movie Choosing Checklist (Appendix A) was created for psychiatrists and psychologists to choose movies for alcohol dependence treatment. The experimental group and the control groups were administered self-report measures in time 1. The measures consisted of Demographic Information Form (Appendix B); Alcoholism History Questions (Appendix C); Stages of Change questions (Appendix D); Self-efficacy Questionnaire (SEQ) (Appendix E); Decisional Balance Scale (DBS) (Appendix F); Movie Identification Questionnaire (FÖÖ) (Appendix G); and Treatment Motivation Questionnaire (TMQ) (Appendix H).

2.2.2 Movie Choosing Checklist

A movie choosing checklist was created to select the movies which would be used in cinematherapy (see Appendix A). The checklist included aspects of drug dependence and social relationships of addicts. The more number of aspects the movie included the more related was the movie with alcohol dependence. In addition, the checklist included aspects of treatment of alcohol dependency and

dealing with relapse in order to include an informative theme for the participants. The checklists were filled after watching the movies by three psychologists who were educated and experienced in the field of addiction.

2.2.3 Post-treatment Measures

In time 2, both experimental and control groups were administered Importance and Belief Questions; Self-efficacy Questionnaire (SEQ), Decisional Balance Scale (DBS), Movie Identification Questionnaire (FÖÖ), and Treatment Motivation Scale (TMS).

2.2.4 Demographic Information Form

The demographic information form (see Appendix B) included information on consent to participate the study at the beginning. In addition, information on age, gender, last educational grade completed, total years of education, marital status, and occupation were gathered.

2.2.5 Alcoholism History Questions

The question about “will to receive help” about alcohol problems were asked by a multiple choice question (see Appendix C; Item 13). Participants’ beliefs about being able to quit drinking alcohol, and importance of quitting drinking alcohol were asked by two 10-point Likert type items (see Appendix C; Item 14 and 15). Total years of alcohol drinking and frequency were assessed by three questions (see Appendix C; Items 16, 17 and 18).

2.2.6 Stages of Change Questions

Stages of change questions (see Appendix D) consisted of the staging algorithm developed by Prochaska et. al (DiClemente, Prochaska, Fairhurst, Velicer, Velasquez, & Rossi, 1991). The questions were translated by Yalçinkaya (2001). These questions were used to assign the participants to the five stages of change. In addition, the terms related to smoking were replaced by terms related to alcoholism. The transformation was supervised by Psychiatrist, Assoc. Prof. Kültegin Ögel who is specialized in the area of alcohol and substance abuse counseling.

The five stages of change assessed by the questions were precontemplation,

contemplation, preparation, action, and maintenance. Some of the subjects were still drinking alcohol. Some of them had remained sober for various periods of time. The following questions were asked to assign them to the five stages: (1) Have you ever tried to quit drinking alcohol, (2) Are you thinking seriously about quitting drinking alcohol in the next six months, (3) Are you thinking seriously about quitting drinking alcohol in the next one month, (4) Did you quit drinking alcohol in the last six months, (5) Are you currently drinking alcohol?

In the study, the five stages of change were defined in relation with the sample as follows: *Precontemplators* were the participants who were currently drinking alcohol and not seriously thinking about quitting drinking alcohol in the next six months; *contemplators* were the participants who were currently drinking alcohol, and seriously thinking about quitting alcohol in the next six months; *preparation* subjects were the participants who were currently drinking alcohol, and thinking about quitting drinking alcohol in the next one month; *action* subjects were the participants who had quit drinking alcohol in the last six months and not currently drinking alcohol; *maintenance* subjects were the participants who had quit drinking alcohol more than six months ago.

2.2.7 Decisional Balance Scale (DBS)

Decisional Balance Scale (Velicer, Diclemente, Prochaska, & Brandenburg, 1985) was translated in the study of Yalçinkaya (2001) by two bilingual academicians (see Appendix E). It was translated to Turkish and then back to English. Transformation of DBS for smoking into DBS for alcohol dependence was supervised by Psychiatrist, Assoc. Prof. Kültegin Ögel who is specialized in the area of alcohol and substance abuse counseling.

DBS is a 24 item, 5-point Likert type scale from (1) not at all to (2) very much. It is a decisional balance measure across stages of change. DBS has two constructs labeled as “pros of smoking” and “cons of smoking”. Each construct has 12 items. It has a high internal consistency (alpha = .88 for the Pros scale and .89 for the Cons scale) (Velicer et. al, 1985). After translation, its internal reliability was found to be .73 for the overall scale by Yalçinkaya (2001) (.74 for the pros scale, .81 for the cons scale). In this study, for the overall scale items, Cronbach’s alpha was found to be .79 (.80 for pros, .63 for cons of the scale items).

2.2.8 Self-efficacy Questionnaire (SEQ)

Self-efficacy Questionnaire (Nicki, Remington, MacDonald, 1984) consists of 25 items, and it is 5-point Likert type scale from (1) “not sure at all that I will be able to refrain from smoking” to (5) “very sure that I will be able to refrain from smoking” (see Appendix F). Karancı (1992) translated and examined the scale’s psychometric properties for a Turkish sample of 174 smokers. It was found that internal consistency ranged between .72 and .84 for the 5 different factors of the scale (psychosocial, habitual, negative-affect, relaxation, restlessness).

In this study, the terms and characteristic behaviors related with smoking were replaced by terms and characteristic behaviors related to alcoholism under the supervision of Psychiatrist, Assoc. Prof. Kültegin Ögel who is specialized in alcohol and drug dependency counseling. The transformation into alcohol related self-efficacy was made in the light of previous findings (Karancı, 1992) that SEQ appeared to have five factors in Turkish samples. Overall reliability was found to be .97, and Cronbach’s alpha for five factors of SEQ ranged between .71 and .94 in this study.

2.2.9 Movie Identification Scale (FIS; Film Özdeşleşme Ölçeği in Turkish)

Movie Identification Scale was developed by Aka (2007) (see Appendix G). It consists of 13 items. The items are 5-point Likert type ranging between (1) “I strongly disagree” and (5) “I strongly agree”. It was found that it had a high internal reliability (Cronbach’s alpha = .94) (Aka, 2007). In this study, its reliability showed differences from movie to movie. Alpha of “When a Man Loves a Woman” (related with alcohol) was .95, alpha of “28 Days” (related with alcohol) was .92, alpha of “Mutluluk” (unrelated with alcohol) was .85, alpha of “Click” (unrelated with alcohol) was .89.

2.2.10 Treatment Motivation Questionnaire (TMQ; “Tedavi Motivasyonu Anketi” in Turkish)

The Treatment Motivation Scale was developed by Ryan et. al (1995) to assess the emotions that keep the patient in treatment, and to prevent relapse. Evren et. al (2006) adapted TMQ into Turkish language (Appendix H). It included four

subscales: (1) internalized motivation, (2) external motivation, (3) interpersonal-help-seeking, and (4) confidence-in-treatment. Cronbach's alpha was .84 for the overall items. Cronbach's alpha for the subscales of the questionnaire ranged between .42 and .91 in the Turkish sample.

2.3 Procedure

2.3.1 Selection of Movies for Cinematherapy

After the literature review on movies which can be used in therapy especially about alcohol dependence (Cape, 2003; Hersey, 2005; Solomon, 1995; Stevenson, 2000), eighteen movies were found with alcohol themes or movies with a metaphorical value for dependence. Number of movies was decreased to three for the experimental group which included *28 Days* (2000), *When a Man Loves a Woman* (1994), *Wilbur Wants to Kill Himself* (2002).

“28 Days” and “When a Man Loves a Woman” includes group therapy, psychoeducation, 12-step program of dependence treatment of therapeutic communities, and group therapy for families of drug dependents. “Wilbur Wants to Kill Himself” is about a family who is trying to survive after the traumatic events they lived through recently. It focuses on coping skills; however it is not about alcohol dependence.

Next, a checklist has been created for assessing inter-rater reliability which includes the components in movies that are needed to exist in the movie for cinematherapy. These checklists were filled by two other researchers who are clinical psychologists specialized in addiction while watching the five movies, hence the movies that were used in cinematherapy were chosen by objective terms. The movies were decided to be *When a Man Loves a Woman*, *28 Days* for the experimental group. “Happiness” (Mutluluk, 2007) and “Click” (2006) were chosen for the control groups. “Happiness” is about customs of chastity, existential anxiety and problem solving skills of three different individuals. “Click” is about a man who has problems with managing his life.

When a Man Loves a Woman (1994) is a Hollywood movie which focuses on a family of four; a couple who has two daughters aged around five. The movie is both drama and romance. The wife is an alcohol dependent person. Additionally, she is a student counselor in a state school. The husband is a pilot who rarely drinks in

social occasions. The family looks like “perfect” from outside as the family members love each other. They are an upper middle class family without any economic difficulties living in a house in San Francisco. The reason behind alcoholism of the woman is shown as the faulty interaction of the couple, as the man is the one with all the responsibilities, “the strong one”. As a result, his wife feels herself weak and empty, not taking any responsibility of her decisions or of the family. The alcoholic mother goes through treatment after hitting her daughter on the face when she was drunk. The first half of the movie is about acceptance of dependence, overcoming denial and treatment. The second half is about alcohol dependency’s effects on family relationships, relapse and meetings of AA. These meetings take place after the detoxification at the maintenance stage. There is a happy ending as the alcohol dependent mother stays clean and sober as well as the family does not fall apart.

On the other hand, *28 Days* (2000) is another Hollywood movie which is more about the treatment procedures and the environment in a therapeutic community for drug and alcohol dependence. There is a woman writer who has an alcohol dependent lover just like she is. They spend their time in parties and carry on a life full of disapproval from neighbors and family members. She is forced by law to be rehabilitated. We watch her while she overcomes denial for her alcohol problem in the therapeutic rehabilitation center. During the movie, the main character lives through the precontemplation stage, a forced action stage. Subsequently, we see the beginning of her maintenance stage too. She decides to change her lifestyle which is a must in the dependence treatment. In accordance with this, she leaves her boyfriend although he proposes to marry her. The movie is a good example with more emphasis on the treatment and less on life style changes.

Happiness (2007) is a Turkish movie. It is about a girl who has been raped by her own uncle, and her relationship with her cousin who is ordered by his father (the rapist uncle) to kill her to fulfill the customs of chastity. The rapist uncle wants his son (her cousin) to kill her on the train while going to a big city from their village. As her cousin can not kill her, their relationship take a different form; from being cousins to falling in love while they run away from the uncle. On their way, they run into a retired professor who gave up city life, and started to make a voyage in his boat in the Aegean Sea. As the three people travel together, they question the meaning of customs, honesty, emotional expression and love. At the end of the

movie, the rapist uncle is killed by the girl's father -his own brother- when the rape is revealed, and the girl starts a new life with her cousin whom she loves, away from their village. Meanwhile the retired professor goes on his voyage happily after fulfilling his duty as their protector. This movie was used with CGA during the cinematherapy session.

Click (2006) is a Hollywood movie with a theme of “you can not turn back the time; you should better learn to appreciate what you have got”. A father, his wife and two small children live in a beautiful house. They are a middle class American family. The conflict occurs for the main character, Michael, when he does not have enough time for his family. He has to work day and night, and even in the weekend. As a result, he buys a multi-functional remote for controlling “everything” in his life. In time, he realizes he can freeze, and play back or forth in time. At the beginning, it is very amusing for him, and he can please everyone around him with the help of the remote. Consequently, he realizes that he by-passes much of his life on autopilot. He experiences enlightenment; he starts to appreciate having a family and love, not work and money any more.

2.3.2 Cinematherapy Application

The Experimental Group

The experimental group (EG) had two sessions of cinematherapy application. The EG filled the questionnaires previously to the first movie (time 1). After each movie, an elaboration session about alcohol dependence theme was made which took about 50 minutes. Two breaks of ten minutes were given; one in the middle of the movie, one at the end of the movie before the elaboration session. After watching each movie, the Movie Identification Scale was given. Subsequently, after the second session was made, the same questionnaires were given again as the post-assessment (time 2).

The cinematherapy group sessions started with questions which were common for all of the movies. Questions were as follows (Bowen, 2006):

- Did you enjoy the movie?
- Why, why not?
- Who was your favorite character?

- In what ways did you relate to your favorite character?
- Were there certain scenes that you enjoyed the most?
- Did you experience similar events?
- What was your reaction to its ending?

Questions asked by the researcher (the cinematherapy session moderator) specifically for each movie following the first seven questions are as follows:

For 28 Days:

- What do you think about the group therapy sessions in the movie? (Assess similarities and differences with their group sessions).
- What do you think about her relationship with her sister? With her mother?
- What did you think when Gwen was returning to the city in the car? What did you feel?
- Gwen (the main character) refused her long-term boy friend's marriage proposal, and left him because he wanted to continue their old style of life, what did you think about it?
- What would you advise Gwen to do in her new life?

For When a Man Loves a Woman:

- What did you think about the couple's relationship?
- What was your reaction to Alice (Meg Ryan) when she hit her daughter?
- Do your family members receive any support as a group therapy like the woman's husband in the movie?
- What do you think your family members think about your alcoholism?
- What did you feel at the end of the movie when Alice took the 6-month sobriety coin of Alcoholics Anonymous?
- What do you think Alice and her family's life will be like from now on?

The questions were not asked in a didactic manner, rather they were asked according to the course of conversation. The elaboration sessions were like a group therapy session with the therapist in a less authoritarian role. It can be said that it was almost like a psychodrama group in which the patients were more active than the group leader (the therapist). It could be stated in other words as it was similar to an

AA meeting however with a mental health professional as a group leader.

At the end of the cinematherapy application, they were given the certificate of achievement (see Appendix I).

The Control Groups

There were two control groups. One of the control groups was the Control Group A (CGA). It was shown one movie (Happiness) and had one non-alcoholic elaboration session over the theme of the movie. It was in a less formal manner; more guided by the participants' will. The aim of CGA was to control the researcher's attention effect.

The other control group was Control Group B (CGB). It was created for practical reasons. Cinematherapy application is defined in the present study as "watching alcohol related movies' and making elaboration sessions on the theme of the movies in a group setting". Previous to the study, the control group was thought to be for controlling the attention effects of the researchers. One movie with a non-alcohol theme was thought to be adequate. Succeeding the collection of data from CGA, it was observed that controlling only the attention effect was not enough. Therefore an exact match of the EG was established. CGB was shown two movies unrelated with alcohol (Happiness and Click), and did not have any elaboration sessions. As a result, CGB would demonstrate a condition to examine the effects of "alcohol relatedness" and elaboration sessions with alcohol dependence theme.

Table 1.*Procedure*

Groups	Treatment	Movies
EG	Treatment + 2 Movies (Alcohol Theme) + Elaboration	28 Days and When a Man Loves a Woman
CGA	Treatment + 1 Movie (Non-alcohol Theme) + Elaboration	Happiness
CGB	Treatment + 2 Movies (Non-alcohol Theme) + No Elaboration	Happiness and Click

2.4 Data Analysis

Sample sizes of experimental and control conditions were small. In addition, the sample was not normally distributed since it was based on patient population. As a result, non-parametric tests were used in the analysis. The Wilcoxon Signed-ranks Tests were applied for paired samples; the Mann-Whitney Tests were applied for independent samples; the Kruskal-Wallis Tests were applied when there were more than two conditions.

CHAPTER III

RESULTS

3.1 Characteristics of Participants

Previous attempts to quit alcohol drinking had a mean of 3.33 times ($SD = 4.77$). 23 participants were quitting alcohol for the first time (21.3 %), 26 participants had quit before for once (24.1 %), the rest of the sample (53.2 %) had quit two times or more before the actual treatment.

Total years of alcohol drinking ranged from 1 to 47 years ($M = 21.83$, $SD = 10.32$). 30 participants (28.7 %) did not have a day that they did not drink alcohol in the last six months; 16 participants (13.8 %) had never drunk alcohol in the last six months who were at the maintenance stage of change. 62 participants (57.4 %) had some days that they did not drink in the last six months ranging between 1 to 160 days with a mean of 40.93 days, and median of 15 days ($SD = 61.48$ days).

In the last six months, 58 participants (54 %) drank alcohol everyday, 15 participants drank once or did not drink (14 %), 34 participants (32 %) drank various days of the week ranging between twice to six days a week in the last six months.

93 participants (86.9 %) received alcohol dependence treatment by their own will, 14 participants (13.1 %) received treatment because of a significant other's will like family or close friends. None of the participants received help by the force of law.

It was found that number of previous attempts to quit drinking alcohol was not affected by educational levels ($H(4) = 4.57$, ns). In addition, total number of years that the participants drank alcohol was not different for different levels of educational histories ($H(4) = 2.13$, ns).

3.2 Decisional Balance

A Wilcoxon Signed-ranks Test indicated that for the overall sample (EG, CGA and CGB), pros of alcohol in time 1 ($\underline{M} = 31.17$) and in time 2 ($\underline{M} = 31.40$) were not significantly different, $\underline{T} = 1153.5$, ns, $r = -.06$. However, cons of alcohol for the overall sample in time 2 ($\underline{M} = 52.48$) were more than cons of alcohol in time 1 ($\underline{M} = 50.80$), $\underline{T} = 869$, $p < .05$, $r = -.15$. This finding could be explained by both cinematherapy plus alcohol dependence treatment in the experimental group (EG), and the alcohol treatment in addition to placebo effect of movie watching with group sessions (although unrelated with alcohol dependence) in the control groups because the patients were either in-patients in a alcohol detoxification clinic or members of Alcoholics Anonymous. To further analyze this significant finding; for group differences, a series of Mann-Whitney Tests; for time 1 and time 2 differences Wilcoxon Signed-ranks Tests were made group by group.

Table 2.

Group Differences for Cons of Alcohol Use

	<i>Groups</i>	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>H</i>	<i>p</i>
Time 1	EG	52	51.42	9.56		
	CGA	42	50.09	10.72	.582	.75
	CGB	14	50.64	8.49		
Time 2	EG	51	53.54	7.54		
	CGA	42	51.78	8.17	2.18	.34
	CGB	14	50.65	8.49		

According to the results, CGA was not different from CGB in time 1 in terms of cons of alcohol ($U = 283$, ns, $r = -.03$), hence they were merged into one control group (CGA+CGB). This new control group also did not have a significant difference between cons at the time 1 and time 2, $T = 80$, ns, $r = -.12$. A Wilcoxon Signed-ranks Test indicated that cons of EG in time 2 were not more than cons of EG in time 1, $\underline{T} = 433.5$, ns, $r = -.17$. Although there was a slight increase, it was not significant (see Table 2). This finding was contrary to the research hypothesis as cinematherapy in accordance with alcohol dependence treatment was expected to

increase cons of drinking for EG. As a result, cinematherapy and addiction treatment, or the addiction treatment alone did not affect perception of cons of alcohol on group basis.

Cons of alcohol were not different for EG, CGA and CGB in time 1 ($H(2) = .582$, ns), and EG, CGA and CGB were not different at the end of the study too ($H(2) = 2.18$, ns). As CGA was not different from CGB in time 1 in terms of cons of alcohol ($U = 283$, ns, $r = -.03$), they were merged into one control group (CGA+CGB). As a result, the EG ($M = 58.59$) did not report more cons than CGA+CGB ($M = 50.61$) in time 2 ($U = 1238$, ns, $r = -.13$) which was similar to the time 1 as EG was not different from CGA+CGB ($U = 1335$, ns, $r = -.07$). It was on the contrary to the research hypothesis.

For the pros of alcohol, CGB did not have sufficient values to get into analysis, hence it was excluded. It was indicated that EG did not report less pros in time 2 than pros in time 1, $T = 567$, ns, $r = -.04$. CGA did not report less pros in time 2 than in time 1, $T = 109$, ns, $r = -.09$. It was concluded that cinematherapy and alcohol treatment or alcohol treatment alone did not affect attitude towards the pros of alcohol neither on the whole sample nor on the group basis.

Table 3.

Group Differences for Pros of Alcohol Use

	<i>Groups</i>	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>H</i>	<i>p</i>
Time 1	EG	52	32.65	8.07	7.11	.03
	CGA	42	28.47	7.71		
	CGB	14	33.78	5.52		
Time 2	EG	51	32.57	7.94	5.34	.07
	CGA	42	29.17	8.14		
	CGB	14	33.78	5.52		

It was found that in time 1, pros of alcohol were different for EG, CGA and CGB ($H(2) = 7.11$, $p < .05$), however this difference dissipated in time 2 ($H(2) = 5.34$, ns). Mann-Whitney Tests were made to further analyze this finding. In time 1,

pros of alcohol were higher for the EG than the CGA ($U = 795$, $p < .05$, $r = .23$), and in time 2 pros of alcohol were still higher in the EG than CGA ($U = 830$, $p < .05$, $r = -.21$) although a small decrease in effect size was attended. This finding was in contrary to the research hypothesis because the pros of alcohol use were expected to be lower in the experimental group than control groups in time 2 (see Table 2). It may be explained by the time 1 differences between subjects.

In addition, in time 1, pros of EG were not different from CGB ($U = 317.5$, ns, $r = -.09$), and in time 2 EG was still not different from CGB ($U = 340$, ns, $r = -.04$). CGA scored less on pros than CGB in time 1 ($U = 182.5$, $p < .05$, $r = -.28$), but CGA was not different from CGB in time 2 ($U = 196$, ns, $r = -.25$). CGA had a slight increase in pros which is in line with literature because the control group A watched difficult situations in a movie and did not have the chance to talk over them in group setting as the discussion was in a less formal manner. As a result, they may have their motivations lessened making advantages of alcohol seem helpful.

3.3 Self-efficacy

Self-efficacy scores of three conditions were different from each other at the beginning of the study (see Table 4).

Table 4.

Group Differences for Self-efficacy

	<i>Groups</i>	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>H</i>	<i>p</i>
Time 1	EG	52	77.38	33.59	8.78	.012
	CGA	42	97.07	33.63		
	CGB	14	72.79	28.37		
Time 2	EG	51	89.71	33.36	5.78	.056
	CGA	42	97.48	31.81		
	CGB	14	72.79	28.37		

It was found that EG, CGA and CGB were significantly different from each other in the time 1 ($H(2) = 8.78$, $p < .05$), but they were not different in the time 2 ($H(2) = 5.78$, ns). Mann-Whitney tests were made to further analyze these groups. Previous to the study, the EG had lower self-efficacy than the CGA ($U = 745.5$, $p <$

.01, $r = .27$) but at the end of the study, the EG and the CGA were no longer significantly different from each other ($\underline{U} = 930.5$, ns , $r = .11$) which could be evaluated as there was an increase of self-efficacy in the EG but the CGA remained almost the same, this led to the big difference at the beginning to extinguish. In addition, previous to the study, the EG and the CGB were not significantly different in terms of self-efficacy ($\underline{U} = 332.5$, ns , $r = .06$) which remained the same at the end of the study although a slightly higher effect size was found. EG and CGB were still not different significantly ($\underline{U} = 250$, ns , $r = .21$). The CGA had higher self-efficacy than the CGB ($\underline{M} = 72.79$) ($\underline{U} = 177.5$, $p < .05$, $r = .29$) at the beginning which remained almost the same at the end of the study; CGA was still higher than CGB ($\underline{U} = 169.5$, $p < .05$, $r = .31$).

A series of Wilcoxon Signed-ranks tests were made to analyze the effects of cinematherapy on self-efficacy; post-test scores were compared with pre-test scores. Results indicated that in the time 2 ($\underline{M} = 90.54$) of the overall sample had more self-efficacy than time 1 ($\underline{M} = 84.45$), $\underline{T} = 917$, $p < .05$, $r = -.15$. In addition, EG had higher self-efficacy in the time 2 than the time 1, $\underline{T} = 298$, $p < .01$, $r = -.26$. CGA did not show any difference between the time 1 and the time 2, $\underline{T} = 155$, ns , $r = -.06$; as well as when the control group A and control group B were merged into one (CGA+CGB), it did not show any difference in the time 1 ($\underline{M} = 91.00$) and time 2 ($\underline{M} = 91.30$), $\underline{T} = 155$, ns , $r = -.05$. These findings were in line with the research hypothesis as it was expected that self-efficacy would increase in the EG who watched alcohol related movies, and would not increase in the control groups. It could be said that cinematherapy with alcohol addiction treatment was more effective on patients than alcohol dependence treatment alone to increase self-efficacy.

3.4 Treatment Motivation

A Wilcoxon Signed-ranks test indicated that the whole sample did not have a difference in terms of treatment motivation between time 1 ($\underline{M} = 97.37$) and time 2 ($\underline{M} = 97.66$), $\underline{T} = 1001.5$, ns , $r = .03$. EG did not have a higher treatment motivation in time 2 ($\underline{M} = 96.48$) than in time 1 ($\underline{M} = 95.54$), $\underline{T} = 411$, ns , $r = -.07$. CGA did not have a higher treatment motivation in time 2 ($\underline{M} = 100.10$) than in time 1 ($\underline{M} = 100.39$), $\underline{T} = 68$, ns , $r = 0$. When CGA and CGB were merged into one control group, it did not show a difference between time 1 ($\underline{M} = 99.31$) and time 2 ($\underline{M} = 98.31$) too,

$T = 108$, ns, $r = -.06$.

In time 1, EG ($M = 95.36$), CGA ($M = 100.00$) and CGB ($M = 96.93$) were not different from each other in terms of treatment motivation ($H(2) = 5.34$, ns). EG ($M = 96.67$), CGA (99.75) and CGB ($M = 96.29$) were still not different from each other in time 2 in terms of treatment motivation ($H(2) = 3.23$, ns). On the other hand, when CGA and CGB were merged into one control group, EG ($M = 95.36$) had lower treatment motivation than CGA+CGB ($M = 100.00$) in time 1 ($U = 587.5$, $p < .05$, $r = -.24$). In time 2, this difference receded (see Table 5).

Table 5.

Group Differences for Treatment Motivation

	Groups	<i>N</i>	<i>M</i>	<i>SD</i>	<i>U</i>	<i>p</i>
Time 1	EG	50	95.36	12.79		
	CGA				587.5	.02
	+ CGB	33	100.00	10.93		
Time 2	EG	49	96.67	11.12		
	CGA				608.5	.08
	+ CGB	32	99.75	10.60		

The EG and CGA+CGB were no longer significantly different from each other ($U = 608.5$, ns, $r = -.18$) (see Table 3). At the end of the study, the experimental group's treatment motivation increased although it was not significant, and CGA+CGB had a slight decrease of it.

3.5 Identification with Characters of the Movies

The experimental group and the control groups watched different movies. As the EG watched specially chosen movies over the discussion topic (alcoholism related) in cinematherapy, and control groups watched movies unrelated with their alcohol dependence experiences. CGA watched only one movie, and had an informal discussion over the movie theme (although unrelated with alcohol); CGB watched two movies, and did not have any elaboration session. It was expected that the EG would score higher in terms of movie identification as major characters were addicts

like the participants, and the results supported the hypothesis. It was indicated that three groups were different in terms of identification ($H(2) = 25.38, p < .001$). Mann-Whitney Tests indicated that EG had a higher identification than CGA, $U = 453.5, p < .001, r = -.48$. EG was not different from CGB, $U = 312.5, ns, r = -.06$. CGB had higher identification than CGA, $U = 99.5, p < .001, r = -.49$. EG had higher identification than CGA+CGB ($M = 74.23, SD = 30.12$), $U = 766, p < .001, r = -.38$.

Table 6.

Identification with Movie Characters According to Groups

Groups	M	SD	χ^2	p
EG	104	40.82	25.38	.000
CGA	65.76	25.69		
CGB	99.64	28.79		

3.6 Importance Ascribed to Treatment by Subjects

In time 1, EG ($M = 9.25$) did not differ from CGA + CGB ($M = 9.80$) in terms of the importance that the group ascribed to the treatment ($U = 1255.5, ns, r = -.18$). In time 2, EG ($M = 9.46$) did not score higher in terms of importance than CGA+CGB ($M = 9.78$) ($U = 1179, ns, r = -.12$). There was not any change of importance ascribed in time 2.

A Wilcoxon Signed-ranks Test indicated that importance of the whole sample ascribed to the treatment in time 1 ($M = 9.53$) did not change in time 2 ($M = 9.63$), $T = 42, ns, r = -.09$. EG in the time 2 ($M = 9.46$) was not higher in terms of importance ascribed to the treatment than time 1 ($M = 9.25$), $T = 17, ns, r = -.14$. CGA did not have a higher importance in time 2 ($M = 9.90$) than in time 1 ($M = 9.94$), $T = 0, ns, r = -.11$. CGB did not have a higher importance ascribed to the treatment as well in time 2 ($M = 9.36$) than in time 1 ($M = 9.50$), $T = 3.5, ns, r = -.11$. When the control groups were merged into one, CGA+CGB still did not have a difference between time 1 ($M = 9.80$) and time 2 ($M = 9.78$) in terms of importance, $T = 7, ns, r = -.01$.

3.7 Belief of Successfully Quitting Alcohol

In time 1, EG ($\underline{M} = 8.42$) did not differ from CGA + CGB ($M = 9.09$) in terms of belief of success ($\underline{U} = 1179$, ns, $r = -.12$). In time 2, EG ($\underline{M} = 8.94$) was again not different from CGA+CGB ($\underline{M} = 9.19$) ($\underline{U} = 1221$, ns, $r = -.05$).

When the whole population was examined, it was found that belief of success increased in time 2 ($\underline{M} = 9.06$) compared to in time 1 measurement ($\underline{M} = 8.77$), $\underline{T} = 44.5$, $p < .05$, $r = -.14$. The experimental group's belief of success ($\underline{M} = 8.42$) did not increase in time 2 ($\underline{M} = 8.94$), $\underline{T} = 21$, ns, $r = -.17$. Similarly, CGA+CGB ($\underline{M} = 9.09$) did not have a significant increase of belief in successful quitting in time 2 ($\underline{M} = 9.19$), $\underline{T} = 5.50$, ns, $r = -.10$. As a result, the overall population has an increased belief of success but the experimental or control groups separately did not show such an increase. This finding could be a result of sample sizes; hence if the sample was bigger, the groups may have shown significant increases.

3.8 Stages of Change

Table 7.

<i>Number of Subjects According to Stage of Change</i>				
	EG	CGA	CGB	Total
Precontemplation	1	0	0	1
Contemplation	0	5	0	5
Preparation	7	4	0	11
Action	38	26	13	77
Maintenance	6	7	1	14
Total	52	42	14	

There was one subject in precontemplation stage, five subjects in contemplation stage, eleven subjects in preparation stage, seventy seven subjects in action stage, and fourteen subjects in maintenance stage.

3.8.1 Decisional Balance and Stages of Change

In time 1, different stages were not different from each other on cons of alcohol use ($H(4) = 9.14$, ns), and different stages scored differently on pros of alcohol use ($H(4) = 12.94$, $p < .05$). In time 2, stages again did not show a difference from each other on cons of alcohol use ($H(4) = 7.28$, ns), and pros of alcohol use showed difference between stages again ($H(4) = 10.48$, $p < .05$).

As mentioned previously, in terms of decisional balance only cons of alcohol was higher in time 2 than in the time 1 for the whole sample but any significant finding was not found on the group basis. There was only one subject in the precontemplation stage, hence that stage was excluded from analysis. It was found that for the whole sample, there was not any difference between five stages of change in terms of cons in time 1 ($H(4) = 9.14$, ns) and in time 2 ($H(4) = 7.276$, ns).

Table 8.

Time 1 vs. Time 2 Cons of Alcohol Scores for Stages of Change

Stages	Time 1		Time 2		<i>T</i>	<i>p</i>
	M	SD	M	SD		
Contemplation	55	8.28	55.6	7.16	2	.59
Preparation	37.19	8.29	36.27	6.69	14	.31
Action	51.28	8.9	52.90	7.18	413.5	.11
Maintenance	45.92	11.84	48.5	9.58	19	.38
Total	50.80	9.83	52.48	7.91	869	.03

Table 9.

Time 1 vs. Time 2 Pros of Alcohol Scores for Stages of Change

Stages	Time 1		Time 2		<i>T</i>	<i>p</i>
	M	SD	M	SD		
Contemplation	31.6	9.15	32.4	9.01	7	.89
Preparation	37.18	9.73	36.27	7.44	20	.76
Action	31.42	6.83	31.61	7.41	516.5	.61
Maintenance	24.79	8.09	26.42	8.79	14.5	.18
Total	31.18	7.89	31.41	7.91	1153.5	.36

Pros of alcohol did not show a decline neither for the overall sample nor according to stages in time 2.

When stages of change were analyzed, it was indicated that the whole population had differences between five stages in terms of pros of alcohol in time 1 ($H(3) = 12.58, p < .05$) and in time 2 ($H(3) = 9.86, p < .05$).

When pros of alcohol were examined for five stages on group basis, it was found that EG had a difference between stages of change both in time 1 ($H(4) = 10.42, p < .05$) and in time 2 ($H(4) = 8.77, p < .05$). It was found that both of the control groups did not show a stage difference for pros of alcohol which may be because of the smaller sample sizes of the control groups. To further analyze stage differences, Mann-Whitney Tests were made. The results indicated that there was not a difference between contemplation and preparation groups in terms of pros of alcohol neither in time 1, $U = 17.5, ns, r = -.28$, nor in time 2, $U = 19.5, ns, r = .22$ (see Table 6). Action group had less pros of alcohol than preparation group both in time 1, $U = 251, p < .05, r = -.23$, and in time 2, $U = 251, p < .05, r = -.23$, in line with the research hypothesis because pros were expected to decrease in every further stage of change. Also maintenance group had less pros of alcohol than action stage group both in time 1, $U = 295.5, p < .01, r = -.28$, and in time 2, $U = 349.5, p < .05, r = -.22$ which confirms the research hypothesis that pros decrease with every further stage of change. As a result, there is a slight increase from contemplation to preparation stage, and then a regular decline of pros in every further stage of change occurs as expected. The slight insignificant increase may be due to small sample sizes at contemplation and preparation stages.

3.8.2 Self-efficacy and Stages of Change

Both in time 1 ($H(3) = 21.25, p < .05$), and in time 2, $U = 19.29, p < .05$, there were differences between stages of change groups in terms of self-efficacy.

A Wilcoxon Signed-ranks test indicated that self-efficacy of the whole population had increased in time 2 (EG, CGA, CGB) (See 2.4.2). When stages of change differences were analyzed for self-efficacy to compare the time 1 and time 2, a Wilcoxon Signed-ranks test indicated that only the “action” stage group had higher self-efficacy in time 2 ($M = 92.06$) compared to in time 1 measurement ($M = 82.69$),

$T = 367$, $p < .05$, $r = .23$. It may be said that cinematherapy worked for the action stage individuals whether the movie was related or not related with alcohol dependence (See Table 7).

Table 10.

Time 1 vs. Time 2 Self-efficacy Scores for Stages of Change

Stages	Time 1		Time 2		<i>T</i>	<i>p</i>
	M	SD	M	SD		
Contemplation	65.6	35.42	63.6	32.73	1	.14
Preparation	65.9	34.72	64.3	33.36	25	.79
Action	82.68	33.26	92.06	30.71	367	.003
Maintenance	115.5	19.85	110.86	29.84	6	.68
Total	84.44	34.25	90.58	32.96	917	.03

As it has been previously mentioned, there were differences between stages of change groups in terms of self-efficacy in time 1 and 2. To further analyze group differences, Mann-Whitney Tests were made. It was indicated that preparation group did not have higher self-efficacy than contemplation group in time 1, $\underline{U} = 26.5$, ns, $r = .03$, and in time 2, $\underline{U} = 24.5$, ns, $r = -.01$. Action group had higher self-efficacy than preparation group both in time 1, $\underline{U} = 284.5$, $p < .05$, $r = -.18$, and in time 2, $\underline{U} = 184.5$, $p < .05$, $r = -.28$. Maintenance group had higher self-efficacy than action group both in time 1, $\underline{U} = 186$, $p < .01$, $r = -.41$, and in time 2, $\underline{U} = 278.5$, $p < .05$, $r = -.30$. Maintenance group had higher self-efficacy than preparation group both in time 1, $\underline{U} = 17$, $p < .01$, $r = -.64$, and in time 2, $\underline{U} = 12$, $p < .01$, $r = -.72$.

3.8.3 Treatment Motivation and Stages of Change

It was found that there was a difference in terms of treatment motivation between the stages of change ($H(3) = 9.27$, $p < .05$) in time 1. However, this difference between the stages of change declined in time 2 ($H(3) = 6.09$, ns). Although the five stages were found to be different from each other in time 1, the Mann-Whitney tests did not show any significant results when the stages were compared with each other. Preparation stage did not have a higher treatment motivation than contemplation as expected, $\underline{T} = 585$, ns, $r = -.17$. In addition,

treatment motivation was significantly lower for the action stage than contemplation stage, $T = 329$, $p < .01$, $r = -.30$, in contrary to the research hypothesis. The action stage's motivation was expected to be higher than contemplation but it was not confirmed.

Table 11.

Treatment Motivation According to Stages of Change

Stages	Time 1		Time 2		<i>T</i>	<i>p</i>
	M	SD	M	SD		
Contemplation	107.20	4.09	107.25	3.30	1	.65
Preparation	101.82	13.5	100.6	14.86	12.5	.79
Action	95.44	11.57	96.69	10.25	582.5	.45
Maintenance	100.25	13.57	97.87	11.86	7	.89
Total	97.16	12.01	97.65	10.86	1001.5	.64

CHAPTER IV

DISCUSSION

The main objective of the study was to examine the effects of cinematherapy as an adjunct to psychiatric treatment on alcohol dependent individuals. The effects of cinematherapy were analyzed in the light of the transtheoretical model of change. Decisional balance, self-efficacy, treatment motivation, and movie identification were included in the analysis.

After discussing the results of the present study, clinical implications and limitations of the study will be presented. Finally, directions for future research will be discussed.

4.1 Decisional Balance

The groups were not different in terms of cons of drinking in time 1. It was good for the equality of groups. However this equality remained the same in time 2. The experimental group was found not to be higher than control groups in terms of cons of drinking. On the other hand, the overall sample had higher cons of drinking in time 2. However it was not higher on the group basis. The control groups were expected to remain at the same level but the experimental group was expected to increase in terms of cons of drinking. In spite of this, this expectation was not confirmed. None of the groups had a decrease in cons, and there was a small increase in the cons of drinking in all groups although it was not significant. This finding can be related to the small sample sizes of the groups as the whole population was significantly different in time 2 (whether the movies were related with alcohol dependence or not). In addition, it may be due to metaphorical value of the movies that the control groups watched. "Click" and "Happiness" were not movies related to alcohol dependence. However, Click is about a man who has problem solving

difficulties in his life. Hence he becomes addicted to a magical remote control. The participants may have identified with the protagonist in Click so that it may have increased their ideas about the negative side of being addicted to a substance. While watching Happiness, the participants may have realized some big problems about customs and norms that people in Eastern Anatolia have to deal with. After watching the difficulties that other people experience, they may have felt weaker because of the negative effects of alcohol. Cons of alcohol may have increased in control groups because of these reasons.

The cinematherapy group or control groups (whether about alcohol dependence or not) did not have a decrease in pros of drinking in time 2. On the other hand, groups were different from each other in terms of pros of drinking in time 1. This difference receded in time 2. This finding may be explained by the slight increase in the CGA (although not significant) because the EG and CGB did not change in time 2, and the difference in means seemed to lessen. The increase of advantages of alcohol in CGA may be because of watching only one movie and having only one group discussion which was not related with alcohol dependence. In addition, it may be related with the movie, "Happiness". The movie had scenes that the actors drank beer and wine on the boat in the Aegean Sea while eating fish. Drinking was shown as a comforting and fun activity; hence the pros of alcohol were pointed out. It may have started a craving for alcohol causing the pros to increase slightly.

4.2 Self-Efficacy

Previous studies have shown that in addiction treatment, self-efficacy is a key construct that is related with change of problem behavior (Prochaska and Norcross, 2003, McKellar, Ilgen, Moos, Moos, 2008, Vielva and Iraurgi, 2001, Sönmez, 2008). In our study, it was found that the group that watched two movies related with alcohol had their self-efficacy increased in time 2. The group that did not have any cinematherapy session (control) was not different at the end of the study. Similarly, the control groups did not change in time 2 in terms of self-efficacy when they were merged into one control group. When the movies were not related with alcohol, discussions were not effective.

In addition, the three groups (EG, CGA, CGB) were different in terms of self-

efficacy in time 1. In time 2, this difference had receded. It may be explained by the previous finding of significant increase of self-efficacy in the cinematherapy (alcohol) group hence that the big difference between the cinematherapy (alcohol) group and control group had declined. These findings were in line with literature and the research hypothesis was supported as cinematherapy was expected to increase self-efficacy because it intervened at different levels of change, included many processes of change during the sessions (Prochaska and Norcross, 2003), and provided patients to learn from the consequences of movie characters' experiences which was called "vicarious learning" by Bandura (1986). The processes of change used in cinematherapy may have been consciousness raising, catharsis/dramatic relief, self-liberation. During the elaboration sessions, there were patients who were attending treatment for the first times besides patients who had previously attended treatment many times. This difference between patients led to very emotionally though conversations which may have increased the awareness of the new patients in alcohol dependence treatment. Experienced patients pointed out the triggers and their experiences during relapse. Many new patients did not know that a wedding or a meal with alcohol dependent friends could be triggering after treatment. Consequently, the elaboration sessions were both educating and emotionally stimulating.

As it was a group setting, the processes of change differed from session to session. Although it was a one or two-sessions-long application, the movies and the group dynamics sometimes allowed to get some intrapersonal conflicts to the surface as well as more situational problems like the society's perspective about "alcoholics" or difficulties about job caused by alcoholism. Additionally, group dynamics created an atmosphere of "being understood" and diminished the anxiety of being labeled as a deviant. The most striking point for the cinematherapy attendees may have been at the disclosure level because some of them stated that they did not ever emotionally express themselves directly before they watched the movies. They seemed to talk about emotions, especially about their emotions towards significant others, in the cinematherapy application as it was easier for them to discuss emotional expressions over the emotions of the protagonist in the movie. Talking indirectly may have attenuated the defense mechanisms of the participants which can be used efficiently in all types of therapies.

4.3 Treatment Motivation

Ryan et. al (1997) had found that the patients who had higher treatment motivation had showed best treatment outcomes. In addition, various researchers argued that cinematherapy provided a novel look at the problem situations, created feedback, gave information about the disorders, and decreased resistance because it is indirect (Dermer and Hutchings, 2000, Calisch, 2001, Sharp et. al, 2002). It was expected to increase treatment motivation. However the results indicated that treatment motivation did not change for any of the groups in time 2. The hypothesis was not confirmed. In addition, the cinematherapy groups who watched alcohol related movies or unrelated movies with alcohol, and the control group that only had one informal group discussion were not different from each other in time 1 or 2. On the other hand, when the control groups were merged into one group, it was found that the cinematherapy group who watched two alcohol dependence related movies had lower treatment motivation than the merged control group, and this unexpected difference dissipated in time 2. It may be explained by the slight increase of treatment motivation in the alcohol related cinematherapy group (the experimental group) in time 2. It was in line with the research hypothesis that alcohol related cinematherapy group would have their motivation increased while the control groups (cinematherapy unrelated with alcohol or one informal group discussion) remained the same. As the alcohol related cinematherapy group watched *28 Days* and *When a Man Loves a Woman*, the cinematherapy sessions were more effective than the movies of control groups, "Happiness" and "Click" which were not about alcohol dependence.

4.4 Identification with Characters of the Movies

As expected, the experimental group participants who watched *28 Days* and *When a Man Loves a Woman* identified with the characters in the movies more than the control group participants (CGA + CGB) who watched *Happiness* and *Click*. Aka (2007) argued in her study that the participants were young. As a result, they did not identify themselves with the movie characters of 1950s. In the current study, modern movies which would be easier for the patients to identify themselves were chosen.

The cinematherapy group with alcohol related movies identified with the

movie characters more than the control group who watched only one movie unrelated with alcohol dependence which supports the research hypothesis. However, the cinematherapy group who watched two alcohol related movies did not identify with movie characters more than the second control group who watched two movies unrelated with alcohol. Watching movies although the movie is not related with patients' disorder may be as beneficial as watching movies related with the disorder of the patients as long as the patients in the group have the same problems. Watching the movies *unrelated with the disorder* of patients in a group setting for treatment purposes may have created a placebo effect on patients. These indicated that although the movies were not related with alcohol, participants could identify themselves with the characters in treatment setting.

4.5 Importance and Belief

Importance that the participants assigned to treatment of alcohol dependence did not increase for any condition or for the overall sample in time 2. Importance ascribed to treatment may be at peak point at the beginning of treatment since the decision-making stage may have been very difficult for them. Consequently, any increase does not occur during treatment.

Belief in treatment increased in time 2 for the overall sample but the same increase was not found on the group basis. This finding may be because of the small sample sizes of the experimental and control groups. The increase may be due to the movies showing successfully treated alcohol dependent patients as well as the detoxification program or individual therapy they received besides the present study.

4.6 Stages of Change

Decisional balance, self-efficacy, and treatment motivation were analyzed in terms of stages of change.

Stages of change theory proposed that pros of alcohol use decreases, and cons of alcohol use increases with every further stage of change because the person starts to see the positives and negatives of alcohol when he/she is more informed about alcohol dependence and more experienced in treatment. In line with literature (Prochaska, 1994, Prochaska and Norcross, 2003, Yalçinkaya and Karancı, 2007), action stage had fewer pros of alcohol than preparation stage, and maintenance stage

individuals had fewer pros than action stage individuals. A slight increase in pros was observed from contemplation to preparation but it may be due to the small sample size of contemplation group. On the other hand, there was not any difference for the cons of alcohol between stages of change. This finding was in contrary to previous findings (Prochaska, 1994, Velicer et. al, 1999, Plummer et. al, 2001, Share et. al, 2003).

When the pre and post-assessments were taken into account, there was not any increase in cons or decrease in pros in time 2 for different stages of change. Effects of cinematherapy did not differ for individuals in different stages of change.

Self-efficacy was found to be changing from stage to stage significantly as expected. In contrary to TTM literature, there was not any difference between contemplation and preparation stage individuals' self-efficacies. On the other hand, in line with previous findings (Berry et. al, 2005, Yalçinkaya and Karancı, 2007), action stage had higher self-efficacy than preparation stage; and maintenance stage had higher self-efficacy than action stage. These findings were valid in 1 time and 2. When the patients see the positive consequences of treatment, their self-efficacies may have increased.

When the effects of cinematherapy were analyzed in terms of stages of change, it was found that only action stage had higher self-efficacy in time 2. It may be evaluated as normal because action stage individuals are the subjects that are the most open to new information and they are in an active change condition.

Treatment motivation did not show any increase in time 2 for any of the stages. In addition, it was not found to be increasing with every further stage of change, rather decreases were observed. For example, action stage had lower treatment motivation than contemplation stage. This finding was in contrary to the previous findings on "readiness to change" of TTM (Prochaska and Norcross, 2003), and motivational interviewing (La Brie et. al, 2006, Roth and Fonagy, 2005). It may be because of many reasons. Firstly, mostly the patients were from a state hospital where psychotherapy was very rarely attended, and pharmacological treatment was the main source of treatment. They may have been disappointed with the alcohol dependence treatment because of treatment conditions. They rarely left the building, did not do any sports except morning walks, and did not have any chance for recreational activities like arts or handcrafts. In addition, most of the population was

under a bad mental state because after watching a movie and a session over the movie, in addition filling out questionnaires took about half an hour. Most of them would prefer smoking a cigarette to filling out a questionnaire after the cinematherapy session.

4.7 Cinematherapy Application

Effectiveness

The cinematherapy sessions were found to be effective on cons of alcohol so the negative side of using alcohol increased for the participants. However, cinematherapy did not increase pros of alcohol use for neither the cinematherapy group with alcohol related movies nor the groups who watched unrelated movies with alcohol. It may be explained by the content of the movies selected for cinematherapy as the movies focused on the disadvantages that alcohol brings to people's lives. Positive side of alcohol was not mentioned in the movies therefore any change about the pros of alcohol may not have occurred.

Cinematherapy application increased self-efficacy of the patients when it was added into the alcohol dependence treatment. In addition, cinematherapy sessions were more effective on the treatment motivation of participants who watched movies related with alcohol than patients who watched movies unrelated with alcohol. Since all the patients were in alcohol dependence treatment during the study, the movies of *28 Days* and *When a Man Loves a Woman* may have been more effective. The impact of the movies can be explained by the higher identification with the movie characters as it was found that the participants identified with characters in *28 Days* and *When a Man Loves a Woman* more than with characters in especially the movie, *Click*. When the significant effects were examined, it could be seen that cinematherapy was more effective when it took at least two sessions, and was specified for the disorder of the patients in the session.

Application Setting

In the cinematherapy sessions, the patients usually brought up the topic of the treatment centers in Turkey and compared them with the treatment centers in movies. The movies took place at rehabilitation centers in with the application of the Minnesota Model of Treatment (p. 36). Especially *28 Days* was very informative

about it. This issue brings to mind that the alcoholism treatment in Turkey is in a worse condition than the rehabilitation centers in United States or Europe. Bakırköy Prof. Dr. Mazhar Osman Hospital is one of the biggest mental health hospitals in Turkey. However, it does not have enough sports or fine-arts facilities. The patients are not allowed to walk by themselves outdoors. Indoors, especially in summer, it is very hot and boring for the patients. For example, while watching *Click*, many patients left the room. Since it was very hot, it may have disrupted the concentration and the motivation of patients.

In the movies (*28 Days & When a Man Loves a Woman*), it can be seen that recreational activities like “horse therapy” or “group exercises like climbing” are very common even in late 1980s in USA. Members of AA were more aware of the differences between the hospitals in Turkey and abroad because there were clean and experienced members for a long time in AA. Turkish Psychological Association and Turkish Psychiatry Association may work on this issue.

Patient Characteristics

The patients were very willing to participate in cinematherapy sessions. There were several reasons for that. One of the reasons was that they were either inpatients in a psychiatry clinic or members of AA. They may have felt that cinematherapy would be something to intervene with the routine of their treatment. When the patients were told that the movies would be about alcohol dependence, it was observed that they were more willing to watch and discuss the issues of the movie. On the other hand, the participants that watched *Happiness* were still eager to watch the movie, but using a comedy movie (*Click*) was not much effective although the movie had appropriate issues to discuss about psychological problems. It may be related with the prejudice in people’s minds that a comedy movie was not something to talk about seriously, rather to have a good time and to empty their minds. Another reason may be that *Click* may have heightened their level of defense mechanisms because the movie is highly metaphorical. The protagonist (Adam Sandler) can not deal with multiple tasks in his life, and can not use time efficiently. He takes the help of an external object to control his life because he can not. Consequently, he becomes addicted to the remote, and can not break free of it. This is similar to an alcohol dependent’s life to a great extent. Another reason for the ineffectiveness of

Click may be conditional obstacles. The weather was very hot during the presentation of the movie. The participants seemed to be uncomfortable because of the air inside the room. Most of them left the room even before the first break. Since the study was based on voluntary participation, the control group which watched Click was very small. Small sample size of control group B who watched Click may have caused several limitations to the study.

Another important patient characteristic was educational level. It was not found to be affecting previous alcohol use or number of previous attempts. On the other hand, it was difficult for some participants with low levels of education to express themselves on a Likert type scale, giving numbers their emotions or thoughts from 1 to 5. Hence the researcher needed to spend time with the participants one by one when the participants could not understand how the questionnaires work.

Cinematherapy Education

As Portadin (2006) argued, there was not any sound training for the use of movies in therapy in colleges. This brought the question of intervention's quality into question. In the present study, the elaboration sessions were made in the light of group therapy education that the researcher had received before the cinematherapy application. The group therapy education of the researcher was more in the form of psychodrama combined with psychoeducation. Hence in the cinematherapy application, the group leader (the researcher) took a less authoritative role than the formal group therapies. It may be useful for therapists to attend open AA meetings as well before the application of cinematherapy. In the group elaboration sessions, the questions may be asked when the patients bring up the issues; not in a didactic manner because the patients usually start to talk about alcohol dependence even if the movie is not about it. Both group therapy education and AA meetings may supply the therapist with the necessary skills for the moderation of group dynamics. If the therapist is not experienced about the group setting, certain difficulties may emerge. For example, the patients may remain silent, and may not disclose personal experiences. During the present study, this was the main difficulty with especially the control group A. CGA was known by the mental health professionals in the hospital as "the silent group". It may be related with the personalities of patients or incoherence of group members with each other. However, they did not seem to

disclose themselves even if the discussion was about the movie characters (indirect). Although the discussion took a short time, the movie “Happiness” seemed to be effective in a respect. Consequently, presenting movies may be beneficial alone. The elaboration session may not be vital in the cinematherapy application.

Today in many places abroad and in Turkey, there are both workshops and classes in psychology programs about cinematherapy and about using movies in psychology. For example, in Middle East Technical University, there has been a workshop in the undergraduate program of psychology department called “Portrayals of Mental Illness” for a year now; with the addition of future studies in this area, trainings may increase in number and quality in time.

4.8 Limitations

The first limitation of the study occurred during selection of movies appropriate for alcohol dependence patients. The movies were chosen if they included alcohol dependence treatment, becoming clean and sober, and staying clean and sober for some time after the study. In addition, the movies were chosen if they had Turkish language dubbing especially because of the mental condition of inpatients. Many patients were inpatients, and they were in the detoxification period of alcohol dependence treatment which may have intervened with their perceptions.

For most of the findings, significant results were gained in the whole population, however they were not gained on the experimental and control groups basis. Sample sizes of groups were small because of the difficulty of finding alcohol dependent patients in a limited time. The small sample sizes called for the use of non-parametric statistics which limited analyzing interaction effects. In addition, the control group movies may have not been as neutral as they were thought to be. Especially “Click” was a movie about a man with inefficient problem solving skills. The protagonist in the movie buys a magical remote control which can control everything in his life. This remote control may be a substitute for alcohol because the alcohol dependent patients start to believe that they can not work or concentrate when they stop alcohol intake. The movie, Click, may have aroused the participants emotionally as it was highly metaphorical for alcohol.

Education levels of participants was another limitation because the study included several scales, and using Likert-type scales was very challenging for most

of the participants. The mean of total years that the participants went to school was 9.86, and they were not used to Likert-type scales. The researcher explained how Likert-type scale was used, and checked if the patients have understood it well while they were filling out the scales. However the low level of education may have caused limitations on disclosure as well. Many patients may have never expressed their emotions verbally in their lives, hence it was difficult to get to their feelings during the elaboration sessions. It may be related with cultural boundaries as well. Turkish culture reinforces a dominant male figure which suppresses emotional expression of men. When the man cries or verbally expresses that he is sad, he is often afraid that people will think he is weak. In Turkish culture, an emotional man is often thought to be unable to make efficient problem solving. It is related with the group dynamics as well. However it may be hard to reach up to the patients when they have lived up to their middle ages in such a culture. Consequently, the cinematherapy application may be easier and more useful in individual therapy and in Western cultures where emotional expression is suppressed less.

Another limitation was about gender of the participants. Most of the participants were male which makes the generalization of findings to the whole population difficult.

The establishment of control group B occurred for practical reasons. Previously, only one control group was thought to be adequate for the comparison of alcohol dependence treatment alone with alcohol dependence treatment with cinematherapy application. Subsequently, the theme of the movies was decided to be included in the analysis. Hence control group B was established to control for the effects of presenting alcohol dependence related movies. Two movies unrelated with alcohol were presented to control group B, and any elaboration session was not made. The limitation was again time about this issue because enough participants were not found for control group B to conduct parametric statistics.

4.9 Recommendations for Future Studies

The lacking side of cinematherapy literature was especially empirical data and controlled trials. In this study, control groups were used, and statistical analysis was made instead of making a case study. More numbers of controlled trials and replication of these findings may be made for creating an empirical background for

cinematherapy.

The selection of movies should be included in the studies (Portadin, 2006). In this study, a checklist was made for alcohol dependence movies, a similar approach may be made for other disorders. Selection of movies for specific disorders by using therapists as participants can be a study by itself because until now, the movies have been offered in the light of experiences of therapists with single cases. Movies related with the disorder of the patient/patients should be chosen for increasing the effectiveness of cinematherapy application.

It is recommended that future studies may have more participants in each both experimental and control groups. In the present study, there were 52 participants in the experimental group, 42 participants in the control group A, and 14 participants in the control group B. Especially the last control group was very small because of time limitations. As a result, nonparametric tests were applied which did not allow for examining interaction effects. In addition, equality of the sample sizes of groups would be beneficial for the statistical analysis.

The therapist should be experienced in group therapy if the cinematherapy application is thought to be done in a group setting. Elaboration sessions may not be beneficial for the patients if the therapist is not well-equipped with group therapy techniques. If the therapist is not educated in group setting, elaboration sessions may be eliminated from cinematherapy, rather than forcing the patients to experience a bad group therapy experience. Cinematherapy application can be beneficial by merely presenting the disorder-related movies. If the therapist is not experienced in group therapy, elaboration sessions may be eliminated from cinematherapy completely. Since the findings showed that watching movies without an elaboration session afterwards was as effective as making an elaboration session for some core dimensions like self-efficacy.

Another point is about creating control groups. The control groups should watch movies that would not cause emotional arousal in the participants because in the present study, the movies unrelated with alcohol seemed to affect self-efficacy and decisional balance to a great extent. The control group movies may be documentaries or short films without any highly stimulating emotional content.

Controlling the group's educational levels may be favorable too. The difference in the educational levels of participants in one group may cause disclosure

to be harder because defense mechanisms seem to start working. They seem to stay silent to examine how different people react in similar situations rather than disclosing themselves. In contrary to the expectations, participants with low levels of education seemed to benefit from the elaboration sessions. Participants with low levels of education used more concrete examples which were more emotionally striking for other members for the groups. They were more realistic, and more open to new information than highly educated participants. On the other hand, they were not successful in filling out the questionnaires because they were unfamiliar with Likert type scales. Consequently, cinematherapy application may be useful for dependent people with low education levels; however they may not express the benefits on paper like their well educated counterparts.

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APPENDICES

APPENDIX A

Movie Choosing Checklist

Filmin adı:

İzleyen:

Lütfen izlediğiniz filmde bulunduğunu düşündüğünüz maddelerin yanına işaret koyunuz. Filmde bulunmayan maddelerin yanını boş bırakınız.

- Aşırı alkol kullanımı. Yaklaşık ne sıklıkla? _____
- Aşırı madde kullanımı (alkol dışında). Yaklaşık ne sıklıkla? _____
- Çevresindekilerin bağımlıyı eleştirmesi
- Geçmişte bağımlılığı bırakma denemesi
- Bırakmayı düşünme
- Tedavi görme
 - 12 basamak tedavisi
 - Grup terapisi
 - Bireysel terapi
 - Yukarıdakilerin hepsini içeren tedavi
- Bağımlılığın ilişkilere etkileri (aile, evlilik, arkadaşlık gibi)
- Bağımlılığın bağımlının işine etkileri
- Madde kullanımının olumsuz yanları
- Madde kullanımının olumlu yanları
- Madde kullanımının kendine güvene₉₀ etkileri

___ Relaps

___ Relaps ile başa çıkma (yeniden tedavi, sosyal destek alma gibi)

___ Alkolü destekleyen çevreyi deęiřtirme

___ Temiz kalma (iyileřme)

APPENDIX B

Demographic Information Form

Bu araştırmanın amacı alkol kullananların ya da bırakmışların alkol kullanma alışkanlıkları ile ilgili bazı davranış ve tutumlarını incelemektir. Yanıtlarken isim yazmanıza gerek yoktur, fakat araştırmanın devamı için rumuz yazmanız gerekmektedir. Katılım gönüllülük esasına dayanmaktadır. Katılımınız için şimdiden teşekkürler.

Psk. İpek Güzide Pur
ODTÜ Klinik Psikoloji
Yüksek Lisans

Rumuz:

- Yaşınız: _____
- Cinsiyetiniz: ___ kadın ___ Erkek
- Eğitim durumunuz:
İlkokul Ortaokul Lise Üniversite
Yüksekokul Yüksek lisans Doktora
- Toplam kaç yıl okula gittiniz? _____
- Medeni durumunuz:
Evli Bekar Nişanlı Dul Boşanmış
- Mesleğiniz: _____

APPENDIX C

Stages of Change Questions

8. Daha önce hiç alkolü bırakmayı denediniz mi?

Evet (Evet ise kaç kere denediđinizi belirtiniz: _____)
Hayır

9. Önümüzdeki 6 ay içerisinde alkolü bırakmayı ciddi olarak düşünüyor musunuz?

Evet Hayır

10. Önümüzdeki 1 ay içerisinde alkolü bırakmayı ciddi olarak düşünüyor musunuz?

Evet Hayır

11. Son 6 ay içerisinde alkolü tamamen bırakmayı denediniz mi?

Evet (Evet ise kaç gün süreyle bıraktığınızı belirtiniz: _____)
Hayır

12. Halen alkol kullanıyor musunuz?

Evet
Hayır (Hayır ise ne kadar süre önce bıraktığınızı belirtiniz: _____)

APPENDIX D

Alcoholism History Questions

13. Şu anda tedavi görüyorsanız, bu kimin isteği ile başladı?

- Kendi isteğim ile
- Yasaları çiğnedikten sonra mahkeme kararı ile
- Yakınlarımla (ailem, arkadaşlarımla gibi) isteği ile

14. Alkolü bırakmak sizin için ne kadar önemli?

Hiç önemli değil 1 2 3 4 5 6 7 8 9 10 Çok önemli

15. Alkolü bırakacağınıza ne kadar inanıyorsunuz?

Hiç inanmıyorum 1 2 3 4 5 6 7 8 9 10 Kesinlikle inanıyorum

16. Ne kadar zamandır alkol tüketiyorsunuz? _____Yıl

17. Son 6 aydır olan alkol tüketiminizi aşağıdakilerden hangisi açıklıyor?

1. Haftada bir veya daha az
2. Haftada 2 kez
3. Haftada 3 kez
4. Haftada 4 kez
5. Haftada 5 kez
6. Haftada 6kez
7. Her gün

18. Ne kadar süredir 17. soruda belirttiğiniz gibi alkol tüketiyorsunuz?

_____Ay _____Yıl

APPENDIX E

Decisional Balance Scale

Aşağıda alkol tüketmenin bazı olumlu ve olumsuz yönleri sıralanmıştır. Her cümleyi dikkatle okuyup belirtilen cümleye ne derece katıldığınızı belirtiniz. Ne derece katıldığınızı belirtmek için 1'den 5'e kadar derecelendirilmiş ölçekte uygun sayıyı seçip işaretleyiniz.

Eğer verilen ifade sizin görüşünüze tamamen uygunsa 5 numarayı, hiç uygun değilse 1 numarayı işaretleyiniz. Katılma derecenizi 1 ile 5 arasında seçeceğiniz bir sayı ile belirtiniz.

1	2	3	4	5
Hiç katılmıyorum	Katılmıyorum	Emin değilim	Katılıyorum	Tamamen katılıyorum
1. İçki içmek keyiflidir.				1 2 3 4 5
2. Bir süre alkol kullanmadıktan sonra içtiğim içki kendimi çok iyi hissettiriyor.				1 2 3 4 5
3. Bazen içki içmek ve bulmaya çalışmak zahmetlidir.				1 2 3 4 5
4. Alkol kullanma alışkanlığımın tutsağı olduğumu hissediyorum.				1 2 3 4 5
5. Alkollü olduğum zaman kendimi daha rahat ve daha keyifli hissediyorum.				1 2 3 4 5
6. Alkolü bırakırsam diğer alkol kullanan kişiler bunu kıskanacaktır.				1 2 3 4 5
7. Alkolik imajından hoşlanmıyorum.				1 2 3 4 5
8. Alkol tüketmem diğer insanları olumsuz etkiler.				1 2 3 4 5
9. Alkol tüketmeseydim şimdi daha enerjik bir insan olurum.				1 2 3 4 5
10. Alkollü olduğum zaman alkol kullanan arkadaşlarım ve ailem tarafından daha fazla kabul gördüğümü hissediyorum				1 2 3 4 5
11. Alkolü bırakmaya çalışırsam büyük olasılıkla çabuk sinirlenen ve çevresine rahatsızlık veren bir insan olurum.				1 2 3 4 5
12. Alkol yüzünden rahatsızlanırsam yakınlarım acı çekecektir.				1 2 3 4 5
13. Ailem ve arkadaşlarım mutlu bir şekilde alkol kullanmamı mutsuz bir şekilde alkolü bırakmaya çalışmama tercih ederler.				1 2 3 4 5

16. Alkol kullanmaya devam edersem, bazı insanlar alkölü bırakacak iradem olmadığımı düşüneceklerdir.	1	2	3	4	5
17. Alkol sağlığıma zararlıdır.	1	2	3	4	5
18. Alkol alışkanlığından vazgeçemediğim için kendimden utanıyorum.	1	2	3	4	5
19. İçtiğim alkollü içkinin kokusu çevremdeki insanları rahatsız eder.	1	2	3	4	5
20. Alkol ile ilgili uyarıları göz ardı ettiğim için insanlar benim akılsız olduğumu düşünüyorlar.	1	2	3	4	5
21. Alkollü olduğum zaman kendimi daha çok seviyorum.	1	2	3	4	5
22. Alkol dikkatimi toplamama ve daha iyi çalışmama yardım ediyor.	1	2	3	4	5
23. Alkol gerginliği azaltır.	1	2	3	4	5
24. Yakınlarım alkol kullanmamı onaylamıyor.	1	2	3	4	5
25. Alkölle ilgili uyarıları dikkate almadığım için aptalım.	1	2	3	4	5
26. Alkol kullanmaya devam ederek kendi kararlarımı kendimin verdiğimi hissediyorum.	1	2	3	4	5

APPENDIX F

Self-efficacy Questionnaire

Aşağıda alkol tüketebileceğiniz bazı durumlar sıralanmıştır. Her durumu dikkatle okuyup **belirtilen durumda alkol tüketip tüketmeyeceğinizi belirtiniz**. Ne derece emin olduğunuzu belirtmek için 1'den 5'e kadar derecelendirilmiş ölçekte uygun sayıyı seçip işaretleyiniz.

Eğer belirtilen durumda alkol **tüketeceğinizden** kesinlikle eminseniz 5 numarayı, alkol **tüketmeyeceğinizden** eminseniz 1 numarayı işaretleyiniz.

1	2	3	4	5
Kesinlikle içmem	Belki içmem.	Bilmiyorum	Belki içerim.	Kesinlikle içerim

1. Sabah uyandıgımda, beni zor bir günün beklediğini bilsem bile.	1	2	3	4	5
2. Araba kullanırken veya bir araçla seyahat ederken.	1	2	3	4	5
7. Yalnız olduğumda ve kendimi bir ölçüde üzüntülü hissettiğimde.	1	2	3	4	5
8. Mutluyken ve mutlu bir olayı kutlarken.	1	2	3	4	5
9. Eşimle veya alkol kullanan bir arkadaşımınla beraberken.	1	2	3	4	5
6. Evde veya dışarda yemek yerken.	1	2	3	4	5
7. Balık, meze benzeri yiyecekler yerken.	1	2	3	4	5
8. Sıkıntılı veya zor bir konuşma yapacaksam	1	2	3	4	5
9. Bir arkadaşla beraberken veya bir arkadaş toplantısındaiken.	1	2	3	4	5
10. İş yerimde, çalışmamla ilgili bir zorluk, baskı hissettiğimde.	1	2	3	4	5
11. Eve döndüğümde.	1	2	3	4	5
12. Bir arkadaşımınla sohbet ederken.	1	2	3	4	5
13. Sabah uyanıpta, zor bir günün beklediğini düşündüğümde.	1	2	3	4	5
14. Yakın olduğum akrabalar ile yemek yerken.	1	2	3	4	5
15. Kendimi huzursuz hissettiğim zamanlarda.	1	2	3	4	5
16. Kendimi eğlendirmek istediğim zaman.	1	2	3	4	5
17. Yapacak bir şey bulamayıp sıkıldığım zaman.	1	2	3	4	5
18. Dinlenirken ya da arkadaşlarla sohbet ederken.	1	2	3	4	5
19. Duygusal bir kriz veya sıkıntı içindeyken (örneğin	1	2	3	4	5

20. Gzel bir manzara karřısındayken.	1	2	3	4	5
21. İř ya da evde alıřmaya ara verdiđimde.	1	2	3	4	5
22. Arkadařlarımı evlerinde ziyarete gittiđim zaman.	1	2	3	4	5
23. Sinirli olduđum zamanlarda.	1	2	3	4	5
24. Dinlenirken ve televizyon seyrederken.	1	2	3	4	5
25. İki itiđim yerlere gittiđim zamanlarda.	1	2	3	4	5

APPENDIX G

Movie Identification Scale

Rumuz: _____ İzlediğiniz Film: _____

- 1=Hiç katılmıyorum 5 =Kısmen katılıyorum
2=Pek katılmıyorum 6=Çoğunlukla katılıyorum
3=Katılmıyorum 7=Tamamen katılıyorum
4=Kararsızım

	Hiç				Tamamen		
1. Seyrettiğim filmde yer alan karakterlerden en az birisinde kendime benzeyen yönler buldum.	1	2	3	4	5	6	7
2. Günlük hayatımda kendime yakın bulduğum karakterin yaşadığı sorunlarla karşılaştım.	1	2	3	4	5	6	7
3. Kendime yakın bulduğum karakterin karşılaştığı sorunlara maruz kalsaydım, ben de aynı şekilde davranırdım.	1	2	3	4	5	6	7
4. Kendime yakın bulduğum karakterin yaşadığı duyguları ben de daha önce hissetmişim.	1	2	3	4	5	6	7
5. Kendime yakın bulduğum karakterin karşılaştığı sorunlar üzerinde daha önce ben de düşünmüştüm.	1	2	3	4	5	6	7
6. Filmde kendime yakın bulduğum karakterin yerinde olsam ben de aynı şekilde hissederdim.	1	2	3	4	5	6	7
7. Genel olarak filmde kendime yakın bulduğum karakterin düşünce yapısına sahibim.	1	2	3	4	5	6	7
8. Filmi seyrederken, kendime yakın bulduğum karakterin ne yaptığına odaklandım.	1	2	3	4	5	6	7
9. Filmde kendi hayatımdaki insanlara benzer yönleri olan karakterler vardı.	1	2	3	4	5	6	7
10. Filmde kendime yakın bulduğum karakterin	1	2	3	4	5	6	7

etrafındaki karakterlerle olan ilişkileri, benim kendi hayatımdaki insanlarla olan ilişkilerime benziyordu.							
11. Filmi seyrederken, sanki filmin içinde, karakterlerden biriymisim gibi hissettim.	1	2	3	4	5	6	7
12. Filmde meydana gelen olaylardan en az birisini kendi hayatımdaki olaylara yakın buldum.	1	2	3	4	5	6	7
13. Filmde meydana gelen olayın/olayların işleniş şekli bana farklı bir bakış açisi kazandırdı.	1	2	3	4	5	6	7

APPENDIX H

Treatment Motivation Questionnaire

Lütfen sizin için doğru olduğunu düşündüğünüz ifadenin altına işaret (X) koyunuz.

Kesinlikle katılmıyorum... (1)

Katılmıyorum... (2)

Bilmiyorum... (3)

Katılıyorum... (4)

Kesinlikle katılıyorum... (5)

- | | | | | | |
|------------------------------------------------------------------|---|---|---|---|---|
| 1.Tedavi için geldim, çünkü değişmek istiyorum. | 1 | 2 | 3 | 4 | 5 |
| 2.Yardım almazsam kendimi iyi hissetmeyeceğim. | 1 | 2 | 3 | 4 | 5 |
| 3.Yasal sistemtarafındantedaviyegönderildim. | 1 | 2 | 3 | 4 | 5 |
| 4.Tedavi için geldim, çünkü kendimi suçlu hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 5.Tedavi için geldim, çünkü bu benim için kişisel olarak önemli. | 1 | 2 | 3 | 4 | 5 |
| 6.Tedaviyi sürdürmezsem başım belaya girer. | 1 | 2 | 3 | 4 | 5 |
| 7.Eğer tedaviyi sürdürmezsem kendimi kötü hissederim. | 1 | 2 | 3 | 4 | 5 |
| 8.En iyi kazancım tedaviyi tamamlamaktır. | 1 | 2 | 3 | 4 | 5 |
| 9.Tedaviyi sürdürmezsem başarısız hissederim. | 1 | 2 | 3 | 4 | 5 |
| 10.Tedaviyi sürdürmekonusunda seçeneğimolduğunu sanmıyorum. | 1 | 2 | 3 | 4 | 5 |
| 11.Tedaviyi sürdürmek kendime yardım etmenin en iyi yoludur. | 1 | 2 | 3 | 4 | 5 |
| 12.Tedaviye geldim, çünkü gelmem için baskı gördüm. | 1 | 2 | 3 | 4 | 5 |
| 13.Bu programın benim için işe yarayacağından emin | 1 | 2 | 3 | 4 | 5 |

değilim.

14. Bu programın işime yarayacağından eminim. 1 2 3 4 5
15. Tedaviye geldim, çünkü yardım almak istiyorum. 1 2 3 4 5
16. İçmeyi bırakmamda programın bana yardımcı olacağından şüphe ediyorum. 1 2 3 4 5
17. Programda başkalarıyla birlikte kalmak istiyorum. 1 2 3 4 5
18. Başkalarıyla endişelerimi ve hislerimi paylaşmak istiyorum. 1 2 3 4 5
19. Tedavide başkalarıyla yakın çalışmak önemli olacaktır. 1 2 3 4 5
20. Bu tedaviyi seçmekten ben sorumluyum. 1 2 3 4 5
21. Programın sorunlarımı çözmeye yardımcı olacağını düşünmüyorum. 1 2 3 4 5
22. Sorunlarımla ilgilenilmesi için sabırsızlanıyorum. 1 2 3 4 5
23. Tedaviyi seçtim, çünkü tedavi değişmem için bir fırsat. 1 2 3 4 5
24. Bu sefer tedaviden sonuç alacağımdan emin değilim. 1 2 3 4 5
25. Tedavide diğerleriyle endişelerimi paylaşmak rahatlatır. 1 2 3 4 5
26. Yardım ve desteğe ihtiyacım olduğu gerçeğini kabul ediyorum. 1 2 3 4 5

APPENDIX I

Certificate of Achievement

Başarı Belgesi

Sayın ‘....,

Alkol Bağımlılığı Tedavisi kapsamında uygulanmış olan Sinematerapi grubu aktivitelerini tamamladığı için kutlarız.

Psk. İpek G. Pur

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