

Abstract

Objective: The aim of this study was to investigate the effectiveness of group dialectical behavior therapy in the improvement of distress tolerance and emotion regulation among substance abusers. **Method:** A quasi-experimental study along with pretest-posttest and control group was used for the conduct of this study. The population of the study consisted of all addicts referring to addiction treatment center of Zahedshahr (Omid Center) in summer 2012. From among this population, the number of 28 addicts was selected via convenience sampling as the participants of the study and was randomly assigned to two experimental and control groups. The participants responded to Difficulties in Emotion Regulation Scale and Distress Tolerance Scale as pretest, posttest, and follow-up test. The experimental group received group dialectical behavior therapy for 20 one-hour sessions whereas the control group received only Naltrexone drug. **Results:** The results showed that dialectical behavior therapy was effective in increasing distress tolerance and emotion regulation in substance abusers. **Conclusion:** Dialectical behavior therapy training can improve distress tolerance and emotion regulation, which could be the main reason for the continued use of drugs.

Keywords: Dialectical Behavior Therapy, Distress Tolerance, Emotion Regulation, Substance Abuse

On the Effectiveness of Group Dialectical Behavior Therapy in the Enhancement of Distress Tolerance and Emotional Regulation in Substance Abusers

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Introduction

Within the history, it is not possible to find any human generation that has not been involved in issues related to drugs. Perhaps, it can be said that drugs have been found with human in this world and drugs will remain operative as long as there are people in the world. The negative effects of drugs have always been identifiable in the fate of nations and peoples. Today, addiction has gone beyond health-mental boundaries and has become a social problem (Vezirian & Mostashari, 2002).

Substance abuse disorder is considered as a chronic relapsing disorder along with many issues in the field of medical, psychiatric, family, work, legal, financial and spiritual domains. These disorders not only affect individuals' personal life but also have led into so many shortcomings and problems in families and societies. Addiction like any other chronic illness is in need of management and time (Daley & Marlatt, 2005, Termor, Krol, Prins, Geskus, Van den Brink & Van Ameijden, 2005).

Drug abuse has led to the incidence of seriously social, economic, political, cultural and health damages such as highly contagious diseases including Hepatitis and HIV; and psychosocial diseases and problems including proliferation of drug related crimes like robbery, murder, self-burning, unemployment, domestic violence, increased divorce rates, and academic failure of children with addicted parents (West, 2008). The concept of drug dependence has had various formal definitions during the past few decades. Today, drug dependence refers to a maladaptive drug abuse pattern that makes a collection of cognitive, behavioral and physiological symptoms over a 12-month period after the use of drugs (Halgin & Whitbourne, 2007).

Although there are so many debates about etiology, the self-medication hypothesis creates some detailed explanations about the cause of this disorder. This theory brings a psychological meaning for one of the biggest public health and medical issues (Khantzian, 1991). Khantzian proposed the theory about two decades ago. He believed that this theory provides a useful vision by which it is possible to perceive powerful emotional factors and the pain that justify one's dependence on alcohol and other drugs. This hypothesis does not aim at ignoring the role of social, cultural and biological factors, but it is considered as an ancillary to other hypotheses. The main advantage of the self-medication hypothesis is that it examines emotional aspects of addiction that is mostly overlooked in most clinical and scientific studies. In this hypothesis, Khantzian (1997) refers to the defects in individuals' ego and their inability to tolerate affects. He points out that these people will find relief with the use of their preferred drugs and their emotional states will become more tolerable than ever. According to self-medication hypothesis, these people have low distress tolerance and impaired emotion regulation (Khantzian, 1997), and this is precisely what is trained in Dialectical Behavior Therapy (DBT). Moreover, the

disease relapse is also stressed in this treatment despite the emphasis on the change in references. It prevents the patient from becoming desperate by the negative feelings and emotions arising from these situations (Dimeff & Linehan, 2008).

Distress tolerance is defined as the capacity to experience and tolerate negative psychological states. Distress may result from cognitive or physical processes, but it appears as an emotional state that is often characterized by action tendencies to alleviate emotional experience (Simons & Gaher, 2005). Emotional regulation is considered as a category including knowledge and understanding of emotions, acceptance of emotions, the ability to control impulsive behaviors, and behave in accordance with the desired objectives in order to achieve individual goals and situational demands (Gratz & Roemer, 2004). Dialectical Behavior Therapy is a form of cognitive behavioral therapy that was developed by Marshal Linhan for the treatment of people with chronic suicidal drives and consists of four components, namely individual therapy, DBT phone coaching, therapist consultation teams, and group skills training (Aliloo & Sharifi, 2011). The fundamental premise of doctor Linhan (1993) in the development of dialectal behavior therapy program was that people with suicidal drives lack the skills needed to solve their problems. This factor causes deep suffering of patients and their problems in creating a valuable lifestyle.

Until today, dialectical behavior therapy has been applied in the treatment of a number of behavioral problems. The application of this therapy in treatment of suicide attempts/ self-injurious behaviors (Mohammad Meiguni, Ahadi, Pashasharifi & Jazayeri, 2010; Woodberry & Popenoe, 2008; McQuillan, Nicastro, Guenot, Girard, Lissner & Ferrero, 2005), drug abuse (Azizi, Borjali & Golzari 2010; Babaei & Hasani, 2012; Fischer, 2007), and bulimia disorder (Kroger, Schweiger, Sipos, Kliem, Arnold & Kahl, 2010; Abolghasemi & Jafari, 2012) is considered as the effectiveness of this therapy. Therefore, with the combination of self-medication hypothesis with dialectical skills training, it can be argued that the therapist will increase the patient's tolerance, which is the main reason for addiction; and the emphasis will be placed on changes whenever the patient felt the therapist focused on the mere acceptance. In Iran, some studies have been conducted on the effectiveness of dialectical therapy in distress tolerance and emotion regulation (Golshani , Mazaheri, Borjali & Ahai, 2010; Babae, Hasani & Mohammadkhani, 2012; Azizi, Borjali & Golzari, 2010; Alavi , Yazdi & Salehi, 2011).

This study aimed to investigate the effectiveness of group dialectical behavior therapy in the enhancement of distress tolerance and emotional regulation in substance abusers. Accordingly, the research hypotheses include:

Training of dialectical behavior therapy along with medication therapy is effective in increasing distress tolerance in drug abusers.

Training of dialectical behavior therapy along with medication therapy is effective in the improvement of emotion regulation among drug abusers.

Method

Population, sample, and sampling method

A quasi-experiment research design along with pre-test, post-test and follow-up and control group was employed for the conduct of the present study. The population of the study consisted of the addicts referring to Zahedshahr's Omid Addiction Treatment Center in the summer of 2012. The sample of the study consisted of 28 patients addicted to opium who were selected via convenience sampling after successful detoxification period. Then, they were randomly assigned into two experimental and control groups (14 participants in each group). The criteria for the inclusion of the participants in the study were as follows: the availability of Substance Abuse criteria based on the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition revised, passage of more than one week after successful detoxification, no regular use of antipsychotic drugs at the moment of program execution, having at least literacy. The exclusion criteria were as follows: suffering from psychotic disorders, having bipolar character or major depression, suffering from physical disorder at the moment of research execution, and illiteracy.

Instrument

1. Difficulties in Emotion Regulation Scale: It is as a self-report scale which has been developed to assess the difficulties in emotion regulation in a more comprehensive way in comparison with the instruments existing in this area. This scale was constructed by Gratz & Roemer in 2004 and consists of 36 questions and 6 subscales. The items are scored based on a five-point Likert scale, i.e. 1) almost never 2) sometimes 3) about half the time 4) often, and 5) almost always. The subscales include: non-acceptance of emotional responses (non-acceptance), difficulties engaging in goal directed behavior (goals), impulse control difficulties (impulse), lack of emotional awareness (awareness), limited access to emotion regulation strategies (strategies), and lack of emotional clarity (clarity). The scale designers reported the total Cronach's alpha coefficient of .93 by conducting a study on a sample of 479 students and obtained Cronach's alpha coefficients above .80 for all the subscales. Test-retest reliability during a 4-to-8-week interval was obtained acceptable ($r = .88$, $P < 0.001$) and statistically significant in the subscales. Furthermore, the reliability of the scale was calculated by Aminian (2009, cited in Heidarian, Ehteshamzadeh & Halajani, 2009). In their study, the reliability of the scale was also calculated through Cronach's alpha coefficient and half-split method equal to .86 and .80, respectively. The concurrent validity of this scale was assessed against Zakermen's Sensation Seeking Scale which was reported significant ($P < .05$, $r = .26$)

2. Distress Tolerance Scale: This is a self- assessment scale, which was designed by Simmons & Gaher in 2005. It includes 15 items and 4 subscales,

including tolerance, appraisal, absorption, and regulation. The items are scored on a 5-point Likert scale, i.e. 1) strongly agree, 2) slightly agree, 3) equally agree and disagree, 4) slightly disagree, and 5) completely disagree. The alpha coefficients for these subscales were reported equal to .72, .82, .78, and .70; and .82 for the total scale, respectively. Alavi (2009) reported a high internal consistency for the total scale (.71) and an average reliability for its subscales (.54 for tolerance, .42 for absorption, .56 for appraisal, and .58 for regulation). Azizi (2009) obtained the Cronbach's alpha and test-retest reliability coefficients of the total scale equal to .67 and .81, respectively. He also reported the reliability coefficients of .71, .69, .77, and .73 for the subscales tolerance, absorption, appraisal, and regulation, respectively.

3. Demographic Characteristics Questionnaire : This questionnaire included questions such as age, education, type of drug, relapse history, employment status, marital status, and addiction duration. This questionnaire was completed by the researcher during a structured interview.

Procedure

The experimental group was treated with 20 one-hour sessions of group dialectical therapy while the control group only received Naltrexone drug without any training. In this program, two sessions were assigned to mindfulness skill training with the aim of creating ability to control attention through non-judgment training, self-mindfulness, and efficiency. Then, 8 sessions were focused on distress tolerance skill training via a series of behavioral practices such as activities, participation in a series of acts, making comparison between the selves and those who are in a superior status, deliberate production of positive emotions, temporary suppression of painful conditions, and thought replacement so that people's tolerance would increase in order to overcome their sufferings. Once more, two sessions were allocated to mindfulness skill training and 8 emotion regulation sessions were then included in which the person learned how to feel relaxed and to control his/her emotions. At the end of the intervention, the two groups were assessed by means of the aforementioned questionnaires. After the passage of two months from the post-test, both groups were tested during the follow-up period. It is noteworthy that dialectical behavior skills training was fulfilled Linehan's Dialectical Behavior Therapy Manual (1993a, 1993b) and McKay, Wood & Brantley's dialectical behavior therapy techniques.

Table 1: The content of dialectical behavior therapy sessions

<i>Session</i>	<i>Content</i>
First	Initial acquaintance and mutual introduction of participants to each other, the introduction of dialectical behavior therapy and its objectives
Second	Training of decision-making based on wise mind, fundamental acceptance, judgment, and labels
Third	Training of fundamental acceptance, distraction from self-injury behaviors, and distraction from enjoyable activities
Fourth	Distraction via diverting the attention to other issues
Fifth	Training of distraction via leaving the position, doing the duties and daily chores
Sixth	Training of distraction by counting and self-relaxation
Seventh	Training how to illustrate the safe places and discover values
Eighth	Training to identify superior strength and improved communication and to determine a break time for the selves
Ninth	Training to live at the present moment and use self-encouragement thought
Tenth	Training of basic acceptance, realistic confirmed self-talk and new coping strategies
Eleventh	Training not to judge people, and make a conscious relationship with others
Twelfth	Training how to do effective activities, mindfulness in daily life, daily schedule and mindfulness
Thirteenth	Training how to identify emotion and what is emotion
Fourteenth	Training how to overcome obstacles to healthy emotions and turn them into behavior
Fifteenth	Training how to reduce physical vulnerability in the face of chaotic emotions
Sixteenth	Training to observe yourself without judging yourself
Seventeenth	Training how to reduce cognitive vulnerability and increase positive emotions
Eighteenth	Training of mindful attention to emotions without judging them
Nineteenth	Training how to deal with emotions and act contrary to severe emotional wishes
Twentieth	Problem solving training

Results

The descriptive statistics of demographic variables are presented in the following table for each group.

Table 2: Descriptive statistics of demographic variables

<i>Variable</i>	<i>Experimental</i>	<i>Control</i>
	<i>Number (percentage)</i>	<i>Number (percentage)</i>
Marital status	Single	4 (28.57)
	Married	8 (57.14)
	Separated	2 (14.28)
Education	Below diploma	1 (7.14)
	Diploma and bachelor	9 (64.28)
	Bachelor and above	8 (57.14)
Relapse history	Once to three times	4 (28.57)
	More than three times	3 (21.42)
Drug type	Opium or sap	11 (78.587)
	Heroin	8 (57.14)
	Crystal	3 (21.42)
	Other drugs	0 (0)
		2 (14.28)

The descriptive statistics of the variables under study are presented in the following table for each group.

Table 3: Descriptive statistics of the variables under study for each group and test type

<i>Variable</i>	<i>Experimental group</i>			<i>Control group</i>		
	<i>Pre-test</i>	<i>Post-test</i>	<i>Follow-up</i>	<i>Pre-test</i>	<i>Post-test</i>	<i>Follow-up</i>
Tolerance	1.24 (.20)	3.5 (.83)	3.38 (.85)	1.5 (.22)	1.5 (.24)	1.33 (.23)
Absorption	1.38 (.32)	3.61 (.79)	3.47 (.824)	1.33 (.292)	1.43 (.30)	1.38 (.37)
Appraisal	1.31 (.14)	3.55 (.70)	3.91 (.70)	1.26 (.13)	1.30 (.13)	1.31 (.14)
Regulation	1.38 (.37)	3.71 (.86)	3.54 (.85)	1.4 (.32)	1.31 (.31)	1.43 (.30)
Non-acceptance	4.55 (.32)	2.38 (.90)	2.48 (.80)	4.63 (.24)	4.61 (.22)	4.63 (.22)
Goals	4.51 (.33)	2.28 (.91)	2.48 (.85)	4.5 (.35)	4.5 (.36)	4.5 (.37)
Impulse	3.78 (.40)	2.39 (.87)	2.54 (.90)	4.68 (.25)	4.57 (.25)	4.63 (.26)
Awareness	4.51 (.25)	2.34 (.62)	2.41 (.71)	4.43 (.23)	4.43 (.29)	4.42 (.25)
Strategies	4.53 (.45)	2.51 (.86)	2.44 (.83)	4.55 (.32)	4.5 (.30)	4.5 (.29)
Clarity	4.68 (.19)	2.4 (.83)	2.6 (.85)	4.51 (.38)	4.37 (.38)	4.46 (.40)

To evaluate the effectiveness of dialectical behavioral therapy in increasing distress tolerance, multivariate analysis of covariance should be applied. There are some assumptions for this test to be safely used. One of these assumptions is the equality of variances. Results of Leven's test suggested that this assumption has been met ($P > .05$). In contrast, the results of Box's test suggested the non-significance of the homogeneity of covariance matrix box ($P < .05$; $M \text{ box} = 24.93$). Finally, the examination of the regression slope between the two groups led to no significant difference in pre-test scores. The results of multivariate analysis of covariance indicated the availability of a significant difference between the groups ($P < .001$; $F = 86.311$; Wilk's Lambda = .097). Univariate analysis of covariance was used to examine the difference in patterns as follows.

Table 4: Results of univariate analysis of variance showing the patterns of differences in the components of distress tolerance

<i>Variable</i>	<i>Mean Square</i>	<i>F</i>	<i>Sig.</i>	<i>Effect size</i>
Emotional distress tolerance	10.17	104.58	.0005	.84
Absorption	13.45	120.16	.0005	.81
Appraisal	17.27	180	.0005	.81
Regulation	22.91	219.14	.0005	.73

As it can be seen in the above table, there is a significant difference between the groups in all distress components ($P < .001$). In addition, multivariate analysis of covariance should be used to evaluate the effectiveness of dialectical behavioral therapy in improving emotional regulation. Results of Leven's test suggested that the assumption of the equality of variances has been met ($P > .05$). Moreover, the results of Box's test suggested the non-significance of the homogeneity of covariance matrix box ($P < .05$; $M \text{ box} = 28.55$). Finally, the examination of the regression slope between the two groups led to no significant difference between the groups in pre-test scores. The results of multivariate analysis of covariance indicated the availability of a significant difference between the groups ($P < .001$; $F = 76.338$; Wilk's Lambda = .102). Univariate analysis of covariance was used to examine the difference in patterns as follows.

Table 5: Results of univariate analysis of variance showing the patterns of differences in the components of emotion regulation

<i>Variable</i>	<i>Mean Square</i>	<i>F</i>	<i>Sig.</i>	<i>Effect size</i>
Non-acceptance	21.45	88.85	.0005	.86
Goals	26.68	111.54	.0005	.84
Impulse	3.82	10.54	.0005	.79
Awareness	39.36	147.35	.0005	.81
Strategies	20.83	68.73	.0005	.77
Clarity	29.55	117.23	.0005	.83

As it can be seen in the above table, there is a significant difference between the groups in all components of emotion regulation ($P < .001$). Repeated measures

test was used to examine the effectiveness of dialectical behavior therapy in both variables as follows.

Table 6: Repeated measures test results examining the effectiveness of dialectical behavior therapy in the variables under study

<i>Variable</i>	<i>Sum of squares</i>	<i>Df</i>	<i>Mean Square</i>	<i>F</i>	<i>Sig.</i>
Distress tolerance	.163	1	.163	.304	.586
Emotion regulation	.063	1	.063	.130	.721

As it can be observed from the above table, the difference between the post-test and follow-up is not significant in any of the variables ($P > .05$). In other words, the effect of the intervention has remained stable.

Discussion and Conclusion

This study aimed to investigate the effectiveness of group dialectical behavior therapy in the enhancement of distress tolerance and emotional regulation in substance abusers. The findings showed that dialectical behavior therapy significantly improved all the subscales of distress tolerance (tolerance, appraisal, absorption, and regulation). In addition, no changes were observed in participants' responses during the follow-up stage. Therefore, it can be concluded that the effect of DBT on all subscales of distress tolerance remains stable after two months. These findings are consistent with those of the studies done by Azizi, et al. (2010), Alavi, et al. (2011), Fisher (2007), and Miller, Rathus, Linehan, Watzler & Leigh (1997).

People with low distress tolerance find emotions unbearable and cannot deal with their distraught and stress. Secondly, these people do not accept the existence of emotions and feel ashamed of the existence of emotions since they underestimate their abilities in coping with emotions. The third characteristic of people with low distress tolerance is their effort to prevent the experienced negative emotions. It should be noted that if these people are not able to relieve these emotions, their attention will be fully drawn to this emotional distress and their performance will be significantly reduced (Simons & Gaher, 2005). Distress tolerance in terms of emotion regulation is a usual construct. For example, Dr. Marshall Linehan's dialectical behavior therapy has been based on the principle that people with borderline personality disorder have low distress tolerance (Linehan, 1993a).

In Ellis's theoretical framework, distress tolerance component can contribute to the reduction of emotional distress by modifying maladaptive beliefs in low tolerance of failure. In this theory, low tolerance of failure stems from the belief that failure is intolerable and must be avoided at all costs. This concept is tantamount to low tolerance of distress in DBT (Alavi, 2009). Several studies in the field of addiction have shown that people with substance abuse disorders have difficulties in distress tolerance components (Smith, 2000; Lubusko, 2006;

Lowengrub, 2006; Humphrey, 2007; Covington, 2008; Dunn, 2008; Rezaei-Dogaheh, 2000; Besharat, 2004; and Nategh, 2006). In addition, these people suffer from some defects regarding the necessary skills to cope with problems and, thereby, they turn to substance abuse as a coping skill to reduce the negative emotions resulting from difficult situations (Daley & Marlatt, 2005; Sobell & Sobell, 1997; Gossop, 1994). Kary (1993, cited in Buckner, Keugh & Schmidt, 2007), Turner (1997, cited in Buckner, et al., 2007) investigated alcohol and drug abusers and found that people with low distress tolerance turn to drug abuse to regulate their emotions. Brown & Lejuez & Kahler (2002) conducted a study on cigarette smokers and found that people with higher distress tolerance acted more successfully in a 3-month period of quitting smoking. This means that these people's tolerance to deal with emotions (without turning to smoking) would rise with an increase in their distress tolerance.

In self-medication hypothesis, Khantzian finds addiction disorders rooted in psychological pain and distress. For him, people who give in addiction are constantly faced with major chaos and confusion and this is the main factor contributing to tendency to addiction. Khantzian points out that it is not so obvious in any other situation that those experiencing severe damage have undergone substance abuse disorder (Khantzian & Albeinize, 2012). He refers to the defects in addicts' ego and their inability to tolerate affects and states that these people use their preferred drug in order to relieve themselves and make their affective states more tolerable. It seems that the therapeutic effect is a good excuse for drug use.

In general, it seems that training of fundamental acceptance has improved emotional distress in relation to the effectiveness of dialectical behavior therapy in the subscale of distress tolerance. Training of distraction from self-harm behaviors through enjoyable activities, distraction through paying attention to work or other issues, distraction from thoughts, and distraction through leaving the situation are effective in the subscale of absorption.

Training of discovery of values, imagination of a safe place, and identification of superior strength have led to the improvement of mental distress. In addition, training of new coping strategies, self-prophecy-driven verification, use of self-encouraging coping thoughts, and life in the present moment have also led to the regulation of efforts to relieve distress.

Moreover, the findings of this study showed that dialectical behavior therapy significantly improves emotional regulation strategies as well as its subscales (non-acceptance, goals, impulse, awareness, strategies, and clarity) in substance abusers. In this way, it can be asserted that the second hypothesis was confirmed. In addition, no changes were observed in participants' responses during the follow-up stage. Therefore, it can be concluded that the effect of DBT on all subscales of distress tolerance remains stable after two months. These findings are consistent with those of the studies done by Babayi, et al. (2012), Alavi, et

al. (2011), Golshani, et al. (2010), and Feldman, Harley, Kerrigan, Jacobo & Fava (2009).

Since emotion regulation constitutes a significant part of each person's life, it is not surprising that turmoil in emotion regulation can lead to sadness and even psychological damage (Amstadter, 2008). When a person becomes addicted, a series of events or stressors alone can play a major role in substance abuse disorder. One of the best theories in explaining the initiation, continuation, and successful recovery of substance use disorders is Khantzian's self-medication hypothesis (SMH). According to self-medication hypothesis, drug addiction is considered as a means to regulate stressful emotions. Drug users describe negative emotions and restlessness as unbearable and frustrating phenomena and cannot manage these emotional states without recourse to drugs. Drug users make use of physiological and psychological properties of substances to regulate their negative emotions and achieve emotional stability (Khantzian, 1997; Khantzian, 1993; Suh & Ruffins & Robins, 2008). In Beck's model, negative emotions and inability to properly manage negative emotions are among the key stimulators for the resumption of substance abuse. Empirical research conducted in this area has shown that those drug abusers who use better emotion regulation strategies are more successful in treatment period. Conversely, people who cannot control their emotions are more likely to become permanent drug users (Doran & McChargue & Cohen, 2007). In general, it can be argued that the effectiveness of dialectical behavior therapy in the subscales of emotion regulation is probably due to the educational content that was offered and practiced in the training sessions. In other words, performance against severe emotional tendencies is effective in the subscale of non-acceptance; training of problem solving influences the subscale of difficulty in doing goal-oriented behavior; training of coping with emotions and training of reducing physical vulnerability in the face of turbulent emotions will affect the subscale of difficulty in impulse control. Moreover, training on how to identify emotions and what emotion is will affect the subscale of lack of emotional awareness; training of positive emotions will be effective in the subscale of limited access to emotion regulation strategies; and training of mindful attention to emotions (without making any judgment about them) will be effective in the subscale of lack of clarity. Indeed, the above-mentioned items have been improved.

As it was mentioned above, those who tend to substance abuse or have been caught up in it suffer from some weaknesses in emotion regulation and distress tolerance. This confirms the necessity that the above-mentioned should be given a top priority of being trained. Therefore, it is suggested that the responsible organizations and centers at the macro level of society notify the public, hold workshops and training sessions based on dialectical behavior therapy for the common people, especially those who are prone to substance abuse (including adolescents and youth). In addition, it should be attempted in terms of training of emotion regulation skills, increasing of distress tolerance, substance abuse

prevention, and making people safer. Moreover, emotion regulation strategies and distress tolerance are generally learned in childhood, are converted to one's automatic cognitive style at the end of adolescence, and get almost stabilized. Therefore, it is recommended to teach how to stop using negative strategies and to turn to using adaptive strategies in childhood. This should begin by parents and be completed at schools by teachers via the teaching of relevant skills. As one limitation of this study, it can be noted that the sampling was made through convenience method.

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