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Effects of a nonviolent communication-based training program for inpatient alcoholics in South Korea

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Abstract

Purpose: This study aimed to evaluate a communication skills program based on nonviolent communication targeted on inpatient alcoholics at the alcoholics specialized ward.

Design and Methods: The sample for this mixed methods quasi-experimental study comprised 47 patients who were hospitalized in the alcoholic wards of two psychiatric hospitals in South Korea.

Findings: The program effectively improved participants' empathy, anger expression, communication competence, and alcohol abstinence self-efficacy ($p < .001$).

Practice implications: This program could be implemented in community-based alcoholic care with the aim of preventing relapse and serve as the basis for developing similar programs for family members.

KEYWORDS

abstinence self-efficacy, alcoholics, anger, empathy, nonviolent communication

1 | INTRODUCTION

Alcoholism is a serious health problem that accounts for more than 5% of the global burden of disease and death,[1] and is a mental disorder requiring continuous and consistent management even after treatment because of its high relapse rate. Relapse in alcoholism involves an alcoholic, who has been maintaining abstinence following treatment, reverting to the previous problem behavior.[2] About 50% of treated alcoholics relapse within one month after discharge, while more than 80% relapse within 3–4 months after discharge.[3] These results suggest that relapse mostly occurs in the early days after discharge, which highlights the need for interventions for relapse prevention during the predischarge hospital stay to improve treatment outcomes.

Previous studies reported that the major predictive factors of alcohol relapse include personality characteristics (e.g., dependence and avoidance), lack of social stability (e.g., family and friend support, employment, and financial status), and negative emotions (e.g., anger, anxiety, and frustration[2–5]). Among these, negative emotions are the most influential and generally result from interpersonal conflicts.[2–4] In other words, while maintaining abstinence from alcohol following treatment, alcoholics experience interpersonal conflict and its consequent negative emotions at work and home. These conflicts and negative emotions trigger relapse since drinking is the familiar coping strategy for alcoholics when faced with problems. Particularly, as alcoholics have difficulty expressing their emotions to others and have a reduced level of empathy,[3,6,7] they have developed alcohol dependency as an avoidance coping strategy in interpersonal conflict situations.[8] Therefore, to decrease negative emotional experiences, alcoholics need to learn and train constructive coping strategies that can be applied in interpersonal conflict situations. In particular, considering that relapse occurs early after discharge, the hospital stay period would be the ideal time for such training and learning.

However, most interventions for alcoholics focus on altering the drinking behavior itself.[2,9] Particularly, they deal with reasons to stop drinking and the process of change, with a focus on alcoholics' cognitive changes.[10] However, these interventions are limited in providing lifestyle skills that enable alcoholics to carry on with their daily lives without drinking, and do not deal with the specific coping skills required when alcoholics experience negative emotions from interpersonal conflicts or ineffective communication. If alcoholics learn to maintain interpersonal relationships and engage in effective communication, they

may be less likely to experience negative emotions.[11] Thus, communication training that teaches alcoholics to express themselves honestly and listen empathically would be beneficial.

Nonviolent communication (NVC) is a form of communication suitable for this purpose. NVC is a specific conversation model that focuses on two components that are essential for building mature relationships, namely honest expression and empathic listening.[11,12] Communication skills can be improved through practice, and several studies have reported that NVC programs have improved participants' empathy and communication skills.[11,12] When alcoholics learn NVC, their ability to express themselves and empathize with others may be improved, which in turn may enable them to control their dysfunctional anger expression even in relationship conflicts, which can ultimately contribute to alcohol relapse.[2,13] Moreover, they may experience increased confidence to abstain from drinking as a coping strategy in high-risk situations (i.e., abstinence self-efficacy).

Therefore, this study aimed to develop and assess the effectiveness of a communication-training program based on the principles of NVC for inpatient alcoholics. The specific objectives were as follows: (1) design an NVC-based training program focusing on the prevention of alcohol relapse and administer the program to inpatient alcoholics, and (2) examine the effects of the NVC-based training program on empathy, anger expression, communication skills, and alcohol abstinence self-efficacy in inpatient alcoholics.

2 | METHODS

2.1 | Design

This study used a mixed methods research design with a concurrent embedded strategy. Participants were recruited through convenience sampling. A control group was first selected according to the order in which they were hospitalized, and pre–post testing was conducted. Subsequently, the experimental group was recruited for a pretest, and the communication skills program was then implemented, followed by a posttest. The quantitative part of the study had a quasi-experimental and non-synchronized design with a nonequivalent control group. In the qualitative part of the study, the participants in the experimental group were individually interviewed, and the collected data were analyzed using content analysis to explain the effects of this program (Figure 1).

2.2 | Participants

Patients from the alcoholic ward of two psychiatric hospitals (in C city and S city) were recruited. The inclusion criteria were: (a) an age of 20–75 years, (b) under inpatient care following diagnosis of alcohol use disorder (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*), (c) no communication disability, and (d) provision of informed consent to participate in this study. The exclusion criteria were (a) less than one week of inpatient care, (b) current alcohol withdrawal symptoms, and (c) other mental disorders. The sample size was determined using a computer program (G*Power 3.1). According to Korean and foreign study findings,[13,14] the minimum sample size for an effect size of 0.85, significance level of 0.05, and power of 0.080 for a two-tailed test was determined to be 46, with 23 participants in each group. In the current study, a 10% withdrawal rate was considered; thus, 25 participants were convenience-sampled for each group. Further, participants in the experimental group were recruited for individual interviews for the qualitative study; six participants agreed to participate in individual interviews.

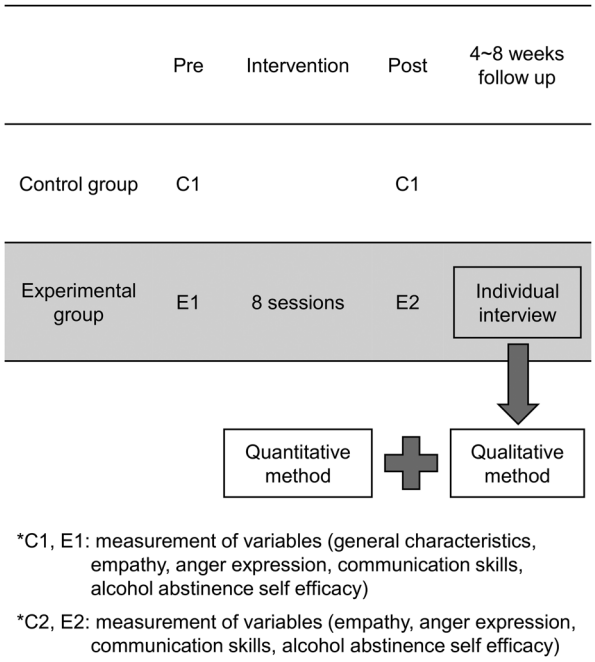

FIGURE 1 Research design of the present study

2.3 | Procedures and data collection

After obtaining approval from the institutional review board of Seoul National University (IRB No. 1606/003001), data were collected from June 14 to October 14, 2016. Before the study, the researcher met with the healthcare providers at the psychiatric hospitals in C and D cities to explain the purpose and methodology of the study and request cooperation. Subsequently, posters for recruitment in the study were posted on the bulletin boards in the wards. To prevent the diffusion effect, 25 participants for the control group were recruited before the baseline survey was conducted. The control group then completed the general program provided at the alcoholism ward (4 weeks), and the post-intervention survey was conducted.

The experimental group was recruited after completion of data collection from the control group, and they completed a baseline survey, intervention program (two sessions/week for a total of eight sessions), and postintervention survey. The intervention program was designed as a group program, with each group comprising 12–13 participants. Each of the two hospitals had one group. The sessions

were held in a designated area for patient education within the ward, and each session lasted for 60–90 min.

After excluding three participants who were discharged before the postintervention survey (one in the experimental group and two in the control group), data from 47 participants were included in the analysis. To prevent experimenter bias, a research assistant performed the baseline and postintervention surveys and data entry, and the investigator was only involved during data analysis. The research assistant was trained on the contents and procedure of the questionnaire before data collection. In the qualitative part of the study, the investigator conducted individual interviews with the six consenting participants during their outpatient visit about two weeks after discharge; interviews took place in a consultation room in each hospital. Each interview lasted less than 60 min, and all interviews were recorded and transcribed.

2.4 | Nonviolent communication based training program

The intervention used in this study was an eight-session group communication skills program based on the basic principles of NVC. Session 1 was the opening session, and sessions 2–5 were introductory sessions during which participants learnt and practiced the basic principles of NVC. Sessions 6–7 involved the application stage designed to help participants practice effective expression and coping with negative emotions triggered in high-risk drinking situations commonly faced by alcoholics. For practice, an example of an actual high-risk drinking situation (e.g., at work, at home, or in social relationships) introduced in a previous study based on a program for alcoholics[15] was used. Finally, session eight was designed as the closing session wherein participants shared their thoughts about the program, and the strategies for preventing relapse were summarized. The details of each session are delineated in Table 1.

2.5 | Instruments

2.5.1 | Empathy

Empathy was measured using the empathy quotient-short (EQ-Short-K[16]), which is a Korean-adapted version of the EQ-Short developed by Wheelwright et al.[17] This instrument has 11 items rated on a three-point Likert scale from 0 to 2, with a total score ranging 0–22, and a higher score indicating a higher level of empathy. The reliability of the instrument as measured with Cronbach's α was .88 at the time of development[16] and .89 in the present study.

TABLE 1 Contents of the communication skills training program based on nonviolent communication

Stage	Session/length	Theme	Contents
Introduction	1 (60–90 min)	• Therapeutic alliance • Understanding the objectives and the program	• Introduction of researcher and participants • General overview of the program and each session
Under-standing of NVC principle	2 (60–90 min)	• Understanding the four components of the NVC	• Finding obstacles in communication • Finding frequently used languages, behaviors, and facial expressions
	3 (60–90 min)	• Awareness of my feelings and needs • Expressing honestly	• Awareness of own feelings and needs • Connecting feelings and desires • Staying in the energy of the needs • Request others while respecting each ones' feelings and needs
	4 (60–90 min)	• Understanding of feelings and needs of others • Listening empathically	• Awareness of others' feelings and needs • Listening empathically • Exploring obstacles to empathy
	5 (60–90 min)	• 4 Ears • 4 Responses for hard to hear	• Inside of Jackal's ears • Outside of Jackal's ears • Inside of Giraffe's ears • Outside of Giraffe's ears
Application of NVC	6 (60–90 min)	• Complete anger expression • Stage of anger expression	• Understanding anger • Self-reflection of current anger expression • Practice anger expression stages
	7 (60–90 min)	• Response in high-risk drinking situation	• Role play: high-risk drinking situation • Refusal in drinking situation • Exploring various refusal methods
Closing	8 (60–90 min)	• Expressing gratitude • Summary of relapse prevention for alcoholism	• Expressing gratitude • Summary of relapse prevention strategies for alcoholism • Sharing impressions and commitments

Abbreviation: NVC, nonviolent communication.

2.5.2 | Anger expression

Anger expression was measured using the Korean state-trait anger expression inventory, which is a Korean standardized version of Spielberger's instrument (1988) developed by Chon et al.[14] This 24-item instrument measures anger-in, anger-out, and anger control using a four-point Likert scale. The anger expression score is calculated as follows: ([anger-in score + anger-out score] – anger control score + 16). The total score range is 0–72, with a lower score indicating lower anger expression. Cronbach's α was .74 for anger-in, .73 for anger-out, and .81 for anger control in the STAXI-K study, and .81, .76, and .84, respectively, in the present study.

2.5.3 | Interpersonal communication competence

Communication competence was measured using the global interpersonal communication competency scale 15 developed by Hur.[18] This instrument has 15 items rated on a five-point Likert scale and comprises three subscales (relationship, language, and interpersonal competency). The total score is calculated as a mean, with a range of 0–5, where a higher mean score indicates higher communication competence. The reliability of the instrument was 0.72 at the time of development by Hur[18] and 0.92 in this study.

2.5.4 | Alcohol abstinence self-efficacy

Alcohol abstinence self-efficacy was measured using the Korean Abstinence Self-Efficacy Scale, adapted by Kim[19] from the original instrument developed by DiClemente et al.[20] This scale comprises 20 items rated on a four-point Likert scale across four subscales (negative affect, social pressure, physical pain, and abstinence and thoughts about using alcohol). The total score ranges from 0 to 80, and a higher score indicates greater confidence regarding abstinence. Cronbach's α was .92 in the study by DiClemente et al.[20] .92 in the study by Kim,[19] and .95 in this study.

2.5.5 | Interview guide

A nonstructured interview guide was used to collect qualitative data, and the main interview questions were as follows:

(1) "Did anything change after you participated in the program?"
(2) "If yes, please explain the changes using specific examples."

2.5.6 | Data analysis

Participants demographic characteristics were analyzed using frequency, percentage, mean, and standard deviation. The normality of the baseline scores of the experimental and control groups was tested using the Kolmogorov–Smirnov test, and baseline homogeneity between the two groups was tested with χ^2, Fisher's exact test, and *t* test. Changes in empathy, anger expression, communication competence, and alcohol abstinence self-efficacy over time within each group were assessed with repeated-measures two-way analysis of variance. The analyses were performed using SPSS 21.0 and the significance level was set at 0.05.

Qualitative data collected through individual interviews were analyzed via content analysis. While repeatedly reading the transcripts, contents that specifically explained the effects of the program were marked, while similar contents were clustered to develop abstract themes. We strived to ensure the quality of the qualitative data analysis according to qualitative research appraisal criteria.[21] Accordingly, we set aside sufficient time for the interviews so that the participants could adequately describe their experiences. The researcher transcribed the interview data to prevent omission or distortion of data. The entire process of data collection and analysis was recorded, and the raw data were inserted as quotes to ensure auditability of the results. In addition, data were collected until saturation, and fittingness was ensured through consultation with a qualitative research expert. The results of the analysis were presented to the six participants to check whether their experiences were reflected as much as possible, thereby ensuring conformability.

3 | RESULTS

3.1 | Demographic characteristics and homogeneity

The sample included 42 men and five women, with a mean age of 50.5 years. The mean age of the experimental group at drinking initiation was 19.7 years, and the mean length of drinking was 35.9 years. There were no significant differences in demographic characteristics between the experimental and control groups at baseline. Table 2 shows participants' demographic characteristics and the results of the homogeneity test.

3.2 | Effectiveness of intervention

The results showed significant changes in empathy, anger expression, communication competence, and alcohol abstinence self-efficacy scores in the experimental group compared with the control group (Table 3). In the normality test, the *p* value for empathy was less than .05; thus, a nonparametric statistical test was used for this variable. The normality of the other three variables, namely anger expression, communication skills, and abstinence self-efficacy, was confirmed.

First, there was a significant main effect of the treatment or group and time on participants' change in empathy scores (F [degrees of freedom = 1] = 79.175; $p < .001$).

Regarding this result, "understand and respect others through empathy and listening" emerged as a theme in the qualitative analysis. One participant described how he was able to understand his family by

TABLE 2 Homogeneity of participant general characteristics ($N = 47$)

Characteristics		*n* (%) or mean ± *SD*			
		Exp. ($n = 24$)	Cont. ($n = 23$)	χ^2 or *t*	*p*
Gender	Male	21 (87.5)	21 (91.3)	0.179	.672
	Female	3 (12.5)	2 (8.7)		
Marital status	Married	10 (41.7)	11 (47.8)	1.343	.836
	Single	14 (58.3)	12 (25.2)		
Living with	Nuclear family	9 (37.5)	13 (56.5)	4.965	.589
	Extended family	12 (50.0)	6 (26.1)		
	Coworker	1 (4.2)	1 (4.3)		
	Alone	2 (8.3)	3 (13.0)		
Employment	White collar	3 (12.5)	3 (13.0)	2.953	.855
	Blue collar	8 (33.3)	10 (43.5)		
	Unemployed	13(54.2)	10 (43.5)		
Income (per month)	<1 million won	4 (16.7)	5 (21.7)	0.970	.905
	1–3 million won	9 (37.5)	10 (43.5)		
	3–5 million won	3 (12.5)	3 (13.0)		
	>5 million won	8 (33.3)	5 (21.7)		
Age (years)		49.4 ± 10.3	51.8 ± 7.1	−0.928	.358
Education (years)		11.7 ± 3.7	10.7 ± 3.0	0.950	.347
Age of drinking initiation (years)		19.8 ± 5.9	19.6 ± 3.2	0.193	.848
Age of problem drinking (years)		36.0 ± 10.0	35.8 ± 11.7	0.068	.946
Duration of drinking (years)		29.5 ± 9.4	32.2 ± 7.4	−1.084	.284
Number of hospitalizations		3.9 ± 3.5	3.4 ± 3.4	0.575	.569

Abbreviations: Cont, control group; Exp, experiment group.

empathizing with and listening to them, which led to more frequent conversations within the family.

> "I live with my parents, but I barely spoke with my father. (I thought) Why does he talk like that? … But when I put myself in my father's shoes, I was able to understand him, and when I ask him 'How are you, dad?' (First), it was so cool to see our conversation continue from there."
>
> *(Participant C)*

Second, there was a significant main effect of the treatment or group and length of treatment on participants' change in

TABLE 3 Effects of nonviolent communication based program ($N = 47$)

Sources			*SS*	*df*	*MS*	*F*	*p*
Empathy	Within-subjects	Time	188.809	1	188.809	84.265	<.001
		Time * group	177.404	1	177.404	79.175	
		Error	100.830	45	7.351		
Anger expression	Within-subjects	Time	4.789	1	4.789	30.829	<.001
		Time * group	1.810	1	1.810	11.654	.001
		Error	6.991	45	0.115		
Communication competence	Within-subjects	Time	3.220	1	3.220	83.845	<.001
		Time * group	.932	1	0.932	24.276	
		Error	1.728	45	0.038		
Alcohol abstinence self-efficacy	Within-subjects	Time	3111.364	1	3111.364	62.429	<.001
		Time * group	1531.364	1	1531.364	30.726	
		Error	2242.743	45	49.839		

Abbreviations: *df*, degree of freedom; *MS*, mean of square; *SS*, sum of squares.

anger expression scores (F [degrees of freedom = 1] = 11.654; $p < .001$).

The theme "becoming able to control anger and expressing with words" emerged in the qualitative analysis and shed light on the relevant effect in detail. One participant who was able to learn how to express his complaints using nonviolent language described how others accepted his needs.

> "When I was with friends, I sometimes shouted 'Hey!' when I was frustrated; (and when I do) then, the mood suddenly freezes up. But now I express my frustration like 'I don't like this and that. I'm upset.' Then the other person seems to be careful too."
>
> *(Participant B)*

Third, there was a significant main effect of the treatment or group and length of treatment on participants' change in communication competence scores (F [degrees of freedom = 1] = 24.276; $p < .001$).

The theme "effective communication in a conflict situation" that emerged in the qualitative analysis supports this quantitative result. One participant described the change in communication competence as follows.

> "Even when I was upset with my coworkers or junior colleagues, I didn't say anything. When I did say something, I used to patronize them, saying things like 'You need to do it like this'… Now I say, 'How can I help?"
>
> *(Participant A)*

Fourth, there was a significant main effect of the treatment or group and length of treatment on participants' change in abstinence self-efficacy scores (F [degrees of freedom = 1] = 30.726; $p < .001$).

The theme "confidence in alcohol abstinence" that emerged in the qualitative study is related to this effect. One participant described situations where he was able to frankly and confidently refuse drinking as follows:

> "(Before,) My work life was horrible. All because of drinking… When I went out drinking with my team and met with people from other companies, I would be either late to work next morning or miss work… Now, I proudly say 'I can't drink' when people invite me for a drink after work."
>
> *(Participant A)*

3.3 | Feasibility

Of 110 alcoholics admitted to the alcoholic ward in two psychiatric hospitals, 50 patients who showed interest in this study were enrolled. During the study period, one patient from the experimental group and two patients from the control group were discharged and thus were withdrawn from the study; 23 out of the remaining 24 patients in the experimental group (92%) completed all eight sessions. In addition, the interviewees reported that they found the communication intervention program useful.

4 | DISCUSSION

The effects of an NVC-based training program on interpersonal relationships, communication, and relapse prevention in alcoholics were analyzed. The experimental group showed a significantly greater increase in empathy compared with the control group, which is consistent with previous findings that NVC-based training programs enhanced understanding of others and empathy.[21,22] This result confirms that communication based on the principles of NVC enables a respectful conversation based on objective facts without judging or criticizing the other person's words or actions.[12,23] Moreover, the theme "understand and respect others through empathy and listening" identified in the qualitative analysis showed that empathy facilitated conversations within the family and improved the quality of alcoholics' family relationships. This is speculated as being able to identify others' needs after NVC training.[22,24–26] Further, considering that negative emotions arising from conflict with family members are a major factor of relapse,[3,4] this result confirms that an NVC-based training that enhances alcoholics' empathy may be a useful intervention for decreasing the risk of relapse.

This study also confirmed that NVC-based training altered participants' anger expression patterns. Before the intervention, the experimental group demonstrated poor anger expression characterized by immediate or violent language; however, by being trained to first understand others' needs, the participants were able to control their anger better. This result is in line with previous findings,[12] and shows that NVC training facilitates conversations by helping individuals express their anger using appropriate communication skills instead of suppressing it or lashing out at the other person. In particular, a study on the characteristics of alcoholics reported that alcoholics who are vulnerable to quarrels and conflicts have a high tendency to drink when angry[27] to mitigate their anger.[5,28] Our results may serve as evidence that NVC training can be utilized for the regulation of such negative emotions among alcoholics.

After the intervention, the experimental group showed improved communication competence compared with the control group. Moreover, qualitative results revealed that, after the intervention, participants were able to try to listen to the other person in a conversation and attempted to initiate a conversation. This suggests that communication competence encompasses the ability to listen and the attitude of trying to interact with others.[6,22,26,29] Further, the improvement in the quantity and quality of communication at home and work is believed to be due to the NVC training, as it taught participants to sufficiently observe the other person, express relevant feelings, and communicate without judging the other person.[12,26,30] Therefore, the findings of this study confirm that NVC training is a useful intervention that can enhance communication competence in a relatively short period of time.

One of the important predictors of relapse in alcoholism confirmed in a previous study was alcohol abstinence self-efficacy.[27] The ability to refuse drinking amid social pressure has an impact on alcoholics' relapse.[31] This study showed that in NVC training, participants practiced expressing their current emotions and refusing drinking, which increased their confidence. We designed the program for participants to repeatedly practice refusing alcohol using real-world high-risk drinking situations, and the outcomes of this study are thus attributable to the actual practice of saying "no" as reported in previous studies.[32] Furthermore, the conversational skills that enabled the participants to turn down drinking invitations nonviolently may have further bolstered their confidence regarding alcohol abstinence.

In conclusion, the communication skills training program based on NVC developed in this study positively altered communication competence, including empathy and understanding others, among inpatient alcoholics. Moreover, by training participants to control their anger and express it appropriately, interpersonal conflicts are lowered, thus reducing the risk of drinking by boosting self-efficacy for alcohol abstinence.

The results of this study showed that the hospital stay period, particularly once the physical withdrawal symptoms subdue, is the most suitable time for communication training for alcoholics. This is because physical stability is required to engage in self-reflection.[2] In the present study, communication skills training was administered at a period in which alcohol-induced physical and emotional problems were alleviated, and this gave the patients an opportunity to anticipate and prepare for conflict situations that they may face in real life after discharge, as confirmed by the qualitative findings.

Communication skills can be improved through repeated practice and training,[13] which requires communication in both directions and rather than one-way.[12] In other words, training them to become both speakers and listeners can result in a positive communication effect. Therefore, implementing this program as a routine in the alcoholic ward would lead to long-term achievements.

4.1 | Limitations

This study has the following limitations. First, participants were convenience-sampled from inpatients in the alcoholic wards of psychiatric hospitals in specific regions; thus, the findings have limited generalizability to other healthcare environments. Second, the effectiveness of the program was assessed immediately after the intervention, and only a short follow-up period elapsed before the collection of qualitative data, which limits the prediction of the longer-term effects of the program based on the qualitative findings.

4.2 | Implications for nursing practice

The results of this study demonstrated that NVC-based communication training is effective for hospitalized persons with a diagnosis of alcohol abuse. The NVC-based communication training can be applied in mental health nursing practice. While hospitalized, these clients are abstaining from alcohol and therefore have an opportunity for self-reflection. The effect is substantial because they practice NVC while they are sober.

The NVC-communication training can be applied to community-based programs that focus on relapse prevention. Because alcoholism affects not only individuals but also their families, their workplaces, and the communities in which they belong, it is important to continue practicing healthy communication techniques in community care settings such as self-help groups, group homes, and community centers. Community mental health nurses can help the client identify and address trigger events that lead to relapse. This program can also serve as basis for the development of various programs for spouses, children, and parents. This nursing intervention program will help to provide regular practice in NVCs during the recovery process.

CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

ETHICS STATEMENT

After obtaining approval from the institutional review board of Seoul National University (IRB No. 1606/003001), data were collected from June 14 to October 14, 2016.

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REFERENCES

1. World Health Organization. Resources for the prevention and treatment of substance use disorders. 2018. https://www.who.int/gho/substance_abuse/en/
2. Witkiewitz K, Marlatt GA. Relapse prevention for alcohol and drug problems: that was zen, this Is tao. *Am Psychol*. 2004;59(4):224–235. https://doi.org/10.1037/0003-066X.59.4.224
3. Shon DG. A study on the relationship between the factors and frequency of alcoholism relapse focusing on the moderating effect of gender. *Mental Health Soc Work*. 2014;42(1):61–90.
4. Cha J, Kim S. The need of sex education for recovering male alcoholics. *J Korean Public Health Nurs*. 2015;29(2):272–284. https://doi.org/10.5932/JKPHN.2015.29.2.272
5. Chang MS, Park GP, Jung SH, Woo SW. The relationship among dependent and avoidant personality trait, psychological trait and addiction. *Korean J East West Sci*. 2011;14(1):1–19.
6. Kim MG, Kim JH. Effects of communication competence and psychosocial problems on alcohol use disorder. *Korean J Journalism Commun Stud*. 2008;52(4):205–222.
7. Franzoni V, Milani A. Emotion recognition for self-aid in addiction treatment, psychotherapy, and nonviolent communication. In: Misra S, ed. *Computational Science, and its Applications–ICCSA 2019. Lecture Notes in Computer Science*. Vol 11620. Springer; 2019:391–404.
8. Hayes SC, Levin ME, Plumb-Vilardaga J, Villatte JL, Pistorello J. Acceptance and commitment therapy and contextual behavioral science: examining the progress of a distinctive model of behavioral and cognitive therapy. *Behav Ther*. 2013;44(2):180–198. https://doi.org/10.1016/j.beth.2009.08.002
9. Galanter M. Combining medically assisted treatment and twelve-step programming: a perspective and review. *Am J Drug Alcohol Abuse*. 2018;44(2):151–159. https://doi.org/10.1080/00952990.2017.1306747
10. Vasilaki EI, Hosier SG, Cox WM. The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic

review. *Alcohol Alcohol*. 2006;41(3):328–335. https://doi.org/10.1093/alcalc/agl016
11. Yang JW, Kim S. Integrative review of nonviolent communication intervention studies. *Perspect Nurs Sci*. 2016;13(1):36–47. https://doi.org/10.16952/pns.2016.13.1.36
12. Rosenberg MB, Chopra D. Nonviolent communication. *A Language of Life: Life-Changing Tools for Healthy Relationships*. Puddle Dancer Press; 2015.
13. Nosek M, Gifford EJ, Kober B. Nonviolent communication training increases empathy in baccalaureate nursing students: a mixed method study. *J Nurs Educ Pract*. 2014;4(10):1–15. https://doi.org/10.5430/jnep.v4n10p1
14. Chon KK, Hahn DW, Lee CH. Korean adaptation of the state-trait anger expression inventory (STAXI-K): the case of college students. *Korean J Health Psychol*. 1998;3(1):18–32.
15. Kim S (2003). *A program to prevent recurrence of alcoholism based on group activities*. Seoul: Hyunmoonsa.
16. Yeo JY. Validation of the Korean version of the empathy quotient short form. *J Korea Acd Industrial Cop Soc*. 2012;13(11):5356–5363. https://doi.org/10.5762/KAIS.2012.13.11.5356
17. Wheelwright S, Baron-Cohen S, Goldenfeld N, et al. Predicting autism spectrum quotient (AQ) from the systemizing quotient-revised (SQ-R) and empathy quotient (EQ). *Brain Res*. 2006;1079(1):47–56. https://doi.org/10.1016/j.brainres.2006.01.012
18. Hur GH. Construction and validation of a global interpersonal communication competence scale. *Korean J Journalism Commun Stud*. 2003;47(6):380–408.
19. Kwon Y, Lee C. The effect of the solution-focused group counseling program on meaning of life and abstinence self-efficacy of alcoholics. *J Korean Psychiatr Ment Health Nurs Acad Soc*. 2002;11(3):336–51.
20. DiClemente CC, Carbonari JP, Montgomery RP, Hughes SO. The Alcohol Abstinence Self-Efficacy Scale. *J Stud Alcohol*. 1994;55.2:141–148. https://doi.org/10.15288/jsa.1994.55.141
21. Sandelowski M. The problem of rigor in qualitative research. *ANS Adv Nurs Sci*. 1986;8(3):27–37. https://doi.org/10.1097/00012272-198604000-00005
22. Cheung K, Choi HN. The effectiveness of an intensive nonviolent communication group-counseling program on employees' interpersonal competence, inter-personal stress, and job satisfaction. *J Human Understand Counsel*. 2011;32(1):31–46.
23. Lee HJ, Kim SO. The development and verification of an experiential couple group therapy program: integration of the Satir growth model and non-violent communication. *Korean J Counsel*. 2010;11(2):831–854.
24. Lee YO, Cheon SM, Ryu WJ, Jeong HG. The effect of classroom-based nonviolent communication training program on middle school students' communication and peer relationships. *Korean J East West Sci*. 2009;12(2):47–57.
25. Baesler EJ, Lauricella S. Teach peace: assessing instruction of the nonviolent communication and peace course. *J Peace Educ*. 2014;11(1):46–63. https://doi.org/10.1080/17400201.2013.777899
26. Riemer D. Creating sanctuary: reducing violence in a maximum-security forensic psychiatric hospital unit. *On the Edge*. 2009;15(1):10–16.
27. Yoon MS, Chung YC, Lee JS, Lee BH, Cho HC. Effects of family support on quality of life among alcohol dependent patients: moderating effect of abstinence self-efficacy. *J Korean Neuropsychiatr Assoc*. 2012;51(5):277–284.
28. Spielberger CD, Krasner SS, Solomon EP. The experience, expression, and control of anger. *Individual Differences, Stress, and Health Psychology*. Springer; 1988:89–108.
29. Marlow E, Nyamathi A, Grajeda WT, Bailey N, Weber A, Younger J. Nonviolent communication training and empathy in male parolees. *J Correct Health Care*. 2012;18(1):8–19. https://doi.org/10.1177/1078345811420979
30. Ji EJ, Bang MR, Jeon HJ. Ego resilience, communication ability, and problem-solving ability in nursing students. *J Korean Acad Soc Nurs Educ*. 2013;19(4):571–579.
31. Lim SB. Effects of withdrawal symptoms and alcohol insight on the alcoholic relapse focusing on the mediating effect of alcohol expectancy and self-efficacy. *Alcohol Health Behav Res*. 2013;14(1):1–15.
32. Bae JY, Kim YH, Hwang WJ, Panuncio RL. Development of an expert system for prevention and management of substance related disorder in adolescents. *J Korean Acad Psychiatr Mental Health Nurs*. 2009;18(2):116–128.

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