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Corinne E. Palanek
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A follow-up study comparing male and female patients who have completed the three-week phase of the Connaught Clinic program

by

Corinne E. Palanek

and

Suzanne E. Selby

A research project submitted to the School of Social Work of the University of Windsor in partial fulfillment of the requirements for the degree of Master of Social Work

September 1976

Windsor, ONTARIO, Canada
CORINNE E. PALANEK
and
SUZANNE E. SELBY

1976.
Research Committee

Professor Robert G. Chandler, Chairman
Professor Forrest C. Hansen, Member
Dr. David Booth, Member
ABSTRACT

There were three objectives of this research project. The first objective was to discover what changes had occurred in the lives of patients who had completed the intensive three-week phase of the Connaught Clinic, a day-care alcoholism treatment program. Changes of particular interest to the researchers were in regard to drinking involvement, absenteeism in employment, and family relationships. The second objective was to describe the Clinic population in terms of demographic data and treatment experiences. The third objective was to see if there were any indications that female patients had special treatment needs.

The sample consisted of 19 males randomly selected from a male population of 109, and 16 females accessible from a female population of 21. The population from which the sample was selected attended the Clinic from September, 1974 through September, 1975. The sample was stratified according to sex. The primary method of data collection was an interview schedule.

At time of intake the mean age of the sample was 43 years. The majority of the sample was married (74.3%). There was no significant differences between males and females in regard to age and marital status.

Sixty-eight percent of the sample were either employed full-time or were housewives. The majority of the
sample were unskilled or semi-skilled workers.

Seventeen percent of the sample were abstinent since completing the program. However, 71.4% achieved some decrease in alcohol consumption; there was statistical significance between differences in males and females.

There was a strong association, with statistical significance, between decrease in drinking involvement and improvement in employee absenteeism. Approximately 55% of the sample showed improvement in employment. More than 50% of the sample reported improvement in family relationships.

Prior to attending the Clinic only 43% of the sample had professional treatment for drinking or drinking-related problems. After attending the Clinic, an additional 25% received further professional treatment. There was also an increase in attendance at self-help treatment services subsequent to Clinic attendance. One of the goals of the Clinic which was achieved to some degree, was to encourage people to receive follow-up treatment.

There was a significant difference in the reasons males and females gave for problem drinking. More females than males associated problem drinking with stresses of domestic life and more males than females associated problem drinking with habitual life style.

There was no significant difference in the ratings of males and females regarding the helpfulness of the
Connaught Clinic program.

The researchers recommended that a research component be incorporated into the Connaught Clinic program, with matching pre-treatment and post-treatment interview schedules.

It was recommended that the Clinic staff capitalize on the patients' interest in follow-up treatment by making greater effort to link patients to appropriate treatment resources.

It was also recommended that the Clinic make a greater effort to encourage the referral of female patients since both males and females showed a preference for equal numbers of both sexes in the treatment group.
ACKNOWLEDGEMENTS

The direction and support of each member of the Research Committee were greatly appreciated by the researchers. Professor Robert G. Chandler was enthusiastic about this project from the beginning and his faith, encouragement and availability deserves special gratitude. The helpfulness and availability of Professor F. C. Hansen, especially in regard to statistics, were above and beyond the call of duty as a reader. Dr. David Booth provided a challenge for the researchers through his stimulating ideas and practical suggestions.

Reverend W. K. Jaggs, Director of the Connaught Clinic and Regional Director of the Addiction Research Foundation is warmly thanked for giving his approval to the project and for allowing himself to be interviewed. His enthusiasm for the project was very encouraging.

Dr. David R. Brown, Executive Director of Windsor Western Hospital Centre, is acknowledged for his approval of the project. Mr. James J. Broderick, Director of Clinical Services of Windsor Western Hospital Centre is thanked for his suggestions regarding the consent procedures.

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Miss Palanek, one of the researchers, expresses appreciation to her parents, Lillian and Frank, for their support and understanding throughout the past two years of study.

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Finally, the researchers are most grateful to the 35 men and women who allowed themselves to be interviewed for the project. We appreciate their willingness to share their experiences and opinions. We learned much from them and we ask God to bless their continued efforts to overcome their drinking problem.

Praise the Lord for his strength and support.
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CHAPTER I

PROBLEM IDENTIFICATION

Types of Alcoholism Treatment

Alcoholism is a growing problem in Canada. Canadians are drinking 30% more alcohol than they did 25 years ago (Archibald, 1973, p. 2). In Ontario, approximately 145,000 people are at the stage of alcoholic illness in their drinking. An equal number drink in amounts that increase the risk of organic problems such as cirrhosis of the liver (Archibald, 1973, p. 3). The problem of alcoholism is not limited to the skid-row stereotype. It affects all aspects of society including leaders in business, law and medicine (Marshall, 1975).

Though not enough to meet the varied needs of the alcoholic population, Ontario has several different types of facilities available to treat alcoholism which operate under the auspices of either church, government or private groups. The success rates of these facilities vary and are hard to determine because of lack of consistency in treatment methods, goals and research. In many cases, research is not incorporated into the program so success rates are unknown.

Out-patient counselling modeled to some extent after
the Yale Plan Clinic which was established in the 1940's (Cahn, 1970, p. 96) is one type of treatment service offered in the province. Treatment is usually provided by a multidisciplinary team which offers individual, group, marital and family counselling. Medical consultation is often available as is psychiatric supervision.

Another type of treatment is provided through special alcoholism wards in mental hospitals. At times, these wards are merely controlled environments offering little in the way of therapy. In some instances, educational and therapeutic programs are offered. Also, Alcoholics Anonymous meetings are held regularly in some hospital wards (LeDain, 1972, p. 47).

Detoxication is often a preliminary step in alcoholism treatment. In the last few years, detoxication units staffed by non-medical people but connected to hospitals have been established in various places and are proving to be adequate in helping the person go through the withdrawal process. Counselling is provided in the detoxication units but since people only remain in these units for up to one week, extended treatment has to be provided elsewhere.

Halfway houses for alcoholics are residences where people can live, receive counselling and eventually begin to participate in the working world while undergoing treatment for alcoholism. Unless under special affiliation, many of the halfway houses adhere to the Alcoholics Anonymous philosophy and have total abstinence as their
goal (LeDain, 1972, p. 48).

The Donwood Institute in Toronto is a special centre for alcoholism treatment which provides treatment first on an in-patient basis for a four-week period and later extensive follow-up out-patient treatment. The Institute provides information on alcoholism and also provides group and individual therapy for the patients, as well as other forms of therapy. Recently, Donwood began to offer its program on a day hospital basis for people who could commute and did not require hospital admission.

The Addiction Research Foundation of Ontario is a major agency involved in the treatment of alcoholism in the province. Under its auspices, each of the major types of treatment outlined above is offered in addition to other experimental, research and training programs. Many of the programs are in the Toronto area. However, each of the regional offices of the Addiction Research Foundation undertakes research projects and provides the community with information, education, and some direct counselling service.

The City of Windsor is the location of the regional office of the St. Clair Region of the Addiction Research Foundation. One of the direct service projects of the St. Clair Region is the Connaught Clinic, a day hospital facility for the treatment of alcoholism. The Clinic is jointly sponsored by the Addiction Research Foundation and Windsor Western Hospital Centre where the Connaught
Clinic is located. The Connaught Clinic will be described more fully in Chapter III.

The Rationale for the Study

Since its inception five years ago in March, 1971, there has not been a follow-up study made of the people who have completed the intensive three-week phase of the Connaught Clinic program.

The writers of this present study had their field placements from the School of Social Work of the University of Windsor at the Addiction Research Foundation and the Connaught Clinic in the year 1974-75. They felt the need for a follow-up study to be done on the Connaught Clinic and explored the possibility of executing such a study as partial fulfillment of the Master of Social Work degree at the University of Windsor.

Both of the joint sponsors of the Connaught Clinic were also interested in having a follow-up study done to discover the effectiveness of the program in terms of what changes had occurred in the lives of the people who had completed the program. Therefore, permission was granted to do the study.

The writers of the present study also felt a need to know in a systematic way more about the patient population of the Connaught Clinic in terms of demographic data and treatment experiences since a survey of the population had never been made.
A third felt need arose as the researchers began reviewing the literature and discovered that very little was known about the female alcoholic especially as to whether or not she had special needs or wants in regards to treatment.

Once a felt need was established it was necessary to see if the felt need could be identified as a researchable problem. In this process, there were three tests to apply: "a) the difficulty lies in the situation itself, not in the feelings of the participants; b) there is a question or issue which requires solution; and c) more than one solution is possible" (Ripple, 1960, p. 33).

Through reading and discussion it was discovered that the first felt need, the concern about follow-up of the patients who had completed the Clinic program, was, indeed, a specific rather than a diffuse need that was inherent in the situation itself. First of all, the sponsors of the Clinic had always intended to conduct a follow-up study but had been prevented by time, money and manpower from doing so. Some intake materials had been incorporated into the program in the hope that they could be used eventually in some type of research project. Second, through reviewing the literature, it became obvious that any treatment program, ideally, should incorporate program evaluation or, at least, a follow-up study, so that the staff could know the effectiveness of its program.
The second test in problem identification, that there was an issue that requires solution, could be met also. It was clear from readings and discussions that the felt need regarding what had happened to the patients could be resolved through a follow-up study. There have been many follow-up studies of patients in alcohol treatment programs indicating that there was a basis in the literature for this kind of research.

The third test in problem identification, that more than one solution was possible, also applied to our problem. There would be no foregone conclusion in a follow-up study. Patients would have shown either some positive change, deteriorated or remained the same. Studies that have been done show that these three alternatives do, in fact, occur. The researchers concluded that the first felt need met the three tests of a researchable problem.

The second felt need, that of describing the population of the Clinic in terms of demographic data and treatment experiences, arose through a review of the literature. The researchers found that it was necessary to know information regarding age, education, occupation and marital status to provide a basis for comparison with other studies. This information related to the generalizability of the study. We would be able to gather this information through survey techniques.

The felt need to describe the population in terms of treatment experiences was, in addition, part of a wish
to know what types of treatment experiences people had and wanted, in order to see what implications arose for the community in regard to providing treatment.

The third felt need, to know more about the female alcoholic to see if she has special needs regarding treatment, arose also through reviewing the literature on the female alcoholic and talking to recovered female alcoholics. The literature indicated that the female alcoholic might have special treatment needs but none had been confirmed. There was evidence in the literature that females had been included in alcoholism treatment programs designed with no thought to sex differences. There was a lack of information regarding the necessity of differential types of programs. The literature advocated the need for exploratory studies to see if, in fact, the female alcoholic saw herself as having special needs in regard to treatment. In reviewing the literature, it appeared that the felt need of wanting to know whether or not the female alcoholic did, in fact, have special needs seemed to be in the situation itself. It could be resolved through hypothesis testing or exploratory study. There would be two possible outcomes to such a study. Either the female alcoholic would present herself as having special needs or she would not. Therefore, the third felt need also met the three tests of problem identification and was a searchable problem.

This process of problem identification formed the basis for the rationale of the study.
As Ripple suggests, "The first step in initiating an investigation begins with a felt difficulty and terminates when the focus of the difficulty has been established." (Ripple, 1960, p. 27). During the process of problem identification, it was determined that there were several problems for research. These problems were 1) What was the population of the Clinic patients like in terms of demographic data? 2) What changes had occurred in the lives of the patients that had completed the intensive phase of the Connaught Clinic program? 3) What were the treatment experiences of the Clinic population and 4) Did the female patients seem to have special treatment needs?

**Windsor and Environs**

Although the Connaught Clinic is supposed to serve Essex, Kent and Lambton counties, because it is a day-care facility most of the patients come from Windsor and environs.

Windsor is the largest and most southerly Canadian city on the U.S.-Canada border. The city population of Windsor is approximately 200,000 and the metropolitan population is 265,000. Located on the Detroit River, Windsor is a very busy port of entry in Canada with easy access to most parts of the U.S., Canada and Europe.

*Information in this section is from the publication of the Greater Windsor Visitors' and Convention Bureau, 1975.*
Windsor is an industrial city, the three leading industries being motor vehicles and parts, foods and beverages and metal working and machinery. Chrysler, Ford and General Motors have plants in Windsor with Chrysler having all of its Canadian assembly operations in Windsor. In addition, Bendix, Champion Spark Plug and Kelsey-Hayes have plants located here.

In addition to being an industrial centre, Windsor is at the hub of the large cash crop farming area of Essex County. Field, fruit, vegetable and greenhouse crops are all grown here in large quantities. Because of its southerly location, Essex County has the largest growing season in Eastern Canada. In addition to crops, there is a sizeable livestock and poultry market in Essex County.

Windsor has a variety of educational institutions including the University of Windsor and St. Clair College of Applied Arts and Technology. A symphony orchestra, an art gallery and a light opera company are among the cultural offerings of the city.

The City of Windsor has four hospitals, and an industrial medical clinic. There are, in addition, a variety of social and medical services in Windsor for families, children, the aged, the emotionally ill, the retarded and people with disabilities of various kinds. Some of these agencies offer services to residents of Essex County.

There are approximately 161 churches and synagogues in Windsor serving people of a wide variety of religious
affiliations. There is also a great variety of ethnic groups in Windsor.

**Summary**

This chapter described the process of identifying a problem for research in the field of alcoholism treatment in regard to a specific facility, the Connaught Clinic. The chapter also briefly described the various types of treatment for alcoholism available in Ontario. In addition, a description of the City of Windsor was provided.

Chapter II of this study will present a review of the literature on 1) three theories of alcoholism, 2) selected follow-up studies of alcoholism treatment programs, and 3) the female alcoholic. A description of the services of the Connaught Clinic will be given in Chapter III. The methodology of the study, including the hypotheses and research questions, will be presented in Chapter IV. Chapter V will present the data analysis and findings. The summary and recommendations will be presented in Chapter VI.
CHAPTER II

REVIEW OF THE LITERATURE

This review of the literature is divided into three major areas: 1) an overview of three theories of alcoholism that affect treatment; 2) selected follow-up studies of alcohol treatment programs, and 3) a review of studies on the female alcoholic. The review has been presented to serve as a reference point for the thesis rather than to be comprehensive.

An Overview of Three Theories of Alcoholism that Affect Treatment

This overview of the major theories of alcoholism that affect treatment of alcohol-troubled people is offered here to provide a reference point for the discussion of treatment offered at the Connaught Clinic. Since this thesis is not attempting to explore the effectiveness of one theoretical orientation to treatment over another, a complete exposition of the theories of alcoholism is not germane to this thesis, and therefore the overview of the theories will be brief.

The Disease Concept of Alcoholism

Although the disease concept of alcoholism is associated with the name of E. M. Jellinek, who made his major contributions to the field of alcoholism in the mid-
twentieth century, people had been writing about alcoholism as a disease since the latter part of the 19th century. The early writings, mainly through the *Journal of Inebriety*, only vaguely defined the concept and only reached a small portion of the medical profession. The disease concept was rejected by the majority of the medical profession in the early years (Jellinek, 1960, pp. 4-7).

Mary Richmond, in her book *Social Diagnosis*, published in 1917, offered a view of alcoholism as a disease similar to the view later associated with Jellinek, indicating that in early social work literature some thought was being given to alcoholism as a disease.

In E. M. Jellinek's first formulations, based on a study of approximately 2,000 alcoholics, he outlined a series of four stages, including a prealcoholic stage, common to many people who become addicted to alcohol. The stages constitute a progression of psychological, social, spiritual, and physiological changes in the person that lead either to death or recovery (Jellinek, 1952). At any point in the progression, the person may, of course, choose to alter his pattern and thereby stop the progressive effects of alcoholism from continuing. These progressive phases known as the prealcoholic symptomatic phase, the prodromal phase, the crucial phase and the chronic phase, apply mainly to steady drinkers rather than bender drinkers and not all steady drinkers experience all of the symptoms or experience them in the same
order (Coleman, 1972, p. 413). Although some people question the validity of Jellinek's phase concept, many treatment persons in the field of alcoholism adhere to it (Cahn, 1970, p. 11).

After developing the phase concept of alcoholism, Jellinek formulated his outline for the species of alcoholism. Jellinek was aware that each country in the world had different problems resulting from the use of alcohol, which clearly might be termed alcoholism. Therefore, he offered an operational definition of alcoholism to apply to the variety of problems related to alcohol use: "any use of alcoholic beverages that causes any damage to the individual or society or both" (Jellinek, 1960, p. 35). Realizing that this definition necessarily was vague and wanting to offer a formulation that would describe the various kinds of alcoholisms found in North America, Jellinek offered descriptions of what he termed five species of alcoholism. His effort was clearly to offer a working hypothesis for describing various kinds of alcoholism rather than a true definition or theory (Jellinek, 1960, p. 36).

Alpha alcoholism is the label Jellinek gave to a psychological, continual dependence on alcohol with no indication of physical dependence. The dependence constituted an attempt to relieve physical or emotional pain. The use of alcohol in alpha alcoholism might be excessive, inappropriate or lead to unacceptable results.
as viewed by society but it did not lead to loss of control or inability to abstain. Damage to interpersonal relations, be they in regard to work or family, would be the chief problem resulting from alpha alcoholism. There would be no signs of a progressive process or severe physical withdrawal symptoms. Jellinek did not consider alpha alcoholism a true disease but possibly a symptom of the mental or physical conditions which the alcoholic drinking relieved. Alpha alcoholism may develop into physical dependency but not necessarily.

Beta alcoholism is the label Jellinek gave to that type of alcoholism where nerve damage, gastritis or cirrhosis of the liver may occur without physical or psychological dependence on alcohol. The heavy drinking necessary for these complications may be due to cultural milieu. The heavy drinking is usually accompanied by poor nutrition because the physical complications involve nutritional deficiency. Withdrawal symptoms are not a part of this species, according to Jellinek. Jellinek did not consider this type of alcoholism a disease.

Gamma alcoholism was the species designated by Jellinek as a disease that was progressive in nature and to which his phase concept applied. Gamma alcoholism was also the species that was recognized by Alcoholics Anonymous to mean alcoholism. This type of alcoholism was characterized by 1) acquired increased tissue tolerance to alcohol; 2) adaptive cell metabolism; 3) withdrawal
symptoms; 4) craving or physical dependence and 5) loss of control once drinking had begun. There was a definite progression from psychological to physical dependence. Serious physical, psychological, social and spiritual damage were more pronounced in this type of alcoholism than in the others.

Delta alcoholism was described in a similar way to gamma alcoholism but instead of loss of control, the inability to abstain— to go on the wagon— was a prime characteristic. Loss of control was not a big factor and therefore many of the social and psychological damage experienced by the gamma alcoholic did not apply.

Epsilon alcoholism or periodic alcoholism was the fifth species mentioned very briefly by Jellinek. He was aware that there were many other kinds of alcoholism worth investigating but he limited himself to mentioning these five.

Jellinek considered gamma and delta alcoholism as the disease species because of the adaptation of cell metabolism, acquired increased tissue tolerance and withdrawal symptoms leading to craving, loss of control or inability to abstain (Jellinek, 1960, pp. 36-40).

The disease concept of alcoholism came into prominence and acceptance through these formulations of Jellinek. Although the disease concept has provided a somewhat simplistic framework to a complex problem, which Jellinek was aware of, and many of the phenomena described by
Jellinek have not been proven, calling alcoholism a disease has had some very beneficial consequences. First of all, the disease concept has helped to remove some of the moralistic, stigmatizing aspects of alcoholism. As a result, more alcoholics are willing to admit they have a problem: it is easier to admit to having a disease than to being of low moral character. Second, more treatment facilities have been made available since the disease concept became prominent. Third, hospitalization insurance and sick benefits from industry have become more readily available since alcoholism has been considered a disease (Plaut, 1971).

Jellinek was careful to state that alcoholism included social and economic factors, not solely medical factors, and that these must be considered in treatment. He was aware also that his formulations lacked clarity and definitiveness and were not necessarily valid and that care was necessary in interpreting them (Jellinek, 1960, pp. 158, 159).

Treatment based on the disease concept invariably has abstinence as its goal. The alcohol-troubled person is informed of the progressive nature of the disease and is warned that if drinking continues or is resumed once sobriety is achieved, the disease pattern will be operative. Counselling for inter-personal problems often accompanies a didactic approach in the treatment model related to the disease concept. Occasionally, drugs that
will induce vomiting upon drinking are given. Treatment for physical problems is often provided.

**Learning Theory**

Learning theory had its roots in the work of E. L. Thorndike and B. P. Skinner (Coleman, 1972, pp. 58, 59). Thorndike observed that behaviours that are rewarded or have positive consequences are learned or strengthened and that result in unpleasant consequences are weakened or extinguished. Skinner postulated that the most important determinants of man's behaviour lay not in man himself but outside of man in his environment. Man's behaviour, therefore, becomes conditioned by factors in his environment.

One aspect of learning theory in relation to alcoholism postulated that alcohol served as a reinforcer because it reduced the unpleasant effects of certain drives or states of tension in the individual. Once the association between drive reduction and alcohol was established, the individual would be more likely to use alcohol repeatedly to achieve the same effect (Conger, 1956). Dollard and Miller (1950, pp. 185-87) specifically talked about alcohol as a reducer of anxiety and conflict. Bandura (1969, p. 533) wrote that those persons more prone to reacting to environmental stress would be more likely to be positively reinforced by the depressant and anesthetic effects of alcohol and, therefore, repeatedly drink quantities of alcohol necessary to achieve these effects. It is also
widely known that excessive use of alcohol leads to aversive physical symptoms following the withdrawal of alcohol which are relieved by additional consumption of alcohol thereby maintaining the reinforcing effects of alcohol.

Another aspect of learning theory in regard to alcoholism postulated that alcoholic drinking was reinforced by the reactions of family, friends, employees, people in the helping professions and others (Vogel-Sprott, 1967). Claude Steiner, in his book *Games Alcoholics Play* (1971), outlined several interpersonal transactions that alcoholics engaged in where drinking led to certain interpersonal pay-offs and these results maintain the drinking behaviour and often serve to increase it. These interpersonal games led to pay-offs for the others involved in the transactions as well which helped to maintain the “games.”

The learning theory approach to alcoholism treatment, especially the drive reduction aspect where alcohol is viewed as the reinforcer, has led to aversive conditioning treatment procedures. In these procedures, electric shock or chemicals that have aversive effects are used to change alcohol from a positive to a negative stimulus (Larkin, 1974, pp. 38-42). Abstinence is not always the treatment goal in these procedures. Attempts have been made to condition drinkers towards controlled drinking rather than abstinence (Larkin, 1974, pp. 41-42).

Some proponents of the learning theory model do not
adhere to the disease concept and do not see loss of control as operative (Larkin, 1974, pp. 53-54). One behaviourist, Arnold Lazarus (1965), makes the point that even though the etiology of alcoholism may be physiological, the alcoholic still has to be trained to modify drinking habits and responses. He also believes that one type of treatment is not sufficient as there are many different types of alcoholics. His broad spectrum behaviour theory is based on learning theory because he believes learning theory affords more plausible explanations and more rigorous controls than other methods. In this approach, there is an assumption that the vicious circle of drinking behaviour and its consequences has to be broken at several strategic points. The therapy involves 1) medical attention to help the person improve his physical condition, 2) aversive conditioning to alcohol to modify the drinking response, 3) desensitization procedures to reduce anxiety, 4) behavioural rehearsal for areas in which the person felt inadequate, 5) desensitization procedures for the spouse to help him or her overcome resentments toward past drinking behaviour, and 6) social drinking therapy.

E. Mansell Pattison is another contributor to the field of alcoholism treatment. He believes that there are several sub-populations of alcoholics requiring differential treatment and outcomes (Abel, 1973). Viewing the learning theory as the preferred treatment model,
Pattison makes the assumption that human behaviour is chosen and determined and both the community and the drinking person must be responsible and responsive to one another (Abel, 1973).

**Personality Theory**

Personality theory concerning alcoholics postulated that alcoholics differed from non-alcoholics in that they possessed different personality traits that make them vulnerable to using alcohol as a means of coping with their problems. However, comparative studies of alcoholics and non-alcoholics have not indicated that alcoholics possess traits which distinguish them from other deviant groups and that the vulnerable personality traits that they do possess are merely an exaggeration of traits possessed by the non-deviant population as well (Krimmel, 1971, pp. 54-55).

Some of the personality traits generally attributed to alcoholics have been: a sense of inadequacy and low self-esteem; a sense of rejection and alienation; frustration of perfectionist tendencies; dependency; aggression; and egocentric behaviour (Krimmel, 1971, pp. 55-60). Depression and anxiety are other traits often seen in alcoholics. Treatment for these characteristics have ranged from insight therapy to behaviour modification techniques either in groups or in individual, marital and family therapy.
Alcoholism Treatment Programs

Problems in Evaluating Alcoholism Treatment

Treatment of alcoholism has increased in the past twenty years. Although there were many published follow-up studies of alcoholism treatment, they offered few reliable conclusions about treatment methods or results. Only selected follow-up studies have been reviewed here. In this review of studies of alcoholism treatment it was discovered that there was very little consistency with regard to in-patient and out-patient treatment, improvement rates, duration of treatment, time between intake or discharge and follow-up, the criteria of improvement, the effect of various treatments, the provision for evaluation of improvement, and data collection procedures. Studies indicated the need for clearer definitions in the above-mentioned areas. Selected follow-up studies and an outline of various criticisms relevant to evaluations of the treatment of alcoholism are presented here.

Evaluation of treatment outcome has mainly focused on abstinence which, as a criterion of improvement, is both misleading and an overstatement. Partial improvement in some areas of life adaptation may be the most feasible therapeutic goal in many cases (Pattison, Headley, Gleser and Gottschalk, 1968). It is impossible to formulate a standard type of treatment due to great variation among the studies.
The majority of studies used a design in which the patient was his own control. However, few studies acknowledged the inherent inadequacies in this design. There was a general lack of sufficient pre-treatment data as well as a lack of recognition by the studies that such inadequacies did exist. Biased sampling procedures were common in the studies, due to the patient populations being so variable in composition. As well as difficulties in locating and following patients, there were problems in the choice of the time interval between the collection of pre-treatment and post-treatment data. Along with general measurement problems, there was a question as to how dependable the source of information was. The majority of the studies reported low improvement rates.

In the studies reviewed, sample selection and data collection procedures often resulted in bias which was not always reported.

**In-patient and Out-patient Treatment**

Neither in-patient nor out-patient treatment of alcoholism can be considered as a treatment of preference. There was no significant difference between in-patient and out-patient treatment in two studies by Edwards and Guthrie during a six month follow-up study (1966), and during a one-year follow-up study (1967). Dietrich (1975), after a four month follow-up period, found no significant difference in improvement between in-patients and day hospital patients. No significant difference in the
therapeutic efficiency of in-patient and out-patient treatment was demonstrated when abstinence was used as a criterion of success (Clancy, Vornbrock and Vanderhoof, 1965).

In the literature with regard to types of treatment, it was impossible to formulate a standard type for evaluation due to the great variation among the studies. For example, psychotherapy was the predominant treatment used by Pfeffer and Berger (1957), while didactic and counselling sessions were evident in the majority of the studies (Gibbins and Armstrong, 1957; Gillies, Laverty, Smart and Aharan, 1974; Fitzgerald, Pasewark and Clark, 1971; Pokorny, Miller and Cleveland, 1968; Selzer and Holloway, 1957). In Gerard and Saenger's study (1966) there was a concentration on individual and group therapy.

**Improvement Rates**

The improvement rates varied widely with the majority of the studies ranging from 18-42% (Gerard and Saenger, 1966; Moore and Buchanan, 1966; Selzer and Holloway, 1957; Davies, Shepherd and Myers, 1956; Gibbins and Armstrong, 1957), and a few studies from 65-75% (Emrick, 1975; Gillies, et al., 1974; Dietrich, 1975). The types of treatment and the setting varied widely.

**Duration of Treatment**

In the literature, the wide variations of the duration of treatment in alcoholism programs further demonstrated the inconsistencies in the evaluation of follow-
up studies. Treatment programs ranged in length from two to three years (Pfeffer and Berger, 1957; Selzer and Holloway, 1957) to two to four months (Rossi, Stach and Bradley, 1963; Moore and Buchanan, 1966; Davies, et al., 1956; Pokorny, et al., 1968; Fitzgerald, et al., 1971), and to two weeks (Gibbins and Armstrong, 1957). Gibbins and Armstrong (1957) justified their short-term treatment by claiming that the specific nature and duration of treatment is of less importance than the personal and social characteristics of the patients who were sufficiently motivated to seek treatment in the first place. Gerard and Saenger (1966) found that frequency of contact was associated with improvement in drinking status but duration of contact was not.

**Time Between Intake or Discharge and Follow-up**

The time between intake or discharge and follow-up varied widely, indicating another inconsistency in the evaluative studies. The lapsed time prior to follow-up ranged in length from four to five years (Pfeffer and Berger, 1957; Fitzgerald, et al., 1971; Selzer and Holloway, 1957), to two years (Glatt, 1961; Rossi, et al., 1963; Belasco, 1971), and to one year which was used by the majority (Gillies, et al., 1974; Gerard and Saenger, 1966; Pokorny, et al., 1968; Pattison, et al., 1968). Two studies felt that six months was an adequate duration in which to evaluate improvement in patients
(Davies, et al., 1956; Sereny and Fryatt, 1966). However, Sereny and Fryatt (1966) admitted in their study that six months had been too short in length for adequate measurement of improvement. The majority of the studies had decided that the follow-up period could be limited to one year. According to Pokorny, et al., (1968) any period longer than one year had produced delayed feedback from the patients. It has been found that a one-year follow-up provided valid evidence of improvement (Fox and Smith, 1959; Gerard and Saenger, 1959; Glatt, 1959). Most relapses occurred within six months of discharge from treatment, and then become less frequent (Davies, et al., 1956; Glatt, 1959; Pokorny, et al., 1968; Edwards, 1966). Fitzgerald, et al., (1971) questioned whether one-year follow-up gave an accurate picture. Other studies did not question the common one-year interval.

Again, there were three varying views regarding the effects of the length of follow-up period upon improvement. Gibbins and Armstrong (1957) had felt that there was an increase in abstinence with longer periods of follow-up; however, Moore and Buchanan (1966) believed that there was a deterioration in improvement rates from discharge to long follow-up periods. Fitzgerald et al., (1971) found that drinking habits were highly sporadic over a four-year follow-up period so that a longer follow-up period gave a more accurate picture. The longer the time interval between treatment termination and the
follow-up study, the better the chance that the change to improvement has been a permanent one (Hill and Blane, 1967).

Criteria of Improvement

The definitions of "improved" varied from program to program. With the exception of three studies (Pfeffer and Berger, 1957; Gerard and Saenger, 1966; Rossi, Stach and Bradley, 1963), the majority of studies were vague in accounting for how ratings were made, or to what extent the informants agreed. The extent of agreement depended on the clarity with which categories were defined; however, the studies did not always have clear definitions. The diverse definitions of classifications of drinking status at time of follow-up caused inconsistencies as to how to evaluate the studies. Some meaningful classification of outcome is necessary prior to looking at the variables in relation to outcome. For example, some studies used broad categories such as "improved," "moderately improved," and "unimproved," without defining the terms (Gillies, et al., 1974; Gibbins and Armstrong, 1957).

In other studies, the classification of drinking status was specified into "abstinent alcoholic," "drinking alcoholic," and "changed-pattern or controlled alcoholic" (Pfeffer and Berger, 1957; Gerard and Saenger, 1966; Rossi, et al., 1963; Davies, et al., 1956). Fitzgerald, et al., (1971) and Glatt (1961) used a multi-fold categorization of drinking status at time of follow-up. Due
to the vagueness and diversity of the classifications of drinking status in the literature, adequate levels of reliability were not obtained.

There is a clear indication in the literature of a need for standardized criteria for evaluating treatment. However, since treatment procedures are so varied, it would be difficult to standardize the criteria for evaluating them.

Evaluation of treatment outcome has focussed mainly on abstinence. By itself it was considered a grossly misleading criterion of improvement (Pattison, et al., 1968; Gerard, Saenger and Wile, 1962; Pfeffer and Berger, 1957; Wallerstein, 1957; Moore and Ramseur, 1960). Evidence demonstrated a necessity for multiple criteria in therapy evaluation for alcoholism (Belasco, 1971; Pattison, et al., 1968). Abstinence as well as behavioural and social adjustments were advocated as criteria for improvement by Belasco (1971) and Pattison et al. (1968). Several studies found that abstinence and changes in drinking pattern were related to changes in social stability yet were not equated with happiness (Gibbins and Armstrong, 1957; Gerard and Saenger, 1966; Gillies, et al., 1974). Some studies found that abstinence did not necessarily mean an improvement in mental health, i.e., self-improvement and better social relationships (Pfeffer and Berger, 1957; Pattison, et al., 1968; Rossi, et al., 1963). Fitzgerald, et al., (1971) considered improvement to be a good overall
adjustment. The majority of the studies favoured multiple criteria of improvement in treatment evaluation. A few studies used abstinence as the lone criterion (Pokorny, et al., 1968; Moore and Buchanan, 1966; Sereny and Fryatt, 1966; Selzer and Holloway, 1957). Moore and Buchanan (1966) saw abstinence as the necessary first step in treating alcoholics, regardless of the method of treatment.

Changes in drinking pattern leading to abstinence was the most frequently evaluated condition; however, there was considerable discrepancy among the studies as to whether it was a valid measure of improvement. Several authors reported that there was a return to normal drinking by a few previously addicted drinkers; however, the percentage of the sample population that drank normally was very small (Davies, et al., 1963; Moore and Ramseur, 1960; Pfeffer and Berger, 1957; Selzer and Holloway, 1957). A partial improvement in some areas of adaptation to living appeared to be the most feasible improvement criteria because it is a more realistic expectation for the alcoholic.

Provision for Evaluation

Studies, attempting to show a causal relationship between treatment and change in behaviour, used one of two kinds of comparison. Firstly, the alcoholic patient may have been his own control by comparing pre-treatment data to post-treatment data (Pfeffer and Berger, 1957; Gillies, et al., 1974). Secondly, a group of alcoholic patients
may have comprised a control group where they had not received the treatment being evaluated, and were compared with a group of patients who had received the treatment. The majority of studies used a design of the patient as his own control with its inherent inadequacies such as the inability of this method to control the nontreatment variables.

According to Gibbins and Armstrong (1957), by having compared pre-treatment and post-treatment changes, they could not have been positive that other factors operating during the follow-up interval had not accounted for all or part of any change. Hence, these authors concluded that a control group was necessary. However, in some instances it would not be practical or even ethical to deny treatment to some patients for the sake of research.

There was a general lack of sufficient or sound pre-treatment data in most studies which meant that the results of such studies could not have been interpreted accurately (Belasco, 1971; Pfeffer and Berger, 1957). Pfeffer and Berger (1957) found that relevant comparisons could not be made unless a follow-up study had been planned before the treatment was initiated. The patient's pre-treatment behaviour was rated as he remembered it at time of follow-up which allowed the direction of changes to be assessed on the basis of judgments by the patient or by the therapist. There was failure of authors to acknowledge or take into account that such inadequacies
did exist. Gibbins and Armstrong (1957) mentioned their concern for a research design prior to intake which would allow sound data to be utilized in the future in the form of a follow-up study. According to Gibbins and Armstrong (1957), their study was lacking in sufficient pre-treatment data, and they questioned the validity of their own data. An acceptable use of pre-treatment and post-treatment comparisons was found in four studies (Ends and Page, 1957, 1959; Gliedman, Rosenthal, Frank and Nash, 1956; Gliedman, 1957).

Hill and Blane (1967) felt that motivation for treatment was probably the most necessary variable to be controlled; however, none of the studies controlled for motivation. Researchers need to keep in mind that the patient's knowledge of being a subject for research and of being treated differently from others can have an effect, negative or positive, on the patient's motivation, and consequently on treatment outcome (Hill and Blane, 1967; Wallerstein, 1956; Wallerstein, Chotlos, Friend, Hammersley, Perlswig and Winship, 1957).

**Data Collection Procedures**

A common problem in the studies was the fact that little or no description of sampling procedures was provided in the literature. The majority of the studies used a population of a facility during a given period of time comprising an investigative unit. If random selection and control conditions were applied in the studies,
problems of generalization of the findings and of the sampling procedures would have been minimized. Sampling procedures developed prior to treatment were only discovered in few studies (Engs and Page, 1957, 1959; Wallerstein, et al., 1957). In the majority of studies, after-the-fact sampling procedures occurred. However, few acknowledged the biased sampling effects when they recorded the results as if they were applicable to the entire alcoholic population rather than to a selected group of alcoholics. Biased sampling is especially troublesome in research on the treatment of alcoholism. Since most alcoholic populations were created by voluntary admissions into treatment, the general population of alcoholics differed with respect to motivation for treatment from the sample population from the treatment centres (Hill and Blane, 1967). A further source of bias occurred when the patients had freedom to choose among types of treatment, since their motivations to enter treatment had been different and thus uncontrolled. Two studies indicated a concern with the problem of randomness, and felt that the assignment of random numbers was the simplest technique, assuming that the patients had had an equal chance of being assigned to one treatment or another (Gibbins and Armstrong, 1957; Rossi, et al., 1963).

Another type of biased sampling occurred when certain individuals were excluded due to being felt unsuit-
able for the purposes of the study. For example, ex-patients who had displayed negative feelings toward the treatment were not contacted at time of follow-up (Pattison, et al., 1965). This form of biased sampling could also have been a result of individuals who had dropped out during treatment, or had failed to report after acceptance into the treatment program (Miller,Pokorny,Valles,and Cleveland, 1970). Gibbins and Armstrong (1957) did not interview patients who had lost contact with the agency during the follow-up interval, which caused a considerable number of the population to be excluded from the study. Patients having had three or less counselling sessions, as well as those in treatment at time of follow-up, were excluded from the Silby and Jones study (1962).

In dealing with the alcoholic population, every study inevitably displayed an inability to trace cases, especially after a long duration since completion of treatment. Some patients were excluded due to death; others were excluded due to residence beyond the feasible follow-up distance. Jones (1971) who collected his data from personal home interviews, sent questionnaires to those patients whom he felt were beyond a feasible distance for interviewing. Hill and Blane (1967) found that improvement rates might be biased on the assumption that the respondents were mainly those patients who benefited from treatment. Pfeffer and Berger (1957) outlined some explanations as
to why the contact rates at time of follow-up were low: (1) it might have been an avoidance of contact with the people and the place that reminded the patient of his drinking past; (2) there was little motivation to return to take part in a research study; and (3) some patients may have relocated in jobs and did not want their new employers to know of their drinking past. In other words, a low return for a follow-up study could be attributed to feelings of resentment, shame and guilt, as well as insufficient interest.

In comparing follow-up studies of treatment programs, the outstanding problem was that the patient populations were variable in composition (Mindlin, 1959).

How dependable is the source of information? In considering this question, it is necessary to look at the issue of self-reporting by alcoholic patients, and its validity. According to Sobell, Sobell, and Samuels (1974), self-reports are accurate enough to be utilized as a primary source of information. Usually alcoholism treatment programs have used patients' self-reports in order to obtain social, vocational and drinking histories of the patients. These histories are later compared with follow-up data. However, few studies have evaluated the validity of self-report data. In a follow-up study of treated alcoholics, Gerard and Saenger (1966) discovered few contradictions between patient responses and responses by their significant
others, regarding drinking status of the patient. Hence, the authors concluded that self-reports had relatively high validity and reliability as long as the interview was strictly factual. These authors felt that the patients were more likely to minimize than to be completely inaccurate in a personal interview.

Mailed questionnaires and interview schedules have been a source of discussion with regard to their validity and reliability. In some studies, (Moore and Buchanan, 1966) only mailed questionnaires were used. In others, (Pokorny, et al., 1968; Rossi, et al., 1963) interview schedules were designed and used with specific research questions in mind. However, the majority of studies utilized both questionnaires and interview schedules in collecting their follow-up data (Gillies, et al., 1974; Gibbins and Armstrong, 1957; Jones, 1971; Sereny and Fryatt, 1966; Davies, et al., 1956; Selzer and Holloway, 1957; Pokorny, et al., 1968). These authors felt that a simple questionnaire aided in the identification of patients who appeared agreeable to the continuing contact of a follow-up interview. Selzer and Holloway (1957) defined the questionnaire as an initial follow-up by mail which located the patients. Most of the authors were in agreement that a mailed questionnaire yielded minimal responses; however, they were encouraged by the fact that few were returned to sender which meant that the letter reached
its destination. The minimal response would indicate that the follow-up interview was the best source of data (Pokorny, et al., 1968). According to Pokorny, et al., (1968), there were several plausible reasons why questionnaires were rejected but interviews were accepted: (1) patients find it more difficult to refuse something in the presence of the individual requesting it; (2) completion of the questionnaire seemed like work, whereas the interviewer was able to make the interview personable and interesting; (3) the personal aspect of the interview situation was considered as a friendly treatment contact rather than as an impersonal, information-gathering contact such as in the case of the questionnaire. Mailed questionnaires by themselves do not provide much validity of the data, yet when combined with direct interviews, the data about post-treatment adjustment carries more confidence in the validity.

A Review of Studies on the Female Alcoholic

General Attitudes about the Female Alcoholic

Although there is an enormous body of literature on alcoholism and alcoholics, there was a conspicuous lack of solid research on the female alcoholic. Many studies on alcoholism either ignored women or assumed they were the same as men. The studies on the female that did exist most frequently dealt with small samples that did not allow for generalizing to the larger population. In
addition, few of the studies offered a definition of alcoholism. There have been very few studies which compared the female alcoholic to a non-alcoholic population of women. Social class was frequently indicated and some differences between classes of female alcoholics was found. However, to the knowledge of the researchers, no studies have been carried out with different classes of female alcoholics that compared differential attitudes and responses to treatment. In general, there was a gross lack of research on treating the female alcoholic.

The lack of literature on the female alcoholic may reflect 1) society's inability to accept the fact that there is a problem in regard to alcoholism among females, 2) the idea that women may have a secondary place in society, or 3) the fact that most treatment facilities have served a larger percentage of men than women. This last fact may be a reflection of the type of treatment facilities available rather than the proportion of male to female alcoholics.

The incidence of alcoholism among women was unclear from the literature. Figures differed depending on the source. For example, in 1966 Senseman reported a 2:1 ratio of male to female alcoholics at a private hospital serving a middle class population. In an out-patient clinic for alcoholics in the same state, the ratio was 4:1 male to female. Block (1965) reported a 1:1 ratio in
his private practice as a physician and said this figure had been confirmed by other physicians. R. Gordon Bell (1970) of the Donwood Institute wrote that the ratio of males to females had changed from 5:1 to about 3 or 2:1. In general, the literature indicated that more women alcoholics were becoming visible but that a large number probably remained hidden.

The researchers could not find actual studies that tested for differences in regard to stigma between male and female alcoholics. However, many authors stated that there were such differences and that the female alcoholic felt more stigmatized. The literature on the female alcoholic indicated that female drinking was accepted now by society and family, but female drunkenness was not (Birchmore and Waldman, 1975; Block, 1965; Cork, 1969; Curlee, 1968; Fox, 1962; Gomberg, 1975; Hirsh, 1962). Because of the stigma attached to alcoholism for the female, she felt more guilt and shame than the male (Fox, 1962). Society's lack of acceptance of alcoholism in women may account for the lack of treatment facilities for women. For example, in Ontario, detoxication unit beds are provided on a ratio of 10:1 males to females (Fraser, 1975). This ratio does not reflect the proportion of male to female alcoholics.

The stigma attached to female alcoholism has led to a variety of attitudes about the female alcoholic. One
such attitude is that the female alcoholic is promiscuous. Evidence for this was found in the literature, at least for lower class populations (Lisansky, 1957). Another attitude about the female alcoholic is that she is more pathological than the male. This term was not clearly defined in many of the studies. One study found that physicians believed female alcoholics to be "sicker" than males (Johnson, 1965). Other studies based on very small samples also have contributed to the belief that female alcoholics were very disturbed and possibly more disturbed than males (Karpman, 1949; Rathod and Thomson, 1971). However, Curlee (1970), in a study of substantial sample size, found that females did not show greater pathology than males.

Part of the reason for the belief in the greater pathology of the female is that medical doctors are often quick to diagnose her as mentally ill rather than alcoholic, possibly because mental illness is less stigmatizing than alcoholism (Fraser, 1973). Possibly it is the female herself, by hiding her drinking symptoms, who permits this type of diagnosis to happen.

Another general attitude about the female alcoholic is that her alcoholism progresses more quickly than in the male. Although there is no clear indication of why this is so, the literature indicated that there is some validity to this idea for some types of female alcoholics but that the ramifications of progression have not been studied
thoroughly enough to elicit firm data (Curlee, 1970; Glatt, 1974; Lisansky, 1957). Some research showed that women begin their problem drinking at a later age than men (Lisansky, 1958; Rathod and Thomson, 1971). Selzer and Holloway (1957) said there is no significant differences regarding age of first drink of males and females. However, Jones (1971) stated that women had their first drink at an earlier age.

Female alcoholism has been related to the menstrual cycle but although some authors found a connection between the menstrual cycle and drinking, others did not (Belfer, Shader, Carroll and Harmatz, 1971; Lisansky, 1957).

This introduction to the literature on the female alcoholic has reflected some commonly held views about female alcoholism. The remainder of this review of the literature will explore three broad aspects of female alcoholism: family of origin, current family relationships, and treatment. Within these categories, information regarding other significant aspects of female alcoholism such as motivation for drinking, sexual adjustment, differential diagnosis, and differences between men and women will be reviewed.

In general, the women studied were of white, married, non-prison populations. A variety of classes were represented but the skid-row population was generally omitted. Most of the women studied were from state hospital or
private alcoholism treatment facilities.

Family of Origin

Many studies reported a high incidence of alcoholism, mental illness, inadequate parenting or broken homes in families of origin of alcoholics. There was some indication that there was greater deprivation in the families of origin of female alcoholics than in the families of male alcoholics (Curlee, 1968, 1970; de Lint, 1964; Lisansky, 1957; Rathod and Thomson, 1971; Sclare, 1970). Many of the female alcoholics reported dominant, rigid mothers and passive fathers. Occasionally the father was the dominant one. The fathers often manifested alcoholism or mental illness (Kinsey, 1966; Johnson, DeVries and Houghton, 1966; Senseman, 1966; Wood and Duffy, 1968). Some of these women felt rejected by both parents. Others felt some attachment to their fathers but almost all felt that they were unable to please their mothers. In general, the picture painted of many of the families of origin of female alcoholics was one filled with deprivation, non-acceptance and little adequate preparation for the role of wife and mother. Lisansky (1957) indicated that women alcoholics from a lower class background had more family deprivation than women from the middle class. However, Cramer and Blacker (1966) indicated that both classes studied had a similar degree of deprivation. Several studies of middle and upper class women alcoholics indicated a family history of alcoholism or some kind of
parental deprivation in childhood (Curlee, 1968, 1970; Senseman, 1966; Wood and Duffy, 1968). Therefore, difficulties in family of origin did not seem to be confined to one social class.

Current Family Relationships

In the studies reviewed, the majority of the female alcoholics were married or had been married. The overwhelming majority of the females studied gave evidence of emotionally unrewarding marriages. Often both partners were poorly prepared for marriage. There was poor communication between them and often poor sexual adjustment. Marital discord, domestic stress and family related problems were often cited as the reason for increased drinking or as a precipitating factor in hospital admission (Curlee, 1970; Rosenbaum, 1958; Sclare, 1970; Senseman, 1966; Wood and Duffy, 1968).

Males were less likely to relate family problems to the onset of alcoholic drinking. Female alcoholics were cited as having a higher divorce rate than the general population and often a higher rate than male alcoholics (Curlee, 1970; Glatt, 1974; Kinsey, 1966; Lisansky, 1957; Rathod and Thomson, 1971; Rosenbaum, 1958). These studies included a range of social classes. However, two studies, both of middle and upper class female alcoholics, found a low incidence of divorce and infidelity albeit in unsatisfying marriages (Senseman, 1966; Wood and Duffy, 1968).
One study found that more of the married women had a successful treatment outcome though not a statistically significant number (Pemberton, 1967).

Several studies reported a high percentage of alcoholism in the spouses of female alcoholics. This rate was higher than for the general population and also higher than for spouses of male alcoholics (Lisansky, 1957; Rosenbaum, 1958; Sclare, 1970). Despite this trend, two studies reported a low incidence of alcoholism in male partners (Busch, Kormendy and Feuerlein, 1973; Wood and Duffy, 1968). Busch hypothesized, however, that his results were due to his middle class population. There was an indication that partners of lower class female alcoholics were more likely to be alcoholic but, in general, they would not participate in the study. Rimmer (1974), in possibly the only study of psychiatric illness in husbands of female alcoholics, found that the majority of the men studied had some form of psychiatric illness or alcoholism, a much larger proportion than in the control group. Admittedly, his sample was small and non-representative but the study is a beginning in a grossly neglected area.

How does the spouse of the female alcoholic react to his wife's alcoholism? Block (1965) stated that he was likely to protect his wife and hide the alcoholism for fear of being criticized for not being able to control
his wife's behaviour. However, when the drinking becomes severe, disgust and disrespect come quickly. Fox (1962) stated that husbands of female alcoholics were more apt to pack up and leave than were wives of alcoholic men. This was probably because the wife of the male alcoholic was more dependent on the husband economically. Fox believed that it was harder for the husband to accept the drinking as an illness and a good deal of therapy is needed involving the husband. Other studies also indicated that the husband was not apt to be understanding (Bacon, 1965; Johnson, et al., 1966). Wood and Duffy (1968) found that often the husband had encouraged the wife to drink in the hope of releasing her sexually. They also found that, in some cases, the wife's sobriety would threaten the husband who enjoyed being in a superior position.

There were few studies on the influence of the mother's drinking on her children. However, the existing literature indicated that the mother's drinking invariably had a profoundly adverse affect on the children and also caused tremendous guilt in the drinking mother (Cork, 1969; Fox, 1962; Hirsh, 1962).

In general, the family situation of the female alcoholic was likely to become the focus of a vicious circle of drinking behaviour. Failure or feelings of frustration and discontent in the role of wife and mother led to heavier drinking which caused more problems and greater feelings of inadequacy which led to more drinking and
possible family break-up. Adding to this was some evidence by Wilsnack (1973) that a significantly greater proportion of married female alcoholics than married non-alcoholic women had some kind of gynecological or obstetrical disorder and that these women perceived these disorders as direct threats to their adequacy as females.

**Treatment of the Female Alcoholic**

It is generally accepted that most treatment facilities for alcoholics have been created with the male in mind. This may be a reflection of the second-class status of women in our society, or a wish on the part of society to deny that some of its females have an alcohol problem. At any rate, several authors have suggested that women may have different treatment needs than men and that research is needed to establish what these needs are (Birchmore and Waldorman, 1975; Curlee, 1971; Fraser, 1975; Gomberg, 1975). One study on sex differences in attitudes towards treatment revealed that women found individual counselling more helpful whereas men preferred group therapy and informal interaction (Curlee, 1971). Pemberton (1967) also found that men tended to interact with one another informally whereas women kept to themselves. However, another study in the same treatment facility as in the Curlee study found that both men and women saw individual counselling as a more significant event of the day than group therapy (Kammeier, Lucero
and Anderson, 1973). A significant difference in one follow-up study showed that fewer women than men completed the program during first admission but in a second admission for non-completers more women than men completed the program (Fitzgeralds, et al., 1971). Glatt (1961) suggested that significantly lower improvement rates for women in his study might have been because alcoholic women were not treated in a separate unit for alcoholism whereas men were. All of these studies indicated the need for more concern, experimentation and research in relation to the treatment needs of female alcoholics.

It has already been shown in this review that marital problems were related to drinking behaviour in the female alcoholic. Other studies have shown that anxiety due to role conflict, poor self-image and feelings of inadequacy in female roles were often temporarily alleviated by drinking or at least were related to alcoholic drinking in female alcoholics (Johnson, et al., 1966; Parker, 1972; Wilsnack, 1973). This would indicate that treatment which focuses on issues relating to conflicts in the female role, self-image and marital problems would be appropriate. Hopefully, this treatment would be carried out by persons who feel comfortable discussing the many options open to women today. It has been suggested too that involving the husband in therapy and focusing on the family as a system that had been affected by the alcoholism was
essential (Fox, 1962; Bowen, 1974).

There was some indication that women had lower improvement rates than male alcoholics (Glatt, 1961; Pemberton, 1967). However, other studies found that the rates for females were not lower (Fitzgerald, et al., 1971; Gerard and Saenger, 1966).

In some studies, outcomes of men and women were not differentiated according to sex. That this practice led to much information loss was shown by Bateman and Peterson (1972) who found that men and women had similar outcomes in relation to only two out of over 15 variables.

The literature also revealed other implications for treatment. Several studies showed that, in some alcoholics, more often in women than in men, depression, antedating the alcoholic drinking, was the primary factor (Kielholz, 1970; Schuckit, Pitts, Reich, Kingand, Winokur, 1969; Winokur, Rimmer and Reich, 1971). One of these studies indicated that subcategories of alcoholism must be defined for accurate diagnosis and treatment (Schuckit, et al., 1969, p. 306).

A series of studies at the Alcoholism Division of the Fort Logan Mental Health Center in Denver, Colorado have found that there were distinct differences in symptoms, behaviour and drinking patterns among alcoholics, with some distinct differences for men and women (Wanberg
and Horn, 1970; Wanberg and Knapp, 1970; Horn, Wanberg and Adams, 1974). These studies advocated a multidimensional approach to diagnosis and treatment instead of the frequent lumping of all alcoholics into one category.

**Summary**

This chapter presented a review of the literature on 1) three theories of alcoholism, 2) selected follow-up studies of alcoholism treatment programs, and 3) the female alcoholic. The review of the literature on the theories of alcoholism was meant to serve as a reference point for the discussion of the Connaught Clinic program rather than a basis for the hypotheses and research questions. The two other areas reviewed were directly related to the research design.
CHAPTER III

THE CONNAUGHT CLINIC

The Connaught Clinic, an out-patient day-care program for the rehabilitation of alcohol-troubled people, opened its doors in March, 1971. The idea for the establishment of an alcoholism clinic was initiated by the Addiction Research Foundation, St. Clair Region. However, Windsor Western Hospital Centre became an early supporter of the program and the Connaught Clinic, from the beginning, has been under the joint sponsorship of the Addiction Research Foundation and Windsor Western Hospital Centre. The Hospital Centre has provided the physical accommodations and full-time staff; the Addiction Research Foundation has provided part-time staff and has been involved in program development. W. K. Jaggs, Regional Director of the Addiction Research Foundation, St. Clair Region is currently the Director of the Connaught Clinic.

Purpose of the Clinic

The purpose of the Connaught Clinic, as outlined in the revised 1975 policy statement, is

To develop and administer facilities and programs for the rehabilitation of persons who primarily have an alcohol problem and who live in the counties of Essex, Kent and Lambton. (Policy Statement, p. 3)

The program endeavors to help people cope with life
without the use of alcohol:

a) by helping the individual improve his/her relations with others, e.g., i) family, ii) community, iii) employment;
b) by enabling the individual to discover healthier ways of handling one's emotions;
c) by enabling the individual to begin to examine and re-evaluate personal values, to discover priorities and to set new goals for one's life;
d) by encouraging the individual, through new insights into one's own inner strength and resources and resulting pride in accomplishment, and through experiencing acceptance and concern from the staff and fellow group members, to develop a new sense of self-respect and self-esteem;
e) in the didactic part of the program the individual will be helped to better understand the substance alcohol and its harmful effects on the human body, emotions and social relationships when consumed in toxic quantities;
f) and to gain a new respect for one's body and an awareness of one's need for proper nutrition, exercise and rest (Policy Statement, p. 3-4).

Services and Staff

The major service offered by the Clinic has been a three-week intensive out-patient program of lectures, films, tapes, relaxation therapy, occupational therapy, individual and group counselling. In its early period, the Clinic offered the intensive phase in a two-week time period. However, during the period of time that was the concern of this study and at the present time, the intensive phase was of three weeks' duration. This chapter will describe Clinic services as they were offered during the time under consideration in this study.

On the first Monday of each month, 10 to 12 men and women were admitted to the intensive phase which was a
combination of didactic material and counselling for the most part. The first week's didactic material consisted mainly of information about the physical, psychological and social effects of excessive use of alcohol. During the second week of the program, the didactic material consisted of information about feelings and how people allow feelings to help or block them in achieving their goals in life. The didactic material in the third week focused more specifically on how to cope with life without alcohol. During the three weeks there were also presentations on alcohol, family, communications, nutrition, Alcoholics Anonymous, and the Open Door Club, a social rehabilitation club for alcoholics. Didactic material was presented through lectures, workshops, films and tapes with discussion included in each presentation. During the three weeks, families and significant others of the patients were asked to attend three evening sessions to receive information about alcoholism.

People were assessed for the intensive phase during an intake period. Patients were interviewed through the use of the Social Assessment Form which enabled staff to assess the patients' drinking pattern and problems they were having in regard to family, employment and mental and physical health. In the beginning of the time period under consideration in this study, only the alcohol-troubled person was interviewed for the most part. Toward
the end of the time period, a policy was established of interviewing the spouse as well. Often, several interviews with each patient and spouse were conducted during the intake phase.

The intake phase helped staff and prospective patients determine whether or not the program would be useful to the individual and, if not, what other community services might be more appropriate. The criterion for admission to the intensive phase was that the person be considered by himself or others to have a problem related to the use of alcohol. Although, technically, the person chose freely to begin or not begin the program if he was accepted for admission, some people were threatened with loss of job or family if they did not attend.

Because the program was group-oriented and highly didactic in format, it was considered necessary to exclude persons who displayed the following: 1) serious emotional disturbance that would interfere with participation in lectures, discussions and group counselling; 2) obvious mental retardation of a severe nature; 3) severe physical withdrawal symptoms from alcohol; 4) strong denial or hostility regarding the need for referral to the program; and 5) weakened physical condition that would preclude participation in a six-hour daily program (Policy Statement, pp. 4-5).

Many of the above reasons for exclusion were matters
of readiness for admission and often people who showed these symptoms were asked to wait for a certain time period before beginning the program, at times receiving counselling during the interim.

In addition to services provided during the intensive phase and intake period, the Clinic offered follow-up services. The follow-up services consisted of evaluating with the patients their continuing treatment needs and helping them make contact with appropriate self-help or treatment resources in the community. The Clinic also offered a follow-up group for patients which met one night a week for the five weeks following the completion of the intensive phase. In the Policy Statement (1975), follow-up contacts for a one-year period were proposed, but this plan was never implemented because of staff shortages. Marriage, family and one-to-one counselling also were offered as part of the follow-up service if patients wanted to make use of these services.

As part of its service function, the Clinic also provided information and assistance to social agencies, industry, and the general public who were attempting to understand or assist people with drinking problems.

Since its inception, the Clinic has been operating with a limited number of staff. During the time period of this study, the full-time staff consisted of a supervisor, who is a clergyman with special training in
counselling, and a clerk-typist. This full-time staff was supplemented by six people from the Addiction Research Foundation who gave varying amounts of time. There were also two fourth-year students from the School of Social Work of the University of Windsor who had their field placement at the Clinic two days a week from October through April. In addition, a Public Health Nurse, people from Alcoholics Anonymous, the Open Door Club and the Occupational Therapy staff from Windsor Western Hospital Centre contributed to the program.

Population

Between March, 1971 and September, 1975, the intensive phase of the program had been completed by 584 people with 16 of these people attending the program twice. Since September, 1975 an additional 61 people have completed the intensive phase with eight of these people attending the program twice. The total number of people completing the intensive phase since the inception of the Clinic has been 645 with 24 repeaters. During the time under consideration in the study, 301 people were referred to the Clinic, 269 came for intake services and 192 people were accepted into the program. Of these 192 people, 155 actually commenced the three-week program and 132 people completed it. Thirty-seven people were accepted but did not begin the program. The 23 people who did not complete the program did so either through voluntary
termination or deselection, a process whereby the staff asked the person to leave either due to drinking or excessive absence. Counselling services were offered to these people but not necessarily accepted.

A demographic description of the patients in our sample will be shown as part of our findings.

Although during the intake interviews patients were asked questions about their drinking patterns and frequency and amount of alcohol consumed, it was difficult to determine the type of alcoholism in each patient and even the presence of actual physical addiction to alcohol because of the lack of adequate diagnostic instruments in the field of alcoholism. In addition, it was not the general intent of the Clinic to screen people in or out on the basis of degree of alcohol involvement or primacy of alcohol as it related to the patient's problems except in the case of severe psychiatric problems. Therefore, patient groups might have included bender and steady drinkers; heavy and relatively moderate consumers of alcohol; long-term and short-term abusers of alcohol; physically addicted and non-addicted people; and people for whom psychiatric problems might have preceded alcohol-related problems and people for whom alcohol-related problems were primary. The groups, as a result, were varied. For the most part, however, there were few skid-row alcoholics who attended the program, that is, people who had lost
family and job and whose entire existence consisted primarily of drinking. Most of the patients were employed and had intact families.

The majority of patients in each month's group were men. During the period of time under consideration in this study, the ratio of males to females was 5:1 though in other periods there have been even fewer females. Participation of females in any particular group ranged from zero to three.

Patients were expected to be abstinent for the duration of the intensive phase of the program. Although there were no formal means of checking to see if abstinence was being maintained, patients were asked to report their own slips from abstinence to the group. Patients who were finding it difficult to maintain abstinence were encouraged to take the drug Antabuse which would induce vomiting if the person drank.

Patients were also expected to arrive promptly and attend each daily session of the program unless an emergency occurred. If they were not able to be present or expected to be late, they were asked to notify the supervisor.

Approximately midway through the time period under consideration in this study, the requirements concerning abstinence and attendance were outlined in a written contract that was signed by each patient during the
intake phase. In addition, the contract asked patients to commit themselves to attending the five weekly follow-up meetings. Spouses of patients were asked to commit themselves to attending the three evening sessions for significant others. If patients did not adhere to the abstinence or attendance requirements, they were confronted and might be asked to withdraw from the program.

**Goals and Expectations**

Abstinence was advocated as the treatment goal for patients at the Clinic. However, some patients set their own goal as that of controlled drinking. While advocating abstinence, the Clinic realized and informed patients that this goal would be difficult to achieve and unrealistic to expect unless the patient participated in treatment or self-help follow-up services on a long-term basis.¹ In an interview, Reverend Ken Jaggs, director of the Connaught Clinic, said that he saw the Clinic as "sowing the seed" toward the goal of abstinence, although abstinence itself might be achieved at a later time.²

In addition to the goal of abstinence, a major objective of the Clinic was to help people develop more positive attitudes towards themselves, their physical condition, family, social relationships and employment.

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¹Interview with Rev. R. Maurice Dobson, Supervisor, Connaught Clinic, February 26, 1976.

²Interview, October 30, 1975.
situation. In conjunction with the development of new attitudes, the Clinic aimed at helping people learn to face and cope with their problems in ways other than through the use of alcohol.

The Clinic adhered to the disease concept of alcoholism and informed patients of the progressive nature of the disease. However, the Clinic always emphasized that it was necessary for the drinking person to take responsibility for his behaviour.

The Clinic also recognized the learning theory of alcoholism which states that alcohol-troubled people have learned to use alcohol as a means of coping with the stresses of life, making it necessary for them to learn new coping mechanisms for dealing with stress. Although the Clinic has recognized some aspects of the learning theory model, during the time period under consideration in this study no attempt had been made to introduce systematic behaviour modification techniques to help people learn new behaviours or reduce anxiety reactions.

From its inception, the Clinic was envisioned as a community-oriented facility and its goal has been to cooperate with industry, social service agencies, alcohol self-help groups and other treatment facilities involved in helping alcohol-troubled people. The Clinic has searched continually for new ways to cooperate with the community in treating alcoholism.
New Directions for the Connaught Clinic

Since the time under consideration in this study, several changes have occurred in the Clinic program. Occupational therapy has been deleted from the program. Presentations on the topics of credit and money management have been added. Also added has been a presentation on social services available in the community. Additional workshops in life skills have been planned. As of June, 1976 two full-time social workers were added to the staff. Changes are anticipated in the follow-up program which had never been fully implemented as planned because of staff shortages. Despite these changes, the basic format of a didactic-counselling model with abstinence and improvement in overall functioning as the ultimate treatment goal will be continued.

Summary

This chapter presented a description of the purpose, services and objectives of the Connaught Clinic, a day hospital treatment program for alcoholics. Special emphasis was on the description of the three-week intensive phase of the program as it existed during the time under consideration in this study, from September, 1974 through September, 1975. Changes in the Clinic that have taken place since that time were briefly noted.
CHAPTER IV

RESEARCH DESIGN

Research Questions and Hypotheses

In Chapter I several questions for research were identified. These questions were: 1) What was the Clinic population like in terms of demographic data? 2) What changes had occurred in the lives of the patients who had completed the intensive phase of the Connaught Clinic program? 3) What were the treatment experiences of the Clinic population? and 4) Did the female patients seem to have special treatment needs?

To respond to the problem of obtaining a demographic description of the population of the Connaught Clinic, one research question was formulated. A hypothesis was also formulated to test the differences between males and females in regard to some of the data.

Research question one.

What were the characteristics of the population of the Connaught Clinic as shown by the sample at time of intake in regard to sex, age, marital status, occupational status, usual occupation, education, religion and religious participation?

The rationale for this question was to enable the researchers to know to what other patient populations the study was generalizable and to provide more knowledge about the patients.

59.
Questions 1-9 of the interview schedule (Appendix A) provided the information for this research question.

**Hypothesis one.**

There would be a significant difference between males and females in regard to age of first drink, age at which regular drinking began and number of years of problem drinking.

The rationale for this hypothesis was primarily to test to see if the Clinic population corresponded to some indications in the literature that female alcoholics had fewer years of problem drinking but entered treatment at about the same age as men.

To obtain information for this question, intake data was used.

To respond to the problem of what changes had occurred in the lives of the patients since completing the Clinic program, one research question and five hypotheses were formulated.

**Research question two.**

What changes have occurred in drinking involvement when comparing the year preceding intake to the time between completion of the three-week program and time of follow-up?

The concept "drinking involvement" was defined broadly as frequency of drinking behaviour and amount of alcohol consumed. The concept "changes in drinking involvement" was operationally defined according to a five-point scale: 1) not improved - continued periodic drinking with no decreased consumption or continued daily drinking with
no decreased consumption; 2) little improved - change from daily to periodic drinking with no decreased consumption; 3) somewhat improved - continued periodic drinking with decreased consumption or continued daily drinking with decreased consumption or abstinent then a relapse to former daily drinking pattern then a return to abstinence for at least three months prior to the follow-up interview; 4) much improved - change from daily to periodic drinking with decreased consumption, or continued former drinking pattern then abstinence for at least nine months, and 5) abstinent - no alcohol consumption at all.

The concept "periodic drinking" was defined as two days a week or less. The concept "decreased consumption" was defined as four or five bottles of beer or the equivalent in draught beer, six or seven ounces of whiskey or six 4 oz. glasses of wine (Addiction Research Foundation, 1975).

Although increased drinking involvement was a possible outcome it was not included as a separate category. Because of difficulties in accurate measurement, increase in alcohol involvement was included in the "not improved" category with special mention to specific instances.

In deciding which operational definition of changes in drinking involvement, or changes in drinking status as it is sometimes called, would be appropriate, the literature of follow-up studies was reviewed. Each study used different
criteria. Many of the studies recognized the problem of
definition of drinking status (i.e., Pokorny, et al., 1968).
Most studies included only changes in amount of alcohol
consumed and did not account for changes in frequency.
The researchers decided to incorporate both aspects of
drinking involvement which necessitated creating new
definitions. The formulations of Gerald Smith in this
regard were helpful (Smith, 1976). Also, the criteria
used in the present study, especially the use of abstinence
as the ideal, were related to the goal of the Connaught
Clinic program which was to enable the patient to learn
how to cope with life without the use of alcohol.

Changes in drinking involvement according to the
five-point scale were determined by ratings of the re-
searchers when comparing self-report information recorded
on intake forms with self-report information in response
to identical questions obtained during the follow-up
interview. (See questions 56 to 58, Appendix A.)

**Hypothesis two.**

There would be significant differences between
males and females in regard to decrease in drinking
involvement.

The rationale for this hypothesis was that in the
literature on the female alcoholic there is some indication
that a significant difference might occur.

**Hypothesis three.**

There would be an association between decrease
in drinking involvement in the follow-up period and
frequency of attendance at the five weekly Clinic
follow-up meetings.
The follow-up period for this and subsequent hypotheses was defined as that time between completion of the intensive phase of the Clinic program and the end of March, 1976.

Information to test this hypothesis was obtained from question 18 on the interview schedule and verification from Clinic records.

**Hypothesis four.**

There would be an association between decrease in drinking involvement and frequency of attendance at follow-up services.

"Follow-up services" were broadly defined to include

1) Alcoholics Anonymous, a self-help organization for alcoholics, 2) the Open Door Club, a self-help rehabilitation centre for alcoholics in Windsor, 3) the .001 group, a group counselling service for alcoholics at the Addiction Research Foundation, 4) group, individual, marital or family counselling through clergy, social agencies, alcohol treatment agencies or the university, 5) medical services, and 6) detox or halfway house services. Information regarding the use of follow-up services was obtained through subject self-report (See questions 20-28, 42-44, Appendix A) and verified whenever possible from Clinic records.

The rationale for including these two hypotheses was that in the intensive phase, the Clinic stressed the importance for the patients of utilizing follow-up services
in their effort to maintain sobriety.

Hypothesis five.

There would be an association between decrease in drinking involvement in the follow-up period and improvement in the employment situation.

"Improvement in the employment situation" was operationally defined as 1) an increase in number of working days or attendance in a retraining program in the follow-up period when compared to an equal amount of time immediately prior to the intake period, or 2) regained employment if the person had been unemployed or had been suspended due to drinking before treatment. The researchers realized that for this last criterion of improvement, some employers reinstated an employee solely on the basis of his completing a treatment program and not necessarily because he had decreased his drinking involvement.

The rationale for including this hypothesis was that an increasing number of people were being referred to the Clinic by employers because of absenteeism related to drinking and that it would be useful to know whether decreases in absenteeism did occur subsequent to treatment and if, in fact, the decreases were associated with decreases in drinking involvement.

"Improvement in the employment situation" was measured on a three-point scale: 1) worse which was defined as increase in absenteeism or lost job during the follow-up period; 2) no change - still a problem which was
defined as no decrease in absenteeism or still suspended
or still unemployed during the follow-up period, and 3) 

improved which was defined as stated above in the opera-
tional definition for improvement in the employment 
situation.

Information to test this hypothesis was obtained
from questions 30 to 35 on the interview schedule (See 
Appendix A) and from Clinic records.

Hypothesis six.

There would be an association between decrease 
in drinking involvement in the follow-up period 
and improvement in family relationships.

Three aspects of family relationships were tested:
relationship with spouse, relationship with children and 
relationship with adult relatives in the home if the 
subject was unmarried. "Improvement in family relation-
ships" was operationally defined in terms of a five-point 
scale from "much improved" to "worse" according to subject 
self-report based on his own perceptions of the changes 
that had occurred in family relationships since completion 
of the intensive phase of the Clinic program. (See questions 
36-38, Appendix A.) There was an assumption that family 
relationships were in need of improvement.

In hypotheses five and six there was an assumption 
that a decrease in drinking involvement would lead to im-
provements in other areas of a person's life. There is 
evidence in the literature that abstinence can occur
without improvements in other life areas (Gerard, Saenger and Wile, 1962; Rossi, et al., 1963; Wilby and Jones, 1962). There was also evidence in the literature that improvements in other life areas can occur without abstinence (Gerard and Saenger, 1966; Fitzgerald, et al., 1971). However, because the goals of the Connaught Clinic associate improvements in various areas of a person’s life with a decrease in drinking involvement, association was tested in the stated direction.

In an attempt to describe the population in terms of treatment experiences, one research question was formulated.

Research question three.

What were the treatment experiences for drinking or drinking related problems of those people who completed the intensive phase of the Connaught Clinic program? Specifically:

1) How often did the people in the sample obtain treatment prior to attending the Clinic program?

2) What types of professional treatment did people receive prior to attending the Clinic program?

3) Through what source were people referred to the Clinic?

4) How soon after completing the Clinic program did people feel the need for treatment?

5) What treatment mode did they feel would be helpful?

6) How often did people receive treatment subsequent to attending the Clinic?

7) What types of treatment did they receive subsequent to attending the Clinic?

8) What were the reasons that they did not
obtain treatment if they had felt the need for it?

9) What types of treatment were wanted but not available?

"Treatment" was defined as any use of self-help or professional services in an effort to ameliorate drinking or drinking-related problems.

"Treatment mode" referred to counselling services - specifically one-to-one, marital, family or group counselling.

Through the formulation of two hypotheses an attempt was made to obtain information about the experiences and attitudes of the sample in regard to four types of alcoholism treatment services - out-patient counselling, detoxication centres, halfway houses, in-patient hospital treatment.

**Hypothesis seven.**

Both sexes would be more likely to have used out-patient counselling than residential treatment services for the treatment of alcoholism.

**Hypothesis eight.**

Out-patient counselling would be mentioned more frequently by both sexes as possibly being helpful in the future than would detoxication centres, halfway houses and in-patient treatment services.

The research question and two hypotheses on treatment experiences were intended to be exploratory. In addition to describing the population in regard to treatment experiences and seeing what differences existed between the experiences of males and females, it was hoped that these
formulations would elicit information that could form the basis for recommendations for planning follow-up treatment programs for the patients of the Clinic.

Interview schedule questions 19-29 and 39-48 provided information for research question three and questions 49-54 provided information for hypotheses seven and eight (Appendix A).

The last major problem of concern to this study was: Did the female alcoholic seem to have special needs in regard to treatment? Some of the other research questions and hypotheses addressed themselves to this question as well though the major focus of those research questions and hypotheses was in the first two problem areas of the study.

Six hypotheses were formulated to test the question of whether or not the female alcoholic seemed to have special treatment needs.

**Hypothesis nine.**

There would be a significant difference between males and females in regard to the rating of helpfulness of the total Connaught Clinic program.

The definition of helpfulness and the scale used were identical to those used in hypothesis six.

The rationale for including hypothesis nine was based on the assumption that because the ratio of males to females was 5:1 during the time period under consideration in the study, much of the focus of discussion would be male-
oriented and possibly less helpful to females.

Hypothesis ten.

In a rating of different aspects of the treatment program, males would rate group therapy higher in terms of helpfulness to themselves than would females.

The rationale for this hypothesis was that one study indicated that females saw group therapy as less helpful than did men (Curlee, 1971) and two other authors indicated that females might be less comfortable than men in mixing in groups (Pemberton, 1967; Fraser, 1975). The researchers wanted to test these findings in relation to the Clinic population.

In testing this hypothesis, subjects were allowed to define helpfulness according to their own perception as was done in the Curlee study. Helpfulness was rated according to a five-point scale from "extremely helpful" to "not at all helpful." Subjects were also asked to rank order the following five aspects of the treatment program in order of helpfulness to them: lectures, films, tapes, group therapy and individual counselling.

Questions 11 and 12 on the interview schedule were used to test this hypothesis (See Appendix A).

Hypothesis eleven.

Females would link their problem drinking to stresses of domestic life, whereas males would link their problem drinking to their habitual life style or work related pressures.

The rationale for this hypothesis was based on findings that female alcoholics indicated problems in the
role of wife or mother or both and that often problem drinking was associated with strains of domestic life, whereas men associated drinking problems with other factors. If this hypothesis tested positively, there might be implications for a differential treatment focus for males and females.

Question 59 on the interview schedule (Appendix A) was used to test this hypothesis.

Hypothesis twelve.

At the time of intake, the majority of the females would have ranked the category "reasons affecting domestic relations" as most influential in their decision to stop drinking, whereas males would have ranked the category "reasons affecting employment" or "financial security" as the most influential.

These categories were among five listed on the Social Assessment form at intake in a section asking patients to rank order reasons for discontinuing drinking. The two other categories were "reasons affecting mental health" and "reasons affecting physical health."

The rationale for this hypothesis was similar to that of hypothesis eight.

Hypothesis thirteen.

Females would prefer a treatment group composition of approximately equal numbers of males and females and males would prefer mostly or all males in the group.

Hypothesis fourteen.

Females would prefer one male and one female therapist for group therapy, whereas males would prefer two males as therapists.
These hypotheses were exploratory in intent. The rationale for including was to see if there were major differences in preferences between males and females that might influence future treatment planning.

Questions 14-17 of the interview schedule (Appendix A) were used to test these two hypotheses.

Assumptions

Several of the assumptions in this study have already been stated in connection with specific hypotheses or research questions. Three additional assumptions were made:

1. The use of alcohol by the patients at the Connaught Clinic had created problems for them either as perceived by themselves or by others in their environment, i.e., family, employer, legal system, physician, or social agency. The basis for this assumption lay in the referral system of the Clinic.

2. The patients at the Connaught Clinic wanted some degree of help in coping with their drinking-related problems. The degree of help ranged from simply understanding the relationship between alcohol use and the patient's own problems to changing specific behaviours. This assumption was based on the goals and objectives of the patients as stated in Clinic files.

3. The treatment program at the Connaught Clinic was primarily male-oriented in focus. The basis for this assumption was the researchers' experience at the Clinic
and the high ratio of males to females in the program.

**Definitions**

Most of the definitions relevant to this study were presented in relation to the hypotheses and research questions. Terms referring to the Connaught Clinic program were defined in Chapter III.

The definition of "alcoholic" used in this study was based on that used by the Connaught Clinic - a person whose use of alcohol has caused problems in one or more aspects of his life. The term is used in a descriptive rather than in a diagnostic sense.

**Population Selection**

Although the Clinic had been operating since March, 1971 and a follow-up study had never been undertaken, it was decided to limit the sub-population for this study to those patients who completed the intensive phase of the Clinic program between September, 1974 and September, 1975. There were three reasons why this particular interval was chosen.

The primary reason for using this sub-population was that extensive intake material relating to drinking involvement became available as of September, 1974 with the introduction of the Social Assessment Form and was still in use as of September, 1975, ensuring reasonably consistent pre-treatment data. A second reason for using this time period was that all of the patients would have completed
the program at least six months prior to the follow-up interview. One study indicated that it was necessary to wait at least a year after treatment before measuring drinking status (Sereny and Fryatt, 1966). However, if the sub-population in the present study had been limited to those who had completed the program one year prior to the follow-up interview, too small a sample, especially of women, would have resulted. Several studies found that most relapses occurred within six months of discharge from treatment (Davies, et al., 1956; Glatt, 1959; Pokorny, et al., 1968; Edward, 1966). A third reason for selecting a more recent sub-population was greater accessibility for the follow-up interview.

There was an assumption that this population was not significantly different from others that have gone through the Connaught Clinic and that the findings will be generalizable to the total population. Some caution was necessary due to the usual changes in treatment variables that occur in any treatment program.

This sub-population consisted of 109 males and 21 females.

**Sampling Strategy**

It was not feasible in terms of time and money to obtain data from the entire sub-population. Therefore, it was decided to limit the sample to all of the women and a random sample of twenty men. The sample of men was
selected through a table of random numbers as a way of obtaining a truly representative sample (Seiltiz, 1959, p. 522). The sample was stratified according to sex because of the desire to insure an adequate number of females.

Two males died during the follow-up period. Forty men were selected randomly from the sub-population to insure substitutes if some of the first twenty were unavailable. Of the first twenty men selected, one died, one refused to participate, one moved away, and two were unable to be located. The next five persons on the randomized list were selected to be contacted. Of these, one refused to participate and a sixth person was contacted. Another of the five substitutes was unable to be reached but it was too late to substitute another name. Nineteen men were interviewed for the study.

Of the 21 women in the sub-population, 16 were interviewed. Three refused to participate, one was unable to be located and one was incapacitated due to a stroke.

These factors of experimental mortality affected the representativeness of the sample.

The size of the sample was small and there was a recognition on the part of the researchers that large samples were preferable. However, according to Isaac and Michael (1971, p. 69) "Small sample statistics assure the researcher of acceptable reliability in estimating sampling error before making decisions about his data."
The sample was not generalizable to the population of alcoholics in Windsor because the population who obtained treatment were not selected randomly from the general population of alcoholics. Those coming for treatment to the Clinic were a select group due to either personal or external motivational factors.

**Data Collection Instruments**

The major data collection and instrument used in this study was an interview schedule (See Appendix A). Pre-treatment data were also obtained from Clinic files from the Social Assessment Form which had been completed during an interview at the time of intake.

The interview schedule used by the researchers at the time of the follow-up study was semi-structured. Specific questions were asked but allowance was made if explanations were needed regarding terms in the questions. Since both researchers administered the interview schedule to half of the sample respectively, rehearsals were held and guidelines for providing explanations were prepared to maximize consistency. A pretest was not done because of the small sample size and the time factor. Some of the questions in the research instrument were open-ended and required coding by the researchers. A preliminary and a final coding were jointly carried out to maximize accuracy. Some of the hypotheses required a rating to be made based on a comparison of pre-treatment and follow-up treatment.
data. These ratings were also made jointly by the researchers.

Interview schedules have been frequently used in following up alcoholism treatment programs. Pokorny, et al., (1968, p. 374) states three advantages for using interviews as opposed to questionnaires: 1) patients find it more difficult to refuse to respond in the presence of an interviewer; 2) the completion of the questionnaire seemed like work, whereas the interviewer was able to make the interview pleasant and interesting; and 3) the personal aspect of the interview situation was considered as a friendly treatment contact rather than as an information-gathering contact as in a questionnaire.

Other advantages to interviewing were obtaining greater depth of response, more complete data and clarification of communication (Isaac and Michael, 1971, p. 96).

Disadvantages of interviewing were that it was time-consuming and inconvenient. There was also greater danger of antagonism developing between interviewer and subject. Less assurance of anonymity and confidentiality was another disadvantage. Interviewer bias through the use of leading questions was another possible disadvantage that had to be controlled through training (Isaac and Michael, 1971, p. 96). Also, possible inconsistency in interviewing styles had to be controlled through
training and a semi-structured interview schedule.

It is important with any data collection procedure to minimize bias and unreliability (Selltiz, et al., 1959, p. 69). The steps the researchers took in preparing for the interviews outlined above helped to minimize bias. However, the researchers were aware that there might be possible bias brought about by female researchers interviewing female subjects regarding special treatment preferences.

The question of reliability was harder to control. According to Selltiz (1959, p. 166):

The evaluation of the reliability of any measurement procedure consists in determining how much of the variation in scores among individuals is due to inconsistencies in measurement.

In other words, would one obtain similar results if the measurement were repeated a number of times? It was not feasible for the researchers to re-interview the sample at various time periods. According to Selltiz (1959, p. 277) interview schedules and questionnaires are not often tested for reliability since they are usually designed for a single study.

Validity was another factor that had to be accounted for in the research instrument. According to Selltiz, et al., (1959, p. 155):

The validity of a measuring instrument may be defined as the extent to which differences in scores on it reflect true differences among individuals, groups, or situations in the characteristics which it seeks to measure, or true differences in the same individual.
group, or situation from one occasion to another, rather than constant or random errors.

In both the intake and follow-up interviews, patients were reporting on their own drinking behaviour, family relationships, employment situation and other facets of their lives. It is common for alcoholism treatment programs to use self-report for gathering such information. There is some speculation as to the validity and reliability of this information. Summers (1970) reports that 14 out of 15 men, after a two-week period, changed responses obtained at intake regarding their drinking histories. On the other hand, Sobell, et al., (1974) found that when self-reports of alcohol-related arrests were compared with official records, that self-reports were found to be reliable. Also, in a follow-up study of treated alcoholics, Gerard and Saenger (1966) discovered few contradictions between patient responses and responses by their significant others, regarding drinking status of the patient.

Because a research component with systematic follow-up procedures had not been incorporated into the treatment program, the use of self-report data was the only means of data collection available to the researchers. Honest responses were encouraged through interview techniques based on a non-judgemental attitude toward drinking and other areas in the interview schedule. Also, specific questions on drinking behaviour were
asked at the end in the hope that some of the drinking information would have been offered informally and perhaps less defensively earlier in the interview. The researchers were aware that some subjects would want to or would unintentionally minimize their drinking behaviour. Assurance was given the subjects on the question of confidentiality in regard to treatment personnel at the Clinic. The effects of this assurance was somewhat minimized because one of the researchers had been involved in the treatment program at the time this population attended the Clinic. In some instances, the researchers were aware of corroborating information regarding the subjects due to contact in the follow-up period although this information was not systematic enough to ascertain reliability.

The researchers chose not to ask subjects for permission to contact spouses, friends or referral sources to provide corroborating information, on the assumption that asking for this permission would make subjects less willing to participate in the study.

**Data Collection Procedures**

Subjects were initially informed about the study and asked to participate through a letter sent to them in April or May, 1976 by R. Maurice Dobson, the supervisor of the Clinic. (See Appendix B.) The subjects were asked to call the Clinic if they did not want to be contacted by telephone by the researchers. One person
called the Clinic asking not to be contacted. However, four other persons refused to participate after being contacted by the researchers.

During the telephone contact by the researchers, the project was explained in more detail to the subjects and appointments were scheduled for interviews at the convenience of the subjects. Interviews were conducted either at the Clinic, in the subjects' home or place of employment according to the preference of the subject. Prior to each interview, the researchers made an introductory, explanatory statement to the subjects about the nature of the project, and assuring the subject of confidentiality. (See Appendix A for guidelines of the statement.) After hearing the introductory statement and asking questions, if necessary, the subjects were asked to sign a release of information form. (See Appendix C.)

Each of the researchers interviewed half of the number of males and half of the number of females. Females were contacted and interviewed first because of the limited sample size. If less than ten females agreed to participate the researchers may have had to revise the study.

**Analysis of the Data**

When deciding on what statistics would be used, a decision was made on the type of scales used in the interview schedule. Whether the scales were nominal, ordinal
or interval determined which specific statistics to use. In other words, the types of scales gave the rationale for the statistics used. The scales in the study were mainly nominal and ordinal.

The chosen statistics have three purposes: (a) to describe a single variable, (b) to describe two variables, via tests of association, and (c) to estimate error, via sample statistics.

To describe a single variable, the mean, a measure of central tendency, was used. The mean was used in the research question concerning the description of the sample. The mean was also used in the description of the treatment experiences of the sample especially in regard to frequency of attendance at treatment services.

In describing two variables, the researchers were concerned with both the strength and the significance of the association between two variables. To test the strength of the association between two variables, this study used gamma, lambda and Cramer's "V" since the scales were mainly nominal and ordinal.

To test the significance of the association between two variables, this study used chi-square. Chi-square enabled the researchers to see if differences in the sample occurred by chance.

In interpreting the data of this study, the researchers compared the results with findings in other
follow-up studies. Even though some of the studies used for comparison may have had somewhat different treatment programs and populations, it was common practice in the literature on alcoholism for comparisons of outcome to be made, and this practice was followed in this study.

**Classification of the Study**

Tripodi, Fellin and Meyer (1969, p. 21) provided a system for classifying empirical research:

> In terms of the major purpose of research with respect to the seeking of knowledge and in terms of the various types of empirical methods employed to achieve such purposes.

They distinguished three major categories of empirical research, experimental, quantitative-descriptive, and exploratory studies, which were divided into nine sub-types. The authors outlined the characteristics of the major categories and sub-types in terms of problem formulation and research design primarily in order to help the consumer of research evaluate studies. However, the classification system offered useful guidelines in the production of research and formed the basis for the logic of the present study.

The present study was classified as being primarily under the category of quantitative-descriptive research, recognizing that there might be some overlap into other categories.

According to Tripodi, et al., (1969) in order for
a study to be classified as quantitative-descriptive, it had to have certain requisites. First of all, it could not be classified as an experimental study. Experimental and quantitative-descriptive studies were similar in that they both sought quantitative-descriptions among specified variables. However, experimental studies assigned subjects to experimental and control groups through random selection and quantitative-descriptive studies did not. Also, quantitative-descriptive studies did not manipulate experimentally the independent variables whereas experimental studies did.

A second requisite for a quantitative-descriptive study was that the variables be measurable. The third requisite was that the study must have one of the following purposes:

The testing of hypotheses or the accurate description of quantitative relations among variables selected for inclusion in the research. (Tripodi, et al., 1969, p. 38, italics omitted.)

Quantitative-descriptive studies were concerned with accurately describing associations among variables but not attempting to determine cause-and-effect relationships. Variables had to be operationally defined so they could be measured. Reliability and validity were important factors in this category of research. However, quantitative-descriptive studies could not control for internal validity to the same extent as ex-
perimental studies. However, experimental studies were not feasible in all situations including the present study.

The four sub-types of quantitative-descriptive studies were: 1) hypothesis testing studies, 2) program evaluation studies, 3) population description studies, and 4) variable relationship studies (Tripodi, et al., 1969). There could be considerable overlap between these various sub-types. The classification according to sub-type depended primarily on the purpose of the study.

The present study was a combination of three sub-types. It was a population description study in that the researchers were attempting to describe the characteristics of those people who completed the intensive phase of the Connaught Clinic program in terms of certain demographic variables, changes in their lives since leaving the program, and treatment experiences and to see if there were associations among some of the variables.

The present study also fell under the sub-type of program evaluation since in describing the changes that occurred in the patients' lives since completing the Clinic program, the researchers were, in essence, evaluating the effects of the program although it was recognized that a cause-and-effect relationship could not be ascertained.

A portion of the study was also classified as a
hypothesis-testing study in regard to the broad question of whether or not the female patients had special treatment needs.

Limitations of the Study

There were several limitations to this study:

1. Lack of a control group or a true experimental design precluded knowing what factors led to changes in the patients' lives as there were many intervening variables between time of intake and time of the follow-up study.

2. Lack of adequate or reliable baseline data from time of intake from which to make comparisons at time of the follow-up interview was another limitation. Ideally, a follow-up study should involve the design of intake material and matching follow-up material.

3. Self-report data would not be totally reliable. Actual behavioural changes were not observed.

4. Possible bias by female researchers interviewing female clients regarding special treatment needs might have occurred.

5. Experimental mortality made the sample less than truly representative.

6. Generalizability would be limited to patients with similar demographic characteristics in similar treatment programs.
Summary

This chapter presented the hypotheses and research questions and the rationale for each. In addition, definitions and assumptions used in the study were presented.

Decisions regarding population and sample selection were outlined. The data collection instrument and procedures used in data collection were described. Methods of data analysis were presented.

The classification of the study was described and the limitations of the study were noted.
CHAPTER V

DATA ANALYSIS

The findings are presented in the order in which the research questions and hypotheses were described in Chapter IV. Because comparisons of males and females were an essential part of the findings and because the number of males and females were different, percentages rather than frequencies were used in presenting the findings.

After the presentation of the data analysis, the researchers summarized those key findings which related to other studies of alcoholism treatment.

Description of the Sample

Research question one.

What were the characteristics of the population of the Connaught Clinic, as shown by the sample, at time of intake in regard to sex, age, marital status, occupational status, usual occupation, education, religion and religious participation?

Sex. The sample of the population who participated in the study consisted of 19 males (54.3%) and 16 females (45.7%). The sample was stratified according to sex and therefore did not represent the true ratio of males to females in the population attending the Connaught Clinic from September, 1974 through September, 1975. The Clinic population during that time period consisted of 111 males
and 21 females, a ratio of approximately 5:1.

Age. The age range in the sample was 26 years to 64 years. Both males and females spanned the entire age range as seen in Table 1.

**TABLE 1**

**AGE BY SEX**

<table>
<thead>
<tr>
<th>AGE</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>55 - 64</td>
<td>15.6%</td>
<td>18.7%</td>
<td>17.1%</td>
</tr>
<tr>
<td>45 - 54</td>
<td>26.3%</td>
<td>37.5%</td>
<td>31.4%</td>
</tr>
<tr>
<td>35 - 44</td>
<td>26.3%</td>
<td>25.0%</td>
<td>25.7%</td>
</tr>
<tr>
<td>25 - 34</td>
<td>31.6%</td>
<td>18.8%</td>
<td>25.7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.9%</td>
</tr>
</tbody>
</table>

n=19 n=16 n=35

Note. $\chi^2 (3) = .95187, p = ns$

There was a higher percentage of males in the 25 - 34 years age group and a higher percentage of females in the 45 - 54 years age group. The mean age for males was 41.5 and for females, 45.1. There was no significant difference in the age of males and females.

**Marital status.** A high percentage of males and females were married at time of intake as seen in Table 2. The differences between males and females in regard to marital status were not statistically significant. At time of follow-up, the marital status of the total
sample remained essentially the same with the exception of one male and one female who changed from married to separated status.

### TABLE 2

**MARITAL STATUS AT TIME OF INTAKE BY SEX**

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>73.7%</td>
<td>75.0%</td>
<td>74.3%</td>
</tr>
<tr>
<td>Single</td>
<td>15.8</td>
<td></td>
<td>11.4</td>
</tr>
<tr>
<td>Divorced</td>
<td></td>
<td>12.5%</td>
<td>5.7</td>
</tr>
<tr>
<td>Separated</td>
<td>10.5</td>
<td></td>
<td>5.7</td>
</tr>
<tr>
<td>Widowed</td>
<td></td>
<td>6.2%</td>
<td>2.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

n=19 n=16 n=35

**Note.** \( \chi^2 (4) = 5.94034, \ p = \text{ns} \)

**Occupational status.** Approximately 68% of the total sample was either employed full-time or was occupied as a housewife at time of intake as seen in Table 3. Twenty percent of the sample was unemployed. A higher percentage of females (25%) than males (15.8%) were unemployed, not including housewives.

**Usual occupation.** The majority of the sample (62.9%) had unskilled or semi-skilled jobs as their usual occupation whether or not they were employed at time of intake as seen in Table 4.
### TABLE 3

**OCCUPATIONAL STATUS AT TIME OF INTAKE BY SEX**

<table>
<thead>
<tr>
<th>Occupational Status</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time employed</td>
<td>73.7%</td>
<td>12.5%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Housewife</td>
<td>-</td>
<td>50.0%</td>
<td>22.9%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>15.8%</td>
<td>25.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Part-time employed</td>
<td>-</td>
<td>6.3%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Retired</td>
<td>5.3%</td>
<td>-</td>
<td>2.9%</td>
</tr>
<tr>
<td>Student</td>
<td>-</td>
<td>6.3%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Suspended</td>
<td>5.3%</td>
<td>-</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.1%</td>
<td>100.1%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Note: n=19 for Male, n=16 for Female, n=35 for Total* 

### TABLE 4

**USUAL OCCUPATION OF TOTAL SAMPLE**

<table>
<thead>
<tr>
<th>Usual Occupation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-skilled and unskilled</td>
<td>62.9%</td>
</tr>
<tr>
<td>White collar</td>
<td>17.1%</td>
</tr>
<tr>
<td>Housewife</td>
<td>11.4%</td>
</tr>
<tr>
<td>Professional</td>
<td>8.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Note: n=35*
Education. The last grade completed in school ranged from grade three to graduation from university as seen in Table 5. Although more males attended high school, all of the females who attended high school completed grades 11, 12, or 13 whereas only 21.1% of the males completed those grades.

TABLE 5
EDUCATION BY SEX

<table>
<thead>
<tr>
<th>LAST COMPLETED YEAR</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade school (3-8)</td>
<td>21.1%</td>
<td>37.5%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Secondary school (9-12)</td>
<td>63.1%</td>
<td>37.5%</td>
<td>51.4%</td>
</tr>
<tr>
<td>Grade 13</td>
<td></td>
<td>12.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Some College or University</td>
<td>10.5%</td>
<td>6.3%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Completed University</td>
<td>5.3%</td>
<td>6.3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
<td>100.1%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

n=19 n=16 n=35

Religion. The majority of the sample was Roman Catholic (60%). Approximately 34% of the sample was Protestant. There was one male who was Greek Orthodox and one female for whom there was no data available.

Church attendance. Of the sample, 71.4% did not attend church prior to intake or attended five times a year or less as seen in Table 6. Of the females, 68.7% attended church at some point during the year prior to
intake whereas only 47.4% of males attended church during that time.

### TABLE 6

<table>
<thead>
<tr>
<th>CHURCH ATTENDANCE PRIOR TO INTAKE</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>No attendance</td>
<td>52.6%</td>
<td>31.3%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Five times per year or less</td>
<td>31.7</td>
<td>25.1</td>
<td>28.5</td>
</tr>
<tr>
<td>Once or twice per month</td>
<td>5.2</td>
<td>18.7</td>
<td>11.5</td>
</tr>
<tr>
<td>Once or twice per week</td>
<td>10.5</td>
<td>18.7</td>
<td>14.2</td>
</tr>
<tr>
<td>Daily</td>
<td>-</td>
<td>6.2</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>n</strong></td>
<td>19</td>
<td>16</td>
<td>35</td>
</tr>
</tbody>
</table>

After completion of the program there was a small decline in church attendance, especially on the part of the females. One female changed her pattern from daily to weekly attendance. According to this female, daily church attendance was an attempt to escape the strain of family life in the mornings. She considered decreased church attendance a positive step toward accepting family responsibilities. The male pattern of attendance during the follow-up period remained essentially the same as it was prior to treatment. Several people in the sample said that although they did not attend church,
they had a deep faith.

**Hypothesis one.**

There would be a significant difference between males and females in regard to age of first drink, age at which regular drinking began and number of years of problem drinking.

**Age of first drink.** Of the total sample, 82.8% had their first drink under the age of 22. Of the females, 37.5% had their first drink after the age of 21 whereas all of the males had their first drink before age 21 as seen in Table 7.

**TABLE 7**

**AGE OF FIRST DRINK BY SEX**

<table>
<thead>
<tr>
<th>AGE OF FIRST DRINK</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (31-40)</td>
<td>-</td>
<td>18.7%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Young adult (22-30)</td>
<td>-</td>
<td>18.8%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Late adolescence (17-21)</td>
<td>21.1</td>
<td>31.2%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Early adolescence (13-16)</td>
<td>52.6</td>
<td>18.8%</td>
<td>37.1%</td>
</tr>
<tr>
<td>Childhood years (5-12)</td>
<td>26.3</td>
<td>12.5%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

| TOTAL                  | 100.0% | 100.0% | 100.0% |
| n=19                   | n=16   | n=35   |

**Note.** $\chi^2 (4) = 10.98964$, $p < .05$

Crâmer's $V = .56035$

There was a moderate association, statistically significant, between males and females in regard to the age of first drink.
Age began regular drinking. Late adolescence was the period in which the highest percentage of the sample (47.1%) began to drink regularly as seen in Table 8.

**TABLE 8**

**AGE BEGAN REGULAR DRINKING BY SEX**

<table>
<thead>
<tr>
<th>AGE BEGAN REGULAR DRINKING</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (31-40)</td>
<td>5.6%</td>
<td>37.5%</td>
<td>20.6%</td>
</tr>
<tr>
<td>Young adult (22-30)</td>
<td>5.5</td>
<td>12.5</td>
<td>8.8</td>
</tr>
<tr>
<td>Late adolescence (17-21)</td>
<td>55.6</td>
<td>37.5</td>
<td>47.1</td>
</tr>
<tr>
<td>Early adolescence (13-16)</td>
<td>33.3</td>
<td>6.2</td>
<td>20.6</td>
</tr>
<tr>
<td>Childhood years (5-12)</td>
<td></td>
<td>6.3</td>
<td>2.9</td>
</tr>
</tbody>
</table>

| TOTAL                     | 100.0%| 100.0%| 100.0%  |
|                          | n=18  | n=16  | n=34    |

Note. $\chi^2 (4) = 9.39103$, p = ns

More males (88.9%) than females (50%) began regular drinking at late adolescence or earlier.

The difference between males and females in regard to this variable missed being statistically significant by a small margin possibly indicating a trend in that direction.

**Number of years of problem drinking.** The mean number of years of problem drinking for males was nine and for females was seven. The highest proportion of the sample (37.5%) had been drinking excessively for four years or less at time of intake, as seen in Table 9. The differences
between males and females in regard to this variable were not statistically significant.

TABLE 9
NUMBER OF YEARS OF PROBLEM DRINKING BY SEX

<table>
<thead>
<tr>
<th>YEARS OF PROBLEM DRINKING</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 - 34</td>
<td>5.9%</td>
<td>6.7%</td>
<td>6.2%</td>
</tr>
<tr>
<td>15 - 19</td>
<td>23.5</td>
<td>6.6</td>
<td>15.6</td>
</tr>
<tr>
<td>10 - 14</td>
<td>29.4</td>
<td>13.4</td>
<td>21.9</td>
</tr>
<tr>
<td>5 - 9</td>
<td>11.8</td>
<td>26.6</td>
<td>18.8</td>
</tr>
<tr>
<td>0 - 4</td>
<td>29.4</td>
<td>46.7</td>
<td>37.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Note. n missing observations = 3
$\chi^2 (4) = 4.19824, p = ns$

Changes in the Sample Between the Year Preceding Intake and the Follow-up Period

Research question two.

What changes have occurred in drinking involvement when comparing the year preceding intake to the time between completion of the three-week program and time of follow-up?

As defined in the previous chapter, the categories "abstinent," "much improved" and "somewhat improved" all
indicated varying degrees of decrease in alcohol consumption. Therefore, 71.4% of the sample achieved some decrease in alcohol consumption during the follow-up period as seen in Table 10. The categories "abstinent," "much improved," and "little improved" indicated a change in drinking pattern. Therefore, 54.3% of the sample changed their drinking pattern from daily drinking to periodic or no drinking. Because the data regarding decrease in alcohol consumption was based on self-report, the findings must be regarded with caution.

**TABLE 10**

<table>
<thead>
<tr>
<th>CHANGES IN DRINKING INVOLVEMENT</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinent</td>
<td>31.6%</td>
<td>-</td>
<td>17.1%</td>
</tr>
<tr>
<td>Much improved</td>
<td>15.8</td>
<td>43.8</td>
<td>28.6</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>31.6</td>
<td>18.8</td>
<td>25.7</td>
</tr>
<tr>
<td>Little or not improved</td>
<td>21.1</td>
<td>37.5</td>
<td>28.6</td>
</tr>
</tbody>
</table>

**TOTAL**

100.0% 100.1% 100.0%

n=19 n=16 n=35

**Note.** $\chi^2 (3) = 8.80756, p < .05$

Lambda = .375 (asymmetric, sex dependent)
Four of the people who were abstinent had completed the program eight months before the time of follow-up and were all in one group. The remainder were fairly well equally distributed over the 6 to 18 month follow-up period.

Hypothesis two.

There would be significant differences between males and females in regard to decrease in drinking involvement.

As seen in Table 10, 62.6% of the females had some decrease in alcohol involvement compared to 79% of the males. No females were completely abstinent during the follow-up period. There was a strong association between sex and decrease in drinking involvement which was statistically significant, as shown in Table 10.

Hypothesis three.

There would be an association between decrease in drinking involvement and frequency of attendance at the five weekly Clinic follow-up meetings.

Approximately 43% (15) of the sample attended all five meetings. These 15 people were fairly equally distributed in all five "changes in drinking involvement" categories. An additional 11.4% (4) of the sample attended four meetings indicating that almost 55% of the sample attended four or more meetings.

There was an association which was not significant between frequency of attendance at the five follow-up meetings and changes in drinking involvement, as shown
in Table 11.

**Hypothesis four.**

There would be an association between decrease in drinking involvement and frequency of attendance of follow-up services.

Follow-up services included both professional treatment and self-help groups. The highest percentage of the sample (45.7%) attended follow-up services one to nine times. These 16 people spanned the entire range of "changes in drinking involvement" categories. There was an association which was not significant between changes in drinking involvement and frequency of attendance at follow-up services. Gamma = .21408. \( \chi^2 (15) = 20.54297 \), \( p = ns \). No one attended professional follow-up services more than 20 times. Three people attended self-help treatment more than 100 times. Separate statistics for attendance at professional and self-help treatment services are given under Research Question Three.

**Hypothesis five.**

There would be an association between decrease in drinking involvement in the follow-up period and improvement in the employment situation.

Table 12 shows that there was a strong association, which had statistical significance, between decrease in drinking involvement and improvement in the employment situation. Eight people in the "improved" category for employment were either "abstinent" or "much improved" in regard to drinking involvement. Approximately 37% of the females and 31% of the males were in the "improved" category.
### TABLE 11

<table>
<thead>
<tr>
<th>FREQUENCY OF ATTENDANCE AT FOLLOW-UP MEETINGS</th>
<th>NOT IMPROVED + LITTLE IMPROVED</th>
<th>SOMEWHE</th>
<th>T IMPROVED</th>
<th>MUCH IMPROVED</th>
<th>ABSTINENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 and 5 meetings</td>
<td>17.2% (6)</td>
<td>14.2% (5)</td>
<td>11.4% (4)</td>
<td>11.4% (4)</td>
<td>54.2% (19)</td>
<td></td>
</tr>
<tr>
<td>3, 2, 1 meetings</td>
<td>5.7 (2)</td>
<td>11.4 (4)</td>
<td>11.4 (4)</td>
<td>2.9 (1)</td>
<td>31.8 (11)</td>
<td></td>
</tr>
<tr>
<td>No meetings</td>
<td>5.7 (2)</td>
<td></td>
<td>5.7 (2)</td>
<td>2.9 (1)</td>
<td>14.3 (5)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>28.7% (10)</td>
<td>25.6% (9)</td>
<td>28.8% (10)</td>
<td>17.2% (6)</td>
<td>100.0% (35)</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Frequencies are in parentheses

\[
\chi^2 (6) = 4.24928, \ p = ns
\]
TABLE 12
CHANGES IN EMPLOYMENT SITUATION BY CHANGES
IN DRINKING INVOLVEMENT

<table>
<thead>
<tr>
<th>CHANGES IN EMPLOYMENT SITUATION</th>
<th>NOT IMPROVED + LITTLE IMPROVED</th>
<th>SOMEWHAT IMPROVED</th>
<th>MUCH IMPROVED</th>
<th>ABSTINENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>4.5%(1)</td>
<td>13.6%(3)</td>
<td>22.7%(5)</td>
<td>13.6%(3)</td>
<td>54.5%(12)</td>
</tr>
<tr>
<td>No change - still a problem</td>
<td>18.2 (4)</td>
<td>-</td>
<td>4.5 (1)</td>
<td>-</td>
<td>22.7 (5)</td>
</tr>
<tr>
<td>Worse</td>
<td>13.6 (3)</td>
<td>9.1 (2)</td>
<td>-</td>
<td>-</td>
<td>22.7 (5)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36.3%(8)</td>
<td>22.7%(5)</td>
<td>27.2%(6)</td>
<td>13.6%(3)</td>
<td>99.9%(22)</td>
</tr>
</tbody>
</table>

Note. Frequencies are in parentheses.

n total = 22 because housewives, retirees and people with no employment problems were not included.

$G (\text{gamma}) = .75652$

$\chi^2 (6) = 12.67139, p < .05$
in regard to employment. A total of 54.5% of the sample showed improvement in their employment situation.

Hypothesis six.

There would be an association between decrease in drinking involvement in the follow-up period and improvement in family relationships.

**Spouse.** As seen in Table 13 there was an association which was not significant between improvement in relationships with spouse and changes in drinking involvement. Although approximately 45% of the sample reported "improved" or "much improved" relationships only half of these people were in the "much improved" or "abstinent" category in regard to their drinking as seen in Table 13.

**Children.** There was an association which was not significant between improvement in relationships with children and changes in drinking involvement, $G (=\gamma) = .3090$. $\chi^2 (12) = 6.39375, p = ns$. Approximately 32% of the sample indicated "much improved" in their relationships with their children whereas only approximately 21% indicated "much improved" in their relationship with their spouse.

**Treatment Experiences of the Sample**

**Research question three.**

What were the treatment experiences for drinking or drinking related problems of those people who completed the intensive phase of the Connaught Clinic program? Specifically:

1. How often did people obtain treatment prior to attending the Clinic program?
# Table 13

**Improvement in Relationship with Spouse by Changes in Drinking Involvement**

<table>
<thead>
<tr>
<th>Improvement in Relationship with Spouse</th>
<th>Not Improved + Little Improved</th>
<th>Somewhat Improved</th>
<th>Much Improved</th>
<th>Abstinent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much improved</td>
<td>-</td>
<td>6.9% (2)</td>
<td>3.4% (1)</td>
<td>10.3% (3)</td>
<td>20.7% (6)</td>
</tr>
<tr>
<td>Improved</td>
<td>3.4 (1)</td>
<td>10.3 (3)</td>
<td>10.3 (3)</td>
<td>-</td>
<td>24.1 (7)</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>13.8 (4)</td>
<td>3.4 (1)</td>
<td>6.9 (2)</td>
<td>3.4% (1)</td>
<td>27.6 (8)</td>
</tr>
<tr>
<td>Not improved</td>
<td>6.9 (2)</td>
<td>3.4 (1)</td>
<td>3.4 (1)</td>
<td>-</td>
<td>13.8 (4)</td>
</tr>
<tr>
<td>Worse</td>
<td>3.4 (1)</td>
<td>3.4 (1)</td>
<td>6.9 (2)</td>
<td>-</td>
<td>13.8 (4)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27.6% (8)</strong></td>
<td><strong>27.6% (8)</strong></td>
<td><strong>31.0% (9)</strong></td>
<td><strong>13.8% (4)</strong></td>
<td><strong>100.0% (29)</strong></td>
</tr>
</tbody>
</table>

**Note.** Frequencies are in parentheses.

n total = 29; missing observations are due to single or widowed status or no response.

G (gamma) = .36255

χ² (12) = 14.74214, p = ns
Professional treatment. Prior to attending the Clinic 58.8% of the sample had no prior professional treatment as seen in Table 14. One male went for treatment 20 times but the other eight who went for prior treatment went four times or less. Four of the six females who went for treatment went from 9 to 15 times. The mean frequency of attendance was approximately two times or less. This sample did not seem to be treatment-oriented prior to attending the Clinic since over 80% received treatment two times or less.

TABLE 14

FREQUENCY OF PRIOR PROFESSIONAL TREATMENT BY SEX

<table>
<thead>
<tr>
<th>FREQUENCY OF TREATMENT SESSIONS</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>No treatment sessions</td>
<td>52.6%</td>
<td>62.5%</td>
<td>57.1%</td>
</tr>
<tr>
<td>1 to 6</td>
<td>42.1</td>
<td>12.5</td>
<td>28.5</td>
</tr>
<tr>
<td>7 to 20</td>
<td>5.3</td>
<td>18.7</td>
<td>11.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
<td>93.7%</td>
<td>97.0%</td>
</tr>
</tbody>
</table>

n=19 n=15 n=34

Note. n missing observations = 1

Self-help treatment. Of the 15 people (42.9%) in the sample who attended Alcoholics Anonymous (A.A.) prior to attending the Clinic, none attended regularly. Eleven of the people attended once or twice and one two attended
10 or more times. More females (56.2%) than males (31.6%) attended A.A. prior to the Clinic but it was two males who attended 10 or more times. The mean frequency of attendance was once.

Only one person attended the Open Door Club prior to attending the Clinic. Attendance was for a total of two times.

2. What types of professional treatment did people receive prior to attending the Clinic?

Medical treatment was the most common and was received by approximately 43% of the sample as seen in Table 15.

<table>
<thead>
<tr>
<th>KINDS OF PRIOR TREATMENT</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>36.8%</td>
<td>50.0%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Social agency</td>
<td>10.5</td>
<td>-</td>
<td>5.7</td>
</tr>
<tr>
<td>Clergy</td>
<td>5.2</td>
<td>12.5</td>
<td>8.5</td>
</tr>
<tr>
<td>Alcoholism treatment facilities</td>
<td>10.5</td>
<td>18.7</td>
<td>14.2</td>
</tr>
<tr>
<td>No treatment</td>
<td>52.6</td>
<td>62.5</td>
<td>57.1</td>
</tr>
</tbody>
</table>

n=19  n=16  n=35

Note. Due to combinations of responses, column totals are more than 100%.
3. Through what source were people referred to the Clinic?

Physicians or hospitals were the referral source for 54.3% of the sample. Employers referred an additional 14.3% to the Clinic. The Addiction Research Foundation and self-referrals each constituted 11.4% of the referrals. The three persons comprising the remaining 8.7% of the sample were referred by a social agency, a Public Health Nurse and a combination of a physician and the Addiction Research Foundation, respectively.

4. How soon after completing the Clinic program did people feel the need for treatment?

Due to inconsistencies in the data collection procedure, the responses to this question were invalid.

5. What treatment mode did people believe would be helpful after completing the Clinic program?

Twenty percent of the sample did not want any particular type of treatment mode. One-to-one, group and marital counselling were named most frequently as being helpful modes for treatment as seen in Table 16. Fifty-six percent of the females and 26% of the males saw group counselling as being helpful.

6. How often did people receive treatment subsequent to attending the Clinic?

Professional treatment. Subsequent to attending the Clinic, 65.7% of the sample obtained professional treatment as seen in Table 17. This percentage represented an increase of approximately 25% over those people who obtained professional treatment prior to attending the Clinic.
### TABLE 16

**MODE OF TREATMENT CONSIDERED HELPFUL BY SEX**

<table>
<thead>
<tr>
<th>MODE OF TREATMENT</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to one counselling</td>
<td>36.8%</td>
<td>31.2%</td>
<td>42.6%</td>
</tr>
<tr>
<td>Group counselling</td>
<td>26.3%</td>
<td>56.2%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Marital counselling</td>
<td>36.8%</td>
<td>31.2%</td>
<td>34.3%</td>
</tr>
<tr>
<td>Family counselling</td>
<td>10.5%</td>
<td>12.5%</td>
<td>11.4%</td>
</tr>
<tr>
<td>No treatment</td>
<td>15.7%</td>
<td>25.0%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

n=19  n=16  n=35

**Note.** Due to combinations of responses, column totals are more than 100%.

### TABLE 17

**FREQUENCY OF FOLLOW-UP PROFESSIONAL TREATMENT BY SEX**

<table>
<thead>
<tr>
<th>FREQUENCY OF TREATMENT</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>No treatment</td>
<td>42.1%</td>
<td>25.0%</td>
<td>34.3%</td>
</tr>
<tr>
<td>1 to 6</td>
<td>42.1%</td>
<td>43.8%</td>
<td>42.9%</td>
</tr>
<tr>
<td>7 to 20</td>
<td>15.8%</td>
<td>31.3%</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

TOTAL 100.0%  n=19  100.0%  n=16  100.0%  n=35

**Note.** $\chi^2 (2) = 3.04065$, $p = ns$
The 15 people who had treatment one to six times were fairly evenly distributed throughout the category. Of the eight people who had treatment 7 to 20 times, four went 10 times, two went 12 and 15 times and two went 20 times. The mean frequency of attendance was four times, a rise of two times from frequency of attendance at prior treatment. Differences in frequency of attendance between males and females were not significant.

**Self-help treatment.** Eighteen people (51.4%) attended A.A. since completing the Clinic program, with only three people attending regularly throughout the follow-up period. The mean frequency of attendance was 41 times. This figure was influenced by four people who attended A.A. between 100 and 540 times. An increase of about 10% attended A.A. between intake and follow-up.

The three people who attended regularly had completed the Clinic program 11, 13 and 18 months before the follow-up study. Their attendance ranged from twice a week to daily for a total of 100, 390 and 540 times, respectively. Two of these people are in the "much improved" category and the third person has been totally abstinent since completion of the program.

Fifteen people attended the Open Door Club in the follow-up period with only one attending regularly. Frequency of attendance ranged from 1 to 36 times. The mean frequency was two times. An increase of 40% attended the Open Door Club between intake and follow-up.
7. What types of treatment did the people receive subsequent to attending the Clinic?

During the follow-up period, the largest percentage of the sample (approximately 46%) obtained treatment at alcoholism treatment facilities as seen in Table 18. This percentage was a marked increase from the 14% who obtained treatment at alcoholism treatment facilities prior to attending the Clinic. Whereas a greater percentage of females obtained treatment at alcoholism treatment facilities prior to attending the Clinic, a much greater percentage of males attended these facilities subsequent to attending the Clinic. This was probably due in part to the lack of a detoxification centre or halfway house for females in Windsor. Of the two people who received treatment in the "other" category, one person attended a church group that she considered therapeutic and one person attended a therapy group at the university. Of the people who had treatment, nine had medical treatment, eight had one-to-one counselling, eight had couple counselling, seven had group counselling, and four had family counselling. Several people had combinations of treatment.

8. What were the reasons that the people did not obtain treatment if they had felt the need for it?

There was no consistent trend in the responses to this question. Of the 13 people who responded, three said that they did not obtain treatment because they did not make the effort. Two others said that they had too much pride to ask for help. Another two responded that they
preferred to do it themselves. Two of the females did not obtain treatment because their husbands refused to go. The remaining four people had individual responses.

| TABLE 18 |
| KINDS OF FOLLOW-UP TREATMENT |
| BY SEX |

<table>
<thead>
<tr>
<th>KINDS OF TREATMENT</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>31.5%</td>
<td>43.7%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Social agency</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clergy</td>
<td>-</td>
<td>12.5%</td>
<td>5.7</td>
</tr>
<tr>
<td>Alcoholism treatment facilities</td>
<td>52.6%</td>
<td>31.2%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Other</td>
<td>5.2%</td>
<td>12.5%</td>
<td>8.5%</td>
</tr>
<tr>
<td>No treatment</td>
<td>42.1%</td>
<td>25.0%</td>
<td>34.2%</td>
</tr>
</tbody>
</table>

n=19 | n=16 | n=35

**Note.** Due to combinations of responses, column totals are more than 100%.

9. What types of treatment were wanted but not available.

Only eight people, three males and five females, responded to this question. No two people responded the same way. Some responses were: group reunion, group therapy at the Clinic, marital counselling with a recovered alcoholic couple, weekend retreats for females and a group of other married female alcoholics.
In describing the treatment experiences of the sample, it became apparent that there was a considerable increase in frequency of use of both self-help and professional treatment between intake and time of the follow-up study. The mean frequency for all kinds of prior treatment was four times and the mean frequency for all kinds of follow-up treatment was 48 times. Only 11.4% of the sample received no follow-up treatment of any kind whereas 42.9% of the sample received no prior treatment of any kind. Alcoholism treatment facilities both professional and self-help were the most frequent treatment used in the follow-up period whereas medical treatment was used most frequently prior to the Clinic. Ten percent more females than males received treatment during each time period.

**Hypothesis seven.**

Both sexes would be more likely to have used out-patient counselling than residential treatment services for the treatment of alcoholism.

Of those people who used any type of alcoholism treatment service other than the three-week intensive phase of the Connaught Clinic, the highest percentage for both males (68.4%) and females (37.5%) used out-patient counselling as seen in Table 19. Therefore, the prediction in the hypothesis was substantiated by the findings. Fifty percent of the females and only about 16% of the males used no alcoholism treatment service other than the Connaught Clinic. Part of the reason for the disparity in the use of these facilities may be
be that there was no detoxication centre or halfway house for females in Windsor.

**TABLE 19**

**USE OF ALCOHOLISM TREATMENT SERVICES BY SEX**

<table>
<thead>
<tr>
<th>ALCOHOLISM TREATMENT SERVICES</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-patient counselling</td>
<td>78.4%</td>
<td>37.5%</td>
<td>54.2%</td>
</tr>
<tr>
<td>In-patient treatment</td>
<td>10.5%</td>
<td>18.7%</td>
<td>14.2%</td>
</tr>
<tr>
<td>Detoxication centre</td>
<td>26.3%</td>
<td>-</td>
<td>14.2%</td>
</tr>
<tr>
<td>Halfway house</td>
<td>5.2%</td>
<td>-</td>
<td>2.8%</td>
</tr>
<tr>
<td>No treatment</td>
<td>15.7%</td>
<td>50.0%</td>
<td>31.4%</td>
</tr>
</tbody>
</table>

\[n=19 \quad n=15 \quad n=34\]

**Note.** \( n \) missing observations = 1

Due to combinations of responses, column totals are more than 100%.

**Hypothesis eight.**

Out-patient counselling would be mentioned more frequently by both sexes as possibly being helpful in the future than would detoxication centres, halfway houses and in-patient treatment facilities.

In the total sample, the highest percentage of people (48.5%) mentioned more often out-patient counselling as possibly being helpful as seen in Table 20. Although out-patient counselling was mentioned most frequently by the males (57.8%) both in-patient treat-
ment and halfway houses were mentioned more frequently by the females (43.7% for each). Therefore, the hypothesis was not completely substantiated by the findings.

TABLE 20
HELPFULNESS OF ALCOHOLISM TREATMENT SERVICES BY SEX

<table>
<thead>
<tr>
<th>ALCOHOLISM TREATMENT SERVICES</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-patient counselling</td>
<td>57.8%</td>
<td>37.5%</td>
<td>48.5%</td>
</tr>
<tr>
<td>In-patient treatment</td>
<td>31.5</td>
<td>43.7</td>
<td>37.1</td>
</tr>
<tr>
<td>Detoxication centre</td>
<td>26.3</td>
<td>25.0</td>
<td>25.7</td>
</tr>
<tr>
<td>Halfway house</td>
<td>31.5</td>
<td>43.7</td>
<td>37.1</td>
</tr>
<tr>
<td>No treatment helpful</td>
<td>10.5</td>
<td>-</td>
<td>5.7</td>
</tr>
</tbody>
</table>

n=18  n=13  n=31

Note. n missing observations = 4
Due to combinations of responses, column totals are more than 100%.

In comparing the findings in Tables 19 and 20, more of the sample considered residential treatment as possibly being helpful than have actually used it. People were asked to give reasons why they saw a particular service as possibly being helpful. There was some indication that people linked use of residential treatment in the future with increased or resumed drinking. There was also some indication that a small percentage of the sample had no
knowledge of the nature of some of the alcoholism treatment facilities.

**Treatment Needs of the Female**

**Hypothesis nine.**

There would be a significant difference between males and females in regard to the rating of helpfulness of the total Connaught Clinic program.

Approximately 53% of the males rated the total Clinic program "extremely helpful" whereas only 19% of the females did so. The ratings of "very helpful" were similar for both sexes: 26.3% for males and 31.3% for females. The rating of "somewhat helpful" was 43.8% for females and 15.8% for males. These differences were not statistically significant, $\chi^2 (3) = 5.14992, p = \text{ns}$. No one rated the program "not at all helpful."

**Hypothesis ten.**

In a rating of different aspects of the treatment program, males would rate group therapy higher in terms of helpfulness to themselves than would females.

There was very little difference in the actual ratings of helpfulness of group therapy by males and females and there was no statistically significant difference, $\chi^2 (4) = 5.39273, p = \text{ns}$. There was a very slight association between sex and the rating of the helpfulness of group therapy, $G (\gamma) = .10$.

In a ranking of helpfulness of five aspects of the Clinic program, 12 males and seven females ranked group
therapy in the first or second position. There was no statistical significance in these rankings. $\chi^2 (4) = 2.9479$, $p = ns$.

**Hypothesis eleven.**

Females would link their problem drinking to stresses of domestic life whereas males would link their problem drinking to their habitual lifestyle or work related pressures.

Approximately 94% of the females and 21% of the males linked their problem drinking to stresses of domestic life as seen in Table 21. Approximately 58% of the males and 13% of the females linked their problem drinking to habitual lifestyle. Job pressure was linked to problem drinking by about 16% of the males and 6% of the females. There was a strong association between sex and reasons for problem drinking, which was statistically significant as noted in Table 21.

**Hypothesis twelve.**

At the time of intake, the majority of the females would have ranked the category "reasons affecting domestic relations" as most influential in their decision to stop drinking whereas males would have ranked the category "reasons affecting employment" or "financial security" as the most influential.

Ten males (52.6%) and ten females (62.5%) gave "reasons affecting domestic relations" as the primary reason for stopping. The next largest percentage of males (26.3%) ranked "mental health" as the primary reason for stopping drinking. "Physical health" was ranked by the next largest percentage of females (25%)
as the primary reason for stopping drinking. Only a small percentage of the sample gave "employment" or "financial security" as the primary reason for stopping drinking.

There were no significant differences between males and females in regard to this hypothesis, $\chi^2 (4) = 6.79276$, $p = ns$.

TABLE 21

REASONS FOR PROBLEM DRINKING

BY SEX

<table>
<thead>
<tr>
<th>REASONS FOR PROBLEM DRINKING</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stresses of domestic life</td>
<td>21.0% (4)</td>
<td>93.7% (15)</td>
<td>54.2% (19)</td>
</tr>
<tr>
<td>Habitual life style</td>
<td>57.8 (11)</td>
<td>12.2 (2)</td>
<td>37.1 (13)</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>10.5 (2)</td>
<td>6.2 (1)</td>
<td>8.5 (3)</td>
</tr>
<tr>
<td>General tension</td>
<td>15.7 (3)</td>
<td>-</td>
<td>8.5 (3)</td>
</tr>
<tr>
<td>Job pressure</td>
<td>15.7 (3)</td>
<td>6.2 (1)</td>
<td>11.4 (4)</td>
</tr>
<tr>
<td>Stress of physical illness</td>
<td>10.5 (2)</td>
<td>-</td>
<td>5.7 (2)</td>
</tr>
</tbody>
</table>

n=18 n=15 n=33

Note. n missing observations = 2
Due to combination of responses, column totals are more than 100%
Frequencies are in parentheses
$\chi^2 (5) = 18.45756$, $p < .01$
Cramer's "V" = .75
Hypothesis thirteen.

Females would prefer a treatment group composition of approximately equal numbers of males and females and males would prefer mostly or all males in the group.

Thirteen males (68.4%) and thirteen females (81.3%) wanted a group composition of equal numbers of males and females. Therefore, there were no real differences between males and females in relation to group composition preference, indicating that the hypothesis was not confirmed.

Hypothesis fourteen.

Females would prefer one male and one female therapist for group therapy whereas males would prefer two males as therapists.

Sixty-nine percent of both males and females preferred one male and one female therapist and 31% of both sexes had no preference.

As in the preceding hypothesis, the prediction concerning females was substantiated by the findings whereas for the males it was not.

Comparison of Key Findings with Other Studies of Alcoholism Treatment

Demographic Data and Alcohol Use

The sample was compared in terms of demographic data and certain aspects of alcohol use with the patients of the day hospital program at Donwood Institute, another Ontario alcoholism treatment program (Dietrich, 1975). The mean age of the Clinic sample was 43 years which was
similar to the mean age of the Donwood population which was 44 years. Although the Clinic sample was stratified according to sex and contained 19 males and 16 females, the ratio of males to females for the Clinic population for September 1974-75 was 5:1, the same as the male to female ratio in the Donwood Study, which had 41 males and nine females. Seventy-four percent of the Clinic sample were married whereas 60% of the day hospital patients at Donwood were married. Twenty percent of the Clinic patients were unemployed at time of intake whereas 26% of the Donwood patients were unemployed. Note that there were more than twice as many males in the Donwood study.

The majority of the Clinic sample were unskilled or semi-skilled workers whereas the majority of the patients of the day hospital program at Donwood were in business, clerical and semi-professional work. The mean number of years completed in school was 10.5 for the Clinic patients and 12.6 for the day hospital patients at Donwood. The majority of the Clinic patients were Roman Catholic (60%) whereas the majority of the Donwood patients were Protestant (82%).

Regarding alcohol use, the mean number of years of regular drinking was 26 for the Clinic sample and approximately 22 for the Donwood group. The mean number of years of excessive drinking was 8.6 for the Clinic sample and 12.2 for the Donwood population.

Several other studies measured differences between
males and females in regard to certain demographic variables and variables pertaining to alcohol use. The present study, and several others, found no significant differences in age of admissions between males and females (Pemberton, 1967; Sclare, 1970; Lisansky, 1957; Fitzgerald, et al., 1971; Curlee, 1970; Pokorny, et al., 1968). In these studies, the mean age was between 40 and 47 years. The present study found no significant differences in the marital status of males and females (Curlee, 1970; Rathod and Thomson, 1971; Selzer and Holloway, 1957). Other studies reported no significant differences between males and females in regard to marital status (Lisansky, 1957; Sclare, 1970).

The present study showed that males and females had been drinking excessively for approximately an equal number of years. Some studies have shown no differences between males and females in age of onset or number of years of problem drinking (Pemberton, 1967; Selzer and Holloway, 1957). Other studies have shown that females entered treatment after a shorter period of problem drinking than did males (Lisansky, 1957; Rathod and Thomson, 1971; Sclare, 1970; Curlee, 1970).

The present study showed a significant difference between males and females in regard to age of first drink. More females had their first drink at a later age than did males.
This finding contradicted the evidence of Selzer and Holloway (1957) who found no significant difference between men and women in regard to age of first drink. The findings of Jones (1971) contradicted the findings in the present study by showing that more females had their first drink at an earlier age than did males.

In the present study there was a significant difference between males and females in regard to reasons associated with problem drinking. Other studies also cited marital discord, domestic stress and family-related problems as the reason more females than males gave for increased drinking or as a precipitating factor in hospital admissions (Curlee, 1970; Sclare, 1970).

Changes in Regard to Drinking Involvement During the Follow-up Period

In the Clinic sample, 17% of patients were completely abstinent during the follow-up period and an additional 28.6% showed much improvement in terms of less frequent use of alcohol and a decrease in the amount consumed at any one time. An additional 25.7% showed some decrease in amount used. Therefore, approximately 71% of the sample showed some decrease in alcohol consumption. Comparisons were made with other programs where outcome was evaluated at least seven months after treatment began. Gillies, et al., (1974), in a study of several Addiction Research Foundation units, found that most alcoholic patients improve (75%) but that few became abstinent.
(12.7%) during the one year after treatment began. Pokorny, et al., (1968), in a review of literature on outcome, found that trends indicated that up to one-third of treatment populations studied were abstinent and approximately 50% of the people studied were improved. Gerard and Saenger (1966) found that 18% of their population were either abstinent or controlled drinkers for at least six months immediately prior to the study. Of the Donwood day hospital, 68% of the population were abstinent four months after discharge. An additional 26% were improved.

In the Clinic sample, there was a significant difference in the outcomes for males and females. All of those people in the "abstinent" category were males. Pemberton (1971), and Glatt (1961), also found that more males than females had higher rates of improvement. Fitzgerald, et al., (1971) found no significant differences between males and females. Gerard and Saenger (1966) found that housewives had a higher improvement rate than women in other employment categories.

In the Clinic sample, there was a strong significant association between improvement in employment and decrease in drinking involvement. A strong association between these two variables was also found in the Gerard and Saenger study (1966). Pfeffer and Berger (1957) found that both drinking and non-drinking groups decreased their absenteeism during the follow-up period.
There was a moderate, but not significant, association between improvement in family relationships and decreased drinking involvement in the Clinic sample. Improvement in family relationships occurred in twice as many cases as were in the "abstinent" or "much improved" categories for drinking involvement. Gerard and Saenger (1966) found a strong association between these two variables. Rossi (1963) found a strong association between improvement in marital relationships and abstinence but also found a decrease in the quality of sibling relationships in association with abstinence. Pfeffer and Berger (1957) found that for the "abstinent" group there was a significant improvement in family relationships but not so for the "changed pattern" and "drinking" group.

**Attitudes Toward Group Therapy**

The Clinic sample showed no significant differences between male and female attitudes toward group therapy. More females than males considered group counselling as a treatment mode that would be helpful during the follow-up period. This finding contradicted Curlee's (1970) results which showed that more males than females found group therapy helpful. The Clinic finding of no significant differences between males and females in ratings of different aspects of the treatment program was similar to the findings of Kammeier, et al., (1973) who found that males and females had similar perceptions of events of crucial importance in the treatment program.
Summary

This chapter presented the data analysis for the three research questions and 14 hypotheses that were described in Chapter IV. A comparison of key findings with findings in other studies was also presented.
CHAPTER VI

SUMMARY AND CONCLUSION

The primary purpose of the research project was to discover what changes had occurred in the lives of patients who had completed the intensive three-week phase of the Connaught Clinic, a day-care alcoholism treatment program at Windsor Western Hospital Centre. The Clinic, under the joint sponsorship of Windsor Western Hospital Centre and the Addiction Research Foundation, began to operate in March 1971. The researchers chose to investigate a sample of those patients who had completed the Clinic program between September, 1974 through September, 1975. The cut-off date allowed patients to have completed the program for at least six months before the follow-up study interview occurred.

There were two additional purposes for the research project. The first was to describe the Clinic population in terms of demographic data and treatment experiences. The second additional purpose was to see if there were any indications that female patients had special treatment needs.

The rationale for the research project involved several aspects. First, a follow-up study had never been done before on the Clinic patients. Therefore,
there was no knowledge of the effectiveness of the program in terms of what changes had occurred in the lives of the patients since treatment in regard to drinking, family relationships and employment. The need for a follow-up study was recognized by the researchers and by both sponsors of the Clinic. Second, the population had never been described in terms of demographic data so there was no knowledge of how different the population was from that of other treatment programs in Ontario. Third, little information was known about the treatment experiences of the Clinic population before and after attendance at the three-week program. The researchers thought that there might be implications for follow-up programming if more concrete information about treatment were known. Finally, little information was known about the female alcoholic in general and there was speculation in the literature that she might have special treatment needs.

Data was gathered primarily through a semi-structured interview schedule. The sample interviewed was stratified according to sex. Nineteen males, randomly selected, and 16 females, representing those accessible out of a total female population of 21, participated. The population from which the sample was selected attended the Clinic from September, 1974 through September, 1975. Other data was gathered from the Social Assessment Form used by the Clinic and completed during an intake interview.
Summary of Findings

The findings were presented under four major areas: description of the sample; changes in the sample between the year preceding intake and the follow-up period; treatment experiences of the sample; and treatment needs of the female. These four areas were described in Chapter IV with regard to the research questions and hypotheses.

Description of the Sample

The Clinic sample consisted of 19 males and 16 females, ranging in age from 26 to 64 years. The mean age for the males was 41.5 years and for the females, 45.1 years. There was no significant difference in the ages of males and females.

Although at time of intake the majority (74.3%) of males and females were married, there was no significant difference between males and females with regard to marital status. At time of follow-up, the marital status of the total sample was essentially the same.

Of the 20% of the sample who were unemployed, 25% of the females as opposed to 15.8% of the males had unemployed occupational status. Housewives and the full-time employed comprised 68% of the total sample at time of intake.

The sample was comprised mainly of unskilled or semi-skilled workers. Both males and females were asked to describe their usual occupation even if they were not working at
time of intake.

The last grade completed in school ranged from grade three to graduation from university. Although a higher percentage of the males attended secondary school, 50% of the females completed the higher grades of 11, 12 or 13, as compared to 21.1% of the males completing those levels.

Sixty percent and 34% of the sample were Roman Catholic and Protestant, respectively.

Approximately 71% of the sample did not attend church or attended five times a year or less prior to intake. A small decline in church attendance especially with regard to females was evident after completion of the program. Although a high percentage of the sample did not attend or attended infrequently during the year, some of this sample remarked that they had a strong faith.

Although 37.5% of the females had their first drink after age 21, all of the males had their first drink before age 21. There were significant differences between males and females with regard to age of first drink.

Forty-seven percent of the sample began to drink regularly during the late adolescent period. Approximately 89% of the males began regular drinking at late adolescence and earlier, whereas 87.5% of the females began drinking at late adolescence and later. The
statistical difference between males and females missed being significant by a small margin.

The differences between males and females with regard to number of years of problem drinking were not statistically significant. For males, the mean number of years of problem drinking was nine whereas for females it was seven.

**Changes in the Sample Between the Year Preceding Intake and the Follow-up Period**

Of the sample, 71.4% achieved some decrease in alcohol consumption as indicated in the "abstinent," "much improved" and "somewhat improved" categories of changes in drinking involvement. Seventeen percent were completely abstinent during the follow-up period, and an additional 28.6% showed much improvement in terms of less frequent use of alcohol and a decrease in the amount consumed at any one time. An additional 25.7% showed some decrease in amount used.

Approximately 63% of the females and 79% of the males had some decrease in alcohol involvement. No females were completely abstinent. The differences between males and females showed a statistical significance.

Fifteen (43%) of the sample attended all five weekly follow-up meetings, and were fairly equally distributed in all five categories of changes in drinking involvement. With the addition of 11.5% (4) of the
sample attending four meetings, approximately 55% of the sample attended four or more meetings. There was some association which was not significant between frequency of attendance at the five follow-up meetings and changes in drinking involvement.

The highest percentage of the sample (45.7%) attended follow-up services (professional treatment and self-help groups) nine times or less. The association between changes in drinking involvement and frequency of attendance at follow-up services was not significant.

A strong association, which had statistical significance, was evident between decrease in drinking involvement and improvement in the employment situation. In the "improved" category for employment, eight people were either "abstinent" or "much improved." Approximately 37% of the females and 31% of the males were improved in regard to employment. A total of 54.5% of the sample showed improvement in employment.

There was a moderate association which was not significant between improvement in relationships with spouse and changes in drinking involvement. Of the 45% who reported "improved" or "much improved" relationships, half of these people were in the "much improved" or "abstinent" category in regard to drinking involvement.

There was a moderate but not significant association between improvement in relationships with children
and changes in drinking involvement. Approximately 32% of the sample showed much improvement in their relationships with their children.

Treatment Experiences of the Sample

Approximately 57% of the sample had no professional treatment prior to attending the Clinic. The mean frequency of attendance prior to the Clinic program was approximately two times or less, comprising 80% of those who received prior professional treatment.

Of the 15 people (42.9%) of the sample who attended Alcoholics Anonymous prior to attending the Clinic program, none attended regularly. More females (56.2%) than males (31.6%) attended A.A. prior to the Clinic program. The mean frequency of attendance at self-help treatment was once. Only one person attended the Open Door Club twice prior to attending the Clinic.

Medical treatment was the most common and was received by approximately 43% of the sample.

Approximately 54% of the sample were referred to the Clinic by physicians or hospitals. An additional 14.3% were referred by employers. The Addiction Research Foundation and self-referrals each constituted 11.4% of the referrals.

Fifty-six percent of the females and 26% of the males saw group counselling as being a helpful treatment mode for follow-up. Also considered helpful by about
50% of the sample were one-to-one and marital counselling. Approximately 66% of the sample obtained professional treatment subsequent to attending the Clinic. There was an increase of approximately 25% of the sample who had subsequent professional treatment over those who had professional treatment prior to the Clinic. The mean frequency of attendance was four times, a rise of two times from frequency of attendance at prior treatment. There were no significant differences between males and females in regard to frequency of attendance.

Of the 18 people (51.4%) of the sample who attended Alcoholics Anonymous subsequent to attending the Clinic program, three attended regularly throughout the follow-up period. The mean frequency of attendance was 41 times. An increase of about 10% attended A.A. between intake and follow-up. Although 15 people attended the Open Door Club in the follow-up period, only one attended regularly. The mean frequency of attendance at the Open Door Club during the follow-up period was two times. An increase of 40% attended the Open Door Club between intake and follow-up.

The highest percentage (46%) of the sample obtained treatment at alcoholism treatment facilities during the follow-up period. There was a marked increase from the 14% who obtained treatment at alcoholism treatment facilities prior to attending the Clinic.
Whereas a greater percentage of the females obtained treatment at alcoholism treatment facilities prior to attending the Clinic, a much greater percentage of males attended such facilities subsequent to attending the Clinic.

Of the 13 people who responded, a variety of reasons were given why they did not obtain treatment if they had felt the need for it. Some of the reasons were that they had too much pride to ask for help, or that they did not make the effort, or that they preferred to do it themselves.

Of the eight people who responded to a question about what types of treatment were wanted but not available, a variety of responses were given. Some were as follows: group reunion, marital counselling with a recovered alcoholic couple, weekend retreats for females, and a group of other married female alcoholics.

In describing the treatment experiences of the sample, a marked increase in frequency of use of both self-help and professional treatment between time of intake and follow-up was an unexpected finding. It became apparent that there was an increase in the use of alcoholism treatment facilities in the follow-up period.

In regard to the types of alcoholism treatment services used by the patients other than the three-week Clinic program, the highest percentage for both males (68.4%) and females (37.5%) used out-patient counselling.
In addition, the highest percentage of the total sample (48.5%) mentioned out-patient counselling as possibly being most helpful. However, the highest percentage of males (57.8%) mentioned out-patient counselling as possibly being helpful whereas the highest percentage of females (43.7%) mentioned in-patient treatment and a halfway house as possibly being helpful. This finding may indicate a need for this type of facility in Windsor for women. There was some indication that people saw residential treatment as being helpful in the future if they continued or resumed drinking. There was also some indication that a small percentage of the sample had no knowledge of the nature of some of the alcoholism treatment facilities.

**Treatment Needs of the Female**

There was no significant difference in the ratings of males and females regarding the helpfulness of group therapy. This finding supported one previous study and contradicted another. There was also no significant difference between males and females in the rating of helpfulness of the total Connaught Clinic program.

Ninety-four percent of the females and 21% of the males linked problem drinking to strains of domestic life. About 58% of the males and 13% of the females linked their problem drinking to habitual life style. Job pressure was linked to problem drinking by
about 16% of the males and 6% of the females. These differences were statistically significant.

The majority of males (52.6%) and females (62.5%) at time of intake ranked the category "reasons affecting domestic relations" as most influential in their decision to stop drinking. Although the researchers predicted this outcome for the females, the prediction for the males was that they would rank "reasons affecting employment" or "financial security" as the most influential.

The majority of the sample, 68.4% of the males and 81.3% of the females, wanted a group composition of equal numbers of males and females. There were no real differences between males and females in regard to preference for group composition.

Sixty-nine percent of the sample preferred one male and one female therapist, and 31% of both sexes expressed no preference.

With regard to preference of group composition and preference of therapist for group therapy, the findings supported the prediction concerning females, but not concerning the males.

Implications

The rates of improvement regarding changes in drinking involvement were similar to those of other treatment facilities with the exception of Donwood Institute which has unusually high improvement rates. One feature of the Donwood plan is an intensive follow-up
program. The Connaught Clinic, which was staffed by only one full-time treatment person during the time of the study, had not been able to offer an intensive follow-up program. As there is some indication (Smith, 1976) that the majority of Clinic patients are abstinent at the end of the three-week program, it would appear that a follow-up program is needed to maintain the rate of improvement.

It was interesting to note the increase in attendance at treatment services after participation in the Clinic program. This was considered to be a positive sign by the researchers since the Clinic program emphasized the need for follow-up treatment. However, the sporadic nature of attendance at these services implied the need for more careful planning of follow-up referrals. Possibly further detailed study is needed to discover more about the patients' reasons for using or not using follow-up services. The patients did not seem to be adventurous in relation to treatment. They tended to go to familiar facilities such as alcoholism treatment services or medical services. Here again, careful referrals and community development work would be necessary to broaden the range of follow-up contacts for patients. It might be particularly important for the large percentage of males, who linked their drinking to a habitual lifestyle, to broaden their leisure time
activities as part of their follow-up program.

Several hypotheses were formulated to discover whether females had special needs regarding treatment. There were significant differences in regard to only one hypothesis, indicating that males and females had similar treatment needs and preferences for the most part. Since the majority of males and females gave "reasons affecting domestic relations" as the primary reason for stopping drinking, it may indicate that both sexes have a strong need for counselling to overcome the damaging effects of drinking on family relationships. However, since a significantly greater number of females associated problem drinking with stresses of domestic life, it would appear that female patients might benefit from counselling to reassess their domestic role and improve their self-concept in regard to it. Therapy to learn new coping skills might be helpful.

One of the major problems in carrying out this research project was the lack of adequate baseline data with which to compare follow-up data. Also, the lack of verifying sources of information to complement the self-report data by the patients was another problem for the researchers. The implication of these two restrictions on the research is the need for a research component that is built into the program. Additional recommendations are presented later in this chapter.
Limitations of the Study

The chief limitation was the use of self-report data that was not systematically confirmed by outside sources. Actual behaviour changes were not observed by the researchers. Another important limitation was the lack of adequate baseline data from time of intake from which to make comparisons at time of follow-up. This lack limited the scope of the research and restricted the type of indices used.

Lack of a control group precluded knowing what factors led to changes in the patients' lives as there were many intervening variables between time of intake and time of the follow-up study.

The interview schedule was not tested for reliability so there is no certainty that the same responses would be forthcoming if the interview was repeated with this sample. Inconsistencies in interviewing by the researchers were minimized by means of training sessions prior to the interviews.

Five females and six males originally selected for participation were not accessible. Therefore, the sample was not truly representative, although the alternative males were randomly selected.

Generalizability would be limited ideally to patients with similar characteristics in similar treatment programs.
Recommendations

The researchers strongly recommend that a research component be incorporated into the Connaught Clinic program. Specific intake material should be designed so that adequate baseline data regarding certain variables could be obtained. Responses to the intake questionnaire should be reviewed ten days to two weeks after the patients begin the three-week program so that more accurate responses could be obtained. A follow-up questionnaire that matched the intake questionnaire on certain variables should also be designed.

Some variables that might be considered for the research component would be drinking involvement, family relationships, employee absenteeism, attitudes toward work, physical health, mental health, self-concept, use of leisure time, and use of follow-up services.

It is recommended that each patient be given an extensive follow-up interview at six month intervals for at least two years after completion of the three-week program. Large sample research is needed to measure outcome at the Clinic adequately.

It is also recommended that staff remain in contact with the patients on a monthly basis for the two years after completion of the three-week program so that follow-up data can be verified. Records should be kept of this contact, especially regarding information concerning drinking involvement.
In addition, it is recommended that spouses and other significant people in the patients' lives be interviewed to validate follow-up data.

"It is recommended that greater effort be made to link the patients with appropriate treatment resources. It is especially recommended that patients be encouraged to obtain marital counseling to repair damage caused by past drinking behaviour as a large percentage of both males and females reported that they wanted to stop drinking to improve domestic relations. It is also recommended that females be given counselling in order to help them reassess their domestic role and improve their self-image in regard to it. Restructuring of their domestic role or the learning of new coping skills may be necessary. It is recommended that males and possibly females be encouraged to reassess their leisure time activities.

As part of the effort to link patients with appropriate follow-up activities, it is recommended that an educational and community development program be undertaken to inform the community of the purposes and goals of the Connaught Clinic, especially in regard to its follow-up program.

The researchers recommend that the staff record an assessment of each patient at the end of the three-week program and also record the suggested follow-up program for each patient. As part of the research
component, types and frequency of follow-up treatment received by each patient should be analyzed and compared with staff assessment and recommendations for follow-up.

Both males and females reported a preference for equal numbers of males and females in the patient group. It is recommended that an effort be made to encourage the referral of female patients. Although the improvement rate for males was higher than for females, there was no indication that females rated the Clinic less helpful than did males. However, to aid the females in their efforts to cope with their drinking problem, it is recommended that a follow-up group for females be offered.

Although church attendance was not high in the sample, several people indicated that they had a deep faith in God. It is recommended that the spiritual needs of the patients be considered as early in the program as possible. Perhaps a re-affiliation with the church would be possible for some people. Perhaps the spiritual component of A.A. could be emphasized for those people who have faith but who have left the church.

Although not part of the actual findings, it was noticed in describing the Connaught Clinic program that there were 37 people who were accepted into the program but who did not start. An additional 23 people started
but did not complete the program. It is recommended that an exploratory study be made of those people who do not start and who do not complete the program in order to see if there are factors present which may suggest a redefinition of selection criteria.

**Summary**

This chapter presented a summary of the findings of the study. It also discussed the implications of the findings and the limitations of the study. Recommendations for future research and for future programming at the Clinic were made.
APPENDICES
APPENDIX A  INTERVIEW SCHEDULE

Introductory Statements

We are interested in evaluating the clinic program in two ways--

1. We are first of all interested in your opinions about the program—what you found helpful or not helpful. What treatment needs you have had that the program did not meet—What treatment needs might be incorporated into future programs--

2. We also are interested in evaluating the program by learning from you what changes have occurred in your life since completing the three-week phase of the program.

All information will be treated confidentially--

It is very important that you be honest with us and share your real feelings and opinions--negative ones as well as positive ones.
1. Birth Date ____________________ (Age) ______
2. Sex M ______ F ______
3. Marital Status:
   Single _____ Married _____ Widowed _____ Divorced _____
   Separated _____ Common-law _____
4. Usual Occupation _________________________________________
5. Current Occupation _________________________________________
6. Employment Status:
   Full-time employed _____ Part-time employed _____
   Unemployed _____ Student only _____ Housewife only _____
   Retired _____
7. Education (last grade completed)
   Grade 0-8 _____
   Grade 9-10 _____
   Grade 11-12 _____
   Grade 13 _____
   Technical training other than school system _____________
   Community College Some _____ Completed _____
   University Some _____ Completed _____
8. Religious Affiliation
   Protestant _____
   Catholic _____
   Jew _____
   Other _____
   No Response _____
9. Religious attendance (before and after Clinic)

Daily ____
Weekly ____
3 times a month ____
2 times a month ____
Once a month ____
Twice a year or less ____
Not at all ____

10. How would you rate the Connaught Clinic program in terms of helpfulness to you on a scale from one to five?

1 Not helpful 2 Somewhat helpful 3 Moderately helpful 4 Very helpful 5 Extremely helpful

11. In terms of helpfulness to you, please rate the following aspects of the treatment program on a scale from one to five where one is not helpful and five is extremely helpful.

Lectures

1 Not helpful 2 Somewhat helpful 3 Moderately helpful 4 Very helpful 5 Extremely helpful

Group Therapy

1 Not helpful 2 Somewhat helpful 3 Moderately helpful 4 Very helpful 5 Extremely helpful

Films

1 Not helpful 2 Somewhat helpful 3 Moderately helpful 4 Very helpful 5 Extremely helpful

Tapes

1 Not helpful 2 Somewhat helpful 3 Moderately helpful 4 Very helpful 5 Extremely helpful
Individual Counseling

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<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Not helpful</td>
<td>Somewhat helpful</td>
<td>Moderately helpful</td>
<td>Very helpful</td>
<td>Extremely helpful</td>
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</tbody>
</table>

12. Please rank in order of helpfulness to you the following aspects of the treatment program - individual counseling, tapes, films, group therapy, lectures.

13. How many males ____ females ____ were in your group?

14. What types of treatment group would you prefer to be in?
   - All male ____
   - All female ____
   - Mostly male ____
   - Mostly female ____
   - Half male-half female ____
   (No preference ____)

15. Please discuss the reasons for your preference.

16. Would you prefer to have
   - 2 male therapists ____
   - 2 female therapists ____
   - 1 male-1 female therapist ____
   (No preference ____)

17. Please discuss the reasons for your preference.
18. How many of the five weekly follow-up meetings did you attend?
   1     2     3     4     5

19. Did you attend A.A. before attending the Clinic?
   Yes     No

20. Have you attended A. A. since completion of the program?
    Yes     No

21. If yes, how many times a month ___, in all ___,
    since completion of the program?

22. Describe your pattern of attendance?

23. Did you attend the Open Door Club before attending the Clinic?
    Yes     No

24. Have you attended the Open Door Club since completion?
    Yes     No

25. If yes, how many times a month ___, in all ___,
    since completion of the program?

26. Describe your pattern of attendance?

27. Have you attended .001 since completion?
    Yes     No

28. If yes, how many times a month ___, in all ___,
    since completion of the program?
29. If an ongoing follow-up group were available once a week at the Connaught Clinic, which would you prefer to attend?

Clinic _____ ARF. _____ A.A. _____ Open Door _____

None _____ Combination (specify) _________________

30. What has your employment status been since completing the program for at least two-thirds of the time?

Full-time employment _____ Part-time employment _____

Unemployed _____ Housewife only _____ Student only _____

Retired _____

31. Are you working at the same job now that you had prior to treatment?

Yes _____ No _____

32. How many days have you lost from work since completing the program?

0 _____ 1 week _____ 2 weeks _____ 3 weeks _____ 1 month _____
2 months _____ 3 months or more _____

33. What was your employment status prior to treatment?

Full-time employment _____ Part-time employment _____

Unemployed _____ Housewife only _____ Student only _____

Retired _____

34. If unemployed, what was the cause?


35. If unemployed due to suspension or firing due to drinking, have you now been reinstated or have other comparable employment?

36. Please rate your relationship with your spouse since leaving the Clinic program.

5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Much Improved _____ Improved _____ Somewhat Improved _____ Not Improved _____

Worse Improved _____ Improved _____ Improved _____
37. Please rate your relationship with your children since leaving the Clinic program.

5  Much improved
4  Improved
3  Somewhat improved
2  Not improved
1  Worse

38. Please rate your relationship with the adult relative in your home since leaving the Clinic program.

5  Much improved
4  Improved
3  Somewhat improved
2  Not improved
1  Worse

39. How often did you receive treatment or go for help for alcoholism or drinking related problems prior to attending the Clinic (including prior attendance at the Clinic)?

Never ____ Once ____ Twice ____ 3-5 times ____ (specify)
5 or more times ____ (specify)

40. What type of treatment did you receive?

Physician ____ Hospital ____ Social agency ____
Clergy ____ Alcohol treatment agency ____
(specify)
Other ____________________________
(specify)

41. After you completed the Connaught Clinic program did you feel the need for additional treatment?

Yes  No

Immediately or within one month
3 months later
6 months later
12 months later
18 months later

42. How often did you receive treatment since completing the Clinic? (other than 5 week follow-up, A.A., Open Door, or .001 but including Connaught Clinic).

Never ____ Once ____ Twice ____ 3-5 times ____ (specify)
5 or more times ____ (specify)
43. If you felt the need for treatment but did not obtain it, what was the reason?

44. If you did receive treatment, what types of treatment did you in fact receive?

Physician ___ Hospital ___ Social agency ___

Clergy ___ Alcohol treatment agency ___ (specify - C.C.)

Other ___ (specify)

45. What was the focus of your treatment?

Medical ___ One-to-One counseling ___

Group counseling ___ Couple counseling ___

Family counseling ___

46. Was there a type of treatment you felt that you needed but were unable to obtain?

Yes ___ No ___

47. If yes, what kind?

48. Which of the following types of treatment do you feel would have been helpful after completing the Connaught Clinic program?

One-to-one counseling ___ Group counseling ___

Marital counseling ___ Family counseling ___

49. (1) Detoxication centre
(2) Half-way house
(3) In-patient program similar to Connaught
(4) Out-patient counseling such as is available at A.R.F.

Of the types of treatment listed above, which have you made use of?

[Blank spaces]
50. Which do you feel you would never make use of?

1  2  3  4

51. Please give your reasons for this.

52. Which do you think might be helpful?

1  2  3  4

53. Please give your reasons for this.

54. Which have you wanted to make use of but have not been available?

1  2  3  4

55. How would you describe your drinking pattern since completing the Connaught Clinic program?

Complete abstinence _______

Much decrease in drinking involvement _______

Some decrease in drinking involvement _______

Little decrease in drinking involvement _______

No decrease in drinking involvement _______

Increase in drinking involvement _______

56. (a) Are you a steady drinker (i.e., do you have something to drink practically every day)?

Yes _____  No _____

(b) or do you have periods of drinking separated by days or weeks of complete sobriety?

Yes _____  No _____
If so, how many of these periods or episodes of drinking, or benders, have you had in the past

3 months ______
6 months ______
12 months ______

(c) On the average, how long do these episodes last?

_______ days

57. In the past year, how often did you drink?  (Give exact number.)

____ 1. Not at all.
____ 2. 1-3 times per year
____ 3. 4-12 times per year
____ 4. 2-3 times per month
____ 5. Once a week
____ 6. 2-4 days a week
____ 7. Almost every day

58. In the past year, how much did you usually drink (wine, beer, and/or liquor) on any one of those days? (Give exact number).

**BEER**

____ 1. None
____ 2. 1-3 bottles
____ 3. 4-6 bottles
____ 4. 7-12 bottles
____ 5. 13-24 bottles
____ 6. 25-36 bottles
____ 7. Over 36 bottles

**WINE**

____ 1. None
____ 2. 1-2 glasses
____ 3. 3-4 glasses (less than 1/4 bottle)
____ 4. 1/2 to 1 bottle
____ 5. 1 bottle to 2 bottles
____ 6. 2 bottles to 3 bottles
____ 7. Over 3 bottles
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<tr>
<td>1. None</td>
<td></td>
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<tr>
<td>2. 1-3 oz.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 4-6 oz.</td>
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</tr>
<tr>
<td>4. 7-13 oz.</td>
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<tr>
<td>5. 14-26 oz.</td>
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<tr>
<td>6. 27-40 oz.</td>
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<td>7. 41 oz. or more</td>
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59. We would like you to share with us how it happened that you began your problem drinking.

60. Wrap-up.

Is there anything additional you would like to say about your treatment experiences or treatment needs?
APPENDIX B

Dear [Name]:

Two graduate students from the University of Windsor have designed a research project to evaluate the program at the Connaught Clinic. This project has been approved by Windsor Western Hospital Centre, the Addiction Research Foundation and the Connaught Clinic.

The two students, Corie Palanek and Sue Selby, worked at the Addiction Research Foundation and the Connaught Clinic, respectively, during the year 1974-75. You or your family may remember them.

In order to evaluate the Clinic program, Sue and Corie would like to interview alumni who have completed the three-week program. We at the Clinic hope you will agree to help them by sharing with them your experiences and opinions about the Clinic.

We would like the participation of as many alumni as possible, both people who have continued to drink as well as those who have stopped. Any information you give will be kept strictly confidential and private - no names will be used in the research project.

Sue or Corie will be telephoning you in a few days to talk to you about your participation in the project and to arrange an interview time. If you do not want them to call you, please call Anne, the secretary at the Clinic, and let her know. (253-4261, ext. 383.)

Your participation will be greatly appreciated, for it is only through your open and honest sharing of your experiences and opinions that the Clinic program can be evaluated.

Sincerely yours,

R. Maurice Dobson
Supervisor
APPENDIX C

WINDSOR WESTERN HOSPITAL CENTRE
I.O.D.E. UNIT
WINDSOR, ONTARIO
(UNIVERSITY OF WINDSOR)

Name: __________________
Address: __________________
City: __________________
Telephone no.: ____________

CONSENT FORM

FOR CONNAUGHT CLINIC RESEARCH PROJECT

The following is to be signed by the research subject.

The following is to be read over and explained to the signatory who stated that he/she understood same and offered his/her signature agreeing thereto.

1. RELEASE OF INFORMATION

I, the undersigned, hereby authorize Windsor Western Hospital Centre to release any and all information from my medical record to any medical, social, and/or educational authority where in the opinion of the hospital, this information will be used for the benefit of the subject.

I also authorize Windsor Western Hospital Centre to release information as to the nature of my illness, for scientific or teaching purposes.

2. GENERAL INFORMATION

I, the undersigned, understand that this study will necessitate an interview where details of my experiences connected with the treatment of alcoholism will be divulged, and hereby consent to release such information. Further, I release the information of my social history, as gathered by an interview questionnaire at time of intake to the Clinic, to be used in this research project.

3. GENERAL COMMENT

I, the undersigned, understand that all information released for research will be treated confidentially, and that my name will not appear in the research study. I have been made aware of the relevant details of the study in which I am going to participate. The pro-
cedures to be followed in this study have been fully explained to me, and I agree to participate in the study.

Date: ___________________________ I have read 1, 2, 3, and give my consent/authorization to all three (3) sections.

Former Patient of the Connaught Clinic: ___________________________

Witness: ___________________________
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UNPUBLISHED MATERIAL


VITA

Corinne Palanek was born on June 2, 1951 in Chatham, Ontario. She received her elementary and secondary school education in Chatham. After graduation from secondary school in 1969, Miss Palanek attended the University of Waterloo, Waterloo, Ontario for a four-year duration where she obtained a B.A. degree in Honours Sociology in 1973. From May through June 1973, Miss Palanek was employed as a teaching assistant for the Dufferin County Board of Education in Orangeville, Ontario where she taught play-school and performed psychometric testing of children ages four through six. From July 1973 to July 1974 she was employed as a social worker in the Psychiatric Unit of Public General Hospital in Chatham. In July 1974, Miss Palanek left Chatham to pursue an undergraduate degree in Social Work. She obtained a B.S.W. degree from the University of Windsor in May 1975. Her field placement as an undergraduate was at the Addiction Research Foundation. From May through August 1975, she returned to the Public General Hospital, Chatham, as a social worker. Miss Palanek entered the Master of Social Work program at the University of Windsor where she expects to graduate in October 1976. Her field placement as a graduate student was at Windsor Western Hospital Centre, Riverview Unit.
VITA

Suzanne Selby was born on July 30, 1937 in New York City. She received her elementary and high school education in Woodmere, Long Island, New York. After graduating from high school in 1955, Mrs. Selby attended New York University for 2 1/2 years and then the School of General Studies, Columbia University where she obtained, in 1959, the B.Sc. degree in English. After another year of study, Mrs. Selby obtained, in 1960, an M.A. degree in the Teaching of English in High School from Teachers College, Columbia University. For the next three years, Mrs. Selby taught English at a junior high school in New York City.

Mrs. Selby immigrated to Canada with her husband in 1964 and lived in Saskatoon, Saskatchewan for six years. During this period, Mrs. Selby was involved in teaching, supervision of student teachers and library research on a part-time basis. After moving to Windsor, Ontario, Mrs. Selby joined the staff of the Essex County Children's Aid Society as a social worker in September 1970. She remained on staff through May 1974 when she left to pursue an undergraduate degree in Social Work. She obtained a B.S.W. degree from the University of Windsor in May 1975. Her field placement as an undergraduate was at the Connaught Clinic. She also worked at the Clinic from May 1975 through August 1975. In September 1975, Mrs.
Selby entered the Master of Social Work program at the University of Windsor where she expects to graduate in October 1976. Her field placement as a graduate student was at the Psychological Centre, University of Windsor.