The effect of alcoholism treatment on patient self-concept and drinking behavior.

Gerald L. Smith
University of Windsor

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UNIVERSITY OF WINDSOR
School of Social Work

The Effect of Alcoholism Treatment on Patient Self-Concept and Drinking Behavior

by

Gerald L. Smith, B.S.W.

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

July, 1976

Windsor, ONTARIO, CANADA
RESEARCH COMMITTEE

Professor R. Chandler, Chairman

Professor V. Cruz, Member

Dr. M. Kaplan, Member
ACKNOWLEDGEMENTS

Of the many people who have provided the writer with assistance during the course of this study, several deserve special mention and praise.

Robert Chandler has given the writer constant support and encouragement with regard to this study since early September of 1975. The comments, suggestions, and overall assistance of Valentin Cruz and Marvin Kaplan have greatly aided the writer in the production and refinement of this document.

Mr. K. Jaggis, regional director of the Lake St. Clair Region of the Addiction Research Foundation, and director of the Connaught Clinic, is thanked for approving the undertaking of the study, as are Dr. D. Brown and Mr. J. Broderick of the Windsor Western Hospital Centre.

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The thirty-three patients who composed the research population will always be remembered by the writer as the very special human beings that they are.

Professor F.C. Hansen deserves credit for undertaking the seemingly impossible task of explaining.
the mysteries of statistical procedures and computers to the writer.

During the course of the year, the writer was offered several valuable comments and suggestions by the colleagues in the Master's class, and these are much appreciated.

This is also an appropriate time to thank Shirley and Ernie, as they are the two people most responsible for my initial interest, and subsequent entrance into the social work profession.

Finally, and most importantly, this document is dedicated to Colleen, who supported, encouraged, and loved me, and helped me laugh when things didn't seem very funny.
ABSTRACT

The research project attempted to study the alcoholism treatment program of the Connaught Clinic with specific regard to its effect on self-concept and drinking behavior patterns of a group of thirty-three patients who were exposed to and participated in the program.

The research population, consisting of thirty-one males and two females ranging in age from twenty-two to sixty years, was examined according to several demographic variables, as well as several measured dimensions of self-concept and reported drinking behavior.

The results of the study suggested that twenty-nine patients had significantly improved their self-concepts and reported drinking behavior at the end of the first treatment program phase, while the twelve patients who completed both program phases also showed significant improvement in self-concept and reported drinking behavior at the conclusion of treatment. Four subjects failed to complete either of the two program phases.

The findings of the study also indicated that for this particular population, there was no association between improvement in self-concept and improvement in drinking behavior.
The study suggests that exposure to the treatment program does result in improved self-concept and improved reported drinking behavior.

The writer concluded that further study is needed to investigate the phenomenon of premature termination of treatment by patients, in addition to investigation of the concept of abstinence as a realistic criterion of success for such a program.

Finally, the writer suggests that future research aimed at finding solutions to the problem of alcohol dependency should focus primarily on the individual, rather than on alcohol itself.
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CHAPTER I
INTRODUCTION

The abuse of alcohol and the resultant social and physical problems arising from such abuse constitute a long-standing and serious disorder in Canada. In its final report, the Le Dain Commission noted that "alcohol is, and is likely to remain, Canada's most serious non-medical drug use problem."  

In Ontario alone, it is estimated that there are 120,000 to 140,000 people who require treatment for alcoholism. This figure may be regarded as conservative when one considers the several hundred thousand problem drinkers across the country who would not be regarded as alcoholics.  

In light of these estimates it would seem logical, and indeed essential that Canada have a large-scale network of effective treatment facilities to treat this segment of the total population competently.

At present, no such network exists. The problem of alcohol abuse continues to confound and baffle professionals in many fields with regard to a comprehensive and permanent solution.

Current approaches to the treatment of alcohol problems may be divided into three distinguishable areas. The first group of approaches comes under the heading of conventional methods, based on various theories of personality. These methods employ techniques such as group and individual therapy and are similar to techniques which are used to deal with a variety of psycho-social problems. The second group of treatment approaches utilizes techniques specifically designed for alcoholism, and based in learning theory. The third group of approaches comes under the heading of self-help groups, and is probably best represented by the fellowship of Alcoholics Anonymous.

This study will address itself to the testing of a few select hypotheses which relate to the first group of treatment approaches, as exemplified by a particular alcoholism treatment clinic. Specifically, the writer is interested in examining the treatment program of the Connalough Clinic as to its effect on the self-concept and drinking behavior of individual patients who

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participate in the Clinic's program phases.

I. Description of the Connaught Clinic Program

The Connaught Clinic is a treatment centre for people in the Windsor-Essex, Kent and Lambton County areas who suffer from a dependence on alcohol. The Clinic is operated by, and located on the grounds of the Windsor Western Hospital Centre, I.O.D.E. Unit, 1453 Prince Road, in Windsor, Ontario. The program components include lectures, films, discussions, group therapy, psychological testing, medical examinations, occupational therapy, individual therapy, and continuing therapy.

Applicants to the program are referred by physicians, industry, social agencies, courts, clergy, relatives, or by themselves. Each applicant is interviewed and assessed by a staff member of the Clinic, and a detailed social history is completed. Applicants are usually seen a total of three times by a staff member prior to commencement of the program. Final selections for admission are made at a general staff meeting.

The Clinic program operates on a closed-group, calendar basis, and consists of two distinct phases. A maximum of twelve patients are admitted to the program at one time. This selected group then commences the first of the two program phases, which is known as the three week or day-care phase. This phase usually commences on the first Monday of each month. During this first phase, the patient group attends from 9:00 a.m. to
4:00 p.m., Monday to Friday, for three consecutive weeks, and is exposed to the components which have been described.

Once this phase is completed, the patient group immediately enters the second program phase which is known as the five week or follow-up phase. In this phase, the patient group attends one group therapy session per week, for five consecutive weeks. Patients also receive individual therapy/ once per week from their respective staff counsellors during this phase.

II. Rationale for the Study

For the past seven months the writer has had the opportunity to work two days per week at the Clinic. During this period the writer has conceptualized and gradually refined several concerns which have led him to undertake this study. The reasons for conducting the study are as follows:

1) The Connaught Clinic program represents one example of a conventional methods approach to the treatment of alcoholism. An analysis of the Clinic program's goals and objectives (see Appendix A) reveals that the theoretical base for the program is that of Alfred Adler's theory of Individual Psychology. Basically, this theory explains alcoholism by suggesting that the alcoholic suffers from feelings of inferiority which make it impossible for him to deal with everyday problems. The alcoholic uses alcohol as a means to produce feelings
of power and superiority in an attempt to cope with life on a day to day basis. In short, the alcoholic is seen as having a negative self-concept, which, in turn, negatively affects his ability to function.

The writer finds much merit in this theory, and wishes to examine the Clinic's treatment program to determine if the program does, in fact, affect the self-concepts of the patients who take part in the program.

2) The Clinic's program goals are also consistent with those of other conventional methods approaches with regard to drinking behavior. Sobriety and total abstinence from alcohol are stressed as one of the major goals of the program.

Material from two sources has spurred the writer's interest in investigating this area. Recent material by E. Mansell Pattison suggests that abstinence may not be a "valid or reliable criterion of successful treatment."

Further to this idea, Pattison has suggested that

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abstinence may be a treatment goal for only a few select persons out of the many who enter any specific treatment program.\(^9\)

This same concept of drinking behavior is noted by the Le Dain Commission in its report on treatment. Specifically, the report recommends that the goal of total abstinence may not be appropriate, and should not be assumed for all those who participate in alcoholism treatment programs.\(^10\)

3) The final reason for undertaking this study is based on a second recommendation of the Le Dain Commission, which indicates the necessity for research that can accurately assess treatment programs and techniques as to their effectiveness with a variety of patients.\(^11\)

By investigating potential changes in self-concept and drinking behavior, the writer hopes to fulfill, at least partially, the above described recommendation. This idea has gained the support and encouragement of the Clinic staff and administration, who are anxious to see the results of this study. No research of this type has been


\(^11\) Ibid., p. 53.
conducted at the Clinic to date, and the writer hopes to be in a position to provide relevant data which would aid in the assessment of the Clinic's effectiveness with specific regard to the stated program goals.

According to the classification system developed by Tripodi et al.\textsuperscript{12}, this study may be classified as an hypothesis-testing study. Specific hypotheses, related to the theoretical areas already mentioned, will be tested within the boundaries of an hypothesis-testing research design.

III. A Description of the City of Windsor

Located on a 630 square mile peninsula which is bordered by Lake St. Clair, the Detroit River, and Lake Erie, Windsor, Ontario, with a population of 266,000\textsuperscript{13} is Canada's twelfth largest, and southernmost city.

Strategically located between markets in central Canada and the midwestern United States, Windsor is Canada's fifth largest manufacturing centre. The economic base of the area is diversified, with manufacturing, agriculture, and tourism being the three major industries.


\textsuperscript{13} \textit{Windsor and Essex County Market Facts}, published in the \textit{Financial Post} 1974/75 Survey of Markets.
Windsor is probably best known as the city that accounts for twenty-five percent of Canada's entire motor vehicle and parts production.14

In the health and welfare field Windsor has been a noteworthy leader. The first amalgamated health unit was established in Windsor in 1919. Windsor Medical Services Inc., was the first doctor-sponsored, prepaid medical plan in Canada. Other services such as Prescription Service Inc., the Windsor Cancer Clinic (1935), homes for senior citizens (1954), and a community co-ordinating centre for rehabilitation services in Ontario (1955) all indicate the genuine, and in many ways unique concern which the people of Windsor have traditionally, and continue to exhibit for one another.

In such a setting, the writer has found much support and encouragement for the undertaking of this study. With this assistance, the writer feels that the theoretical and practical concerns which have been briefly outlined in this chapter, can be investigated within the structured framework of this research project. The following chapters of this report will describe in a detailed and focused manner, the relevant material and processes which are involved in such an undertaking.

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14 Exposure to Canada's Southland, (Windsor: The Windsor Star)
15 Noteworthy Facts on Windsor and Essex County, (Greater Windsor Visitor's and Convention Bureau)
CHAPTER II

REVIEW OF LITERATURE

An extraordinary amount of literature exists which describes alcohol, alcohol use, and abuse from a variety of viewpoints and opinions, as well as practical and theoretical stances. Rather than attempting the impossible task of adequately covering and reviewing all such material, the writer will present in this chapter, material which seems particularly relevant to the present study. Thus, the reader is cautioned in advance, that this chapter should in no way be regarded as an all encompassing review of the available literature on alcohol and alcoholism.

I. Definitions of Alcoholism

As has already been mentioned, alcoholism is widely regarded as Canada's most serious and widespread non-medical drug use problem. Just as the problem is widespread, so too, are the many descriptions of the phenomenon itself. Two formal definitions of alcoholism are presented here, primarily because they are well-known and subscribed to by many people working in treatment facilities.
10.

As John Seely points out, "a suitable sensible definition of 'alcoholism' is probably as much to be desired as any research development or finding." 16

Basically, the term alcoholism refers to alcohol use. Jellinek described alcoholism as "any use of alcoholic beverages that causes any damage to the individual or society, or both." 17 Thus, Jellinek's definition refers to the broad consequences of alcohol abuse.

The Alcoholism Sub-Committee, of the Expert Committee on Mental Health, of the World Health Organization developed a similar definition, but went one step further in describing consequences, in addition to adding cultural and social components to their description of alcoholism. This definition describes the "alcoholic" rather than alcoholism.

Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations, and their smooth social and economic functioning; or who show the prodromal signs of such developments. 18

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In addition, the alcoholics of the above definition are characterized by:

any form of drinking which in its extent goes beyond the traditional and customary 'dietary' use, or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behavior and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physiological and metabolic influences. 19

The above two definitions describe alcoholism in terms of observable behavior and the consequences of such behavior. The Connaught Clinic closely subscribes to Jellinek's definition, especially in terms of the Clinic's concern as to the effects of the patients' drinking, both to themselves as alcoholics, and to significant others in the patients' lives.

II  Theories of Alcoholism

Of the many theories which attempt to explain the phenomenon of alcoholism, there are two which are particularly prevalent at the present time. These are, the disease concept of alcoholism, and the learning theory concept as applied to alcoholism.

Jellinek's concept of alcoholism as a disease is probably the most widespread, and at the same time, one of the most controversial theories of alcoholism. This particular theoretical construct forms the base for much of the Connaught Clinic's treatment approach.

In 1960, Jellinek published his most famous work, *The Disease Concept of Alcoholism*. In this book, he outlined the major components of the theory of alcoholism as a disease. On an overall basis, Jellinek saw a progression of alcoholism, resulting from alcohol use:

The excessive drinker who has been using alcohol intoxication as a means of 'problem solution', while still continuing that use is, in addition--and probably, more prominently--using alcohol to remedy the psychological, physiological, and social stresses and strains generated by heavy drinking. Only when this occurs in conjunction with acquired increased tolerance, withdrawal symptoms, inability to abstain, or loss of control, may the excessive user of alcohol be termed an 'alcohol addict' and his drinking behavior regarded as a disease process. 20

The single most important criterion which separates "excessive drinkers" from "alcohol addicts" is that theoretical construct known as "loss of control." "Generally, loss of control (LOC) implies that after one drink, the alcoholic is unable to stop drinking, and that he continues to drink for and indefinite period of time." 21

Keller describes loss of control as the invisible line which separates problem drinkers from those people who have drinking problems.

20 E.M. Jellinek, *The Disease Concept of Alcoholism*, p. 66.
There is another kind of drinking however, that is somewhat different from and more than simple drunkenness. It is problem drinking. This is drinking, usually to excess, in order to escape from some basic problems in living... Drinking is perceived and used as a way out of a deeper and more persistent problem. 22

Crossing over the loss of control line the individual then has a drinking problem because "even if the problems were resolved the excessive drinking would continue." 23

Jellinek's classification system, which included five categories of alcoholism, also distinguished between those people who are problem drinkers, and those with drinking problems.

Alpha alcoholism denotes a purely psychological reliance on alcohol to remove bodily or emotional pain. While the drinking breaks social conventions concerning time and amount, it does not involve (LOC). Beta alcoholism involves physiological disturbances such as gastritis and cirrhosis. Withdrawal symptoms are not present and there is no physical or psychological dependence. Gamma alcoholism identifies a type of alcoholism involving 1) acquired tolerance to alcohol, 2) metabolic adaptation, 3) withdrawal symptoms, and 4) LOC. Delta alcoholism is similar to gamma alcoholism. The first three symptoms are present but instead of inability to maintain sobriety, the delta alcoholic is unable to withdraw from drinking. Epsilon alcoholism involves periodic bouts of drinking often resulting in serious damage. Jellinek had little to say about this species and did not define or describe it further. 24

23 Ibid., p. 4.
Finally, Jellinek himself described loss of control and the concept of withdrawal symptoms as follows:

The withdrawal symptoms as they occur within a drinking bout, in the presence of loss of control, are tremors of the fingers and lips, slight twitchings, some motor restlessness and sometimes delusions (but not hallucinations). These symptoms are promptly relieved by more alcohol, but the relief is of short duration and the symptoms recur after a short interval, whereupon the drinker again takes recourse to more alcohol. This process goes on and on until the drinker either cannot ingest more alcohol, or the drinking is stopped through extraneous circumstances. As the bout in the presence of loss of control progresses, anxiety increases in intensity and is relieved by renewed alcohol intake only for short periods. The anxiety may originate in the failure of the euphoric effect of alcohol and the heaping of drinks gives the impression of an obsessive behavior.

In addition to loss of control and withdrawal symptoms, the component of tolerance is an integral part of the disease concept.

Tolerance depends upon the individual susceptibility to the effects of alcohol and is both inherent; i.e., susceptibility to alcohol varies widely among different individuals, and is acquired. Acquired tolerance to alcohol differs from inherent tolerance in that the former is acquired by repeated drinking of alcoholic beverages over a long period of time.

It becomes apparent that several complex factors are involved in the disease concept of alcoholism.

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26 Harold E. Himwich, "Metabolism and Pharmacology of Alcohol", in *Alcoholism*, ed. by Ronald J. Catanzaro, p. 32.
During the last decade there has been an increasing recognition and acceptance of alcoholism as a disease, not a moral-criminal problem. This development has given legitimacy to the disorder and focused attention away from moral factors and other simplistic and naive causal theories. It is now recognized that the etiology of alcoholism is a complex matter. There is no single cause of alcoholism; multiple factors are involved. Personality, sociological, physiological, and possibly other factors contribute to the development of alcoholism. 27

Despite the complex etiology and the several components of the disease concept, it must be recognized that this is still a theoretical construct, and should not be regarded as empirical fact, as some authors have done. 28

The application of the disease concept to treatment will be discussed later in this chapter. Prior to this examination however, the writer will present material dealing with the second major theory of alcoholism, that of learning theory.

Learning theory in general, is an attempt to explain human behavior. As such, it can be applied to the specific phenomenon of alcoholism. The basic concept of learning theory may be stated as follows:


"Behavior is shaped by responses that are learned when they are followed by either reward or punishment." 29

The alcoholic then, through reward and punishment experiences, has learned to drink in a certain manner and pattern.

Alcohol drinking thus appears to be a response which may be developed by a relatively consistent physiological reinforcement as well as by one or more environmental rewards occurring regularly or intermittently. 30

An example of environmental rewards would be that of friendship with drinking companions, or attention from family and friends as a result of the drinking.

In addition to environmental factors, it has been hypothesized by some authors that alcohol is employed as a drive reducer, specifically with such drives as anxiety. 31

The physiological factors also enter into the concept of drive reduction in that certain emotions may produce physical discomfort in the alcoholic. Discomforts such as cold sweats and heart palpitations may be substantially reduced or perceptually eliminated by the consumption of alcohol. 32


From an overall viewpoint, the assumption is that alcohol abuse is a learning problem in that patients learn to either escape or avoid unpleasant events or gain access to pleasurable events through excessive drinking.\footnote{33}

The writer sees several common areas between these two apparently opposing theories. Both the disease concept and learning theory of alcoholism recognize the problem-solving or coping aspect of the alcoholic with regard to his use of alcohol. Both theories also have conceptual views of alcoholism as an on-going process.

The major point of disagreement between the two theories is apparently that of their conceptual view of the consciousness of the alcoholic with regard to his alcohol use. The proponents of the disease concept seem to feel that once loss of control (LOC) exists, the alcoholic is no longer responsible for his drinking, specifically because he cannot control it. Learning theorists would argue that the alcoholic is always consciously in control of his drinking, and therefore, is always responsible for it.

\footnote{32} M. Vozell-Sprott, "Alcoholism as Learned Behavior," p. 50.

\footnote{33} Steven M. Ross, "Behavioral Group Therapy with Alcohol Abusers," in Alcohol Abuse and Rehabilitation Approaches ed. by John G. Cull and Richard E. Hardy, p. 114.
Notable among the many learning theorists is E.M. Pattison, who has noted that the alcoholic consciously uses alcohol in certain specified component areas of his life, as an attempt to cope. Rather than the drinking being out of control, Pattison maintains that the alcoholic never loses control of the drinking, but rather, perceives himself as having lost control of a particular area of his life, such as family area, job area, or social area. Pattison describes the drinking as spreading and retreating in these various areas depending upon the amount of perceived control the alcoholic sees himself as having in any of the particular life areas at any given time. An alcoholic would be someone whose drinking was involved in 55% or more of his total life.34

The apparent conceptual differences with regard to the alcoholic which arise from the two above mentioned theories have resulted in the development and application of differential treatment methods. The three distinguishable treatment approach categories are described as follows.

III Treatment Approaches to Alcoholism

It has been noted that there are three distinct groups of treatment methods in the area of alcoholism treatment. These are, conventional methods approaches, approaches based on learning theory, and self-help groups.

Conventional Methods Approaches

Conventional methods approaches to alcoholism treatment are usually characterized by the multi-disciplinary team approach, which may be found in specialized alcoholism clinics and treatment centres, both private and public, addiction wards of general and psychiatric hospitals, and community health centres.

The prototype of this approach method was the Yale Center, established in 1944 as a specialized outpatient clinic for the treatment of alcoholism. The Yale Center incorporated the fields of psychiatry, medicine, public health nursing, psychology, and social work into its treatment approach.35

Because of the influential presence of physicians and psychiatrists in early specialized clinics, the disease concept of alcoholism gained prevalence as a theoretical base,36 and is still widely subscribed to at the present time in a large number of treatment facilities. Because of this entrenchment of the disease concept, many conventional methods programs have three major goal areas which are consistent with this concept. These goals are, generally, stabilization of the alcoholic's drinking and abstinence; the development of the patient's insight and

36 Ibid., p. 98.
awareness into his behavior; and, the increased functioning of the patient in the various areas of his life. Depending upon the individual patient and the particular treatment person and/or program, these goals may be pursued sequentially or simultaneously within an overall treatment process.

Interestingly enough, these three goal areas are, in themselves, involved in the initial selection of patients prior to the commencement of treatment. For instance, most individual therapists, or group treatment facilities will not accept someone for treatment unless they are physically stabilized and sober for a minimum period of time. This may be accomplished through initial hospitalization or detoxification and usually involves the services of a physician.

The objective of the physician with a patient in a state of alcohol intoxication is to detoxify him as quickly as possible so that the effect of the alcohol will no longer exist. Most other remedial measures given to the alcoholic must be postponed until the acute intoxication is removed. The period of recovery from the acute intoxicated state may be utilized for the purposes of indoctrination, but this becomes much more effective when the patient's mind is cleared and he can understand and co-operate with the therapist.37

Following a medical examination, the physician may prescribe a certain diet, specific medication such as tranquilizing drugs;38 and may also suggest that the

37 Marvin A. Block, "Treating the Acute Withdrawal Phase and Associated Complication." in Alcoholism, ed. by Ronald J. Catanzaro, p. 90.
38 Ibid., pp. 92-98.
patient take Antabuse (disulfram) as an initial step towards maintaining sobriety and abstinence.\(^\text{39}\)

If the above mentioned procedures are successful the patient is then in a position to enter the next phase of treatment, which usually involves a combination of group and individual therapy. However, in order to gain access to such treatment, the alcoholic must appear to possess certain traits and characteristics.

The treatment modes in alcoholism clinics are generally similar to those in generic psychiatric clinics, and the same stress is placed on the patient's verbal ability, motivation, and family stability...Almost always, the person with the intact family is favored as a better success probability. Verbal ability and motivation, largely formed by three interrelated conditions—social class, education and occupation—tend to act as a sort of intake sieve to eliminate those who do not fit the treatability pre-judgments of clinic personnel.\(^\text{40}\)

John Klein has observed that the desired patient traits are often those possessed by treatment staff, thus increasing the chances that "white collar" patients will do better in treatment, because the majority of staff are "white collar" themselves.\(^\text{41}\)

\(^{39}\) Ruth Fox, "The Effectiveness of Antabuse in Treating Alcoholism", article source unknown, p. 6.

\(^{40}\) Sidney Cahn, The Treatment of Alcoholics, p. 99.

Lastly, and perhaps most importantly with regard to treatment, is the concept of the patient's social class.

The social class of the patient influences his attitudes, values and expectations. Particularly in reference to treatment for alcoholism, it influences his attitudes toward drinking, and to a certain extent, the types of treatment that will be accepted and can be used by him. 42

Should an individual pass the intake procedures, he will usually enter group or individual therapy, and begin the dual process of trying to understand and become aware of himself, while attempting to discover constructive means to deal with his concrete problems - including the drinking, and to improve his general level of functioning in the various component areas of his life.

For some time group therapy was considered merely a way for the therapist to treat more people. Now, however, it is known that the group has something to offer that the individual counsellor cannot match. In a group, the alcoholic has several people to talk to, several people to upset him, and several people to show him ways to do something about his problem. 43

Group therapy sessions may be roughly divided into two categories: those sessions which focus on the patient's self and situation, with the therapist(s)

42 Joseph Mayer and Rebecca Black, "A Description of Some Selected Treatment Approaches in Alcohol Abuse," in Alcohol Abuse and Rehabilitation Approaches, ed. by John G. Cull and Richard E. Hardy, p. 162.

using a wide range of techniques,44 and those sessions which are didactic and provide concrete information to the patient.45

In terms of those group sessions which focus on the patient's self and situation, the content of expression by the patient during such sessions is largely influenced by the position taken by the therapist. Some therapists feel that specified significant areas need to be covered in group therapy, and thus, they may direct patients to express themselves around such issues as family life, job, and feelings the patient has about himself, as these areas relate to the patient's use of alcohol.

A second stance, taken by some therapists, is an open-ended approach, where the group therapy session is unstructured, so that patients raise and discuss issues which they themselves select as being important.

In a two year study of 300 patients in an alcoholism out-patient clinic, four main themes emerged when patients were allowed to raise their own issues.

The first was labelled The Punitive Mother-Rebellious Child Theme, and described role changes and shifts between the alcoholic husband and his wife as a result of the drinking. The alcoholic became threatened as the drinking progressed, and was aware that his spouse gradually took on a greater responsibility for overall operation of the family, and at the same time, took on a punishing maternal role towards her alcoholic husband. Conflict resulted in fighting between the couple as to who had final control. The second theme, Making Up For Lost Time, involved the alcoholic's attempts to compensate for those times when he neglected his family due to drinking. Attempts at compensation resulted in the alcoholic being overly permissive with his wife and children, thus creating feelings of guilt and resentment at being manipulated. A third theme, Inability to Express Feelings, is notable in that it described the holding in or denial of feelings of hostility, anger, and resentment. The continued build-up of these feelings resulted in explosive releases of emotions during a resultant drinking episode. The fourth theme observed

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48 Ibid., p. 478.
during this study was *The Striving For Perfection*, and was characterized by the alcoholic setting standards for himself in the areas of work, personal achievement and personal activities which were much higher than those set by others around him. In addition, the examination of this theme revealed that external approval did not result in complete satisfaction on the part of the alcoholic. Related feelings of omnipotence, inadequacy, and inferiority were observed in this area.

The perception of these, and other common factors by treatment staff has often led to the development and implementation of structured programs in the conventional methods approach area.

There is considerable agreement among authors that alcoholic patients have many psychologic features in common, such as low frustration tolerance, low self-esteem, strong dependency needs, strong but suppressed hostility, impulsiveness, and a lack of insight that is manifested by such primitive defences as denial, projection and somatization. Group therapy is seen as an effective way of defusing and immobilizing some of these defences, which often act as an impediment to successful individual psychotherapy.

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51 Ibid., p. 16.
Finally, although many programs using conventional methods approaches are in existence on the North American continent, there is a disappointingly small amount of research evidence to substantiate the true value of such programs.

The biggest problem by far in conventional methods programs is that of premature termination of treatment by patients. As an example of this phenomenon, Larkin studied 153 out-patients admitted to a clinic during a three month period in 1969. Of these, 106 dropped out of treatment without discussing this with their therapist. 71 dropped out within five interviews or less, while all those who dropped out did so within twelve interviews or less.

Data collected from questionnaires administered to the subjects indicated that those patients who remained showed a definite preference for treatment which was related to the disease concept, and that those who dropped out were exposed to treatment which was not oriented to the disease concept.

Larkin suggests that in addition to the potential invalidity of the loss of control and abstinence components, the disease model creates problems due to the fact that patients prefer a disease model treatment program because the terms of reference of the model allow them to escape from taking responsibility for their drinking and the

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resultant behavior.\textsuperscript{54}

In assessing the applicability of the various components of conventional methods approaches, a study by Kissin, \textit{et al.}, suggested that:

socially and psychologically stable patients do best in psychotherapy; the socially intact but psychologically less sophisticated patient does better under drug therapy; and the socially unstable but intellectually intact patient does best on an inpatient rehabilitation program.\textsuperscript{55}

Finally, using abstinence as the major criterion of success has resulted in an average "success rate" of between 9-20\% for conventional methods programs.\textsuperscript{56} This figure in itself suggests the necessity of examining other treatment approach methods.

\textbf{Learning Theory Treatment Approaches}

If one accepts the theory that alcoholism is learned behavior, it follows that the application of specific techniques by a therapist to a patient can lead to alteration of the specific behavior of alcohol abuse. Such is the basis of treatment approaches based on learning theory.

\textsuperscript{54} E.J. Larkin, \textit{The Treatment of Alcoholism}, p. 29, 53, 54.


\textsuperscript{56} E.J. Larkin, \textit{The Treatment of Alcoholism}, p. 1.
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Just as there are many variations within conventional methods programs, so too are there differences in the programs which rely on learning theory techniques. There are also similarities between programs using conventional methods approaches, and those using learning theory approaches. In general, group and individual therapy are employed, the processes by which patients are selected are similar to those of conventional methods programs, and the goals of both approaches are similar, with the exception of the systematic desensitization and behavior modification techniques which attempt, in some cases, to help patients return to social or normal drinking.

This specific difference in the goal of drinking—whether it be abstinence, or normal drinking, forms the dividing line between the different types of learning theory approaches to treatment.

The first group of treatment approaches utilizing learning theory techniques, have as their primary goal the attainment of abstinence by the patient, and in this respect are similar to disease model programs. Various names are used to describe the abstinence-producing techniques. Conditioned reflex therapy, aversive conditioning, and aversion therapy all refer to techniques which are aimed at producing an abstinent patient.
Conditioned reflex therapy is described as follows:

The treatment essentially consists of presenting an unconditioned stimulus and a conditioned stimulus. The unconditioned stimulus is usually an emetic drug and the alcoholic beverage is the conditioned stimulus. The aim of the treatment is to cause nausea and vomiting induced by the emetine to become associated with the alcoholic beverage. The important point in treatment is to present the alcohol to the patient just before the onset of nausea and vomiting. Further repetition of this sequence should cause the alcohol to elicit the nausea and vomiting response, and hopefully this will cause the patient to avoid alcohol in the future.57

A variation of this technique, often called aversion therapy, employs simulated drinking conditions and electric shocks.

In this experiment, the hospital simulates real-life drinking conditions by having both an actual bar and a simulated home-drinking setting. The patients are placed in the setting appropriate to their alcohol drinking habits and are fitted with electrodes; electric shocks are paired with the intake of drinks. The patients are permitted to drink in quantities appropriate to their drinking styles, but they may request non-alcoholic beverages as well. If they do, they are rewarded with tokens that entitle them to certain privileges. The rewards are positive reinforcers; the shocks are aversions to drinking. Shock sessions continue until the patient refuses to come to sessions or orders only non-alcoholic beverages.58

Hopefully, the alcoholic learns to associate alcohol with nausea, vomiting and pain, rather than associating it with pleasurable feelings and effects.

Antabuse (disulfram) is also employed as an aversion therapy drug, in a slightly different manner. Patients who are given Antabuse are not encouraged to drink, but rather, are forewarned of the potential physical effects should they drink while on an Antabuse regimen.

As Clancy has noted, treatment which attempts to eliminate alcohol use and produce abstinence in the patient, has been criticized in that "it is a purely symptomatic treatment, and makes no attempt to deal with the underlying cause of the symptom."^59

The systematic desensitization process is employed as a way of dealing with hypothesized causes as well as the drinking itself. Firstly, the patient is trained in deep muscle relaxation which produces an anxiety free condition. While relaxation is continuing, the therapist builds an anxiety hierarchy which consists of the therapist recognizing stimuli which produced anxiety in the patient, and grading these stimuli according to their degree of effect on the patient. Finally, the treatment itself consists of the therapist presenting the patient with various scenes, such as imaginary social situations, which are relevant to the patient's life history, and produce anxiety. Repeated presentation of the scenes takes place until the patient is no longer sensitive to them.^60

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^60 Sidney Cahn, The Treatment of Alcoholics, p. 114.
This particular technique is regarded as the most complex of all the behavior therapies. Systematic desensitization is probably most effective with those individuals whose problem drinking is provoked by stressful interpersonal situations. Alleviation of the stress and anxiety will hopefully modify or eliminate the problem drinking behavior.61

One implication of this specific technique is that the alcohol abuser could return to normal or social drinking if he no longer used alcohol to deal with the stress and anxiety. However, it is suggested that systematic desensitization be used in conjunction with aversion therapy, therefore suggesting that abstinence is still a treatment goal.62

A third technique based on learning theory, is that of behavior modification, stressing the primary use of positive reinforcement. This is somewhat different from aversion therapy, where positive reinforcement is secondary to the negative reinforcement of shocks and drugs.

One excellent example of this approach method was an experiment conducted by Hunt and Azrin. An operant-reinforcement approach based on Skinner's work was employed. The potential positive reinforcers of job,

62 Ibid., p. 35.
family, and social relations were re-arranged through the experimental program, so that the "drinking produced a time-out from a high density of reinforcement."\textsuperscript{63}

Thus, the alcoholic was reinforced positively by his employment situation, family, and friends if he drank less, and/or stayed sober. Intensive counselling with the family and the alcoholic was carried out in addition to job counselling and the arrangement of the alcoholic's social contacts with relatives and friends who would not tolerate excessive drinking,\textsuperscript{64} to ensure that reinforcement by these individuals was perceived as positive by the alcoholic. The results of this program indicated that those alcoholics who were exposed to this treatment approach "drank less, worked more, spent more time with their families and out of institutions than did a matched control group of alcoholics who did not receive the procedures.\textsuperscript{65}

What is interesting in both the operant reinforcement approach and the systematic desensitization approach is that both make implicit the possibility of continued


\textsuperscript{64} Ibid., pp. 94-96.

\textsuperscript{65} Ibid., p. 91.
drinking, rather than total abstinence. Drewery suggests that social drinking be thought of and developed as a treatment goal, rather than maintaining abstinence-only programs, which, by their very criterion may be discouraging people from seeking treatment. 66

In support of this idea, Pattison has noted that alcoholics seek treatment which is consistent with their needs, and also with their perceptions and definitions of alcoholism. 67

Pattison has developed a multi-faceted treatment model which aids patients in the selection of treatment goals and drinking goals which are most appropriate for each patient. 68 Some patients' goals will be abstinence, while others' will be social or normal drinking. 69

Finally, social or normal drinking, can be successfully achieved only if the treatment program is effective in helping the individual to change his symbolic view of alcohol as a drug. If the alcoholic continues to view alcohol as a magic potion which will

68 Ibid., p. 3.
69 E.M. Pattison, "Planning Treatment" (paper presented at A.R.F. Annual Advanced Summer Course)
solve his problems he will continue to use it in such a manner. If, through treatment, he can learn to solve his problems and cope by using other means, and if he can come to view alcohol as a social beverage, then he stands a good chance of being able to use alcohol in an appropriate fashion.\textsuperscript{70}

\textbf{Self Help Groups}

The third distinct treatment approach to alcoholism is best exemplified by the society of Alcoholics Anonymous. Founded in 1935 by two alcoholics, A.A. has grown to the point where it has groups in North and Central America, as well as several European countries.\textsuperscript{71}

Despite A.A.'s widespread existence it is difficult to describe in terms of how and why it works. A.A. subscribes to the disease concept, and believes in total abstinence. In fact, much of Jellinek's work in regard to the disease model and the concepts of loss of control and abstinence were based totally on research carried out by Jellinek between 1946 and 1952, using A.A. members as subjects.\textsuperscript{72}

It seems accurate to say that A.A. is as much responsible for the above mentioned concepts as is Jellinek.

\textsuperscript{70} E.M. Pattison, "Planning Treatment".
\textsuperscript{71} Barry Leach, "Does Alcoholics Anonymous Really Work?" in Alcoholism Progress in Research and Treatment, ed. by Bourne and Fox, p. 246.
\textsuperscript{72} \textit{Ibid.}, p. 246.
Between 1935 and 1938 membership in A.A. grew slowly but steadily with small numbers of alcoholics helping others to get sober and maintain abstinence through a gradually evolving program. This program has as its base, the Twelve Steps.  

The Twelve Steps

1) We admitted that we were powerless over alcohol— that our lives had become unmanageable.
2) Came to believe that a Power greater than ourselves could restore us to sanity.
3) Made a decision to turn our will and our lives over to the care of God as we understood Him.
4) Made a searching and fearless moral inventory of ourselves.
5) Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6) Were entirely ready to have God remove all these defects of character.
7) Humbly asked Him to remove our shortcomings.
8) Made a list of all persons we had harmed, and became willing to make amends to them all.
9) Made direct amends to such people whenever possible, except when to do so would injure them, or others.
10) Continued to take personal inventory and when we were wrong, promptly admitted it.
11) Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12) Having had a spiritual awakening as a result of these steps we tried to carry this message to alcoholics and to practice these principles in all our affairs.

These steps provide a guide which alcoholics can use as a progressive process to achieve recovery from alcoholism.

In addition to the twelve steps, A.A. bases its

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approach on mutual support; one alcoholic helping another. This support is operationalized by means of A.A. group meetings.

There are basically two kinds of A.A. meetings—open and closed. In meetings open to the public the customary format is a moment of silence (meditation), a speaker or speakers, the Lord’s prayer, and a social hour. The purpose of this meeting is basically three fold. 1) To give the beginner a chance to see and hear recovering alcoholics tell their stories in their own way so that he can make identification with both their problem and their recovery and thus begin to feel hopeful; 2) To give the spouse, friend, or community members an opportunity to hear what alcoholism is and does; 3) To inspire and give continuing support for other members of the fellowship. All this, of course, can also serve to benefit those who speak at the meeting as they are supported by those who listen and respond. The closed meeting does not usually revolve around a main speaker. It is a real group meeting where in small numbers the members discuss some aspects of the A.A. way of life as it relates to their own problems and needs.74

A.A. is seen by its members as more than a self help group. Rather it is regarded as a philosophy and a way of life which A.A. members can follow in order to maintain their recovery process from alcoholism.

In addition to individual groups, A.A. is a highly structured organization with elected delegates and representatives. Policies are set at annual conferences which are held at various centres across North America.

No other system of helping alcoholics has such a widespread, uniform network of central information gathering and information disseminating facility as A.A. It therefore exerts a forceful and ubiquitous, if sometimes shadowy, influence on alcoholism treatment and research far beyond its professedly narrow range of interest.  

A.A. is extremely difficult to describe beyond the general principles of the Twelve Steps and those outlined in "the big book". This difficulty arises from differences between A.A. groups and individual A.A. members, whose views and approaches toward alcoholism vary widely. For instance, although A.A. subscribes to the disease model, some A.A. members use techniques in helping one another that are definitely based on learning theory. Rewards in the form of tokens and medallions for attainment of certain periods of sobriety, or the granting of a personal key which gives access and privileges to a group's rooms only after three months consecutive sobriety, can be regarded as a positive-reinforcement approach.

Certain A.A. groups' closed meetings resemble "the game" technique as practiced by Synanon, while other groups conduct closed meetings as if they were a purely social function.

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75 Barry Leach, "Does A.A. Really Work?", pp. 246-247.
Despite these differences, and what superficially may appear to be a collection of alcoholics swapping clichés ("one day at a time", "easy does it"), several studies reviewed by Leach, 78 revealed that A.A. does work in helping alcoholics to stay sober and find a new way to live.

Finally, it must be noted that all three approach methods which have been described so far, have some value in terms of treating the alcoholic. It would be presumptuous and inaccurate to say that one method is always better than another.

New respect is needed by all people in the helping professions for one another's potential contribution in treating the problem drinker. One must wonder why psychiatrists, social workers, psychologists, members of Alcoholics Anonymous, nurses, ministers, internists, and others are so defensive in protecting their own peculiar contribution to the healing process. Could it be that when one has experienced limited success in helping some gain sobriety, that one questions one's own authenticity to the degree that one cannot acknowledge the validity of another person's approach toward healing? 79

Despite the apparent differences in the three described treatment approaches, there also appears to be a commonality among the three. The writer notes a basic implicit aim in all three approaches— that is, helping the alcoholic to cope with himself and the various components of his life without using alcohol as a means

78 Barry Leach, "Does A.A. Really Work?", pp. 275-279.
of coping, or as a "problem-solving" mechanism. This aim seems to be present, regardless of whether the drinking goal of a particular approach is abstinence or normal drinking.

Two related concepts seem to emerge at this point; that of the alcoholic's ability to cope, and, his use of alcohol as a "problem-solving" mechanism. The appearance of these two concepts has led the writer to investigate a specific theory, which has been applied to alcoholism; that of Alfred Adler's theory of Individual Psychology. From this theory, the concept of the individual's self-concept has emerged.

**Individual Psychology and the Self-Concept of the Alcoholic**

As the name of his theory implies, Adler viewed man as a unique being.

Adler considered each person to be a unique configuration of motives, traits, interests and values; every act performed by the person bears the stamp of his own distinctive style of life.

Further to this view of man as a unique individual, Adler saw man as a social being.

Man is, according to Adler, inherently a social being. He relates himself to other people, engages in co-operative social activities, places social welfare above selfish interest, and acquires a style of life which is predominantly social in orientation.

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81 Ibid., p. 120.
Finally, and most importantly in terms of alcohol use, Adler noted the conscious awareness of man.

"Man is a conscious being; he is ordinarily aware of the reasons for his behavior. He is conscious of his inferiorities and conscious of the goals for which he strives. More than that, he is a self-conscious individual who is capable of planning and guiding his actions with full awareness of their meaning for his own self-realization." 82

This conscious awareness of one's inferiorities is a central component of Individual Psychology, when applying the theory to alcoholism.

Adler's theory of personality explains alcoholism by suggesting that the alcoholic does not know how to cope with normal, everyday problems. The alcoholic then uses alcohol to produce feelings of self-esteem and power and thereby attempts to overcome his feelings of inferiority. 83

As Adler himself stated:

Very frequently, the beginning of addiction shows an acute feeling of inferiority, marked by shyness, a liking for isolation, oversensitivity, impatience, irritability, and by neurotic symptoms like anxiety, depression, and sexual insufficiency. 84

The concept of alcohol as a problem-solving mechanism is also dealt with by Adler when he notes that:

"In all cases of addiction we are dealing with people who are seeking alleviation in a certain situation." 85 Through drinking, alleviation is temporarily obtained.

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82 Hall and Lindzey, Theories of Personality, p. 121.
85 Ibid., p. 423.
By a trick, the oppressive feeling of inferiority is temporarily removed or...it may be transformed into increased activity. The immediate effects of the drug often give the victim a feeling of being unburdened.  

If one accepts Adler's viewpoint, the appearance of the problem-solving aspect of drinking becomes clear. In addition, the idea of the individual's self-concept comes into play. The use of the terms inferiority and the attempts of the alcoholic to produce feelings of self-esteem seem to lead directly to the concept of self-concept. The implication here is that the alcoholic sees himself in a negative way; i.e., he has a poor or negative view of, and feelings about himself. This negative concept of self seems to come to the forefront in social situations.

Therefore, if confronted strongly by a situation which he feels to be in the nature of an examination, a test of his social value, a judgment upon his social usefulness, a person of this type acts in an unsocial way.  

Very similar to Adler's view of the alcoholic's attempts to deal with inferiority feelings is Steiner's conception within a Transactional Analysis framework, specifically in terms of scripts.

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The life script is a life plan which a person assumes in childhood and becomes the blueprint for future behavior. The life script is based on one's own self-concept or identity (especially about one's worth) and the worth of significant others.89

Roebuck goes on to note that:

Steiner adopted the frame of reference presented by Berne, in his book Games People Play, a position similar to that of Alfred Adler, though neither Berne nor Steiner acknowledges Adler as a precursor.90

From a Transactional Analysis stance, however, the alcoholic's self-concept would be expressed as an "I'm Not OK" life position.91

From a slightly different perspective, Carl Rogers sees the self-concept as the person's habitual ways of thinking about himself.92 It can also be seen as a screening mechanism employed by the person, who, when he receives stimuli, will translate these into ideas and perceptions, and integrate these into his self, only if they are consistent with his self-concept.93

89 Julian B. Roebuck, "The Psychological Approach to the Understanding of Alcoholism," in Alcohol Abuse and Rehabilitation Approaches, ed. by Cull and Hardy, p. 58.
90 Ibid., p. 58.
91 Steiner, Games Alcoholics Play, p. 44.
93 Ibid., p. 71.
The importance of the individual's self-concept becomes clear in terms of the impact it may have on perceptions and behavior. Sullivan noted that the self-concept may be used as a control mechanism, through the principle of consistency, as a means of dealing with anxiety.

Experiences consistent with the Self are security-enhancing and are admitted to awareness; experiences inconsistent with the Self are anxiety-producing and require defensive measures to diminish or obliterate their potentially noxious effects. The key phrase here appears to be "defensive measures."

This has been identified as a supposed alcoholic trait. In introducing a study of perception of depression in male alcoholics, the authors note that:

Such denial of reality, or distorted perception of self, particularly the refusal to acknowledge the degree of certain pathological personality characteristics, is a means of defending the self from stress, but it does not allow the person to recognize those social and environmental cues necessary for effective functioning and adjustment.

It appears that the alcoholic is trapped. In order to receive the help he needs to improve his self-esteem, confidence, and sense of worth, he must first admit that he has "certain pathological characteristics." Rogers has noted this apparent double bind in his description of subjection.

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In protecting his self-concept by means of defensive measures, one of which is drinking, the alcoholic exhibits certain behavior patterns. Haigh found that such measures included denial, withdrawal, justification, rationalization, projection, and hostility. These findings seem to dovetail with those of Selzer, who noted that the alcoholic's areas of pathological deviation included dependency, egocentricity, depression, and hostility.

Still another author has noted that the identified characteristics include low frustration tolerance, excessive dependency needs, use of denial, resistance to deeper explanations of their condition, underlying feelings of inferiority and self-doubt, and recurrent themes of loneliness, emptiness, and depression.

It becomes increasingly apparent that the self-concept is inexorably tied to, and perhaps responsible for, the many so-called alcoholic personality characteristics. Therefore, it seems reasonable to suggest that the self-concept of the alcoholic might be a crucial variable to be

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97 Hall and Lindzey, *Theories of Personality*, p. 542.
focused upon, specifically in terms of treatment approaches, the purpose being to determine what, if any, effect a particular treatment method might have on the alcoholic's self-concept. Secondly, it also seems reasonable to study the self-concept as to any relationship which might exist between it and the individual alcoholic's drinking behavior.

**Drinking Behavior**

In examining the material relating to the three treatment approaches, and also to the self-concept, some mention has been made of the alcoholic's use of alcohol. Several factors seem to require investigation in this area. Firstly, drinking behavior is an important factor in relation to treatment, due to the fact that all treatment types discussed to this point, have as one of their goals, either abstinence or normal drinking on the part of the patient. Secondly, in relation to self-concept, it has been noted that alcohol is used as a problem-solving mechanism. Again, regardless of treatment goals, both the disease concept and the learning theory concept recognize alcohol use as a problem-solving mechanism, or coping mechanism as employed by the alcoholic. Therefore, it seems appropriate to examine the concept of drinking behavior according to any relationship that might exist between it and the concepts of treatment programs, and self-concept.
Two components appear to combine to form the concept of drinking behavior. Firstly, the alcoholic's drinking pattern must be taken into account. This component describes the frequency of drinking as to whether the alcoholic drinks every day, on weekends, or perhaps engages in periodic "drinking binges." Jellinek noted these different frequencies within his species classification system. It is quite apparent that each individual alcoholic's drinking pattern is somewhat unique. The particular culture of which the alcoholic is a member, and the predominant alcoholic beverage itself also affects the particular drinking pattern of an individual.

dependence on alcohol in the United States is usually characterized by heavy consumption of strong spirits during short periods of the day, by a tendency to periodic drinking, and by overt drunkenness. In some other countries, on the other hand, alcohol is customarily consumed in wine, usually with meals. In these countries, dependence on alcohol is characterized by the drinking of wine throughout the day, by a relatively continuous intake of alcohol in this manner, and by relatively little overt drunkenness. A similar pattern occurs where beer is the common beverage.

Closely aligned with the drinking pattern component is the idea of intent, purpose, or motivation for drinking. In an experiment where patients could be rewarded

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with alcohol or money by performance of a simple operant task, the researchers found that:

alcoholics do not drink the maximum amount of alcohol available and under the conditions of this experiment do not drink to achieve a state of oblivion. 102

The authors concluded that "motivation for alcohol is a complex interaction of availability and effort required to obtain alcohol." 103

In terms of the alcoholic's own conscious perception of his reasons for drinking, Gerard and Saenger provide the following information based on a study of 686 patients.

Fifty six percent drank for relief of psychological symptoms, especially anxiety and depression; fourteen percent sought alleviation of physical symptoms or discomfort, such as menstrual cramps, peripheral vascular disease, arthritis; twenty eight percent felt they drank because they could not stop, which of course was the most appealing type of evidence for the fact of, or the belief by patients in, their dependent need for alcohol. On the other hand, eleven percent boldly asserted that they had no need to stop drinking because their drinking was completely under their control; parenthetically, they were sometimes acutely intoxicated while making this assertion. 104

103 Ibid., p. 116.
Despite the various frequencies of drinking and the complexity of factors involved in terms of individual alcoholics' motivations for drinking, an attempt has been made by some authors to classify drinking behavior into a few select categories.

Abstinence has been designated as one such category, and of course, refers to those individuals who do not consume any alcohol whatsoever.

Controlled Drinking has been designated by Pattison as a category of drinking behavior which refers to alcohol use in a premeditated manner, at specific times, the intent of the drinker being to alter his state of consciousness through drinking, as a means of coping with a specifically perceived problem or situation. ¹⁰⁵

A third category, Normal Drinking, indicates alcohol use within customary boundaries, with no intent to use alcohol as a problem-solving mechanism. Social drinking is a name often applied to this category. ¹⁰⁶

The final category, Uncontrolled Drinking, also referred to as pathological drinking, encompasses those individuals who drink to make themselves unconscious, or

¹⁰⁵ E.M. Pattison, "Planning Treatment".
¹⁰⁶ James Drewery, "Social Drinking as a Therapeutic Goal in the Treatment of Alcoholism".
49.
to cause physical damage to themselves as a direct result of their alcohol consumption. 107

Having briefly reviewed the literature with regard to treatment approaches, self-concept, and drinking behavior, the writer has undertaken to develop three specific hypotheses to test for the possible associations between and among these three concepts. These hypotheses, and the framework within which they were tested, appear in the following chapter.

CHAPTER III
RESEARCH DESIGN

In accordance with the stated rationale for this study, the writer sought to collect and analyse data related to three hypotheses.

Specifically, the three hypotheses were:

1) Exposure to and involvement in the Connaught Clinic treatment program phases will result in a positive change in the self-concept of the individual patient, i.e., self-concept will improve as a result of treatment.

2) Exposure to and involvement in the treatment program phases will result in an improvement in the individual patient's drinking behavior.

3) There is an association between improvement in self-concept and improvement in drinking behavior.

It was believed that by gathering data related to the stated hypotheses, the concerns outlined in the previous sections of this report would be at least partially answered. In addition to the theoretical concerns, it was hoped that the collection and analysis of data related to the stated hypotheses would help to shed some objective light on the treatment program itself, since no research of this nature had previously been conducted at the Clinic. Findings of this study, related to the effects of the treatment program on patients' self-concepts and drinking behavior might conceivably lead to constructive changes in the program - if the results of
the study so indicated. Such a study might aid the
Clinic in its search for permanent status, funding,
and commitment from the local community and the
provincial government.

Assumptions

The following assumptions which related
specifically to this study, had a direct bearing on the
design framework, data collection, and analysis procedures
which were employed.

1) As far as could be determined by the writer, all
components of the treatment program phases were
constant during the time that the study was
conducted. These components included didactic
material and presentations to patients, treatment
personnel, and the overall structure and process
of the entire treatment program.

2) Variables other than those specifically measured
in the study were not regarded as being
responsible for affecting the predicted changes
in patients' self-concepts and drinking behavior.

Population

The study undertook to examine a particular,
time-limited sample population, rather than a random
sample. This population consisted of thirty-three (33)
persons, thirty-one (31) males, and two (2) females,
who, during the period commencing February 2, 1976, and
ending May 21, 1976, took part in the treatment program
at the Connaught Clinic, located at 1453 Prince Road,
Windsor, Ontario.

The Clinic program is designed to serve people in
the Windsor-Essex, Kent and Lambton County areas who suffer from a dependence on alcohol. During the time that this study was conducted, the Clinic program consisted of two phases. The first phase is known as the three week or day-care phase, and consists of the following components: lectures, films, discussions, group therapy, psychological testing, medical examinations, occupational therapy, and individual therapy. Patients attend this phase for three consecutive weeks, Monday to Friday, from 9:00 a.m. to 4:00 p.m.

The second phase of the program is known as the five week or follow-up phase. During this phase, patients attend one group therapy session per week for five weeks, and also receive individual therapy once per week for each of the five weeks.

The Clinic program operates on a closed-group, calendar basis, i.e., on the first Monday of every month, a new program commences with a new group of patients. Once the new program has begun, no new patients are admitted, even if someone in the patient group drops out or leaves part way through the program. Thus, a program might start with a full complement of twelve patients, and end with seven or eight patients.

The population used in this study consisted of three separate patient groups. Numbers and dates are
shown below:

<table>
<thead>
<tr>
<th>Group no.</th>
<th>No. of Patients in group</th>
<th>Date Begun 3 wk. phase</th>
<th>Date Completed 3 wk. phase</th>
<th>Date Completed 5 wk. phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11</td>
<td>Feb. 2/76</td>
<td>Feb. 20/76</td>
<td>Mar. 26/76</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>Mar. 1/76</td>
<td>Mar. 19/76</td>
<td>Apr. 23/76</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>Mar. 29/76</td>
<td>Apr. 15/76</td>
<td>May 21/76</td>
</tr>
</tbody>
</table>

In order to be selected for this program, the applicant must be interviewed by a member of the Clinic staff a minimum of one time. In most cases, the applicant is seen individually by a staff member two or three times over a period of two to three weeks prior to entering the program. Final decisions as to admittance are made at a staff meeting which takes place during the week prior to the commencement of a new program. Applicants are subjectively assessed according to their motivation, desire for treatment, past treatment history, and their availability and willingness to participate fully in all parts of the program for the entire eight week period.

Persons who are judged by the staff to be severely disturbed for reasons other than those related to alcohol are not accepted. Those applicants who appear to be incapable of understanding the various components of the program (e.g., severely retarded persons) are not accepted. In such cases where a person is not accepted, the Clinic, in all instances, attempts to refer the person to a more
appropriate resource within the community. Biases of individual staff members toward potential patients were controlled effectively due to the procedure whereby an applicant required approval by a majority of staff in order to be selected for the program. It was also observed by the writer that in cases where the desireability or suitability of an applicant for the program was in question, there was a consistent tendency on the part of the Clinic staff to give the applicant the benefit of the doubt, and admit him or her to the program.

Finally, during the time that the study was conducted, the number of referrals for each subsequent monthly program was always very close to, if not equal to, the number of available spaces for the particular program, thus resulting in the acceptance of almost all applicants.

During the time that the writer worked at the Clinic, less than five applicants were rejected for the program, and in all cases, these rejections were based on the criteria which have been mentioned.

Methodology

In order to test the stated hypotheses, the following instruments were employed in this study.

1) A questionnaire was designed to obtain general information on each patient. Specifically, this questionnaire gathered data as to the age, sex, marital status, level of education, and employment status of each patient at the time he or she entered treatment. (see Appendix B)
2) A multi-variable, self-report instrument which is used to measure various components of the perceived self-concept of the individual. This instrument is known as the Tennessee Self-Concept Scale. (see Appendix B)

3) A self-report questionnaire, developed by the writer, which attempts to assess the individual's perception of his or her drinking behavior. (see Appendix B)

All three above mentioned instruments were administered to the patients in the following manner. As each patient entered the Clinic on the first morning of the respective three week phase, the patient was immediately greeted by the writer, who explained that he was a student worker at the Clinic. Each patient was told simply that a research project was being conducted, and was asked to complete the questionnaire package, which was then handed to the patient.

Each patient was assured that the results of the questionnaire would be kept completely confidential and would only be used for research purposes, and not for any part of the treatment program itself. Also, each patient was informed that he or she had been assigned a code number, and that no names would be used at any point in the research project.

Each patient was then taken to a large room in the Clinic and was given a place to sit at a table where the questionnaire could be completed. Each patient was asked to read all instructions prior to filling out the questionnaire, and to return the completed questionnaire
to the writer. Talking between and among patients was kept to a minimum, and when an individual completed his or her questionnaire, he or she was instructed to leave the room, and go to another area of the Clinic where coffee was available.

If a patient could not understand a particular question, or was not sure as to the correct answer, the writer responded by telling the patient to answer the question as it applied to himself or herself.

Time allotted for the completion of the questionnaire on the first morning, for each of the three groups was one hour. The majority of patients completed the entire questionnaire within twenty minutes. Fifty minutes was the longest time taken by any patient to complete the entire questionnaire.

The procedure for completing the questionnaires was carried out at three specific times for the entire subject population. Each patient completed a questionnaire on the first morning of the three week phase, as described above. The second measurement was taken on the morning of the final day of the three week phase. The third measurement was taken immediately prior to commencement of the final group therapy session of the five week phase.

During the taking of the second and third measurements, only the Tennessee Self-Concept Scale and the Drinking Behavior questionnaire were administered.
In addition, the words "During the past three weeks", were added as prefaces to all questions on the Drinking Behavior questionnaire which was administered at the second measurement time. The words "During the past five weeks", were added as prefaces to all questions on the Drinking Behavior questionnaire which was administered at the third measurement time.

By adding such prefaces, the responses to the Drinking Behavior questionnaire indicated the reported drinking behavior of each individual during the two program phases. By comparing responses to this questionnaire across all three measurement times, the writer was able to determine specific changes in the reported drinking behavior on the part of each patient.

Following the completion of the questionnaires at the third measurement time, patients were informed as to the purpose and intent of the research project, and were also given an explanation of the instruments which had been employed. This was the only time that patients were informed as to the nature of the instruments themselves, and the project as a whole.

The Tennessee Self-Concept Scale

This particular instrument was selected for use in this study for several reasons. Firstly, the Scale had been used in similar projects, and it was felt that the
results of this study might be compared to these already completed studies. 108, 109

In order that this comparison might be accomplished the writer selected eleven (11) key sub-scores from the thirty-two (32) sub-scores which comprise the entire Scale. The remaining Scale sub-scores were not selected as they were not regarded as essential to the measurement and assessment of self-concept changes within the context of this study.

The eleven selected sub-scores, in addition to being regarded as the major indices of overall self-concept by the writer, appear in both studies whose results were to be compared to those of the present study.

The eleven selected sub-scores are described as follows:

1) Self-Criticism (SC) Score 110
This scale is composed of ten items, and consists of mildly derogatory statements which most people admit to as being true for them. High scores indicate a normal and healthy openness and capacity for self-criticism.

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Scores above the 99th percentile indicate a lack of defenses, and indicate possible pathological undefensiveness. Low scores indicate defensiveness and suggest that the Positive Scores are probably artificially elevated.

2) The Total Positive (Total P) Score
   This is the single most important score on the entire scale, as it indicates the overall level of self-esteem. People who score high on this scale generally like themselves, feel that they have value and worth, and display these feelings by their behavior. Low scorers are doubtful as to their worth, see themselves as undesirable, have little faith or confidence in themselves, and display feelings of anxiety, depression, and unhappiness.

3) The Row One(1) Score (Identity)
   The score on this scale indicates how the individual sees himself as to what he is.

4) The Row Two(2) Score (Self-Satisfaction)
   This score indicates how the individual feels about himself which he describes in the Row One scale. Generally, this score reflects the level of self-satisfaction or self-acceptance.

5) The Row Three(3) Score (Behavior)
   This score measures the individual's perception of his functioning or behavior.

6) Column A Score (Physical Self)
   This score indicates the individual's view of his body, state of health, physical appearance, skills and sexuality.

7) Column B Score (Moral-Ethical Self)
   This score indicates the person's view of self in terms of moral worth, satisfaction with his religion and relationship to God.

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112 Ibid., p. 2.
113 Ibid., p. 2.
114 Ibid., p. 3.
115 Ibid., p. 3.
116 Ibid., p. 3.
8) **Column C Score (Personal Self)**

The individual's sense of personal worth and adequacy as well as an evaluation of personality, apart from the body and relationships to others is measured by this score.

9) **Column D Score (Family Self)**

This score reflects the person's feelings of adequacy worth and value as a family member, in addition to indicating the perception of self in relation to one's most immediate and closest circle of associates.

10) **Column E Score (Social Self)**

The individual's sense of adequacy and worth in social interactions with people in general is indicated by this score.

11) **The Variability Score (Total V)**

High scores on this scale indicate that the person's overall self-concept is very inconsistent and is not highly integrated. High scorers tend to see themselves in a compartmental way, and view certain parts of themselves quite apart from the remainder of self. Well integrated people score below the mean, but above the first percentile on this scale.

In addition to the Scale's precision in measuring several key components of self-concept, it can easily be completed by anyone twelve years of age or over, and requires minimal reading and comprehension ability.

The Scale did not require the services of a psychometrist for its administration or scoring, and was also chosen for its standardized scoring procedures, which helped to minimize the possibility of researcher bias or error.

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Finally, the Scale was chosen for use in this study due to the availability of standardized means, standard deviations, and reliability coefficients for a normal population. The writer hoped to compare the scores of this study's population to those of the designated normal population.

**Drinking Behavior Questionnaire**

This particular instrument was designed and developed by the writer, the aim being the ability to classify each patient according to the perceived frequency of consumption and intent with regard to alcohol use. By comparing responses to this questionnaire over the three time periods it was hoped that changes in the patients' drinking behavior could be recorded and analysed.

From the literature, a classification system was developed which defined drinking behavior according to frequency of consumption and intent for initial drinking. The resultant classification system consisted of the following seven categories:

1) Abstinent (A)
2) Normal Irregular (NI)
3) Normal Regular (NR)
4) Controlled Irregular (CI)
5) Controlled Regular (CR)
6) Uncontrolled Irregular (UI)
7) Uncontrolled Regular (UR)

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121 Fitts, *The Tennessee Self-Concept Scale Manual*, p. 14. Norms based on a sample of 626 persons, are range from 12-to-68, approximately equal numbers of both sexes, and representatives of all social, economic, intellectual and educational levels from sixth grade through the Ph.D. degree.}
As abstinence is one of the Clinic program's goals, the Abstinent category was chosen as the ideal position on the drinking behavior scale for the purposes of the study. The remaining six categories were placed in relation to the Abstinent category in terms of their respective distance from the ideal.

(A) (NI) (NR) (CI) (CR) (UI) (UR)

Improvement or positive change in drinking behavior was assessed as movement from right to left on the above scale. For example, a person who, during the course of treatment changed from an uncontrolled regular (UR) drinker to a controlled irregular (CI) drinker, would be regarded as having improved his or her drinking behavior.

This instrument took the form of a self-report questionnaire consisting of eighteen questions, which patients answered on a five point scale. The responses were then scored by the writer, using a fixed question cluster scoring procedure, in order to arrive at a category designation for each patient.

The limited time and resources of the writer, as well as the time boundaries imposed by the Clinic program precluded the use of a structured interview schedule as a means of assessing reported drinking behavior. Realistically, the questionnaire format was chosen as the practically optimal instrument in the present study situation.
Verification of the accuracy of the questionnaire was accomplished by comparing the responses of Group (1) at measurement time one (1), with the responses given by these same patients to questions on the intake and assessment forms completed on each patient during their application and intake interviews. This comparison indicated that the questionnaire was 90 percent accurate in being able to classify patients' drinking behavior according to how they had described their drinking during intake.

**Operational Definitions**

The following operational definitions were employed in the research design of this study.

**Clinic treatment program phases** - an eight week program designed to treat alcohol dependent persons. The program consists of two phases: a three week day-care phase during which patients attend daily (Monday to Friday, 9:00 a.m. to 4:00 p.m.). During this time patients receive group therapy, discussions, films, lectures, individual therapy, medical examinations and occupational therapy. The second, or five week phase consists of one group therapy session per week for five weeks, as well as individual therapy once per week for this period.

**Connaught Clinic staff** - At the time this study was conducted the staff was composed of the following personnel: the Clinic supervisor, the Clinic secretary, a medical...
doctor, a social service worker, three social work students from the University of Windsor, and several staff members of the Addiction Research Foundation who participated as lecturers and discussion leaders on a rotating basis.

Self-Concept - as measured by the Tennessee Self-Concept Scale. Specifically, eleven dimensions of self-concept were measured in this study.

Drinking Behavior - as measured by the aforementioned Drinking Behavior questionnaire.

Design Classification and Limitations

The present study may be classified as an Hypothesis-Testing Study, and as such, it represents one sub-type of a major category of research studies, known as Quantitative-Descriptive Studies. This classification system was developed and outlined by Tripodi et al., in their book, The Assessment of Social Research.

The major purpose of hypothesis-testing studies is the testing of hypotheses which are usually related to, or derived from theory. The present study sought to test three such hypotheses by use of a self-report questionnaire.

Practical and ethical considerations precluded the use of control groups and manipulation of the independent

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variable (treatment program). In light of these factors
the hypothesis-testing design framework was chosen,
although the hypotheses posed lent themselves to other
design types and applications.

The hypotheses posed were of two types. The first
two hypotheses posit a cause-effect relationship, while
the third hypothesis attempts to test for the existence
of an association between two dependent variables, without
suggesting any causal relationship.\textsuperscript{123}

The literature describing hypothesis-testing
designs notes the limitations of such frameworks. The
limitations which are applicable to the present study
are as follows:

\textbf{Internal Validity}

When considering the effect of the treatment
program on self-concept and drinking behavior of the study
population several factors as outlined by Issac and Michael
apply to the procedures employed in this study.
Contemporary History\textsuperscript{124}

This factor is concerned with the experiences the
study population may have outside the experimental
situation. These experiences may affect the scores of the
study population in regard to the dependent variables

\textsuperscript{123} Tripodi, et al., The Assessment of Social
Research, p. 34.

\textsuperscript{124} Stephen Issac and William B. Michael,
Handbook in Research and Evaluation (San Diego: EdITS
being measured.

This factor applies very much to the present study. During the three week phase, patients were exposed to the treatment program a total of six hours per day, leaving them a great deal of time to be exposed to other potential influences. The same holds true for the five week phase, where patients were exposed to treatment for approximately one and one half hours per week.

Although the assumption has been stated that predicted changes in self-concept and drinking behavior occur only as a result of exposure to the treatment program, the assumption itself and the factor of contemporary history comprise one of the study's major limitations. Pretesting Procedures, and Familiarity with the Instrument.

By administering the same instrument several times within a short time period, as is the case in this study, subjects' responses on T₂ and T₃ may be inaccurate due to their recent exposure to the instrument at T₁.

The factor of test recency had been a major concern since the beginning of the study. However, this concern largely disappeared when the majority of subjects reported that they had completely forgotten completing the questionnaire at any time. (One group was so insistent on this point, that the writer was almost convinced that he

125 Issac and Michael, Handbook in Research, p. 32.
had forgotten to administer the instrument to this particular group.)

**Measuring Instruments**

Changes in the instruments, raters, interviewers, or scoring procedures can affect the obtained results. This factor is minimally applicable in the present study. Mention has been made as to word changes (prefaces) with the drinking behavior questionnaire. These prefaces did not at all alter the meaning or subsequent scoring of this questionnaire. Both the Tennessee Scale and the Drinking Behavior questionnaire are numerically, and key scored, respectively, and cannot be altered or arbitrarily interpreted by the marker. The Tennessee Scale is particularly strong in this area as all sub-scores are computed both vertically and horizontally, thus providing an instant double-check as to possible mathematical scoring errors.

**Differential Selection of Subjects**

This factor comprises the second major limitation of this study. Because of the selection method of patients for the treatment program, it is conceivable that certain "types" of people are not accepted for the program, and are therefore not represented in the study's population.

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Differential Experimental Mortality

The third major limitation of the study concerns those subjects who dropped out or prematurely terminated treatment during the course of the study. Of the total thirty-three (33) subjects, four (4) terminated treatment without completing the three week phase, while an additional seventeen (17) subjects did not complete the five week phase. Of these twenty-one drop outs, almost all were known to be experiencing difficulty with their drinking either immediately prior to, or immediately following their termination of treatment.

This factor had a serious effect on the study. The implication was that those people who appear to be suffering the most from their alcohol use, do not complete all phases of the program. Thus, only those people who do relatively well in the program end up being measured at all three points in the study. The study’s results in terms of changes in self-concept and drinking behavior may apply only to a very small and select population. Thus, the results may be exaggerated or distorted.

Statistical Procedures

A variety of statistical procedures were employed in the analysis obtained from this study.

The demographic variables obtained from the first

128 Issac and Michael, Handbook in Research, p. 33.
section of the questionnaire were regarded as nominal data and were processed accordingly to ascertain frequencies and related percentages.

The sub-scores of the Tennessee Self-Concept Scale were treated as interval data, and were accordingly processed by a series of one-tailed t-tests to yield means and differences between these at all three measurement times.

A t-test series was also employed to ascertain changes in Drinking Behavior.

In order to test the third hypothesis, the Spearman Rank Order Correlation Co-efficient was employed.

The analysis of the data obtained from the study's procedures appears in the following chapter.
CHAPTER IV

ANALYSIS OF DATA

The analysis of data related to the three stated hypotheses is presented in the following manner. The first section of the chapter describes the total population according to the following headings:

A) age
B) sex
C) marital status
D) education
E) employment status

Presentation and examination of these variables will provide a description of the population, with regard to the frequency of observations and their related percentages.

For the purposes of analysis, each research subject has been assigned to a distinct subgroup, based on the length of time each person remained in the treatment program. Specifically, Subgroup 1 consists of those twelve subjects who completed both the three week and five week program phases. Subgroup 2 consists of the seventeen subjects who completed the three week phase, but, did not complete the five week phase. Finally, Subgroup 3 consists of the four subjects who did not complete either of the two program phases.
In the second section of this chapter each subgroup will be examined as to their demographic characteristics, and a description of these variables as to the observed frequencies and their related percentages will be given.

The third section of the chapter will present and examine data related to the first hypothesis. Analysis of data in this section is performed independently for each subgroup. The fourth section of the chapter will examine data related to the second hypothesis, and once again, data for each subgroup is examined independently. The fifth and final section of this chapter describes data related to the third hypothesis.

I Description of the Population

A) Age:

The population consisted of thirty-three subjects, ranging in age from twenty-two to sixty years of age, as indicated in Table 1.

<table>
<thead>
<tr>
<th>AGE IN YEARS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>22-30</td>
<td>9</td>
<td>27.3</td>
</tr>
<tr>
<td>31-40</td>
<td>12</td>
<td>36.5</td>
</tr>
<tr>
<td>41-50</td>
<td>7</td>
<td>21.1</td>
</tr>
<tr>
<td>51-60</td>
<td>5</td>
<td>15.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>33</td>
<td>100.0</td>
</tr>
<tr>
<td>MEAN AGE</td>
<td>38.27 years</td>
<td></td>
</tr>
</tbody>
</table>
The largest category consisted of those subjects 31-40 years of age who comprised 36.5%(12) of the population. The next largest category was composed of those subjects from 22-30 years of age who comprised 27.3%(9) of the population. The third largest category was made up of those subjects ranging in age from 41-50 and comprising 21.7%(7) of the population, while the smallest category was composed of 5 subjects in the 51-60 age range, who represented 15.1% of the population. The mean age of the population was 38.27 years.

B) Sex:

The population consisted of thirty-one males, who represented 93.9% of the population, and two females who represented 6.1% of the population as indicated by Table 2.

<table>
<thead>
<tr>
<th>SEX</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE</td>
<td>31</td>
<td>93.9</td>
</tr>
<tr>
<td>FEMALE</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>

C) Marital Status:

Those subjects who were single represented 12.1%(4) of the population, while 42.4%(14) were married. Divorced persons represented 6.1%(2) of the population, with separated subjects comprising 24.2%(8). Those people
living in a common-law union accounted for 15.2%(5) of the population, as indicated by Table 3.

TABLE 3
MARITAL STATUS

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>single</td>
<td>8</td>
<td>12.1</td>
</tr>
<tr>
<td>married</td>
<td>14</td>
<td>42.4</td>
</tr>
<tr>
<td>divorced</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>separated</td>
<td>8</td>
<td>24.2</td>
</tr>
<tr>
<td>common-law</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>

D) Education:

The population's educational attainment ranged from Grade 0-5 to 3 years attendance at Community College. As indicated by Table 4, 91.9%(3) of the population had completed their education at the Grade 0-5 level, while 39.4%(13) had achieved Grade 6-8. Those people completing Grade 9-11 comprised 33.3%(11) of the population, while 6.1%(2) had completed Grade 12-13. Three subjects, representing 9.1% of the population had completed some trade or technical training, after either Grade 8 or 12, and one subject(3.0%) had completed, 3 years of Community College.


### Table 4

**EDUCATION**

<table>
<thead>
<tr>
<th>EDUCATION last year completed</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 0-5</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Grade 6-8</td>
<td>13</td>
<td>39.4</td>
</tr>
<tr>
<td>Grade 9-11</td>
<td>11</td>
<td>33.3</td>
</tr>
<tr>
<td>Grade 12-13</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>Trade/Technical Training</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Community College 3 years</td>
<td>1</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**TOTAL** | 33 | 100.0 |

E) Employment Status:

Those subjects who were employed at the time they entered treatment comprised 63.6% (21) of the population while those who were unemployed represented 30.3% (10). One subject (3.0%) was retired, and one (3.0%) was a housewife. Table 5 describes the employment status of the population.

### Table 5

**EMPLOYMENT STATUS**

<table>
<thead>
<tr>
<th>EMPLOYMENT STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>employed</td>
<td>21</td>
<td>63.6</td>
</tr>
<tr>
<td>unemployed</td>
<td>10</td>
<td>30.3</td>
</tr>
<tr>
<td>retired</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>housewife</td>
<td>1</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**TOTAL** | 33 | 100.0 |
II Description of the Three Subgroups

Subgroup 1.
A) Age: Subgroup 1.

The twelve subjects of Subgroup 1 ranged in age from twenty-six years to fifty-six years, with the mean age being 38.91 years.

TABLE 6

<table>
<thead>
<tr>
<th>AGE</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>26-35</td>
<td>5</td>
<td>41.6</td>
</tr>
<tr>
<td>36-45</td>
<td>4</td>
<td>33.4</td>
</tr>
<tr>
<td>46-56</td>
<td>3</td>
<td>24.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>

MEAN AGE 38.91 years

B) Sex: Subgroup 1.

Table 7 indicates that Subgroup 1 consisted of eleven males and one female.

TABLE 7

<table>
<thead>
<tr>
<th>SEX</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11</td>
<td>91.7</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>
C) Marital Status: Subgroup 1.

Table 8 indicates that 8.3%(1) of this population were single, 58.3%(7) were married, 8.3%(1) were divorced, 8.3%(1) were separated, while 16.7%(2) were living common-law.

**TABLE 8**

MARITAL STATUS - SUBGROUP 1

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>single</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>married</td>
<td>7</td>
<td>58.3</td>
</tr>
<tr>
<td>divorced</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>separated</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>common-law</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

D) Education: Subgroup 1.

Table 9 indicates the levels of education for the population of this subgroup.

**TABLE 9**

EDUCATION - SUBGROUP 1

<table>
<thead>
<tr>
<th>EDUCATION last grade completed</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 0-5</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Grade 6-8</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Grade 9-11</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Grade 12-13</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Trade/Tech</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Community College 3yr.</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Subgroup 1 consisted of ten employed people who comprised 83.3% of the population, while the two unemployed subjects represented 16.7% of the subgroup's population, as is indicated by Table 10.

<table>
<thead>
<tr>
<th>EMPLOYMENT STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>employed</td>
<td>10</td>
<td>83.3</td>
</tr>
<tr>
<td>unemployed</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Summary of Demographic Variables - Subgroup 1.

In order to test for possible relationships between the previously described characteristics of this subgroup, a series of crosstabulations was performed. Significance was not revealed for any of the variables when crosstabulated with each other. This finding would seem to suggest that the demographic characteristics for Subgroup 1 were quite independent of each other, and did not exert any noticeable influence on one another.

Subgroup 2.
A) Age: Subgroup 2.

The seventeen subjects of this subgroup ranged in age from twenty-two to sixty years, the mean age being 38.0 years. Table 11 illustrates the age frequencies and percentages for this subgroup.
TABLE 11

AGE - SUBGROUP 2

<table>
<thead>
<tr>
<th>AGE</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>22-30</td>
<td>6</td>
<td>35.4</td>
</tr>
<tr>
<td>31-40</td>
<td>3</td>
<td>17.7</td>
</tr>
<tr>
<td>41-50</td>
<td>6</td>
<td>35.4</td>
</tr>
<tr>
<td>51-60</td>
<td>2</td>
<td>11.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>17</td>
<td>100.0</td>
</tr>
</tbody>
</table>

MEAN AGE 38.00 years

B) Sex: Subgroup 2.

All seventeen subjects in this subgroup were males as is indicated by Table 12.

TABLE 12

SEX - SUBGROUP 2

<table>
<thead>
<tr>
<th>SEX</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>17</td>
<td>100.0</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>17</td>
<td>100.0</td>
</tr>
</tbody>
</table>

C) Marital Status: Subgroup 2.

Single subjects in this subgroup comprised 11.8%(2) of the population, while 35.3%(6) were married. Divorced subjects constituted 5.9%(1) of the subgroup's population, while those subjects who were separated represented 35.3%(6). Finally, Table 13 indicates that 11.8%(2) of this subgroup's population were living in a common-law union.
TABLE 13
MARITAL STATUS - SUBGROUP 2

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>single</td>
<td>2</td>
<td>11.8</td>
</tr>
<tr>
<td>married</td>
<td>6</td>
<td>35.3</td>
</tr>
<tr>
<td>divorced</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>separated</td>
<td>6</td>
<td>35.3</td>
</tr>
<tr>
<td>common-law</td>
<td>2</td>
<td>11.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>17</td>
<td>100.0</td>
</tr>
</tbody>
</table>

D) Education: Subgroup 2.

Table 14 indicates that the educational attainment levels of this subgroup ranged from Grade 0-5 to Grade 12-13.

TABLE 14
EDUCATION - SUBGROUP 2

<table>
<thead>
<tr>
<th>EDUCATION last grade completed</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 0-5</td>
<td>2</td>
<td>11.8</td>
</tr>
<tr>
<td>Grade 6-8</td>
<td>8</td>
<td>47.1</td>
</tr>
<tr>
<td>Grade 9-11</td>
<td>6</td>
<td>35.3</td>
</tr>
<tr>
<td>Grade 12-13</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>17</td>
<td>100.0</td>
</tr>
</tbody>
</table>


Employed people represented 52.9% (9) of this subgroup's population, while unemployed people composed 41.2% (7) of the population. As Table 15 indicates, one
subject, representing 5.9% of the subgroup's population, was retired.

TABLE 15

EMPLOYMENT STATUS - SUBGROUP 2.

<table>
<thead>
<tr>
<th>EMPLOYMENT STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>employed</td>
<td>9</td>
<td>52.9</td>
</tr>
<tr>
<td>unemployed</td>
<td>7</td>
<td>41.2</td>
</tr>
<tr>
<td>retired</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>17</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Summary of Demographic Variables - Subgroup 2

A series of crosstabulations was again performed and as with Subgroup 1, no significance was revealed between any of the above described variables, once again suggesting that for Subgroup 2, the variables were fairly independent, and exhibited little influence on one another.

Subgroup 3.
A) Age: Subgroup 3.

Subgroup 3, consisting of the four subjects who did not complete either of the two program phases was also the smallest of the three subgroups. Their ages ranged from twenty-six to forty-five years, with the mean age being 37.5 years, as Table 16 indicates.

B) Sex: Subgroup 3.

Subgroup 3 consisted of three males and one female, as is shown by Table 17.
C. Marital Status: Subgroup 3.

Each subject in Subgroup 3 represents a different marital status category, as is indicated by Table 18.

TABLE 18
MARITAL STATUS - SUBGROUP 3.

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>single</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td>married</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td>separated</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td>common-law</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
D) Education: Subgroup 3.

Two subjects, representing 50% of the population, completed Grade 6-8, while the remaining 50%(2) had completed Grade 9-11.

<table>
<thead>
<tr>
<th>EDUCATION last grade completed</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 6-8</td>
<td>2</td>
<td>50.0</td>
</tr>
<tr>
<td>Grade 9-11</td>
<td>2</td>
<td>50.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>


As is indicated by Table 20, 50%(2) of Subgroup 3's population were employed, 25%(1) were unemployed, while one subject (25%) was a housewife.

<table>
<thead>
<tr>
<th>EMPLOYMENT STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>employed</td>
<td>2</td>
<td>50.0</td>
</tr>
<tr>
<td>unemployed</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td>housewife</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Summary of Demographic Variables - Subgroup 3.

Consistent with the procedures employed for Subgroups 1 and 2, crosstabulations were performed on the demographic variables for Subgroup 3. Once again,
significance of relationships was not revealed, suggesting that the variables described in this section were independent of each other, and had little influence on one another.

Comparison of Demographic Variables for 3 Subgroups

Table 21 provides a comparison of the frequencies and percentages of the demographic variables for all three subgroups. Extensive analysis with regard to this comparison has not been carried out, but a certain trend has been observed, and is noted. It was stated in the second chapter of this report that those persons with a higher degree of education, stable employment, and family ties are often given priority when applying for treatment because they are often regarded as better success possibilities than those applicants who do not possess such characteristics. It is interesting to consider these criteria when examining Table 21. Subgroup 1, whose twelve subjects completed both program phases, consistently exhibits higher percentages in terms of marital ties, employment, and higher levels of education than the other two subgroups. Subgroup 2, whose members completed one of two program phases, also tends to show higher levels on these demographic variables than Subgroup 3, with the exception of education.

The reader is cautioned that analysis to determine the possible significance of these observations was not performed, but nevertheless, the trend appears to have some
TABLE 21

COMPARISON OF DEMOGRAPHIC CHARACTERISTICS FOR THREE SUBGROUPS

<table>
<thead>
<tr>
<th>DEMOGRAPHIC VARIABLE</th>
<th>SUBGROUP 1</th>
<th>SUBGROUP 2</th>
<th>SUBGROUP 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>freq. %</td>
<td>freq. %</td>
<td>freq. %</td>
</tr>
<tr>
<td>AGE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22-30</td>
<td>2 16.6</td>
<td>6 35.4</td>
<td>1 25.0</td>
</tr>
<tr>
<td>31-40</td>
<td>7 58.4</td>
<td>3 17.4</td>
<td>2 50.0</td>
</tr>
<tr>
<td>41-50</td>
<td>0</td>
<td>6 35.4</td>
<td>1 25.0</td>
</tr>
<tr>
<td>51-60</td>
<td>3 24.9</td>
<td>2 11.8</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12 100.0</td>
<td>17 100.0</td>
<td>4 100.0</td>
</tr>
<tr>
<td>MEAN AGE</td>
<td>38.9 years</td>
<td>38.0 years</td>
<td>37.5 years</td>
</tr>
<tr>
<td>SEX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>11 91.7</td>
<td>17 100.0</td>
<td>3 75.0</td>
</tr>
<tr>
<td>female</td>
<td>1 8.3</td>
<td>0</td>
<td>1 25.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12 100.0</td>
<td>17 100.0</td>
<td>4 100.0</td>
</tr>
<tr>
<td>MARITAL STATUS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>single</td>
<td>1 8.3</td>
<td>2 11.8</td>
<td>1 25.0</td>
</tr>
<tr>
<td>married</td>
<td>7 58.3</td>
<td>6 35.3</td>
<td>1 25.0</td>
</tr>
<tr>
<td>divorced</td>
<td>1 8.3</td>
<td>1 5.9</td>
<td>0</td>
</tr>
<tr>
<td>separated</td>
<td>1 8.3</td>
<td>6 35.3</td>
<td>1 25.0</td>
</tr>
<tr>
<td>common-law</td>
<td>2 16.7</td>
<td>2 11.8</td>
<td>1 25.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12 100.0</td>
<td>17 100.0</td>
<td>4 100.0</td>
</tr>
<tr>
<td>EDUCATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 0-5</td>
<td>1 8.3</td>
<td>2 11.8</td>
<td>0</td>
</tr>
<tr>
<td>Grade 6-8</td>
<td>3 25.0</td>
<td>8 47.1</td>
<td>2 50.0</td>
</tr>
<tr>
<td>Grade 9-11</td>
<td>3 25.0</td>
<td>6 35.3</td>
<td>2 50.0</td>
</tr>
<tr>
<td>Grade 12-13</td>
<td>1 8.3</td>
<td>1 5.9</td>
<td>0</td>
</tr>
<tr>
<td>Tech. Training</td>
<td>3 25.0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community College</td>
<td>1 8.3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12 100.0</td>
<td>17 100.0</td>
<td>4 100.0</td>
</tr>
<tr>
<td>EMPLOYMENT STATUS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>employed</td>
<td>10 83.3</td>
<td>9 52.9</td>
<td>2 50.0</td>
</tr>
<tr>
<td>unemployed</td>
<td>2 16.7</td>
<td>7 41.2</td>
<td>1 25.0</td>
</tr>
<tr>
<td>retired</td>
<td>0</td>
<td>1 5.9</td>
<td>0</td>
</tr>
<tr>
<td>housewife</td>
<td>0</td>
<td>0</td>
<td>1 25.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12 100.0</td>
<td>17 100.0</td>
<td>4 100.0</td>
</tr>
</tbody>
</table>
validity. Further research might be indicated by these results.

III Analysis of Data Related to Improvement in Self-Concept

In order to determine the effect of the treatment program on patients' self-concepts the writer performed a series of t-tests on the eleven selected sub-scores of the Tennessee Self-Concept Scale, over the three measurement times.

Results of this analysis are reported in this section. Results for the entire program are available for Subgroup 1 only, while changes between Time 1 and Time 2 are recorded for Subgroup 2. Finally, the Time 1 scores for Subgroup 3 are presented.

Subgroup 1.

Table 22 examines the changes in the self-concept scores between Time 1 and Time 2 for this subgroup. As the table indicates, positive change occurred in eight of the eleven measured dimensions, while negative change occurred in three dimensions. It was also revealed that significant change occurred in four of the eleven measured dimensions during the three week program phase.

Table 23 presents the results of the self-concept score changes during the five week phase of the program. This analysis reveals that positive change occurred in ten of the eleven dimensions, and that this change was significant in five of these eleven dimensions.
TABLE 22
ANALYSIS OF SELF-CONCEPT CHANGES BETWEEN TIME 1 AND TIME 2 FOR SUBGROUP 1

<table>
<thead>
<tr>
<th>SUB-SCORE NAME AND MEANING</th>
<th>MEAN SCORE TIME 1</th>
<th>MEAN SCORE TIME 2</th>
<th>DIRECTION OF CHANGE</th>
<th>SIGNIFICANCE OF CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.C self-criticism</td>
<td>34.41</td>
<td>35.33</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>TOTAL P total self-esteem</td>
<td>296.33</td>
<td>309.66</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>ROW 1 identity</td>
<td>108.00</td>
<td>116.50</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>ROW 2 self-satisfaction</td>
<td>93.50</td>
<td>92.75</td>
<td>-</td>
<td>N.S.</td>
</tr>
<tr>
<td>ROW 3 behavior</td>
<td>94.83</td>
<td>100.41</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>COLUMN A physical self</td>
<td>61.16</td>
<td>66.66</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN B moral-ethical self</td>
<td>59.16</td>
<td>62.75</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN C personal self</td>
<td>54.91</td>
<td>58.41</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>COLUMN D family self</td>
<td>59.83</td>
<td>59.25</td>
<td>-</td>
<td>N.S.</td>
</tr>
<tr>
<td>COLUMN E social self</td>
<td>61.25</td>
<td>62.58</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>TOTAL V integration</td>
<td>45.25</td>
<td>51.08</td>
<td>-</td>
<td>N.S.</td>
</tr>
</tbody>
</table>
The changes in significance levels appear to indicate that changes in overall self-esteem, self-satisfaction, physical self, personal self, and family self continued to improve during the patients' exposure to the five week phase, while changes made in identity, behavior, moral-ethical self, social self, and integration of self began to stabilize during the five week phase.

Table 24 examines the self-concept score changes between Time 1 and Time 3, and as such, provides the best assessment as to the overall effect of the entire treatment program on the self-concepts of those people who were exposed to and participated in the whole program.

The results of this examination suggest that for those people who completed the entire program, overall self-concept significantly improved with the exception of the self-criticism, social self, and variability dimensions. Social self may not have improved during the program due to the fact that opportunities for exposure to social situations were greatly diminished for patients due to their involvement in the program itself, in addition to the fact that the program stressed the desireability of patients making an effort to find new friends and social activities, rather than return to situations with old acquaintances where drinking was prevalent.
<table>
<thead>
<tr>
<th>SUB-SCORE NAME AND MEANING</th>
<th>MEAN SCORE TIME 2</th>
<th>MEAN SCORE TIME 3</th>
<th>DIRECTION OF CHANGE</th>
<th>SIGNIFICANCE OF CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.C. self-criticism</td>
<td>35.33</td>
<td>33.91</td>
<td>-</td>
<td>N.S.</td>
</tr>
<tr>
<td>TOTAL P total self-esteem</td>
<td>309.66</td>
<td>332.58</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>ROW 1 identity</td>
<td>116.50</td>
<td>120.33</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>ROW 2 self-satisfaction</td>
<td>92.75</td>
<td>105.66</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>ROW 3 behavior</td>
<td>100.41</td>
<td>106.66</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>COLUMN A physical self</td>
<td>66.66</td>
<td>70.41</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN B moral-ethical self</td>
<td>/ 62.75</td>
<td>66.16</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>COLUMN C personal self</td>
<td>58.41</td>
<td>63.00</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN D family self</td>
<td>59.25</td>
<td>65.66</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN E social self</td>
<td>62.58</td>
<td>67.33</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>TOTAL V integration</td>
<td>51.08</td>
<td>49.66</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>SUB-Score Name and Meaning</td>
<td>Mean Score Time 1</td>
<td>Mean Score Time 3</td>
<td>Direction of Change</td>
<td>Significance of Change</td>
</tr>
<tr>
<td>----------------------------</td>
<td>------------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>S.C. self-criticism</td>
<td>34.41</td>
<td>33.91</td>
<td>-</td>
<td>N.S.</td>
</tr>
<tr>
<td>TOTAL P total self-esteem</td>
<td>296.33</td>
<td>332.58</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>ROW 1 identity</td>
<td>108.00</td>
<td>120.33</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>ROW 2 self-satisfaction</td>
<td>93.50</td>
<td>105.66</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>ROW 3 behavior</td>
<td>94.83</td>
<td>106.66</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN A physical self</td>
<td>61.16</td>
<td>70.41</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN B moral-ethical self</td>
<td>59.16</td>
<td>66.16</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN C personal self</td>
<td>54.91</td>
<td>63.00</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN D family self</td>
<td>59.83</td>
<td>65.66</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN E social self</td>
<td>61.25</td>
<td>67.33</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>TOTAL V integration</td>
<td>45.25</td>
<td>49.66</td>
<td>-</td>
<td>N.S.</td>
</tr>
</tbody>
</table>
The score changes in self-criticism and variability indicate a movement away from the mean scores given by Fitts for a normal population. It has been inferred from these scores that the members of Subgroup 1 were slightly less self-critical and slightly less integrated as to their overall perceptions of self than the normal population described by Fitts. However, the scores of Subgroup 1 on these two dimensions are consistent in direction with scores obtained in a study by Ashcraft and Fitts involving thirty psychotherapy patients, as well as being consistent with the results obtained by W.F. Cross in his study of alcoholics in a sixty day alcoholism treatment program.

Table 25 presents a comparison of Subgroup 1's scores with the scores obtained in these two similar studies.

The study by Ashcraft and Fitts studied thirty psychotherapy patients who had been exposed to therapy for at least one month. Although pre-treatment and post-treatment scores are not provided by the authors, the direction of change and level of significance are recorded, and appear in Table 25.

Ashcraft and Fitts suggest that the results of their study indicate that those subjects who were exposed to psychotherapy did improve in a predicted direction on those dimensions of self-concept which were measured.
The study conducted by W.F. Gross, which examined changes in 60 alcoholic patients over a sixty day period, revealed that the self-concept scores changed in the predicted direction on ten of the eleven measured dimensions. The recorded post-treatment scores for Gross's study population are presented in Table 25, and are compared to those obtained by this writer in the present study for Subgroup 1.

Subgroup 2

The seventeen people who comprised Subgroup 2 completed the three week or day-care phase of the Clinic program, but did not complete the five week or follow-up phase. Results of the t-test series for the eleven subscores for this group are presented in Table 26. These results suggest that the members of Subgroup 2 made significant changes in their self-concepts in seven of the eleven dimensions measured, and overall positive change in ten of the eleven dimensions.

Also of interest are the comparable scores at Time 1 and Time 2 for Subgroups 1 and 2. As is shown by Table 27, there are no glaring discrepancies between the scores obtained by these two subgroups at Time 1 or Time 2. In searching for a possible indication as to why people may have prematurely terminated their treatment, the writer is unable to make any inference from the data obtained with regard to self-concept.
### TABLE 25

**COMPARISON OF STUDY SCORES**

<table>
<thead>
<tr>
<th>SUB-SCORE</th>
<th>NORMAL MEAN SCORE</th>
<th>SUBGROUP 1 TIME 3 MEAN SCORE</th>
<th>POST-TREATMENT MEAN**</th>
<th>SUBGROUP 1 direction and sign. of change</th>
<th>POST-TREATMENT SCORE*** direction and sign.</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.C.</td>
<td>35.5</td>
<td>33.91</td>
<td>28.1</td>
<td>- N.S.</td>
<td>not given</td>
</tr>
<tr>
<td>TOTAL P</td>
<td>345.6</td>
<td>332.58</td>
<td>290.9</td>
<td>+ .05</td>
<td>+ .005</td>
</tr>
<tr>
<td>ROW 1</td>
<td>127.1</td>
<td>120.33</td>
<td>110.8</td>
<td>+ .05</td>
<td>+ .02</td>
</tr>
<tr>
<td>ROW 2</td>
<td>103.7</td>
<td>105.66</td>
<td>84.6</td>
<td>+ .05</td>
<td>+ .001</td>
</tr>
<tr>
<td>ROW 3</td>
<td>115.0</td>
<td>106.66</td>
<td>95.3</td>
<td>+ .05</td>
<td>+ .02</td>
</tr>
<tr>
<td>COLUMN À</td>
<td>71.8</td>
<td>70.41</td>
<td>61.8</td>
<td>+ .05</td>
<td>+ .005</td>
</tr>
<tr>
<td>COLUMN B</td>
<td>70.3</td>
<td>66.16</td>
<td>55.4</td>
<td>+ .05</td>
<td>+ .05</td>
</tr>
<tr>
<td>COLUMN C</td>
<td>64.6</td>
<td>63.00</td>
<td>55.0</td>
<td>+ .05</td>
<td>+ .005</td>
</tr>
<tr>
<td>COLUMN D</td>
<td>70.8</td>
<td>65.66</td>
<td>57.7</td>
<td>+ .05</td>
<td>+ .05</td>
</tr>
<tr>
<td>COLUMN E</td>
<td>68.1</td>
<td>67.33</td>
<td>60.9</td>
<td>+ N.S.</td>
<td>+ .01</td>
</tr>
<tr>
<td>TOTAL V</td>
<td>48.5</td>
<td>49.66</td>
<td>55.3</td>
<td>- N.S.</td>
<td>- .005</td>
</tr>
</tbody>
</table>

---


<table>
<thead>
<tr>
<th>SUB-SCORE NAME AND MEANING</th>
<th>MEAN SCORE TIME 1</th>
<th>MEAN SCORE TIME 2</th>
<th>DIRECTION OF CHANGE</th>
<th>SIGNIFICANCE OF CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.C. self-criticism</td>
<td>35.23</td>
<td>35.64</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>TOTAL P total self-esteem</td>
<td>290.76</td>
<td>313.52</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>ROW 1 identity</td>
<td>107.17</td>
<td>117.70</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>ROW 2 self-satisfaction</td>
<td>89.47</td>
<td>95.05</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>ROW 3 behavior</td>
<td>94.17</td>
<td>100.76</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN A physical self</td>
<td>58.76</td>
<td>63.05</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN B moral-ethical self</td>
<td>58.11</td>
<td>63.64</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN C personal self</td>
<td>53.82</td>
<td>59.82</td>
<td>+</td>
<td>.05</td>
</tr>
<tr>
<td>COLUMN D family self</td>
<td>59.94</td>
<td>63.64</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>COLUMN E social self</td>
<td>60.11</td>
<td>62.17</td>
<td>+</td>
<td>N.S.</td>
</tr>
<tr>
<td>TOTAL V integration</td>
<td>49.58</td>
<td>51.17</td>
<td>-</td>
<td>N.S.</td>
</tr>
<tr>
<td>SUB-SCORE NAME AND MEANING</td>
<td>SUBGROUP 1 MEAN SCORE TIME 1</td>
<td>SUBGROUP 2 MEAN SCORE TIME 1</td>
<td>SUBGROUP 1 MEAN SCORE TIME 2</td>
<td>SUBGROUP 2 MEAN SCORE TIME 2</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>S.C. self-criticism</td>
<td>34.41</td>
<td>35.23</td>
<td>35.33</td>
<td>35.64</td>
</tr>
<tr>
<td>TOTAL P total self-esteem</td>
<td>296.33</td>
<td>290.76</td>
<td>309.66</td>
<td>313.52</td>
</tr>
<tr>
<td>ROW 1 identity</td>
<td>108.00</td>
<td>107.17</td>
<td>116.50</td>
<td>117.70</td>
</tr>
<tr>
<td>ROW 2 self-satisfaction</td>
<td>93.50</td>
<td>89.47</td>
<td>92.75</td>
<td>95.05</td>
</tr>
<tr>
<td>ROW 3 behavior</td>
<td>94.83</td>
<td>94.17</td>
<td>100.41</td>
<td>100.76</td>
</tr>
<tr>
<td>COLUMNA physical self</td>
<td>61.16</td>
<td>58.76</td>
<td>66.66</td>
<td>63.05</td>
</tr>
<tr>
<td>COLUMNB moral-ethical self</td>
<td>59.16</td>
<td>58.11</td>
<td>62.75</td>
<td>63.64</td>
</tr>
<tr>
<td>COLUMNC personal self</td>
<td>54.91</td>
<td>53.82</td>
<td>58.41</td>
<td>59.82</td>
</tr>
<tr>
<td>COLUMND family self</td>
<td>59.83</td>
<td>59.94</td>
<td>59.25</td>
<td>63.64</td>
</tr>
<tr>
<td>COLUMNE social self</td>
<td>61.25</td>
<td>60.11</td>
<td>62.58</td>
<td>62.17</td>
</tr>
<tr>
<td>TOTAL V integration</td>
<td>45.25</td>
<td>49.58</td>
<td>51.08</td>
<td>51.17</td>
</tr>
</tbody>
</table>
Subgroup 3

The four subjects who comprised Subgroup 3 did not complete either of the two program phases. Time 1 mean scores for the eleven self-concept dimensions are presented in Table 28, which also compares these scores to the Time 1 scores of Subgroups 1 and 2.

The major discrepancies observed from an examination of Table 28 are those between the Total P and Total V scores. Although an extensive analysis was not performed, the results of Table 28 would seem to suggest that the members of Subgroup 3 had a lower level of overall self-esteem and were less integrated as to their own perceptions of self than those subjects in Subgroups 1 and 2, at the time treatment commenced.

Summary of Data Analysis Related to Self-Concept

The testing of the hypothesis that self-concept would improve as a result of exposure to the treatment program yielded the data which has been tabled and described in this section. On an overall basis it appears that the self-concepts of the patients who completed the entire program, as measured by the Tennessee Self-Concept Scale, did improve significantly. The results of the analysis of data also suggest that those subjects who completed the first treatment phase had improved self-concepts at the end of this phase, as indicated by the changes in the Scale sub-scores.
### Table 28
Comparison of Self-Concept Scores for All Subgroups at Time 1

<table>
<thead>
<tr>
<th>Sub-Score Name and Meaning</th>
<th>Subgroup 3 Mean Score Time 1</th>
<th>Subgroup 1 Mean Score Time 1</th>
<th>Subgroup 2 Mean Score Time 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.C. self-criticism</td>
<td>38.00</td>
<td>34.41</td>
<td>35.23</td>
</tr>
<tr>
<td>TOTAL P total self-esteem</td>
<td>282.25</td>
<td>296.33</td>
<td>290.76</td>
</tr>
<tr>
<td>ROW 1 identity</td>
<td>101.50</td>
<td>108.00</td>
<td>107.17</td>
</tr>
<tr>
<td>ROW 2 self-satisfaction</td>
<td>88.00</td>
<td>93.50</td>
<td>89.47</td>
</tr>
<tr>
<td>ROW 3 behavior</td>
<td>92.75</td>
<td>94.83</td>
<td>94.17</td>
</tr>
<tr>
<td>COLUMN A physical self</td>
<td>57.75</td>
<td>61.16</td>
<td>58.76</td>
</tr>
<tr>
<td>COLUMN B moral-ethical self</td>
<td>56.50</td>
<td>59.16</td>
<td>58.11</td>
</tr>
<tr>
<td>COLUMN C personal self</td>
<td>52.00</td>
<td>54.91</td>
<td>53.82</td>
</tr>
<tr>
<td>COLUMN D family self</td>
<td>59.75</td>
<td>59.83</td>
<td>59.94</td>
</tr>
<tr>
<td>COLUMN E social self</td>
<td>56.75</td>
<td>61.25</td>
<td>60.11</td>
</tr>
<tr>
<td>TOTAL V integration</td>
<td>54.75</td>
<td>45.25</td>
<td>49.58</td>
</tr>
</tbody>
</table>
IV Analysis of Data Related to Changes in Drinking Behavior

In order to test the hypothesis that drinking behavior of patients would improve as a result of exposure to the treatment program phases, a series of t-tests was performed for each subgroup. Once again, the reader is asked to note that improvement in drinking behavior was regarded as movement from right to left on the following drinking behavior category scale:

(A) (NI) (NR) (CI) (CR) (UI) (UR)*

1 2 3 4 5 6 7

A further note regarding statistical procedures is in order prior to presentation of the findings for this particular section. The drinking behavior improvement scale was regarded as ordinal due to the fact that it was not possible to state accurately that the distances between the categories were equal. It was also not feasible to assign equal values to these distances between categories. Thus, the use of interval statistical procedures such as a t-test, would normally be precluded. However, it has already been stated that a t-test was employed. Those readers who, with justification, wish to criticize the employment of interval procedures with ordinal data are asked to consider the following viewpoint and considered

*(the reader is referred to pages 61-63 for a complete description of the drinking behavior scale and the seven drinking behavior categories.)
opinion of Sanford Labovitz:

Although some small error may accompany the treatment of ordinal variables as interval, this is offset by the use of more powerful, more sensitive, better developed, and more clearly interpretable statistics with known sampling error. 129

Subgroup 1 - Drinking Behavior

Table 29 reveals the reported drinking behavior at Time 1 for the twelve subjects who comprised this subgroup's population. Those who perceived themselves as Uncontrolled Irregular drinkers accounted for 33.3%(4) of the population, while an additional 33.3%(4) regarded themselves as Uncontrolled Regular drinkers. One subject representing 8.3% of the population of this subgroup, saw himself as a Normal Regular drinker, while 16.7%(2) reported themselves as being Controlled Regular drinkers. One subject, comprising 8.3% of the population, could not be categorized.

At Time 2, 91.7%(11) of Subgroup 1 reported that they had been abstinent during the three week phase of the program, while one subject (8.3%) considered himself as a Normal Irregular drinker during the first program phase. Table 30 indicates the results of the measurements taken at Time 2.

128
TABLE 29
REPORTED DRINKING BEHAVIOR OF SUBGROUP 1
AT TIME 1

<table>
<thead>
<tr>
<th>DRINKING BEHAVIOR</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>normal regular</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>controlled irregular</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>uncontrolled irregular</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>uncontrolled regular</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>unable to categorize</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

TABLE 30
REPORTED DRINKING BEHAVIOR OF SUBGROUP 1
AT TIME 2

<table>
<thead>
<tr>
<th>DRINKING BEHAVIOR</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>abstinent</td>
<td>11</td>
<td>91.7</td>
</tr>
<tr>
<td>normal irregular</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

At the end of the entire program (Time 3) all subjects in Subgroup 1 reported themselves as abstinent during the five week phase, as indicated by Table 31.

TABLE 31
REPORTED DRINKING BEHAVIOR OF SUBGROUP 1
AT TIME 3

<table>
<thead>
<tr>
<th>DRINKING BEHAVIOR</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>abstinent</td>
<td>12</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Examination of Tables 29, 30, and 31, reveals that the reported drinking behavior of Subgroup 1 did improve from Time 1 to Time 2, from Time 2 to Time 3, and on an overall basis from Time 1 to Time 3.

Analysis of the t-test data revealed that the positive change in reported drinking behavior during the three week program phase was significant at the .001 level, as was the change in reported drinking behavior during the five week phase.

Finally, the positive change in reported drinking behavior for the entire program for Subgroup 1 was significant at the .001 level. These results would seem to indicate that for those people who completed the entire program, reported drinking behavior did improve significantly as a result of exposure to the treatment program.

Subgroup 2 - Drinking Behavior

Table 32 illustrates the reported drinking behavior of Subgroup 2 at Time 1 and Time 2. An examination of this table indicates that the subjects in this subgroup did improve their drinking behavior during the three week phase. The t-test results indicated that this change was significant at the .001 level. Once again, any inference as to why these subjects did not complete the second program phase cannot be drawn from the data related to reported drinking behavior.
TABLE 32
REPORTED DRINKING BEHAVIOR OF SUBGROUP 2
AT TIME 1 AND TIME 2

<table>
<thead>
<tr>
<th>DRINKING BEHAVIOR</th>
<th>TIME 1</th>
<th>TIME 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>frequency</td>
<td>%</td>
</tr>
<tr>
<td>abstinent</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>controlled irregular</td>
<td>3</td>
<td>17.6</td>
</tr>
<tr>
<td>controlled regular</td>
<td>3</td>
<td>17.6</td>
</tr>
<tr>
<td>uncontrolled irregular</td>
<td>3</td>
<td>17.6</td>
</tr>
<tr>
<td>uncontrolled regular</td>
<td>8</td>
<td>47.1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>17</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Subgroup 3 - Drinking Behavior

Table 33 provides a comparison of reported drinking behavior for all three subgroups at Time 1, and reveals that Subgroup 3 had the highest percentage of Uncontrolled Regular drinkers, as well as the second highest percentage of Uncontrolled Irregular drinkers. As a group then, Subgroup 3 represented the highest percentage of the two worst drinking behavior categories, at the time treatment commenced. However, both Subgroup 1 and Subgroup 2 had greater numbers of these types of drinkers, so that no conclusions can be drawn from this comparative data with regard to possible reasons for premature termination of treatment by the subjects in Subgroup 3.
TABLE 33
COMPARISON OF REPORTED DRINKING BEHAVIOR FOR ALL SUBGROUPS AT TIME 1

<table>
<thead>
<tr>
<th>DRINKING BEHAVIOR</th>
<th>SUBGROUP 1 frequency %</th>
<th>SUBGROUP 2 frequency %</th>
<th>SUBGROUP 3 frequency %</th>
</tr>
</thead>
<tbody>
<tr>
<td>abstinent</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>normal irregular</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>normal regular</td>
<td>1 8.3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>controlled irregular</td>
<td>2 16.7</td>
<td>3 17.6</td>
<td>0</td>
</tr>
<tr>
<td>controlled regular</td>
<td>0</td>
<td>3 17.6</td>
<td>0</td>
</tr>
<tr>
<td>uncontrolled irregular</td>
<td>4 33.3</td>
<td>3 17.6</td>
<td>1 25.0</td>
</tr>
<tr>
<td>uncontrolled regular</td>
<td>4 33.3</td>
<td>8 47.1</td>
<td>3 75.0</td>
</tr>
<tr>
<td>unable to categorize</td>
<td>1 8.3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12 100.0</strong></td>
<td><strong>17 100.0</strong></td>
<td><strong>4 100.0</strong></td>
</tr>
</tbody>
</table>

Summary of Data Analysis Related to Drinking Behavior

The results obtained for this section of the study seem to indicate that there was a significant and positive change in the reported drinking behavior of those subjects who completed either one or both phases of the program.

V Analysis of Data Related to the Association Between Self-Concept and Drinking Behavior

In order to test the hypothesis that there was an association between improvement in self-concept and improvement in drinking behavior, the following statistical procedures were carried out.

Firstly, the Total P sub-score of the Tennessee
Self-Concept Scale was selected to represent overall self-concept, and improvement in self-concept was assessed according to changes in the Total P score over the three measurement times.

Improvement in reported drinking behavior was assessed and noted as was described in the previous section of this chapter.

Two specific statistical procedures were employed in an attempt to determine if any association did, in fact exist between improvement in self-concept and improvement in drinking behavior. A series of crosstabulations was performed to yield chi square values. In addition, the more powerful Spearman Rank Order Correlation Co-efficient test was applied to the raw data. Both procedures were employed for each Subgroup. Results from Subgroup 1 would indicate if any association existed during the entire program, while results from Subgroup 2 would indicate the existence of any relationship during the first program phase.

The results obtained for this section of the study indicated no significance with regard to any association. Neither the Spearman Rank Order test, nor the chi square values indicated significance at the .05 level.

In addition to the lack of statistical significance there was no evidence of any trend toward the hypothesized association. In short, no evidence of any association was found by this study. These results suggest that for this
particular population, improvement in self-concept is not associated with improvement in drinking behavior, nor is improvement in drinking behavior associated with improvement in self-concept.
CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of the research project was to determine the effect of the Connaught Clinic treatment program on the self-concepts and reported drinking behavior of alcohol-dependent patients who participated in the Clinic's program. The Clinic was operated by the Windsor Western Hospital Centre with assistance from the local office of the Addiction Research Foundation. The population studied was a time-limited sample of patients who entered the program from February 2, 1976 to March 29, 1976.

The rationale for investigating the effect of the Clinic's program centred on the writer's interest in Alfred Adler's theory of Individual Psychology, which suggested that alcoholics drink as a means of coping with everyday problems due to their negative self-concepts. The Clinic represented one example of a conventional methods approach to alcoholism treatment, and many of its goals were indirectly based on Adler's theory.

In addition to the above mentioned theoretical concerns, it was felt that the results of the study might shed some objective light on the overall Clinic program. This idea had the support of the Clinic staff and administration.
The sample population was described and evaluated according to several demographic variables such as age, sex, marital status, education, and employment status, in addition to the scores obtained from the two instruments which attempted to measure several dimensions of self-concept, and drinking behavior, respectively.

The demographic variables were considered important in describing the characteristics of the population, while the data obtained from the self-concept and drinking behavior measurement instruments was analysed in an attempt to verify the three hypotheses posed by the writer.

I Summary of the Findings

The population studied in this project consisted of thirty-three patients, thirty-one males and two females, ranging in age from twenty-two to sixty years. 57.6% of the population was either married or living in a common-law union, while the remainder were either single, divorced, or separated.

The population as a whole had a low level of education, with 81.8% having a Grade 11 level education or less. 63.6% of the patients were employed at the time they entered treatment, the remainder being either unemployed, retired, or homemakers.

If one accepts the validity of the measurement instruments and their accuracy in assessing change in self-concept and drinking behavior respectively, then, the results
obtained in the investigation strongly suggest that exposure to, and participation in the Clinic program resulted in a positive and statistically significant change in the majority of dimensions of self-concept which were measured, for those patients who completed either one or both program phases. The results of this section of the study were also found to be similar to results obtained in two similar studies, conducted by Ashcraft and Pitts, and W.F. Gross.

The investigation also produced statistically significant results which strongly suggest that the reported drinking behavior of patients who completed at least one of the two program phases changed positively during the time that these patients were involved in the program.

The results obtained with regard to the third hypothesis were most surprising to this writer. No significant association was found to exist between an improvement in self-concept and improvement in drinking behavior, or visa versa.

For the population studied, this result would seem to raise certain questions regarding the interpretation of Adler's theory. Theoretically, an improvement in self-concept would seem to negate the use of alcohol as a coping mechanism, and result in a parallel improvement in drinking behavior. The results of this study suggest that improvement in drinking behavior and self-concept are quite
independent of one another. This result would seem to verify, at least partially, the viewpoint of authors such as E. Mansell Pattison, who has suggested that improvement in the alcoholic's ability to cope with the various life components is not necessarily related to any improvement in drinking behavior.

II Limitations of the Study

Two major limitations exist in this study. The first limitation concerns the self-reports of the patients on the drinking behavior questionnaire. The writer found it impossible to cross-check responses given to the questions posed by this instrument, which necessitated the assessment and acceptance of these responses at face value.

When asking patients to respond honestly to questions concerning their drinking, the writer was acutely aware of the potential invalidity of these responses. Caution is definitely required in assessing and analyzing the results obtained in this section of the study, as the questions asked were in no way disguised, and were thus easily available for manipulation.

The second limitation concerns the overall generalizability of the findings. The subjective admission criteria for the program immediately precludes any widespread applicability of this study's findings. In addition, the extreme skewness of the population with regard to the sex of the patients also limits the
potential application of the results.

Finally, although the Connaught Clinic does represent a conventional methods approach to treatment, it is, as is any treatment facility, quite unique. Therefore, the results obtained in the study apply primarily and directly to the specific population which was studied within the context of this particular program.

III Recommendations for Further Research and Study

The writer recommends that every attempt be made to conduct extensive and long-term follow-up of the patients studied in this project. At the time of this writing, the local office of the Addiction Research Foundation has undertaken to conduct on-going group therapy sessions with eight of the study's thirty-three patients, and will continue to employ the self-concept and drinking behavior measurement instruments used in the study. The results of such an undertaking will no doubt be fruitful.

Due to the fact that no association was found to exist between improvement in self-concept and improvement in drinking behavior, the writer suggests that further research and study be carried out in an attempt to ascertain possible associations between such variables as employment status, family stability, social adequacy, and sexual function. Research of this nature might conceivably lead to further insights and understanding of the alcohol-
dependent person.

Further research is necessary to search for solutions to the problem of patients who prematurely terminate their involvement in treatment. Although the drop-out rate of the patients studied is comparable to that described by other authors, the similarity does nothing to lessen the suffering resulting from alcohol dependence and its related problems. Of the twenty-one patients who dropped out of treatment during the time that this study was being conducted, it was known that many of them were experiencing difficulty with drinking very soon after having left treatment.

No specific reason for the drop-out rate was uncovered as a result of this investigation. The writer speculates that the criterion of abstinence may be a factor, and may also act as a preventative barrier to those patients who drop out, find themselves in difficulty, and may need to return for assistance, but cannot do so due to potentially inappropriate criteria for success and recovery.

Although the majority of patients who completed either one or both program phases reported themselves as abstenent, the writer's experience in working with these people leads him to question the length of time that this drinking pattern will be maintained.

Further research is needed to determine if abstinence is a valid, realistic, and long-term goal
for those people suffering from alcohol dependence.

Finally, this writer remains convinced that "alcoholism" is not primarily a "drug problem", but rather it is a part of a complex of factors involving personality, environment, lifestyle, and human values. Research projects which continue to concentrate their efforts on alcohol as a drug, and as the "problem", rather than focusing on the human beings involved, may well continue to produce results which do little in the way of finding and developing truly positive solutions for dealing with this phenomenon.
APPENDIX A

CONNAUGHT CLINIC GOALS AND OBJECTIVES
The following statement of goals and objectives has been abstracted from the Connaught Clinic program description document, dated February 24, 1975.

PURPOSE AND GOALS (page 3)
The purpose of the Connaught Clinic 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.

The program is designed to assist individuals toward the attainment of the following goals which coincide with the stated needs of the majority of the patients who have sought admission to this Clinic.

The program is set up to help the individual 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 needs for proper nutrition, exercise and rest.
APPENDIX B

Dear Connaught Clinic Patient,

Welcome to the program. I look forward to working with you during the next few weeks as you take part in the Clinic. I am also asking for your help with a research project which I am conducting at the Clinic. During the time that you are here I will periodically be asking you to answer a questionnaire, the first of which is attached to this letter.

This questionnaire has three parts. The first deals with general information, such as age, sex, and education. The second part asks questions as to how you feel about yourself, while the third part asks questions about your drinking.

It has been my experience in the past that some people are uncomfortable answering questionnaires, sometimes because they are not sure how the results will be used. I would like to assure you that this questionnaire is not a test, there are no right or wrong answers. All results will be kept completely confidential, and no names will be used. Each person has been given a code number to make sure that confidentiality is maintained. By conducting the project in such a way it is my hope that you will feel able to answer all questions as honestly and truthfully as you can. This will help to make the results of the research meaningful and worthwhile.

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SECTION 1  General Questions.  PAGE 1.

Please answer all questions in this section as they apply to you at the present time. Where squares are provided, please place a check mark (✓) or an x (X) in the box next to the answer which applies to you.

(A) Age: 

(B) Sex:  Female: [ ]  Male: [ ]

(C) Marital Status:  Single [ ]  Married [ ]
                   Divorced [ ]  Widowed [ ]
                   Separated [ ]  Common-Law [ ]

(D) Education (last grade completed)

- Grade 0 - 5 [ ]
- Grade 6 - 8 [ ]
- Grade 9 - 11 [ ]
- Grade 12 - 13 [ ]
- Trade or technical training after grade 8 [ ]
- Or grade 12 [ ]
- Community College, 1 year [ ]
- Community College, 2 years [ ]
- Community College, 3 years [ ]
- University, 1 year [ ]
- University, 2 years [ ]
- University, 3 years [ ]
- University, 4 years [ ]

(E) Employment.
At the present time are you:

- Employed [ ]
- Unemployed [ ]
- Retired [ ]
- Student [ ]
- Housewife [ ]
PREVIOUSLY COPYRIGHTED MATERIALS,
IN APPENDIX B, LEAVES 118-125,
NOT MICROFILMED.

Tennessee (Department of Mental Health) Self Concept Scale, by William H. Fitts, Ph.D. Published by Counselor Recordings and Tests, Box 6184 - Acklen Station, Nashville, Tennessee 37212, U.S.A. Copyright, William H. Fitts, 1964.
DRINKING QUESTIONNAIRE  TIME 1

Please answer the following questions according to how they apply to you most of the time. Please circle your response to each question on the attached answer sheet.

ITEM NO.

1. I do not drink any alcohol at all......................1.
2. I drink alone...........................................2.
3. I drink with others.....................................3.
4. I drink every day.........................................4.
5. I drink almost every day.................................5.
6. I drink only on weekends.................................6.
7. I am sober for periods of time, and then go on a drinking "binge"............................7.
8. When I drink, my purpose is to solve problems which I have..........................8.
9. When I drink, my purpose is to avoid problems which I have..........................9.
10. I drink only when I have problems...............10.
11. I drink because drinking is a social custom..11.
13. When I drink, it is not my intention to get drunk..........................13.
15. I do not look for any effect from alcohol when I drink..........................15.
16. When I drink, once I start, I cannot stop myself.................................................16.
17. If I start drinking, I will continue until I become unconscious.........................17.
18. My purpose when I drink, is to make myself unconscious..........................18.
DRINKING QUESTIONNAIRE  TIME 2

Please answer the following questions according to how they applied to you during the past three weeks. If you have not consumed any alcohol during the past three weeks, please answer question 1 only.

1. During the past three weeks, I did not consume any alcohol. ......................... 1.

2. During the past three weeks I drank alone ........ 2.

3. During the past three weeks I drank with others. 3.

4. During the past three weeks I drank every day .... 4.

5. During the past three weeks I drank almost every day .................................. 5.

6. During the past three weeks I drank only on weekends .................................. 6.

7. During the past three weeks I was sober for periods of time, and then went on a drinking "binge." .................................................. 7.

8. During the past three weeks, when I drank, my purpose was to solve problems which I had .......... 8.

9. During the past three weeks, when I drank, my purpose was to avoid problems which I had ....... 9.

10. During the past three weeks, I drank only when I had problems .......................... 10.

11. During the past three weeks I drank because drinking is a social custom ................. 11.

12. During the past three weeks, when I drank, I did not get drunk .......................... 12.

13. During the past three weeks, when I drank, it was not my intention to get drunk ............. 13.

14. During the past three weeks, when I drank, I did not get any effect from alcohol .......... 14.

15. During the past three weeks, when I drank, I did not look for any effect from alcohol ....... 15.

16. During the past three weeks, when I drank, once I started, I could not stop myself ........ 16.

17. During the past three weeks, once I started drinking, I continued until I became unconscious 17.

18. During the past three weeks, when I drank, my purpose was to make myself unconscious .... 18.
Please answer the following questions as they applied to you during the past five weeks. If you have not consumed any alcohol during the past five weeks, please answer question 1 only.

ITEM NO.

1. During the past five weeks, I did not consume any alcohol.........................1.

2. During the past five weeks, I drank alone........2.

3. During the past five weeks, I drank with others.3.

4. During the past five weeks, I drank every day...4.

5. During the past five weeks, I drank almost every day...............................5.

6. During the past five weeks, I drank only on weekends...............................6.

7. During the past five weeks, I was sober for periods of time, and then went on a drinking "binge".........................................................7.

8. During the past five weeks, when I drank, my purpose was to solve problems which I had.......8.

9. During the past five weeks, when I drank, my purpose was to avoid problems which I had.......9.

10. During the past five weeks, I drank only when I had problems..........................10.

11. During the past five weeks, I drank because drinking is a social custom.............11.

12. During the past five weeks, when I drank, I did not get drunk........................12.

13. During the past five weeks, when I drank, it was not my intention to get drunk........13.

14. During the past five weeks, when I drank, I did not get any effect from alcohol..........14.

15. During the past five weeks, when I drank, I did not look for any effect from alcohol.....15.

16. During the past five weeks, when I drank, once I started, I could not stop myself.......16.

17. During the past five weeks, once I started drinking, I continued until I became unconscious. 17.

18. During the past five weeks, when I drank, my purpose was to make myself unconscious........... 18.
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VITA

Gerald Smith was born on March 19, 1951, in Sarnia, Ontario, where he attended elementary and secondary school. Following graduation from high school in 1969, Mr. Smith entered the University of Windsor, where he graduated with his Bachelor of Social Work degree in 1973.

In August of 1973, upon termination of a temporary position with the Addiction Research Foundation in Windsor, Mr. Smith moved to Sydney, Nova Scotia, where he was employed in the Out-Patient Department of the Cape Breton Addiction Centre. For two years Mr. Smith was involved in direct service to individual patients, families, couples, and patient groups, as part of the Centre's comprehensive treatment approach with drug dependent people.

In August of 1975, Mr. Smith resigned from the staff of the Addiction Centre, and returned to Windsor to enter the Master of Social Work program, from which he expects to graduate in October of 1976.

During his graduate work at the University, Mr. Smith's field practicum was at the Connaught Clinic in Windsor. This same clinic became the focus of study and research, which culminated in the production of this research document.

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