

LAKEHEAD UNIVERSITY

PERSONALITY FACTORS AND TREATMENT RESPONSE IN
HOSPITALIZED MALE ALCOHOLICS

by

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Abstract

The purpose of this thesis was to investigate the relationship between the personality of male alcoholics and their response to an in-patient treatment program. Twenty male alcoholic in-patients were tested on admission and at discharge from a 21 day structured treatment program using a combination of Forms A and B of the 16PF and the Bell Alcoholism Scale of Adjustment (BASA). Three months after discharge a follow-up questionnaire was sent to the patients.

Two factors of the 16PF, B (intelligence) and I (premsia), changed significantly during the 21 day treatment program. A significant change was also found in the BASA scores indicating that a movement toward greater acceptance of their alcoholism took place during treatment. A significant relationship was found between the pre-treatment 16PF profiles of the subjects in the present sample and the profiles of a similar sample of alcoholics (Fuller, 1966). Comparison with a general neurotic 16PF profile was not significant. The relevance of these findings in relation to the use of the 16PF, the BASA and follow-up questionnaires in the evaluation of an alcoholism treatment program are discussed. Suggestions for further research are also presented.

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Introduction and Review of Literature

The helping professions have been concerned with the clinical problem of alcoholism for a good number of years. Recently there has been an increase in the amount of attention being paid to the treatment of this disorder, as the effects of excessive consumption of beverage alcohol are becoming more widespread. The treatment of alcoholism has taken many forms ranging from medical treatment of the physical complications of alcoholism, such as the Wernicke - Korsakoff Syndrome, neuritis, gastritis to various combinations of social and psychological measures to enable the patient to return to normal functioning. Comprehensive reviews of current treatment strategies can be found in Blum and Blum (1967) and Glasscote, Plaut, Hammersley, O'Neill, Chafetz and Cumming (1967). Each treatment approach has claimed a varying amount of success. Studies by Rossi, Stach, and Bradley (1963), Pemberton (1967), and Gallant (1968) point out the wide range of success rates currently being documented.

Recently there have been a number of individuals (Pattison, 1966; Pokorny, Miller, & Cleveland, 1968; Hill & Blane, 1967; Pattison, Coe, & Rhodes, 1969;

Miller, Pokorny, Valles, & Cleveland, 1970) voicing concern over the methods used to evaluate alcoholism treatment programs. Some of the issues raised by these authors are sample bias (Miller et al., 1970), differing definitions of alcoholism (Pattison, 1966), and assuming alcoholics are a homogeneous population (Pattison et al., 1969). Pattison et al., (1969), for example, state :

. . .although it is recognized that all alcoholics are not the same, some clinicians such as Robson et al., have concluded that population differences make no difference once an alcoholic starts in a treatment program. However, reviews by Pattison, Hill and Blane, and Pokorny et al, have cited numerous studies which demonstrate that population variables have been ignored in most treatment evaluation studies.

(Pattison et al., 1969, p.478).

Pattison et al., (1969) go on to point out that "what is lacking to date is a systematic way of linking population differences in order to provide clinically useful profiles for programming treatment." (p.479)

The Hill and Blane (1967) study which contains a number of specific recommendations to improve research in alcoholism treatment notes "how few (studies)* used easily applied statistical techniques, how few used readily available psychological tests as a means of measuring change and how few built on evaluation reported in similar previous work. (p.100)." In view of the foregoing and also the fact that population variables have largely been

* author's inclusion

ignored in evaluative studies, it would seem desirable that more use should be made of the reliable and valid psychological tests currently in use to-day.

A review of the literature indicates that two popular personality tests, the Minnesota Multiphasic Personality Inventory (MMPI) and Catell's Sixteen Personality Factor Questionnaire (16PF) have been used with the alcoholic population. The MMPI has been used for diagnostic purposes (Brown, 1950; Button, 1956; Hill, Haertzen & Glaser, 1962; Rotman, Vestre, 1964; MacAndrew, 1965; Uecker, 1970), and for predicting treatment outcome in alcoholics (Mazekari, 1965), in measuring the degree of improvement in alcoholics (Ends & Page, 1959). More recently Rohan, Tatro, and Rotman (1969) measured an alcoholic population (N=58) before and after a defined 72-day treatment program using the MMPI and found that:

There were several significant changes in the profile of the population after an average of 72 days treatment, all the scales changing in the direction of reduced symptoms. Scales 1, 2, 3 and 7 were significantly lower ($p < .01$), as were scales 4 and 0 ($p < .05$). Scales 2 and 4 fell within two standard deviations of the mean on the post treatment test but remained the highest scale.

(Rohan et al., 1969, p. 393).

They further point out that, "the changes in scores after treatment were consistent with clinical experience. The

group appeared to be much less depressed. The subjects had more poise and confidence and were less introverted in social situations. (p.393)."

Wilkinson, Prado, Williams and Schnadt (1971) obtained similar results.

The MMPI pre - to posttreatment results of the present study are quite similar to and appear to substantially confirm the findings of a recent investigation by Rohan, Tatro and Rotman.
(Wilkinson et al., 1971, p.64).

Whether reduced symptomatology and a lowered MMPI profile is necessarily reflected in an improved, i.e. more abstinent patient, or at least a patient who is prepared to attempt sobriety, has not been clearly demonstrated through the use of the MMPI. Rohan et al., (1969) make a reference to the problem by stating:

. . .in the low - 4 sample, scales 1, 3, 9, and MAC* change the latter two increasing. A possible interpretation is that these depressed somatically concerned patients lost many of their somatic complaints as they feel healthier and tend toward hyperactivity and elevation of morale. They also seem to become more aware of their alcohol problem, that is, they more readily admit items in the MMPI which suggest the presence of an alcohol problem.

(Rohan et al., 1969, p.397).

It appears that a more precise measure of the patient's change in relation to his alcohol problem is required.

Catell's 16PF test (Catell, 1957) has attracted a number of alcoholism researchers in the last decade. This test allows for the delineation of 16 relatively independent

* The MacAndrew Scale (MacAndrew, 1965)

factors and according to Catell (1957), "this test sets out to cover planfully and precisely all the main dimensions along which people can differ according to basic factor analytic research. (p.1)." Studies using the 16PF on alcoholics centre on two basic problems; description of an alcoholic personality (Depalma and Clayton, 1958; Fuller, 1966; Golightly and Reinehr, 1969; Hoy, 1969; Lawlis and Rubin, 1971), and in comparing the effectiveness of different forms of treatment (Shaffer, Hanlon, Wolf, Foxwell, Kurland, 1962; White, 1965).

Regarding the description of the alcoholic personality Fuller (1966) stated:

The Willmar State Hospital over the past three years has been engaged in developing personality profiles for an alcoholic population from psychological data. One test selected for this purpose was the Sixteen Personality Factor Questionnaire, the 16PF. We feel that a relatively permanent personality profile has now been developed on this test for alcoholics.
(Fuller, 1966, p.1).

Golightly and Reinehr (1969) attempted to replicate these findings and suggested that further research regarding the characteristics of the alcoholic profile was needed.

Unfortunately, it is difficult to assess the usefulness of these studies as the authors rarely quote what forms of the 16PF they employed and only one study, a drug study by Shaffer et al., (1962) used a combination

of forms of the 16PF as suggested by Catell (1957) for important research. The 16PF test has a distinct advantage over other personality tests as the very low intercorrelations of the factors allow for statistical treatment of these independent factors with other psychometric measures. In the case of alcoholism treatment, the correlation of these factors with a psychometric measure of response to treatment could be calculated.

Measures of response to treatment poses a distinct problem to researchers in alcoholism treatment. Abstinence, although of great importance, is all too frequently the only criteria employed to measure response to treatment. Gerald, Saenger, Wile (1962), Bolman (1965), Pattison (1966), Pokorny et al., (1968) have attempted to point out the necessity of using other measures such as employment stability, family life adjustment and other social variables as well as abstinence in evaluating the outcome and effectiveness of treatment. A review of some of the techniques of measuring these variables is contained in an article by Pattison (1966).

A problem in evaluating the outcome and effectiveness of alcoholism treatment is that follow-up data are difficult and expensive to obtain due to the difficulty in contacting

mobile patients and the low rate of return of follow-up questionnaires. Kissin, Rosenblatt & Machover (1968) state:

unfortunately with our present patient population the follow-up interview was possible in only about 50 per cent of the original patients, i.e., 225 of the original 480. In order to keep our criteria as rigid as possible, all subjects on whom follow-up were not obtained were generally considered a failure.

(Kissin et al., 1968, p.24).

In addition, the use of this type of criteria frequently allows a number of months to pass before an assessment of the patient's functioning is taken; this interval allows for the distinct possibility of numerous extra-treatment variables such as new acquaintances, unforeseen problems, etc., to influence the patient's behaviour after treatment.

In view of these problems, what appears to be required is a more precise measure of the individual patient's response to treatment that will allow the treatment facility to assess the changes that have occurred in the patient during the course of treatment. A measure of response to alcoholism treatment has been designed by Bell, Weingold, & Lackin (1969) who developed a 40-item Likert-type rating scale, the Bell Alcoholism Scale of Adjustment (BASA) based on his earlier work with the physically disabled, (Bell, 1967). According to Bell et al., (1969),

. . .the underlying rationale of the BASA is the assumption that acceptance* of a disabling condition, such as alcoholism is an essential element involved in the rehabilitation process. This assumption stems from the observation that before an alcoholic is willing and able to deal effectively with this problem, he must admit he has a problem. Thus, it is suggested that admission of the existence of a drinking problem is one of the first and important steps for the alcoholic to take in the rehabilitation and adjustment process.

(Bell et al., 1969, p.634).

The successful organization Alcoholics Anonymous (Hoffer and Osmond, 1968) employs the concept of 'acceptance' as a basic ingredient of their program. Alcoholics Anonymous literature contains numerous references to acceptance, for example:

Our very first problem is to accept our present circumstances as they are, ourselves as we are, and the people about us as they are. This is to adopt a realistic humility without which no genuine advance can even begin. Again and again, we shall need to return to that unflattering point of departure. This is an exercise in acceptance that we can profitably practice every day of our lives.

(Anonymous, 1967, p.44).

The changes in scores on the BASA during the patient's exposure and participation in a defined treatment program can be then considered indicative of how much the individual patient has taken the important step of accepting the nature of his disabling condition - alcoholism.

* author's emphasis

Although, as described above, the need for a valid psychometric description of the patient population and his response to treatment, is a necessity for evaluative studies; it is the long term results of treatment that are of most concern both from the standpoint of the patient and the expense involved in treatment. Consequently, appropriate follow-up procedures should also be used to give a well-rounded description of the patient's status before, during, and after treatment.

As referred to above, the issues of the personality characteristics of alcoholics, and measures of both short-term and long-term treatment response remain to be clarified. A purpose of this research will be to obtain a psychometric description of the personality of male alcoholics entering and leaving a specific in-patient treatment program using the 16PF test. Another purpose will be to use the BASA scale to measure these patients' immediate response to treatment and a mailed questionnaire to assess the long term results of treatment.

The data obtained will hopefully help to elucidate some of the problems regarding the in-patient treatment of alcoholics in view of the treatment strategies currently being employed.

Method

Subjects

The experimental subjects were 20 medically diagnosed male alcoholics admitted for in-patient treatment of alcoholism, in the Special Medical Unit, St. Joseph's General Hospital, Thunder Bay, Ontario, Canada. Their mean age was 40.6 years with a range of 24 to 60 years. Education ranged from grade 7 to grade 12 with a mean of 9.1 years. A previous study (Lyons, 1969) confirmed the adequacy of the currently used medical diagnostic criteria for alcoholism.

Also, to be included in the study the subject was required to have a reading knowledge of the English language; to have a willingness to partake in the prescribed treatment program; to complete the 21 day treatment program; and to have an absence of any other detectable psychiatric problem on admission.

Techniques of Measurement

The subjects were asked to co-operate in a project which would involve completing some tests, the results of which would be kept confidential. The subjects were then administered a test battery consisting of a combination of Forms A and B of the 16PF 1962 edition and the Bell

Alcoholism Scale of Adjustment (BASA). Appendix I contains the BASA measure. The battery was administered as soon after admission as possible and before a maximum of 2 days participation in the treatment program. After this initial testing session (T1), the subjects proceeded through the 21 day treatment program.

After the 21 day period, the same test battery was re-administered, subsequently referred to as (T2) and the subjects were told that in 3 months time a letter with brief questions about their progress would be mailed to them. A stamped pre-addressed envelope was provided for the returned questionnaire. Appendix II contains a sample of this questionnaire.

Treatment

All the alcoholic subjects took full part in an on-going 21 day in-patient alcoholism treatment program consisting of didactic lectures, group therapy, films, counselling and exposure to the philosophy and program of Alcoholics Anonymous. Appendix III contains a detailed description of the treatment program.

Control Devices

The BASA scale was administered to a group of 20

males with a mean age 27.3 years, ranging in age from 21 to 42 years at 2 occasions, T1 and T2 with a 21 day interval between the administrations. This was administered to establish the 21 day reliability of the BASA.

Results

The dependent variables in this study were personality factors, acceptance of alcoholism and behavioural and social factors. The 16PF was used to obtain a personality profile of the alcoholics before and after treatment. The BASA was used to measure the patients acceptance of their alcoholism during treatment. The behavioural and social factors were used to describe the long term effects of treatment.

16PF Results

Two measures of the alcoholic subjects personality were obtained in this study using the 16PF test. The means and standard deviations of these measures in sten scores are contained in Table I. T-tests for correlated means indicate two factors, B (intelligence) and I (harria), changed significantly ($p < .05$) during the 21 day period. Table I contains the results of these calculations.

Table 1

MEAN 16PF STEN SCORES ALCOHOLIC GROUP

FACTOR	T _L MEAN	S.D.	T ₂ MEAN	S.D.	T VALUE
A Affectothymia	5.35	1.51	5.10	1.71	0.73
B Intelligence	5.80	1.94	6.50	1.14	2.57*
C Ego Strength	2.65	1.48	3.30	2.27	1.71
E Dominance	4.80	2.65	4.05	2.37	1.74
F Surgency	5.20	1.95	4.60	2.23	1.64
G Superego Strength	4.65	1.46	4.80	2.26	.27
H Parma	3.75	1.97	3.20	1.84	1.50
I Premsia	5.55	1.73	4.75	1.97	2.63*
L Protension	7.60	1.82	7.30	1.87	.75
M Autia	6.55	1.23	5.70	1.75	1.78
N Shrewdness	4.00	1.92	4.55	2.33	.33
O Guilt Proneness	8.65	1.50	8.45	1.64	.67
Q1 Radicalism	4.20	1.06	4.65	1.81	.35
Q2 Self-Sufficiency	6.05	1.85	5.65	2.30	1.36
Q3 Self-Concept Control	4.55	1.27	4.50	2.01	.90
Q4 Ergic Tension	8.65	1.62	7.85	2.16	1.74

* p. < .05

Four derived factors of the 16PF were calculated at T1 and T2. The derived factors maintain relative stability over the 21 day treatment period. Factor Q11 (Anxiety) is uniformly above the other factors. Table 2 contains the factor means and standard deviations of these factors in sten units.

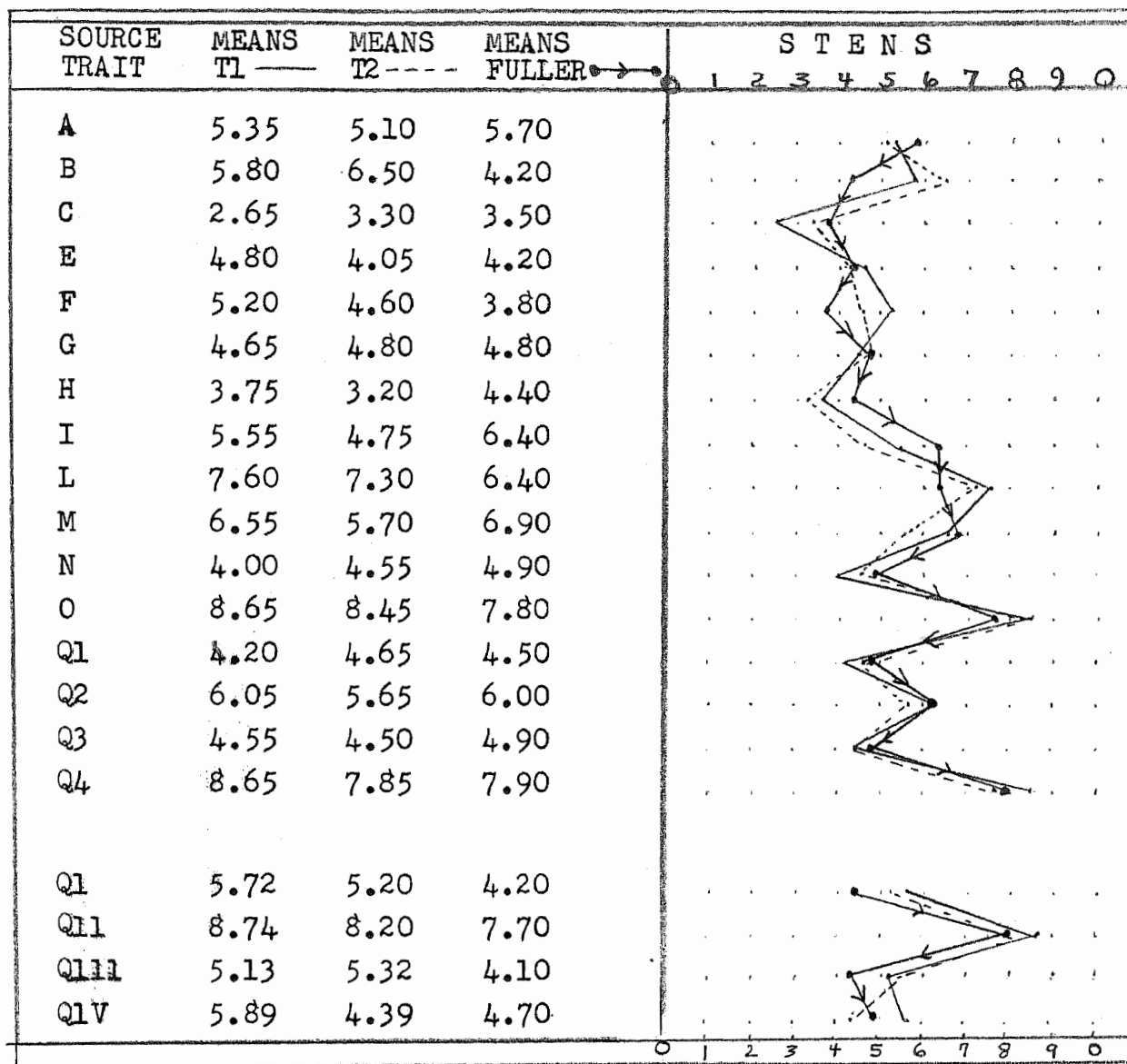
Table 2

FACTOR MEANS AND STANDARD DEVIATIONS OF 4 DERIVED FACTORS ALCOHOLIC GROUP

FACTOR	T1 MEAN	S.D.	T2 MEAN	S.D.
Q1 Exvia	5.72	1.91	5.20	1.87
QII Anxiety	8.74	2.11	8.20	1.90
QIII Cortertia	5.13	1.78	5.32	1.81
QIV Independence	5.89	1.81	4.39	1.90

The obtained 16PF personality profiles and the four derived factors were compared with Fuller's (1966) profile. Figure I is a graphical representation of this comparison. A strong visual resemblance between these three profiles exists.

16PF PROFILES OF FORMS A & B OF 20 HOSPITALIZED MALE ALCOHOLICS AT T1 AND T2 AND FULLER'S (1966) GROUP



In order to more accurately assess the similarity between Fuller's (1966) profile and the present profiles, the profile similarity coefficients (r_p 's) were calculated using the method proposed by Cattell (1970) Appendix 3. The resultant r_p for T1 and the Fuller Group was significant. ($r_p = .361$, $p < .05$). The r_p for T2 and the Fuller Group was not significant. Tables 3 and 4 contain a summary of these calculations.

The lack of a significant relationship between the Fuller (1966) profile and the present sample at T2 was thought to be due to the significant change in Factor B (intelligence) as reported above. Consequently the profile similarity coefficient for 15 profile elements (excluding Factor B) was calculated. The resultant r_p is significant ($r_p = .387$ $p < .05$). Table 5 contains a summary of this calculation.

Table 3

PROFILE SIMILARITY COEFFICIENT (rp) FOR ALCOHOLIC GROUP
AT TL AND FULLER'S (1966) GROUP

FACTORS	ALCOHOLIC GROUP MEAN	FULLER GROUP MEAN	DIFFERENCE d*	d ^a	WEIGHT w**	wd ^a
A	5.4	5.7	.3	.09	3	.27
B	5.8	4.2	1.6	2.6	3	7.80
C	2.7	3.5	.8	.64	4	2.56
E	4.8	4.2	.6	.36	2	.72
F	5.2	3.8	1.4	1.96	2	3.92
G	4.7	4.8	.1	.01	3	.03
H	3.8	4.4	.6	.36	4	1.44
I	5.6	6.4	.8	.64	3	1.92
L	7.6	6.4	1.2	1.44	2	2.88
M	6.6	6.9	.3	.09	3	.27
N	4.0	4.9	.9	.81	4	3.24
O	8.7	7.8	.9	.81	2	1.62
Q1	4.2	4.5	.3	.09	6	.54
Q2	6.1	6.0	.1	.01	4	.04
Q3	4.6	4.9	.3	.09	3	.27
Q4	8.7	7.9	.8	.64	2	1.28
Σ wd ^a = 28.80						rp = .361***

* negatives omitted

** weight for clinical groups (Catell, 1970, p.312).

*** p < .05

Table 4

PROFILE SIMILARITY COEFFICIENT (rp) FOR ALCOHOLIC GROUP
AT T2 AND FULLER'S (1966) GROUP

FACTORS	ALCOHOLIC GROUP MEAN	FULLER GROUP MEAN	DIFFERENCE d*	d ^a	WEIGHT w**	wd ^a
A	5.1	5.7	.6	.36	3	1.08
B	6.5	4.2	2.3	5.29	3	15.87
C	3.3	3.5	.2	.04	4	.16
E	4.1	4.2	.1	.01	2	.02
F	4.6	3.8	.8	.64	2	1.28
G	4.8	4.8	.0	.0	3	.0
H	3.2	4.4	1.2	1.44	4	6.76
I	4.8	6.4	1.6	2.56	3	7.68
L	7.3	6.4	.9	.81	2	1.62
M	5.7	6.9	1.2	1.44	3	4.32
N	4.6	4.9	.3	.09	4	.36
O	8.5	7.8	.7	.49	2	.98
Q1	4.7	4.5	.2	.04	6	.24
Q2	5.7	6.0	.3	.09	4	.36
Q3	4.5	4.9	.4	.16	3	.48
Q4	7.9	7.9	.0	.0	2	.0
$\sum wd^2 = 41.21$ $rp = .181$ non significant						

* negatives omitted

** weight for clinical groups (Catell, 1970, p.312).

Table 5

PROFILE SIMILARITY COEFFICIENT r_p FOR THE ALCOHOLIC GROUP
AT T2 FOR 15 FACTORS OF THE 16PF (EXCLUDING FACTOR B)

$\sum wd^a$	for 16 factors	=	41.21
$\sum wd^a$	for Factor B	=	15.87
$\sum wd^a$	for 15 Factors	=	25.34
r_p	=	.387	$p < .05$ level for 15 profile elements

The four derived factors of this present profile and Fuller's (1966) profile were also compared using the profile similarity co-efficient. The resemblance was not significant at T1. At T2 the results were significant ($r_p = .66$ $p < .05$). Table 6 contains a summary of these calculations.

Table 6

PROFILE SIMILARITY COEFFICIENT r_p FOR THE 4 DERIVED FACTORS
OF THE ALCOHOLIC GROUP AT T1 AND T2 AND FULLER'S (1966) GROUP

4 DERIVED FACTORS				
	Q1	Q11	Q111	Q1V
T1 Mean	5.7	8.7	5.1	5.9
Fuller Mean	4.2	7.7	4.1	4.7
T1 d^*	1.5	1.0	1.0	1.2
T1 d^a	2.25	1.0	1.0	1.44
T2 Mean	5.2	8.2	5.3	4.4
Fuller Mean	4.2	7.7	4.1	4.7
T2 d^*	1.0	.5	1.2	.3
T2 d^a	1.0	.25	1.44	.09
$\sum T1 d^a$	= 5.69	T1 $r_p = .41$ n.s. for 4 profile elements		
$\sum T2 d^a$	= 2.78	T2 $r_p = .66$ $p < .05$ for 4 profile elements		

* negatives omitted

In order to compare the present alcoholic profile with another major clinical group, the profile similarity coefficient between these profiles and a general neurotic profile was calculated. The resemblance between the alcoholic profiles and a general neurotic profile was not significant at either T1 or T2. Tables 7 and 8 contain a summary of these calculations.

Table 7

PROFILE SIMILARITY COEFFICIENT (rp) FOR HOSPITALIZED ALCOHOLIC
GROUP AT TI AND THE GENERAL 16PF NEUROTIC PROFILE (CATELL 1970)*

FACTORS	ALCOHOLIC GROUP MEAN	NEUROTIC MEAN	DIFFERENCE d**	WEIGHT w***	d ^a	wd ^a
A	5.4	5.8	.4	3	.16	.48
B	5.8	6.5	.7	3	.49	1.47
C	2.7	3.0	.3	4	.09	.36
E	4.8	4.0	.8	2	.64	1.28
F	5.2	3.6	1.6	2	2.56	5.12
G	4.7	4.6	.1	3	.01	.03
H	3.8	4.3	.5	4	.25	1.00
I	5.6	7.0	1.4	3	1.96	5.88
L	7.6	7.2	.4	2	.16	.32
M	6.6	6.5	.1	3	.01	.03
N	4.0	5.4	1.4	4	1.96	7.84
O	8.7	8.1	.6	2	.36	.72
Q1	4.2	5.4	1.2	6	1.44	8.64
Q2	6.1	6.1	.0	4	.0	.0
Q3	4.6	4.4	.2	3	.04	.12
Q4	8.7	8.0	.7	2	.49	.98
$\sum wd^a = 34.27$						

* from (Catell, 1970, p.265).
 ** negatives omitted
 *** weight for clinical groups (Catell, 1970, p.312).

$rp = .28$ non significant

Table 8

PROFILE SIMILARITY COEFFICIENT (rp) FOR HOSPITALIZED ALCOHOLIC GROUP AT T2 AND THE GENERAL 16PF NEUROTIC PROFILE (CATELL 1970)*

FACTORS	ALCOHOLIC GROUP MEAN	NEUROTIC MEAN	DIFFERENCE d**	d ^a	WEIGHT w***	wd ^a
A	5.0	5.8	.8	.64	3	1.92
B	6.5	6.5	.0	.0	3	.0
C	3.3	3.0	.3	.09	4	.36
E	4.1	4.0	.1	.01	2	.02
F	4.6	3.6	1.0	1.0	2	2.0
G	4.8	4.6	.2	.04	3	.12
H	3.2	4.3	1.1	1.21	4	4.84
I	4.8	7.0	2.2	4.84	3	14.52
L	7.3	7.2	.1	.01	2	.02
M	5.7	6.5	.8	.64	3	1.92
N	4.6	5.4	.8	.64	4	2.56
O	8.5	8.1	.4	.16	2	.32
Q1	4.7	5.4	.7	.49	6	2.94
Q2	5.7	6.1	.4	.16	4	.64
Q3	4.5	4.4	.1	.01	3	.03
Q4	7.9	8.0	.1	.01	2	.02
Σ	32.23	rp = .31 non significant				

* (Catell, 1970, p.265).

** negatives omitted

*** weight for clinical groups (Catell, 1970, p.312).

Bell Alcoholism Scale of Adjustment (BASA)

In order to measure the changes in 'acceptance' during treatment, the scores obtained on the BASA at T1 were compared with the scores at T2. A t-test for correlated means between the means of these scores yielded significant differences ($t = 2.44$ $df = 19$, $p < .05$). Table 9 contains a summary of these calculations.

In addition, the split-half reliability of the BASA at T1 and T2 was computed using the standard deviation of the half tests rather than the Spearman - Brown formula. The results were $r = .78$, $r = .89$ respectively.

Table 9

T-test Between Means of BASA scores on Hospitalized Male Alcoholics

TIME	MEAN	n	df	t
T1	118.15	20	19	2.435*
T2	101.30			

* $p < .05$

In order to control for the time factor, and to obtain additional data on the reliability of the BASA, the BASA was administered to a group of male students. A t-test for correlated means between the means of their BASA scores did not yield any significant differences.

Table 10 contains a summary of this calculation.

Test retest reliability using Pearson product - moment correlation coefficient formula was .61. Using the standard - deviations of the half-tests, the split-half-reliabilities at T1 and T2 for this group was .76 and .86 respectively.

Table 10

T-TEST BETWEEN MEANS OF BASA SCORES ON 20 ADULT MALE STUDENTS

TIME	MEAN	n	df	t
T1	138.29	20	19	.3933 N.S.
T2	139.94			

Behavioural and Social Measures

Table 11 provides a summary of BASA changes and behavioural measures of long term treatment results in raw data form. No systematic relationship between BASA changes and long term treatment results are evident in these data.

The percentage of patients responding to the various items in the follow-up questionnaire is presented in Table 12. The percentages are based on an 80% return of the questionnaire.

Table 11

BASA CHANGES* IN INDIVIDUAL ALCOHOLICS COMPARED WITH QUESTIONNAIRE RESPONSES

SUBJECT NO.	BASA CHANGE*	DAYS ABSTINENT	A.A. AFFILIATION	PERSONAL CIRCUMSTANCES	AGREEMENT WITH STATEMENT "I ACCEPT THE FACT THAT I AM AN ALCOHOLIC"
1	-31	90	NO	MUCH IMPROVED	AGREE VERY MUCH
2	+14	-50	NO	"	DISAGREE A LITTLE
3	-68	50	YES	"	AGREE VERY MUCH
4	+20	90	YES	"	AGREE VERY MUCH
5	+ 5	(NOT RETURNED)			
6	-14	90	YES	MUCH IMPROVED	AGREE VERY MUCH
7	-75	(NOT RETURNED)			
8	- 6	90	YES	MUCH IMPROVED	AGREE VERY MUCH
9	- 2	(NOT RETURNED)			
10	+ 9	90	YES	SAME	AGREE VERY MUCH
11	-14	90	YES	SAME	AGREE VERY MUCH
12	+38	90	YES	MUCH IMPROVED	AGREE PRETTY MUCH
13	-42	90	YES	MUCH IMPROVED	AGREE PRETTY MUCH
14	- 3	90	YES	MUCH IMPROVED	AGREE VERY MUCH
15	-20	(NOT RETURNED)			
16	-62	90	YES	MUCH IMPROVED	AGREE VERY MUCH
17	+ 6	-50	YES	MUCH IMPROVED	AGREE PRETTY MUCH
18	-27	90	YES	MUCH IMPROVED	AGREE VERY MUCH
19	-57	90	NO	MUCH IMPROVED	AGREE VERY MUCH
20	- 8	90	YES	MUCH IMPROVED	AGREE PRETTY MUCH

* negative BASA changes indicate greater acceptance of alcoholism

Table 12

SUMMARY OF RESULTS OF FOLLOW-UP QUESTIONNAIRE* EXPRESSED
AS PERCENTAGES

1. How many days complete abstinence from alcohol did you have in the last 90 days since you left the treatment unit in Thunder Bay? You left the unit on approximately 1970.

1. 90 days abstinence 75%
2. 70 -80 days abstinence 0%
3. 50 - 70 days abstinence 12.5%
4. less than 50 days 12.5%

2. If you did resume drinking, how long after discharge did you start drinking?

1. 1-20 days 6%
2. 20-40 days 6%
3. 40-60 days 0%
4. 60-90 days 6%
5. did not resume drinking 81.75%

3. Do you attend A.A. yes (68.75%) no (31.25%)

4. How would you describe your general and personal circumstances since you were discharged?

1. worse than before 0%
2. about the same 18.75%
3. much improved 81.25%

5. Do you accept the fact that you are an alcoholic?

1. Yes 93.75%
2. No 6.25%
3. Uncertain 0%

6. How do you agree with the following statement?

"I accept the fact that I am an alcoholic".

- | | |
|------------------------------------|-------------------------|
| 1. Agree a little <u>0%</u> | 4. Disagree a little |
| 2. Agree pretty much <u>18.75%</u> | 5. Disagree pretty much |
| 3. Agree very much <u>81.25%</u> | 6. Disagree very much |

* based on 16/20 returned or 80%.

Discussion

The 16PF profile and the derived factors of the alcoholic group in this study show a strong resemblance to previous studies of alcoholic populations (Fuller, 1966; Golightly, 1969). The statistical similarity to the Fuller study, however, is significant only at the initial testing (T1) as shown by Table 3. The significant changes in Factor B and I account in part for the lack of a significant relationship at the terminal testing (T2). According to Catell (1970) Factor B (intelligence) has a low retest reliability, "The lower figure for intelligence is not unusual, and seems due to subjects solving intelligence items by reminiscence between testings". (Catell, 1970,p.30).

The high (in comparison to the normal population) derived anxiety factor sten score of 8.74 at T1 and 8.20 at T2 in the patient group, is consistent with the recent finding of Lawlis and Rubin (1971) who state

Computing the anxiety formula of the anxiety factors (C,H,L,O,Q3,Q4) the sten score was 9.7 ($p < .001$). The real danger is to maintain that the test results indicate any kind of cause and effect relationship to alcoholism. Suffice it is to say that this is a group of highly anxious persons who possibly utilize alcohol as a means of release from anxiety - producing situations.

(Lawlis and Rubin, 1971, p.325).

The high level of resemblance between this hospital

sample and the Fuller (1966) group adds further to the position established by Fuller (1966) that

one is inclined to speak of an alcoholic personality profile which has a great deal of permanency and generality based on a solid N of 818 or more cases. (Fuller, 1966, p.2).

It is important to remember that these profiles are of hospitalized male alcoholics remaining in treatment, thus the generalization to females or even to male out-patients cannot yet be made. Wilkinson et al., (1971) suggest there may be personality differences between 'Completers' and 'Drop-outs' amongst male alcoholic in-patients.

Fuller (1966) reported a significant ($r_p = .62, p < .01$) relationship between an alcoholic profile and a general neurotic profile. The relationship between the present alcoholic sample and the general neurotic 16PF profile (Catell 1970) was non significant. This finding is in agreement with Golightly and Reinehr (1969) who also failed to find a significant relationship between an alcoholic profile and the general neurotic profile. These results suggest that the alcoholic has a characteristic profile rather than one basically similar to the neurotic profile as measured by the 16PF.

The patients' response to the treatment program involved two methods of measurement, the BASA scale and

the 16PF questionnaire. Table 9 indicates the significant changes in the patient group toward greater acceptance of their alcoholism as defined by the BASA. This finding is in general agreement with the work of Bell et al., (1969) and Bell 1969 (a).

In the 1969 study it was stated

the primary hypothesis of this study is that if the BASA represents a valid instrument, then BASA scores would be significantly affected in the direction of greater acceptance of one's own alcoholic disability after being exposed to the alcoholism treatment program at Colony 8. Since BASA scores did in fact change significantly over time in the predicted direction and were not affected significantly by any of the variables (e.g. level of intelligence, age, etc.) included in this study, the data lends support to this hypothesis.

(Bell et al., 1969, p.693).

A similar general finding came out of Bell's 1969(a) study comparing established AA members and a group of hospitalized alcoholics. The AA members differed significantly ($p < .05$) in the degree of acceptance from the non AA group.

Despite the substantial evidence of the present and previous findings regarding the use of the BASA in assessing treatment response, a number of issues still appear to require further clarification. First, from the point of view of test construction the original quoted reliability co-efficients for test-retest (24 hr) of .80

although satisfactory is still low and as previously indicated the test-retest coefficient for a no treatment group was only .61 for a 21 day period. The split-half reliability coefficients calculated in the present study do not meet the level quoted by Bell (1969). Bell employed the Spearman-Brown formula in his calculations, which according to Anastasi (1966) is not always appropriate.

a weakness of the Spearman-Brown formula stems from its assumption that the variabilities of the two half-scores are equal. Such an assumption may not always be met, even when the half-scores appear to be comparable.

(Anastasi, 1966, p.122).

Another factor is the higher split-half reliability of the BASA at T2 in both the patient and not-patient group found in this study. The possibility of test acquiescence influencing the results still remains a possibility in using this instrument.

The potential of the BASA still remains great, and as shown by this and the other studies a significant change in acceptance has been consistently found in patients exposed to a structured treatment program.

The significant changes in personality dimensions as measured by the 16PF questionnaire during the treatment program involved Factor B and Factor I. The alcoholic

group moved in the direction of the I-. According to Catell "I- thus represents some sort of tough, masculine, practical, mature group-solidarity-generating and realistic (no-nonsense) tempermental dimension." (Catell, 1970, p.93) There is a movement away from the I+ score, "I+ individuals receive significantly more descriptions as fussing, slowing up group performance in arriving at decisions and making negative socio-emotional (morale upsetting remarks)". (Catell, 1970, p.93)

The changes that occurred in this factor are certainly deserving of further study as the movement in the I- direction may be a preliminary indication of a movement toward the interpersonal and pragmatic attitude of successful AA members. These changes are in keeping with the significant changes in BASA scores referred to above.

Assessing the longer term benefits of in-patient alcoholism treatment have taxed the resources of psychological researchers for some time. Pattison (1966) makes the point that with the varying social groups of alcoholics such as workhouse inmates, AA members, industrial employees, hospitalized alcoholics etc. it is impossible to compare treatment effectiveness. Pattison (1966) elaborates this point of view in the following way:

One of the outstanding problems, then, in comparing follow-up studies of treatment programs is that the patient populations are so variable in composition. The evidence all suggests that rather than being uniform, the population of alcoholics is a complex heterogeneous one.

(Pattison, 1966, p.54).

An additional consideration is that apart from the differing social groups of alcoholics, the fact that the circumstances alcoholics are likely to face and their reactions to them are largely unpredictable. This is further illustrated by the measured personality profiles of male alcoholics that indicate a susceptibility to stressful situations. Great caution then must be used in evaluating the behaviour of male alcoholics after a treatment experience. McCance and McCance (1969) reported that

the outcome of alcoholism depends very little upon the type of treatment given, but very much upon the many personal and environmental factors pertaining to the individual patient treated and to the natural history of the condition.

(McCance and McCance, 1969, p.197).

Within the limits of the hospitalized male alcoholics in this study, however, it is interesting to note that 81% of the group felt their general personal circumstances were much improved three months after treatment (see Table 12). None felt they were worse than before treatment.

Caution should be used in the interpretation of changes found in Factor I (harria) as reported above, as the alcoholic groups' scores at both T1 and T2 remain within the average range on this factor.

In future studies, the matching of the individual profile to the Fuller reference profile would be useful in studying the hospitalized male alcoholic.

Suggestions for Future Research

This thesis suggests that a number of issues need further investigation. The following suggestions are advocated for future research.

1) Research using the 16PF in all phases of alcoholism treatment should continue. It is important, however, that consistent use be made of certain forms and/or combination of forms of the 16PF to facilitate comparative study of the personality profiles of alcoholics.

2) A comparison between 16PF profiles of the "stayers" and "early leavers" in hospitalized alcoholics may yield differences that could have ramifications in treatment strategy.

3) Studies using the 16PF on male and female alcoholic out-patients as well as female in-patient alcoholics would also be useful for comparative investigations.

4) The BASA requires further study in order to increase its reliability.

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A P P E N D I C E S

APPENDIX I

BELL ALCOHOLISM SCALE OF ADJUSTMENT
BASA

Mark each of the following statements on the line next to each item according to how much you agree or disagree with each statement. Write +1, +2, +3; or -1, -2, -3, depending upon how you feel in each case.

+1: AGREE A LITTLE	-1: DISAGREE A LITTLE
+2: AGREE PRETTY MUCH	-2: DISAGREE PRETTY MUCH
+3: AGREE VERY MUCH	-3: DISAGREE VERY MUCH

-
- ___ 1. If I were eligible for vocational rehabilitation benefits, I would prefer to get my own job.
 - ___ 2. I would be all right if people would just leave me alone.
 - ___ 3. I am not an alcoholic.
 - ___ 4. When people offer to help me I get the feeling I'm being treated like a child.
 - ___ 5. It is hard for me to make important decisions.
 - ___ 6. I do not feel that I have a drinking problem.
 - ___ 7. I try to keep to myself how much I really drink.
 - ___ 8. I can stop drinking any time I want to.
 - ___ 9. I just can't seem to accept help when I need it.
 - ___ 10. I do not think of myself as a person with a drinking problem.
 - ___ 11. Most people simply do not understand me.
 - ___ 12. Only a weakling admits he is powerless over alcohol.
 - ___ 13. I would rather not go any place if someone has to drive me.
 - ___ 14. All an alcoholic needs is a little will power to control his drinking behaviour.
 - ___ 15. For some reason I feel uncomfortable in the presence of an AA member.

- ___ 16. It makes me angry when people try to do things for me that I can do by myself.
- ___ 17. I can take criticism better than most people.
- ___ 18. It is a sign of weakness to admit defeat.
- ___ 19. Just because I might drink too much people think they can tell me what to do.
- ___ 20. I do not want or need any help from anybody.
- ___ 21. I feel that people are prying into my private affairs when they question me about my drinking behaviour.
- ___ 22. My drinking behaviour doesn't really hurt me all that much.
- ___ 23. It upsets me when someone opens a door for me.
- ___ 24. Nobody is affected by my drinking but me.
- ___ 25. I envy non-alcoholics because they can do so much more than I can do.
- ___ 26. I wish people wouldn't look at me like I've got two heads or something.
- ___ 27. Even when no offense is intended, it bothers me to be called an alcoholic.
- ___ 28. I do not like to be shown how to do things.
- ___ 29. It makes me feel sad when I cannot join others in certain social activities.
- ___ 30. My drinking habits are my business and my business alone.
- ___ 31. My drinking habits haven't caused anybody any trouble.
- ___ 32. I am no different from anyone else.
- ___ 33. I am not understood by anyone.
- ___ 34. In spite of my drinking habits, I can still be a successful person.
- ___ 35. I just can't believe that I am an alcoholic.
- ___ 36. I do not like to be told I am going to have to stop drinking.
- ___ 37. If I really wanted to, I could stop drinking by myself.

- ___ 38. I can control my drinking behaviour when I really want to.
- ___ 39. Somehow it is difficult for me to take advice about my drinking behaviour.
- ___ 40. It makes me feel anxious when the subject of alcoholism is discussed.

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APPENDIX II

LETTER AND FOLLOW-UP QUESTIONNAIRE

BASA RESEARCH STUDY

Dear

As discussed with you while you were in St. Joseph's Hospital during 1970, a follow-up letter would be sent to you approximately 90 days after you were discharged. Would you kindly complete the enclosed short questionnaire and forward it in the enclosed self-addressed stamped envelope as soon as possible. As always your reply will be treated in strict confidence.

I wish to thank you very much for co-operating in this special study and wish you the very best in the future.

Yours truly

Barry Lyons

APPENDIX II continued

FOLLOW-UP QUESTIONNAIREPLEASE ANSWER CAREFULLY

1. How many days complete abstinence from alcohol did you have in the last 90 days since you left the treatment unit in Thunder Bay? You left the unit on approximately 1970.

(Mark with an X)

1. 90 days abstinence _____
2. 70-80 days abstinence _____
3. 50-70 days abstinence _____
4. less than 50 days _____

2. If you did resume drinking, how long after discharge did you start drinking? (Mark X)

1. 1-20 days _____
2. 20-40 days _____
3. 40-60 days _____
4. 60-90 days _____
5. did not resume drinking _____

3. Do you attend A.A. yes () no ()
If yes, how many meetings per week do you attend? ().

4. How would you describe your general health and personal circumstances since you were discharged. (Mark X)

1. worse than before _____
2. about the same _____
3. much improved _____

5. Do you accept the fact that you are an alcoholic?

1. Yes _____
2. No _____
3. Uncertain _____

6. How do you agree with the following statement? (Circle your choice) "I accept the fact that I am an alcoholic".

- | | |
|----------------------|-------------------------|
| 1. Agree a little | 4. Disagree a little |
| 2. Agree pretty much | 5. Disagree pretty much |
| 3. Agree very much | 6. Disagree very much |

Signature

APPENDIX III

SUMMARY OF 21 DAY TREATMENT PROGRAM
AT SPECIAL MEDICAL UNIT
ST. JOSEPH'S GENERAL HOSPITAL
THUNDER BAY, ONTARIO (1970) *

LECTURE DISCUSSION SESSIONS:

- 1) What is alcoholism.
- 2) Surrender - Treatment - Addiction.
- 3) How to make an alcoholic.
- 4) I had to stop because I couldn't quit.
- 5) How to remake an alcoholic.
- 6) Attitudes re: treatment.
- 7) Learning process in alcoholism.
- 8) Unlearning process in recovery.
- 9) Motivation.
- 10) Anatomy of a relapse.
- 11) Miserable but sober.
- 12) Contented sobriety.
- 13) What kind of person am I.
- 14) Recividism.

SPECIAL GROUP THERAPY

10 Sessions

FILM AND DISCUSSION SESSIONS

- 1) David: Profile of a Problem Drinker.
- 2) Decision: Alcohol in Industry.
- 3) To Your Health.
- 4) Summer We Moved to Elm Street.
- 5) For Those Who Drink.

OTHER SESSIONS

- 1) 4th and 5th steps of AA - clergy.
- 2) Phenomena of Alcohol - doctor.
- 3) Family Life - counsellor.

APPENDIX III continued

- 4) AA quest lecture - AA member.
- 5) Anxiety Discussion - psychologist.
- 6) Forgiveness - clergy.
- 7) Medical Lecture - doctor.
- 8) General Health - nurse.
- 9) City Social Services - social worker.

INDUSTRIAL AND OCCUPATIONAL THERAPY

15 Sessions.

Individual Counselling and General Feedback discussion groups are held frequently as well as selected visits to AA club rooms. All patients are encouraged and expected to attend all sessions.

* specific details can be obtained from the hospital.

EXTERNAL EXAMINER

M. A. Thesis - Barry Lyons

PERSONALITY FACTORS AND TREATMENT
RESPONSE IN HOSPITALIZED MALE ALCOHOLICS

Dr. C. H. Aharan
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477 Waterloo Street
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Canada.

Dr. Aharan is a respected psychologist in the field of research and treatment of alcoholism. The following are some examples of his work in this field.

- 1) Aharan, C. H., Oglivie, R. D., & Partington, J. T.
Clinical Indications of Motivation in
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thesis, University of Western Ontario, 1965.

Dr. Aharan is also a Registered (Ontario)
Psychologist and a member of the Ontario Board of Examiners
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