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A COMPARISON OF ALCOHOLIC AND NONALCOHOLIC PSYCHIATRIC PATIENTS IN A RURAL COMMUNITY MENTAL HEALTH SYSTEM

THE UNIVERSITY OF ARIZONA M.S. 1982

A COMPARISON OF ALCOHOLIC AND NONALCOHOLIC PSYCHIATRIC PATIENTS IN A RURAL COMMUNITY MENTAL HEALTH SYSTEM

by

Julie Anne Kaminskas

A Thesis Submitted to the Faculty of the

DEPARTMENT OF PSYCHOLOGY

In Partial Fulfillment of the Requirements
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STATEMENT BY AUTHOR

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ABSTRACT

One hundred nineteen patients at rural community mental health centers were divided into three diagnostic groups. These groups were (1) primary diagnosis of alcoholism (N = 34), (2) primary diagnosis of emotional disturbance (N = 39), and (3) "other" diagnosis (N = 46). The alcoholic patient group tended to be single, male, inpatients, while the nonalcoholic group tended to be married, female, outpatients. These two groups differed significantly with respect to alcohol consumption and drinking patterns and effects, but did not differ significantly with respect to their attitudes toward treatment or their MMPI profiles. The total subject population evidenced elevated MMPI profiles, indicating the presence of a fair amount of psychopathology. The results of the "other" diagnostic group generally fell between those of the alcoholic and nonalcoholic groups, suggesting that it was a heterogeneous group of subjects.

CHAPTER 1

INTRODUCTION

Much research has been conducted to determine whether it is possible to accurately identify and diagnose individuals as alcoholic or nonalcoholic based on personality factors. A variety of objective personality tests have been employed in this research, but the Minnesota Multiphasic Personality Inventory (MMPI), which was originally constructed to provide psychologists and psychiatrists with information for making psychiatric diagnoses, has been the most widely used instrument (Donovan, Chaney and O'Leary, 1978). Dahlstrom, Welsh and Dahlstrom, 1975) cite over 150 studies on alcoholism which employed the MMPI, and Knox (1976) in her review of the use of objective psychological measurement in the study of alcoholism, reported that the MMPI is the most frequently used research instrument.

The ways in which the MMPI has been employed in alcoholism research are varied and the studies often yield contradictory results. Apfeldorf (1974) reviewed studies of the MMPI and alcoholism in an effort to understand the conflicting data extant in this body of literature. He suggested that researchers in this area can be conceptualized as belonging to two separate groups, which operate under different assumptions about the nature of alcoholism. The first group consists of researchers who assume that alcoholism is a distinct category of psychological disorder and conduct studies accordingly.

These investigators, acting on this hypothesis, develop special MMPI alcoholism scales, which usually demonstrate that alcoholics have substantive personality characteristics that are distinct from those of other psychiatric patients and of "normal" control populations. The second group consists of researchers who accept the nosological system containing the neurotic, psychotic, and psychopathic disorders. These investigators generally employ the MMPI clinical scales to the exclusion or deemphasis of special MMPI alcoholism scales, and, on the basis of their data, often conclude that alcoholics share common symptoms with comparable psychiatric patients, and do not require unique diagnoses.

Researchers belonging to the first group characterized by Apfeldorf (1974) have constructed several alcoholism scales from the item pool of the MMPI. Three such scales were developed from the MMPI in the 1950's. Hampton (1953) used a highly selected criterion group to derive his alcoholism scale. He required that his subjects be members of Alcoholics Anonymous, be hospitalized or imprisoned, and be diagnosed alcoholic. Hampton reported that his alcoholism scale produced significant mean differences on cross-validation with 100 alcoholics and 150 normal controls. Button (1956) reported an MMPI alcoholism scale developed by Holmes and Rahe (1967), which discriminated between alcoholics and normal controls on cross-validation. Hoyt and Sedlacek (1958) developed an MMPI alcoholism scale and evaluated it using alcoholics, normal controls, and psychiatric controls. They found that their scale significantly differentiated the

alcoholics from the normal controls, but did not distinguish the alcoholics from the psychiatric patients. MacAndrew and Geertsma (1964) reviewed these three MMPI alcoholism scales and reported that they all seem to successfully discriminate alcoholics from normal controls, but not from nonalcoholic psychiatric controls. Based on the failure of these three scales to discriminate between different psychiatric populations, MacAndrew and Geertsma (1964) suggested that these scales may measure a general adjustment factor rather than alcoholism.

MacAndrew (1965) developed an MMPI-derived alcoholism scale for the purpose of differentiating alcoholics from nonalcoholic psychiatric populations. In a cross-validation study, MacAndrew (1965) found that the correct assignment of outpatient alcoholics and outpatient psychiatric controls was 81.5 percent. Based on these results, MacAndrew (1965) concluded that substantive personality differences exist between alcoholics and comparable psychiatric patients, and that these personality differences involve more than differential alcohol consumption.

Since its development, the MacAndrew Alcoholism Scale has been one of the most widely used MMPI alcoholism scales in this research area (Knox, 1976). Rhodes (1969) replicated MacAndrew's (1965) study with a comparable sample of 200 male outpatient alcoholics and 200 male psychiatric outpatients. He found that the MacAndrew Alcoholism Scale correctly classified 80 percent of the alcoholics and 71.5 percent of the psychiatric patients, and he concluded that the scale is valid for use with outpatient populations. Uecker (1970) investigated the efficacy of the MacAndrew scale with inpatient alcoholics and inpatient

psychiatric patients. The results indicated that the psychiatric patients scored higher than those in MacAndrew's sample. Based on these results, Uecker concluded that MacAndrew's scale may not be appropriate for use with inpatient populations. Vega (1971) compared the efficacy of the MMPI alcoholism scales developed by MacAndrew, Hampton, Holmes and Rahe, and Hoyt and Sedlacek with alcoholic patients, psychiatric controls, and normal controls. He found that all of the scales except that of Hoyt and Sedlacek discriminated "reasonably well" between the alcoholics and both control groups. Using the MacAndrew Alcoholism Scale, Kranitz (1972) found significant mean score differences between heroin addicts and nonalcoholic psychiatric patients, and between alcoholics and nonalcoholic psychiatric patients. Lachar et al. (1976) also reported that both alcoholics and polydrug users evidenced significantly higher mean scores on the MacAndrew scale than did a matched control group of psychiatric patients. Schwartz and Graham (1979) reported that for their patient sample, the MacAndrew scale significantly differentiated female alcoholics from other female psychiatric patients, but failed to discriminate male alcoholics from male nonalcoholic patients. In a review of MMPI-derived alcoholism scales, Apfeldorf concludes:

> whatever the ultimate answers may be, the accumulation of findings on alcoholism scales appears to justify the strategy of studying alcoholics with MMPI alcoholism scales and newer scales in an effort to delineate personality characteristics of alcoholics and to study the development and persistence of these characteristics over the life span and following intensive treatement (Apfeldorf, 1978).

Researchers belonging to the second group categorized by Apfeldorf (1974) have employed the MMPI clinical scales to (1) attempt to discriminate alcoholics from nonalcoholic psychiatric patients, and (2) identify distinct personality subtypes within alcoholic samples. Examination of the MMPI profiles of alcoholic and nonalcoholic populations have yielded a consistent finding of significantly elevated T-scores for alcoholics on Scales 4 (Psychopathic Deviance) and 2 (Depression), and to a lesser extent, 7 (Psychasthenia) (Button, 1956; Dahlstrom, Welsh and Dahlstrom, 1972; Goldstein and Linden, 1969; Goss and Morosko, 1969; Hoyt and Sedlacek, 1958; Lisansky, 1967; MacAndrew and Geertsma, 1963; Rosen, 1960; Whitelock, Overall and Patrick, 1971). Jansen and Hoffman (1973) reported that their sample of male and female inpatient alcoholics evidenced mean T-scores of greater than 70 on Scale 4 and presented a 4-2 high point scale coding. Gilberstadt and Duker (1965) described 2-7-4 as the most frequent MMPI code type found among alcoholics. Whitelock et al. (1971) examined the MMPI protocols of 136 inpatient alcoholics and found a predominance of elevated Scale 4 scores and of 4-2 scale codes. Goss and Morosko (1969) reported that more than half of their alcoholic subjects showed T-score elevations greater than 70 on Scales 2 and 4, and that the most frequently occurring scale code types were combinations of 4-2-7. Schroeder and Piercy (1979) also found that Scales 2 and 4 were likely to be the most elevated scales in the average MMPI profile for alcoholics, and that Scales 2 and 4 were likely to appear in the majority of the two-point code pairs. Hodo and Fowler (1976)

reported that for 1009 male alcoholic subjects, the mean profile was characterized by peak T-scores on Scales 4 and 2. They also found that the most common code types of 2-4 and 4-2 collectively classified about 21 percent of the cases. All of the twenty most frequent code types, which classified about 73 percent of the cases, involved either Scale 2 or 4. The authors concluded that since a majority of the subjects did not evidence a 2-4 or 4-2 MMPI profile, a "basic" alcoholic profile does not exist, and the existence of an "alcoholic personality" is doubtful. MacAndrew and Geertsma (1963) found that Scale 4 significantly differentiated 200 outpatient alcoholics and 200 psychiatric outpatients. They further found, however, that when three MMPI items were removed from Scale 4, it no longer discriminated the two groups. These three scale items were: (1) "I have used alcohol excessively," (2) "I have never been in trouble with the law," and (3) "I have not lived the right kind of life." In a review of these studies, Miller (1976) concludes that although alcoholics are consistently found to score higher on Scales 4 and 2 of the MMPI, the elevation of Scale 4, at least, may be due to the endorsement by alcoholics of a few items that are related to alcohol consumption or the effects of excessive alcohol consumption on an individual's life. Despite these results that question the nature of the discriminability of MMPI scale scores when dealing with alcoholics and nonalcoholics, many investigators continue to regard the 4-2 and 2-4 high point codes as indicative of the "basic" alcoholic MMPI profile (Hodo and Fowler, 1976).

Hoyt and Sedlacek (1958) found that their nonalcoholic psychiatric samples tended to evidence markedly elevated MMPI profiles in comparison with both alcoholic and normal samples. Additionally, they reported that the percentage of alcoholics exhibiting T-scores above 70 was significantly less than that of their nonalcoholic psychiatric sample. Hodo and Barker (1976) found that individual MMPI clinical scales discriminated significantly between alcoholic and nonalcoholic subjects, and argued that collectively the MMPI scales seem to predict alcoholism as well as some of the specially designed alcoholism scales. Conley and Kammeier (1980) reported that alcoholic MMPI profiles generally indicate intermediate psychiatric adjustment in comparison with normal controls and nonalcoholic psychiatric patients. These authors found that seven MMPI items discriminated male and female alcoholics from comparable psychiatric and normal controls. These seven items tended to be related to alcoholism either explicitly or implicitly, and were identified by the authors as face-valid MMPI responses that are particularly characteristic of diagnosed alcoholics. Lachar, Gdowski and Keegan (1979) examined MMPI responses of alcoholics, heroin addicts, polydrug users, and psychiatric patients. They found significant differences between the alcoholics and the other groups on nineteen MMPI scales. Alcoholics evidenced less deviant elevations than did the other groups on eight of these scales (i.e. Hs, D, Hy, Mf, Pt, Sc, Dep, and R), leading the authors to conclude that the alcoholic group was the least pathological of the four groups. Eshbaugh, Toshi and Hoyt (1978), on the other hand, concluded from

an examination of the MMPI profiles of hospitalized male alcoholics, that this population generally evidences extensive psychopathology.

Other researchers, however, have failed to find significant differences between the MMPI profiles of alcoholics and nonalcoholic psychiatric patients. Rosen (1960) compared the MMPI profiles of alcoholics and nonalcoholics and found that the total shape and form of the profiles of these groups was very similar. He concluded that outpatient alcoholic and psychiatric patients display the same or similar psychiatric symptoms. Brown (1950) employed the MMPI scales and a slightly different methodology than did Rosen (1960), and reported similar conclusions.

The inconsistencies found in the attempts to define MMPI profiles of alcoholics that are distinct from those of other psychiatric groups has led some researchers to investigate the existence of a number of subtypes of MMPI profiles in alcoholic populations (Miller, 1976) Eshbaugh et al. (1978) analyzed the MMPI profile configurations of inpatient male alcoholics and reported finding seven distinct personality subtypes of this alcoholic population. Goldstein and Linden (1969) used a cluster analysis method to distinguish four MMPI subtypes that accurately classified approximately 45 percent of their alcoholic sample. Donovan et al. (1978) reported that the results of their study, in which 102 male inpatient alcoholics completed the MMPI and a measure of drinking behavior, indicate that distinct alcoholic personality subtypes exist, and that these subtypes are differentially associated with drinking-related behaviors. With a cluster analysis

of the MMPI profiles of 207 male and female inpatient alcoholics, Svanum and Dallas (1981) found four distinct alcoholic subtypes which appeared to be highly representative of the sample studied. In a review of studies investigating MMPI-based typologies of alcoholism, Conley (1981) distinguished four subtypes that appear repeatedly in the literature: (1) the "neurotic" subtype, which is characterized by primary elevations on the Hysteria (Hy), Hypochondriasis (Hs), and Depression (D) scales; (2) the "classic alcoholic" subtype, which shows elevations on the Depression (D), Psychopathic Deviance (Pd), and Psychasthenia (Pt) scales; (3) the "psychopathic" subtype, which is distinguished by elevations on the Psychopathic Deviance (Pd) and Mania (Ma) scales; and (4) the "psychotic" subtype, characterized by marked elevations on the four scales of the "psychotic tetrad" (i.e. Psychasthenia, Paranoia, Schizophrenia, and Mania), particularly on the Schizophrenia (Sc) scale. In a review of the attempts to classify the alcoholic personality, Hoffman (1976) reports that general agreement exists that alcoholics can be classified by the broad symptom complex of a depressive, neurotic-depressive, sociopathic, and anxious personality structure, but that typological studies also demonstrate that distinct personality subtypes can be distinguished in alcoholic populations that can also be found in other psychiatric populations.

Few studies have been done comparing alcoholic and non-alcoholic patients in rural community mental health facilities. Some researchers have reported demographic and other characteristics of the general population of specific community mental health centers.

Silverman (1980) described the variety of presenting problems reported by 273 persons seeking treatment in a communing mental health center. He reported that the most frequently reported problems were interpersonal, including family difficulties, social withdrawal loss or grief reactions, and school-related problems. The second most frequent presenting problems related by Silverman were drug-alcohol abuse and cognitive disturbances. Silverman also found that age, sex, marital status, ethnicity, and previous experience with mental health services were each related to presenting problem. Ndetei And Muhangi (1979) reported the prevalence of psychiatric disorders in a rural clinic in Africa. Of 140 patients, the authors found 19 percent of the males and 22 percent of the females to be primarily psychiatrically disabled; 64 percent of the males and 46 percent of the females to be organically disabled; and 17 percent of the males and 32 percent of the females to have an uncertain diagnosis. The authors also reported that, for this population, psychiatric disturbance increased with age and with being married. Based on these results, Ndetei and Muhangi concluded that the prevalence of psychiatric disturbance in their rural subject population was high. Heiman and Kahn (1975) investigated the utilization of a Barrio community health center by Mexican Americans, and presented demographic and other characteristics of this mental health patient population. The patients ranged in age from 5 to 44 years, with the majority falling between 15 and 44 years. Roughly three-fourths of the mental health patients were Mexican American, and 77 percent were female. Many of the mental health patients were divorced, and a high

percentage were living on pensions rather than being actively employed. More than half had lived in the city for more than four years, and one-third had lived in the same neighborhood for more than four years. Heiman and Kahn reported that the main reasons for referral to the mental health services were depression, anxiety, and family conflict. Suicide attempt was reportedly present in nearly 20 percent of the Mexican American patients. Generally, a physician was the main referral source.

O'Briant (1974), cited in Dominick (1976), described the patients of a detoxification program for alcoholics in Stockton, California. The majority of these patients fell into the 30 to 50 year old range, with an average age of 39.2 years. Slightly more than one-third were single, more than two-fifths were separated or divorced, and less than ten percent were married. O'Briant reported that the admission rates for the first and second years were, respectively, 2,999 and 2,968, with an average monthly admission rate of 248. Gordon, Gibson and Werner (1977) reported demographic data on a sample of fifty alcoholics treated in a community alcoholism treatment facility. Their subject population ranged in age from 15 to 79 years, with an average age of 34.1 years. The average educational level was 10.25 years. Almost half were married, 20 percent were single, 24 percent were divorced, 6 percent were separated, and 2 percent were widowed. Almost one-third of the patients were unemployed. Law enforcement agencies were the referral source in 40 percent of the cases, with other referrals coming from physicians, families, social service agencies,

alcoholics anonymous, friends, and self. The mean length of treatment was three months, and the average number of treatment sessions was 12.5. Finally, Tien-Teh (1975) explored the relationship between alcoholic and drug addic patients' demographic characteristics, achievement levels, personality traits (assessed by the MMPI), and discharge status from a "community-like" treatment setting. The results indicated that a higher proportion of alcoholics and of males left treatment against medical advice, and that these patients evidenced more elevated scores on the F (a validity scale) and the Psychopathic Deviance (Pd) MMPI scales than did patients with regular discharges from the treatment program. The general lack of studies reported in the literature focusing on the comparison of alcoholic and nonalcoholic patients in rural community mental health facilities points to the need for research in this area.

CHAPTER 2

FOCUS OF RESEARCH

The present study was part of a larger study which was funded by the Cochise County Behavioral Health Services (CCBHS). This larger study was designed to assess the characteristics of the population being served by the rural community mental health centers that are part of CCBHS, and to investigate the effects on individuals of participating in the treatment.

The present study was designed to describe and compare the alcoholic and nonalcoholic patient populations of these rural community mental health centers in terms of demographic characteristics, objective alcoholism measures, attitudes toward treatment, and MMPI profiles. The following questions were addressed:

1. What is the overall normative description of the clients receiving treatment at the community mental health centers studied?
2. Do the alcoholic and nonalcoholic subject populations differ significantly in terms of demographic characteristics?
3. Do the alcoholic and nonalcoholic subject populations differ significantly in terms of alcohol consumption patterns and the effects of alcohol consumption on their lives?
4. Do the alcoholic and nonalcoholic patients differ significantly in terms of attitude toward treatment?

5. Do the alcoholic and nonalcoholic patients differ significantly in terms of psychopathology, as assessed by pretreatment MMPI profiles?

Based on the data from the studies that were previously mentioned, it was hypothesized that the alcoholic and nonalcoholic patients would significantly differ in terms of both alcohol consumption patterns and psychopathology. Specifically, it was hypothesized that alcoholic patients would report greater alcohol consumption and more detrimental results of their drinking patterns, and that nonalcoholic patients would evidence more psychopathology on their MMPI profiles.

CHAPTER 3

METHOD

Setting

The treatment centers from which subjects were drawn were residential and outpatient centers in the southern Arizona rural communities of Bisbee, Sierra Vista, Benson, Willcox, and Douglas. The residential treatment centers originally provided services strictly for individuals diagnosed as alcoholics. Recently, however, these centers have accepted for treatment both those individuals diagnosed as alcoholics and those diagnosed as having emotional difficulties. This change was the result of a lack of funds for the hospitalization of rural residents presenting emotional problems.

Patients who received treatment at the residential centers lived at the centers (the amount of time spent at the center during the day varied with the program), and received an eclectic treatment program including individual and group counseling, Alcoholics Anonymous-type counseling, gestalt therapy, and peer interaction therapy. The treatment program employed in the outpatient centers included supportive individual and group counseling. The communities from which the subjects were drawn were quite different with respect to their composition and needs, and thus the treatment centers were different from each other.

Subjects

Total Subject Population

The total subject population consisted fo 234 patients admitted for treatment over a period of approximately seven months (due to the existence of missing data, however, not all of the following data is based on a total subject number of 234). This population of subjects was 58.2 percent male and 41.8 percent female. Ages ranged from 4.0 to 66.0 years, with a mean age of 34.0 years (N = 144). As is evident from Table A-1 (Appendix A), the largest number of subjects lived in Douglas, and the Bisbee and Douglas outpatient treatment centers contributed the most subjects to the sample. The majority of the subjects were treated in outpatient centers. Approximately one-half of the subjects were referred for substance abuse problems, approximately one-third for emotional disturbances, and 15.2 percent for "other" reasons. The most frequent sources of referral were self and the legal system.

As is indicated in Table A-1, the majority of the subjects classified themselves as caucasian, and the majority of subjects were not currently married. Years of education of the subjects ranged from 6 to 19, with a mean of 11.9 years (N = 136). Semi-skilled worker and housewife were the most frequently reported occupations. Most of a small number of subjects received primarily individual treatment, while a lesser number received primarily group treatment (see Table A-1 in Appendix A). The majority of the small number of subjects who received

a rating of improvement were judged by the therapists to be improved following termination of treatment.

Data Subject Population

The data subject population consisted of 119 subjects who were selected from the total subject population on the criteria that they had a reason for referral and a completed pretreatment MMPI. This selected sample was then separated into three groups based on their reason for referral. The three groups were (1) primary diagnosis of alcoholism (N = 34), (2) primary diagnosis of emotional disturbance (N = 39), and (3) "other" diagnosis (N = 46). The composition of this last group is unknown due to the unspecified nature of their reasons for referral.

This population of subjects was 57.8 percent male and 42.2 percent female. Ages ranged from 16.0 to 66.0 years, with a mean of 33.9 years (N = 113). Table A-2 (Appendix A) indicates that more subjects lived in Douglas than in any other community, and a majority of the subjects were contributed by the Bisbee and Douglas outpatient centers. The majority of subjects were treated in outpatient centers. Roughly half of the subjects were referred for substance abuse problems, one-third for emotional disturbances, and 17.8 percent for "other" reasons. The most frequent sources of referral were self and the legal system.

As can be seen in Table A-2, the majority of the subjects classified themselves as caucasian, and the majority of the subjects

were not currently married. Years of education of the subjects ranged from 7 to 19, with a mean of 12.1 years (N = 108). Semi-skilled worker and housewife were the most frequently reported occupations. Table A-2 indicates that of a small number of subjects, most received primarily individual treatment, while a small percentage received primarily group treatment.

Although the data subject population is a selected sample of the total subject population, the striking similarity in the demographics for the two populations provides supporting evidence for the claim that the selected sample is representative of the total sample.

Instruments

Upon admission to treatment, subjects who gave their written consent were administered a battery of paper and pencil tests (see Appendix B). Included in this battery were (1) a demographics questionnaire; (2) the Life Event Schedule; (3) a questionnaire on drinking patterns and effects; (4) the G-K Attitude Survey; (5) the CPH Factor Scale; and (6) the Minnesota Multiphasic Personality Inventory (MMPI). The MMPI was also administered post-treatment for a small number of subjects (N = 5). The CPH Factor Scale and the MMPI were available in Spanish in addition to English.

Demographics Questionnaire

The demographics questionnaire was divided into (1) initial contact information, and (2) completion of contact information. The initial contact information included the subject's name and

identification number, address, center where treatment was delivered, reason for referral, referral source, preliminary diagnosis, age, ethnicity, education, occupation, and marital status.

The completion of contact information was filled in by the therapist. This information included number of treatment sessions (or days in residence), type of treatment, number of days from initial contact to completion, and rating of change.

Life Event Schedule

The Life Event Schedule (Holmes and Rahe, 1967) contains 43 life event items. The subject scans the list of events and checks off those events that he or she has experienced within the past year. The total life event score is the total number of events checked off by the subject. The Life Event Schedule has been used to assess the amount and kinds of stress under which an individual is functioning. This assessment instrument has primarily been studied in the context of its use as a predictor of future pathology on the basis of stressful events encountered in a patient's life (Dohrenwend and Dohrenwend, 1974; Hudgens, Morrison and Barchha, 1967; Paykel et al., 1969).

Drinking Patterns and Effects Questionnaire

This questionnaire includes demographic information (i.e. age, sex, education, ethnicity, occupation, residence, and marital status) as well as 38 items regarding drinking patterns and resultant effects on the subject's life. These 38 items range from true-false, to multiple choice, to fill-in questions. This assessment instrument was

designed to assess an individual's amount and pattern of drinking alcohol, and the resultant effects of his or her drinking on his or her life (Gingras and Kahn, in press). In a study by Gingras and Kahn (in Press) this questionnaire was found to be significantly discriminate alcoholic patients from nonalcoholic patients on a number of different variables.

G-K Attitude Survey

The G-K Attitude Survey is a 54 item, true-false questionnaire with 34 critical items. This scale is designed to discriminate alcoholics from nonalcoholics on the basis of the power-motive hypothesis of alcoholism (Gingras and Kahn, 1980). If the subject responds to 20 or more of the 34 critical items in the alcoholic direction, the subject is classified as alcoholic. Gingras and Kahn (1980) found that this scale, overall, correctly identified 84 percent of the alcoholic patients in their subject population.

CPH Factor Scale

The CPH Factor Scale (Kahn et al., 1963) consists of 45 statements to which subjects indicate their degree of agreement or disagreement on a Likert-type scale. This assessment instrument is designed to measure attitudes of individuals toward the nature, cause, and treatment of mental illness, and toward mental health facilities and personnel. Responses to the test items are grouped under five factor scales.

Factor 1 is labelled "Authoritarian Control and NonPsychological Orientation." This factor appears to measure a tendency to view mental health facilities as external sources of control. Factor 2 is labelled "Negative Hospital Orientation." Subjects scoring high on this factor scale feel victimized and view the mental health facility as restrictive and penal. A general hostile complaining attitude is also included in this factor. Factor 3 is labelled "External Control, Cause, and Treatment." The causes of illness are seen as externally controlled and the mental health facility is viewed as externally controlling. There is no hostile complaining attitude found in this factor. Factor 4 is labelled "Mental Illness and Treatment as Physical-Hospital Supplies Regressive Dependency." This factor focuses on physical treatment, passive dependency needs, and stigmatizing secondary gain potential. Factor 5 is labelled "Letdown of Control for Therapeutic Gain--Arbitrary Restriction." This bipolar factor has the two extremes of (1) the view of the mental health facility as a safe place for positive change, and (2) the view of the mental health facility as a place of arbitrary and penal control.

Minnesota Multiphasic
Personality Inventory (MMPI)

The MMPI contains 566 items that are answered true or false by the subject. The test items are scored on thirteen scales, three of which are validity scales. The MMPI is designed to provide a measure of psychopathology and is commonly cited in the literature as such a measure.

Examiners

The test batteries were administered by admissions personnel or by paraprofessionals on the staff of the treatment centers. The MMPI profiles were scored by a psychometrician from the University of Arizona Educational Psychology Department. The post-treatment clinician ratings were made by the staff member who was the primary clinician for each individual subject. These clinicians were, in most cases, masters level therapists or paraparofessionals.

Procedure

Upon admission to both residential and outpatient treatment, subjects who gave their written consent were administered the test battery discussed above. They then participated in the treatment program. The lengths of the treatment programs were variable. While some of the residential centers had a twenty-one day program in which the patient returned to the community after living in the center for twenty-one days, the outpatient centers and other residential centers had an indefinite, flexible length of treatment. Following termination of the treatment, the patients were supposed to have been given a post-treatment MMPI and the primary clinicians were supposed to have subjectively rated the patients' change in psychopathology. This post-treatment procedure was not consistently or frequently followed by the clinicians and other treatment center personnel, thus post-treatment data for the subject population was not collected.

After the pre-treatment batteries were completed, the MMPI profiles were scored and the results of the other tests in the battery were encoded by administrative personnel. The MMPI profile data was made available to the clinicians to aid them in the treatment process.

CHAPTER 4

RESULTS

Demographic Variables

Alcoholic and Nonalcoholic Groups

As is indicated in Table A-3 (Appendix A), the alcoholic and nonalcoholic groups differed significantly on a number of demographic variables. A majority of the alcoholic group was treated at an inpatient facility, while only 12.8 percent of the nonalcoholic group were inpatients. Two of the referral sources differed with respect to the groups. All of those subjects referred by a friend were in the nonalcoholic group, while three fourths of those subjects referred by the legal system belonged to the alcoholic group. Although small cell numbers were involved, the preliminary diagnoses given by the therapists corresponded highly with the reason for referral for the two groups. All of the subjects in the nonalcoholic group were given a diagnosis in one of the following categories: situational problems, neurotic disturbance, psychotic disturbance, and "other". Table A-3 shows that most of the alcoholic group was given a preliminary diagnosis of alcoholism and that 13.3 percent of this group was diagnosed as having a drug related disturbance.

The majority of the subjects in the alcoholic group were men, while the majority of the subjects in the nonalcoholic group were

women. Table A-3 also shows that the alcoholic and nonalcoholic groups differed with respect to type of occupation. Of those subjects employed in managerial positions, 81.8 percent were in the nonalcoholic group, while of those not currently employed, 77.8 percent were in the alcoholic group. More alcoholics than nonalcoholics were employed in semi or unskilled positions, and all of the subjects employed as housewives fell into the nonalcoholic group. The majority of non-alcoholics were currently married, while the majority of alcoholics were not currently married. The subjects in the alcoholic group were slightly older than those in the nonalcoholic group (alcoholic group mean = 36.9 years; nonalcoholic group mean = 31.2 years; $F = 3.55$; $df = 1.72$; $p = .06$). The alcoholic and nonalcoholic groups did not differ with respect to number of years of education (alcoholic group mean = 11.6 years; nonalcoholic group mean = 11.8 years). The total life stress scores for the two groups also did not differ (alcoholic group mean = 9.7; nonalcoholic group mean = 9.7).

"Other" Reason for Referral Group

Results are presented separately for the "other" diagnostic group because although its number of subjects is large, it consists of a subject population whose initial diagnosis is of an unknown nature.

More than half (56.1 percent) of these subjects were men. Table A-4 (Appendix A) indicates that the majority of the subjects in this third group were treated on an outpatient basis. Of the total

number of subjects in all three groups, 40.3 percent of those treated in an outpatient center belonged to this third group, and 32.4 percent of those treated in an inpatient center belonged to this third group. The majority of the subjects in this group were referred by another mental health agency. Of the three subjects in this third group who received a preliminary diagnosis, two were diagnosed as having a neurotic disorder and one was diagnosed as having an anti-social disturbance.

As can be seen in Table A-4, of the subjects in this third group, almost one-third were employed in managerial positions, almost one-third were employed in semi or unskilled positions. Housewives constituted 27.3 percent of this group, and 12.1 percent of the subjects were not currently employed. The majority of the subjects in this group were not married at the time of the study. Table A-5 (Appendix A) shows the mean age of this group fell in between and did not significantly differ from that of the other two groups (mean = 34.0 years). The subjects in this third group had a slightly, but not significantly, higher mean number of years of education than that of the other two groups (mean = 12.7 years) (see Table A-6, Appendix A). The mean life stress total score was slightly but not significantly lower than that of the other two groups (mean = 8.2).

Drinking Patterns and Effects Questionnaire

Alcoholic and Nonalcoholic Groups

As is indicated in Table A-7 (Appendix A), many of the items on this questionnaire clearly discriminated between the alcoholic and nonalcoholic groups. While almost three-fourths of the alcoholic group reported that they drank three or more days per week, less than one-fourth of the nonalcoholic group reported this amount of drinking. Most of the subjects in the alcoholic group reported that drinking alcohol had caused them trouble with their family, while most of the nonalcoholic group had reportedly not had family trouble caused by alcohol.

Table A-7 reveals that a majority of the alcoholic group, as opposed to a small percentage of the nonalcoholic group, reportedly had trouble getting or holding a job because of drinking alcohol. While less than one quarter of the nonalcoholic group had ever been in trouble with the police because of drinking, almost all of the alcoholic group responded in the affirmative to this question. The alcoholic group also had significantly more arrests relating to the use of alcohol (means = 5.32 arrests) than did the nonalcoholic group (mean = 1.0 arrests) ($F = 5.5$; $df = 1,53$; $p = .02$).

As can be seen in Table A-7, although drinking alcohol seemed to have caused health problems for both groups, significantly more subjects in the alcoholic group than in the nonalcoholic group responded that drinking had affected their health adversely. Among the drinking related health problems reported significantly more frequently by the

alcoholic group were vomitting, hangovers, memory loss, confusion, sadness and depression, loss of temper and fighting, uncontrollable shaking, and D.T.s (delerium tremens).

While only a small number of subjects in the nonalcoholic group reported having lost friends due to drinking, more than half of the alcoholic group reported the occurrence of this problem. When asked what they enjoyed about drinking, the subjects in the alcoholic group responded significantly more frequently than the subjects in the nonalcoholic group that they liked the way that alcohol made them feel, and that alcohol helped them forget about their problems. Most of the alcoholic group reported that they would like to be able to better control their drinking or to stop drinking, compared to only about one-quarter of the nonalcoholic group that reported this desire.

Table A-7 shows that most of the alcoholic group compared to only 20.0 percent of the nonalcoholic group, reported excessive drinking when faced with disappointment, arguments, or aggravation. When feeling troubled or under pressure, the alcoholic group reported drinking significantly more than did the nonalcoholic group. The two groups also significantly differed with respect to sneaking extra drinks. More subjects in the alcoholic group than in the nonalcoholic group reported feeling ill at ease if alcohol was not available. More than two-thirds of those in the alcoholic group reported feelings of guilt regarding their drinking, while less than one-quarter of the nonalcoholic group reported such feelings. The alcoholic group also felt significantly

more resentful when family and friends discuss their drinking than did the nonalcoholic group.

Significantly fewer nonalcoholics reported frequency of blackouts than did alcoholics (see Table A-7). More than half of the alcoholic group, compared to only 10.7 percent of the nonalcoholic group reported wanting to continue drinking when others advise them to stop. More than three-fourths of the alcoholic group reported embarrassment regarding their behavior when drunk, while less than one-fourth of the nonalcoholic group responded in this direction. Many more subjects in the alcoholic group than in the nonalcoholic group reported that they make promises to control their drinking, and then they break the promise.

Nearly half of the alcoholic group reported avoiding family and friends when drinking, while only a small percentage of the nonalcoholic group reported this avoidance. While nearly two-thirds of the alcoholic group reported that financial and work problems were increasing for them, less than one-third of the nonalcoholic group reported the increase of these problems. Table A-7 indicates that three-fourths of the alcoholics group reported eating irregularly and very little when drinking, as compared to only 17.2 percent of the nonalcoholic group reporting this behavior. While only a very small percentage of the nonalcoholic group reported drinking in the morning to quiet their "shakes", more than half of the alcoholic group reported this behavior. Again, a very small percentage of the nonalcoholic group as compared to more than half of the alcoholic

group responded that they occasionally remained drunk for several days at a time. The majority of subjects in the alcoholic group reported having vague fears after drinking heavily, while only 11.1 percent of the subjects in the nonalcoholic group reported these fears. Lastly, the two groups differed significantly with respect to the amount of money that they spent on drinks per week (alcoholic group mean = 34.6 dollars; nonalcoholic group mean = 4.4 dollars; $F = 16.4$; $df = 1,44$; $p = .000$).

The two groups did not differ significantly with respect to the type of alcohol that they drank or the age at which they began to drink (alcoholic group mean = 15.7; nonalcoholic group mean = 15.0).

"Other" Reason for Referral Group

As can be seen in Table A-7, this third group fell in between the alcoholic and nonalcoholic groups on most of the questionnaire items. The majority of the subjects in this group reported drinking less than three days per week. Most of these subjects reported that their drinking had not caused trouble with either their family, their job, or the police. Almost three-fourths of this "other" group had experienced alcohol-related health problems. Among the health problems reported by a majority of these subjects were vomitting, hangovers, and memory loss. More than half of these subjects responded that what they liked about alcohol was its taste, the way that it made them feel, and its relaxing effects. A majority of the subjects in this group

stated that they would like to be able to better control their drinking or to stop their drinking.

Table A-7 shows that exactly one-half of these subjects reported excessive drinking when troubled or under pressure, and more than half reported that financial and work problems were increasing. Approximately half stated that they occasionally have feelings of guilt about their drinking. They reported spending a mean amount of $17.50 per week on alcohol, and reportedly began drinking at a mean age of 16.5 years, which is a slightly older age than that reported by the other two groups.

The G-K Attitude Survey

As was mentioned in the description of this instrument, 34 of the 54 test items have been experimentally indicated as critical items. Endorsement by the subject of 20 or more of the critical items in the alcoholic direction is the basis for classifying that subject as alcoholic. Table A-8 (Appendix A) indicates that the alcoholic group in this study endorsed 23 of the 34 critical items in the alcoholic direction, while the nonalcoholic group endorsed only 15 of the critical items in the alcoholic direction. The "other" group endorsed 19 of the critical items in the alcoholic direction, again falling between the other two groups in its scores. Thus, the alcoholic group fulfilled this instrument's criteria for alcoholism, while the other two groups did not.

CPH Factor Scale

There were no significant differences between any of the three groups with respect to the mean scores on each of the five factor scales (see Table A-9, Appendix A).

MMPI

Scale by Scale Analysis

The MMPI profiles of the three experimental groups and the original sample population are remarkably similar (see Figures 1-5). Table 1 shows that the alcoholic and nonalcoholic groups differed significantly with respect to only two of the MMPI scales. The alcoholic group had a mean T-score of 59.2 on the Male/Female Scale (Mf), compared to a mean T-score of 50.3 for the nonalcoholic group ($F = 11.7$; $df = 1,72$; $p = .001$). The "other" group had a mean T-score of 55.9 on this scale. Table 1 also indicates that the nonalcoholic group had a higher mean T-score on the Social Introversion Scale (Si) than did the alcoholic group ($F = 4.0$; $df = 1,72$; $p = .05$). The "other" group scored exactly the same mean as that of the nonalcoholic group on this scale (60.4).

The nonalcoholic group had slightly but not significantly higher mean T-scores than the alcoholic group on the following scales; Depression (D), Hysteria (Hy), Psychopathic Deviance (Pd), Paranoia (Pa), Psychasthenia (Pt), and Schizophrenia (Sc).

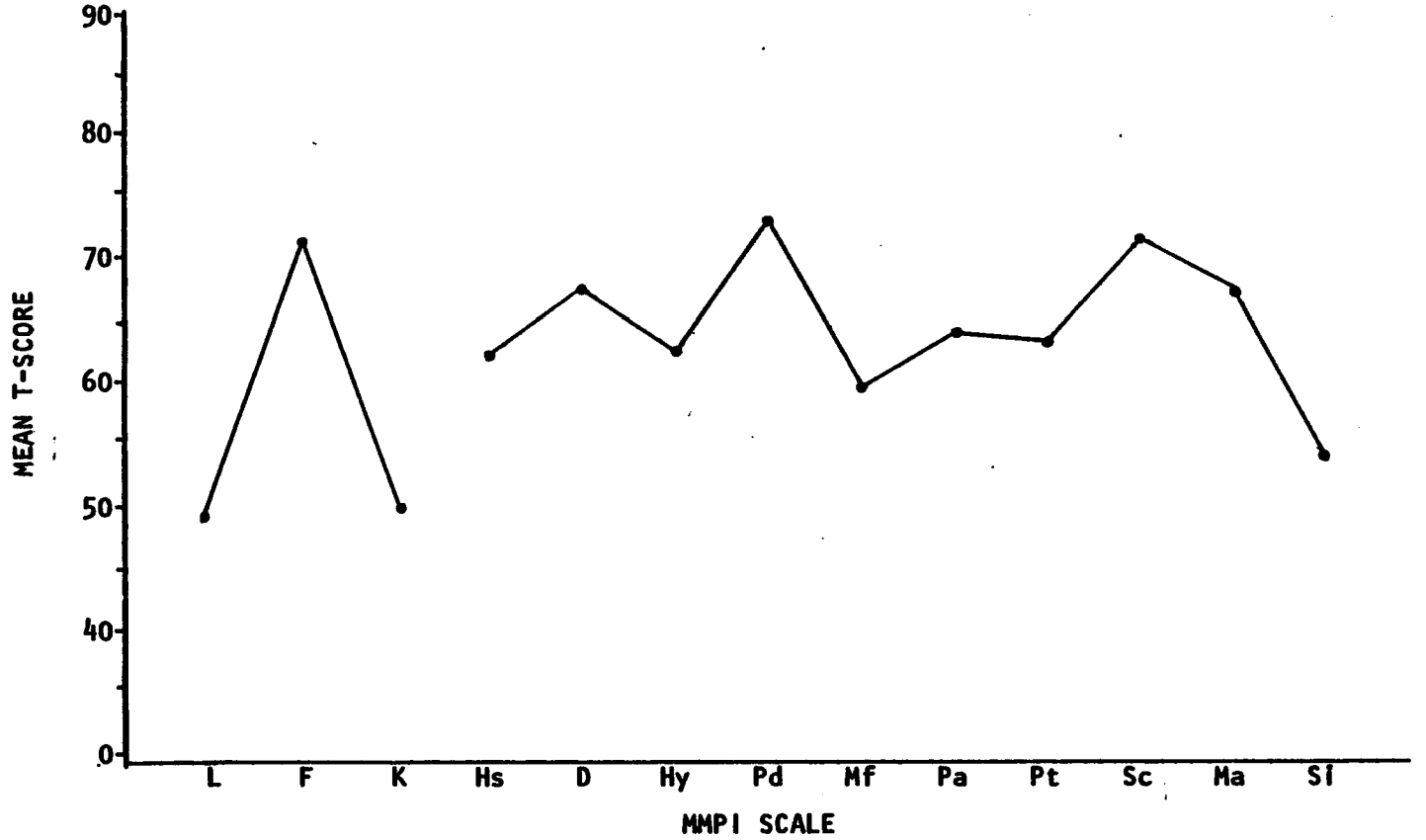

Figure 1. Mean MMPI Profile for Alcoholic Group (N = 34).

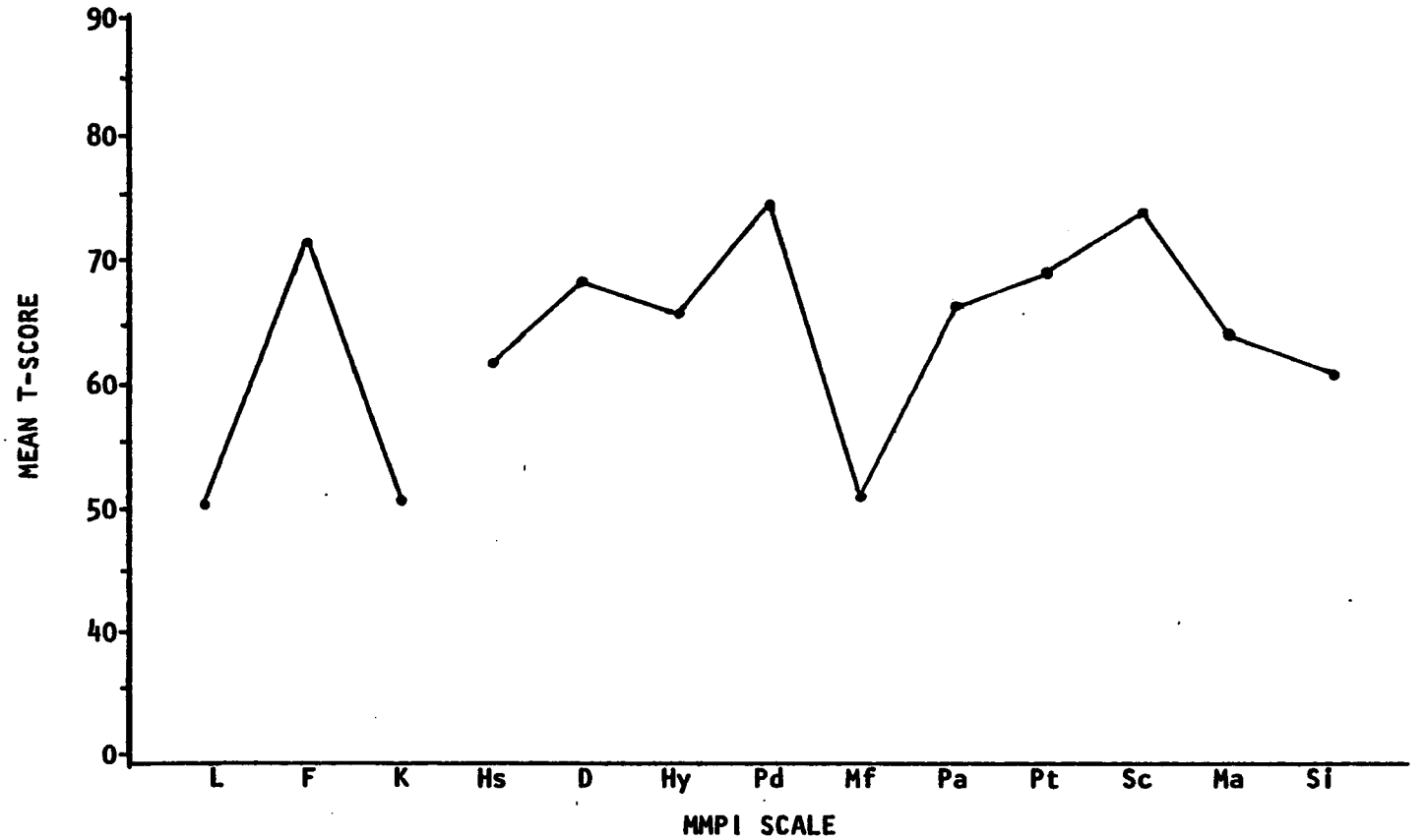

Figure 2. Mean MMPI Profile for Nonalcoholic Group (N = 39).

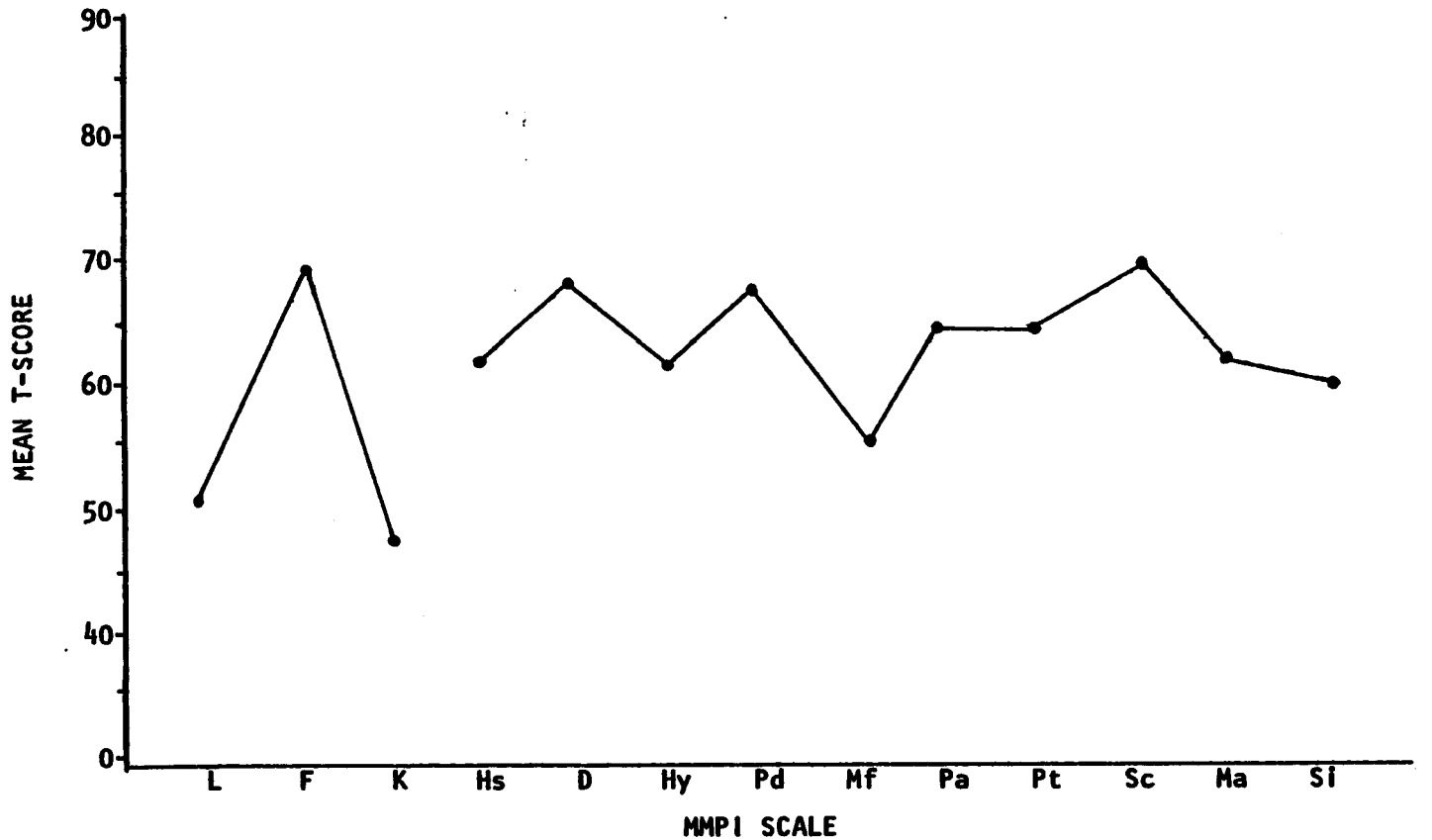

Figure 3. Mean MMPI Profile for "Other" Diagnostic Group (N = 46).

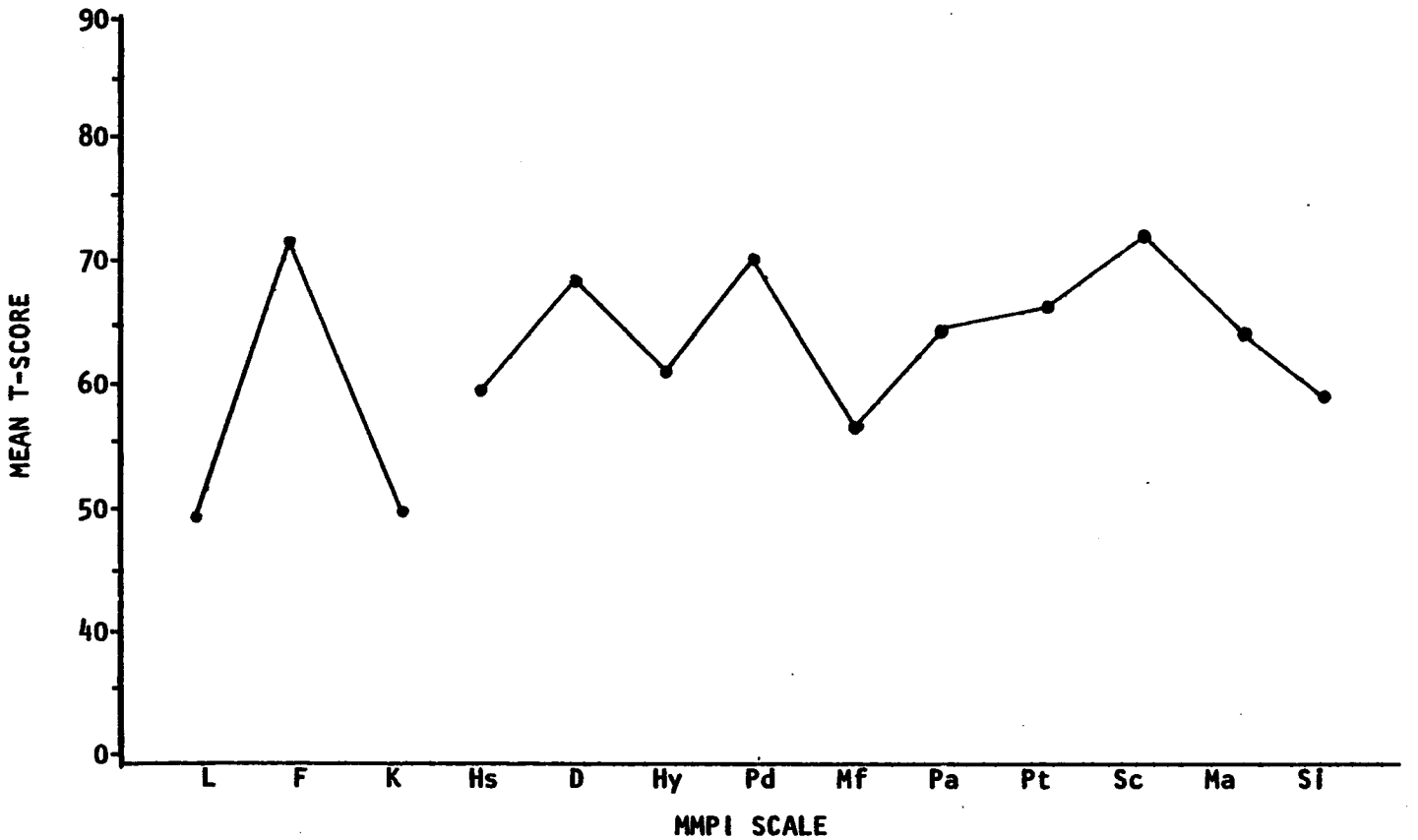

Figure 4. Mean MMPI Profile for Total Subject Population (N = 203).

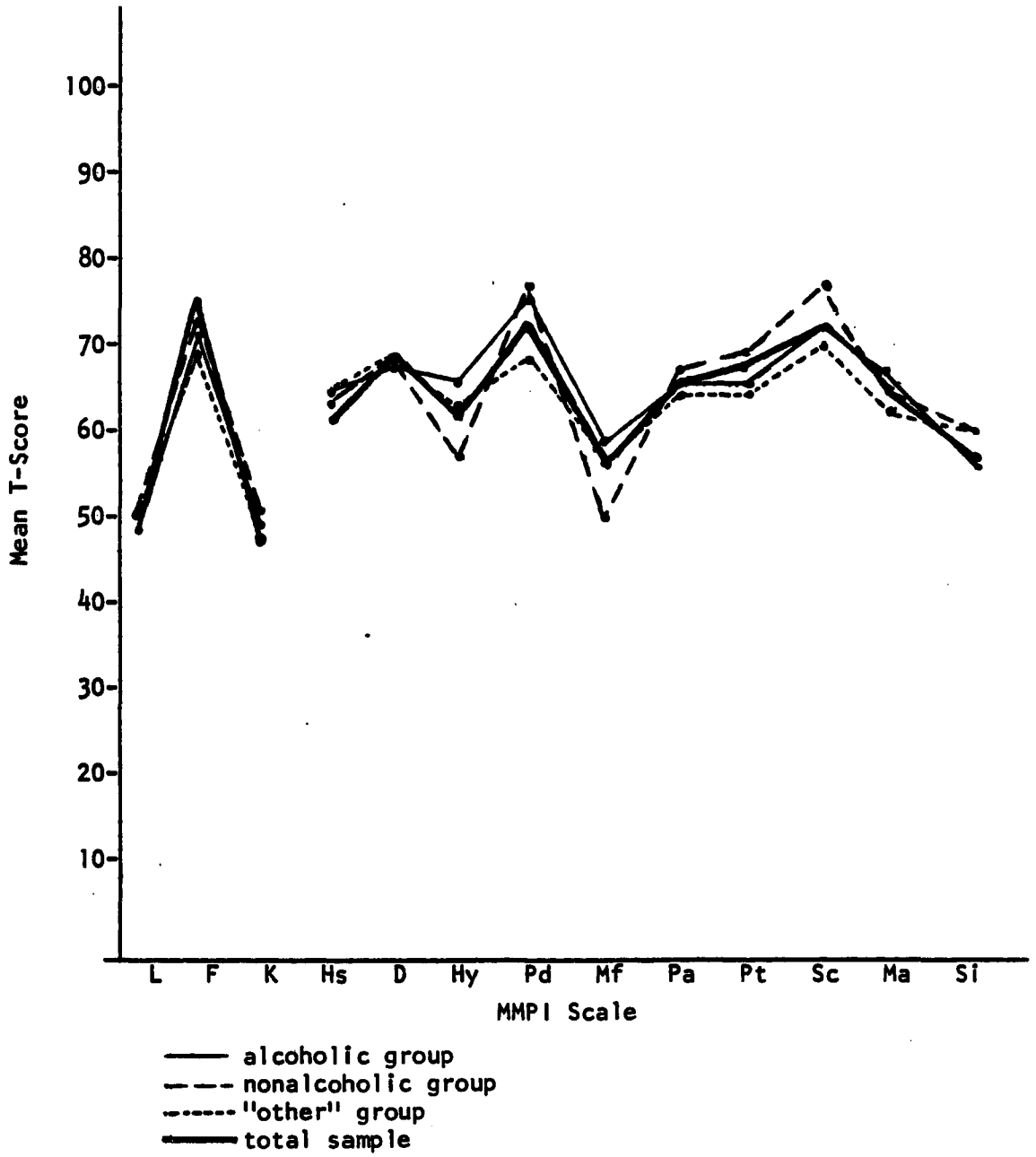

Figure 5. Composite of Figures 1 through 4.

Table 1. Mean MMPI T-Scores by Diagnosis.

MMPI Scale	Alcoholic Group	Nonalcoholic Group	"Other" Group	Significance Test (df = 2,118)
L	49.2	50.1	50.7	F = .378; NS
F	70.5	71.1	69.8	F = .044; NS
K	49.6	50.4	47.8	F = .81; NS
Hs	62.9	61.2	62.3	F = .103; NS
D	67.8	68.7	68.2	F = .03; NS
Hy	63.1	65.9	61.1	F = 1.86; NS
Pd	73.4	74.1	67.5	F = 4.0; p = .02
Mf	59.2	50.3	55.9	F = 5.1; p = .01
Pa	65.3	66.4	64.6	F = .21; NS
Pt	64.1	68.1	64.4	F = .828; NS
Sc	70.4	73.2	69.7	F = .357; NS
Ma	67.2	63.5	61.1	F = 2.53; NS
Si	55.0	60.4	60.4	F = 2.63; NS

Peak Score Pattern Analysis

Each subject was categorized into one of five MMPI profile categories depending on the pattern of his or her top three peak scores. This analysis was conducted twice, once using only those peak scale T-scores of 70 or above as the criterion for category assignment (see Table 2), and once using the three top scale scores as the criterion for category assignment regardless of their elevation (see Table 3). The five categories were (1) subjects whose scores were not classifiable into any of the three predetermined categories; (2) neurotic symptomology, based on peak scores on the Hs, Hy, and D scales; (3) psychotic symptomology, based on peak scores on the Pa, Pt, and Sc scales; (4) classic alcoholism profile, based on peak scores on the Pd and D scales; and (5) subjects whose scores fell into two or more of categories (2) through (4).

As is evidenced by Table 2, when the criteria for profile category assignment was peak scores of 70 or above, 35.9 percent of the nonalcoholic group and 29.4 percent of the alcoholic group fell into the "classic alcoholic" profile category. Slightly less than one-quarter of the "other" group fell into this category. None of the subjects in either the alcoholic group or the nonalcoholic group fell into the neurotic symptomology category, while a small percentage of the "other" group fell into this category. A very few of the non-alcoholic group, compared to none of the alcoholic group or the "other" group, was assigned to the psychotic symptomology category. The category of "no classifiable profile pattern" was comprised of 41.2

Table 2. Diagnosis by MMPI Profile Type: Criteria of T-Scores of 70 or Above on Appropriate Scales.

DIAGNOSIS	PROFILE TYPE				
	No Classifiable Profile	Neurotic (Hs, D, Hy)	Psychotic (Sc, Pt, Pa)	Classic Alcoholic (Pd, D)	Combination Profile
Alcoholic					
Frequency	14	0	0	10	10
Row %	41.2	0.0	0.0	29.4	29.4
Nonalcoholic					
Frequency	9	0	2	14	14
Row %	23.1	0.0	5.1	35.9	35.9
"Other"					
Frequency	24	2	0	11	9
Row %	52.2	4.3	0.0	23.9	19.6

Table 3. Diagnosis by MMPI Profile Type: Criteria of Three Peak Scale Scores.

DIAGNOSIS	PROFILE TYPE				
	No Classifiable Profile	Neurotic (Hs, D, Hy)	Psychotic (Sc, Pt, Pa)	Classic Alcoholic (Pd, D)	Combination Profile
Alcoholic					
Frequency	10	1	5	18	0
Row %	29.4	2.9	14.7	52.9	0.0
Nonalcoholic					
Frequency	12	0	3	24	0
Row %	30.8	0.0	7.7	61.5	0.0
"Other"					
Frequency	15	2	5	22	2
Row %	32.6	4.5	10.9	47.8	4.3

percent of the alcoholic group, 23.1 percent of the nonalcoholic group, and 52.2 percent of the "other" group. Approximately one-third of the nonalcoholic and slightly more than one-quarter of the alcoholic group fell into the category that was a combination of two or more of the three symptomology categories. Less than one-quarter of the "other" group fell into this category.

Table 3 reveals that a slightly different distribution of subjects was obtained when the three top scale scores, regardless of their elevation, were used as the criteria for profile category assignment. More than half of both the nonalcoholic and the alcoholic groups met the criteria for the "classic alcoholic" profile category, as did almost half of the "other" group. A small percentage of the alcoholic group, and none of the nonalcoholic group fell into the neurotic symptomology category. Two of the subjects in the "other" group also fell into this category. Table 3 indicates that 14.7 percent of the alcoholic group, 7.7 percent of the nonalcoholic group, and 10.9 percent of the "other" group fell into the psychotic symptomology category. A small number of the subjects in the "other" group, and none of the subjects in the alcoholic and nonalcoholic groups fell into the "combination" category. Lastly, the "no classifiable profile pattern" category was comprised of one-third of the "other" group, and slightly less than one-third of both the nonalcoholic group, and the alcoholic group.

CHAPTER 5

DISCUSSION

The results indicate that the alcoholic and nonalcoholic patient groups differed significantly with respect to alcohol consumption and drinking patterns and effects, but not with respect to psychopathology. The alcoholic patients reported drinking more frequently, having more alcohol-related health problems, and having more detrimental effects on their lives resulting from alcohol consumption. The Drinking Patterns and Effects Questionnaire highly discriminated between the alcoholic and nonalcoholic patient populations, lending evidence to support its validity as a face-valid instrument for distinguishing these two populations.

The alcoholic and nonalcoholic patient groups did not differ significantly in terms of their MMPI profiles. The profiles for these two groups, the "other" diagnosis group, and the total subject population all consisted of fairly highly elevated scale T-scores, indicating that this subject population evidenced a fair amount of psychopathology. The results of this study support those of both Rosen's (1960) and Brown's (1950) studies, in which no significant differences were found between alcoholic and nonalcoholic MMPI profiles, and Eshbaugh et al.'s (1978) study, in which alcoholics were found to evidence extensive psychopathology.

As is commonly found in the literature, the results of the present study indicate elevated Pd and D scale scores for the alcoholic group. Similar elevations on these scales were also, however, found for the nonalcoholic group, the "other" diagnosis group, and the total subject population. MMPI profiles resembling the "neurotic", the "psychotic", and the "classic alcoholic" patterns were found for all three diagnostic groups, lending support to the notion of subtype personality profiles for the general diagnostic category of alcoholism. Of those cases that were classifiable into one of these three profile subtypes, the largest percentage of all three diagnostic groups fell into the "classic alcoholic" profile. The nonalcoholic group MMPI profile was slightly, but not significantly more elevated (i.e. on six of the clinical scales) than was the alcoholic profile. These results are consistent with Lachar, Gdowski and Keegan's (1979) conclusion that alcoholics are less psychopathological than are other psychiatric groups. In summary, contrary to the hypotheses made in this study, the distinguishing variable between the alcoholic and nonalcoholic patient populations studied seems to be related to alcohol consumption, rather than to personality factors.

A normative description was obtained for the total subject population served by the various mental health centers. The population was predominantly male, young, caucasian, single, and treated on an outpatient basis. Most were referred by themselves or the legal system, and alcoholism was the single largest reason for referral. The normative description of the experimental subject population was very

similar to that of the total subject population. The alcoholic group, however, tended to be single, male, inpatients, while the nonalcoholic group tended to be married, female, outpatients. Thus, the two subject groups differed both in terms of alcohol-related factors and demograpic description. This normative description of the subject population provides valuable information to the Cochise County Behavioral Health Service and may also provide information relevant to health providers in similar rural communities.

The limitations of the present study restrict both the conclusions that can be drawn from the data and the generalizability of the results. Probably the greatest limitation of the study was the large amount of data missing from the majority of collected test batteries. Unfortunately, the CCBH system was in a period of turmoil and upheaval during part of the data collection period. A result of this turmoil was that staff cooperation with and support for the study was inconsistent. The data to be completed by the therapist was often incompletely filled-out or altogether omitted, and the post-treatment data was obtained for only 5 of 234 subjects. Many of the test batteries were incompletely filled-out by the subjects, leading the investigators to suspect that the staff was possibly inadequately explaining to the subjects the necessity of completing the entire test battery.

An additional limitation of the study involves the selection of patients who completed the test batteries. Due to the necessity of obtaining the subjects' consent to participate in the study, a self-selection process may have occurred, which may bring into question

the sample's representativeness of the total population served by CCBHS. Additionally, the possibility exists that staff may have given test batteries only to selected patients, rather than to all patients admitted consecutively for treatment. This possibility is small, but should, nonetheless, be considered when examining the data.

Lastly, the time at which the alcoholic patients completed the test batteries may, in part, account for the high degree of psychopathology evidenced by their MMPI profiles. It is possible that these patients were still showing symptoms of acute alcoholism or of withdrawal at the time that they completed the batteries. Uecker, Kish and Ball (1969) commented that it is reasonable to suppose that the MMPI profiles of alcoholics are most similar to those of other psychiatric patients when the alcoholics are in an acute or withdrawal phase. Knox (1976) and Libb and Taulbee (1971) mention that MMPI profiles of alcoholics evidence more psychopathology when they are tested before these patients are detoxified. Since we did not have information regarding the condition of the subjects at the time that they completed the test batteries, we cannot discount the possibility that the high degree of psychopathology indicated by the group MMPI profile may have been due, in part, to the effects of not being detoxified.

The main implication of the results obtained for the rural community mental health centers studied is that the population being served by these facilities is possibly more homogeneous than one would expect. The relative homogeneity of this patient population suggests the feasibility of treating the alcoholic and nonalcoholic patient

populations in the same community facility. The opportunity to effectively serve all psychiatric patients in their own communities has both financial and psychological advantages. Financially, a great deal of money could be saved by treating individuals in their own rural communities rather than hospitalizing them in a costly urban institution. Psychologically, Berry and Davis (1978) comment that the use of community-based mental health programs reduces the occurrence of stigma from mental hospitalizations, helps patients maintain contact with their friends and families, and by making services locally available, facilitates the treatment and prevention of emotional problems. Sarason (1974) also argues that treatment of mental health problems within an individual's own community encourages a "psychological sense of community," which, Sarason argues, helps prevent psychiatric disturbance.

Further research is needed investigating psychiatric populations in rural community mental health centers, particularly alcoholic and nonalcoholic patient groups. Research is needed in other rural communities to determine whether the group norms and differences found with this subject population are representative of other similar geographic areas. If other studies find similar results, the use of community mental health centers for all mental health populations in rural communities would be supported and strongly indicated.

APPENDIX A

TABLES A-1 THROUGH A-9

Table A-1. Demographic Characteristics of Total Subject Population.

Demographic Variable	Frequency	%
Agency		
Bisbee Outpatient	29	22.5
Doublas Outpatient	29	22.5
Sierra Vista Outpatient	13	10.1
Benson Outpatient	6	4.7
Willcox Outpatient	2	1.6
Tombstone Outpatient	2	1.6
Total Outpatient	81	
Bisbee Inpatient	21	16.3
Benson Inpatient	9	7.0
Huachuca City Inpatient	9	7.0
Douglas Inpatient	5	3.9
Total Inpatient	44	
N = 125 TOTAL MISSING CASES = 109		
Address		
Douglas	48	35.6
Bisbee	24	17.8
Sierra Vista	21	15.6
Benson	16	11.9
Willcox	2	1.5
Transient	2	1.5
Other	22	16.3
N = 135 TOTAL MISSING CASES = 99		
Reason for Referral		
Alcoholism	44	47.8
Anxiety	13	14.1
Marital Difficulties	13	14.1
Family Difficulties	5	5.4
Drug	2	2.2
Legal	1	1.1
Other	14	15.2
N = 92 TOTAL MISSING CASES = 142		

Table A-1--Continued

Demographic Variable	Frequency	%
Referral Source		
Self	27	30.0
Legal System	21	23.3
Mental Health Agency	16	17.8
Friend	9	10.0
Social Work Agency	9	10.0
Family	4	4.4
Physician	3	3.3
Other	1	1.1
N = 90 TOTAL MISSING CASES = 144		
Diagnosis		
Alcoholism	37	52.9
Situational Problems	15	21.4
Neurotic	8	11.4
Drug Abuse	4	5.7
Psychosis	1	1.4
Antisocial	1	1.4
Other	4	5.7
N = 70 TOTAL MISSING CASES = 164		
Ethnicity		
Caucasion	86	70.5
Mexican-American	32	26.2
Indian	3	2.5
Other	1	.8
N = 122 TOTAL MISSING CASES = 112		
Occupation		
Semi-Skilled	31	26.5
Housewife	27	23.1
Unskilled	17	14.5
Minor Managerial	14	12.0
Unemployed	12	10.3
Supervisorial	7	6.0
Major Managerial	5	4.3
Retired	4	3.4
N = 117 TOTAL MISSING CASES = 117		

Table A-1--Continued

Demographic Variable	Frequency	%
Marital		
Married	52	37.1
Never Married	34	24.3
Divorced	27	19.3
Separated	16	11.4
Widowed	11	7.9
N = 140 TOTAL MISSING CASES = 94		
Type of Treatment		
Individual	22	84.6
Group	3	11.5
Other	1	3.8
N = 26 TOTAL MISSING CASES = 208		
Rating of Improvement		
Moderate Improvement	8	47.1
Slight Improvement	4	23.5
Unimproved	2	11.8
Marked Improvement	2	11.8
Worse	1	5.9
N = 17 TOTAL MISSING CASES = 217		

Table A-2. Demographic Characteristics of Experimental Subject Population.

Demographic Variable	Frequency	%
Agency		
Douglas Outpatient	27	23.7
Bisbee Outpatient	26	22.8
Sierra Vista Outpatient	11	9.6
Benson Outpatient	6	5.3
Wilcox Outpatient	2	1.8
Tombstone Outpatient	2	1.8
Total Outpatient	74	
Bisbee Inpatient	17	14.9
Benson Inpatient	8	7.0
Huachuca City Inpatient	7	6.1
Douglas Inpatient	37	
Total Inpatient	37	
N = 111 TOTAL MISSING CASES = 8		
Address		
Douglas	42	37.8
Bisbee	21	18.9
Sierra Vista	15	13.5
Benson	14	12.6
Willcox	2	1.8
Transient	2	1.8
Other	15	13.5
N = 111 TOTAL MISSING CASES = 8		
Reason for Referral		
Alcoholism	33	45.2
Marital Difficulties	10	13.7
Anxiety	9	12.3
Family Difficulties	5	6.8
Drug Abuse	2	2.7
Legal	1	1.4
Other	13	17.8
N = 73 TOTAL MISSING CASES = 46		

Table A-2--Continued

Demographic Variable	Frequency	%
Referral Source		
Self	23	30.3
Legal System	16	21.1
Mental Health Agency	15	19.7
Friend	8	10.5
Social Work Agency	7	9.2
Family	3	3.9
Physician	3	3.9
Other	1	1.3
N = 76 TOTAL MISSING CASES = 43		
Diagnosis		
Alcoholism	26	47.3
Situational Problem	12	21.8
Neurotic	7	12.7
Drug Abuse	4	7.3
Psychosis	1	1.8
Antisocial	1	1.8
Other	4	7.3
N = 55 TOTAL MISSING CASES = 64		
Ethnicity		
Caucasian	72	73.5
Mexican-American	23	23.5
Indian	2	2.0
Other	1	1.0
N = 98 TOTAL MISSING CASES = 21		
Occupation		
Semi-Skilled	23	25.0
Housewife	21	22.8
Unskilled	14	15.2
Unemployed	13	14.2
Minor Managerial	11	12.0
Major Managerial	5	5.4
Supervisorial	5	5.4
N = 92 TOTAL MISSING CASES = 27		

Table A-2--Continued

Demographic Variable	Frequency	%
Marital Status		
Married	39	35.8
Never Married	29	26.6
Divorced	23	21.1
Separated	11	10.1
Widowed	7	6.4
N = 109 TOTAL MISSING CASES = 10		
Type of Treatment		
Individual	18	85.7
Group	2	9.5
Other	1	4.8
N = 21 TOTAL MISSING CASES = 98		
Rating of Improvement		
Moderate Improvement	6	46.2
Slight Improvement	4	30.8
Unimproved	2	15.4
Worse	1	7.7
N = 13 TOTAL MISSING CASES = 106		

Table A-3. Demographic Variables by Diagnosis (Alcoholic and Non-Alcoholic).

Demographic Variable	Alcoholics Frequency	%	Nonalcoholics Frequency	%	Percent of Total
Agency					
Douglas Outpatient	6	18.8	15	38.5	29.6
Bisbee Outpatient	0	0.0	11	28.2	15.5
Sierra Vista Outpatient	3	9.4	3	7.7	8.5
Benson Outpatient	3	9.4	2	5.1	7.0
Tombstone Outpatient	0	0.0	2	5.1	2.8
Willcox Outpatient	0	0.0	1	2.6	1.4
Total Outpatient	12	37.6	34	87.2	64.8
Bisbee Inpatient	9	28.1	3	7.7	16.9
Benson Inpatient	6	18.8	1	2.6	9.9
Douglas Inpatient	2	6.3	1	2.6	4.2
Huachuca City Inpatient	3	9.4	0	0.0	4.2
Total Inpatient	20	62.6	5	12.9	35.2
chi square = 27.5; df - 9; p = .001					
Address					
Douglas	10	37.0	17	63.0	38.0
Benson	9	26.5	3	8.1	16.9
Bisbee	3	8.8	8	21.6	15.5
Sierra Vista	5	14.7	3	8.1	11.3
Transient	2	5.9	0	0.0	2.8
Willcox	0	0.0	1	2.7	1.4
Other	5	14.7	5	13.5	13.2
	N = 34		N = 37		
chi square = 11.0; df = 7; NS					
Reason for Referral					
Alcohol	34	100.0	0	0.0	46.6
Marital	0	0.0	10	25.6	13.7
Anxiety	0	0.0	9	23.1	12.3
Family	0	0.0	5	12.8	6.8
Legal	0	0.0	1	2.6	1.4
Other	0	0.0	14	35.9	19.2
	N = 34		N = 39		
chi square = 73.0; df = 8; p = .000					

Table A-3--Continued

Demographic Variable	Alcoholics Frequency	%	Nonalcoholics Frequency	%	Percent of Total
Referral Source					
Self	11	33.3	10	29.4	31.3
Law	12	36.4	4	11.8	23.9
Mental Health Agency	5	15.2	5	14.7	14.9
Friend	0	0.0	8	23.5	11.9
Social Work Agency	3	9.1	3	8.8	9.0
Family	1	3.0	2	5.9	4.5
Physician	1	3.0	1	2.9	3.0
Other	0	0.0	1	2.9	1.5
	N = 33		N = 34		
chi square = 13.4; df = 7; p = .06					
Diagnosis					
Alcoholism	26	86.7	0	0.0	50.0
Situational Prob.	0	0.0	12	54.5	23.1
Neurotic	0	0.0	5	22.7	9.6
Drug Dependence	4	13.3	0	0.0	7.7
Psychosis	0	0.0	1	4.5	1.9
Other	0	0.0	4	18.2	7.7
	N = 30		N = 22		
chi square = 52.0; df = 5; p = .000					
Ethnicity					
Caucasian	22	71.0	24	66.7	68.7
Mexican-American	9	29.0	10	27.8	28.4
Indian	0	0.0	2	5.6	3.0
	N = 31		N = 36		
chi square = 1.78; df = 2; NS					
Occupation					
Supervisorial/Managerial	2	8.3	9	25.7	18.6
Semi-Skilled/Unskilled	15	62.5	12	34.3	45.8
Housewife	0	0.0	12	34.3	20.3
Not Currently Employed	7	29.2	2	8.3	15.3
	N = 24		N = 35		
chi square = 25.5; df = 7; p = .001					

Table A-3--Continued

Demographic Variable	Alcoholics Frequency	%	Nonalcoholics Frequency	%	Percent of Total
Marital Status					
Currently Married	5	15.2	21	55.3	36.6
Divorced	12	36.4	2	5.3	19.7
Widowed	2	6.1	4	10.5	8.5
Separated	1	3.0	3	7.9	5.6
Never Married	13	39.4	8	21.1	29.6
	N = 33		N = 38		
chi square = 20.2; df = 5; p = .001					
Type of Treatment					
Individual	7	87.5	9	81.8	84.2
Group	1	12.5	1	9.1	10.5
Other	0	0.0	1	9.1	5.3
	N = 8		N = 11		
chi square = .80; df = 2; NS					
Rating of Improvement					
Moderate Improvement	2	40.0	3	42.9	41.7
Slight Improvement	2	40.0	2	28.6	33.3
Unimproved	1	20.0	1	14.3	16.7
Worse	0	0.0	1	14.3	8.3
	N = 5		N = 7		
chi square = .89; df = 3; NS					

Table A-4. Demographic Variables and "Undiagnosed" Group.

Demographic Variable	Frequency	%
Agency		
Bisbee Outpatient	15	34.9
Douglas Outpatient	6	14.0
Sierra Vista Outpatient	5	11.6
Benson Outpatient	1	2.3
Willcox Outpatient	1	2.3
Other	3	7.0
Total Outpatient	31	72.1
Bisbee Inpatient	5	11.6
Huachuca City Inpatient	4	9.3
Douglas Inpatient	2	4.7
Benson Inpatient	1	2.3
Total Inpatient	12	27.9
N = 43		
Address		
Douglas	15	37.5
Bisbee	10	25.0
Sierra Vista	7	17.5
Benson	2	5.0
Willcox	1	2.5
Other	5	12.5
N = 40		
Referral Source		
Mental Health Agency	5	55.6
Self	2	22.2
Physician	1	11.1
Social Work Agency	1	11.1
N = 9		
Diagnosis		
Neurotic	2	66.7
Antisocial	1	33.3
N = 3		

Table A-4--Continued

Demographic Variables	Frequency	%
Ethnicity		
Caucasian	26	83.9
Mexican-American	4	12.9
Other	1	3.2
N = 31		
Occupation		
Supervisorial/Managerial	10	30.3
Semi-Skilled/Unskilled	10	30.3
Housewife	9	27.3
Not Currently Employed	4	12.1
N = 33		
Marital Status		
Married	13	34.2
Divorced	9	23.7
Widowed	1	2.6
Separated	7	18.4
Never Married	8	21.1
N = 38		
Type of Treatment		
Individual	2	100.0
N = 2		
Rating of Improvement		
Moderate Improvement	1	100.0
N = 1		

Table A-5. Age by Diagnosis.

Diagnosis	Mean	Standard Deviation	N
Alcoholic	36.9	14.5	34
Nonalcoholic	31.2	11.2	39
"Other"	34.0	12.5	40
F = 1.8; df = 2,112; NS			

Table A-6. Education by Diagnosis.

Diagnosis	Mean	Standard Deviation	N
Alocholic	11.6	2.0	33
Nonalcoholic	11.8	2.4	37
"Other"	12.7	2.3	38
F = 2.5; df = 2,107; NS			

Table A-7. Drinking Patterns and Effects By Diagnosis.

QUESTION	Alcoholics Frequency	%	Nonalcoholics Frequency	%	"Others" Frequency	%	Percent* of Total
1. How often drink?							
less than 1 day a week	5	16.1	19	63.3	16	39.0	39.3
1 or 2 days a week	3	9.7	5	16.7	7	17.1	13.1
3 or 4 days a week	8	25.8	4	13.3	6	14.6	19.7
almost every day	15	48.4	2	6.7	12	29.3	27.9
chi squares = 19.9; df = 3; p = .000							
2. What drink?							
beer	14	70.0	9	42.9	23	76.7	56.1
wine	3	15.0	4	19.0	2	6.7	17.1
spirits	2	10.0	5	23.8	3	10.0	17.1
other	1	5.0	3	14.3	2	6.7	9.8
chi squares = 3.49; df = 3; NS							
3. Drinking cause family trouble?							
No	7	21.9	22	71.0	24	58.5	46.0
Yes	25	78.1	9	29.0	17	41.5	54.0
chi squares = 13.4; df = 1; p = .000							
4. Drinking cause job problems?							
No	14	43.8	30	93.8	32	78.0	68.8
Yes	18	56.3	2	6.3	9	22.0	31.3
chi square = 16.4; df = 1; p = .000							

Table A-7--Continued

QUESTION	Alcoholics Frequency	Alcoholics %	Nonalcoholics Frequency	Nonalcoholics %	"Others" Frequency	"Others" %	Percent* of Total
5. Drinking cause trouble with police?							
No	3	9.4	24	77.4	25	61.0	42.9
Yes	29	90.6	7	22.6	16	39.0	57.1
chi square = 27.1; df = 1; p = .000							
6. Drinking cause health problems?							
No	2	6.3	14	43.8	12	29.3	25.0
Yes	30	93.8	18	56.3	29	70.7	75.0
chi square = 10.1; df = 1; p = .002							
7. Drinking caused to vomit?							
No	6	18.8	14	43.8	13	32.5	31.3
Yes	26	81.3	18	56.3	27	67.5	68.8
chi square = 3.56; df = 1; p = .05							
8. Drinking caused hangover?							
No	4	12.5	12	37.5	12	30.0	25.0
Yes	28	87.5	20	62.5	28	70.0	75.0
chi square = 4.09; df = 1; p = .04							

Table A-7--Continued

QUESTION	Alcoholics Frequency	%	Nonalcoholics Frequency	%	"Others" Frequency	%	Percent* of Total
9. Drinking caused stomach aches or cramps?							
No	16	50.0	22	68.8	28	70.0	59.4
Yes	16	50.0	10	31.3	12	30.0	40.6
chi square = 1.62; df = 1; NS							
10. Drinking caused diarrhea?							
No	13	40.6	21	65.6	20	51.3	53.1
Yes	19	59.4	11	34.4	19	48.7	46.9
chi square = 3.07; df = 1; NS							
11. Drinking caused memory loss							
No	11	34.4	24	75.0	19	47.5	54.7
Yes	21	65.6	8	25.0	21	52.5	45.3
chi square = 9.08; df = 1; p = .003							
12. Drinking caused confusion?							
No	8	25.0	21	67.7	21	52.5	46.0
Yes	24	75.0	10	32.3	19	47.5	54.0
chi square = 9.92; df = 1; p = .002							

Table A-7--Continued

QUESTION	Alcoholics Frequency	%	Nonalcoholics Frequency	%	"Others" Frequency	%	Percent* of Total
13. Drinking caused sadness or depression?							
No	5	15.6	19	59.4	21	52.5	37.5
Yes	27	84.4	13	40.6	19	47.5	62.5
chi square = 11.3; df = 1; p = .001							
14. Drinking caused to lose temper?							
No	6	18.8	21	65.6	25	62.5	42.2
Yes	26	81.3	11	34.4	15	37.5	57.8
chi square 12.6; df = 1; p = .000							
15. Drinking caused shakes?							
No	14	43.8	27	84.4	26	65.0	64.1
Yes	18	56.3	5	15.6	14	35.0	35.9
chi square = 9.77; df = 1; p = .002							
16. Drinking caused hallucinations?							
No	21	65.6	28	87.5	35	87.5	76.7
Yes	11	34.4	4	12.5	5	12.5	23.4
chi square = 3.13; df = 1; NS							

Table A-7--Continued

QUESTION	Alcoholics Frequency	Alcoholics %	Nonalcoholics Frequency	Nonalcoholics %	"Others" Frequency	"Others" %	Percent* of Total
17. Drinking caused D.T.s?							
No	23	71.9	31	96.9	34	87.5	84.4
Yes	9	28.1	1	3.1	5	12.8	15.6
chi square = 5.81; df = 1; p = .02							
18. Drinking caused liver trouble?							
No	27	84.4	29	93.5	35	92.1	88.9
Yes	5	15.6	2	6.5	3	7.9	11.1
chi square = .574; df = 1; NS							
19. Drinking cause loss of friends?							
No	13	41.9	29	90.6	35	87.5	66.7
Yes	18	58.1	3	9.4	5	12.5	33.3
chi square = 14.7; df = 1; p = .000							
20. Do enjoy tase of alcohol?							
No	18	56.3	17	53.1	18	43.9	54.7
Yes	14	43.8	15	46.9	23	56.1	45.3
chi square = .06; df = 1; NS							

Table A-7--Continued

QUESTION	Alcoholics Frequency	%	Nonalcoholics Frequency	%	"Others" Frequency	%	Percent* of Total
21. Do enjoy way alcohol makes you feel?							
No	6	18.8	16	50.0	16	40.0	34.4
Yes	26	81.3	16	50.0	24	60.0	65.6
chi square = 5.61; df = 1; p = .02							
22. Does alcohol make you feel happy?							
No	14	43.8	21	67.7	20	48.8	55.6
Yes	18	56.3	10	32.3	21	51.2	44.4
chi square = 2.76; df = 1; NS							
23. Does alcohol help you forget problems?							
No	10	31.3	20	64.5	23	56.1	47.6
Yes	22	68.8	11	35.5	18	43.9	52.4
chi square = 5.72; df = 1; p = .02							
24. Does alcohol make you more relaxed?							
No	10	31.3	14	45.2	12	29.3	38.1
Yes	22	68.8	17	54.8	29	70.7	61.9
chi square = .770; df = 1; NS							

Table A-7--Continued

QUESTION	Alcoholics Frequency	Alcoholics %	Nonalcoholics Frequency	Nonalcoholics %	"Others" Frequency	"Others" %	Percent* of Total
25. Does alcohol make it easier to make friends?							
No	20	62.5	22	71.0	29	70.7	66.7
Yes	12	37.5	9	29.0	12	29.3	33.3
chi square = .198; df = 1; NS							
26. Does alcohol make it easier to get sex?							
No	25	78.1	27	87.1	31	77.5	82.5
Yes	7	21.9	4	12.9	9	22.5	17.5
chi square = .367; df = 1; NS							
27. Does alcohol make it easier to feel part of a group?							
No	21	65.6	26	83.9	27	65.9	74.6
Yes	11	34.4	5	16.1	14	34.1	25.4
chi square = 1.89; df = 1; NS							
28. Do you want to control your drinking or stop drinking?							
No	2	6.7	22	75.9	16	42.1	40.7
Yes	28	93.3	7	24.1	22	57.9	59.3
chi square = 26.5; df = 1; p = .000							

Table A-7--Continued

QUESTION	Alcoholics Frequency	%	Nonalcoholics Frequency	%	"Others" Frequency	%	Percent* of Total
29. Drink excessive when disappointed or aggravated?							
No	5	15.6	24	80.0	21	52.5	46.8
Yes	27	84.4	6	20.0	19	47.5	53.2
chi square = 23.3; df = 1; p = .000							
30. Able to drink more without feeling it than when first started to drink?							
No	19	59.4	23	79.3	31	77.5	68.9
Yes	13	40.6	6	20.7	9	22.5	31.1
chi square = 1.97; df = 1; NS							
31. Drink more when under pressure?							
No	6	18.8	23	76.7	20	50.0	46.8
Yes	26	81.3	7	23.3	20	50.0	53.2
chi square = 18.6; df = 1; p = .000							
32. Suffer loss of memor without passing outs?							
No	11	34.4	26	86.7	20	50.0	59.7
Yes	21	65.6	4	13.3	20	50.0	40.3
chi square = 15.5; df = 1; p = .000							

Table A-7--Continued

QUESTION	Alcoholics Frequency	%	Nonalcoholics Frequency	%	"Others" Frequency	%	Percent* of Total
33. Try to sneak drinks?							
No	21	65.6	29	96.7	33	82.5	80.6
Yes	11	34.4	1	3.3	7	17.5	19.4
chi square = 7.67; df = 1; p = .006							
34. Feel uncomfortable if alcohol not available?							
No	16	50.0	27	93.1	27	67.5	70.5
Yes	16	50.0	2	6.9	13	32.5	29.5
chi square = 11.6; df = 1; p = .001							
35. Rush to get first drink?							
No	24	75.0	27	90.0	34	85.0	82.3
Yes	8	25.0	3	10.0	6	15.0	17.7
chi square = 1.47; df = 1; NS							
36. Have guilt feelings about drinking?							
No	n0	31.3	23	79.3	21	52.5	54.1
Yes	22	68.8	6	20.7	19	47.5	45.9
chi square = 12.3; df = 1; p = .001							

Table A-7--Continued

QUESTION	Alcoholics Frequency	Alcoholics %	Nonalcoholics Frequency	Nonalcoholics %	"Others" Frequency	"Others" %	Percent* of Total
37. Resent others talking about your drinking?							
No	11	35.5	26	92.9	28	75.7	62.7
Yes	20	64.5	2	7.1	9	24.3	37.3
chi square = 18.3; df = 1; p = .000							
38. "Blackouts" more frequent?							
No	22	71.0	27	96.4	30	81.1	83.1
Yes	9	29.0	1	3.6	7	18.9	16.9
chi square = 5.09; df = 1; p = .02							
39. Want to continue drinking when others say stop?							
No	14	45.2	25	89.3	27	73.0	66.1
Yes	17	54.8	3	10.7	10	27.0	33.9
chi square = 10.9; df = 1; p = .001							
40. Have a reason when get drunk?							
No	18	58.1	22	78.6	29	74.4	67.8
Yes	13	41.9	6	21.4	10	25.6	32.2
chi square = 1.97; df = 1; NS							

Table A-7--Continued

QUESTION	Alcoholics Frequency	Alcoholics %	Nonalcoholics Frequency	Nonalcoholics %	"Others" Frequency	"Others" %	Percent* of Total
41. Embarrassed by actions when drunk?							
No	7	22.6	22	75.9	23	60.5	48.3
Yes	24	77.4	7	24.1	15	39.5	51.7
chi square = 15.0; df = 1; p = .000							
42. Switched drinking or changed pattern to control drinking?							
No	20	62.5	25	86.2	24	61.5	73.8
Yes	12	37.5	4	13.8	15	38.5	26.2
chi square = 3.28; df = 1; NS							
43. Promise to control drinking, and then don't?							
No	9	28.1	24	82.8	21	53.8	54.1
Yes	23	71.9	5	17.2	18	48.2	45.9
chi square = 16.2; df = 1; p = .000							
44. Changed jobs or moved to control drinking?							
No	18	56.3	28	96.6	36	92.3	75.4
Yes	14	43.8	1	3.4	3	7.7	24.6
chi square = 11.2; df = 1; p = .001							

Table A-7--Continued

QUESTION	Alcoholics Frequency	%	Nonalcoholics Frequency	%	"Others" Frequency	%	Percent* of Total
45. Avoid friends and family when drinking?							
No	18	56.3	25	86.2	28	71.8	70.5
Yes	14	43.8	4	13.8	11	28.2	29.5
chi square = 5.20; df = 1; p = .02							
46. Financial and work problems increasing?							
No	11	35.5	19	67.9	19	48.7	50.8
Yes	20	64.5	9	32.1	20	51.3	49.2
chi square = 4.94; df = 1; p = .03							
47. Feel people being unfair?							
No	23	71.9	28	90.3	31	79.5	81.0
Yes	9	28.1	3	9.7	8	20.5	19.0
chi square = 2.38; df = 1; NS							
48. When drinking, eat little and irregularly?							
No	8	25.0	24	82.8	24	63.2	52.5
Yes	24	75.0	5	17.2	14	36.8	47.5
chi square = 18.1; df = 1; p = .000							

Table A-7--Continued

QUESTION	Alcoholics Frequency	Alcoholics %	Nonalcoholics Frequency	Nonalcoholics %	"Others" Frequency	"Others" %	Percent* of Total
49. Drink in morning to quiet shakes?							
No	13	41.9	28	96.6	32	82.1	68.3
Yes	18	58.1	1	3.4	7	17.9	31.7
chi square = 18.2; df = 1; p = .000							
50. Drinking capacity decreased lately?							
No	15	46.9	18	64.3	23	62.2	55.0
Yes	17	53.1	10	35.7	14	37.8	45.0
chi square = 20.3; df = 1; p = .000							
51. Sometimes stay drunk for days?							
No	12	37.5	27	96.4	31	82.1	65.0
Yes	20	62.5	1	3.6	7	17.9	35.0
chi square = 20.3; df = 1; p = .000							
52. Sometimes depressed and feel life not worth living?							
No	13	40.6	15	53.6	22	55.0	46.7
Yes	19	59.4	13	46.4	18	45.0	53.3
chi square = 11.1; df = 1; p = .001							

Table A-7--Continued

QUESTION	Alcoholics Frequency	%	Nonalcoholics Frequency	%	"Others" Frequency	%	Percent* of Total
53. Sometimes hallucinate after drinking?							
No	23	71.9	25	89.3	33	84.6	80.0
Yes	9	28.1	3	10.7	6	15.4	20.0
chi square = 1.85; df = 1; NS							
54. Vague fears after heavy drinking?							
No	14	43.8	24	88.9	23	59.0	64.4
Yes	18	56.3	3	11.1	16	41.0	35.6
chi square = 11.1; df = 1; p = .001							

*The percent of total category consists only of figures from the alcoholic and nonalcoholic groups.

Table A-8. Critical Items of G-K Attitude Survey Endorsed by Alcoholic and Nonalcoholic Groups.

CRITICAL ITEM	Alcoholics Frequency	%	Nonalcoholics Frequency	%
1. Have had period of not recalling actions.				
False	11	34.4	27	73.0
True*	21	65.6	10	27.0
2. Have never been in trouble with the law.				
False*	27	81.8	18	47.4
True	6	18.2	20	52.6
3. Have not lived the right kind of life.				
False	9	27.3	27	71.1
True*	24	72.7	11	28.9
4. Sweat easily even on cool days.				
False	15	45.5	29	76.3
True*	18	54.5	9	23.7
5. Parents objected to choice friends.				
False	12	36.4	16	42.1
True*	21	63.6	22	57.9
6. Do not like to see women smoke.				
False*	28	84.8	24	63.2
True	5	15.2	14	36.8

Table A-8--Continued

CRITICAL ITEM	Alcoholics Frequency	%	Nonalcoholics Frequency	%
7. Do many things that later regret.				
False	11	33.3	20	54.1
True*	22	66.7	17	45.9
8 Lacking in self-confidence.				
False	15	45.5	20	52.6
True*	18	54.5	18	47.4
9. Feel strangers are critical of me.				
False	16	50.0	22	57.9
True	16	50.0	16	42.1
10. Engaged in petty theft when was young.				
False	10	30.3	19	50.0
True*	23	69.7	19	50.0
11. Used to steal when was young.				
False	13	39.4	21	55.3
True*	20	60.6	17	44.7
12. Have used alcohol excessively.				
False	7	21.2	23	60.5
True*	26	78.8	15	39.5

Table A-8--Continued

CRITICAL ITEM	Alcoholics Frequency	%	Nonalcoholics Frequency	%
13. Have often broken rules or inwardly rebelled against them.				
False	12	36.4	16	42.11
True*	21	48.8	22	57.9
14. Have been times when was mean.				
False	6	18.2	10	26.3
True*	27	81.8	28	73.7
15. Have never done any heavy drinking.				
False	30	90.9	17	44.7
True*	3	9.1	21	55.3
16. Have used alcohol moderately or not at all.				
False*	22	66.7	8	21.1
True	11	33.3	30	78.9
17. Can usually let go and have great time at parties.				
False*	14	42.4	21	56.8
True	19	57.6	16	42.3
18. Feel scared when move to strange place.				
False	16	50.0	10	26.3
True*	16	50.0	28	73.7

Table A-8--Continued

CRITICAL ITEM	Alcoholics Frequency	%	Nonalcoholics Frequency	%
19. Often get disgusted with myself.				
False	12	36.4	11	30.6
True*	21	63.6	25	69.4
20. Always do business before pleasure.				
False*	25	75.8	21	56.8
True	8	24.2	16	43.2
21. In school was sent to principal for cutting up.				
False	16	48.5	21	56.8
True*	17	51.5	16	43.2
22. Crave excitement.				
False*	15	45.5	20	54.1
True	18	54.5	17	45.9
23. Little things upset me.				
False	13	39.4	11	29.7
True*	20	60.6	26	70.3
24. It is bad not to love and respect your parents.				
False*	18	56.3	23	63.9
True	14	43.8	13	36.1

Table A-8--Continued

CRITICAL ITEM	Alcoholics Frequency	%	Nonalcoholics Frequency	%
25. It is possible to be good in all respects.				
False*	19	59.4	22	59.5
True	13	40.6	15	40.5
26. Would like to wear expensive clothes.				
False	19	59.4	17	45.9
True*	13	40.6	20	54.1
27. Am a good mixer				
False*	13	41.9	20	57.1
True	18	58.1	15	42.9
TOTAL ITEMS ENDORSED IN THE ALCOHOLIC DIRECTION:	Alcoholics = 23		Nonalcoholics = 15.	

*Indicates alcoholic direction

Table A-9. CPH Factor Scales by Diagnosis.

DIAGNOSIS	FACTOR 1		
	Mean	Standard Deviation	N
Alcoholics	13.3	4.20	27
Nonalcoholics	11.9	3.73 3.73	37
"Others"	12.7	3.40	43
F = 1.04; df = 2,106; NS			
	FACTOR 2		
	Mean	Standard Deviation	N
Alcoholics	8.41	3.26	27
Nonalcoholics	8.86	3.43 3.43	37
"Others"	7.65	4.97	43
F = .90; df = 2,106; NS			
	FACTOR 3		
	Mean	Standard Deviation	N
Alcoholics	7.56	2.28	27
Nonalcoholics	7.11	2.48	37
"Others"	6.98	2.03 2.03	43
F = .57; df = 2,106; NS			
	FACTOR 4		
	Mean	Standard Deviation	N
Alcoholics	9.56	4.24	27
Nonalcoholics	9.54	2.92	37
"Others"	9.63	3.53	43
F = .007; df = 2,106; NS			

Table A-9--Continued

DIAGNOSIS	FACTOR 5		
	Mean	Standard Deviation	N
Alcoholics	2.67	1.78	27
Nonalcoholics	2.73	1.92	37
"Others"	2.72	1.88	43
F = .01; df = 2,106; NS			

APPENDIX B

BATTERY OF TESTS

INITIAL CONTACT INFORMATION

NAME: _____ AGENCY: _____

ADDRESS: _____ CLIENT ID #: _____

_____ DATE: _____

REASON FOR REFERRAL: _____

REFERRED BY: _____

PRELIMINARY DIAGNOSIS: _____

_____

AGE: _____ ETHNICITY: _____

EDUCATION: _____ OCCUPATION: _____

MARITAL STATUS: _____

PRETESTS TAKEN: _____

PRETESTS NOT TAKEN: _____

INDICATE REASON: _____

_____

COMPLETION OF CONTACT DATA

DATE COMPLETION CONTACT: _____ THERAPIST: _____

NO. OF INTERVIEWS (OR DAYS IN RESIDENCE): _____

TYPE OF TREATMENT: _____ INDIVIDUAL COUNSELING _____ GROUP COUNSELING

_____ FAMILY COUNSELING _____ MEDICATION (GIVE TYPE/DOSAGE)

_____

_____ OTHER (LIST:) _____

_____

NO. OF DAYS FROM INITIAL CONTACT TO COMPLETION: _____

RATING OF CHANGE: _____BECAME WORSE _____UNIMPROVED _____SLIGHT IMPROVEMENT

_____MODERATE IMPROVEMENT _____MARKED IMPROVEMENT

POST MMPI TAKEN: _____

POST MMPI NOT TAKEN: _____

INDICATE REASON IF NOT TAKEN: _____

_____

LIFE EVENT SCHEDULE

NAME _____

DATE _____

AGENCY _____

The following is a list of life events or happenings. Please read the list over carefully and put a check mark in the blank beside each event that happened to you during the past year.

EVENT

_____ Death of spouse (husband or wife)
_____ Divorce
_____ Marital separation
_____ Jail term
_____ Death of close family member
_____ Personal injury or illness
_____ Marriage
_____ Fired from job
_____ Marital reconciliation
_____ Retirement
_____ Change in health of family member
_____ Pregnancy
_____ Sex difficulties
_____ Gain of new family member
_____ Business readjustment
_____ Change in financial state
_____ Death of close friend
_____ Change to different line of work
_____ Change in number of arguments with spouse
_____ Mortgage over $10,000
_____ Foreclosure of mortage or loan
_____ Change in responsibilities at work

EVENT

_____ Son or daughter leaving home
_____ Trouble with in-laws
_____ Outstanding personal achievement
_____ Wife begins or stops work
_____ Begin or end school
_____ Change in living conditions
_____ Revision of personal habits
_____ Trouble with boss
_____ Change in work hours or conditions
_____ Change in residence
_____ Change in schools
_____ Change in recreation
_____ Change in church activities
_____ Change in social activities
_____ Mortgage or loan less than $10,000
_____ Change in sleeping habits
_____ Change in number of family get-togethers
_____ Change in eating habits
_____ Vacation
_____ Christmas
_____ Minor violations of the law

Name_____
Date_____
Agency_____

Questions on Drinking Patterns and Effects:

We would appreciate your cooperation in answering these questions about drinking and its effects. We hope that the finding will be helpful to people who have drinking problems. It is not necessary to give your name. Your answers will not be used to cause you trouble.

Age_____
Sex_____
Education_____

Ethnic Group_____
Occupation_____
Marital Status: Single___
Married___
Separated____
Divorced_____
Widowed_____

Where from:_____
Where live:_____

1. How often do you drink?

____less than one day a week
____one or two days a week
____three or four days a week
____almost every day

2. When you drink, how much do you drink?
Beer_____
Wine_____
Spirits_____
Other_____

3. Has drinking ever caused you trouble with your family?
Yes_____ No_____

(a) How do your parents feel about your drinking?
_____

(b) How does your wife (husband) or girlfriend (boyfriend) feel
_____

(c) How do your children feel about your drinking?
_____

4. Have you ever had trouble getting or holding a job, because of drinking?
   Yes_____ No_____
   (a) How often have you lost a job because of drinking?
   _____
   (b) How many jobs were refused you because of drinking?

5. Have you ever been in trouble with the Police becuase of drinking?
   Yes_____ No_____
   (a) How often have you been arrested?_____
   (b)How often have you been in jail or prison?_____
   (c) What were you arrested for doing?_____
   _____
6. Has drinking ever caused you to be sick or caused a health problem?
   Yes_____ No_____
   Throw up or vomit_____
   Be hung over_____
   To have stomach aches or cramps_____
   To have diarrhea or loose bowels_____
   To lose your memory for a time_____
   To be confused and mixed up_____
   To feel sad and depressed_____
   To lose your temper or get into fights_____
   To have the shakes_____
   To see or hear things_____
   Caused the D.T._____
   Caused trouble with your liver_____
7. Have you lost your friends because of drinking?
   Yes_____ No_____
8. What do you enjoy about drinking?_____
   _____
   The taste_____
   The way it makes you feel_____
   (a) Happy_____
   (b) Forget problems_____
   (c) More relaxed_____
   (d) Easier to make friends____
   (e) Easier to get sex_____
   (f) Part of a group_____

9. What kind of problems does drinking cause you?_____

_____

_____

_____

10. Do you want to be able to better control your drinking or to stop drinking?

Yes_____ No_____

Please answer yes or no to each of the following questions:

_____ 11. Do you sometimes drink excessively when you are disappointed, argued with, or aggravated by someone?

_____ 12. Are you able to drink more now without feeling it than when you first started to drink?

_____ 13. Do you drink more than usual when you are troubled or under pressure?

_____ 14. Do you suffer memory losses of events during the evening, and yet not pass out?

_____ 15. Do you try to squeeze in a couple of extra drinks during the evening without other people knowing it?

_____ 16. On some occasions, do you feel ill at ease if alcohol is not available?

_____ 17. Are you rushing more to get that first drink than you did, say last month?

_____ 18. Do you occasionally have feelings of guilt about your drinking?

_____ 19. When your friends and family discuss your drinking, do you quietly resent it?

_____ 20. Are your "blackouts" more frequent, recently?

_____ 21. Do you want to continue drinking when your friends say "enough"?

_____ 22. Do you have a reason when you get drunk?

_____ 23. Are you embarrassed by the things you say and do when drunk?

_____ 24. Have you switched drinks or changed your pattern to control your drinking?

_____ 25. Do you promise yourself to control your drinking and then break the promise?

_____ 26. Have you changed jobs or moved to a new place to control your drinking?

_____ 27. Do you avoid friends and family when drinking?

_____ 28. Are financial and work problems increasing?

_____ 29. Do you feel people are treating you unfairly?

_____ 30. When drinking, do you eat irregularly and very little?

_____ 31. Do you take another drink in the morning to quiet your "shakes"?

_____ 32. Has your drinking capacity decreased lately?

_____ 33. Do you occasionally stay drunk for several days?

_____ 34. Are you sometimes depressed and feel that life is not worth living?

_____ 35. Do you occasionally have hallucinations after a period of drinking?

_____ 36. Do you have vague fears after drinking heavily?

_____ 37. How much do you spend a week on drinks? $_____

_____ 38. How old were you when you started to drink? _____

The G-K Attitude Survey

Name_____
Date_____
Agency_____

Directions: Please answer the following questions as they apply to you. If you feel the statement is generally true, mark the "T" beside the statement; if it is generally false, mark the "F". Do not mark both.

T F 1. I have had periods in which I carried on activities without knowing later what I had been doing.

T F 2. I have never been in trouble with the law.

T F 3. I have not lived the right kind of life.

T F 4. I sweat very easily even on cool days.

T F 5. My parents have often objected to the kind of people I went around with.

T F 6. I have had several blank spells in which my activities were interrupted and I did not know what was going on around me.

T F 7. I have a cough most of the time.

T F 8. I do not like to see women smoke.

T F 9. I have few or no pains.

T F 10. I do many things which I regret afterwards. (I regret things more or more often than others seem to).

T F 11. My sould sometimes leaves my body.

T F 12. I cannot keep my mind on one thing.

T F 13. I frequently notice my hand shakes when I try to do something.

T F 14. I am certainly lacking in self-confidence.

T F 15. I have often felt that strangers were looking at me critically.

T F 16. During one period when I was a youngster I engaged in petty thievery.

T F 17. I used to steal sometimes when I was a youngster.

T F 18. I have used alcohol excessively.

T F 19. I have often either broken rules (school, club, etc.) or inwardly rebelled against them.

T F 20. There have been a few times when I have been very mean to another person.

T F 21. I have never done any heavy drinking.

T F 22. I have used alcohol moderately (or not at all).

T F 23. I can usually let myself go and have a hilariously good time at a party.

T F 24. I must admit that I feel sort of scared when I move into a strange place.

T F 25. I often get disgusted with myself.

T F 26. When in a group of people I have trouble thinking of the right things to talk about.

T F 27. I have always followed the rule; business before pleasure.

T F 28. I enjoy planning things, and deciding what each person should do.

T F 29. I like to read newspaper articles on crime.

T F 30. I have been quite independent and free from family rule.

T F 31. I have never vomited blood or coughed up blood.

T F 32. In school I was sometimes sent to the principal for cutting up.

T F 33. I crave excitement.

T F 34. I think I am stricter about right and wrong than most people.

T F 35. Little things upset me.

T F 36. Obedience and respect for authority are the most important virtues children should learn.

T F 37. Science has its place, but there are many important things that can never possibly be understood by the human mind.

T F 38. An insult to our honor should always be punished.

T F 39. There is hardly anything lower than a person who does not feel a great love, gratitude and respect for his parents.

T F 40. Nowadays, more and more people are prying into matters that should remain personal and private.

T F 41. Most men are brave.

T F 42. It is possible to be good in all respects.

T F 43. People suffering from incurable diseases should have the choice of being put painlessly to death.

T F 44. I would like to wear expensive clothes.

T F 45. I am a good mixer.

T F 46. If I were a reporter I would very much like to report sporting news.

T F 47. I liked school.

T F 48. It is hard for me to start a conversation with strangers.

T F 49. I do not like to see people carelessly dressed.

T F 50. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

T F 51. Nobody ever learned anything really important except through suffering.

T F 52. Most of our social problems would be solved if we could somehow get rid of the immoral, crooked and feeble-minded people.

T F 53. Some day it will probably be shown that astrology can explain a lot of things.

T F 54. The biggest difference between most criminals and other people is that criminals are stupid enough to get caught.

CPH FACTOR SCALE FORM O-P

NAME: _____

DATE: _____

AGENCY: _____

WE ARE INTERESTED IN YOUR OPINION ABOUT THE FOLLOWING STATEMENTS CONCERNING MENTAL HEALTH PROBLEMS AND TREATMENT.

READ EACH STATEMENT CAREFULLY. IF YOU STRONGLY AGREE WITH IT, CIRCLE THE WORDS "STRONGLY AGREE" ON THE SCALE FOLLOWING THE ITEM. IF YOU MILDLY AGREE WITH THE STATEMENT, CIRCLE THE WORDS "MILDLY AGREE". IF YOU STRONGLY DISAGREE WITH THE STATEMENT, CIRCLE THE WORDS "STRONGLY DISAGREE" ON THE SCALE, AND IF YOU MILDLY DISAGREE, CIRCLE THOSE WORDS ON THE SCALE.

1.	The staff should not expect patients to be in so many activities all the time.	1. Strongly Agree / Mildly Agree / Mildly Disagree / Strongly Disagree
2.	Mental illness is something that runs in families.	2. Strongly Agree / Mildly Agree / Mildly Disagree / Strongly Disagree
3.	A counselor is able to understand patients no matter how little patients cooperate with him.	3. Strongly Agree / Mildly Agree / Mildly Disagree / Strongly Disagree
4.	There should be more control over patients exerted in mental hospitals and clinics.	4. Strongly Agree / Mildly Agree / Mildly Disagree / Strongly Disagree
5.	The best place for patients to get hold of themselves is a mental hospital or clinic.	5. Strongly Agree / Mildly Agree / Mildly Disagree / Strongly Disagree
6.	The mental hospital or clinic is where patients go when they are tired and physically run down.	6. Strongly Agree / Mildly Agree / Mildly Disagree / Strongly Disagree
7.	Once patients have been in a mental hospital or clinic, people treat them like they are peculiar or different.	7. Strongly Agree / Mildly Agree / Mildly Disagree / Strongly Disagree
8.	There is not enough for patients to do in mental hospitals or clinics.	8. Strongly Agree / Mildly Agree / Mildly Disagree / Strongly Disagree

9.	It's always possible that a patient might be hurt by other patients in a mental hospital or clinic.	9. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
10.	The principle reason for mental hospitals or clinics is to get the mentally disturbed person out of the public's way.	10. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
11.	The mental hospital or clinic is a place to get away from your problems.	11. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
12.	A person is more likely to be hurt than helped in a mental hospital or clinic.	12. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
13.	Most of the counselors here are too inexperienced to know what they are doing and what might be best for patients.	13. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
14.	A mentally well person is one who is liked and appreciated by everybody.	14. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
15.	Coming to a clinic or hospital like this is good insurance against having to face longer term hospitalization.	15. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
16.	I think the mental patients' troubles could be cured by the right drug.	16. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
17.	Mental hospitals are like prisons for keeping people locked up.	17. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
18.	I feel that patients coming to a mental health clinic is a mistake.	18. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
19.	The main job of the staff is to see that patients stay in line.	19. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
20.	Locked settings are sometimes just what some patients need.	20. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /

21.	Most patients become very close friends with some of the other patients here.	21. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
22.	A mental hospital is a place where patients can benefit by receiving three well-balanced meals a day.	22. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
23.	Times goes very slowly in the mental hospital.	23. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
24.	The mental health clinic treats a patient's nervous system and brain.	24. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
25.	A counselor is someone who treats mainly physical problems.	25. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
26.	The mental hospital is like a vacation at a resort.	26. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
27.	The only thing about the mental hoepital or clinic that really helps the patient is his counselor's care.	27. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
28.	A patient should always put his best foot forward when he sees his counselor.	28. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
29.	A person is deprived of most of his rights while in a mental hospital or clinic.	29. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
30.	This clinic may help some patients but quite a few are discharged without real improvement.	30. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
31.	The best thing a mental hospital or clinic can do for a patient is to get him back to the normal state he was in before his breakdown.	31. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
32.	I do not believe a counselor can help patients with their problems.	32. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /

33.	A mentally well person is one that keeps his feelings and his emotions to himself.	33. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
34.	Attendants usually are available when patients need them.	34. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
35.	No matter what anyone does, a patient will always have his problems.	35. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
36.	It's a lot tougher for a patient to get a job once he has been in a mental hospital or clinic.	36. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
37.	A good attendant is one who is always gay and cheerful with the patients.	37. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
38.	Once a patient has been in a mental hospital or clinic, people won't ever treat him the same as they did before his mental illness.	38. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
39.	The job of the counselor is to see that each patients learns the right way of living.	39. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
40.	If people were left alone they could avoid mental illness.	40. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
41.	Once having been mentally ill a patient should be excused for many things he does.	41. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
42.	A patient has little to say about when he will be released from a mental hospital.	42. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
43.	Mental illness is due to past experiences patients have had with other people.	43. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
44.	Patients like to go to lots of hospital activities such as dances and patient programs.	44. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /
45.	A mental hospital or clinic is the best place for a patient to let go of his emotions.	45. Strongly Agree /	Mildly Agree /	Mildly Disagree /	Strongly Disagree /

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