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PERSONALITY AND PSYCHOPATHOLOGY AMONG INDIGENT ALCOHOLICS

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PERSONALITY AND PSYCHOPATHOLOGY AMONG INDIGENT ALCOHOLICS

by

Charles Henry Hinkin

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DEPARTMENT OF PSYCHOLOGY

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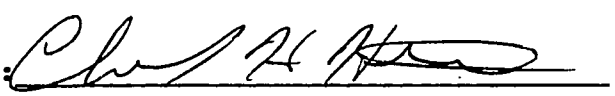
SIGNED: 

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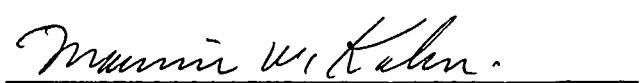

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ABSTRACT

A frequent observation of the treatment staff of alcohol programs targeting indigent alcoholics is the concommittant presence of severe psychopathology and personality disorder in addition to alcohol dependence. To investigate this clinical phenomena, 368 consecutively admitted indigent alcoholics were administered the Minnesota Multiphasic Personality Inventory and a drinking patterns and effects survey following successful detoxification. The results indicate severe psychopathology to be widespread among the "skid-row" populace. Depending on the criterion employed, the rate of severe mental illness ranged from a conservative estimate of 25% to a high of 60% based on Goldberg's sign of psychosis. Cluster analytic techniques revealed three distinct personality types which were cross-validated through a split-half replication. Type I alcoholics, 28% of the sample, were diagnosed as psychotiform alcoholics. Type II alcoholics, 26% of the sample, received the diagnosis alcoholism superimposed on a characterological depression. Type III alcoholics, 46% of the sample, produced MMPI profiles suggestive of an antisocial personality disorder. The social, legal, medical and treatment implications of the data were also discussed.

CHAPTER 1

INTRODUCTION

Theorists and researchers who have investigated the personality dynamics of the alcohol abusing individual have tended to adopt one of two theoretical approaches. The first research paradigm is based on the premise that alcoholism is a distinct diagnostic entity which substantially differs from other psychiatric disorders. Advocates of the model contend alcoholics share a similar constellation of personality traits and form a relatively homogeneous group. This approach is typified by the formation of various measures purported to differentiate alcoholics from nonalcoholics such as those proposed by Button (1956), Hampton (1953), Hoyt and Sedlacek (1958), and MacAndrew (1965).

However, the emerging current consensus is that alcoholism is better understood as emanating from various neuroses or personality disorders and as such is a behavioral manifestation, or symptom, of emotional maladjustment (C. F. Brown 1950; Chafetz, Blane and Hill 1970; Jellinck 1952; Mogar, Wilson and Helms 1970). Chafetz et al. succinctly summarize this position, stating, "Alcoholism is a symptom of some underlying personality

disorder fueled by an intricate interplay of emotional, social, interpersonal and physiological factors" (1970, p. 17). Furthermore, adherents of this position reject the belief that alcoholics are a homogeneous group. Jellinck states, "Reactions to excessive drinking--which have quite a neurotic appearance--give the impression of an 'alcoholic personality' although they are secondary behaviors superimposed over a large variety of personality types which have few traits in common" (1952, p. 683).

A major thrust of the research based on this paradigm has been to identify and classify the various alcoholic personality types to which Jellinck alludes. Goldstein and Linden (1969) note that most approaches to the classification of alcoholism have been dichotomous in nature (e.g., chronic-acute, process-reactive) and thusly share a common shortcoming. When only two subclasses are hypothesized, if an individual does not meet the criterion for one group, then, by definition, that individual must fall in the other. Clearly, logic dictates that often at least one of these groups must be of questionable validity. Jellinck (1952) was one of the first to dismiss this bipolar approach, instead positing the existence of five alcoholic types differentiated by the severity, or phase, of their drinking.

Many attempts at classifying and identifying personality characteristics of alcoholics have employed the

Minnesota Multiphasic Personality Inventory (MMPI), a 550 item self-report personality measure. The MMPI is a useful classification instrument in that it provides for more than two dichotomous typologies and assignment to types is both reliable and not overly time consuming. The MMPI was originally designed to be used as a diagnostic instrument; today it is most often used as an objective screening index of personality and behavioral characteristics. Analysis of MMPI profiles provides the clinician with both an indication of which personality traits are dominant and emphasized (configuration) and also the extent to which the individual admits to varying degrees of these traits (elevation). Most of the research which has utilized the MMPI in the study of alcoholism has focused on the one or two scales which were most elevated while a smaller number of studies have looked at profile elevation. Only a few studies have attempted to incorporate both configuration and elevation in their analyses.

Traditionally, MMPI research directed at elucidating the personality dynamics of alcoholics has relied on the computation of an overall mean profile through pooling individual MMPI profiles (Curlee 1970; Huber and Danahy 1975; Overall 1973). In a review of the literature, Clopton (1978) found this approach has most frequently yielded a profile more neurotic than psychotic with peaks on scale 4 (psychopathic deviance), scale 2

(depression), and to a lesser degree, scale 7 (psychasthenia).

These findings are consonant with most theoretical and clinical conceptualizations of the stereotypical (and perhaps mythical) average alcoholic. The elevation on the psychopathic deviance scale reflects the poor self-control, impulsivity, rebelliousness, hostility and anti-social behaviors which often are present in alcoholics. The high score on the depression scale is indicative of depression, lack of self-confidence, pessimism and self-depreciation which again are also seen as characteristic traits of the alcoholic (Graham, 1977).

Although combining individual profiles to form a mean profile can indeed shed some light on the personality dynamics of alcohol abusing individuals, this approach is not without its critics. Hodo and Fowler assert, "Different and possibly unrelated code types are grouped together to form a composite. . .which could obscure very important differences among the individual profiles (1976, p. 487). As Chang, Caldwell and Moss (1973) have noted, the "leveling off" phenomena obtained through averaging profiles gives a very incomplete picture of the actual heterogeneity of alcoholics. Skinner, Jackson and Hoffmann (1974) go on to state that in an extreme case, none of the individual MMPI profiles could resemble the group profile.

In an effort to address this problem, several researchers have differentiated groups of alcoholics on the basis of two-point codes (Hodo and Fowler 1976; Hoffmann 1973; McLachlan 1975). Their findings have been relatively equivalent regardless of the type of treatment center from which subjects were drawn. The 24/42 code-type was generally found to be the most common; other code-types frequently found were the 27/72 and the 49/94. Table 1 provides a summary of these studies by way of listing those code-types identified which "caught" over 5 percent of each sample.

These findings underscore the heterogeneity of alcoholics as reflected by the disparate behavioral patterns usually manifested by these different code-types. For example, the 27/72 code-type is associated with ruminative, internalized anxiety and depression, whereas the 49/94 code-type is found in impulsive, externally focused, acting out individuals. Significantly, the 24/42 code-type that usually results from the computation of a mean profile is actually found in less than 21 percent of subjects in Hodo and Fowler's study, 16 percent of Hoffmann's two groups, and in only 12 percent of McLachlan's subjects.

Chang et al. (1973) focused on the relative elevation of individual profiles in an attempt to gauge the severity of emotional disorder. They grouped their

alcoholic sample based on the number of MMPI scales obtained which exceeded a T-score of 70. Profiles with all scales under a T-score of 70 were deemed normal, profiles with one or two primed scales were considered mildly disturbed, and three or more primed scales were defined as indicative of moderate to severe disorder. They found 31 percent of their sample to fall in the normal category, 50 percent to be mildly disturbed, and 19 percent to be moderately to severely disordered. Unfortunately, they omitted any consideration of which scales were elevated which undeniably detracts from the usefulness of their results. Mogar, Wilson and Helms (1970) used a similar technique and found almost 50 percent of their subjects to be severely disturbed.

Rohan (1972), in an investigation of profile changes following treatment for alcohol abuse, found three distinct personality types. The first he termed depressive neurotic (35 percent of cases) which was characterized by a neurotic profile with all scales falling under a T-score of 70 on both pre- and post-treatment assessments. The second group he considered to be a psychopathic personality type (47 percent of cases) as defined by an elevation on scale 4 in excess of a T-score of 70 on both testings. The third type identified by Rohan he felt constituted a psychopathic reaction syndrome. This group (18 percent of cases) initially produced MMPI profiles similar

to the psychopathic personality type, but upon retesting, the scores on scale 4 fell below the T of 70 cutoff. Gellens, Gottheil and Alterman (1976) replicated Rohan's study and found roughly the same percentage of cases falling into these groups.

Mogar et al. (1970) employed a sorting technique based on frequently occurring personality patterns in terms of prominent scale-score configurations. They identified four personality types for males, the most common termed the passive-aggressive type (33 percent of subjects) as defined by elevations on scales 4, 9 and 10. Other types found were depressive-compulsive (29 percent of cases) characterized by elevation on scales 2, 7 and 10; schizoid-prepsychotic (25 percent of cases) which was marked by peaks on 8 and F; and the passive dependent type (15 percent of cases) defined by high points on scales 1 and 3.

Without denying the fact that grouping alcoholics on basis of the highest two or three scales can yield a wealth of data, one runs the risk of oversimplifying the intricate and complex personality dynamics that can be revealed by the MMPI. After all, the MMPI is a <u>multiphasic</u> personality inventory. It is not inconceivable that two individuals could have vastly different two-point code types yet have identical scores on every other scale or, conversely, could share the same two-point code and

still be radically different on the other scales. Fortunately, with the advent of high speed computers, the researcher is able to take into consideration the entire profile in the search for subgroups through the use of statistical techniques such as discriminant function analysis, cluster analysis and profile analysis.

One of the first attempts to differentiate alcoholics using a multivariate technique was carried out by Button (1956). Utilizing a cluster analysis procedure, Button identified two personality types which he termed the candid and the defensive alcoholic. While both groups shared the usual 24/42 code type with a neurotic slope, the candid group was characterized by a high F (T=59) and a low K (T=50) while the defensive group was low on F (T=53) and high on K (T=62). Button saw the candid group as ruefully admitting their drinking problems and reaching out for help; the defensive alcoholics he conceptualized as denying their guilt and hostility and refusing to accept their plight.

Goldstein and Linden (1969), in a study of legally committed alcoholics drawn from a state hospital, identified four alcoholic personality types through a cluster analysis. Their Type I alcoholic, who received the diagnosis of psychopathic personality with emotional instability, produced a MMPI profile neurotic in slope with only scale 4 above a T-score of 70. The Type II alcoholics had

the most elevated profiles with peaks on scales 2 and 7 with secondary elevations on scales 8, 4, 1 and 3 (all in excess of a T-score of 70). The nosological label assigned to this type was psychoneurosis with either an anxiety reaction or reactive depression component. The third sub-type displayed the classic alcoholic profile peaking on scales 4 and 2 with all elevations well within normal limits. The diagnosis assigned this group was alcoholism with a secondary psychopathic personality disorder, mixed type. Their Type IV alcoholic evidenced a 4-9 code-type which they labeled alcoholism with secondary characteristics of polydrug abuse and paranoid features. Whitelock, Overall and Patrick (1971) also identified four MMPI profile patterns, three of which were similar to Goldstein and Linden's. Whitelock et al.'s one dissimilar type was characterized by a single peak on the depression scale.

Kline and Snyder (1985) also employed a similar research design which resulted in three personality types being distinguished. Unlike most prior studies, they isolated one personality type which was highly suggestive of marked psychopathology. This Type I alcoholic produced an extremely elevated profile with peaks on scales 8, 4 and 2, all in excess of a T-score of 80. Their Type II alcoholic, diagnosed as having psychopathic features, evidenced a 4,8,9 configuration that was moderately elevated.

Finally, their Type III alcoholic was characterized by a 49 code-type.

English and Curtin (1975) employed Taylor's Manifest Anxiety Scale (MAS) and Barron's Ego Strength Scale (ES) in addition to the usual clinical and validity scales. Again the usual mean profile was obtained (2-4), but subsequent analyses yielded two dimensions along which their subjects could be differentiated. Their first dimension they termed anxiety vs. ego strength. Loading on the anxiety pole were scale 7 and the MAS; the ES scale defined the other pole. Their second dimension they considered to be tapping high vs. low self-esteem which was defined by scales L and K on the high end and scale 2 on the low end. They also felt this dimension could be alternatively termed openness and help-seeking vs. defensiveness which seems to parallel Button's candid vs. defensive construct. Subjects could then be classified based on where they fell in this two-dimensional space.

Clearly, a multivariate approach to the assessment of alcoholic personality types yields a much richer portrayal of the various personality constellations present in alcohol abusing individuals. By evaluating MMPI profiles based on overall configuration and elevation, especially focusing on the complex relationships between the different scales, it becomes possible to obtain a more complete conceptualization of the personality dynamics

found in alcohol abuse. To summarize the MMPI studies focusing on alcoholism, the literature indicates most alcoholics have a nonconforming, antisocial and hostile component to their personality makeup. Many are also depressed, some are impulsive, yet others are anxiety laden. A lesser number have profiles suggestive of more serious mental disorder. The interested reader can consult Table 2 for a condensed summary and comparison of multivariate studies which dealt with personality typologies.

Purpose of This Study

Virtually every systematic study of alcoholism has sampled from hospitals, Veterans' Administration hospitals, or private alcohol treatment programs, all of which are utilized by patients eligible for either third party billing or government-provided free medical care. A subpopulation largely ignored in the literature is the indigent alcoholic, colloquially known as a "skid-row" dweller, the alcoholic who cannot afford traditional alcohol treatment programs. The ranks of this group have swelled in recent years, likely due in part to the deinstitutionalization of the chronic mentally ill. Many of these individuals, confused and disorganized, have turned to alcohol in an attempt at self-medication. Often they are bereft of family support, a viable livelihood, or even

a roof over their heads, leaving them to wander the streets seeking shelter and warmth where they can. Tucson, in part due to its temperate climate, has become a haven for many of these individuals. It appears to be common knowledge amongst this indigent population that there is a local alcohol treatment center which is required to treat them without financial cost.

This study was initiated in collaboration with this alcohol treatment center. The staff there had noticed that subsequent to detoxification many of their clients evidenced behaviors more bizarre and unusual than when they were drunk. Thus, one major thrust of this study was to ascertain the prevalence of serious mental disorder in this population as reflected by the MMPI. It was hypothesized that a much higher rate of severe mental disorder would be found than has been reported in past studies.

Of course the majority of clients at this treatment center are not psychotic. However, they are not all alike. Another emphasis of this study was the determination of how they are different; that is, what distinct personality types can be identified. As Meehl (1959) points out, a classification system is only meaningful if so classifying members results in their separation from other groups so that they can be considered to have a degree of similarity. Following Meehl's advice, several

classification procedures were employed to maximally differentiate between groups of alcoholics. The specific analyses are detailed in the methods section. Again, it was hypothesized that at least one personality type would emerge that is suggestive of severe mental disorder.

Upon discerning personality sub-types of indigent alcoholics, the interplay of the types with various demographic variables was investigated. Furthermore, personality types were also compared on a series of drinking related variables.

To summarize, the goals of this study are:

1. To ascertain the rate of severe psychopathology in an indigent alcoholic population.
2. To identify personality sub-types characteristic of this population.
3. To describe demographic and drinking patterns of this population.
4. To explore the interplay of personality and pathology with demographic and drinking pattern variables.

CHAPTER 2

METHOD

Subjects

The subjects studied were 368 inpatients admitted from October of 1982 through July of 1983 to a local publicly funded alcohol treatment center which primarily serves lower income and indigent clients. While an attempt was made to test every consecutive admission, practical considerations such as illiteracy and clients leaving prematurely against medical advice unfortunately interfered. Many of the clients were self-referred; others were brought there by the police due to public intoxication.

Materials

All subjects completed the MMPI, Form R. In addition to scoring the three validity scales and ten clinical scales, the MacAndrews Alcoholism Scale (MacAndrews 1965) was also scored. In accordance with previous findings which found that delaying psychological testing until after detoxification minimizes the effects of withdrawal on the test results (Libb and Taulbee 1971), the MMPI was not administered until after successful detoxification (approximately a week to ten days following admission).

Drinking behavior data was collected using Kahn's (1978) Drinking Patterns and Effects Survey, a normed questionnaire which measures the physical, psychological, social and legal difficulties arising from alcohol abuse (see Appendix A). The following demographic data was also collected:

1. Age
2. Sex
3. Ethnicity
4. Educational Level
5. Marital Status
6. Socioeconomic Status
7. Current Employment Status

Overview of the Analyses

All demographic, drinking patterns and MMPI data collected were first descriptively analyzed. Subsequently, in order to ascertain the degree of similarity between this sample and those previously reported in the literature, a mean MMPI profile for all subjects was calculated. Frequency of two-point code types was calculated following the guidelines of the Missouri Actuarial System (Gynther, Altman, Warbin and Sletten 1972). To obtain an objective index of serious mental disorder, the Goldberg sign, a means of differentiating between neurotic vs. psychotic profiles, was calculated (Goldberg 1965). The Goldberg index is calculated by adding the T-scores of the L, Pa, and Sc scales and from that subtotal subtracting the T-scores of the Hy and Pt scales. Goldberg recommends

that a profile should be considered neurotic if that sum is less than forty-five; if it exceeds that cutoff, then the profile should be deemed psychotic.

A more sophisticated analysis of the MMPI profile configurations was performed utilizing cluster analytic techniques such as those proposed by Lorr, Klett and McNair (1963) and implemented by the BMD statistical package. Conceptually, this technique pictures profile as interpoint distances in Euclidean space and identifies profiles which "cluster" together. Clusters were initially extracted based on half the sample and were then cross-validated using the remainder of the sample. After clusters were identified, multivariate analyses of variance (MANOVAS) and univariate analyses of variance (ANOVAS) were performed using the clusters as dependent variables and selected demographic and drinking variables as independent variables in an effort to determine similarities and differences between these personality types on a wide range of measures.

CHAPTER 3

RESULTS

Demographics

Demographically, this population was 94 percent male and ranged in age from eighteen to seventy with a mean age of thirty-eight (S.D. = 10.7). Ethnically, 70 percent were white, 17 percent Black, 6 percent Hispanic and 3 percent Native American. Only 7 percent were currently married, 35 percent were single, 40 percent divorced, 11 percent separated and 7 percent widowed. The mean level of educational experience was nearly twelve years of school ($\bar{x}$ = 11.8, S.D. = 3.7) with 70 percent reporting having received a high school diploma or its equivalent. Although the subjects were better educated than might have been expected, 80 percent described themselves as laborers. At the time of testing, 98 percent stated they were unemployed.

Drinking Patterns

Results of the Drinking Patterns and Effects Survey (see Table 4) indicate 80 percent of the subjects drink on a daily basis. The average amount of alcohol consumed per sitting was reported to be nearly two six-packs of beer, or a gallon of wine, or a fifth of liquor,

depending on what was preferred or available. The majority of subjects (57 percent) had previously been in some form of alcohol treatment program; several had over 100 prior admissions. They generally began drinking at an early age ($\bar{x}$ = 16.6, S.D. = 8) with 50 percent drinking before age fifteen. 73 percent reported having other family members with drinking problems. Polydrug use was admitted by 40 percent of the sample with marijuana being the drug most frequently mentioned.

Alcohol abuse was associated with many problems for these individuals. Alcohol-related family difficulties were reported by 88 percent of subjects, job troubles reported by 76 percent, and alcohol-related legal difficulties were incurred by 86 percent of subjects. Excessive alcohol use was reported to have caused health problems in 93 percent of subjects including such severe symptoms as hallucinations (52 percent), delirium tremens (41 percent) and liver damage (36 percent). 74 percent stated they had lost friends due to their alcoholism. Virtually every subject (99 percent) stated they wished to better control or cease their drinking.

MMPI

The MMPI profiles produced by these indigent alcoholics were strikingly different from most described in the literature as typical for alcoholics in terms of both

elevation and configuration (C. F. Clopton 1978), with 94 percent of subjects evidencing a profile with at least one scale in excess of a T-score of 70. One in four profiles had at least one scale exceeding a T-score of 100. Such extreme elevations suggest considerable psychopathology.

In order to assess the severity of pathology, two objective indices thought to differentiate degree of mental disorder were calculated, one being the Goldberg sign (Goldberg 1965) and the other Chang et al.'s (1977) criterion. As previously stated, the Goldberg sign differentiates neurotic profiles (those whose Goldberg index exceeds 45). Results of this analysis revealed 66 percent of subjects to exceed that cutoff or, in other words, to produce MMPI profiles which Goldberg considers indicative of psychosis. The mean Goldberg score obtained by this sample was found to be 60.5. Using the criterion proposed by Chang's group (see page 5), 6 percent of this sample would be considered normal, 21 percent mildly disturbed, and 72 percent moderately to severely disturbed.

In order to better compare this population with others reported in the literature, a mean MMPI profile was computed. The mean profile was characterized by peaks on the schizophrenia (8), psychopathic deviance (4) and depression scales (2), with scale 8 in excess of a T-score of 80 and the others in excess of a T-score of 70. The overall mean profile is represented by the following

coding based on Welsh's (1948) system 8"427'961350-F'-/KL:. The validity scales (L,F,K) formed a distinct inverted V configuration with F quite elevated (T=73) and the other scales well within normal limits. The means and standard deviations for all scales are summarized in Table 5.

On the individual level, scale 8 was the most frequent peak being the single highest scale in 30 percent of cases and one of the two highest points in 45 percent of cases. Scale 4 was the high point in 26 percent of cases and one of the two highest in 46 percent of cases; scale 2 was the high point in 17 percent of subjects and one of the two highest scales in 33 percent of cases. No other scale approached these three in terms of frequency of highest elevation.

The two-point code types most frequently obtained were the 4-9/9-4 (12 percent of subjects), the 2-8/8-2 (11 percent), the 4-8/8-4 (10 percent), the 2-4/4-2 (9 percent), the 8-9/9-8 (8 percent) and the 7-8/8-7 (6 percent). A complete list of two-point code types obtained along with their related frequencies can be found in Table 6.

In an effort to further differentiate personality types among these indigent alcoholics, cluster statistical analyses were performed. The sample of 368 subjects was randomly subdivided on an odd-even basis into two groups

of equal size; analyses were then performed on one group and cross-validated using the other. Based upon both accuracy of replication and clinical utility, a three cluster solution was adopted.

The first cluster identified (Type I alcoholic) was composed of 102 subjects (28 percent of the sample). This group evidenced an extremely elevated profile with peaks on the schizophrenia scale (T=105), the psychopathic deviance scale (T=86), and the depression scale (T=85). The overall profile code for the Type I alcoholic was 8*427"6193'05-F*"'-/LK: (based on Welsh's (1948) coding system). Cluster 1 initial and replication profiles are plotted in Figure 1.

The second cluster (Type II alcoholic) also produced an elevated profile although, with only four scales in excess of a T-score of 70, was much less elevated than the Type I group. The Type II alcoholic profile described 94 subjects (26 percent of the sample) and was characterized by peaks on the depression scale (T=80), the psychopathic deviance scale (T=76), the schizophrenia scale (T=76) and the psychasthenia scale (T=75). All other scales were well within normal limits. The Welsh code for the Type II alcoholic was 2"487'06953-1/F'-/LK:. (See Figure 2 for Type II initial and replication profiles.)

The third cluster (Type III alcoholic) included 172 subjects (46 percent of the sample). Several features

distinguished this group: only one scale in excess of a T-score of 70 (scale 4); a secondary peak on the hypomania scale, a relatively low score on the social introversion scale (T=49); and a relative absence of indications these subjects were experiencing notable levels of self-professed psychic pain (lower 2, 7 and F; higher K). The Welsh code for the Type III alcoholic was 4'958273-16/0:F-K/L:. Type III initial and replication cluster profiles are plotted in Figure 3. Table 7 details the obtained cluster means for all the scales by cluster membership. As Table 7 shows, highly significant differences were obtained on the majority of MMPI scales when compared across clusters. Only the L scale and the masculinity-femininity scale failed to discriminate between groups.

Upon differentiating the three broad personality types which these indigent alcoholics manifest, a series of analysis of variance procedures were performed in order to ascertain if these groups differed on any of the demographic or drinking pattern variables. Thirty-one variables were selected for comparison; of these, eight proved to differentiate between groups at an extremely high degree of statistical significance. The only demographic variable along which the alcoholic types differed was age, with the Type I alcoholics being significantly younger than the other two groups. Type I alcoholics also

differred on several variables which assessed the more deleterious effects of alcohol abuse. They admitted to temper-control difficulties, hallucinations, delirium tremens and liver problems at higher rates than did the other two groups. Both Type I and Type II alcoholics admitted to drinking-related confusion and loss of friends at higher rates than did Type III alcoholics. Type I alcoholics also admitted to polydrug abuse significantly more than did the other two groups. The obtained F ratios, degrees of freedom, alpha levels, group means and the results of Scheffé tests for the above mentioned variables can be found in Table 8.

It is axiomatic among statisticians that multiple comparisons between groups can lead to alpha slippage, or spurious differences which may be due to chance. This potential pitfall was not overlooked; the overall alpha level for the obtained significant differences was computed and found to be .0377, meaning that the probability that at least one of the differences is simply due to chance to be less than 4 percent. Such a low probability supports the contention that these differences are indeed meaningful.

CHAPTER 4

DISCUSSION

The results of this study suggest a considerable degree of psychopathology is present in this population. Several objective indices of psychopathology were calculated resulting in rates of severe psychopathology ranging from an extremely conservative estimate of 25 percent when mental illness was defined by an MMPI profile with at least one scale in excess of a T-score of 100 (!) to a less conservative estimate of 72 percent when the criterion was three or more MMPI scales in excess of a T-score of 70. One of the more widely used differential measures employed to distinguish severity of mental illness, the Goldberg sign, resulted in two-thirds of the indigent alcoholic subjects producing MMPI profiles indicative of psychosis.

Such an alarmingly high rate of apparent severe psychopathology can be explained in several ways. The most straightforward and parsimonious hypothesis is that these obtained rates are indeed accurate reflections of the prevalence of mental illness present in this population. Adopting such an explanation leads to the conclusion that approximately two out of three subjects suffer

from severe mental disorder. However, our clinical observations and feedback from the staff at the treatment center do not support such an explanation; instead, a more conservative and probably more accurate estimate would place the rate of severe mental disorder in the neighborhood of 25-35 percent.

How then can the extremely elevated profiles evidenced by these subjects be explained. One contributory factor which cannot be over-emphasized is the atypical experiences encountered by individuals living on the streets. Such people have, by society's definition, strange and unusual experiences on a daily basis. Their very survival is often dependent upon what for them is a healthy dose of paranoia. They are alienated from society and are persecuted for their lifestyles. Furthermore, chronic alcohol abuse does result in sensory and cognitive disturbances. Anyone acquainted with the MMPI is aware that the above mentioned "symptoms" are tapped by many MMPI items, particularly those which contribute to the psychotic tetrad scales. Simply put, nearly all indigent alcoholics, especially those living on the streets, in all likelihood substantially differ from the Minnesota population on which normative data was originally obtained. Until normative data can be gathered on this unique population, clinicians utilizing the MMPI with such individuals would be well advised to not accept sheer elevation

on the psychotic tetrad, without supporting data, as in and of itself indicative of psychosis.

The markedly atypical lifestyles characteristic of this group of indigent alcoholics is further underscored by their demographic makeup and reported drinking behaviors. They evidently have encountered a great deal of difficulty in maintaining stable interpersonal relationships as reflected by their skewed marital status (only 7 percent currently married), their loss of friends due to drinking (74 percent having lost friends), and their high rate of alcohol-related family difficulties (reported by 88 percent of subjects). Although it is difficult to establish direction at initial causality without benefit of a longitudinal study (e.g., did their drinking cause dysfunctional interpersonal relationships or did their dysfunctional relationships fuel their drinking), by the time they received treatment, a self-perpetuating vicious circle had long been established. The prototypical scenario would involve a relationship strife caused by drinking, in reaction to which the alcoholic would drink to mitigate the resultant distress, from which would then ensue additional interpersonl discord, ad infinitum.

Their drinking-related difficulties were not confined to only their social interactions but in addition also disrupted their occupational status. Although as a group they had achieved a modicum of academic success, the

majority were only able to work as laborers. Furthermore, at the time of testing, virtually all of the patients (98 percent) were unemployed. Such a discrepancy between ability and achievement illustrates the debilitative effects of chronic alcohol abuse. While some researchers, notably Hollingstead and Redlich (1958), have suggested the phenomena of social drift to be a byproduct of severe mental illness, based on this data one could argue that alcoholism also can result in a similar process.

The tenaciousness of alcohol addiction was revealed through the patients' tragic self-reports. Although 99 percent of the subjects stated they wished to better control or cease drinking, and 93 percent felt their excessive drinking had caused them health problems, for most this was not the first time they had sought inpatient treatment.

Clearly alcohol abuse has caused myriad difficulties for this group of indigent alcoholics as revealed through descriptive analyses of demographic, drinking and MMPI data. However, it is through the multivariate differentiation of personality typologies that one can best understand the intrapsychic disturbances which underlie their addiction.

The personality types derived in this study appear to possess a high degree of validity based on the similarity between the initial and replication groups as well as

the resemblance between these groups and others previously identified in other MMPI alcoholic typological investigations. The Type I group, defined by extreme elevations on scales 8, 4, 2, 7 and 6, is similar to Mogar and Wilson's (1970) Type III, Whitelock et al.'s (1971) Type II, and Kline and Snyder's (1985) Type I. This group, which we termed psychotiform, is described as

> odd, peculiar, and queer...nonconforming and resentful of authority...they have marked problems with impulse control. They tend to be angry, irritable and resentful, and they tend to act out in asocial ways... Excessive drinking and drug abuse may also occur. They lack basic social skills and tend to be socially withdrawn and isolated. Their world is seen as a threatening and rejecting place, and their response is to withdraw or to strike out in anger as a defense against being hurt... Psychiatric patients...tend to be diagnosed as schizophrenic (paranoid type), asocial personality, schizoid personality, or paranoid personality (Graham 1977, p. 74).

Graham's description of the profile type manifested by the Type I alcoholic captures the confusion, anger, pain and isolation which typifies these individuals. They clearly are troubled by much more than just their alcohol abuse. In fact, it appears their alcoholism may be an attempt to mitigate the painful affect and disturbing thoughts which beleaguer them. Owing to their difficulty fitting into their environment as well as their bizarre mannerisms and peculiar behavior, this group is the most visible of the three identified, often receiving the disparaging label of "bag people."

The second group identified in this study produced a cluster profile which, although elevated above normal limits, is much less so than the Type I alcoholic. This group replicates Whitelock et al's (1971) Type III alcoholic and Goldstein and Linden's (1969) Type II alcoholic. Furthermore, the high points of this cluster profile are the same as those found in most studies which have compiled overall mean profiles. The nosological descriptor which best reflects this group is alcoholism superimposed over a characterological depression with hostile, impulsive and anxious features.

Graham describes individuals with this profile configuration as

> impulsive and unable to delay gratification of their impulses. They have little respect for social standards and often find themselves in direct conflict with societal values. Their acting out behavior is likely to involve excessive use of alcohol, and their histories include alcoholic benders, arrests, joblessness and family discord associated with drinking. They may react to stress by drinking excessively or by using addictive drugs... They tend to be introverted, self-conscious and passive dependent. They harbor feelings of inadequacy and self-dissatisfaction, and they are uncomfortable in social interactions (Graham 1977, pp. 68-69).

Their alcohol abuse may be in reaction to the stress caused by the turmoil in their lives. They also may drink in an effort to subdue their chronic feelings of inadequacy and inferiority and to obtain feelings of

powerfulness and control. This group fits the colloquial description of "trying to get courage out of a bottle."

The third type identified was by far the largest of the three groups. With only one scale in excess of a T-score of 70, this group's cluster profile was the least elevated and most normal of the cluster groups. The psychiatric descriptor which best characterizes this group is alcoholism superimposed over an antisocial personality disorder. Profiles produced by these individuals are seen as reflecting a

> marked disregard for social standards and values... They have poorly developed consciences, easy morals and fluctuating ethical values. Alcoholism, fighting, marital problems, sexual acting out and a wide variety of delinquent acts are among the difficulties in which they may be involved... They are quite impulsive and unable to delay gratification of their impulses. They show poor judgment...and they fail to learn from experience... They harbor intense feelings of anger and hostility, and these feelings get expressed in occasional emotional outbursts. They are likely to seek out emotional stimulation and excitement. In social situations they tend to be uninhibited, extroverted and talkative, and they tend to create a good first impression... A diagnosis of antisocial personality or emotionally unstable personality is usually associated with this code (Graham 1977, pp. 74-75).

Their drinking may likely emanate from their impulsivity, low tolerance for frustration and inability to delay gratification as well as their tendency to seek out excitement and self-stimulation.

It appears three distinct types of indigent alcoholic are reflected in this sample, each with their own constellation of psychopathology and each with their own motivations for drinking. It then follows that different treatment plans would be indicated for the self-medicating psychotiform alcoholic, the rueful, hostile, depressed neurotic, and the thrill-seeking, personality disordered alcoholic.

Examination of how the three indigent alcoholic types differ on a range of demographic and drinking patterns further underscores the differences in degree of psychopathology and biopsychosocial adjustment manifested by these groups. As might be expected, the psychotiform alcoholics produced MMPI profiles with eight of the ten clinical scales indicative of a greater degree of psychopathology than did the other two groups (the two exceptions being the masculinity-femininity and the social introversion scales). The psychotiform alcoholics were also significantly younger than the other two groups. In all likelihood, this can be attributed to two factors. For one, it has been well documented that the typical age of onset of functional psychoses to be in the late teens and early twenties. Secondly, due to the disruptive effects of severe psychopathology on daily functioning and support group maintenance, the younger, more seriously disturbed alcoholics would tend to have more difficulty

masking the deleterious effects of alcohol abuse and would tend to have fewer supportive allies outside of treatment centers, thus necessitating earlier, and more intensive, outside intervention.

This group also reported a significantly higher frequency of what can be termed the "serious side effects" of alcohol abuse. Compared to the other two groups, they more frequently admitted to drinking-related hallucinations, delirium tremens, liver problems and loss of temper due to drinking. Both the psychotiform and the depressive alcoholics admitted to drinking-related confusion and the loss of friends secondary to their drinking in higher proportions than did the personality disordered alcoholics. Since these three groups all reported a commensurate amount of drinking, clearly these findings cannot be explained solely by alcohol abuse. Instead, it again appears likely the operative factor is the degree of underlying psychopathology which seems to interact with their alcoholism to produce such distressing symptomatology. Symptoms such as confusion, hallucinations, temper loss and loss of friends are characteristic of psychosis and conceivably may have predated or arisen independently of their alcohol abuse.

Examination of how the Type III alcoholics compare on these variables adds further support to the contention that degree of psychopathology is strongly involved. All

of the above mentioned variables except loss of temper were admitted to at lower frequencies by the Type III alcoholics relative to the other two types. They also admitted to less mental disorder on the MMPI than did the other groups. Such an association underscores the positive relationship between degree of psychopathology and frequency of reported deleterious symptomatology ostensibly related to alcohol abuse.

Finally, the ANOVA revealed a greater proportion of drug use by the Type I alcoholics. Whether this is due to their younger age, a greater need to self-medicate distressing symptomatology, or some other factor is unclear. An unexpected finding was a smaller percentage of alcoholics of the antisocial personality disorder type admitted to poly-drug usage than did the other two groups. Although the 4-9/9-4 mean MMPI code type produced by this group is more often associated with drug use than the configurations evidenced by the other types, only one-third of the Type III alcoholics reported poly-drug abuse. Again, it appears MMPI elevation, rather than configuration, to be a better predictor of drug use.

CHAPTER 5

CONCLUSIONS

Three indigent alcoholic typologies were identified and cross-validated through the use of a cluster analysis procedure. The Type I alcoholic, or psychotiform alcoholic, accounted for 28 percent of the sample. They evidenced extremely elevated profiles with peaks on scales 8, 4, 2 and 7. The Type II alcoholic (26 percent of the sample) received the nosological descriptor alcoholism superimposed over a characterological depression with hostile, impulsive and anxious features. The cluster profile produced by this group was moderately elevated with peaks on scales 2, 4, 8 and 7. The third type, termed alcoholism superimposed over an antisocial personality disorder, accounted for 46 percent of subjects. Their cluster profile was distinguished by peaks on scales 4 and 9 and an absence of any indications these patients were experiencing psychic pain.

Across the entire sample, rates of severe psychopathology ranged from an extremely conservative estimate of 25 percent when defined by an MMPI profile with at least one scale in excess of a T-score of 100 to a less conservative estimate of 72 percent when mental illness

was defined by three or more MMPI scales in excess of a T-score of 70. While it is clear that by usual definitions severe mental disorder is quite prevalent in this population, one can argue that the effects of street life and chronic alcohol abuse contribute heavily to such seemingly high rates and that removal of such noxious influences might result in a reduction of apparent psychopathology. Further research following some of these individuals is currently being undertaken and should shed some light on this question.

The data obtained through the Drinking Patterns and Effects Survey capture the devastating effects of chronic alcohol abuse on the physical, social and economic functioning of the individuals. Again, causality is difficult to infer without a longitudinal design; however, one can safely conclude alcoholism, at the very least, is a substantial contributor and maintainer of their current difficulties. Virtually all of these patients would require a multi-modal treatment regimen targeting not only their drinking behaviors and underlying motivations per se, but also focusing on their physical, interpersonal and economic needs, and most importantly, on their concomitant mental illness.

LIST OF TABLES

TABLE 1. FREQUENCY OF TWO-POINT CODE TYPES FOUND IN ALCOHOLIC POPULATIONS

Researcher:	Hoffmann (1959)	Hoffmann (1971)	McLachlan (1975)	Hodo & Fowler (1976)
Population:	393 Male Inpatients at State Hospital	279 Male Inpatients at State Hospital	2200 Male Inpatients at Private Inst.	1009 Male Inpatients at Mental Health Center
Code Type Frequency:				
	2/4/4-2 - 15.8%	2-4/4-2 - 16.5%	2-7/7-2 - 12.3%	2-4/4-2 - 20.8%
	4-9/9-4 - 13.7%	4-9/9-4 - 10.1%	2-4/4-2 - 12.2%	4-9/9-4 - 11.2%
	1-4/4-1 - 5.6%	3-4/4-3 - 6.5%	4-9/9-4 - 7.1%	2-7/7-2 - 9.1%
	4-7/7-4 - 4.9%	4-6/6-4 - 5.8%	1-2/2-1 - 6.7%	3-4/4-3 - 6.7%
	3-4/4-3 - 4.3%	2-7/7-2 - 5.4%	2-5/5-2 - 5.5%	1-2/2-1 - 6.6%
	2-0/0-2 - 4.3%	1-4/4-1 - 5.1%	2-8/8-2 - 4.7%	4-8/8-4 - 4.3%
	1-2/2-1 - 4.0%	4-7/7-4 - 4.6%	2-3/3-2 - 4.4%	
	4-6/6-4 - 4.0%	1-2/2-1 - 4.3%		
		2-6/6-2 - 4.0%		

TABLE 2. ALCOHOLIC TYPOLOGIES FOUND THROUGH MULTIVARIATE ANALYSES

Researcher: Goldstein & Linden (1969)
Population: 513 Legally-committed Male State Hospital Inpatients

Alcoholic Typologies

Profile Description	Nosological Description
1. Only scale 4 > 70	Psychopathic personality with emotional instability.
2. Scale 2 > 80; scales 7,8,1,4,3 > 70	Psychoneurosis, either anxiety reaction or reactive depression.
3. Scales 4,9 and 2 high points, all > 70	Alcoholism with secondary psychopathic personality, mixed type.
4. Scales 4 and 9 > 70	Alcoholism with secondary characteristics of drug addiction and paranoid features.

Researcher: Mogar, Wilson, and Helms (1970)
Population: 201 Male and Female State Hospital Inpatients

Alcoholic Typologies

Profile Description	Nosological Description
1. Scales 4,9 and 0 elevated	Passive Aggressive Alcoholic
2. Scales 2,7 and 0 elevated	Depressive Compulsive Alcoholic
3. Scales 8 and F elevated	Schizoid Prepsychotic Alcoholic
4. Scales 1 and 3 elevated	Passive Dependent Alcoholic

Researcher: Whitelock, Overall, and Patrick (1971)
Population: 136 Male State Hospital Inpatients

Alcoholic Typologies

Profile Description	Nosological Description
1. Only scale 4 > 70	No nosological descriptors given.
2. Scales 2,8,1,4,7 > 70	
3. Scales 4,2 and 7 > 70	
4. Scale 2 > 70	

TABLE 2, Continued

Researcher: Rohan (1972)
Population: 40 Male Inpatients at Alcohol Program

Alcoholic Typologies

Profile Description	Nosological Description
1. All scales < 70	Depressed Neurotic
2. Scale 4 > 70 on pre- and post-treatment tests	Psychopathic personality
3. Scale 4 > 70 pre-treatment Scale 4 < 70 post-treatment	Psychopathic reaction type

Researcher: Kline and Snyder (1985)
Population: 300 Inpatients (188 males; 112 females)

Alcoholic Typologies

Profile Description	Nosological Description
1. Scale 8 > 90, scales 2,4 and 7 > 80	Marked Psychopathology
2. Scales 9,8 and 4 > 70	Psychopathic
3. Scales 9 and 4 > 60	Normal, subclinical

TABLE 3. DEMOGRAPHIC CHARACTERISTICS

Age	Sex	Education
Mean 38 yrs.	Male 95%	Mean 11.6 yrs.
S.D. 10	Female 5%	S.D. 3.7

Ethnicity		Economic Status	
White	- 70%	Executive/Professional	- 2%
Black	- 17%	Managerial	- 3%
Hispanic	- 6%	Administrative	- 6%
Native American	- 3%	Clerical/Sales	- 3%
Other/Unknown	- 4%	Skilled Laborers	- 25%
		Semi-Skilled Laborers	- 30%
		Unskilled Laborers	- 24%
		Unknown	- 7%

Currently Employed		Marital Status	
Yes	- 1.9%	Single	- 35%
No	- 98.1%	Married	- 7%
		Separated	- 11%
		Divorced	- 40%
		Widowed	- 7%

TABLE 4. RESULT OF DRINKING PATTERNS AND EFFECTS SURVEY

PATTERNS OF DRINKING

Drinking Frequency (Days Per Week)

Less than 1 / week	2%
1 - 2 / week	6%
3 - 4 / week	12%
Every Day	80%

Beverage Imbibed

Beer	19%
Wine	30%
Liquor	16%
Combination	35%

Quantity Drank Per Drinking Occasion

Beer:	Six 12 oz. beers or less	13%
	Six-twelve 12 oz. beers or less	37%
	More than 12 beers	50%
Wine:	Less than 1 quart	8%
	1 quart to 1 gallon	69%
	1 gallon or more	23%
Liquor:	Less than one-fifth	49%
	One-fifth or more	51%

ALCOHOL-RELATED PROBLEMS

Family Problems Caused By Drinking

Yes	88%
No	12%

Job Troubles Caused By Drinking

Yes	76%
No	23%

Job Lost Due to Drinking

Yes	74%
No	26%

TABLE 4, Continued

Arrested Due to Drinking

Yes	89%
No	11%

HEALTH PROBLEMS

Sickness or Health Problem Caused By Drinking

Yes	94%

Types of Health Problems Caused By Drinking
(Percentage Reporting Symptom)

Vomiting	91%
Stomach Problems	75%
Diarrhea	83%
Memory Loss	90%
Confusion	92%
Sadness and Depression	92%
Loss of Temper	82%
The Shakes	81%
See or Hear Things	57%
Delirium Tremens	42%
Liver Problems	36%

SOCIAL PROBLEMS

Loss of Friends Due to Drinking

Yes	74%
No	26%

ATTRACTION TO ALCOHOL

What Subjects' Enjoy About Drinking

Taste	49%
Feeling	80%
Forget Problems	78%
Euphoria	46%
Relaxation	76%
Make Friends	42%
Easier to Get Sex	31%
Part of Group	47%

TABLE 4, Continued

Is Better Control or Cessation of Drinking Desired?	
Yes	99%
No	1%
Age Subject Began Drinking:	
X	16.6
SD	8
Does Subject Have Other Family Members with Drinking Problems?	
Yes	73%
No	27%
Which Family Members?	
Father	42%
Mother	20%
Brother	30%
Sister	13%
Uncle/Aunt	36%
Grandparent	18%
Does Subject Abuse Other Drugs?	
Yes	40%
No	60%
Which Drugs?	
Marijuana	31%
Amphetamines	18%
Barbituates	12%
Opiates	19%

TABLE 5. COMPOSITE MMPI SCALE MEANS AND STANDARD DEVIATIONS

(K Corrected T-Scores)

MMPI SCALE	Mean	S.D.
L	47.2	7.5
F	72.8	16
K	47.6	8.8
1	63.5	15.7
2	73.2	16.4
3	62.9	11.3
4	77.9	11.8
5	62.1	11.2
6	65.5	12.6
7	70.8	13.1
8	79.7	20.9
9	69.4	12.0
0	59.7	11.4
MacAndrews	72.0	13.6

TABLE 6. OBTAINED TWO-POINT CODE TYPES IN ORDER OF DESCENDING FREQUENCY

Code-Type	Frequency
4-9/9-4	12%
2-8/8-2	11%
4-8/8-4	10%
2-4/4-2	9%
8-9/9-8	8%
7-8/8-7	6%
1-8/8-1	5%
4-5/5-4	5%
4-7/7-4	4%
6-8/8-6	4%
2-7/7-2	4%

No other code-type describes more than 2% of cases.

TABLE 7. MMPI SCALE CLUSTER MEANS

(In k-corrected T-scores)

	Cluster 1	Cluster 2	Cluster 3	P - Value
L	45	45	48	.085
F	93	70	62	.000
K	44	44	51	.000
1	76	58	59	.000
2	86	80	63	.000
3	71	60	60	.000
4	88	76	75	.000
5	64	64	65	.362
6	80	65	59	.000
7	85	75	63	.000
8	105	76	65	.000
9	72	65	69	.000
0	65	67	49	.000

TABLE 8. ANALYSIS OF VARIANCE

(Comparison of Alcoholic Typologies on Selected Demographic and Drinking Variables)

Variable	Cluster Means			F	df[a]	P	Scheffé[b]
	Type I	Type II	Type III				
Age	35.2	40.4	39.7	6.11	(2,365)	.0025	231
Drinking-Related Confusion	Yes=97%	Yes=94%	Yes=88%	4.03	(2,360)	.0185	123
Temper Loss From Drinking	Yes-92%	Yes=68%	Yes=83%	9.96	(2,358)	.0001	132
Drinking-Related Hallucinations	Yes=80%	Yes=53%	Yes=46%	16.47	(2,359)	.0000	123
Delirium Tremens	Yes=58%	Yes=38%	Yes=34%	6.44	(2,345)	.0018	123
Liver Problems	Yes=50%	Yes=38%	Yes=27%	6.95	(2,344)	.0011	123
Loss of Friends Due to Drinking	Yes=81%	Yes=80%	Yes=66%	4.95	(2,348)	.0076	123
Poly-Drug Use	Yes=54%	Yes=37%	Yes=33%	5.11	(2,283)	.0066	123

a. Degrees of freedom differ due to response omission by some subjects.

b. Scheffé's results are significant at the .05 level and are ordered from the highest mean value to the lowest. Group numbers with common underscores are different from each other.

LIST OF ILLUSTRATIONS

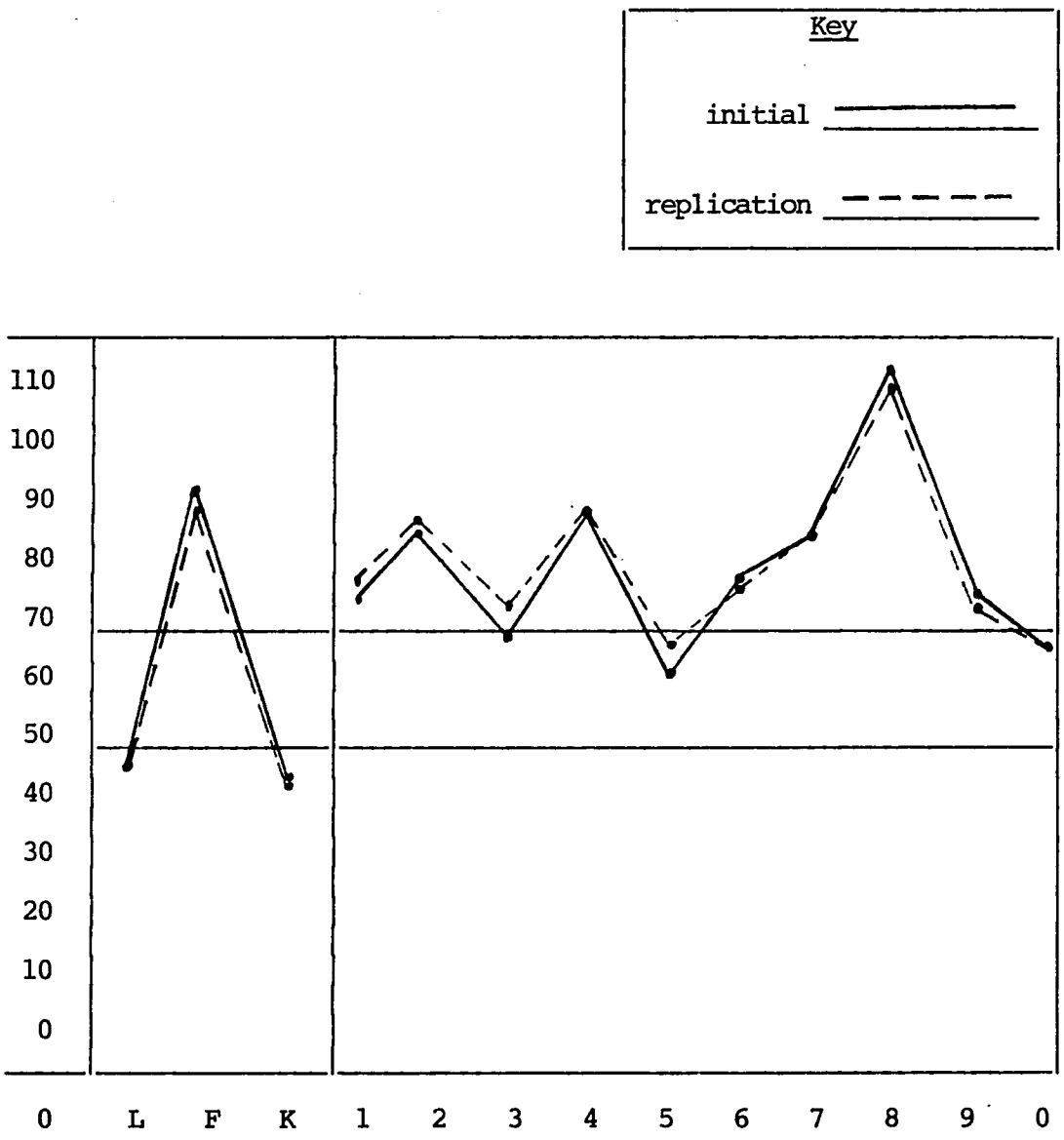

Figure 1. MMPI Profile: Cluster I
(k-corrected T-scores)

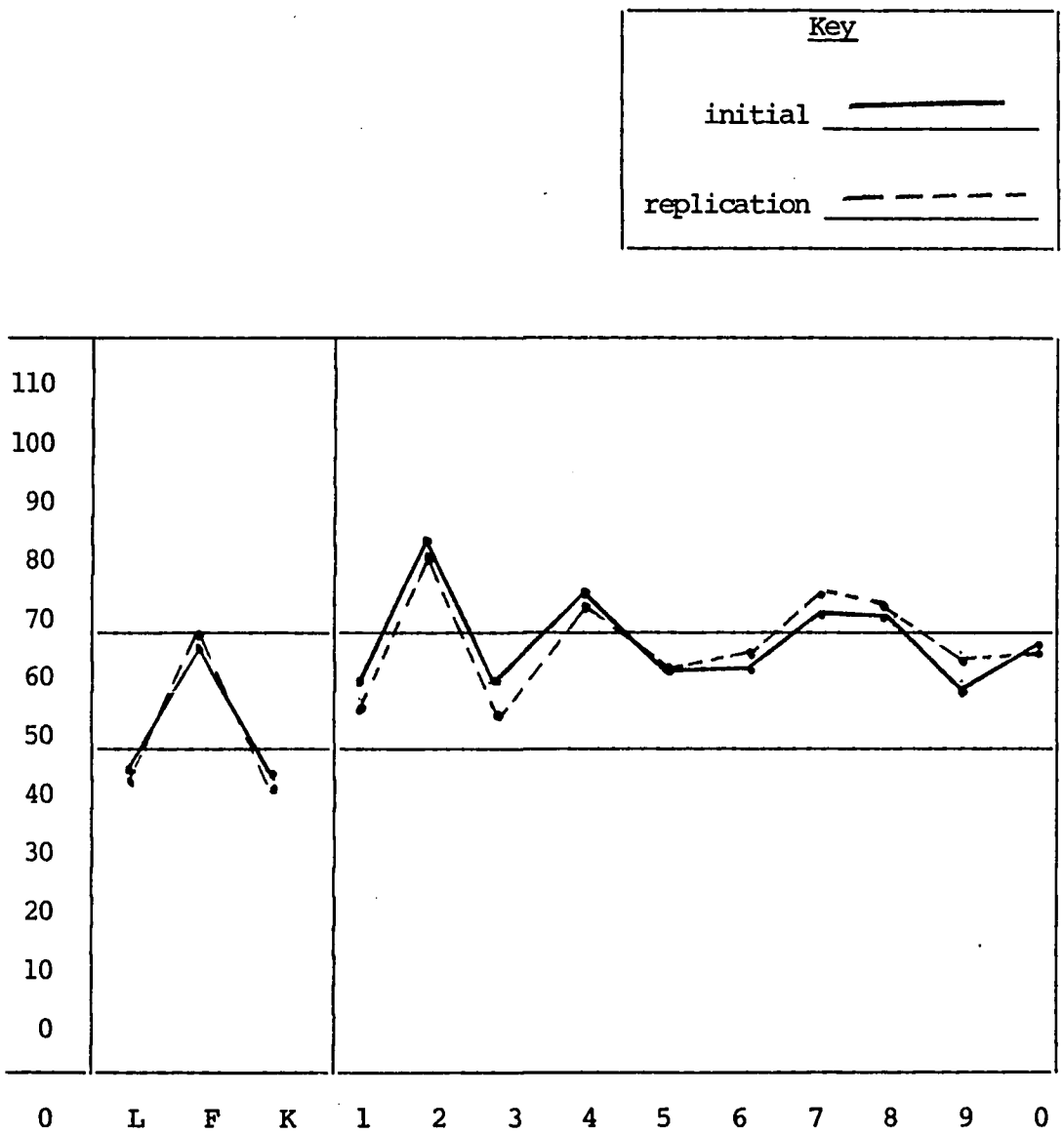

Figure 2. MMPI Profile: Cluster II
(k-corrected T-scores)

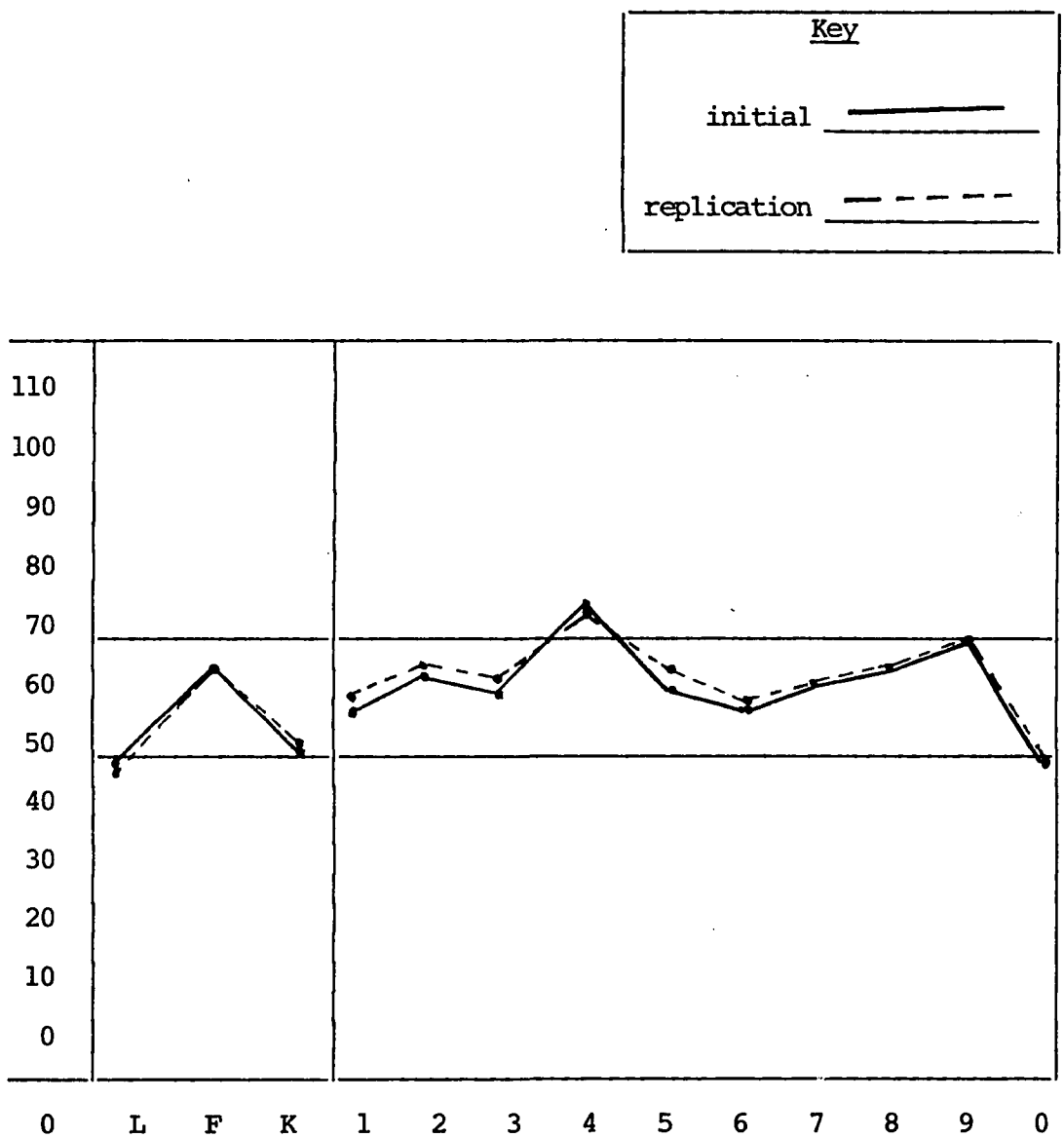

Figure 3. MMPI Profile: Cluster III
(k-corrected T-scores)

APPENDIX A

SURVEY OF DRINKING PATTERNS AND EFFECTS

Age ____ Ethnic Group: ____ Caucasian ____ Black ____ Latino

____ Indian ____ Oriental ____ Other

Sex ____ Marital Status: ____ Single ____ Married ____ Separated

____ Divorced ____ Widowed

Education _____ Occupation _____

Number of Previous Admittances to LARC _____.

Number of Previous Admittances elsewhere _____.

1. How often do you drink? (Check one)

____a. less than one day a week.

____b. one or two days a week.

____c. three or four days a week.

____d. almost every day.

____e. Do not drink. (If you checked here, do not continue. Turn in survey.)

2. When you drink, what do you mostly drink--how much a day?

____a. Beer (How many 12 oz. cans?) ____

____b. Wine (____less than 1/2 pint____1/2 pint____pint____quart

____1/2 gallon____gallon or more).

____c. Hard Liquor (____less than 3 shots____1/2 pint____1 pint

____1 1/2 pints____one-fifth____more than one-fifth).

____d. 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 girl/boyfriend feel about your drinking?

_____

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

5. Have you ever been in trouble with the police because 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

a. Has drinking ever caused you to:	Yes	No
throw up or vomit	____	____
have stomach aches or cramps	____	____
have diarrhea or loose bowels	____	____
lose your memory for a time	____	____
be confused and mixed up	____	____
feel sad and depressed	____	____
lose your temper or get into fights	____	____
have the shakes	____	____
see or hear things	____	____

caused the D.T.'s ____ ____

caused trouble with your liver ____ ____

7. Have you lost your friends because of drinking? ____ ____

8. What do you enjoy about drinking? (Check those that apply to you)

____ 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 the group

9. What do you like best about drinking? _____

_____

10. What kind of problems does drinking cause you?

_____

_____

_____

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

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

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

14. Have any other members of your family had drinking problems?

____Yes____No

15. If so, which ones (check ones who had problem) ____Mother____Father ____Sister____Brother____A grandparent____Uncle or aunt____A cousin

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