A STUDY OF TREATMENT OUTCOMES IN ALCOHOLISM TREATMENT

by

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Submitted in Partial Fulfillment of the Requirements

for the Degree of

Master of Science

in the

Criminal Justice

Program

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ABSTRACT

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Youngstown State University, 1981

This study was conducted to investigate differences between male alcoholics who obtained a satisfactory discharge from therapy and were not arrested within six months following release and those who did not obtain a satisfactory discharge and were subsequently arrested in order to determine if the differences might be predictive of successful treatment completion. Subjects were selected from an existing data base developed for clients admitted to the Mahoning County Committee on Alcoholism Program, Inc., Residential Intermediate Supportive Care Facility between May of 1979 and July, 1980. Data were available for a total of 200 adult male alcoholics who could be classified for treatment outcome. Successfully treated people were defined as those individuals who obtained an acceptable professional discharge from therapy and were not arrested within six months following release.

It was hypothesized that differences would be observed between those who obtained a satisfactory discharge and those who did not. Discriminant Function analyses were used to evaluate the contributions to predictive relationships from demographic variables, measures of intellectual functioning (WAIS), and personality test scores (MMPI).

The results lead to the conclusion that high scores on generalized measures of intelligence are one of the better predictors of treatment outcome. The findings relative to age lead to the suggestion that people who experience success in treatment have had less exposure to a long history of alcohol consumption. With regard to particular characteristics of individuals selected for treatment, high scores on the Psychopathic Deviancy scale and low scores on the Masculinity/ Femininity scale of the MMPI are indicative of failure in treatment. However, when a stereotypically masculine orientation is not present and rebelliousness is accompanied by a willingness to admit one's problem in a mature fashion, then independece in thought and action are predictive of success in treatment. The small sample size used in this study allows only tentative conclusions. Future research with approximately 1000 subjects per group would be needed before practical utilization on an individual basis could be recommended.

ACKNOWLEDGEMENTS

I am indebted to many people for their assistance and advice. Mrs. J. Colucci is appreciated for her good nature and for her typing competency. I would like to express my appreciation to Mr. Gregory Cvetkovich and Mr. C. Ernest Ranshaw for facilitating the data collection. Dr. Joseph Waldron has provided advice, criticism and served as a sounding board for many of the ideas contained in the present thesis; his help has been much appreciated. Last, but in many ways foremost, I thank my parents and Nancy, for their understanding and generousity.

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CHAPTER I

INTRODUCTION

The idea that judicial commitment to treatment for offenders with alcohol related problems works to facilitate recovery and reduce recidivism is a concept that is frequently debated. One position asserts that judicial commitment will not benefit offenders with alcohol related problems because treatment is effective only when a person asks for help.[1] On the other hand, it has been advanced that detoxification and early treatment can penetrate the denial system of offenders with alcohol related problems so they come to identify the necessity for getting help.[2] In that neither perspective is well substantiated by the current literature, the need exists for greater research into the characteristics of alcoholics and offenders with alcohol related problems relative to their likelihood for successfully completing an alcoholism treatment program.

Overview

This first chapter is intended to provide the reader with sufficient background to appreciate the seemingly disparate, yet integrally related concepts and disciplines underscoring this study.

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[1] J. Clark Laundergan, Jerry W. Spicer, and Mary Leo Kammeier, Are Court Referrals Effective? (Center City: Hazelden Foundation, 1979), p. 5.

[2] Ibid.

The chapter is divided into three subject areas: 1. Alcohol abuse and the criminal justice system with a statement of the problem to be addressed; 2. Methods of treatment outcome prediction; and 3. Characteristics of alcoholics and the utility of compulsory treatment. Chapters 2 and 3 explicate the research methodology employed and the findings derived from this study of treatment outcome predictions relative to the personality characteristics of individuals successfully vs. unsuccessfully completing alcoholism treatment.

Alcohol Abuse and the Criminal Justice System

Historically, alcohol consumption and the consequent problem of overindulgence was of some concern to the emperors of the Chou Dynasty in China.[3] Socrates, Plato, Aristotle, and Cicero were also concerned about the debilitating effects of alcohol.[4] In the United States, a series of national studies on drinking behavior are reasonably consistent in confirming that 63-68% of American adults report drinking at least once a year.[5] Among those that drink, there are many that abuse alcohol. In the United States there are an estimated 9,000,000 alcoholics. Contrary to the popular viewpoint, only three percent of these alcoholics are of the "skid row" variety.[6] Of the 9,000,000 alcoholics, 70% are males; 45% hold managerial positions; and 26% are white collar workers.[7] It has estimated that the alcoholic costs his employer an additional 25% above annual salary through direct and indirect losses; that 50% of

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[3] D. Calahan, I. H. Cisin, and H. M. Crossley, American Drinking Practices (New Haven: College & University Press, 1969), p. 40.

[4] Ibid.

[5] Third Special Report to the U.S. Congress on Alcohol and Health, (Washington, D.C.: Government Printing Office, 1978), p. 4.

[6] Ibid.

[7] Ibid.

all first admissions to mental hospitals suffer from alcoholism, and that 40% of all problems brought to a domestic relations court involve alcoholism in some way.[8]

Research on alcoholics in prison populations indicates that as many as 83% of inmates have reported alcohol as a contributing factor in their crime.[9] While frequent drinking has been thought to be associated more with crimes against persons than with crimes against property, prison data indicate that drunkenness is equally frequent in both types of offenses.[10] Banay notes that chronic inebriate offenders, excessive drinkers, and alcoholics in treatment programs have criminal behavior records far in excess of those expected in a sample from the general population. He suggests that when a serious alcohol related crime is committed early in a person's life, it can be predicted that a long career of criminal offenses involving alcohol abuse is apt to ensue.[11]

Acknowledging the relationship of alcohol and criminal behavior, numerous research studies have been undertaken to assess the correlation between alcohol abuse and the commission of violent crimes. In a study of New York inmates, 163 (25%) of 651 cases of homicide and 149 (32%) of 462 cases of assault, the chronic use of alcohol was considered to be closely related to the commission of a crime or directly responsible

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[8] J. J. Plaut, Alcohol Problems: A Report to the Nation (New York: Oxford, 1970), p. 14.

[9] A. B. Logan, "Alcohol Abuse: Overloading the American Justice System," Alcohol and Drug Problems 9 (December 1978):52.

[10] Ibid., p. 53.

[11] K. R. Banay, Conjectures and Refutations (New York: Harper & Row, 1976), p. 11.

for it.[12] In an English study, 22 of 85 murderers and 59 of 100 assaulters were labeled as heavy drinkers according to Alcoholics Anonymous classification.[13] A French study indicated alcoholics commited 39 (51%) of 76 murders and 13 of 30 episodes of assault with wounding.[14] Similarly, Scott studied different groups of inmates in the United States who excessively used alcohol and has reported comparable results.[15] The alcohol problem becomes even more significant when one realizes that each person who is an alcoholic directly affects four to five other people immediately around him.[16]

Traditionally, the American public has thought of alcohol abuse as offensive to society and, therefore, a matter for the attention of the criminal justice system.[17] Accordingly, the criminal justice system had to assume responsiblity for dealing with the problem using the processes of arrest, trial, and incarceration.[18] Some alcohol related crimes, such as public drunkenness, disorderly conduct, and vagrancy, have shown a substantial downward trend from 1965 to 1975.[19]

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[12] Ibid., p. 198.

[13] J. McGeorge, "Alcoholism and Violence," Medical Science Law, 3 (1963):47.

[14] P. Derville, P. Lepee, H. J. Lazarini, and E. Dervillee, "Collective Alcoholism," Alcoholism Review, 7 (July, 1961):21.

[15] P. D. Scott, "Consequences of Alcoholism," British Journal of Addiction, 63 (1968):225.

[16] M. B. Bailey and J. Stewart, "Normal drinking by persons reporting previous problem drinking," Quarterly Journal of Studies on Alcohol, 28 (1967):305.

[17] Logan, Alcohol and Drug Problems, p. 53.

[18] Ibid.

[19] Third special Report to the U.S. Congress on Alcohol and Health, p. 5.

As cited in the Third Special Report to the U.S. Congress on Alcohol and Health in 1978, this downward trend was due largely to the decriminalization of public intoxication in twenty-eight states.[20] Even with decriminalization, alcohol related offenses accounted for 38 percent of all crimes reported by the F.B.I. in 1975.[21] Apparently, the criminal justice process of decriminalization accomplished the destigmatization of alcohol abuse, but failed to make any substantial impact on the relationship between alcohol and crime.

Many disciplines have contributed to a better understanding of the relationship between alcohol and crime, however, a truly comprehensive understanding has yet to be realized. Within the criminal justice system itself, there exists considerable disagreement about the system's ability to address the rehabilitation needs of offenders in general.[22] The complexity of the problem of rehabilitation is further compounded when the offender is also an alcoholic and the correctional process must include alcoholism treatment.[23] In addition, inadequacies currently inherent in the system including overcrowding, treatment personnel, and lack of physical space and resources available for programming.[24] There are, however, additional problems involved in translating

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[20] Ibid., p. 10

[21] Ibid.

[22] Andrew Von Hirsh, Doing Justice (New York: Hilland Wang, 1976), p. 55.

[23] D. J. Armor, J. M. Polich, and H. B. Stambul, Alcoholism and Treatment (New York: John Wiley & Sons, 1978), p. 88.

[24] Ibid.

traditional methods and goals of alcoholism treatment to the offender population.

Alcoholism treatment programs rely predominantly on psychotherapy, group counseling, and vocational rehabilitation.[25] Most of these treatment approaches depend upon the individual's willingness to undergo self-analysis and exploration to achieve his or her treatment goals.[26] Such motivations are by no means necessarily characteristic of an offender. Concomittantly, alcoholism treatment efforts are further confounded in a prison system, due to the involuntary nature of treatment, and the fact that need for change is defined and imposed by an authority responsible for determining length of punishment.[28] It is not surprising, given these and other impediments, that the criminal justice system has not significantly contributed to the reduction of alcohol related crime.

At the same time, it should be recognized that even with its many limitations, the criminal justice system has tried to grapple with one important aspect of alcohol and crime that other systems tend to neglect. It confronts the basic question-"which offenders might be immediately diverted to community treatment programs in lieu of incarceration?"[29] More often than not, determination of the course

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[25] J. Fort, Our Biggest Drug Problem (New York: McGraw-Hill, 1973), p. 40.

[26] Ibid.

[27] Ibid., p. 42.

[28] D. J. Helms, W. C. Scura, and C. C. Fisher, "Treatment of the Addict in Correctional Institutions," in Medical Aspects of Drug Abuse, ed. R. W. Richter (Hagarstown, Md.: Harper & Row, 1975), p. 362.

[29] Ibid., p. 364.

which is most likely to minimize recidivism is a complicated and uncertain process.[30]

Problem Statement

Determination of the course of treatment regarding offenders with alcohol related problems has long been a questionable undertaking, especially since little research has been done in this area.[31] Nevertheless, insights distilled from available empirical investigations may throw some light on the area of the rehabilitation of offenders with alcohol related problems.

The remaining sections of this chapter provide a sample of related investigations within an overview of the: 1) methods of treatment outcome prediction; and 2) characteristics of alcoholics and the utility of compulsory treatment. To conclude the discussion and to preface the remainder of this thesis, Chapter 1 culminates in a statement of the hypothesis for the present study.

Methods of Treatment Outcome Prediction

What happens to people who participate in alcoholism treatment programs after they leave treatment? Are treatment programs effective? Does alcoholism treatment have any lasting effects on offenders with alcohol related problesm? What are the outcomes of treatment versus incarceration? In order to study these and related questions, it is necessary to have a basic understanding of current research on the prediction problem and predictive indices.

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[30] R. J. Catanzaro, Alcoholism (Illinois: Charles C. Thomas, 1968), p. 64.

[31] J. J. Platt, C. Labate, and R. J. Wicks, Evaluative Research in Correctional Drug Abuse Treatment (Toronto: Lexington, 1977), p. 106.

The use of formal prediction devices in a correctional setting relies on the assumption that individuals possessing a certain pattern of characteristics will tend to react in a similar fashion in a given situation. Prediction problems involve an attempt to forecast an individual's future behavior on the basis of what one is led to expect from previous assessments of that individual and others similarly situated.[32] Such assessments may be in the form of interviews and casual observation, or they may follow a more structured approach via the administration of psychological tests. Subsequently, on the basis of an observed relationship between predictor and outcome measures, an attempt is made to determine the most probable outcome for different subgroups of persons. Such studies can ultimately provide information concerning the relative effectiveness of different treatment programs.[33]

Generally, investigators have found indices of past criminal behavior to be among the best predictors of parole outcome. Cartwright reported that type of offense, age, prior commitments, and delinquency contact record were included in the California Youth Authority Base Expectancy Table for predicting success on parole.[34] However, one of the major problems in a significant proportion of studies employing either life history or criminal behavior predictors is their failure to be confirmed on cross validation.[35] Some early successes were achieved

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[32] Ibid., p. 104.

[33] Ibid.

[34] D. S. Cartwright, "Measuring and Predicting Probation Outcomes: An Exploratory Study," Criminology, 10 (1972):160.

[35] R. Fildes and D. M. Gottfredson, "Cluster Analysis in a Parolee Sample," Journal of Research in Crime and Delinquency, 9 (1972):11.

in predicting recidivism from life history variables, however, due to the inadequacy of most prison records, the reliability and validity of such data is of questionable value in these situations.[36]

Personality variables constitute another category of recidivism predictors. Such variables were believed to offer great potential in prediction based on an individual's current functioning rather than from a review of his past behavior.

Much of the research in this area has focused on the Minnesota Multiphasic Personality Inventory (MMPI). The MMPI was originally developed to discriminate those traits that are commonly characteristic of disabling psychological abnormalities.[37] The inventory consists of 566 statements, to which the examinee gives the responses: "true," "false," or "cannot say." It has been accepted principally because it has been found to be useful in a wide variety of situations.[38] Appendix G contains a complete description of the instrument.

Mixed results were obtained by Panton in attempting to use the MMPI as a predictor of successful parole.[39] Panton constructed a twenty-six item Parole Violators Scale from MMPI items which differentiated the parole violators from non-violators.[40] However, the scale failed

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[36] S. J. Dean, "Treatment of the reluctant client," American Psychologist, 13 (1968):630.

[37] S. R. Hathaway and J. C. McKinely, The Minnesota Multiphasic Personality Inventory Manual (New York: Psychological Corporation, 1967), p. 2.

[38] S. R. Hathaway and E. S. Monachesi, Adolescent Personality and Behavior (Minneapolis: University of Minneapolis Press, 1963), p. 2.

[39] J. H. Panton, "Predicting Prison Adjustment with the MMPI," Journal of Clinical Psychology, 14 (1962a):308.

[40] Ibid.

to be confirmed on cross validation.[41] Panton also attempted to identify Habitual Criminalism (HC) using the MMPI; once again, the results of this study must be interpreted with caution.[42]. The HC scale survived initial cross validation but was of limited predictive accuracy in identifying offenders having only one or two previous sentences.[43]. Other research using the MMPI identified the Hypochondriasis (Hy) and Psychopathic Deviancy (Pd) scales as helpful in differentiating recidivists from non-recidivists, however, there is much contradictory evidence on this point.[44] Despite the modest success Panton and other investigators have had in predicting recidivism from the MMPI, the majority of investigators have failed to confirm its usefulness in prediction.[45] The limitations of the instrument according to these authors is that the MMPI is generally unable to discriminate within homogeneous populations.[46]

Acknowledging the incongruities in the above approaches, Clopton warns that as with most variables that initially appear to have predictive power, a substantial amount of supportive research remains

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[41] Ibid., p. 312.

[42] J. H. Panton, "The Identification of Habitual Criminalism with the MMPI," Journal of Clinical Psychology, 18 (1962b):134.

[43] Ibid., p. 136.

[44] See J. Smith and R. J. Lanyon, "Prediction of Juvenile Probation Violators," Journal of Consulting and Clinical Psychology, 32 (1968):58; R. A. Freeman and H. M. Mason, "Construction of a Key to Determine Recidivists from Non-recidivists Using the MMPI," Journal of Clinical Psychology, 8 (1952):250; and J. L. Mack, "The MMPI and Recidivism," Journal of Abnormal Psychology, 74 (1969):614.

[45] Ibid.

[46] Ibid.

to be done before the generalizability of these early results can be confirmed.[47].

Evident from this review of approaches to prediction is the lack of substantive consistent data which can be generalized beyond a given study. Specifically, the utility of life history variables as well as personality variables have proven to be of limited reliability as predictors of recidivism.[48] However, in comparing the life history and personality research approaches it has been consistently demonstrated that social factors are more closely related to type of outcome than personality factors.[49] Additionally, it has been shown that a combination of both the life history and personality approaches is a better predictor of outcome than either approach by itself.[50] It seems that the utility of life history variables as well as psychometric evaluations, have proven to be of limited reliability in the prediction of recidivism.

It is obvious from the shortcomings of the previously referenced research that additional prognostic indicators need to be identified and explored. For example, Cowen found that the use of opiates and

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[47]J. R. Clopton, "Alcoholism and the MMPI: A Review," Quarterly Journal of Studies on Alcohol, 39 (1978):1558.

[48]See Cartwright, Criminology, p. 159; E. A. Wenk and R. L. Emrich, "Assaultive Youth: An Exploratory Study of the Assaultive Experience and Assaultive Potential of California Youth Authority Wards," Journal of Research in Crime and Delinquency, 9 (1972):196; and P. P. Rempel, "The Use of Multivariate Statistical Analysis of Minnesota Multiphasic Personality Inventory Scores in the Classification of Delinquent and Nondelinquent High School Boys," Journal of Consulting Psychology, 22 (1958):17-23.

[49]Ibid.

[50]Ibid.

alcohol are significant negative prognostic factors for recurrent criminal behavior.[51] This relationship is not surprising given the estimate that as many as 83 percent of offenders in prison or jail have reported alcohol involvement in their crimes.[52] Furthermore, the continued compulsive use of contraband in prisons, specifically drugs and alcohol, have been documented extensively in the literature.[53] Perhaps the continued use of substances is primarily responsible for the observations that numerous individuals leave prisons less emotionally stable than when they entered.[54] Kalinich suggests that all the responsibility for that continued usage may not rest solely on the inmates but may be a control mechanism of the system to assist in the internal management of inmates by keeping individuals pacified.[55]

In their evaluation of an alcoholism treatment program, Platt et al. identified another variable when they suggest that a significant relationship exists between completion of an alcoholism treatment program and successful parole performance.[56] The authors indicated that it is not

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[51] J. Cowen, "A six year follow-up of a series of committed alcoholics," Quarterly Journal of Studies on Alcohol, 15 (1954):423.

[52] Logan, Alcohol and Drug Problems, p. 53.

[53] Banay, Conjectures and Refutations, p. 12.

[54] See Banay, Conjectures and Refutations, p. 60; M. Cohen et al., "Alcoholism: Controlled drinking and incentives for abstinence," Psychology Report, 28 (1971)L580; and Logan, Alcohol and Drug Problems, p. 63.

[55] D. Kalinich, "The Impact of Contraband Control Policy on the Stability of a Prison Environment: A Theoretical Perspective," paper presented at the Annual convention of the Academy of Criminal Justice Sciences, Oklahoma City, 14 March, 1980.

[56] Platt, et al., Evaluative Research in Correctional Drug Abuse Treatment, p. 120.

simply participation in, but successful completion of the program that is related to success on parole.[57] Expanding on their ideas, it seems reasonable that such a relationship would exist if the same skills necessary for successfully completing the treatment program were also required for successful parole performance. In previous research, Plaut, Scura, and Hannon indicated that alcoholics showed differences in their ability to conceptualize a means of reaching stated life goals.[58] A related idea is found in a study by Spieker, Sarner, and Hill, who found that a large percentage of recidivism by prisoners was due to their lack of understanding of the complexities of human emotions and conditions in society.[59] To the extent that personal and social understanding and planning skills are required for coping with the problems a former inmate faces on parole, it seems logical that the successful completion of an alcoholism treatment program would contribute significantly to parole success.

There is considerable evidence that an effective approach to the reduction of recidivism would be to treat those offenders with alcoholism problems outside of the criminal justice system.[60] This

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[57] Ibid.

[58] J. J. Plaut, W. C. Scura, and J. Hannon, "Problem-solving Thinking of Youthful Incarcerated Addicts," Journal of Community Psychology, 1 (1973):281.

[59] G. Spieker, R. C. Sarner, and J. R. Hill, "Alcohol Use As An Aid to Criminal Activity," (Ph.D. dissertation, University of Arkansas, 1978), p. 12.

[60] See Laundergan et al., Are Court Referrals Effective?, p. 6; Cartwright, Criminology, p. 60; J. E. Cowden, "Predicting Institutional Adjustment and Recidivism in Delinquent Boys," Journal of Criminal Law, Criminology, and Police Science, 57 (1966):40; and F. M. Davis and K. S. Ditman, "The effect of court referral and disulfiram on motivation of alcoholics," Quarterly Journal of Studies on Alcohol, 24 (1963):279.

would insure that treatment of the alcoholism problem would be the primary objective, rather than an ancillary goal as in the criminal justice system.[61] Hypothetically, criminal activity and/or recidivism of these offenders should be reduced by directly addressing their alcohol problems and teaching living and planning skills. However, when one attempts to precisely delineate specific processes, the limitations of present knowledge and the need for more carefully conducted research becomes apparent. The following section addresses several factors likely to be of importance to the design of such research.

Characteristics of Alcoholics and the Utility of Compulsory Treatment

Diagnostically, most alcoholics suffer from a range of personality disorders. Research with the MMPI and other instruments indicate that alcoholics can be characterized as depressive and defensive especially in terms of giving socially desirable self descriptions.[62] The typical MMPI profile obtained from alcoholics has peaks on the Depression and Psychopathic scales. Pattison, Sobell, and Sobell state that the rest of the profile is unremarkable. Their research suggests that one should not expect a great deal of traumatic change either for better or worse, in this population. However, it is their contention that the chronic, lingering dissatisfaction characteristic of the alcoholic should not prevent movement in social settings or of their social acceptance.[63]

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[61] Ibid.

[62] H. Hoffman, "Depression and defensiveness in self-descriptive moods of alcoholics," Psychological Reports, 26 (1970):26.

[63] E. M. Pattison, M. B. Sobell, and L. C. Sobell, Emerging Concepts of Alcohol Dependence (New York: Springer Publishing Co., 1977), p. 210.

Marshall compared 120 male alcoholics without psychosis with 179 non-alcoholic non-psychotic males similar in age, education, and occupational level. The comparison included a combined questionnaire and rating scale for memories of early environment and an evaluation of present personality on the Chassel Experience Variables Records, the Humm-Wadsworth Temperment Scale, and the Strong Vocational Interest Test. Marshall concluded: 1) alcoholics come from homes with greater security, both economic and emotional, 2) alcoholics are lower in familial, occupational, and emotional and social adjustment, 3) alcoholism may be due to an environment which fails to develop ability to deal with frustration, 4) all of the personality characteristics found in adult alcoholics can be interpreted as the result of alcoholism rather than as causes of it.[64]. These traits have been observed over several years and are thought to be relatively stable indicators for identifying alcoholics.[65]

While these studies do not fully explain the source of differential susceptability to treatment, they do seem to have some implication concerning differential needs of subsets of the alcoholic population. Pattison, et al. found that committed alcoholics had significantly higher mean scores than their voluntary hospitalized counterparts on the MMPI Lie (L), Correction (K), and Social Introversion (Si) scales.[66] The study failed to generalize treatment

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[64] H. Marshall, "A study of personality of alcoholic males," American Psychology, 2 (1947):289.

[65] Ibid.

[66] Pattison et al., Emerging Concepts of Alcohol Dependence, p. 212.

implications, a failing it shares with most of the research literature on alcoholism.[67] What had been observed is an apparent tendency for committed subjects to present a positive self-image and deny unfavorable personality traits.[68]

Unfortunately, the principles which should govern the treatment of alcoholics have never been sufficiently clarified. Pattison states that useful treatment methods in a particular working environment may be inappropriate, redundant, or even destructive when attempted in other facilities. He indicates that treatment philosophy and methods should be congruent with the anticipated population. Further, it cannot be determined why such a high degree of congruence between population and treatment approach is found. He goes on to suggest that there is no single comprehensive treatment approach for all types of alcoholic populations; there is no established treatment which guarantees more than 35% total abstinence rates.[69]

In their books on comprehensive community treatment programs for alcoholics, Plaut and Blum and Blum recommend the use of multiple treatment approaches.[70] One aspect of treatment which has been studied

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[67] Ibid.

[68] Ibid.

[69] Ibid., p. 60.

[70] See J. J. Plaut, Alcohol Problems: A report to the nation (New York: Oxford, 1970), p. 78; E. M. Blum and R. H. Blum, Alcoholism: modern psychological approaches to treatment (San Francisco: Jossey-Bass, 1967), p. 290.

has been the effectiveness of compulsory therapy with alcoholics. Marglis, Krystal, and Siegal reported on a group of alcoholic offenders who were treated for their alcoholism on an outpatient basis as part of a special clinical study. Half of the residents were voluntary and half were involuntary commitments. It was the authors' conclusion that involuntary patients became even more involved in the treatment situation than did voluntary patients.[71] Selzer and Holloway successfully followed up a group of 83 alcoholics who had been committed to a state hospital in Michigan. They found that 41 percent were rehabilitated. About half of those rehabilitated were totally abstinent and the other half were moderate drinkers.[72] Davis and Dittman compared the attendance at an alcoholism clinic of a group of twenty-six court referred alcoholics to the attendance of thirty-six self referred alcoholics over a fifteen week period. They found no significant difference in clinic attendance between the court referred and self referred groups.[73]

Brunner-Orne described an experimental clinic which was set up in Stroughton, Massachusetts, for the purpose of treating alcoholics sent there by court order. Of 38 patients who initially entered under court order, 22 of 58 percent responded favorably.[74] Cowen followed up

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[71] M. Marglis, J. Krystal, and S. Siegal, "Psychotherapy with alcoholic offenders," Quarterly Journal of Studies on Alcohol, 25 (1964):99.

[72] M. D. Selzer and W. H. Holloway, "A follow-up of alcoholics committed to a state hospital," Quarterly Journal of Studies on Alcohol, 18 (1957):120.

[73] F. M. Davis and K.S. Dittman, "The effect of court referral and dissulfiram on motivation of alcoholics," Quarterly Journal of Studies on Alcohol, 24 (1963):278.

[74] M. A. Brunner-Orne, "Court clinic for alcoholics," Quarterly Journal of Studies on Alcohol, 12 (1951):600.

a group of 68 patients who had been committed to the state hospital in Raliegh, North Carolina, six years previously. He found that twenty-five (37%) had improved in terms of their drinking behavior, even though the treatment consisted of little more than custodial care.[75] Gallant et al. studied enforced treatment of paroled criminal alcoholics. Although the number of subjects studied was small (n=19), it was concluded that there were significant improvement differences supporting compulsory treatment with outpatient psychotherapy wherein abstinence and legal and employment status were used as outcome measures.[76]

Smart reported on the outcome of employed alcoholics receiving treatment under a program of "constructive coercion" mandated by the employer in contrast with patients attending treatment voluntarily.[77] Although Smart's study was not concerned with court referral to treatment, the findings are relevant here because the study dealt with residential therapy contrasting mandatory and voluntary patient treatment. It was found that there were no differences in drinking behavior at follow-up between the mandatory and voluntary patients at two treatment sites wherein mandatory patients showed the same level of improvement in drinking behavior and social functioning as did voluntary patients.[78]

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[75] Cowen, Quarterly Journal of Studies on Alcohol, p. 423.

[76] D.M. Gallant et al., "Enforced Clinic Treatment of Paroled Criminal Alcoholics," Quarterly Journal of Studies on Alcohol, 29 (1968):83.

[77] R.G. Smart, "Employed Alcoholics Treated Voluntarily and Under Constructive Coercion: A Follow-up Study," Quarterly Journal of Studies on Alcohol, 35 (1974):209.

[78] Ibid.

Laundergen et al. studied follow-up data of individuals judicially committed to treatment at Hazelden Rehabilitation Center in Minnesota. It was found that for the majority of committed patients, alcohol use had been reduced or stopped altogether. Most committed patients reported improvements in their social relationships and their physical and emotional health. The majority were gainfully employed and reported a low arrest rate during the twelve months following treatment. Consistent with much of the alcoholism treatment outcome literature, low socioeconomic and educational backgrounds were found to be negatively related to successful outcome.[79] It can be concluded from this brief review, that alcoholism treatment can have salutary effects on people who are ordered by a court to obtain alcoholism treatment.

However, there is little research oriented toward predicting which individuals are likely to succeed in treatment on either a compulsory or voluntary basis. Although substantial numbers of treatment programs exist, several issues need to be addressed regarding offenders with alcohol related problems. Not all individuals are appropriate for referral outside the criminal justice system. Some may grossly exaggerate pathology to escape the legal consequences of their past behaviors.[80] Others may exhibit alcoholism as a secondary problem to psychological difficulties which necessarily requires a more appropriate referral to a psychiatric facility.[81] The majority of low socioeconomic offenders, may not have the financial resources to fulfill

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[79] Laundergan et al., Are Court Referrals Effective?, p. 12.

[80] D.P. Crowne and D. Marlow, The approval motive: studies in evaluative dependence (New York: Wiley, 1964); p. 80.

[81] Ibid., p.83.

admission criteria and generally exhibit mistrust of approaches adopted by the dominant culture.[82]

In addition, studies utilizing the MMPI as a predictor of successful treatment, generally indicate that alcoholics who left treatment programs without staff approval were characterized as defensive about admitting interpersonal problems and denied dependency needs and conflicts.[83] In essence, clients in alcoholism treatment programs are asked to make fundamental changes in their needs, priorities, and life styles.[84] Pattison indicates that they are asked to undergo profound changes in their behavior. Given the profundity of the change that the treatment is supposed to bring about, it is not surprising that there is no established treatment which guarantees more than 35% total abstinence rates.[85]

The assumption in the preceeding paragraphs is that treatment can ultimately be improved by an understanding of the psychological and sociological variables that underlie constructive rehabilitation. While there has been some research pertaining to the relationships between socio-demographic variables obtained on hospital admission and MMPI scale scores, research has typically been limited in the number of

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[82]N. J. Davis, Sociological Constructions of Deviance (Iowa: W. C. Brown Co., 1975),p. 57; and E. M. Schur, Labelling Deviant Behavior: Its Sociological Implications (New York: Harper and Row, 1971), pp.12-20.

[83]Clopton, Quarterly Journal of Studies on Alcohol, p. 1559.

[84]Armor et al., Alcoholism and Treatment, p. 180.

[85]Pattison et al., Emerging Concepts of Alcohol Dependence, p. 240.

demographic variables considered.[86] Such data as criminal justice status and background characteristics including arrest and detention history are important and characteristically neglected variables which should be explored along with personality characteristics.

The sheer numbers of offenders with alcohol related problems in relation to our limited knowledge about causes and treatment makes it dubious to speak in terms of solutions. The pursuit of more knowledge and better means of predicting outcomes are necessary to accomplish the goals of sophisticated program design and to provide means for determining appropriate systems and levels of care for individuals requiring treatment. Representing that awareness and logic the following hypothesis is proposed and governs the scope of the present study:

> Hypothesis 1: A prediction equation can be constructed which will identify characteristics of alcoholic individuals who are likely to obtain satisfactory discharges from therapy.

There are some important and promising direction to the verification of this hypothesis. If it is supported, it might indicate that offenders with alcohol related problems and simple alcoholics require different types of treatment programs for maximum benefit to each group. Another benefit of investigating traditional treatment approaches that are found to be ineffective with offenders with alcohol related problems is that offenders could more effectively be channeled to appropriate treatment rather than reimposing sentences and overtaxing the criminal justice system.

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[86] H. Hoffman, D. G. Jansen, and L. R. Wefring, "Relationships between admission variables and MMPI scale scores of hospitalized alcoholics," Psychological Reports, 31 (1972):662.

Additional implications according to Cantanzaro, would include the idea that if an offender with alcohol related problems is exposed to therapy for his alcoholism, the sooner he begins therapy following arrest, the more profitable it will be for him. He further notes that with such commitments the alcoholic can receive immediate treatment and avoid the stigma of criminal conviction and effects of prisonization.[87]

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[87]Cantanzaro, Alcoholism, p. 302.

CHAPTER II

METHODOLOGY

This chapter considers the operational measures and research methodology employed in this study. Accordingly, Chapter 3 continues with the results, a narrative description and interpretation of the study findings, and recommendations for future research.

Definitions

As previously stated, the hypothesis governing the present thesis is:

> Hypothesis 1: A prediction equation can be constructed which will identify characteristics of alcoholics who are likely to obtain satsifactory discharges from therapy.

Within that hypothesis the major concepts that require specific definition due to their unique relationship to this thesis include alcoholism, treatment, and treatment outcome.

Rather than attempt to obtain a consensus by way of representative sampling of the various definitions of alcoholism, the following definition was selected on the basis of comprehensiveness and operational consistency with the agency wherein this study was conducted:

> "Alcoholism is a chronic disorder in which the individual in unable, for psychological or physical reasons, or both, to refrain from frequent consumption of alcohol in quantities sufficient to produce intoxication and, ultimately, injury to health, social, and psychological functioning."

Included therein are the basic elements of chronicity, compulsive drinking, intoxication, and injury to functioning. The essential

element is compulsive, uncontrollable drinking. Therefore, relative to this study, alcoholics are those individuals admitted to the Mahoning County Committee on Alcoholics Program, Inc. (MCAAP), for assessment and subsequent treatment for alcoholism. These people may be voluntary admissions or may have been individuals referred or ordered to treatment upon referral by judicial authority.

For the purpose of the present study, treatment is defined as admission to a Residential Intermediate Supportive Care Facility for alcohol related problems.[88] Residents of MCAAP whose records were utilized for this study lived in a home-like supportive milieu of extended residential care. During residency total abstinence from all mood altering chemicals was mandatory for continued treatment. Consonant with Alcoholics Anonymous philosophy, alcoholism was defined as a disease; treatment emphasized the surrender of one's previous life style, and stressed living one day at a time.[89] Treatment modalities utilized included group therapy, individual counseling, sensitivity groups, lectures on the addictive process, bibliotherapy, programmed recreational activities, vocational counseling by the state's Bureau of Vocational Rehabilitation personnel, and required attendance and participation in local AA meetings. Also provided when indicated were medical; psychosocial and psychological evaluations, psychiatric consultations; and family and marital counseling. Treatment objectives included enhanced

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[88] Joint Commission on Accreditation of Hospitals, (Washington D.C.: Government Printing Office, 1976), p. 28.

[89] See Cantanzaro, Alcoholism, p. 308; H. J. Eyesenck, The Effects of Psychotherapy (New York: International Science Press, 1966), p. 64; and D. J. Pittman and C. R. Snyder, Society Culture and Drinking Patterns (New York: Wiley, 1960), p. 14.

psychological, social and vocational functioning and the acquisition of practical skills for the conduct of one's life. Collectively staff efforts were directed toward gradual social reentry of the alcoholic into the community.

With the above definitions of "alcoholism" and "treatment" defined, consideration was given to operationalizing the concept of treatment outcome. Treatment outcome could be defined in several ways. The introductory material (see Chapter 1) implies that at least two components should be used in the definition of treatment outcome (therapeutic gains and social adjustment). Under this system, one could not reasonably classify an individual's record of treatment as successful if the individual was subsequently arrested. Furthermore, an individual who was discharged after some minimal period of therapy but was professionally evaluated as having made no therapeutic gains during his stay (unacceptable) would not be considered a treatment success. Consequently an individual to be defined as successful must receive an acceptable discharge from treatment and remain free of arrest for at least six months subsequent to treatment. This form of definition jointly considered the professionals judgment and the subsequent social adjustment of the individual, thus enabling one to define "success" on both professional and objective grounds. The two levels on each of the components are displayed in Table 1.

Treatment outcome was further qualified in terms of Subsequent Arrest (arrested vs not arrested) and in terms of Therapeutic Gains Evaluation (acceptable vs unacceptable). Under the Subsequent Arrest Categories a determination of arrested or not arrested within six months

TABLE 1

Categorization of Treatment Outcome

		Social Outcome	
		Arrested	Not Arrested
Therapeutic Gains	Acceptable	Unsuccessful G_1	Successful G_2
	Unacceptable	Unsuccessful G_3	Successful G_4

of leaving the treatment program could be ascertained. The determination of arrested or not arrested classification was accomplished from available aftercare records of the MMCAP. Those records contained the results of phone contacts to referral sources and a follow-up questionnaire sent to former residents six months after treatment. These reports contained information on clients' current drinking and drug use habits, and levels of social, psychological, vocational, and health adjustment including changes in alcohol consumption, quality of life, and involvement with the criminal justice system.[90]

Under the Therapeutic Gains Evaluation the two categories of acceptable and unacceptable were identified for professional determination of the classifications. Information relative to classifying Therapeutic Gains was acquired from the discharge summary written by the

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[90] See Appendix A and B which contain the Referral Follow-up and Client Follow-up forms respectively.

caseload counselors for each resident within five days of discharge from treatment.[91] Each report contains statements delineating therapeutic gains accomplished by the resident and identified the type of discharge according to staff approval. Based on these statements and on type of discharge awarded, classification of acceptable or unacceptable discharge were derived.

A review of the bifurcated definition of treatment outcome as displayed in Table 1, leads to the definition of successful treatment outcome as those individuals who obtained an acceptable professional discharge from treatment and were not arrested in the six months following release. All other groups would be defined as unsuccessful treatment outcome for purposes of hypothesis testing. However, group four, or those individuals who obtained an unacceptable discharge but were not arrested in six months following discharge, are of additional interest. Specifically, the relationship of group four to group two (all individuals who do not become entangled in the legal system again), avails opportunity to explore common characteristics of individuals who are able to remain free of arrest.

Design

The discriminant function analysis was considered to be the most parsimonius data analytic approach to constructing equations which would identify members of the groups displayed in Table 1.[92] This type of analysis yields a maximum of n-1 equations (n≥ the number of groups) of the form:

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[91] The discharge summary format is contained in Appendix C.

[92] H. Tatsuoka, Discriminative Function Analysis (Chicago: Institute for Personality and Ability Testing, 1970), p. 19.

$$D_n = d_{i1} Z_{i1} + d_{i2} Z_{i2} + d_{i3} Z_{i3} \ldots . d_{ip} Z_{ip} \quad (p<n)$$

D = group membership

d = standardized score

Z = standardized beta weight

The independent variables for the analysis consisted of various demographic, social, and psychological data which will be discussed subsequent to addressing ethical implications relative to the present study.

Human Subjects Consideration

The unit of analysis in the present study was existing client files. No individual was submitted to any form of experimental manipulation and, after reviewing the Human Subjects Research Regulations and Procedures, it was concluded that permission to use existing data was needed from both the Executive Director of the Mahoning County Committee on Alcoholism Programs, Inc., and the Executive Director of the Mahoning County Diagnostic and Evaluation Clinic, who are legally responsible for the institutional records utilized in the present study.[93]

Independent Variables and Subjects

The introductory review of the literature (see Chapter 1) leads to the conclusion that demographic and social variables such as life history characteristics, drinking patterns and indices of past criminal behavior were potential prognostic indicators of recidivism. In

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[93] See Human Subjects Research Regulations and Procedures, (Washington D. C.: Government Printing Office, 1977), p. 16. Appendix D and E contain the appropriate letters of permission from the respective Directors.

addition, psychological concommittants derived from the MMPI, Wechsler Adult Intelligence Scale (WAIS), and other instruments were found to have potential for prediction.[94]

For this study demographic and social data were collected from the Admission and Psychosocial History forms routinely compiled in the case record files of the Mahoning County Committee on Alcoholism Programs.[95] Psychological data such as personality protocols deirved from the MMPI and intellectual functioning derived from the WAIS were extracted from narrative reports contained in the same files prepared by the Mahoning County Diagnostic and Evaluation Clinic. Actual test scores were collected directly from psychological files of the Mahoning County Diagnostic and Evaluation Clinic. The files search of both agencies began with the first file entry on May 1, 1979, and all data as previously described were collected contingent on the following data:

1. Only those male residents between the ages of 18-60,
2. Intake, psychological history, discharge summary, WAIS, and MMPI present in the file, and
3. Follow-up information available.

Subject files came from a pool of files on residents referred to the facility from a variety of sources including: courts, hospitals, families, clergy, Alcoholics Anonymous, employers, physicians, social agencies, and self. The average age of the males admitted was 33 years.

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[94] Descriptions of the WAIS and MMPI scales are contained in Appendix F and G respectively, while Appendix H contains a facsimile of the data sheet which indicates the values of the specific variables collected for analysis in the present study.

[95] See Appendix I and J which contain the Admission and Psychosocial History forms respectively.

The average length of stay was 62 days. An analysis of female resident files was not pursued since the number of files was insufficient for a useful study. Data were collected from 200 consecutive files of persons admitted which met the above outlined criteria. Subsequent to the collection of the data, each resident represented by a subject file was assigned to one of the four groups as displayed in Table 2. There were no missing data in the present analysis. Results, discussion, and suggestions for future research are presented in the following chapter.

TABLE 2

Number of Subjects Assigned to Each Experimental Group

		Social Outcome	
		Arrested	Not Arrested
Therapeutic Gains	Satisfactory	G_1 (n=41)	G_2 (n=54)
	Unsatisfactory	G_3 (n=52)	G_4 (n=53)

CHAPTER III

SUMMARY

Results

Two discriminant function analyses were conducted using the stepwise discriminant function analysis wherein the criterion for each function was the minimization of Wilks' lambda (λ).[96] The first analysis considered all variables previously described. The second analysis considered only the Minnesota Multiphasic Personality Inventory Scales. In the first analysis, three significant functions which accounted for 23 percent of the total variance were derived. The first function accounted for 48 percent of the common variance ($X^2_{(63)} = 154.37$; $p < .05$) or 11 percent of the total variance. The second function accounted for 31.43 percent of the common variance ($X^2_{(40)} = 83.626$; $p < .05$). Table 3 displays the centroids (group means) for each group in each function while Table 4 displays the standardized discriminant function coefficients of variables included in the analysis. When the guidelines set out by Tatusuoka were used, it was determined that values greater than .35 were useful determiners of a function; it can be seen that seven, six and eight variables from their respective functions should be used to interpret the data in the present analysis.[97]

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[96] Norman H. Nie et al., Statistical Package For the Social Sciences (New York: McGraw-Hill, 1970), p. 435.

[97] Tatusuoka, Discriminative Function Analysis, p. 48.

TABLE 3

Discriminant Functions Evaluated at Group Means

(Centroids)

Group [a]	Function 1	Function 2	Function 3
1	0.46752	-0.74433	-0.40859
2	0.42666	0.05464	0.73431
3	-1.04079	-0.36568	-0.07198
4	0.20058	0.87065	-0.33494

[a]See Table 2 for a description of each group

TABLE 4

Standardized Discriminant Function Coefficients

Scale	Function 1	Function 2	Function 3
MPF	0.63*	0.13	-0.30
NDP	0.57*	-0.21	-0.13
EOV	0.52*	-0.44*	0.07
WBL	-0.48*	1.02*	-0.33
ABB	-0.45*	0.34	-0.24
WIZ	0.40*	-0.79*	2.50*
MP6	-0.39*	0.24	0.43*
MP4	-0.28	-0.54*	0.38*
WPI	0.32	0.38*	-0.46*
NCH	-0.10	-0.35*	0.01
WAR	-0.22	-0.21	-1.34*
WVO	-0.07	-0.11	-0.90*
AGE	-0.28	0.27	-0.37*
MP3	-0.22	-0.23	-0.37*
CRE	0.27	0.20	0.09
PRS	-0.17	0.05	0.30
RPA	-0.25	-0.29	0.21
MTA	0.28	0.07	0.27
FTA	-0.30	-0.15	-0.25
SIB	-0.20	0.07	0.21
NSC	-0.02	0.34	-0.30

[a]See Appendix H which describes the specific variables collected for analysis in the present study.

*Determiners of the function.

As can be seen in Table 3, the first function discriminates individuals identified as unsatisfactory discharge/not arrested from those identified as satisfactory discharge (both arrested and not arrested). An inspection of Table 4 indicates that individuals identified as unsatisfactory discharge/not arrested exhibit fewer tendencies to obtain elevations on the Fake Scale of the MMPI, have lower number of pretherapy drunk arrests, lower IQ scores on the WAIS; higher scores on the WAIS block design, greater incidence of amphetamine abuse and elevations on the paranoia scale of the MMPI.

The second function discriminates individuals identified as satisfactory discharge/arrested from those identified as unsatisfactory discharge/arrested. An inspection of the second function in Table 4 indicates that individuals identified as satisfactory discharge/arrested exhibited lower scores on the WAIS block design and picture arrangement with higher overall IQ scores; greater incidences of overdose, elevations on the Psychopathic Deviancy scale of the MMPI and were more likely to be parents.

The third function confirms the hypothesis tested and indicates that individuals identified as satisfactory discharge/not arrested can be discriminated from those identified satisfactory discharge/arrested and unsatisfactory discharge/not arrested. An inspection of Table 4 indicates that individuals identified as satisfactory discharge/not arrested exhibit higher IQ scores on the WAIS, elevations on the MMPI Paranoia and Psychopathic Deviancy scales, are chronologically younger and have lower scores on the MMPI Hysteria scale.

In the second analysis two discriminant functions which accounted for 27 percent of the total variance were derived, however, only the

first function was significant ($X^2_{(6)} = 19.83$; $p < .05$) and it accounted for 97 percent of the common variance (25 percent of the total variance). Table 5 displays the centroids for each group in each function, while Table 6 displays the standardized discriminant function coefficients of variables included in the second analysis.

TABLE 5

Discriminant Function Evaluated at Group Means

(Group Centroids)

Group[a]	Function 1	Function 2
G_1	-0.23010	0.18727
G_2	-0.22439	0.14165
G_3	-0.04693	-0.08413
G_4	0.44352	-0.20524

[a]See Table 2 for a description of each group.

TABLE 6

Standardized Discriminant Function Coefficients

Scale[a]	Function 1	Function 2
MP4	0.96	0.38
MP5	-0.60	0.84

[a]See Appendix H which describes the specific variables.

As can be seen in Table 6, individuals who were identified as unsatisfactory discharge/arrested exhibited higher scores on the MMPI Psychopathic Deviancy scale and lower scores on the Masculinity/

Femininity Scale. A discussion of the obtained results is presented in the following section.

Discussion

The hypothesis for the present thesis was confirmed by the third function of the first analysis, that is a function was constructed which has a greater probability than chance of identifying groups of individuals prior to admission who will obtain satisfactory discharges from treatment and will not be arrested for at least six months following treatment. Furthermore, the first function of the second analysis indicates that the MMPI is of use if identifying individuals who are unlikely to benefit from treatment insofar as they will not obtain satisfactory discharges from treatment and are likely to be rearrested within six months of leaving the program. The present analyses also provide additional information with regard to groups of individuals who do not appear to derive benefit from treatment but do not have subsequent arrests for at least six months following treatment.

Before proceeding to a discussion of these results, the limitations of the present study need to be considered with regard to subject characteristics (generalizability) and methodological problems. In terms of generalizability, the present study was confined to a sample population of adult males involved in residential milieu therapy on either a voluntary or semi-voluntary basis. To the extent that this residential milieu had within it a variety of clinical conditions, it may not be compared to other residential therapies using similar populations. Therefore, the applicability of translating the findings to outpatient treatment settings cannot be ascertained. Additionally,

the variables of voluntary or semi-voluntary admission were not studied so the relationship of coercion to treatment outcome cannot be discerned. Compounding the aforementioned limitations, the small sample size forming the basis for this study precludes anything but tentative conclusions with regard to any one individual. Approximately 1000 subjects per group would be needed before practical utilization on a individual basis could be recommended. An additional limiting factor is in the nature of the discriminant function analysis which capitalizes on chance to an unknown degree and at times produces spurious results. Furthermore, discriminant function analysis can only be used to understand the structure of groups in general. This limitation permits extreme intergroup variations on the function with indeterminant meaning.

Conclusions

With these caveats in mind, the group of individuals who obtained a satisfactory discharge and were not arrested in six months following release exhibit a balanced intellectual capacity, suggesting that organic brain dysfunction is not as readily observable (or present) in this group relative to groups that experience subsequent adjustment problems. The findings relative to the age variable suggest that possibly those persons who experience success in treatment have had less exposure to a long history of drinking given their younger ages.

It is of some interest to note that consonant with general psychological theory concerning the types of people who profit from any therapeutic approach, the present analysis leads to the suggestion that "good" global intelligence is one of the best predictors of gains in treatment.[98] Beyond this often replicated finding, it was also

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[98] Eyesenck, The Effects of Psychotherapy, p. 42.

noted that alcoholics who appear to derive gains from intermediate supportive residential care are independent/rebellious individuals who do not deny their own contribution to their social problems, yet exhibit a reasonable suspicion of the intentions of others. Prior studies with the MMPI indicate that a moderate elevation on the Paranoia scale is indicative of a realistic adult maturity, and this is in agreement with the present analysis insofar as one could reason that more mature people are more likely to benefit from therapeutic intervention.[99] It is also probable that younger individuals with this particular personality configuration do not exhibit rigid personality structures and are therefore more amenable to therapy.

It would seem that more attention should be directed to personal characteristics of individuals selected for treatment in settings similar to the one studied here. Specifically, younger individuals who show signs of independence and maturity should be further studied as "good" candidates for various types of alcoholism programs. It is possible that felons with these characteristics should be diverted from incarceration. However, further study is needed before firm conclusions could be drawn.

With regard to particular characteristics of individuals selected for treatment, the results of the second analysis, first function, are of particular interest to practitioners and researchers in criminal justice settings.

It has long been known that 60 to 80 percent of incarcerated individuals exhibit elevations on the Psychopathic Deviancy Scale and it is thought that such elevations are indicative of social dysfunction,

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[99] Clopton, Quarterly Journal of Studies on Alcohol, p. 1541.

especially criminal conduct.[100] In the second analysis it was also noted that high scores on the Psychopathic Deviancy scale and low scores on the Masculinity/Femininity scale are indicative of failure in treatment. This finding suggests that a macho orientation (as tapped by the Masculinity/Femininity scale) accompanied by rebelliousness and independence in thought and attitude lead to failure. However, as function three of analysis one indicates, when a macho orientation is not present and rebelliousness is accompanied by a willingness to admit one's problems in a relatively mature fashion, then independence in thought and action are predictive of success in treatment. The obvious implication here is that forensic psychologists and others should not readily dismiss individuals with elevated Psychopathic Deviancy scale profiles without giving due consideration to the contributions from other personality characteristics. Such a procedure would suggest that many more individuals could be considered for therapeutic programs.

Summary and Recommendations

The study was conducted to investigate differences between male alcoholics who obtained a satisfactory discharge from therapy and were not arrested within six months following release and those who did not obtain a satisfactory discharge and were subsequently arrested in order to determine if the differences might be predictive of successful treatment completion. A literature review was conducted to provide an appreciation for the seemingly disparate yet integrally related concepts underscoring this study. Particularly striking from this review of the literature was the idea that a need

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[100] Ibid., p. 1542.

exists for more research into the characteristics of alcoholics and offenders with alcohol related problems relative to their likelihood for successfully completing an alcoholism treatment program. The review led to the hypothesis that such people could be identified.

Subjects were selected from an existing data base developed for clients admitted to the Mahoning County Committee on Alcoholism Program Inc., Residential Intermediate Supportive Care Facility between May of 1979 and July, 1980. Personality (MMPI), intellectual (WAIS) demographic, and follow-up data were available for a total of 200 adult male alcoholics who could be classified for treatment outcome. Successful treatment was defined as those individuals who obtained an acceptable professional discharge from therapy and were not arrested within six months following release.

It was hypothesized that differences would be observed between those who obtained a satisfactory discharge and those who did not. Discriminant Function analyses were used to evaluate the contributions to predictive relationships from demographic variables, measures of intellectual functioning and personality test scores.

The hypothesis for the present study was confirmed by the third function of the first analysis, that is, a function was constructed which has a greater probability than chance of identifying groups of individuals prior to admission who will obtain satisfactory discharges from treatment and will not be arrested for at least six months following release. Furthermore, the first function of the second analysis indicated that the MMPI is of use in identifying individuals who are unlikely to benefit from treatment insofar as they will not obtain satisfactory discharges from treatment and are likely to be arrested within six months of leaving the program.

The results lead to the conclusion that high scores on generalized measures of intelligence are one of the better predictors of treatment outcome. The findings relative to age lead to the suggestion that people who experienced success in treatment have had less exposure to a long history of alcohol consumption. With regard to particular characteristics of individuals selected for treatment, high scores on the Psychopathic Deviancy scale and low scores on the Masculinity/Femininity scale of the MMPI are indicative of failure in treatment. However, when a stereotypically masculine orientation is not present and rebelliousness is accompanied by a willingness to admit one's problems in a relatively mature fashion, then independence in thought and action are predictive of success in treatment.

Considering the parameters of the present study relative to the nature of the sample and methodological problems, the following implications for future research are recommended. As was noted in the discussion section, approximately 1,000 subjects per group should be used to facilitate practical utilization on an individual basis. Concomitantly, it is suggested that future research give specific consideration to the use of longitudinal studies to test further the predictive powers of personality, demographic and intellectual factors.

In addition, it is proposed that future research consider the treatment implications of social pressure and the sociology of defining masculinity in conjunction with antisocial personality characteristics as defined by the Masculinity/Femininity scale of the MMPI. The present study implies that researchers should separate populations based on androgenous perceptions.

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Spieker, G., Sarber, R. C., and Hill, J. R. "Alcohol Use As An Aid to Criminal Activity." Ph.D. dissertation, University of Arkansas, 1978.

APPENDIX A

Referral Follow-Up

MAHONING COUNTY COMMITTEE ON ALCOHOLISM PROGRAM INC.
REFERRAL FOLLOW-UP

Name of client _____

Date of interview _____

Name of interviewer _____

PLEASE DO NOT OMIT ANY QUESTIONS

1. Have you been in a hospital or in a halfway house for a problem related to alcohol since you left the program?_____If yes, which one and how many times?_____
2. Have you been arrested at all for any alcohol-related offense since you left the program?_____If yes, how many times?_____
3. Have you had anything (any alcohol) to drink during the past month? _____
4. About how many days in the past six months since you left the program have you been drinking?_____If client never drank at all since discharge, skip # 5 & 6.
5. About how many days after leaving the program did you take your first drink?_____
6. About how many days ago did you have your last drink?_____
7. Have you gone to a hospital for any counseling or therapy since you left the program?_____
8. Have you attended any meetings of Alcoholics Anonymous during the past month?_____
9. Have you attended AA meetings at all since you left the program?_____
10. Have you had any other forms of counseling or therapy since you left the program?_____
11. Has anyone in your faminly attended Al-Anon?_____
12. Have you used Antabuse at all since you left the program?_____
13. When you were in the program, what experiences were more helpful to you? I will read off some of the experiences and then you tell me which two you believe were most helpful to you: (check two)

Psychologist_____	Group therapy _____	Contact with other res.___
Individual therapy____	Family therapy_____	AA meetings_____
The lectures _____	Films_____	Work therapy_____

14. I will read of a list of possible things that might have happened in your life since you left the program. After I read each one, please simply answer YES if it has happened to you, and NO if it has not. (check if YES)

Death of spouse _____	Personal injury or illness___
Divorce _____	Getting married_____
Marital seperation _____	Fired at work _____
Jail term _____	Marital reconciliation_____
Death of close family member___	Retirement _____

14. (Continued)

Change in health of family member _____
Pregnancy in family _____
Sex difficulties _____
Gain of new family member _____
Business readjustment _____
Change in financial situation _____
Death of close friend _____
Mortgage over $10,000 _____
Change of responsibilities at work _____
Son or daughter leaving home _____
Trouble with in-laws _____
Outstanding personal achievement _____
Change in living conditions _____
Change in personal habits _____
Trouble with boss _____
Change in work hours _____
Change in residence _____
Change in recreation _____
Change in church activities _____
Mortgage or loan less than $10,000 _____
Change in sleep habits _____
Change in eating habits _____
Vacation _____

APPENDIX B

Client Follow-Up

MAHONING COUNTY COMMITTEE ON ALCOHOLISM PROGRAM INC.

CLIENT FOLLOW-UP

1. What is the extent of your drinking today, in terms of frequency, compared to what it was before your treatment?
2. What is your mood-altering drug use today, in terms of frequency, compared to what it was before your treatment?
3. How often do you attend AA meetings at present?
4. Have you participated in the following AA activities since leaving treatment?
   -Led a meeting.
   -Told my story
   -Did 12th step work
   -Sponsored an AA member
5. Since leaving treatment, have you taken or retaken the fourth step?
6. Since leaving treatment, have you taken or retaken the fifth step?
7. Would you like to take or retake the fourth or fifth step?
8. The following is a list of possible growth areas for most alcoholics and other chemically dependent people (and just about everyone else). Think about how you dealt with each area before treatment and how you are presently dealing with it. Then place a check mark on the proper blank according to whether you think you have improved, stayed about the same, or became worse in the area. Place a check mark on the last line (not applicable) only when you are unable to answer by checking one of the first three.

	Improved	Same	Worse	N/A
Relationship with spouse	_____	____	_____	____
Relationship with children	_____	____	_____	____
Relationship at work	_____	____	_____	____
Relationship with higher power	_____	____	_____	____
Your own job performance	_____	____	_____	____
General physical health	_____	____	_____	____
Ability to handle problems	_____	____	_____	____
Ability to accept help & advice	_____	____	_____	____
Ability to give help & advice	_____	____	_____	____
Ability to assume responsibility	_____	____	_____	____
Ability to manage financial affairs	_____	____	_____	____
Acceptance of need for abstinence	_____	____	_____	____

9. Have you consciously continued working steps six through twelve of the AA program after leaving MCCAP Inc.?
10. Through which of the following means have you tried to maintain some kind of conscious contact with a higher power?
    -Prayer
    -Meditation
    -Church attendance
    -Spiritual counseling

11. Have you experienced any of the following changes in marital status since treatment?
    -Divorced
    -Separated
    -Widowed
    -Remarried
    -Married
    -None of the above

12. Do you feel this change in marital status was a positive or negative step in terms of your abstinence from alcohol and other drugs?

13. Why do you feel this change in marital status took place?

14. Have you been involved in any legal actions as a result of continued alcohol or drug use since leaving MCCAP Inc.?

15. Since leaving treatment, how many times have you been picked up or arrested by the police?

16. Would you return to MCCAP Inc. for treatment again if it should become necessary?

APPENDIX C

Discharge Summary

DISCHARGE SUMMARY

Name:_____ Admission Date:_____

Discharge Date:_____

IDENTIFYING DATA: Age, race, sex, marital status and number of children. Employment status, occupation, referred by, date of admission, number of admissions and initial impressions, e.g., emotional functioning.

DRINKING HISTORY SUMMARIZED BY SOCIAL HISTORY: This would include alcohol and drug history and how it has affected his/her life, family job, health, etc., and would lead to a diagnostic impression.

PREVIOUS TREATMENT: This would include AA involvement, medical and psychiatric.

DIAGNOSTIC IMPRESSIONS: Specific to alcoholism and other specific diagnostic impressions to include medical evaluation, social history and evaluation, psychological evaluation and initial impressions.

REHABILITATION PLAN AND PROGRESS SUMMARY: This section would include a summary of the treatment plan which included the presenting problems and strengths, change objectives, and primary treatment objectives. The progress made and a record of patient's involvement in treatment is included, e.g., attendance at groups, lecture series, AA meetings, involvement of significant others, and other signs of change or motivation seen during treatment.

PROGNOSIS: This includes the most immediate plans upon discharge.

AFTERCARE PLAN SUMMARY: Summarize the plan contracted for upon discharge.

Date:_____ Counselor Signature:_____

Revised 6-11-79

APPENDIX D

Letter of Permission from the Mahoning County Committee on Alcoholism Program, Inc.

Mahoning County Committee On Alcoholism Programs, Inc.

"Donofrio Homes"
1161 McGUFFEY ROAD
YOUNGSTOWN, OHIO 44505

Telephone: 216/747-2614

STEPHENS, President
JONES, 1st Vice-President
MOTHY O'NEILL, 2nd Vice-President
ANKHAUSER, Secretary
AYNE, Treasurer

C. ERNEST RANSHAW
Executive Director

June 26, 1980

TO WHOM IT MAY CONCERN:

The unit of analysis in the proposed study is existing client files. No individual is submitted to any form of experimental manipulation and, after reviewing the Human Subjects Regulations and Procedures (1975), it can be concluded that permission to use existing data is needed from the Executive Director of Mahoning County Committee on Alcoholism Programs, Inc. "Donofrio Homes" Program, who is legally responsible for the institutional records.

To that extent, permission is granted to Stevan Szpytko, to gather existing data to be submitted in partial fulfillment of the requirements for the degree of Master of Science in the Criminal Justice Program at Youngstown State University under the supervision of Dr. Joseph Waldron.

Sincerely,

C Ernest Ranshaw

C. Ernest Ranshaw
Executive Director

APPENDIX E

Letter of Permission from the Mahoning County Diagnostic and Evaluation Clinic

Mahoning County Committee On Alcoholism Programs, Inc.

"Donofrio Homes"
1161 McGUFFEY ROAD
YOUNGSTOWN, OHIO 44505

Telephone: 216/747-2614

C. ERNEST RANSHAW
Executive Director

STEPHENS, President
ONES, 1st Vice-President
IOTHY O'NEILL, 2nd Vice-President
NKHAUSER, Secretary
YNE, Treasurer

June 26, 1980

TO WHOM IT MAY CONCERN:

The unit of analysis in the proposed study is existing client files. No individual is submitted to any form of experimental manipulation and, after reviewing the Human Subjects Regulations and Procedures (1975), it can be concluded that permission to use existing data is needed from the Executive Director of Mahoning County Diagnostic and Evaluation Clinic, who is legally responsible for the institutional records.

To that extent, permission is granted to Stevan Szpytko, to gather existing data to be sumbitted in partial fulfillment of the requirements for the degree of Master of Science in the Criminal Justice Program at Youngstown State University under the supervision of Dr. Joseph Waldron.

Sincerely,

Gregory Cvetkovic

Gregory Cvetkovic, M.A.
Executive Director

APPENDIX F

Doppelt Form of Wechsler Adult Intelligence Scale Test

DOPPELT FORM OF WECHSLER ADULT INTELLIGENCE SCALE TEST

Wechsler describes the WAIS in the following manner:

The WAIS consists of eleven tests. Six of these are grouped into the Verbal Scale; the remaining five comprise the Performance Scale; all eleven tests are combined to make the Full Scale.

VERBAL TESTS	PERFORMANCE TESTS
Information	Digit Symbol
Comprhension	Picture Completion
Arithmatic	Block Design
Similarities	Picture Arrangement
Digit Span	Object Assembly
Vocabulary	

In general, the tests which comprise the Verbal Scale are more closely related to each other than they are to the Performance Scale, and vice versa. The abilities measured by the tests are complex, and practitioners will often find other groupings and classifications are meaningful for specific applications.

The Doppelt estimates the full scale I.Q. on the WAIS from scores on four subtests. The subtests are arithmatic, vocabulary, block design, and, picture arrangement. [101]

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[101] D. Wechsler, Wechsler Adult Intelligence Scale Manual (New York: Psychological Corporation, 1955), p. 8.

APPENDIX G

Minnesota Multiphasic Personality Inventory

Description of Scales

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY

DESCRIPTION OF SCALES

Carson describes the MMPI scales in the following manner:

The L Scale

The L scale consists of 15 items selected on the basis on "face" validity to identify persons who attempt to given an orderly perfectionistic view of themselves. The items refer to attitudes and practices which have a very positive valence culturally but which are actually found-if they occur at all-only in the most conscientious persons. Item example: "I do not read every editorial in the newspaper every day" (scorable F).

A raw score of 5 or more is suggestive of excessive rigidity, if not of conscious deception, if it cannot be explained on the basis of occupation (e.g., clergy) or naivete' associated with a culturally limited background. In the general population, scores above 6 occur with persons who, for one reason or another, have pathologically intense needs to present a good front; it is interesting that high scores have been found actually to predict underachievement. The scale often does not detect deception in sophisticated individuals; and, in fact, a high score in an individual of mature background may be associated with judgment deficiencies and should be further investigated in this light.

The F Scale

The F scale consists of 64 items that were answered almost always in the same direction by the normal standardization group.

Content varies widely. Item examples: "Everything tastes the same" (T), "I believe in law enforcement" (F). T scores above 80 suggest the following possibilities: (1) error by the examiner in scoring the test; (2) failure of the patient to understand the items; (3) lack of cooperation, the patient having purposely responded in a random and haphazard fashion; (4) distortion due to confusion, delusional thinking, or other psychotic processes; or (5) distortion due to the wish to put oneself in a bad light or falsely to claim mental symptoms.

With the T score above 80, the examiner should entertain the hypothesis that he has an invalid profile and should attempt to check this out by considering the characteristics of the remainder of the profile and (with the booklet form) the patient's responses to repeated items from the standpoint of intratest consistency. T scores in the range of 65 to 80 are indicative of unusual or markedly unconventional thinking and frequently appear in sullen, rebellious personalities of the schizoid, antisocial, or "Bohemian" type. Young people struggling with problems of identity and the need to define themselves by exhibiting nonconformity (the beard and sandals set) frequently score in this range of F. The profile in such cases is usually a valid one. Occasionally individuals who are intensely anxious and pleading for help may get F scores somewhat about 80 that are bona fide and do not represent psychotic distortions; in such cases the profile will be markedly elevated but interpretable. F appears to be positively correlated with severity of illness in a clinic population. Individuals having moderately elevated F scores are likely to be described as moody, changeable, dissatisfied, opinionated, talkative, restless and unstable. Low scorers are often described as sincere, calm, dependable, honest, simple, conventional, moderate, and as having narrow interests.

The K Scale

The K scale consists of items selected on the basis of their ability to identify "false negative" cases; there are 30 items, of which 24 have been found to be highly correlated with Edwards' Social Desirability factor. The scale in its present form is the product of long efforts to devise empirically a scale to measure guardedness or defensiveness in test-taking attitude. In this sense, K is seen as a "suppressor variable." It measures approximately what L was intended to measure, but it does so in a much more subtle and effective manner. K is used as a correction factor for some of the clinical scales. Item example: "Often I can't understand why I have been cross or grouchy" (F).

High K scores are people who cannot tolerate any suggestion that they are insecure, that they have difficulties in social relations, or that they may not have their lives well ordered and controlled. They are intolerant and unaccepting of unconventional or nonconformist behavior in others. Markedly concerned about their own social stimulus value, they are nevertheless relatively without insight concerning their effect upon others. In a clinical situation, they show much hesitance and a great desire to ensure confidence and approval. Moderate elevations on K are found in people described as enterprising, ingenious, resourceful, sociable, reasonable, enthusiastic, and as having wide interests. Some elevation is seen as desirable prognostically (T = 55 to 65), and successfully treated patients appear to show some rise on K; in this high average range it suggests adaptiveness and the availability of ego resources. High K is associated with low expectancy of delinquency in adolescents, especially females. Generally speaking, prognosis tends to be poor

with extreme scores in either direction. A low K is usually accompanied by caustic manners, suspicion of the motivations of others, and exaggeration of the ills of the world. Low K scorers have been described as awkward, cautious, peaceable, high strung, cynical, dissatisfied, and individualistic. In terms of the K correction on other scales, one should be aware that the patient who gets an elevation on scale 8 by virtue of his having a high K is not the same kind of person as the one who gets a high 8 by claiming or admitting 8-type problems and symptoms.

Scale 1 (Hs)

This scale contains 33 items of a fairly obvious nature having to do in the main with bodily function and malfunction. The complaint items tend to be vague and nonspecific. Although scale 1 rises slightly with physical disease, it is mainly a "character" scale, and physically ill patients generally score higher on scale 2. Scale 1 is a gross index of something related to optimism-pessimism. High scorers are sour on life, whiny, complaining, and generally handle their hostile feelings by making those around them miserable. Frequently they use somatic complaints to control others. They tend to be cynical and defeatist, especially as reguards others' efforts to help them. They are highly skilled in frustrating and infuriating physicians, of whom they often engage a great number in succession. Elevation is associated with poor progress in psychotherapy. Even persons having moderate elevations on scale 1 tend to be seen as unambitious, lacking in drive, stubborn, and narcissistically egocentric; they appear readily to develop a paranoid posture when pressured. In contrast, persons scoring low on scale 1 are described as alert, capable, and responsible. Effectiveness in living is suggested by a low 1.

Scale 2 (D)

Scale 2 consists of 60 items relating to matters such as worry, discouragement, self-esteem, and general outlook. Scale 2 is the most frequent peak in the profiles of psychiatric patients. It tends to be fairly unstable, being highly sensitive to mood changes, and its meaning tends to vary depending upon the characteristics of the remainder of the profile. In general, it is the best single -and a remarkable efficient- index of immediate satisfaction, comfort, and security; it tells something of how the individual evaluates himself and his role in the world. High 2 people tend to be silent and retiring, perhaps withdrawn, and are seen by others as aloof, evasive, timid, and more or less inhibited. Low 2 people are active, alert, cheerful, and outgoing and are likely to be seen by others as enthusiastic, self-seeking, and perhaps given to self-display. Occasionally, one sees a profile in which 2 is the only elevated scale. Usually this will be a so-called reactive depression, even when the person may deny depressive feelings; particular attention should be given to a cautious evaluation of the suicidal risk.

Scale 3 (Hy)

Scale three consists of 60 items, most of which fall into two general types: (1) rather specific somatic complaints and (2) items that deny any emotional or interpersonal difficulty. In normal subjects these two clusters show no tendency to occur together; in persons organized around hysteric operations, they seem to be closely associated. High 3 people are very likely to be extremely naive and self-centered in outlook. They are very demanding of affection and support and endeavor to get these by indirect but obtrusively manipulative means. Often they are highly visible and rather uninhibited in

social relations; but such relations are carried on at superficial, immature level. Some high 3 people act out sexually and aggressively in blatant fashion with convenient and often incredible inattention to what they are doing. They are, on the whole, people blandly without insight. Because they have strong needs to be liked, their initial response to treatment is apt to be enthusiastic. Sooner or later, however, they become intolerant of the inevitable challenges to their defenses, frequently make impossible demands on the therapist, and become generally resistive, often complaining that they are being mistreated, that the therapist does not understand them, etc. The person with an elevated 3 is unlikely to be seen as psychotic, regardless of what shows on other scales; the examiner should, therefore, be very wary about diagnosing psychosis when 3 is clearly elevated. Little of a reliable nature is known about low 3 people, but many of them seem to be socially isolated, cynical and generally misanthropic.

Scale 4 (Pd)

The 50 items in this scale deal in the main with general social maladjustment and absence of strongly pleasant experience. These include complaints against family, feelings of having been victimized, boredom, and feelings of alienation from the group--of not being in on things. High 4 people are generally characterized by angry disidentification with recognized conventions; their revolt may be against family or society or both. Many high 4s exhibit an apparent inability to plan ahead, if not a reckless disregard of the consequences of their actions, and unpredictability is a feature of their behavior. Usually social relationships are shallow; the individual rarely develops strong

loyalties of any kind. These people sometimes make a good impression at first, but on a longer acquaintance their essential unreliability, moodiness, and resentment become apparent. They may justify their disregard of convention on the basis of being "above" mere propriety, reflecting the high value many of them place on themselves. High 4 is associated with inability to profit from experience, including psychotherapy; in adolescent delinquents with 4 peaks, therapy appears to be less effective in producing changes than does increasing age. Low scorers on 4 tend to be conventional, rigid, and overidentified with social status; frequently they manifest very low levels of heterosexual aggressiveness.

Scale 5 (Mf)

Scale 5 contains 60 items having to do with interests, vocational choices, aesthetic preferences, and an activity-passivity dimension. The same scale is used for both sexes and is merely scored in the opposite direction for females. It was originally intended to measure masculinity-femininity but is far from being a pure measure of this dimension; it is, for example, definitely correlated with education and intelligence, and interpretative statements should take this correlation into account. An elevation on scale 5 is never in itself sufficient reason to diagnose homosexuality, overt or "latent". Moreover, homosexuals who wish to conceal their inversion appear able to do so with relative ease insofar as this scale is concerned.

In general, scale 5 is a measure of sophistication and aesthetic interest. Clear elevations are suggestive of nonidentification with the culturally prescribed masculine or feminine role. For males, high scorers tend to be relatively passive individuals; some are definitely

effeminate in manner. These men are seen as imaginative and sensitive and tend to have a wide range of interests. Low 5 males are easygoing, adventurous, perhaps somewhat "coarse." In some low 5 scorers, there is an element of compulsive masculinity; the individual's efforts to appear masculine seem overdone and inflexible, often taken the form of exhibitionistic display of physical strength and endurance. Not surprisingly, if such people enter treatment they are usually found to have very disturbing questions concerning their own identity and maleness.

For females, high scorers tend in general to be aggressive, dominating, and competitive; they are found in large numbers in activities and occupations that are traditionally male. These women are typically confident, spontaneous, and somewhat uninhibited in those areas of living in which heterosexual implications are absent; they become anxious in situations in which they are expected to adopt a feminine sexual role. Their interests tend toward the mechanical and scientific. Some elevation of Mf may be considered normal in girls in their middle to late teens and in women from atypical cultural backgrounds. Low 5 females are passive, submissive, yielding, and demure--sometimes to the point to representing living caricatures of the feminine stereotype. Women who achieve extremely low T scores are usually highly constricted, self-pitying, and faultfinding; they seem unable to tolerate pleasant experiences.

Scale 6 (Pa)

Scale 6 consists of 40 items that tap such processes as sensitivity, being easily hurt, moral virtue, rationality, denial of suspiciousness, and complaints about others' shortcomings. This is one of the proper MMPI scales, at least from the viewpoint of performing its intended function of detecting paranoid thinking. Many people

who are clinically extremely paranoid show no elevations at all. It is true, however, that persons who do get definite elevations on scale 6 can nearly always be demonstrated to have paranoid ideation, if not frank delusions. To a lesser extent this is also true of persons who get extremely low scores on scale 6. The latter apparently are identified by virtue of being too cautious in what they say about themselves. Moderate elevation on 6 (T = 60 to 70) suggests an individual who adopts an intropunitive role outwardly but who expresses hostility by "arranging" events in which others are victimized (the "What did I do wrong?" syndrome). In general, high 6 scorers tend to be suspicious and brooding, to harbor grudges, and usually to feel that in some way, they are not getting what is coming to them. In treatment, they are rigid and rationalistically argumentative. With an elevated 6 it is frequently useful to look at the person's responses to individuals items in the scale to differentiate between general characterological paranoia and the presence of clearly delusional thinking. Low 6 scorers tend to be stubborn and evasive, often feeling that dire consequences will follow upon their revealing themselves in any way. There may be, then, little essential difference between high and low scorers on 6; this, of course, leaves unexplained why they differ in their responses to the items in this particular scale.

Scale 7 (Pt)

Scale 7 consists of 48 items relating to anxiety symptoms, inability to resist, irrational fears, and self-devaluation. This scale is a general measure of anxiety and ruminative self-doubt. High scorers tend to be obsessionally worried, tense, indecisive, and unable to concentrate. Low scorers are usually relaxed, self-confident, and secure. Individuals having marked elevations on this scale almost always exhibit

extreme obsessionalism, but this must be differentiated from the so-called compulsive defense system. Many rigidly compulsive people show no elevation at all, presumably because their rigid organization wards off any feelings of insecurity, concern about their own worth, etc.

Scale 8 (Sc)

Scale 8 contains 78 items dealing with social alienation, isolation, complaints of family alienation, bizarre feelings, influence of external agents, peculiar bodily dysfunction, and general dissatisfaction. The examiner should be wary of an understandable tendency to interpret scale 8 too narrowly. It was developed on schizophrenic individuals, and it is extremely valuable in the diagnosis of schizophrenic illness. It is necessary to point out, however, that a limited conception of this important scale will needlessly restrict its range of usefulness and encourage a disregard of available and potentially very enlightening information.

High scorers on 8 almost always feel alienated, misunderstood, and peculiarly not a part of the general social environment. They have fundamental and disturbing questions about their own identity and worth. They are somehow confused about how one goes about the business of being a socialized human being; many of these persons feel that they are hopelessly lacking something fundamental which is the key to successful relations with others. Among high 8s there are many painfully withdrawn people who have little or nothing in the way of social relationships and who occupy themselves excessively with private autistic fantasy. Even with moderate elevations there is usually some difficulty in thinking and communication. These people seem to be in contact and seem to be talking sense, but one is vaguely aware that he is really not understanding very well what it is they are saying; they appear

habitually to avoid making unequivocal statements. A high score on 8 makes the prognosis for short-term psychotherapy relatively poor. It should be noted that patients who are clinically most schizophrenic get T scores in the 80 to 90 range. Agitated neurotics, prepsychotics, and so-called pseudoneurotic schizophrenics score highest on 8.

Scale 9 (Ma)

Scale 9 contains 46 items having to do generally with expansiveness, egotism, and irritability. High scores are warm, enthusiastic, expansive, generally outgoing, and uninhibited. They tend to become easily offended, however, and may be seen as tense and hyperactive. Many of these people have an unusual capacity for sustained activity and effort. T scores in the range of 60 to 70 suggest a pleasant outgoing temperment. Above this, there is increasing likelihood of maladaptive hyperactivity, irritability, and insufficient inhibitory capacity. Low scorers often exhibit listlessness, apathy, and lack of drive; almost always they are people lacking in self-confidence and a normal degree of optimism regarding the future. A very low score on 9 suggests serious depression even when scale 2 is not markedly elevated.

Scale 0 (Si)

This is one of the "additional" MMPI scales. Its development was somewhat different from that of the other scales of the standard clinical profile in that the criterion instrument did not involve a psychiatric syndrome. The items deal mainly with social participation. This scale provides a fairly gross, but sometimes quite useful, index of comfort in interpersonal relationships. High scorers tend to be withdrawn, aloof, and anxious in contact with people. Scores above 70

will on rare occasions identify a schizoid factor in well-controlled, socialized psychotic personalities when this is missed by other scales. Low scorers on 0 are sociable, warm people. Extremely low scores suggest a certain flightiness and superficiality of relationships; these hail-fellow-well-met individuals have well-developed social techniques and very many social contacts, but they do not establish relationships of real intimacy.[102]

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[102]R. C. Carson, "Interpretive manual to the MMPI," in MMPI Research Developments and Clinical Applications, ed. J. N. Butcher (New York: McGraw-Hill, 1969), pp. 150-168.

APPENDIX H

Data Sheet

DATA SHEET

99=Unknown

Subject			01-03
ARP	Arrested in 6 mo. post therapy Y=1, N=2	___	04-04
SAD	Satisfactory Discharge Y=1, N=2	___	05-05
NDT	# times drunk 6 mo. post	___	06-07
NDP	# times drunk arrest pretherapy	___	08-09
NDA	Other arrests	___	10-11
PND	# drunk arrest 6 mo. post therapy	___	12-13
PNO	Other arrests	___	14-15
NMA	# times married	___	16-17
NCH	Children Y=1, N=2	___	18-18
CRF	Currently employed prior to treatment Y=1, N=2	___	19-19
PRS	Probation status on admission prob=1, NP=2	___	20-20
RPA	Previous alcoholism treatment Y=1, N=2	___	21-21
AGE	Age	___	22-23
RAC	Race B=1, W=2, SA=3, O=4	___	24-24
MTA	Mother alcoholic or drug addict Y=1, N=2	___	25-25
FTA	Father alcoholic or drug addict Y=1, N=2	___	26-26
SIB	Siblings Y=1, N=2	___	27-27
NSC	# of years school completed	___	28-29
AGO	Age started drinking	___	30-31
EBL	Experienced blackouts Y=1, N=2	___	32-32
EDV	Overdose Y=1, N=2	___	33-33
ABA	Abuse of amphetamines Y=1, N=2	___	34-34
ABB	Abuse of barbituates Y=1, N=2	___	35-35
ABN	Abuse of narcotics Y=1, N=2	___	36-36
ACH	Abuse of alcohol Y=1, N=2	___	37-37
WAIS (Stand)			
WAR	Arithmetic	___	38-39
WVO	Vocabulary	___	40-41
WBL	Block design	___	42-43
WPI	Picture arrangement	___	44-45
WIQ	Intelligence Quotient	___	46-48

Data Sheet, Continued

MMPI t Scores

MPL	Lie	____ ____	49-50
MPF	Fake	____ ____	51-52
MPK	Correction	____ ____	53-54
MP1	Hypochondriac	____ ____	55-56
MP2	Depression	____ ____	57-58
MP3	Hysteria	____ ____	59-60
MP4	Psychopathic Deviancy	____ ____	61-62
MP5	Masculinity/Femininity	____ ____	63-64
MP6	Paranoia	____ ____	65-66
MP7	Psychastenia	____ ____	67-68
MP8	Schizophrenia	____ ____	69-70
MP9	Mania	____ ____	71-72
MP0	Social Introversion	____ ____	73-74

APPENDIX I

Admission Form

MAHONING COUNTY COMMITTEE ON ALCOHOLISM PROGRAMS, INC.

(ALCOHOLIC REHABILITATION HOMES)

ADMISSION FORM

Resident Day Resident

Address: (Circle One) Date of Application:

Name of Applicant Date of Birth:

Address (Street, City, State, Zip Code): County of Residence

Next of Kin: Social Security Number:

Address: Phone Number:

TO THE DIRECTOR OF SAID HOME:

In accordance with the provisions of the Revised Code of Ohio, application is hereby made for the voluntary admission of the above named person, hereinafter designated as the patient, to the aforesaid home for such necessary care, treatment or surgery that may be necessary in promoting the recovery of the said resident:

1. That said resident will obey all rules and reulations of said home.
2. That said resident will leave the home on the request of the Director of the home if said applicant requires different care of treatment than that afforded by said home.
3. That by making this application, said resident and the person, if any, who makes the application in said resident's behalf, give consent to said home to administer such form of treatment to said resident as may be deemed necessary by the direction of the home to promote said resident's recovery.

NO APPLICANT SHALL BE DENIED SERVICES ON THE BASIS OF SEX, RACE, COLOR, CREED, OR NATIONAL ORIGIN.

ADMITTED BY: _____ SIGNED: _____
RESIDENT

_____ BY: _____
(PARENT, GUARDIAN, OR CUST
DION)

If resident is under eighteen years of age, this application must be signed by a parent or guardian of the person having the legal custody of

said minor. If the resident is an adult incompetent, the application must be signed by his guardian or by the person having custody.

INTERVIEWER: _____
REFERRED BY: _____ RELATIONSHIP _____
ADDRESS: _____ PHONE: _____
AGE _____ SEX _____ ETHNIC GROUP: Anglo ___ S.A. ___ Negro ___ Indian ____
JOB STATUS: _____
OCCUPATION: _____
EMPLOYER: _____ BS. PHONE _____
MARRIED: ____ SINGLE ____ DIVORCED ____ SEPARATED ____ WIDOWED ____
NAME OF SPOUSE: _____
NO. AND AGES OF CHILDREN: _____
EARNING LEVEL (Previous 12 months): _____
EDUCATION: _____
MILITARY SERVICE: _____
RELIGION: _____
FAMILY PHYSICIAN: _____ PHONE: _____
OTHER PERTINENT HEALTH INFORMATION: _____

ALCOHOL HISTORY: Age alcohol first used ____, Number of years alcohol used ____
Age at which alcohol became a problem _____. What occurred at that time _____
_____
Date alcohol last ingested _____ How long and how much did resident drink in last episode _____. Blackouts _____
Loss of Control _____, Personality Change _____
DT's _____, Tremors/Shakes _____, Convulsions _____
Hallucinations Audio _____, Visual _____, Tactial _____
Areas of life affected by drinking: Marriage ____ Job ____ Health ____
Financial _____ Legal _____

DRUG HISTORY: Current drugs most frequently used _____
_____
Drugs used in the past (age and length of time used) _____
_____
OD _____ Hallucinations: Visual _____ Audio _____ Tactial _____
Blackouts _____ Other withdrawl symptoms _____
Areas of life affected by drug use: Marriage _____ Job _____
Health _____ Financial _____ Legal _____

ADDITIONAL INFORMATION:

HOSPITALIZATIONS AND TREATMENT FOR ADDICTION: _____
_____
OTHER SERVICE AGENCIES USED: _____
_____
COUNSELOR'S SUMMARY:

APPENDIX J

Psychosocial Data Sheet

MAHONING COUNTY COMMITTEE ON ALCOHOLISM PROGRAMS, INC.

PSYCHO-SOCIAL DATA SHEET

Name_____ Age_____ Birth date_____Birth place_____

FAMILY ORIGIN

Mother - Living_____Age _____ Deceased ___ Age at Death ____Date of D

Alcohol or Drug Problem _____
Illnesses _____ Nationality_____
Cause of Death _____ Occupation _____
Relationship with resident _____
_____

Father - Living_____Age_____ Deceased____ Age at Death____ Date of De

Alcohol or Drug Problem _____
Illnesses _____ Nationality_____
Cause of Death _____ Occupation_____
Relationship with resident _____
_____

Relationship between parents _____
_____

Religious Affiliation _____
Siblings (order of birth, age, sex) _____
_____

Resident's relationship with siblings _____
_____

Problems _____
_____

EDUCATION

Age of entry_____ type of School - Public____ Private____ Parochial_____

Extent of schooling_____
Problems _____
_____
_____

MILITARY HISTORY

Branch _____Date of entry_____Date of discharge _____

Type of discharge _____Rank at discharge_____
Problems_____
_____

MARITAL HISTORY

No. of times married____ Date of most recent marriage____ W ___ Sep____ D __
Age of resident when married___ Age of spouse when married _____
Previous marriabe of spouse _____
Age and sex of children _____ this marriage _____previous_____
other _____

Status of present marriage _____
Problems _____

EMPLOYMENT

Occupation _____ Currently employed: yes ____ no _____
Employer _____ Address _____
Length of employment _____ Major source of income _____
Family income _____
Status of present employment _____
_____
Problems _____
_____
Hobbies _____

LEGAL STATUS

Legal action pending _____ Probation/Parole Status _____
Probation/Parole Officer_____
Lifetime arrests _____Charge _____No. _____ Disposition _____
_____ _____
_____ _____
_____ _____

PRIOR TREATMENT

Prior treatment for alcoholism or other drug addition _____
_____
_____
Previous A.A. involvement _____
_____
A.A. contact or sponsor _____
Spouse's previous Alanon involvement _____

Problem and Strength areas identified in Psycho-Social history:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

_____
Counselor's Signature

_____
Date