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Personality Deterioration of Relapsed Alcoholics Employing the MMPI: an Exploratory Study

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Chapter One

> First the man takes a drink, then the drink takes a drink, and then the drink takes the man. ---Japanese Proverb

Introduction

Alcoholism has come to be regarded as a major health problem in the United States today. Industry is faced with an estimated $25 billion financial annual drain because of alcohol-related incidents, such as absenteeism, accidents, crime, and health care. There are an estimated 10 million alcoholics in the country, whose behavior affects another 40- to 60-million people daily. Alcoholics live a shorter life span: approximately 12 years shorter than nonalcoholics. In part, this is a result of the tragic figures on alcohol-related automobile accidents, which amount to half of the fatal and major injuries. Alcoholism has, indeed, tragic consequences; yet, ironically, people seem determined to catch this illness. Two hundred thousand additional cases per year indicate alcoholism is on the rise. These facts and figures are from Alcohol and Health, Morris Chafetz, ed., 1974.

Substantial efforts have been made at both private and governmental levels to alert the public to the signs

of alcoholism. Early warning signs include frequent desire, increased consumption, extreme behavior while under the influence, blackouts, and morning drinking (Coleman, 1976, p. 421). Hopefully, this recent imparting of information is being heeded by the public.

Vern Johnson, in his book I'll Quit Tomorrow (1973), posited the nature of the illness:

> When you demythologize it (alcoholism), you find this disease is an entity as distinct as measles. Alcoholism has a describable, predictable pattern of pathology. It is primary in the sense that it effectively blocks any cure or treatment we might want to deliver to any other problem; if an alcoholic has a diseased liver, which he frequently does, the doctor cannot do anything about the liver until the alcoholism is brought under control. Our observation of the illness leads us to believe that it is always progressive. It never plateaus. It always worsens. (p. 2)

From Dr. M.M. Glatt's famous chart of addiction and recovery, the pattern of alcoholism is illuminated. With cessation of alcohol ingestion (abstinence), the alcoholic begins recovery and eventually an "enlightened and interesting way of life opens up" (Catanzaro, 1968, p. 193).

Traditionally, the main tenet for recovery from this devastating illness has been abstinence. Alcoholics Anonymous, a remarkable organization, has opened the doors of recovery to thousands of alcoholics. The basic text for Alcoholics Anonymous is the Big Book (1976), and from this volume came the warning:

> We have seen the truth demonstrated again and again: "Once an alcoholic, always an alcoholic". Commencing to drink after a period of sobriety, we are in a short time as bad as ever. If we are planning to stop drinking, there must be no reservation of any kind, nor any lurking notion that someday we will be immune to alcohol. (p. 33)

This position has been disputed in recent years in theory and in research. In 1962, D.L. Davies reported the follow-up results of 93 treated alcohol addicts. "He noted that 7 of 93 ... former 'alcohol addicts', followed up 7 to 11 years after discharge from treatment, were found to have been drinking 'normally' for the better part of those years" (Pattison, Sobel & Sobel, 1977, p. 124). As a result of this modest statement, a new perspective on alcoholism emerged. Abstinence was no longer the major goal of some theorists and researchers, rather "controlled social drinking" for alcoholics.

Steiner (1969) stated that if the psychological games are ended and after a one-year period of abstinence and therapy, an alcoholic can, indeed, partake of alcohol socially (p. 938). The Rand Report (1977) again reiterates that alcoholics, if "cured", can return to social drinking if they so choose. When the Rand Report was presented, it seemed to create shock waves within those institutions where abstinence was sought. Yet the report was only one of many studies since 1962 presenting an alternative to abstinence.

One detail apparently has been overlooked: that of

etiology. Since no one theory has provided a satisfactory and comprehensive explanation, it was virtually impossible to define a "cure" at this time. Generally, it is agreed that alcoholism is a multifaceted illness composed of physical, psychological, and cultural components (Milam, 1970; Bacon, 1973; Clinebell, 1956).

Statement of the Problem

It was the purpose of this research to compare the psychological profiles of diagnosed alcoholics upon first admission with profiles of these same persons after readmission. An attempt was then made to characterize some specific features of personality deterioration associated with a relapse of the illness.

Hypothesis

With a return to drinking after a period of abstinence, the personality profiles, as measured by the Minnesota Multiphasic Personality Inventory of diagnosed alcoholics, will show a significant difference when compared with their previous profiles.

Need for the Study

There are two schools of thought concerning alcoholism and recovery thereof. Pattison, Sobel & Sobel and others seemed to represent those who were not positive alcoholism was progressive; and consequently, they indicated social drinking might be resumed under certain

circumstances by alcoholics. For the purposes of this study, hereafter, this school of thought was termed non-traditionalist.

Others in the field, such as Milam, Fox, Mann, and Jellenik, stated alcoholism was progressive and accordingly abstinence was the only viable method for recovery. For the purposes of this study, hereafter, this school of thought was termed traditionalist.

This research study was undertaken with the intent to verify progressive personality deterioration and therefore support the traditionalists or to refute them if personality deterioration was not identified.

Method

All first admissions to the Heartview Foundation are administered a battery of psychological tests in addition to physical examinations and counseling interviews. The psychological battery is composed of the Minnesota Multiphasic Personality Inventory, the Bender-Gestalt, the Shipley Test, the Edwards Personal Preference Schedule, and the Draw-A-Person Test. If a person is readmitted, that person is readministered the battery provided six months or more has elapsed between admissions.

For this study, the 10 clinical scales of the MMPI were the basis of the personality comparison, as well as the three validity scales: L, F, and K. The 10 clinical scales are: (1) hypochondriasis, (2) depression, (3)

hysteria, (4) psychopathic deviation, (5) masculinity-femininity, (6) paranoia, (7) psychasthenia, (8) schizophrenia, (9) mania, and (0) social introversion. Previous research has shown that alcoholics have an elevated clinical scale (2) and (4) on pretreatment profiles (Rohan, 1972, p. 66).

Limitations

The sample was drawn from the male patient population of the Heartview Foundation, Mandan, North Dakota. The Heartview Foundation is a therapeutic community designed for the treatment of alcoholism and drug addiction. The average patient population is 60 members, for an average treatment stay of 49 days. The Foundation is private and nonprofit. Patients may not reflect a representative sample of the United States' alcoholic population.

Definitions

1. Abstinence. The term referred to refraining from consumption of the beverage alcohol.

2. Alcoholism. American Medical Association's definition offered these statements: Alcoholism is a) a disease, b) a compulsive drinking of alcohol, c) an addiction, and d) drinking of alcohol produces continuing or repeated problems in the patient's life.

Alcoholism was also defined as "primary, progressively pathological, constitutional reaction to alcohol ingestion; psychosocial symptoms are secondary, derivative,

and progressive regardless of premorbid psychosocial antecedents" (Milam, 1970, p. 3).

3. Blackout. The term referred to a state of amnesia induced by alcohol ingestion. Generally, a blackout is considered a symptom of alcoholism (Mann, 1958, p. 26).

4. Chronic intoxication. A state in which an individual has been intoxicated for longer than six months.

5. Craving. The process that determines a drink of alcohol to be the answer for relief or pleasure. Craving does not necessarily lead to drinking.

6. Cured. The term is used by some for when an alcoholic has regained the ability to drink socially (Steiner, 1969, p. 938). Others contended that there is not a cure, only recovery involving abstinence.

7. Dependence. A term that is disputed in the literature. There seems to be psychological and/or physical dependence, depending on the mood-altering drug employed. (See Kissin, 1977, Chap. One, for an in-depth explanation.)

8. Dry. A term which means the alcoholic is abstaining, however has not experienced a personality change so that the individual is happy or content in being abstinent.

9. Intoxication. The term refers to the altered state of consciousness, the temporary impairment of motor coordination, and the extreme lability of a person as

the result of alcohol ingestion. An old description of the pattern is "verbose, jocose, lachrymose, bellicose, and comatose" (Rosenbaum and Beebe, 1975, p. 127).

10. Loss of control. The inability to regulate alcohol consumption. (See Ludwig and Wikler, 1974, pp. 108-129.)

11. Pass out. The condition when sleep or unconsciousness overcomes the drinker during a bout.

12. Problem drinking. The term refers to the repetitive use of the beverage alcohol causing physical, psychological, or social harm to the drinker or to others. Recent thought in the field contends this term may be less stygmatizing and more relevant than the term alcoholism (Rosenbaum and Beebe, 1975, p. 116).

13. Recidivist. The chronic alcoholic who "revolves through the door" of various social agencies.

14. Relapse. A return to drinking after a period of abstinence by an alcoholic; this phraseology is consistent with the disease concept of alcoholism.

15. Sober. The alcoholic who willingly chooses abstinence. A change in behavior and personality has made this willingness possible.

16. Social drinking. The term refers to the drinking practices of nonalcoholics. Social drinkers rarely suffer from disasterous consequences of their drinking (Mann, 1958, p. 78). Drinking to be social is not considered to be social drinking (NIAAA).

Chapter Two

> Keller's Law: The investigation of any trait in alcoholics will show that they have either more or less of it. (Keller, 1972, p. 1147)

A review of the literature on alcoholism suggested that the constructs progression, loss of control, craving, and relapse were controversial, as they were repeatedly referred to in the literature. Researchers such as Pattison, Paredes, Sobel, and Sobel have seemingly focused more on loss of control and craving than on progression and relapse. These researchers appeared to nullify these latter constructs employing empirical research and were considered, for the purpose of this study, nontraditionalists. On the other hand, researchers such as Jellenik, Mann, Kissin, and Milam focused on all four constructs, in particular progression, employing empirical research as well as clinical observation. For the purpose of this study, this latter group was termed traditionalists. This review of the literature explained these constructs and where possible presented both the traditional and nontraditional arguments.

Progression

Progression is one of the key descriptors of the illness alcoholism. Generally, the topic is handled in an ominous tone in educational films or reading material. Films like "The Secret Love of Sandra Blaine" (1971)

begin with a happy housewife and mother, then move toward a grim scene of a bedraggled, comatose victim of alcoholism clutching a half-empty wine bottle. This phenomenon has been demonstrated repeatedly by case study. The Alcoholics Anonymous' Big Book (1976) shared with the reader the spiraling troubles of 43 people who suffered the ravages of alcoholism. However, these people recovered through abstinence to share their story. The Christopher D. Smithers Foundation (1976) again warned the reading public of alcoholism's methodical progression in the publication Experimentation: the Fallacy of 'Controlled' Drinking; where Alcoholism Exists.

Even if the illness is arrested, the threat of progression still existed:

> There is a theory that seems to be validated in clinical experience that even while the alcoholic is apparently recovering with sobriety in all areas of his life, the illness in some mysterious way continues to progress during the years of his sobriety. This means that if he has ten years of sobriety and then starts drinking again, he will begin not where he left off in the progression, but in a short time will be where he would have been had he continued drinking during that ten-year period. (Keller, 1966, pp. 33-34)

Supposedly, an abstaining alcoholic would have been gaining over the years living skills, physical health, emotional stability, and other bulwarks to prevent a collapse of the system; yet the quote suggested that the progressive nature of alcoholism was some force immune to such efforts. To date, this writer has not found

research evidence to support the theory.

Progression in the active illness has a definable course, contended the traditionalists. Generally, it was classified under three symptom categories: early, middle, and late (Mann, 1968, p. 19). Mann noted that this describable course is based on the recollections of recovered alcoholics. It may be she referred to E.M. Jellenik's work. (Though Jellenik offered a different schema: pre-alcoholic phase, early alcoholic phase, the crucial phase, and the chronic phase [Catanzaro, 1968, p. 20-23].) Jellenik, in the mid-1940's, mailed an open-ended questionnaire to 1,600 A.A. members through the services of the organization's monthly publication, the Grapevine. Only 98, or 6.13%, of the respondents provided the data base for Jellenik's model of progression (Pattison, Sobel & Sobel, 1977, p. 165). Not surprisingly, Jellenik's methodology met with sharp criticism; yet few have ventured to offer an alternative model which has gained acknowledged acceptance.

A review of the phases combining Mann (1958) and Keller (1966) follows. Jellenik (1953) cautioned that an alcoholic may or may not exhibit these symptoms necessarily in this order (Mulford, 1977, p. 563).

Early stage. In the early stages, which can last up to 10 years, the drinker may note to himself he needs a little more of the "social lubricant". Awareness is not a key criterion, although the drinker may notice he

is gulping drinks, experienced a blackout or two, and even found himself passed out on occasion. This type of behavior is explained to himself or others through "white lies" which begin the basis of an alibi system. Generally, feelings of guilt begin to accompany morning-afters. And although preoccupied with alcohol, the drinker avoids talking about his drinking.

Middle stage. The middle stages are marked with loss of control of the drinking. Neglect of nutrition; beginnings of hospitalizations for bruised bones, ulcers, and other indirect manifestations of excessive drinking; and a decrease in sexual desire are notable physical signs of progression. The drinker is plagued with persistent feelings of remorse and guilt, marked self-pity, unreasonable resentments, and consuming jealousy; yet, ironically, his behavior becomes grandiose and aggressive. Through a by now elaborate and entrenched defense system of rationalization, denial, and projection, the drinker feels more alienated from what he perceives a hostile world and seeks solace increasingly in the bottle.

Late stage. The late stage is noted for one statement: "The alcoholic now drinks to live and lives to drink" (Mann, 1958, p. 46). The drinker experiences tremors, solitary drinking, and benders. Undefinable fears engulf him. Possibly, there is reversible brain damage and alcoholic psychosis (Keller, 1966, p. 34).

Accordingly, such a person has lost vestiges of responsibility in family life as well as in the community. Perhaps a once promising citizen now lies on skid row. However, it is important to bear in mind that only 3% of the alcoholic population is on skid row (Brussel, 1969, p. 124).

From a sample of 945 consecutive admissions (1962-1963) to a Florida rehabilitation center, Williams formulated the following time description of progression. The mean age for the first drink was 17. The subjects began drinking regularly at age 21. They became excessive drinkers at age 30, with their first blackout at age 35. At age 37, they became uncontrolled drinkers. Delirium tremens were first experienced at age 39. By age 42, they were involved in their first alcoholism treatment and by age 45 were in at least their second alcoholism treatment (Catanzaro, 1968, p. 424).

This study, furthermore, investigated psychological deterioration with excessive alcohol consumption by reviewing the literature on psychoses. Mann and Keller wrote for the lay public and did not elaborate on recognized psychoses associated by alcoholism. The Diagnostic and Statistical Manual of Mental Disorders (DSM II) in the second edition classifies alcoholic psychoses as "psychoses caused by poisoning with alcohol" (DSM II, 1968, p. 24). Delirium tremens, classification number 291.0, is a variety of acute brain syndrome characterized

by tremors and visual hallucinations. In Korsakov's psychosis, classification number 291.1, the psychosis rather than being acute is now chronic. Memory impairment, disorientation, and confabulation are the key descriptors. Alcoholic deterioration, classification number 291.5, is defined as "all varieties of chronic brain syndrome of psychotic proportion caused by alcohol and not having the characteristic features of Korsakov's psychosis" (DSM II, 1968, p. 26). Alcoholic deterioration manifests itself in a large number of people who regularly consume large amounts of alcohol over a prolonged period of time. Typically, a certain disintegration of personality becomes apparent. The change ranges from impairment of emotional stability and control to dementia (Noyes, 1968, p. 206). (It is of interest that simple drunkenness is classified as a nonpsychotic organic brain syndrome [DSM II, 1968, p. 26].) The present writer speculated Mann and Keller implied alcoholic deterioration in their third stage, however for the lay public avoided such terminology.

Wexberg (1951) had a thoughtful comment on what he termed "the alcoholic syndrome", but Jellenik countered this was an accurate description of alcoholic deterioration:

> ...prolonged excessive drinking produces what may be legitimately called an alcoholic personality which appears to be specific and closely correlated, in many cases, with excessive drinking... The far-reaching identity

> of the experience of progressive alcoholism may account for the uniformity of personality changes in alcoholics: their progressive loss of interest, their loss of emotional stamina..., their irritability, their lack of persistence of effort in work..., their dishonesty...their loss of 'sense of honor', their superficial sentimentalism and tearfulness... and so forth. (1960, pp. 65-66)

Earlier, the scare tactics of the current alcoholism education were alluded to. In view of conflicting viewpoints of etiology and as little is known in the literature about progression, one is left to conclude that perhaps "The Secret Love of Sandra Blaine" (1971) was not as farfetched as one might have thought.

Loss of Control and Craving

Jellenik in 1960 introduced two concepts into the literature concerning alcoholism. These concepts were (a) loss of control and (b) craving. These two concepts are discussed next.

Loss of control has been acknowledged by the traditionalists as a turning point in the progression of alcoholism. Around the tables of A.A., it was what was humorously known as "when the cucumber became the pickle". Jellenik mentioned that loss of control and craving are the criteria "par excellence" for distinguishing between his prototypes of alcoholics. From the recollections of the members of A.A., he interpreted loss of control as:

> ...that stage in the development of their drinking history when the ingestion of one alcoholic drink sets up a chain reaction so

> that they are unable to adhere to their intention to 'have one or two drinks only' but continue to ingest more and more--often with quite some difficulty and disgust--contrary to their volition. (1960, p. 41)

Loss of control, along with withdrawal symptoms and the acquired increase of tolerance, are the identifiers of an alcohol addict (Jellenik, 1960, p. 66). This, then, according to Kissin, established the condition of physical dependence (1977, p. 5).

Milam has observed that when a person became aware of his "loss of control", often that person has developed strategies to obtain control. A controlling strategy, for example, was "going on the wagon" for periods of time. Perhaps an attempt to limit consumption to wine with meals or drinking only beer was undertaken by the concerned individual. Controlled drinking has been around as long as there have been alcoholics. Controlled drinking can be maintained; however, Milam warns that it is only a matter of time until the infrequent uncontrolled episodes become frequent (1970, p. 15).

Paredes, Hood, Seymour, and Gollob (1973) in an effort to investigate loss of control administered alcohol to 29 alcoholic subjects during the course of a five-week inpatient treatment. The subjects were provided with an average of 225 ml. of 95% ethanol per day for two days. Interestingly, the researchers decided on a two-day limit as "prolonged drinking can induce

hallucinations, memory disturbances, and deterioration which may prevent the patient from making therapeutic use of the experience" (p. 1149). They concluded that the induced drinking did not trigger a reaction to obtain more alcohol, as the subjects completed the five-week program as scheduled. Three members of the original sample did leave shortly after their drinking experience. The researchers offered controlled drinking as an alternative since the ingestion of alcohol did not lead to uncontrolled drinking (p. 1158).

Pattison, Headley, Gleser and Gottschalk reported that 11 alcoholics who were defined at intake to an outpatient treatment center as gamma (i.e., true) alcoholics were "normal drinkers" 20 months later at a follow-up interview. Of the 11, five were located two years later and again confirmed to be "normal drinkers" (1968, p. 620). Pattison, Sobel, and Sobel (1977) reviewed 74 studies that reported similar findings. The generalization drawn from their analysis and presented as "modest" by the authors "strongly contradicts the traditional concept that an alcoholic can never drink again" (p. 127). Pattison, Sobel, and Sobel seemed to support the idea that loss of control is related to environmental factors that cue undesirable consequences when drinking (1977, p. 103). Accordingly, if one were trained to interact with the environment in a more productive fashion, one would not need to drink

alcoholically. This was the viewpoint supported by those seeking alternatives to abstinence as the chief therapeutic goal or, termed for this study, nontraditionalists.

> Indeed, addiction appears better conceptualized as behavior based on the use of drugs as the central integrative symbol around which the person organizes his life... If this be so, we may assume that a person who has changed his patterns of living could use (without harm) a drug to which he had previously been "addicted". (Pattison et al., 1968, p. 625)

Indirectly, this viewpoint disputed the loss of control construct. By redefining alcoholism and locating "normal drinkers", loss of control and progression are de-emphasized or entirely ignored in the latter case.

Dr. Ruth Fox has stated that of 3,000 patients she has seen with alcoholism, she did not know of one that had been able to resume "normal drinking". Many have tried and failed (Smithers, 1976, p. 20). Kissin noted that what Pattison, Sobel, and Sobel have achieved with their "normal drinking" alcoholics sounded more like "controlled bingeing rather than controlled drinking" (1977, p. 79).

Pittman and Tate completed a one-year follow-up study of 255 alcoholics. They concluded that those who had returned to drinking were drinking less and exhibited moderated drinking patterns. Sixteen percent of the sample had maintained abstinence for the one-year period. They also reported they did not find one patient

who was drinking normally. Although some of the subjects were drinking moderately, the researchers observed loss of control in their drinking habits (1969, p. 899).

Abstinence, the converse of consumption, likewise indicated loss of control in the respect that the same dynamic was present. By abstention, an alcoholic was maintaining the premise that he had lost control of his drinking behavior and "couldn't handle it" (Ludwig & Wikler, 1974, p. 122). Rather than dismissing the construct, Ludwig and Wikler advise regarding it in a simple light: "...all that loss of control connotates is the relative inability to regulate ethanol consumption" (1974, p. 122).

Returning to an earlier source, the organization of Alcoholics Anonymous have as the basis of recovery their 12 suggested steps. The first step clearly implied that loss of control was a reality and an important aspect of the illness. "Step One: We admitted we were powerless over alcohol, that our lives had become unmanageable" (1952, p. 21). The construct loss of control was maintained as a reality by the traditionalists. The nontraditionalists disputed the existence of such a phenomenon.

Craving has been defined by the World Health Organization as follows.

> Craving and its alternative terms have been used to explain drinking arising from (a) a psychological need, (b) the physical need to

> relieve withdrawal symptoms or (c) a physical need which originates in physio-pathological conditions involving the metabolism, endocrine functions, etc., and existing in the drinker before he starts on his drinking career or developing in the course of it. (As cited in Jellenik, 1960, p. 144)

Of concern to this study was the psychological need or "craving" a person experienced after a period of abstinence. The World Health Organization stated that a physical dependence cannot adequately explain the urge to drink after a period of abstinence and, accordingly, determined this to be a psychological dependence if the drinker had completed withdrawal. Kissin noted that craving "occurs only after drinking has stopped and withdrawal symptomatology has subsided" (1977, p. 24). In heroin addiction, physical craving in the tissues of the body can last up to six months (Kissin & Begleiter, 1977, p. 23). With alcohol addiction, overt withdrawal is usually completed in three to ten days.

Maintaining abstinence for a year is considered a resounding success (Miller & Caddy, 1977, p. 989). Davies, Shepard, and Meyers stated that six months after treatment, 88% of their 50 alcoholic patients had returned to excessive drinking; and usually resumption had occurred at three months (Faillace, Flamer, Imber, & Ward, 1972, p. 86).

Ludwig, based on the self-report of 161 alcoholics, gathered reasons for resumption of drinking (1972, p. 93). The reasons are presented as follows.

Reasons for Returning to Drinking, N=161

Reason	Percent	Comments
Psychological distress	25%	"I felt sorry for myself"
No specified reason	19%	"I don't know"
Family problems	13%	"Because of my wife"
Effect or pleasure	11%	"I just like beer"
Sociability	10%	"Trying to drink socially"
Curiosity	7%	"Have something to do"
Employment problems	5%	"Hated my job, bored"
Craving or a need to	1%	"Just felt I had to"
Other	9%	"Had my teeth pulled"

Reasons for Abstaining, N=94

Reason	Percent	Comments
No need or desire	24%	"I just didn't feel like it"
Afraid of consequences	19%	"Can't handle it"
Insight into problems	14%	"Understand myself now"
No special reason	7%	
A.A.	7%	
Hospital treatment	6%	
Disulfiram	4%	
Family influences	3%	"To keep family together"
Other	14%	"Been too busy"

Surprisingly, only 1% were cognizant of craving. Ludwig suggested that some responses may, indeed, be related to craving; however, the subject misinterpreted this "feeling" (1972, p. 94). Ludwig did not comment on the 24% who abstained because of non-need or nondesire other than to note an "almost magical quality" in their responses.

Hershon reported 91% of his sample were provoked to drink by craving (1977, p. 967). By redefining terms, Ludwig found an overwhelming response indicated craving as reason for relapse in a latter study conducted in 1974. (78% of them experienced craving for alcohol,

62% claimed that craving was increased after one or two drinks, 43% defined craving in terms of relief from discomfort, 57% reported an inability to stop drinking after one or two drinks [p. 113].)

Engle and Williams (1972) administered one ounce of 100 proof ethanol to alcoholics (N=40) and derived that craving for more was most likely psychologically based, as 10 subjects who were told they were receiving alcohol were, in fact, not, and they reported craving. The researchers commented that, indeed, it appeared that one drink did not initiate craving or ensuing loss of control (p. 1104). Yet they cautioned perhaps more alcohol may produce different results, as illustrated by the next study.

By introducing levels of alcohol consumption (16 ounces per day for five days, then 24 ounces per day for five days, then 30 ounces per day for five days) to four alcoholics, Funderbunk and Allen (1977) reported that increase in consumption occurred regardless of prior knowledge of the intended availability, and therefore concluded that prior consumption activated increased consumption (pp. 417-420).

It appeared that resumption of drinking after a period of abstinence was related to a type of psychological craving; and once drinking was initiated, physical craving perpetuated the drinking behavior.

Ludwig (1974) proposed an explanation combining

psychological and physical components. Rather than relying on a psychological/physical dichotomy, he suggested the terminology "subclinical withdrawal syndrome" (1974, p. 116). This was craving which can be produced with cues, either internally or externally and/or in combination. By passing a familiar bar or meeting old drinking buddies, an abstinent alcoholic could be cued to recall prior withdrawal experience and thus reestablish a desire to obtain relief for the symptoms of this recalled withdrawal. Ludwig likened craving to other needs or desires a person experiences, like hunger, thirst, or sex. Just as these needs did not necessarily lead to obtainment, craving in itself was not sufficient to induce drinking; yet it was necessary for a relapse or loss of control (p. 115).

From the literature, it appears that craving, depending on the definition, did exist; and perhaps procedures to determine and measure it will eventually be refined. It was also evident that the entire subject required more study and definition.

The traditional school recognized these constructs as valid based on clinical observation. Nontraditionalists tended to ignore or redefine these constructs using empirically based research. Thus, very opposing views emerged.

Relapse

From the literature, a relapse seemed to be initiated by craving or psychological distress or "subclinical withdrawal syndrome". Once drinking was initiated by the alcoholic, it seemed to be only a matter of time before loss of control became reactivated, and once again the alcoholic was in the throes of his illness.

In addition to the earlier section on craving and loss of control, relapse needed further clarifying. Many of the studies introduced in that section would be applicable here. However, the term relapse was generally employed when the subject had made an attempt to maintain abstinence. Suggestions have been offered for explanation of this occurrence. Cahn proposed crisis to be closely associated with a relapse (1970, p. 118). Employing ex post facto research, Rosenberg, Manohar, O'Brien, Cobb, and Weinberger (1973) noted that when a fire gutted a halfway house for 30 male alcoholics, 15 returned to drinking within the succeeding 24-hour period. The researchers commented that a crisis could be handled by a person with a variety of coping mechanisms, yet alcoholics frequently used "maladaptive coping techniques" which eventually lead to drinking behavior as a means to cope with crisis (p. 201).

It has been alluded to that abstinent rates are very low from previous citations (Miller & Caddy, 1977;

Davies, Shepard & Meyers, 1972; Pittman & Tate, 1969). Accordingly, such implications for treatment procedures have been suggested calling for acceptance of some type of limited drinking. Steiner (1969) stated, "The concept of alcoholism as a chronic, progressive disease is the basis for acceptance of the 'joylessness' of alcoholism therapy and recommendations by experts that therapists should limit their objectives rather than suffer the discomfort of failure" (p. 935).

Yet, Gitlow contended "the only generally accepted and time-tested technique for treatment of this highly recidivistic illness entails the achievement of abstinence" (Bourne & Fox, 1973, p. 5).

Completion of a 6-week alcoholism treatment program was significantly associated with fewer readmissions in the following 18 months according to McWilliams and Brown. Furthermore, they found the MMPI did not predict prognosis for a sample of 111 (1977, p. 485). Alcoholism treatment programs were one modality for achieving abstinence.

Milam stated that "although the rate of deterioration in the alcoholic may be temporarily slowed by controlled drinking, it can not be stopped. The alcoholic who goes off the wagon or who drinks rarely and sparingly is still a drinking alcoholic and it is only a matter of time until he reaches the later stages of the illness" (1970, p. 16).

Implications for the Present Study

From the search of the literature, the writer found one study which measured pre-and-post personality profiles of known alcoholics employing the MMPI and alcohol consumption, thus approximating the present study. Paredes, Gregory, and Jones administered alcohol during the course of a five-week treatment to 33 known alcoholics. They report that the only significant changes in pre-and-post testing with the MMPI were scale 3 (Hy) significantly decreased while scale 9 (Ma) increased (1974, p. 1,285). In an earlier investigation, elevations were reported on scale 2 (D) and scale 9 (Ma), with pre-and-post testing employing the MMPI and the same conditions (Paredes, Hood, Seymour, & Gollob, 1973, p. 1,151). Consequently, the MMPI fluctuated slightly with the consumption of alcohol, however did not reflect dramatic deterioration.

When feelings of helplessness, depression, anger, or anxiety are experienced, the alcoholic in comparison to nonalcoholics will most likely "go to the bar, drink booze, smoke, and take pills" (Tokar, Brunse, Stefflre, Napior & Sodergren, 1973, p. 141). Anxiety and depression are the two most common feeling states associated with chronic alcoholism (Kissin, 1977, p. 7).

Warren and Raynes measured mood changes in 12 subjects as alcohol consumption progressed. They concluded that as the blood alcohol concentration increased, "the

subjects tended to become more depressed, less friendly, more angry, less vigorous, more fatigued, and more confused; they also became less tense and anxious" (1972, p. 985).

Clinebell (1956) compiled 10 psychological characteristics of alcoholics from previous studies. His characteristics are as follows: (1) a high level of anxiety in interpersonal relationships, (2) emotional immaturity, (3) ambivalence toward authority, (4) low frustration tolerance, (5) grandiosity, (6) low self-esteem, (7) feelings of isolation, (8) perfectionism, (9) guilt, and (10) compulsiveness (p. 49). In some ways, these characteristics can be measured by the MMPI, mainly with clinical scales 2 (D), 4 (Pd), and 7 (Pt).

To the knowledge of this writer, studies designed to assess personality deterioration after a relapse or as consumption of alcohol progressed have not been undertaken. An accepted article to be published in a future issue of the Journal of Studies on Alcohol, "Personality Changes while Drinking", J.E. James, may shed further light on the subject.

Summary

A review of the literature indicated that the constructs progression, loss of control, craving, and relapse are recognized, however still not clearly understood. A major schism has developed in the field between

the traditionalists and the nontraditionalists. Some researchers, like Ludwig, have attempted to bridge the gap. There appeared to be a need to investigate personality deterioration with continued use of alcohol or with relapse. The basic body of knowledge in the field, with persistent research and documentation, will expand. As with any illness, advances are made in a tedious manner.

Chapter Three

Methods

The Problem

It was the purpose of this research to compare the psychological profiles of diagnosed alcoholics upon first admission with profiles taken on these same persons after re-admission. An attempt was then made to characterize some specific features of personality deterioration associated with a relapse of the illness.

The Hypotheses

Research hypothesis. With a return to alcohol consumption after a period of abstinence, the diagnosed alcoholic's personality characteristics as measured by the MMPI will exhibit significant differences when compared with his earlier profile. Validity scales L, F, and K were selected for analysis as well as clinical scales 1, 2, 3, 4, 5, 6, 7, 8, 9, and 0.

Null hypothesis. There will be no significant difference between first and second measurements with the validity scales or with the clinical scales.

The Research Procedure

The Minnesota Multiphasic Personality Inventory, hereafter referred to as the MMPI, was selected for the measurement tool because of its proven utility. The instrument was one of a test battery employed at the

Heartview Foundation, Mandan. Its use has been standard there since 1964. Other tests employed in the battery are not as desirable for objectively measuring personality deterioration. The Bender-Gestalt Test and the Draw-A-Person test necessitated clinical training and are probably more subject to personal interpretation. The Shipley Institute of Living Scale measured intelligence, a factor of personality, yet did not furnish enough information to be used solely. Bergman and Agren (1974) found even in severe cases of alcoholism there was no correlation with intellectual deterioration and progression (p. 1,242). The Edwards Personal Preference Schedule measured a person's needs. Selection, therefore, narrowed to the MMPI. The MMPI has been thoroughly researched and proven to be a resourceful research tool.

The MMPI was designed by S.R. Hathway, Ph.D., and J.C. McKinley, M.D., and published in 1943. The test has been considered a landmark in personality testing. David A. Rodgers, in the Mental Measurements Yearbook (1972), noted it as "psychological instrument of choice for the routine assessment of nature and degree of emotional upset in adult patients or other adult clients seeking help..." (p. 243).

The test was fairly easy to administer. The client needed a modest understanding of English, or at least enough to read at the sixth-grade level (Dahlstrom &

Welsh, 1960, p. 26). A quiet room was preferable. Five hundred and sixty-six items were answered in a true or false fashion. The client was encouraged to answer all items; however, a client can omit up to 30 items before validity becomes questionable (Dahlstrom & Welsh, 1960, p. 46). Thomas R. Hedin, past lecturer at the Heartview Foundation, offered some comments on the testing time. He mentioned that average testing time was between 60 to 90 minutes. A time of less than 60 minutes may indicate carelessness on the part of the test-taker. He added that a test time of over 120 minutes may suggest some type of interference.

The test was designed to highlight personality characteristics measured in 10 basic areas. This was based on self-report. One needs to keep in mind that the MMPI has not been re-normed since its inception in the early 1940's. Obviously, this left the test open to much criticism. The original population of 700 "normals" was selected from the state of Minnesota. This population was tested against 700 Minnesota psychiatric cases to provide a norm. Regardless of recent re-norming, the test has generated thousands of studies and maintains a recognized reputation.

Highlighting self-report personality characteristics was accomplished by plotting raw scores on a profile, after K correction. The profile converted the raw scores into T scores with a Standard Deviation of 10.

The significance of each scale needed to be interpreted in light of the overall pattern. Many "cookbooks" have been developed to discuss the different patterns. In the final analysis, the single most effective method of evaluating patterns was the trained professional. From Dahlstrom and Welsh came this warning:

> In the clinical use of the MMPI it has continually been emphasized that the individual scale in a profile is not to be evaluated on its own, but rather the pattern afforded by the whole group of scales, including the validity indicators. (1960, p. 18)

Each scale did have a meaning, albeit not necessarily a psychiatric one as first proposed by the authors.

The Validity Scales.

L - This scale was a measure of denial.

F - This scale was a measure of fakery.

K - This scale was an index of test-taking attitude (Dahlstrom & Welsh, 1960, p. 50).

The Clinical Scales.

Scale 1 (Hs), Hypochondriasis - This scale was a measure of somatic concern or an index of the importance of bodily functions and symptoms of the person (Good & Brantner, 1974, p. 25).

Scale 2 (D), Depression - This scale was originally developed to measure depression and the depth of it. Later research indicated the scale "reflected depressive mood changes on a neurotic basis" (Dahlstrom & Welsh,

1960, p. 57). Elevation suggested hopelessness, poor morale, pessimism, dejection, and depression (Good & Brantner, 1974, p. 24).

Scale 3 (Hy), Hysteria - This scale, as explained by Good and Brantner (1974), suggested two subareas: (1) somatic complaints and, ironically, (2) a measure of well-being. The second subarea was explained as, more or less, a subtle denial or rationalization (p. 27).

Scale 4 (Pd), Psychopathic Deviation - This scale was originally developed to measure psychopathy. Later, it came to mean an indicator of family discord, authority problems, social alienation, and self alienation (Good & Brantner, 1974, p. 30). Mogar, Wilson, and Helm (1970) summed it as a measure of unconventional attitudes and practices (p. 102).

Scale 5 (MF), Masculinity-Feminity - This scale was affected by education, occupation, and socio-economic level. To be considered as a sole criteria as an index of sexual deviance was a risky venture. Mogar et al. describe it as a measure of sex-related interests or preferences (1970, p. 102). Perhaps, in this era of liberation, another way to regard this scale was as a measure of passivity.

Scale 6 (Pa), Paranoia - This scale was an index of paranoid thinking including ideas of persecution, grandiose self-concepts, suspiciousness, oversensitivity, and egotism (Good & Brantner, 1974, p. 33). It was

also an index of basic trust (Mogar et al., 1970, p. 102).

Scale 7 (Pt), Psychasthenia - This scale was a measure of worry, anxiety, or compulsiveness. Mogar et al. added that guilt feelings are also measured (1970, p. 102).

Scale 8 (Sc), Schizophrenia - This scale was an indicator of bizarre and unusual thoughts or behavior (Good & Brantner, 1974, p. 36).

Scale 9 (Ma), Mania - This scale was a measure of activity or energy level, originally designed to measure hypomania (Dahlstrom & Welsh, 1960, p. 74). Mogar et al. added that emotional excitement or flight of ideas can be detected (1970, p. 103).

Scale 0 (Si), Social Introversion - This scale was a measure of attraction to or avoidance of social contacts (Mogar et al., 1970, p. 103).

Once again, Dahlstrom and Welsh (1960) noted the following:

> ...it can be seen that they (the scales) are by no means homogeneous, internally consistent groupings of behavioral features. Rather, they are pragmatically formed clusters of symptoms which overlap and interrelate in a variety of ways. (p. 79)

The Sample

A sample of 30 diagnosed male alcoholics was selected from a population of 5,000 admissions to the Heartview Foundation. The requirement for selection

was length of abstinence prior to relapse, two MMPI profiles, and sex. A criterion of six months was instituted to control for the recidivist. Hopefully, the six months also indicated a more motivated person. In addition, the six-month criterion attempted to control for test familiarity.

At the Heartview Foundation, case numbers are filed in large notebooks from the very first admission to the most recent one. From these notebooks, the researcher recorded case numbers which had a "-2" (dash two). For example, a case number may look like this "6078-2", thus indicating two admissions. Those case numbers with more than two admissions were excluded, as well as those who were deceased. The corresponding charts were then pulled and systematically checked for (1) length of abstinence prior to relapse, as recorded on the Counselor's Report; and (2) MMPI profiles from first and second admission. Age, sex, and length of abstinence were recorded, as well as the K corrected scores of the MMPI validity and clinical scales. Two hundred and two case numbers with the "-2" (dash two) were initially selected to provide a data base. Of the 202, only 30 met the established criteria. From observation, many of the unusable charts had returned to drinking prior to six months.

The Statistical Analysis

t-test for correlated samples (Bartz, 1976, p. 261).

$p < .05$
$df = N-1$

Mean of the Difference

$$\bar{D} = \frac{\Sigma D}{N}$$

Standard Deviation of the Differences

$$SD = \sqrt{\frac{\Sigma D^2}{N} - \bar{D}^2}$$

Standard Error of the Mean of the Differences

$$S\bar{X}D = \frac{SD}{\sqrt{N-1}}$$

Correlated t-Test

$$t = \frac{\bar{D}}{S\bar{X}D}$$

Chapter Four

Presentation of the Data

A sample of 30 male alcoholics who had maintained at least six months abstinence between first and second admissions to a treatment center can be described as follows. The group entered treatment at an average age of 40.33 years, with a range of 19 years to 70 years. At the time of second admission, the average age had increased to 43.37 years, with a range of 21 years to 71 years.

Concerning the months abstinent, the range was 6 to 138 months, from self-report. The average was 18.33 months abstinence before resumption of drinking. Nine of the 30 were drinking shortly after reaching the six-month mark. Eleven started drinking at or before the 12th month. Therefore, two-thirds (66.7%) of the sample group was drinking on or before one year of abstinence. From the 12th month to the 18th month, there were no relapses for the group. At the 18th month, four of the sample returned to drinking, followed by one at the 19th month and one at the 20th month. Another member of the sample broke abstinence at the 24th month. At the end of two years, 27 members of the sample had resumed drinking. One maintained abstinence until the 48th month. Another maintained until the 66th month, and one maintained sobriety 138 months (over 11 years).

Out of context these figures look dismal, as all eventually returned to drinking. Yet the purpose of this study was to gather this group together to discern if a relapse would be related to progressive deterioration with these persons' personality profiles.

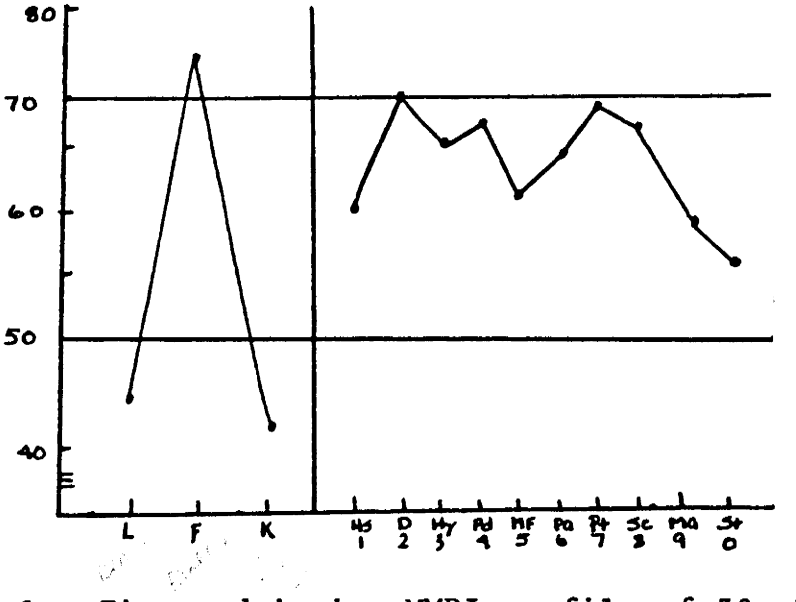

Figure 1. First admission MMPI profile of 30 alcoholics.

The first admission MMPI profile of this group was not as representative as Rohan's findings of typical alcoholics (1972, p. 66). His group had peaks on scale 2 (D) and scale 4 (Pd) above T-score 70, whereas this group seemed to have slight peaks on scale 2 (D) and scale 7 (Pt) and a dramatic peak on validity scale F.

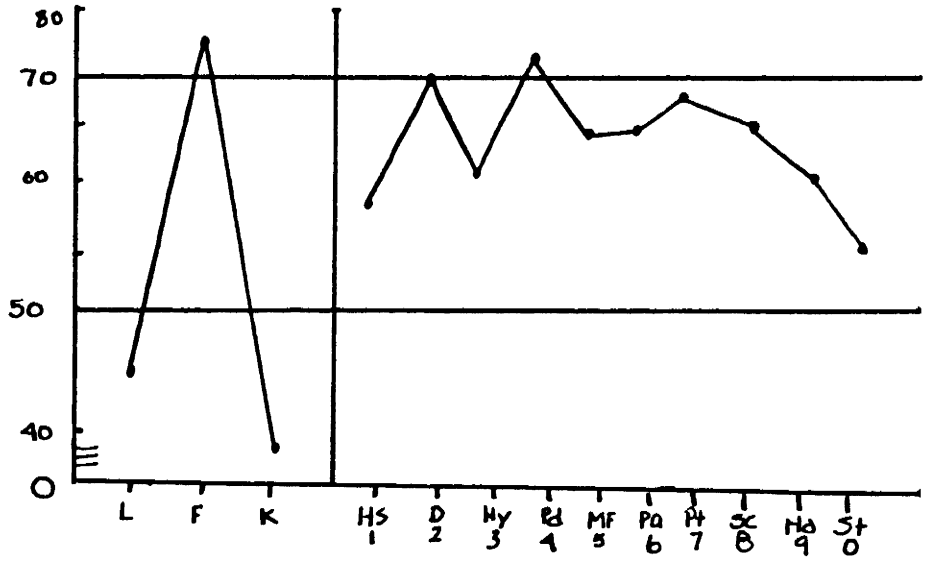

Figure 2. Second admission MMPI profile of 30 alcoholics.

Second admission profiles revealed a slightly altered pattern, approximating Rohan's findings (1972, p. 66). The rise in scale 4 (Pd) and slight drops in scale 3 (Hy) and scale 7 (Pt) added enought of a shift in pattern to do this. However, once again, the dramatic peak on scale F did not approximate Rohan's. Rohan had a similar inverted V but not nearly the same acuteness.

Table 1

Significant Differences between MMPI Scores on First and Second Admission of 30 Alcoholics

Scale	First Admit Mean	Second Admit Mean	SD[a]	t[b]	p
L	3.37	2.97	1.98	1.09	p>.05
F	13.47	13.60	5.08	- .141	p>.05
K	7.87	5.67	6.30	.484	p>.05
1	15.10	14.43	5.56	.647	p>.05
2	25.13	25.13	6.85	.000	p>.05
3	24.23	23.53	5.59	.673	p>.05
4	26.40	28.6	5.16	-2.30	p<.05
5	26.50	27.63	5.82	-1.05	p>.05
6	12.90	13.17	4.82	- .289	p>.05
7	32.70	31.70	7.32	.318	p>.05
8	30.00	30.33	10.26	- .280	p>.05
9	20.70	20.93	5.67	- .221	p>.05
0	30.60	30.53	10.74	.033	p>.05

Note. Where df = 29, t_{05} is 2.045.

[a]SD stands for the standard deviation of the differences of the means.

[b]t is the correlated test for means.

From Table 1, the following hypotheses were retained or rejected.

Validity scale L was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Validity scale F was hypothesized to reveal a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Validity scale K was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Clinical scale 1 (Hs) was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Clinical scale 2 (D) was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Clinical scale 3 (Hy) was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Clinical scale 4 (Pd) was hypothesized to show a significant difference between first and second admissions. A significant difference was found, therefore the null hypothesis was rejected.

Clinical scale 5 (MF) was hypothesized to reveal a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Clinical scale 6 (Pa) was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Clinical scale 7 (Pt) was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Clinical scale 8 (Sc) was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Clinical scale 9 (Ma) was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore the null hypothesis was retained.

Clinical scale 0 (St) was hypothesized to show a significant difference between first and second admissions. No significant difference was found, therefore

the null hypothesis was retained.

In Chapter Five, the implications of these findings are discussed as well as some conclusions and recommendations.

Chapter Five

Conclusions and Implications

This study researched the probable progression of personality deterioration on selected Heartview patients who had a relapse between admissions. MMPI scores were used to evaluate personality deterioration. The validity scales maintained their overall shape, that of an inverted V, on first and second admissions. The results of the statistical analysis indicated some slight movements in the clinical scales. Only scale 4 (Pd) exceeded a significance level of .05. The overall patterns from the two admissions were slightly different. The researcher has concluded sampling procedures would need to be revised for future studies.

Recommendations for Sampling

Of 202 potential files, only 30 meet the three established criteria: male, at least six months abstinence between admissions, and two MMPI profiles. Many of the rejected had returned to drinking at three months. It should be kept in mind that those who were incorporated in this study returned to drinking in a fashion that was not acceptable, either to themselves or a significant other, because they re-established contact with a treatment center. So, it appeared, as a whole, this group's drinking was of such proportion to necessitate hospitalization; however actual drinking practices after

resumption were not recorded. For example, a male could have been abstinent for nine months, drank for one day, returned to treatment, completed two sets of tests, and could have been included in the study. Another could have maintained two years of sobriety, then drank a quart of ethanol a day for the next five years, was re-hospitalized, and had completed two sets of tests. These two very different viewpoints could have been incorporated into the same sample. Therefore, if this study were to be replicated, this writer recommends recording drinking practices after resumption and then organizing the sample according to drinking practices depending on length of time relapsed.

Discussion of Results

The validity and clinical scales of the MMPI need further consideration and are thus presented.

On validity scale L, a measure of denial, change did not meet the established significance level. However, there was a slight decrease on the mean of the second admission testing. Both means were within normal limits on the profile.

Validity scale F, a measure of fakery, on both testings averaged above T-score of 70 on respective profiles. There was a slight increase on second admission, however, not significant. Because of the high score, validity of the testing could be questioned. Generally,

with a T-score above 70 on scale F, it was interpreted as a deliberate attempt to make one's self look bad.

Validity scale K, an index of test-taking attitude, was generally low for both means. There was a slight decrease on second testing, however, not significant. Again, both means were within normal limits.

Clinical scale 1 (Hs), a measure of somatic concern, showed a slight decrease on second testing, however, not significant. Both means were within normal limits.

Clinical scale 2 (D), a measure of depression, interestingly showed no change from test to retest. The writer had anticipated a significant difference under the assumption that resumption of drinking would bring about increased feelings of depression, remorse, pessimism, and a general lack of hope. Also, the studies done by Tokar et al. and Warren and Raynes both noted depression either prior to resumption or during the course of drinking. Scale 2 was exactly at T-score 70 and was a major peak on both profiles.

Clinical scale 3 (Hy), a measure of somatic concerns and well-being, was within normal limits on both profiles. There was a slight decrease with the second admissions, however, not significant. This added support to Paredes et al. (1974), who reported a significant decrease after alcohol consumption.

Clinical scale 4 (Pd), a measure of unconventional

attitudes or practices, showed a significant difference at the .05 level. Second admission testing was, indeed, elevated slightly above T-score 70, exceeding normal limits and producing a major peak along with scale 2. First testing was below T-score 70. This finding suggested that the group became more firmly entrenched in unconventional attitudes and practices which could lead to family discord, authority problems, social alienation and self alienation, all of which were commonly associated with alcoholism.

Scale 5 (MF), a measure of sex preferences or interests, showed a slight increase on second admission testing, however, not significant. Both means were within normal limits. If this scale were interpreted as a measure of passivity, then the group became slightly more passive.

Scale 6 (Pa), a measure of basic trust, showed a slight increase on second admissions testing, however, not significant. One would have suspected that this scale would have shown a significant difference, as with the progression of the illness one became more self-centered and involved with alcohol to the exclusion of others. However, on both testings, the means were within normal limits.

Scale 7 (Pt), a measure of anxiety and/or guilt feelings, on both testings were within normal limits. With the second admissions there was a slight decrease,

however, not significant. Again, one would have suspected this scale to exhibit more of a difference as tension, anxiety, and guilt are effects commonly associated with the illness. In a recent study, Durick (1978) noted anxiety in alcoholics was lower than non-alcoholics (p. 69). Since scale 7 decreased slightly, perhaps anxiety was not as prominent a feature in alcoholics as formerly thought.

Scale 8 (Sc), a measure of bizarre and unusual thoughts or behavior, had a slight increase on second admission, although not significant. Both means for scale 8 were within normal limits.

Scale 9 (Ma), a measure of emotional excitement or flight of ideas, had a slight increase on second admission, however, not significant. Both means were within normal limits. Again, this finding supported Paredes et al. (1974).

Scale 0 (Si), a measure of social introversion, showed a slight decrease on second admission testing. With increased alcohol consumption, one would have suspected an avoidance of social contact to become a facet of personality. Yet, this scale indicated this assumption was not necessarily so, as both means were within normal limits.

The first admission profile (Figure 1) and second admission profile (Figure 2) of the means of the scales converted to T-scores provided an interesting comparison.

Clearly, there was not a major upheaval between the two patterns. Figure 1 was coded as a 2-7-4 pattern, whereas Figure 2 was coded as a 4-2-7 pattern. Both were fairly close or within normal limits, indicating no gross pathology. Both were patterns commonly associated with alcoholism. Yet, the mere fact that these two profiles were so similar could be interpreted to mean that the group as a whole is neither gaining nor losing in personality integration. In fact, this writer suggests this group as a whole was becoming slightly more entrenched in a profile which could cause continuing problems associated with alcoholism. For instance, psychopathic deviance became more pronounced on second admission testing. Overall, the first admission profile as well as the second admission profile compared with McWilliams and Brown's (1977) elopers' profiles who had significant readmissions in an 18-month follow-up study. The present profile pattern is similar to, however does not match, the higher elevations of the elopers (p. 481).

Author's Comments on Review of Literature

Alcoholism is a multifaceted illness: "Cunning, powerful, and baffling". Although the illness has been present since Biblical times, only recently has there been recognized research and treatment modalities. From a casual observation, there have been pioneering efforts through the years (1930-1968); and seemingly since 1970 a real research explosion has happened. Recent research

seemed more sophisticated and involved a wider variety of techniques. However, from the review of the literature for this study, it appeared that some researchers concluded that loss of control and craving are not verifiable alcoholic characteristics. This has dramatic implications for the illness alcoholism and for treatment modalities. By negating these constructs, alcoholism was often viewed as a behavioral problem; and an alcoholic could, therefore, be taught to drink socially. By introducing alcohol (upwards to 24 ounces a day) into a treatment setting, some investigators have concluded that those who choose to drink in a hospital setting fare just as well as those who choose to abstain (Paredes, Gregory & Jones, 1974, p. 1,288).

Ludwig has pointed out that on the street numerous incidents can cue "subclinical withdrawal syndrome" and perhaps eventual excessive drinking. So, it seemed to this writer, rather than the endorsement of controlled social drinking, which has not been a time-tested technique for recovery, a more pragmatic approach would be to involve as many persons as possible in an alcoholic's treatment. For instance, involve people who may have been associated in the cueing process of the alcoholic, such as family members, A.A. members, employers, relatives, and significant others. This was what could be called a systems approach to the problem.

Ignoring the consequences of continued drinking

either alcoholically, excessively, moderately, or normally, by alcoholics was a great disservice to those persons and to the field of alcoholism. In this writer's opinion, advocating controlled social drinking overlooked the construct progression and the concomitant factors loss of control and craving. Ultimately, progression leads to three places: jail, early death, or the back ward of a state hospital, which has been repeatedly demonstrated by case study. Yet, progression seemed to be poorly researched.

It has been said that for every drinking alcoholic there was someone who was helping, often unwittingly, the alcoholic to continue drinking. It was called enabling the illness. It would be the hope of this writer that the growing body of knowledge, research, and treatment modalities would not be guilty of enabling the illness.

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