The Educational Treatment Program for Alcoholics at the Nova Scotia Hospital: The Extent to Which it Effects Attitudinal Change and Adjustment Patterns in Patients

by

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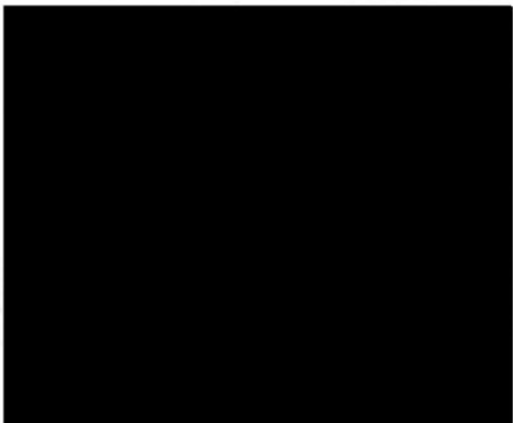

ABSTRACT

The purpose of this study was to examine the therapeutic value of the three week educational treatment program for alcoholics offered at the Nova Scotia Hospital. This educational treatment program provided for alcoholic inpatients was compared to the non-directive outpatient program offered by the Nova Scotia Alcoholism Research Foundation. The effectiveness of each program was measured by the resultant amount of attitude change and fluctuations in adjustment patterns for the respective clients. The study further attempted to distinguish between the variables of 'attitude' and 'adjustment' to see how the relationship between them was affected by treatment.

The major findings showed that the educational treatment program contributed significantly towards bringing about attitudinal changes and adjustment to the condition of alcoholism within a three week period. However, within the N.S.H. group, which undertook the educational treatment program, those patients who showed mild impairment in the areas of behavior and social relations were able to adjust significantly when compared to those who had more severe impairment. A related finding was that patients who were making better adjustment to their condition were observed to be poor participants in the program. This behavior could be reflective of their deep concern with understanding and assimilation of the new material and less motivation to develop new social relations. It was also found that the two variables of 'attitude' and 'adjustment' correlated significantly prior to treatment and that as an outcome of treatment these two variables showed even greater influence upon each other. Finally, it was found that variations in demographic variables did not alter the outcome of treatment.

An unexpected finding was that the N.S.H. group showed poorer adjustment initially but after treatment they adjusted to a level where the A.R.F. group was prior to their treatment. This may give evidence that the two programs are sequential in their purpose and that treatment should be provided in states. It could be indicative of the patient's capacity to benefit depends on his degree of impairment.

The validity of these findings could be enhanced by further research that would use other comparative groups and by examining the effectiveness of the educational program at different points in time.

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TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	ii
LIST OF TABLES	v
LIST OF FIGURES	vi
Chapter	
I INTRODUCTION	1
Short Term Treatment for Alcoholism	1
Statement of Problem	3
II REVIEW OF LITERATURE	4
Directive Therapy	4
Didactic Group Therapy for Alcoholics	7
Attitude Change Toward the Condition of Alcoholism	11
Attitude Change Versus Adjustment to the Condition of Alcoholism	19
III METHODOLOGY	23
Sampling Procedure and Subjects	23
Treatment: N.S.H. Milieu and A.R.F. Milieu	25
Apparatus	26
Procedure	27
Research Design	28
IV RESULTS	30
Comparison Between the N.S.H. Group and the A.R.F. Group and Within the N.S.H. Group	32
The Relationship Between Attitude Toward The Condition of Alcoholism and Adjustment to the Condition of Alcoholism	39
V DISCUSSION	46
Implications For Social Work Practice	57
Limitations	58
Recommendations for Future Research	59

Page

Appendix

A. The Bell Alcoholism Scale of Adjustment. . . . 61

B. The Attitude Scale for Alcoholism 64

C. Distribution of Demographic Variables and Proportion of Improved and Non-Improved Cases 72

REFERENCES. 74

LIST OF TABLES

Table		Page
I	A T-Test Comparison of the Attitude Scales and the B.A.S.A. in the Pre-Test and Post-Test Situation for N.S.H. and A.R.F. Groups	33
II	A T-Test Comparison of Six N.S.H. Groups to Determine The Significance of Change for the Total Attitude Scale and the B.A.S.A. Score	37
III	A Chi-Square Comparison of Proportions of Groups That Improved or Did Not Improve for The Attitude Scale and the B.A.S.A.	38
IV	A Correlation Matrix for the Attitude Scale With the B.A.S.A. in the Pretest and Post-Test Situations for Both Groups	40
V	A T-Test Comparison of Means For the Total Attitude Scale and the B.A.S.A. for Both Groups in the Pre and Post-Test Situations	44

LIST OF FIGURES

Figure		Page
1	A Comparison of Attitude Scale Scores for Both Groups in the Pre Test and Post Test Situations	34
2	A Comparison of Groups for Attitudes Scores and Adjustment Scores	35
3	A Comparison of the Relationship of Subscales to the B.A.S.A. for Both Groups in the Pretest and Posttest Situations.	41
4	The Relationship of the Total Scale to the B.A.S.A. for Both Groups in the Pretest and Posttest Situations	42

CHAPTER I

INTRODUCTION

Any treatment or counselling is aimed at producing constructive change in an individual in regard to some type of faulty condition. The direction of the change ethically goes from a state of dysfunction, destruction, or disequilbrium to one that is functional, constructive or harmonious. This type of movement from one state to another is usually labelled as 'attitude change,' 'behavioral change' or 'personality change.'

In particular, this study is concerned with one type of treatment, didactic group therapy, and one dysfunctional state, alcoholism. It relates to how the former causes movement away from the latter to effect a constructive change. Underlying most treatment programs for the rehabilitation of alcoholics is the assumption that acceptance of the condition of alcoholism is an essential element involved in the rehabilitation process. This assumption stems from the observation that before an alcoholic is willing and able to deal effectively with his problem, he must accept it as a problem.

In short term therapy this same assumption becomes the task goal of the treatment, and in order to bring an alcoholic to his point of acceptance the process goal becomes one of attitude change towards the condition of alcoholism. A further

assumption is made which equates attitude change toward the condition of alcoholism to attitude change toward the 'self' in relation to the condition of alcoholism. That is to say, a cognitive acceptance of the condition is the same as a personal acceptance of the condition.

An effective way of achieving the process goals is through the use of didactic group therapy in which alcoholics are exposed to information regarding the condition of alcoholism and then allowed to discuss the topical information with peers and a therapist. This process is sometimes called an educational treatment program.

In the literature it can be seen that research done on the outcome of didactic group therapy has been done without giving consideration to the experimentation done in the field of attitude change. On the other hand the experimentation done on attitude change has, by in large, limited itself to the laboratory situation, in that, researchers usually use a normal sample like housewives or college students and have tight controls (e.g. Rhine, 1958, Canon, 1964, Weiss, 1969). It will be attempted in this study to measure the amount of attitude change (on a cognitive level as well as personal) elicited by a selected group of alcoholics who are involved in a didactic group treatment program which has all the ear marks of being a type of persuasive communication. If this is so, the entire treatment program could be explained

in terms of an attitude change theory thus helping the practioner to better able understand exactly what therapy is doing and through improved understanding will be in a more advantageous position to better their methods.

Because there may not be a relationship between attitude change towards the condition of alcoholism and the actual adjustment to the condition, the study will attempt to differentiate between the attitude toward the condition and adjustment to the condition.

Statement of Problem

The purpose of the study will be to measure and evaluate the effectiveness of the three week didactic group therapy program offered at the Nova Scotia Hospital for the treatment of alcoholism with regard to attitude change and adjustment; and with the view to answering the following questions:

(1) Does a didactic group therapy elicit attitude change?

(2) Does didactic group therapy facilitate adjustment?

(3) To what degree is adjustment to the condition of alcoholism continguent upon attitude change?

CHAPTER II

REVIEW OF THE LITERATURE

The treatment program offered to those suffering from alcoholism at the Nova Scotia Hospital has three attributes that has direct implications for the facilitation of attitude change towards the condition of alcoholism. The program is short-termed 21 days in duration thus focus is given to process goals; it is educational in nature (it uses films and lectures) hence dissimination and discrimination of information is imparative; and the service is delivered in a milieu of discussion groups which assumes direct active dialogue on, at least, a cognitive level.

I Directive Therapy

The evolution of short-term therapy has been purposeful, it has stemmed from the realization that not enough clients were being served and that short-term therapy was effective. Stekel (1967) was responsible for a number of techniques that found later expression in many contemporary short-term therapies. His successful innovations included active participation through direct interpretations of client situations and reactions on the part of the therapist. It was suggested that this directiveness be extended even to the point of advice-giving and exhortation, keeping the client within relevant boundaries, and selection of pertinent topics for

discussion. Alexander and French (1967) also emphasized similar techniques when they suggested the use of direct interviewing, that is, not allowing the client to give the direction, and the use of advice and suggestions.

These techniques can also be seen as coersive and persuasive measure to have the client change his attitudes toward his given situation.

Wolberg (1965, pp. 129-218) attempts to apply the concepts of active or directive interpretations to facilitate adjustment to a given condition by stressing the use of insight in short-term therapy. This he states can be facilitated by teaching the patient how to employ insight as a corrective force or teach the client how to see where and how he relates to each specific situation; and by outlining with the patient a definite plan of action by which he utilizes his insight in the direction of desired change.

It should be noted here that Wolberg does not equate insight to automatic behavior change. He states that the therapist should actively and directly point out the patients irrationale philosophies and faulty values and in their place offer healthier ones.

While recognizing the wide range of possible therapeutic interactions Bellak and Small (1965) put forth a basic procedure in short term therapy which includes the directive measures, the use of group therapy in which didactic dialogue

is used, informing the client of resources available to him (eg social agencies) and the use of educational techniques (eg films and lectures) centering around a condition (eg alcoholism).

Active and directive communication involves not only interpretation but the offering of guidance, suggestion, advice, general information and so on. Despite the varying degrees of directiveness implied by advice, suggestion, guidance and provision of general information, there seems to be considerable controversy as to the degree of directiveness actually employed in each instance. Haley (1963, p. 71) in comparing the similarities found between directive and non-directive therapies states "actually nondirective therapy is a misnomer". To state that any communication between two people can be non-directive is an unlikelihood. Whatever a therapist does not say to a patient as well as what he says will circumscribe the patient's behavior.

Despite this, Hollis (1964) and Jacobson (1967) strongly advise against giving direct advice for fear it leads to the clients greater dependency on the therapist. Bellak and Small (1965) suggest giving a number of alternatives to those patients who are capable of making logical decisions. For those less capable the therapist can offer recommenations. For the acting-out patient, they recommend a flat direct statement of desired action. Wolberg (1965) in recognizing

the therapists inevitable influencing of the clients philosophies and values, poses the rhetorical question, "Why not then openly present new percepts that can serve the patient better?" Barton (1965) advocates the use of exhortation.

Also implied in the above recommendations and observation is that the more direct the method and message elicited by the therapist the greater the element of persuasion becomes evident.

Rapaport (1967) in describing techniques suitable to brief treatment states, "In general, the approach needs to be more active and directive than in traditional work. Implied is the greater use of authority. Advice-giving, which for a long time acquired a kind of taboo for historical as well as theoretical reasons, is being re-examined for its utility. Aside from the controversial issue of directivity, most of the writers such as Wolberg (1965), Bellah and Small (1965), Baldwin (1968), Morris (1968), Krider (1969), Rapoport (1967) and Strickler (1965) suggest the provision of immediate help (eg. suggestions, advice, general information) for the client.

II Didactic Group Therapy

Therapists and theorists have extended the operationalization of directiveness and activity a step further so that they can be applied to groups. Application to the group

situation has resulted in insight therapy, in fact, become didactic group therapy. Phillips and Johnston (1954) state, "seemingly, man finds it necessary to structure vague, formless, rootless experiences, so that he is better able to cope with them." They hypothosize that the didactic approach teachs the individual patient to give meaning to his experiences thus giving him a structure or frame of reference by which he will be better able to adapt to his situation or condition. Regarding didactic therapy Phillips and Weiner (1963) argue that increased structure not only does not violate the uniqueness of the individual, but makes the therapeutic situation more satisfying for both patient and therapist and also provides a better basis for mutual problem solving.

The use of didactic techniques (the dissemination of information, suggestion and advice followed by a discussion of topical interest) in group therapy is not without precedent. Some of the earliest methods used in therapy used a classroom model in which a therapist even lectured for part of each group meeting. Marsh (1935) using the rationale that didactic information disarms the patient of his foreboding fears, seeing the patient as a student described his Mental Hygiene Classes conducted at Worchester State Hospital which took the form of a lecture course with group discussions. Shrader et al (1969) using a

similar didactic group technique with parents of first-born claim that any number of problems pertaining to children, adolescents and adults can conceivably be treated by similar didactic techniques used in a free interactive group setting.

The essential of the approach consists of (1) a relatively homogenious group of patients seeking help with a common problem and (2) a carefully prepared body of information relevant to the problem.

In the case of this study groups will consist of male alcoholics with an active problem of not being able to control their drinking and the information is prepared and presented via films and lectures pertaining to different aspects of the condition of alcoholism.

Battegay (1966) evaluates the didactic group therapy as being useful in providing a means for the participants to overcome their fear of being addressed and to adjust their expectations to the inward and outward realities. He claims that these results are partially due to the pace-maker function associated with therapeutic group discussion. Leib and Snyder (1967) in attempting to discriminate the effects of group discussion group as opposed to lecture groups found significant increments in self-actualization in both groups without significant differences between lecture and discussion groups.

The directiveness involved in the didactic approach has also been advocated and implemented in the treatment of alcoholism. Regarding the treatment of alcoholics Block (1965, pp. 122-126) states that adjustment can be made by the patient if there is sufficient interest shown and explanation given by the therapist .... actually, the whole program of treating the alcoholic is a re-educational one ... we must teach the patient to observe those around him who have exactly the same problems but use other methods of meeting them. Emphasis must be laid on the importance of not necessarily solving every problem perfectly. The ability to compromise and adjust must be learned by repetitious discussions. Brunner-Orne (1967, pp. 152-163) working from the premise that alcoholism results from a combination of physiological, biological, psychological and environmental factors advocates a three dimensional approach which besides using medical and psychiatric treatment includes group activity programs which makes use of professional guest lectures and films followed by a discussion and question period. She feels that the main impact of this part of the program is that it makes the patients realize that attitudes must be changed. As a result of the total approach Brunner-Orne boasts a 38% success rate. Blum and Blum (1967, pp. 143-148) in describing the utility of didactic group therapy states that it can serve to acquaint the

alcoholic patient with the nature and management of his disorders, including his social and vocational problems; it can serve to orient him to the facilities of the community and its change-agencies and to the respective roles of patient and change-agent in the treatment process. Like Marsh (1935) the authors also view the patient as a student and attempt to organize treatment as a lecture course with active student participation in discussions, questions, and in deciding the content of the course.

III Attitude Change

Throughout the research and theory of attitudes there seems to be no one acceptable or universal definition of this concept because of its high degree of abstraction. Without conditions it can be basically defined as a feeling, an emotion, or psychological state associated with some cognition, object, person, situation or want. With such a definition in mind it would be only reasonable to say that if the external is altered the related attitude will also change. However if the "self" is added to the definition an attitude would become a feeling associated with the perception of the self in relation with an object. Thus only an alteration in the perception of the self in relation to an object would result in a change in attitude. If these two definitions are mutual exclusive concepts then two types

of attitudes may exist. That is to say, attitude change can occur by altering the external, which for the purpose of this treatise shall be called attitude change; or attitude change can occur by altering the persons perception of his self in relation to the external, which shall be called adjustment. Also if these two types of change are not mutually exclusive then conversely they are contingent upon each other.

Blum (1965) makes an observation regarding the attitudes of alcoholics and how or if this is related to his adjustment. The observation is stated as follows:

> "In attempts to evaluate the attitude of the individual to ascertain what his attitude is toward his own drinking and his drinking problem. We know that many use alcohol as an escape from reality. We know that many alcoholics punish themselves by ingesting alcohol. But not enough attention has been given these attitudes by the average therapist, the family physican, and the people around the patient; not enough effort has been made to aid the alcoholic patient in changing such attitudes, understanding himself and his problems, and modifying his methods of meeting this problem."

Blum goes on to state that treatment should be aimed at changing the faulty attitudes of the alcoholic by the use of essentially a didactic approach. However, he fails to describe what type of attitude change will occur as a result of this approach or in fact to what degree attitude change is related to adjustment. In spite of this, he does set up a basically sound equation that the didactic approach facilitates attitude change, at least.

In comparing inpatients self-perceptions to the perception of the therapists of the patient Reinehr (1969) found that, by in large, the treated alcoholics gave themselves a poorer self-description, thus showing a discrepancy between the therapist's and patient's perception of the same object, namely, the patient.

Katz, Sarnoff, and McClintock (1956) partially counter Blum's equation from the results of an experiment which compared the effects of insight therapy to didactic therapy. One group of subjects were exposed to insight into the psychodynamic relationship between anti-negro attitudes and the defense mechanisms, the other group was exposed to accurate information about negroes. The results showed that the changes in attitude produced by the arousal of insight persisted longer than the changes induced by pure information. This experiment helps to point out two points regarding the didactic approach. The first is that new accurate information alone can elicit attitude change in a desired or predicted direction. Secondly, the didactic approach does not rely solely on the provision of new information but also depends on the new situations provided by group discussions and question periods. For example, Mitnick and McGinnis (1958) reported greater attention of attitude change among groups who had seen a film and then spent thirty minutes discussing the film informally than

among groups who had only seen the film. Immediately after the sessions there were no differences in attitude change between the two conditions, but when measured again a month later the film-alone groups had regressed backward toward their pre-session position, whereas the film-discussion groups showed no significant change from their immediate posttreatment scores.

Both the new information and the new situation according to Festinger (1957) because of their cognitive newness will be condusive to eliciting attitude change. In keeping with his theory of cognitive dissonance these two novel cognitions when they become known to a person create, at least, a momentary dissonance with existing knowledge, opinion, or cognition concerning behavior. In turn, because dissonance is psychologically uncomfortable the individual will be motivated to try to reduce the dissonance and achieve consonance. The reduction of dissonance can be achieved in one of two ways. First, an individual can accept the new cognitions and hence change his attitude to incorporate them; and conversely he can reject them and hence reinforce his original attitude toward a given object, person or behavior.

Whether or not a person accepts or rejects the new cognition is continguent upon some attributes of the new information i.e. the attractiveness of the cognitions and the amount and scheduling of exposure to the cognitions.

(1) The Attractiveness of the Cognition. In order for the new information or new situation to facilitate a desired attitude change it must be seen as attractive or rewarding to the recipient. Brehm (1957) had female subjects rate eight appliances for desirability. Subsequently, the subjects were given a choice between two of the eight products given the chosen product, and after some interpolated activity (consisting of reading research reports about four of the appliances) were asked to rate the products again. Half the subjects were given a choice between products which they rated in a similar manner, and half between products on which the ratings differed. The prediction from the dissonance theory that there should be an increase in the attractiveness of the chosen alternative and decrease in the attractiveness of the rejected alternative was, on the whole, confirmed. Tannenbaum (1956) exposed some of his groups to favorable and some to unfavorable communications toward an attitude object to find that the amount of positive attitude change is directly proportional to the degree of attractiveness.

It is assumed that the didactic treatment program for alcoholics at the Nova Scotia Hospital is seen as attractive or rewarding in that, the program suggests and encourages modes of behavior that will have positive consequences if they are adhered to. The theme of the therapy seems to be that life can be much more productive and satisfying without the excessive use of alcohol.

(2) The Amount and Scheduling of Exposure. Obviously, the amount of exposure over time will effect the degree to which a person is likely to change his attitude. Bozohi (1970) in studying attitude change as a function of presentation of persuasive communications found that subjects who received information over a given period of time were better able to assimilate the information better than the group who received the information all at once, and also that the subjects who received the distributed information did not regress to their original position as did the other group of subjects. Weiss (1969) in focusing in on the effects of the amount of exposure of persuasive communication upon attitude change exposed half his subjects to the communication once and the other half were exposed to the same communications three times. He simply found that three exposures resulted in greater attitude change than did one exposure. Jecker (1964) through similar studies explained the results by theorizing that on the initial scanning of the information, there is a tendency to spend less time on material that is dissonant with decisions the person has made. But then the person goes back to the dissonant information to reinterpret it. And the evidence is that he succeeds in reducing dissonance to some extent by such reinterpretation.

The amount and scheduling of exposure of information

and discussion is spread over a 21 day period during which the patients are usually exposed one film and/or lecture each day as well as daily group sessions.

Because didactic therapy is usually given in a milieu of dialogue and more specifically in a group setting, this situation will have attributes that will facilitate or hinder desired attitude changes. That is to say, attitude change is not only affected by the nature of the issue but also by the source of influence. From a series of studies Weiss (1963) put forth the principle that the content of the message is made more believable and acceptable by its link with a credible source. More specifically, it is asserted that a high credibility source is significantly more effective in inducing positive attitude change than is a low credibility source. It should be noted here that this principle only holds in the case when the recipient has a lower sense of self-esteem or confidence than the communicator. But as pointed out in a previous study Reinehr (1969) alcoholics, by in large, have a poorer self-image of themselves as compared to their therapists or communicator. So for the purpose of this treatise it will be assumed that the sleeper effect (or the converse of the above principle) will not apply. Further support of this assumption is given by Canon (1964) who states that the less confidence the person has in being able to cope with the

dissonant material, the greater is the preference for reliable material. He found that subjects who were highly confident actually showed a strong preference for reading dissonance increasing information while the opposite was true for subjects lacking self confidence. Rhine (1970) also argues, as a result of his study, that attitudes do change as a function of the amount of dissonance and the source credibility. These results concur with Aronson's (1963) findings that for a given level of discrepancy, a highly credible source will produce more attitude than a less credible source. In attempting to show that credibility not only depends on the expectness of the communicator but also the trustworthiness Choo (1964) held the variable of expertness constant and manipulated the variable of trustworthiness and found that trustworthiness alone can differentially affect the subject's opinion change.

Applying these variables to the group milieu seems to have a multiplier effect regarding the changing of attitudes in a desired direction. This, of course, assumes the definition of a group that the group is rather homogenious regarding its purpose and are committed to their goals. Cohen (1964, pp. 37-41) explains this multiplier effect as resulting from the fact that the expectation of a group acts as a source of social approval or disapproval, that is, a group member is more likely to conform to the norms of his given group. This effect can be seen in a previously sited

study by Mitnick and McGinnies (1958) in which the group discussions gave stability to an attitude change. Pennington et al (1958) arrived at similar results which favored group discussion for changing attitudes. An example of how the group's position influences attitude change can be seen in an experiment by Rhine (1958). In this experiment, some subjects made responses after hearing the responses of three fellow students and other subjects made their responses in private. The results showed that the subjects who heard the responses first adopted similar attitudes more readily than those who responded in private.

IV Attitude Change Versus Adjustment

Often in the literature regarding attitudes the terms 'attitudes' and 'behavior' are used interrelatedly, that is, it assumes that attitude change necessarily effects a change in behavior. The literature that has been sited regarding the use of didactic therapy measures effectiveness by looking at behavior changes and assumes an attitude change. While the literature pretaining to cognitive dissonance does the converse, in that, it measures the effectiveness of studies by looking at attitude change and assumes behavior change. Cohen (1964) addresses himself to this problem by stating:

> A critical issue in the understanding of attitude change is the degree to which outer conformity to persuasive appeals is transformed into inner change, and the conditions

> under which this transformation will occur .... attitudes are always seen as precursors of behavior, as determinants of how a person will actually behave in his daily affairs. In spite of the wide acceptance of the assumption, however, very little work on attitude change has dealt explicitly with the behavior that may follow a change in attitude.

On reviewing the literature of therapy Schonbar (1965) concludes that not all change (adjustment) is due to insight (attitude change) and conversely not all insight (attitude) change) leads to adjustment. Defleur and Westie (1958) using a unidimensional scale to measure attitudes found on one hand expressed attitudes which significantly related to the direction of the action taken by subjects regarding being photographed with a Negro of the opposite sex. On the other hand, a third of the subjects behaved in a manner quite inconsistent with that which might be expected from their expressed attitudes. Kilty (1969) with similar concerns divides attitudes into affect and cognition and states that if affect and cognition are closely related, measuring one is sufficient. If affect and cognition are not closely related, separated measurements of each aspect of attitude is indicated. Using a university student sample the author found these two variables to correlate at ($r = .39$) which led to the conclusion that a change in cognition does not necessarily assume a change in affect even though these two aspects are not entirely mutually exclusive.

In theorizing about adjustment to a disability like alcoholism Bell (1970) also is aware of the distinction between cognition and affect when he states that adaptive adjustment to a disability, the attitude object, involves the conscious recognition of the condition, and an accepting attitude toward the self and the condition. In essence, he is saying that if a person is to adjust to a condition the person must not only develop good attitudes about the condition but also about the condition in relation to the person himself. Thus an adaptive type of adjustment is reflected in both attitude and behavior. Because the author feels these variables are not necessarily dependent there are several ways in which a reaction to a condition can be described. Therefore, Bell outlines the following four types of adjustment to the disability of alcoholism:

> The passive acceptor accepts his condition and identifies completely with the alcoholic population and yet is not motivated for therapy .... The active acceptor, on the other hand, is highly motivated for therapy. This person accepts his condition, identifies with other alcoholics, and does something positive about alleviating the problem.... At the other end of the acceptance-rejection continuum, the passive rejector would deny that he is an alcoholic and would not identify with other alcoholics at all, hence would lack sufficient motivation to alter his drinking patterns. The active rejector who also rejects the motion that he is an alcoholic, would be highly motivated to abstain from alcoholic.

In the case of the active acceptor the person would be able to accept a new attitude toward the condition and view

himself in relation to that the condition ~~and view himself in relation to that condition~~, whereas, the passive acceptor would not be able to relate himself to his condition. In the former situation there would be dissonance reduction and in the latter an increase in dissonance. The final outcomes that would be of concern would be that of the passive rejector who neither changes his attitude nor his behavior, hence achieves a state of consonance.

CHAPTER III

METHODOLOGY

A. Sampling Procedure and Subjects

Since this study had a time limitation which decreased the number of possible candidates available for the study, choice of sampling procedures was also limited to that of incidental sampling. The subjects selected for this study were all those being treated for alcoholism for the first time at either the Nova Scotia Hospital or the Nova Scotia Alcoholism Research Foundation during the last siz weeks of 1971 and the first two weeks of 1972.

This sampling procedure allowed 18 subjects to be selected from the Alcoholic Research Foundation within an eight week time period of which 50 per cent were employed and 50 per cent unemployed; 28 per cent were single, 39 per cent were married (which included common law marriages), 33 per cent were separated (which included those who were divorced and widowed); 22 per cent were between the ages of 21 to 35, 50 per cent were between the ages of 36 to 50 and 28 per cent were over 50 years of age; 67 per cent were voluntary referral and 33 per cent were non voluntary (referred by courts or an employer); and finally, 22 per cent had primary education, 45 per cent had junior high school education and 33 per cent had better than junior high school education.

In the group at the Nova Scotia Hospital 36 subjects were selected within a six week period of which 53 per cent were employed and 47 per cent were unemployed; 36 per cent were single, 44 per cent were married and 20 per cent were separated; 39 per cent were between the ages of 21 to 35, 39 per cent were between the ages of 36 to 50 and 22 per cent over 50 years of age; 75 per cent were voluntary referrals and 25 per cent were certified (non-voluntary); and 28 per cent had primary education, 33 per cent had junior high school education and 39 per cent had better than junior high school education.

The steps in the sampling procedure were simple. When a candidate came for treatment of alcoholism he was asked if he would participate in a study sponsored by the agency and Dalhousie University. If the candidate was from the Alcoholic Research Foundation he was asked to do the test battery right there and then. After the instructions were given the subject was then left alone to complete the battery (the Attitude and Adjustment Scales). When the subject finished he was asked to return three weeks later (the date for the appointment was set in co-operation with the doctor and therapist) to complete the final part of the study. Eighteen of twenty-six subjects returned to do the second part of the study.

In the N.S.H. group the same procedure was employed, in that, the whole test program was done on a voluntary basis.

Before commencing the didactic treatment program the subjects were asked if they would volunteer to be part of a study sponsored by the Nova Scotia Hospital and Dalhousie University If they agreed they were given the test battery (the B.A.S.A. and the Attitude Scale) immediately and usually done in a small group setting and was monitored. The post tests were given about twenty days later after the patient has been exposed to treatment. During this three week period the client was a resident of the hospital. Thirty-six of 47 patients were retested.

This incidental sampling procedure, in effect, allowed for the maximum use of all possible candidates. The drawback in using this procedure is that samples may be representative of the population on which the study is to be used but leaves more to chance than other sampling methods.

B. Treatment

i. The Treatment Milieu for the N.S.H. Group: The alcoholism treatment regimen, or schedule is organized within a 21 day treatment period. During the 21 day period each patient is given a protein rich diet, receives chemotherapy as needed and prescribed by the physician primarily for anxiety, depression and insomnia, along with certain routine vitamins and deterrents; participates in group therapy at least once a day for an hour and individual counselling, if indicated; he attends, daily, didactic lectures and films on

the nature of alcohol and alcoholism e.g. the disease concept, stages in the development of alcoholism, definitions, and symptoms; and is exposed to the program of Alcoholics Anonymous.

ii. The Treatment Milieu for the A.R.F. Group: Within a given 21 day period patients of the Alcoholism Research Foundation are given chemotherapy, vitamins and deterrents, on an outpatient bases as prescribed by a physician and is seen at least once for a half an hour on an individual basis by a trained therapist.

C. Apparatus

i. The Bell Alcoholism Scale of Adjustment: The B.A.S.A. (Appendix A) was used in the pre and post test situations as a measure of adjustment to the condition of alcoholism.

ii. The Attitude Scale: This scale (Appendix B) was used in the pre and post test situations to measure the patients attitude toward four aspects related to the condition of alcoholism; (A) treatment of alcoholism, (B) education regarding alcoholism, (C) social drinking and (D) the alcoholic. For these scales there are are parallel forms (r = .93).

Scores from the B.A.S.A. constituted the degree of adjustment for a subject in regard to his condition of alcoholism. There is one total score which can range from 40 to 240. The lower the score the better the adjustment to the condition.

The Attitude Scale related to the attitude of a subject toward the condition of alcoholism. The scale yields five scores; a score for each subcategory which can range from 0 to 12 and a total score which can range from 0 to 48. High scores on each sub scale and hence the total score reflect a positive attitude.

D. Procedure

The B.A.S.A. and Attitude Scale were administered to each new patient within 24 hours of his arrival on S - 6 (The Alcoholism Unit of the N.S. Hospital). The subjects to be tested had to be first admissions and they had to be physically able to take the tests. The B.A.S.A. and the Attitude Scale (parallel form) were administered to the same subjects within 48 hours before their discharge. In order for retesting to occur the subject had to be exposed to the treatment program for not less than 2 and not more than 3 weeks.

In order to make valid pre and post test comparisons within and between groups certain factors were looked at before and during treatment; specifically the degree of impairment in behavior and social relations as diagnosed by the unit's psychiatrist. Further information regarding the patient's age, marital status, type of referral, education and employment status were gleaned from the social history of the patient. Finally, each patient was rated as to the extent of his involvement in the treatment program by a

based on what?

therapeutic staff member (nurse or social worker) other than the psychiatrist.

The same procedure was followed for the subjects in the A.R.F. group, with the exceptions that they were not rated as to their degree of involvement in the program since there was none. They also did not have a psychiatric assessment to determine the degree of impairment of their behavior and social relations. Further, the conclusion of the three week period did not necessarily coincide with the termination of the treatment program.

E. Research Design

This experimental study employed comparative groups, the Nova Scotia Hospital alcoholic patient population of first admissions and the Nova Scotia Alcoholism Research Foundation patient population of new referrals to determine the effectiveness of didactic group treatment as offered at the hospital as opposed to the more conventional individual treatment as offered at the foundation within a given three week period. The effectiveness was measured by changes in the attitudes as measured by the Attitude Scale and changes in adjustment as measured by the B.A.S.A.

Research Model:

	N.S.H. Group			N.S.A.R.F. Group		
	Before		After	Before		After
Attitude :	M	3 wks →	M_1	E	3 wks →	E_1
Adjustment :	N	3 wks →	N_1	F	3 wks →	F_1

Basically, the same research design was used to measure the relationship between the two variables of attitude toward the condition of alcoholism and adjustment to the condition before and after treatment within each of the two groups as well as between groups.

CHAPTER IV

RESULTS

The analysis of the data was done in a manner to facilitate the answering of the questions asked earlier in the statement of the problem. As a result, this chapter has the purpose of seeing how the two treatment groups compare between each other as to their effectiveness and how the Nova Scotia Hospital group compares within itself; and how the two variables of attitude and adjustment are related to each other and if any changes occur as to the mutual influence upon each other as a result of treatment.

The first part was concerned with how the two groups (the N.S.H. group and the A.R.F. group) compared in the degree of effectiveness to elicit positive attitudinal changes and adjustment to the condition of alcoholism as a result of 3 weeks of treatment. Further, within groups of the N.S.H. group were compared to measure the same effectiveness. Three different methods of statistical analysis were used to make these comparisons:

1. The N.S.H. group was compared to the A.R.F. group by employing t-tests to see if each of the subcategories of the Attitude Scale, the Total Scale and the B.A.S.A. changed significantly in the post-test situation.

2. Three pairs of subgroups of the N.S.H. group were compared to each other by employing t-tests to see if the Total Scale

score and the B.A.S.A. changed in the post-test situation.

3. The N.S.H. group was compared to the A.R.F. group by employing a chi-square test to see if the proportion of those who improved on the Total Scale and on the B.A.S.A. in the two different groups were significantly different.

The second focus was on how the two variables of attitude toward the condition and adjustment to the condition related to each other or how much one variable influenced the other both in the pre and post test situations. This was done by correlating the Total Scale score with the B.A.S.A. score in the pre and post test situations for both groups. Further to this comparison an analysis was done to see how the subscales of the Attitude Scale separately related to the B.A.S.A. in the pre and post test situation for both groups.

Finally, in order to determine of the two samples were different two types of comparisons were made:

1. A t-test was used to see if pre and post test means for the Total Scale and the B.A.S.A. differed significantly between groups.

2. Chi-square tests were employed to see if the demographic variables differed significantly between groups as they related to improvement and non-improvement ratings both for the Total Scale and the B.A.S.A. (refer Appendix C).

I Comparisons Between And Within Groups

The first comparison was between groups. The educational treatment program (didactic group therapy) offered at the Nova Scotia Hospital (N.S.H.) was compared to the program offered at the Alcoholism Research Foundation (A.R.F.) which was basical individual therapy. Differences in between the programs was achieved by seeing how each program was able to effectively elicit positive changes in the four Attitude Scales (attitude toward treatment, education, social drinking and alcoholism), the Total Scale (the summation of the four Attitude Scales) and the amount of negative change in the B.A.S.A. from the pre-test to the post-test situations.

Each Attitude Scale (4) as well as the Total Scale score and the B.A.S.A. were computed as to their means and standard deviations in the pre-test and post-test situation for both groups. The Nova Scotia Hospital group had 36 subjects while the Alcoholic Research Foundation group had only half that number (18). A t-test was employed to find the level of significance between each pre-test and post-test mean.

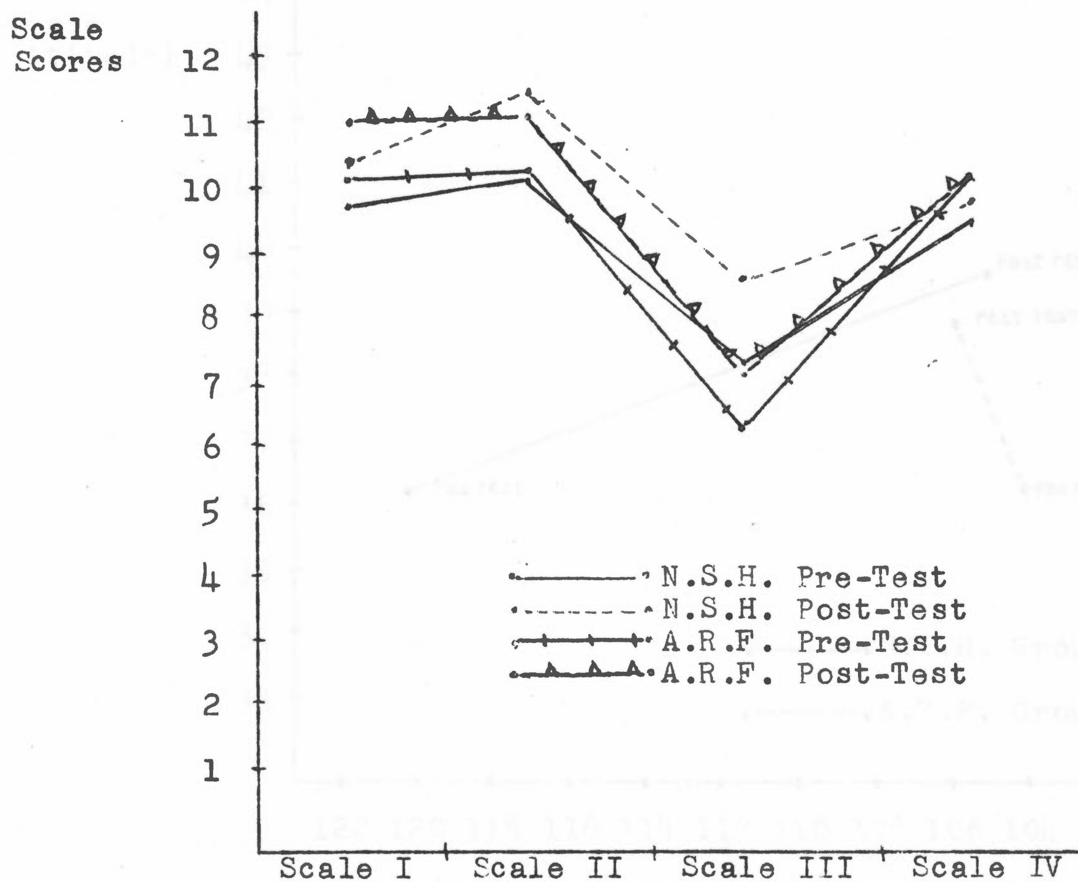
TABLE I

A T-Test Comparison of the Attitude Scales and the B.A.S.A. in the Pre-Test and Post-Test Situation for N.S.H. and A.R.F. Groups

	Scale I Treatment	Scale II Education	Scale III Social Drink	Scale IV Alcoholic	Total Scale Attitude	B.A.S.A. Adjustment
N.S.H. Group						
Pre-Test						
Mean	9.81	10.03	7.31	9.11	36.19	120.17
S.D.	1.47	1.28	2.04	1.60	3.73	30.31
Post-Test						
Mean	10.53	11.42	8.53	9.22	39.69	105.42
S.D.	1.36	0.87	1.92	1.76	3.58	20.74
Significance of Difference	t=2.16 $p < .05$	t=5.39 $p < .01$	t=2.62 $p < .01$	t=0.28 N/S	t=4.06 $p < .01$	t=2.41 $p < .01$
A.R.F. Group						
Pre-Test						
Mean	10.06	10.00	6.22	9.83	36.11	104.56
S.D.	1.73	1.75	2.82	1.82	5.80	28.41
Post-Test						
Mean	11.00	10.94	7.00	9.83	38.67	106.06
S.D.	1.46	1.11	2.54	2.01	5.34	27.12
Significance of Difference	t=1.77 $p < .05$	t=1.93 $p < .05$	t=0.87 N/S	t=0.00 N/S	t=1.83 N/S	t=0.16 N/S

Figure 1

Comparison of Attitude Scale
Scores for Both Groups in the Pre-Test
and Post-Test Situations



Scale I - Attitude toward treatment.

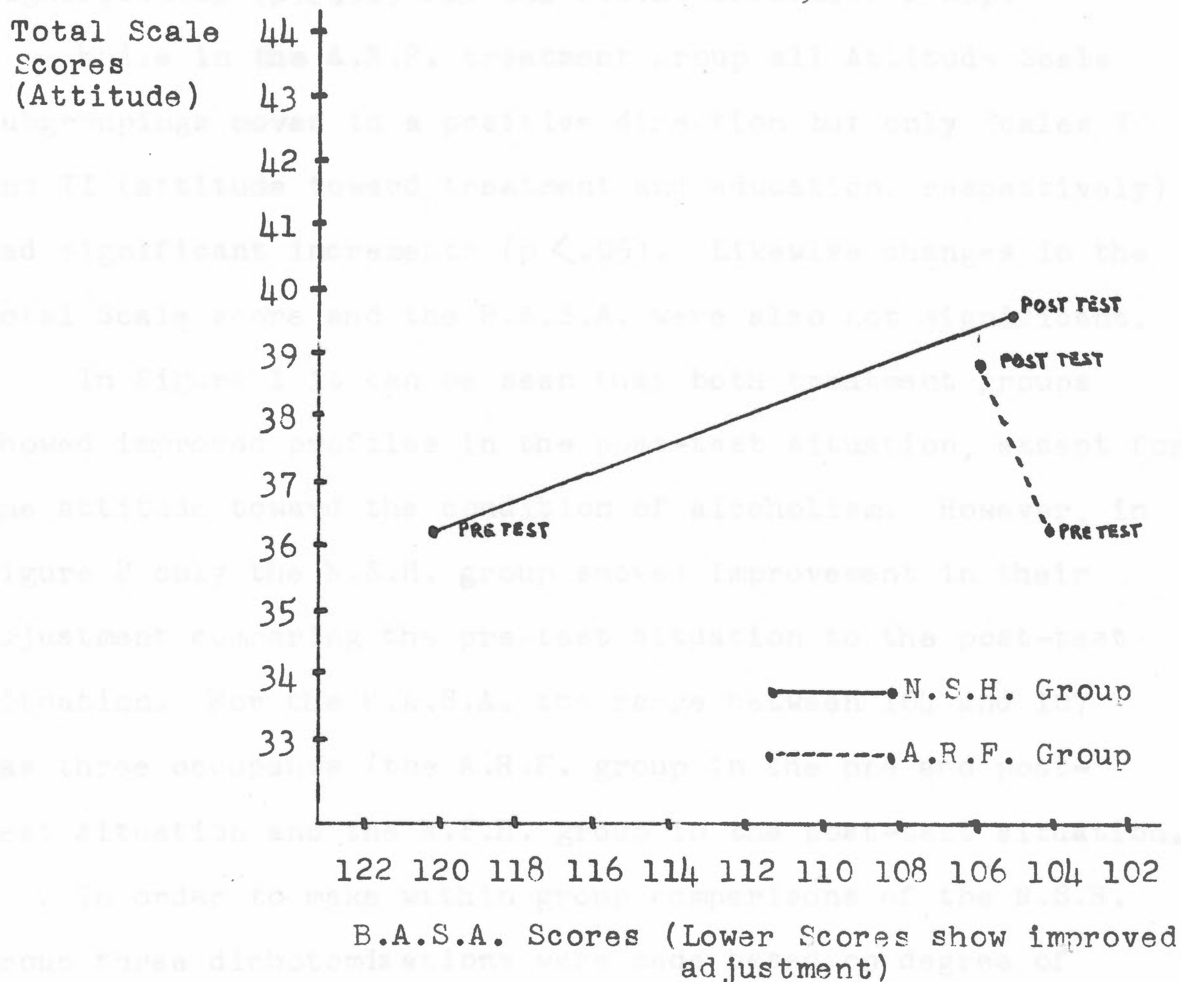
Scale II - Attitude toward education.

Scale III - Attitude toward social drinking.

Scale IV - Attitude toward alcoholism.

Figure 2

Comparison of Groups for Attitude Scores and Adjustment Scores



The results showed that for the N.S.H. group the means of all Attitude Scale's subgroupings (treatment, education, social drinking and the alcoholic) as well as the Total Scale score moved in a positive direction (i.e. increased). With the exception of Scale IV (attitude toward the alcoholic) the increments were significant (p .01 for Scales II, III and

Total Scale, $p < .05$ for Scale I). The mean for the B.A.S.A. also moved in the desired direction (i.e. decreased) significantly ($p < .01$) for the N.S.H. treatment group.

While in the A.R.F. treatment group all Attitude Scale subgroupings moved in a positive direction but only Scales I and II (attitude toward treatment and education, respectively) had significant increments ($p < .05$). Likewise changes in the Total Scale score and the B.A.S.A. were also not significant.

In figure 1 it can be seen that both treatment groups showed improved profiles in the post-test situation, except for the attitude toward the condition of alcoholism. However, in figure 2 only the N.S.H. group showed improvement in their adjustment comparing the pre-test situation to the post-test situation. For the B.A.S.A. the range between 104 and 107 has three occupants (the A.R.F. group in the pre and post-test situation and the N.S.H. group in the post-test situation.

In order to make within group comparisons of the N.S.H. group three dichotomizations were made based on degree of impairment of behavior, of social relations and degree of participation in the program. There were 18 subjects in each subgrouping which are as follows:

1. A. Those who had <u>mild</u> behavior impairment as rated by the psychiatrist.

   B. Those who had <u>moderate</u> behavior impairment.

2. A. Those who had mild social relation impairment as rated by the psychiatrist.

B. Those who had moderate impairment.

3. A. Those who participated poorly in the treatment program as rated by the nurse or social worker.

B. Those who participated in the treatment program.

These subgroups were, in turn, measured to find the amount of change for the Total Attitude Scale and the B.A.S.A.

TABLE II

A T-Test Comparison of Six N.S.H. Groups To Determine The Significance of Change For The Total Attitude Scale and The B.A.S.A. Score

Area And Degree of Impairment		Total Att. Score	B.A.S.A. Score
Behavior			
	Mild	2.62**	2.36*
	Moderate	3.08**	1.12
Social Relations			
	Mild	2.74**	2.10*
	Moderate	2.96**	1.19
Prog. Participation			
	Poor	2.19*	1.77*
	Average	3.65**	1.62

*p $<.05$
**p $<.01$

The results of these comparisons showed that the Total Attitude Score increased in all subgroups, in most cases at

the .01 level of significance. On the other hand the B.A.S.A. score decreased (desired direction) significantly in only three of the subgroupings. These changes were significant at the .05 level for the two groups whose impairment in behavior was mild and impairment in social relations was mild, and for the group who were rated as participating poorly in the program

Finally, the impact of the different programs for the treatment of alcoholism was estimated by the two groups (N.S.H. group and the A.R.F. group) as to how many improved or did not improve on the Total Attitude Scale and the B.A.S.A. or attitude and adjustment. A chi-square analysis was employed to discriminate any critical differences.

TABLE III

A Chi-Square Comparison of Proportions of Groups That Improved or Did Not Improve For The Attitude Scale and the B.A.S.A.

	Total Att. Scale Score		B.A.S.A. Score	
	N.S.H. Group	A.R.F. Group	N.S.H. Group	A.R.F. Group
Improved Score				
Number	27	12	26	9
Per dent	75	67	71.25	50
Non-Improved Score				
Number	9	6	10	9
Per cent	25	33	28.75	50
Totals				
Number	36	18	36	18
Per cent	100	100	100	100

Attitude scores improved at a 3:1 ratio for the N.S.H. group as compared to a 2:1 ratio for the A.R.F. group. The B.A.S.A. scores improved at an approximately 7:3 ratio for the N.S.H. group as compared to a 1:1 ratio for the A.R.F. group. However, the chi-square analysis failed to find any significant differences between these proportions.

II The Relationship Between Attitude and Adjustment

In order to determine to what degree the B.A.S.A. (adjustment to the condition of alcoholism) was influenced by the Attitude Scale scores and/or treatment a Pearson Product Moment Correlation was employed. Pre-test Scale Scores were computed with pre-test B.A.S.A. scores and likewise post-test Attitude Scale Scores with post test B.A.S.A. scores for both groups (i.e. the N.S.H. group and the A.R.F. group).

In the Nova Scotia Hospital group two trends appeared. The first is that all subcategories of the Attitude Scale correlated negatively (desired direction) to at least the .05 level of significance, with the exception of Scale I (attitude toward treatment) in the pre-test situation. The second trend that appeared was that the correlation coefficient, hence the amount influence (as represented by the r^2 values) on the B.A.S.A. (adjustment) increased in the post-test situation when compared to the pre-test situation for each subcategory with the exception of Scale IV (attitude toward alcoholics) which looses its influence, that is, the correlation coefficient decreases.

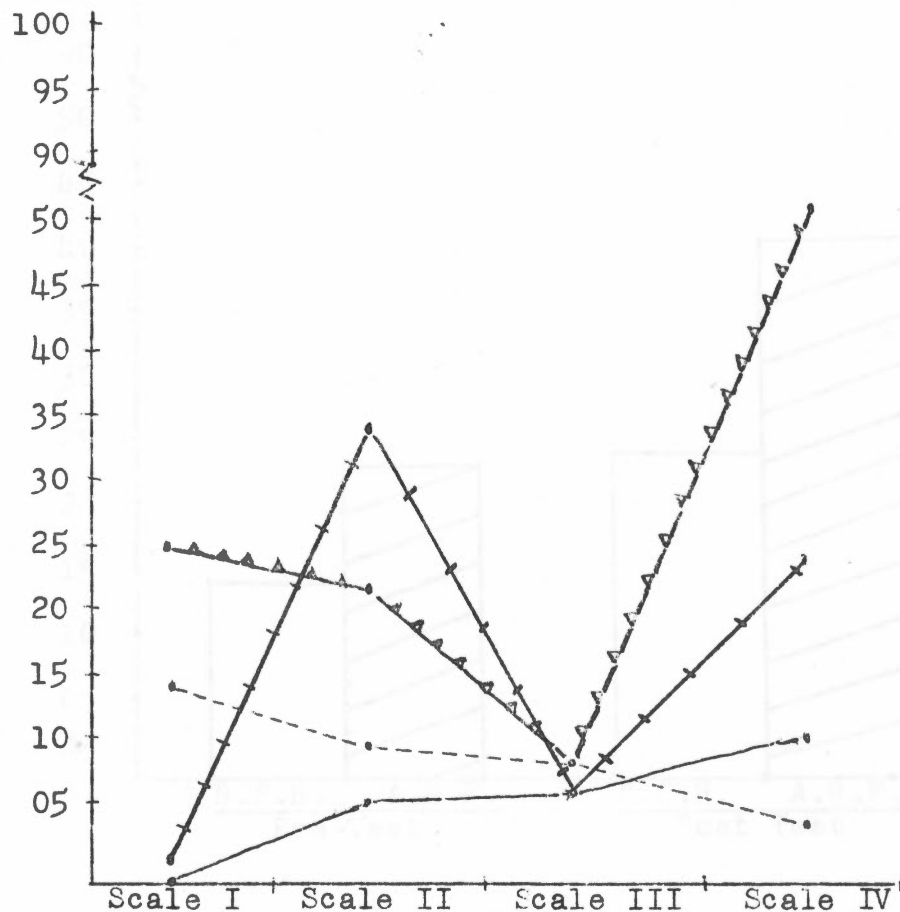
TABLE IV

A Correlation Matrix for the Attitude Scale With the B.A.S.A. in the Pretest and Posttest Situations for Both Groups

		Scale I (Treatment)		Scale II (Education)		Scale III (Social Drink)		Scale IV (Alcoholic)		Total Scale (Attitude)	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
N.S.H. Group											
B.A.S.A.	r	-.02	-.37	-.25	-.32	-.26	-.30	-.35	-.21	-.38	-.48
	r^2	.00	.14	.06	.10	.07	.09	.12	.04	.14	.23
Significance of r		N/S	.01	.05	.01	.05	.01	.01	.05	.01	.01
A.R.F. Group											
B.A.S.A.	r	-.15	-.51	-.58	-.47	-.26	-.31	-.51	-.71	-.51	-.63
	r^2	.02	.25	.34	.22	.07	.09	.25	.50	.25	.40
Significance of r		N/S	.05	.01	.05	N/S	N/S	.05	.01	.05	.01

Figure 3

Comparison of the Relationship of Subscales to the B.A.S.A. for Both Groups In the Pre-Test and Post-Test Situations



N.S.H. Pre-Test

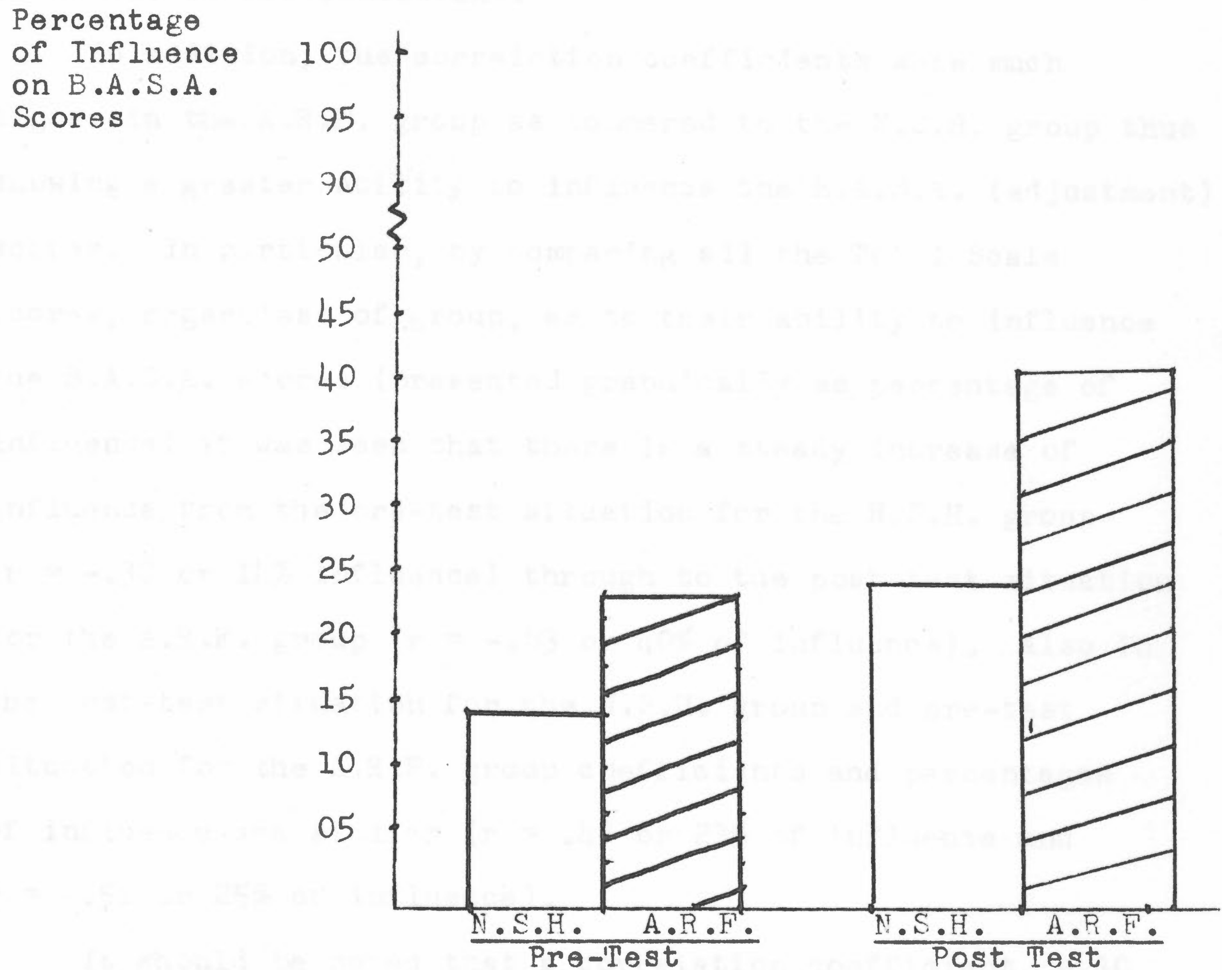
N.S.H. Post-Test

A.R.F. Pre-Test

A.R.F. Post-Test

Figure 4

The Relationship of the Total Scale to the B.A.S.A. for Both Groups in the Pre-Test and Post-Test Situations



In the A.R.F. group the same trends were also evident. In the first case there were more exceptions, in that Scale III (attitude toward social drinking) in the pre and post test situation yielded non-significant correlations as well as Scale I (attitude toward treatment) in the pre-test situation. The remainder of correlation coefficients were significant at

least at the .05 level. Like the N.S.H. group the correlation coefficients increased in the post-test situation as compared to the pre-test situation, with the exception of Scale II (attitude toward education).

In addition, the correlation coefficients were much higher in the A.R.F. group as compared to the N.S.H. group thus showing a greater ability to influence the B.A.S.A. (adjustment) scores. In particular, by comparing all the Total Scale Scores, regardless of group, as to their ability to influence the B.A.S.A. scores (presented graphically as percentage of influence) it was seen that there is a steady increase of influence from the pre-test situation for the N.S.H. group (r = -.38 or 14% influence) through to the post-test situation for the A.R.F. group (r = -.63 or 40% of influence). Also in the post-test situation for the N.S.H. group and pre-test situation for the A.R.F. group coefficients and percentages of influence are similar (r = .48 or 23% of influence and r = -.51 or 25% of influence).

It should be noted that a correlation coefficient, -.30, is significant in the N.S.H. group, while a coefficient of -.31 is not significant in the A.R.F. group because of the differences of degrees of freedom for each group.

In order to determine, not only the amount of significant change but also the comparative performance levels of each group as to their attitude and adjustment, it was attempted to

compare the two groups as to their pre-test and post-test means for the Total Attitude Scale Score and the B.A.S.A.

TABLE V

A T-Test Comparison of Means for the Total Attitude Scale and the B.A.S.A. for Both Groups in the Pre and Post Test Situations

	N.S.H. Group	A.R.F. Group	Significance of Diff. t-Score	p
Total Scale Score				
Pre-Test Mean	36.19	36.11	.06	N/S
Post-Test Mean	39.69	38.67	.84	N/S
B.A.S.A. Score				
Pre-Test Mean	120.17	104.56	1.82	.05
Post-Test Mean	105.42	106.06	.10	N/S

The results of this comparison showed that only the pre-test means of the B.A.S.A. (adjustment) differed significantly ($p < .05$) when the N.S.H. group to the A.R.F. group.

Finally, comparisons were made between and within groups for the demographic variables of age, education, marital status, employment status and referral source based on improvement and non-improvement for both the Total Attitude Scale and the B.A.S.A. However, when a chi-square analysis was applied no significant results were found.

In conclusion, the major findings can be summarized in the following manner:

1. The educational treatment offered at the N.S.H. was able to elicit significant attitudinal and adjustment changes

in their patient, whereas, the A.R.F. treatment regime was not able to do so. (refer to Table I)

2. Those patients at the N.S.H. who are diagnosed as having moderate or worse impairment in the areas of behavior and social relation do not respond in a positive manner to the educational treatment program as did the patients who were diagnosed as having only mild impairment. (refer to Table II)

3. The N.S.H. educational program elicits a higher ratio of patients, who improve their attitude and adjust when compared to the A.R.F. program but not to a significant degree. (refer to Table III)

4. The two variables of attitude and adjustment correlate significantly in the pre and post test situation for both groups and the amount of influence of the Total Scale score increased on the B.A.S.A. in the post-test situation for both groups. (refer to Table IV)

5. Only the pre-test B.A.S.A. means was significantly different when comparing between groups. (refer to Table V)

6. The proportion of the demographic variables did not differ significantly between groups. (refer to Appendix C)

CHAPTER V

DISCUSSION

Since the treatment, as provided in the Nova Scotia Hospital group, was able to elicit both attitudinal and adjustment improvements to a significant degree and the Alcoholism Research Foundation was unable to show similar results an important question becomes answerable. Does an educational treatment program have a therpeutic impact? The reply to this question is that an educational treatment program for alcoholics is effective, in not only changing an alcoholics overt attitudes to the condition of alcoholism but it is also effective in allowing him to adjust to his condition. Due to the fact that adjustment does occur within the bounds of the treatment program, the educational program itself takes on the quality of being therapeutic. If only attitudinal changes had occurred then the program would have been reduced to a persuasive technique and hence non-therapeutic.

These results concur with the directive therapeutic frameworks suggested by Stekel (1967), Alexander and French (1967), Wolberg (1965), Bellak and Small (1965), Baldwin (1968), Morris (1968), Drider (1969), Rapoport (1967) and Stickler (1965); and with the findings of Haley (1963). Within the bounds of their frameworks the success of the educational program would be attributed to the fact that the program was active and direct, that is, through the use of films, lectures

and didactic discussion the program gave the client suggestions, advice, general information and interpretation to facilitate adjustment. In particular, the findings supports Rapoports (1967) statement regarding brief treatment. "In general, the (brief) approach needs to be more active and directive than in traditional work."

Expanding the interpretations to include the structure and procedures of the program, the results seem to confirm the argument proposed by Phillips and Johnston (1954) and Phillips and Weiner (1963), in that, even though the educational treatment program was highly structured and patients submitted to schedules, it was more therapeutic in its final outcome when compared to more traditional individual approaches. Because the educational program was similar in structure to those established by Marsh (1935) the results could be interpreted from his point of view i.e. information and didactic dialogue from a valid source reduces neurotic defenses and foreboding fears.

In particular, if the educational program is viewed as a specialized treatment milieu for the rehabilitation of alcoholics the results could be explained by Block (1965) who stated that the treatment process for alcoholics must be a re-educational one.

The positive results found in the Nova Scotia Hospital treatment group can be explained in more abstract terms. Festinger's (1957) cognitive dissonance theory would claim that the new

situation and new information, as provided by the educational treatment program, caused the client to achieve a state of dissonance because these new inputs were contrary to his old attitudes and belief systems. In order to regain a state of consonance the client must have adapted himself to this new attitudinal position, and this he did by adjusting to his condition. That is to say, the alcoholic attempted to relate himself to the new information that he has obtained.

With regard to the N.S.H. group, the improvement on Scales I and II (attitude toward treatment and education respectively) would indicate that the alcoholic, in therapy, must see treatment as being valid and beneficial if adjustment is to follow. The improvement on Scale III (attitude toward social drinking) may show that the alcoholic client must come to see himself as being uniquely influenced by the consumption of alcohol unlike that of the social drinker. Conversely, the lack of significant change on Scale IV (attitude toward the alcoholic) may indicate that it is necessary that the alcoholic client sees himself as an unique individual rather than classifying himself into the general category of "alcoholic." Therefore, it appears that if an alcoholic is to adjust to his condition he must view therapy as being helpful and information as being useful while at the same time must see himself as an individual who is effected detrimentally by the intake of alcohol.

In looking at the results for the Nova Scotia Alcoholism Research Foundation treatment group in comparison with the Nova Scotia Hospital treatment group, the fact that these clients showed improvement for Scales I and II (attitude toward treatment and education, respectively) may be interpreted by saying that a positive attitude toward treatment and education regarding alcoholism is a precondition to any further adjustment. In effect a positive attitude in these areas must exist before adjustment can occur.

For the A.R.F. group adjustment did not follow eventhough there was significant improvement in attitudes toward treatment and education. This phenomena could be explained by saying that in this case dissonance did not result from the first contacts with the agency. The A.R.F. client, in order to come for treatment on an outpatient basis, must have already had an attitude or belief that treatment and education were necessary and beneficial. Therefore, the beginning contacts with the agency only reinforce this attitude. Because the emphasis, in the A.R.F. group was on chemotherapy the client was not forced or influenced to really confront himself, therefore, did not have to change overall attitudes and consequently did not really improve his adjustment to his condition. According to Bell (1970) these clients would be labeled as passive acceptors.

It also became apparent that short term didactic group therapy can elicit attitudinal change and adjustment in a

desired direction, that is, the educational treatment program as pffered at the Nova Scotia Hospital, in a given three week period, was sufficient to have a client, suffering from the condition of alcoholism, to make at least an initial adjustment to that condition. On the other hand the three week period was not long enough for more conventional out-patient therapy, as offered at the Alcoholism Research Foundation, to have a significant impact as far as adjustment to the condition of alcoholism was concerned. Within Bozoki's (1970) and Weiss' (1969) framework regarding the exposure and scheduling of information these results could be explained by stating that the clients at the A.R.F. did not have enough regular exposure to information and thus were unable to assimilate. Jecker (1964) would see the initial contacts with the A.R.F. as not being dissonance provoking.

The results also indicate that alcoholics who have mild impairment in the area of behavior and social relations, as diagnosed by the unit's psychiatrist, have a better chance of adjusting to their condition than those patients with moderate impairment. This latter group who have moderate impairment show less ability to adjust to their condition of alcoholism in a given three week period. While in the case of the more severe impairment in one or both of the areas it could be said that these clients like the other clients involved in the N.S.H. program are put in a state of dissonance through the addition of new information but the strength of

their old and destructive belief system will not allow them to adjust. These clients could be described as passive acceptors because eventhough they do not make significant adjustment gains they are able to change their attitude to a significant degree. This, of course, was only within the time bounds of three weeks and it is felt that given more time of the same didactic treatment, patients having moderate impairment in the areas of behavior and social relations would also make a significant adjustment to their condition of alcoholism. It takes time to break down old belief systems, behavior patterns and destructive relationships. These results apparently confirm Canon's (1964) results if the patients with the greater impairment are seen as less confident. Those persons lacking a greatdeal of confidence have difficulty assimilating dissonance provoking material.

Due to the fact that the staff of the Nova Scotia Hospital involved in the treatment program were unable to distinguish between participation and adjustment suggests that the adjustment process is anxiety provoking and introspective. Adjustment makes excessive demands on the individual involved in this process which detracts from total engagement in the treatment program. Thus adjusting patients appear to be poor participants. Conversely, those who are not involved in the process of adjusting, hence in a state of harmony with old belief systems and attitudes, appear to be participating satisfactorily in the treatment program. Therefore, it can

be concluded that the extent of the patient's involvement in the educational treatment program is a poor indicator of how successful the patient is in adjusting to his condition.

In a more global view of the comparison of the two groups, the Nova Scotia Hospital treatment group showed a higher percentage rate of improvement for both attitude and adjustment scores, thus showing that the concentration and emphasis on information giving and group discussion can quicken the therapeutic process.

Thus far in the discussion it has been assumed that attitude change is a forerunner or prerequisite for adjustment to the condition of alcoholism and this assumption is based on the cognitive dissonance theory. Evidence found in this study would support this assumption. For the N.S.H. group all of the attitude scales, with the exception of Scale I (attitude toward treatment) in the pre-test situation, and accordingly the Total Scale score correlated significantly with the adjustment (B.A.S.A.) score for both the pre-test and post-test situation. Likewise, similar results were found for the A.R.F. group.

This fact alone will atest to the conclusion that the two variables of attitude and adjustment are independently related. However, attitude change does not necessarily lead to adjustment. It appears that adjustment is more likely to

occur if the client can come to deal with specific related attitudes rather than more generalized attitudes. For example, an alcoholic may agree that all alcoholics are irresponsible, and he may perceive himself to be an alcoholic, but he may not be able to come to the logical conclusion, that he, himself, is irresponsible. When and if the alcoholic makes this latter linkage then adjustment is more likely to occur. These findings support the conclusions reached by Schonbar (1965) who distinguished between insight and adjustment, Defleur and Westie (1958) who found expressed attitudes did not necessarily dictate the direction of action and Kilty (1969) who found cognition and affect are not necessarily related.

The impact of therapy, in general, seems to be shown by the fact that in most scales and in the Total Scale for both groups, there is a significant progressive difference between pre-treatment and post-treatment correlations with adjustment. That is, the two properties of attitude and adjustment come closer in their influence upon one another after a three week period of treatment. Therapy seems to force or allow the client to better see himself in relation to his attitudes.

If one looks at the Total Scale and B.A.S.A. correlation coefficients for both groups an interesting trend seems to appear. The coefficients increase from a low level for the N.S.H. group in the pre-test situation through to a higher level for the A.R.F. group in the post-test situation. As far as the effect of therapy is concerned it appears that the

N.S.H. group are taken up to a level (post-test situation) where they are similar to the client beginning treatment on an out patient basis (pre-test correlation for A.R.F. group). Thus in the first instance it appears that the N.S.H. group were not the same type of alcoholic population as found in the A.R.F. group. However, they differed not in their attitude toward the condition but rather in their degree of adjustment.

Similarly, in the pre-test situation for the two groups there was a difference in adjustment means in that the N.S.H. group was significantly higher. However in the post-test situation for the both groups there was no significant difference in adjustment. Likewise no difference existed between the post-test adjustment means of the N.S.H. group and the pre-test adjustment mean for the A.R.F. group. In other words the N.S.H. group adjusted to a level where there was no difference between the groups and the A.R.F. group did not change.

The alcoholic population as found in the hospital setting could be described as needing more crisis intervention and direct active therapy to get them immediately away from the detrimental effects of a recent alcoholic episode. This type of population would need more attention and direction and be given good reasons to stop drinking. On the other hand, the population found in the A.R.F. group are usually not in need of crisis intervention, but rather need more ongoing supportive

therapy to reinforce already established controlled modes of behavior.

The educational treatment program therefore, in effect, brings the alcoholic client to an adjustment level where he has gotten over the effects of drinking and is now (post treatment stage) in need of support from his community to reinforce the new behaviors and attitudes attained from the hospital's treatment program. This extended support, according to the cognitive dissonance theory, will allow the client to further adjust to his new attitudes and help him achieve a state of consonance. A logical extension of this thought would be that treatment program offered at the Nova Scotia Hospital is not complete until the client has been followed up by community resources prepared to deal with such a referral.

Finally, this study concludes that an alcoholic's ability to change his attitude about his condition and to adjust to it is not related to demographic variables like age, marital status, employment status, type of referral or education. However, if his behavior or social relations are impaired moderately or worse, then the alcoholic client is less likely to adjust to his condition.

In summary, the study was able to provide strong evidence that an educational treatment program for alcoholics can be

successful in eliciting positive attitudinal and adjustment changes within a relatively short period of three weeks. Therefore direct and assertive techniques can be therapeutically valuable especially if they are delivered in a milieu that allows for at least didactic dialogue. Conversely, the more conventional outpatient treatment programs have very little therapeutic value in the short run, that is, little improvement can be seen in a client with regard to his attitudes and adjustment.

fast short term change
slow long-term change

The study was also able to distinguish between an attitude toward the condition of alcoholism and adjustment to the condition, but not to the point where they could be considered as independent factors. An interesting finding was that treatment affected the degree to which these two variables influenced each other. Both types of treatment, conventional outpatient treatment and didactic group therapy, brought these two variables closer together in their mutual influence.

Two factors revealed unexpected findings that lead to the conclusion that the two populations studied were different. Firstly, the two groups seemed to be at different points on one adjustment continuum in the pre-test stage. The N.S.H. group initially displayed poorer adjustment than the A.R.F. group. However, after treatment the N.S.H. group were almost equal in adjustment to the A.R.F. in the pre-treatment stage. Secondly, in the N.S.H. group before treatment the gap between

attitude and adjustment was comparatively great but after treatment this situation was remedied to the extent that it was to the A.R.F. group before treatment. In the A.R.F. group it was also noticed that the gap between the two variables got even smaller after treatment. From these results it may be concluded that the treatment of alcoholism develops in stages and that outpatient services are an extension of an educational treatment program. Therefore, from this viewpoint, the two different treatment programs, namely, the educational treatment program and the outpatient program are likely to have more therapeutic impact of the educational program is soon followed by an outpatient's program.

Implications for Social Work Practice. The results of this study has implications for two roles performed by the Social Worker, namely casework and community organization. In the role of casework information is provided to help the Social Worker better understand the function of attitudes in the alcoholic. In particular, it appears that in some cases the alcoholic has poor attitudes toward the condition of alcoholism which must be improved before adjustment can occur. This improvement, it appears, should be on a specific level where the alcoholic can see himself in relation to his attitudes. Further, it seems that a didactic approach can facilitate this initial change.

After the initial attitude change some adjustment will occur but if the client is not followed up and supported in

based on what?

his new beliefs then no further adjustment will occur. In fact, if the alcoholic does start drinking again after making some adjustment gains and attitude changes, it is likely that the effects of the episode will be much more psychologically stressful and he may be worse off than he was prior to treatment. The process of getting an alcoholic to a functional adjustment level appears to be a very long process especially if the alcoholism has caused any noticeable behavioral or relationship impairment. The caseworker should learn that the adjustment process takes a long time.

For those Social Workers involved in community organization the study points up the necessity for continuity of services in treating the alcoholic. The adjustment process seems to flow in stages and at least the initial stage and the follow-up stage can be better handled by different agencies. Therefore the emphasis on referral from the hospital to a functional agency becomes paramount; to ensure that a client progresses toward optimum adjustment the referral must likewise show continuity. If society is to effectively cope with the problem of alcoholism communities must be prepared to provide the needed supportive services to ensure that a client can be helped through to functional adjustment. To date most communities have failed in this task.

Limitations. The study was lacking in two vital areas. First, the scope of the study could be considered too limited in that the N.S.H. treatment group was evaluated only with

reference to one other treatment program namely the Alcoholism Research Foundation. The use of additional comparative groups that claim to primarily treat alcoholics (i.e. the Salvation Army Halfway House Program and Alcoholics Anonymous) would have given the study more validity and the N.S.H. treatment program would have been put into better perspective. This present study did not take on more groups for comparison because of the time factor. Secondly, the impact of the three week educational treatment program as offered at the Nova Scotia Hospital could have been also measured by the behaviors displayed by the firmer clients. Therefore if the research design had also been more longitudinal by including a follow-up stage then a better understanding of the adjustment process may have evolved.

Recommendations for Future Research. Two recommendations for research stem directly from the limitations of the study. More comparison groups should be employed to see if the adjustment continuum can be extended and to see how and if the different treatment milieus complement each other. Further, a longitudinal design should be employed to see if, in fact, different degrees of adjustment elicits different types of behaviors and to see how long the effectiveness of the initial program (educational) lasts with follow-up and without follow-up.

Similar to comparing follow-up groups with non-follow up groups, a comparison of first admissions to second admissions

to the educational program may give further insights into the adjustment process.

For the province of Nova Scotia there seems to be geographical areas more intent on coming to grips with the problem of alcoholism than others, an interesting study, therefore, would be a geographical comparison of what happens to the adjustment process in clients from these different areas after they leave the hospital.

APPENDIX A

The Bell Alcoholism Scale of Adjustment

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

+1	Agree a little	-1	Disagree a little
+2	Agree pretty much	-2	Disagree pretty much
+3	Agree very much	-3	Disagree very much

___ 1. If I were eligible for vocational rehabilitation benefits, I would prefer to get my own job.

___ 2. I would be all right if people would just leave me alone.

___ 3. I am not an alcoholic.

___ 4. When people offer to help me I get the feeling I'm being treated like a child.

___ 5. It is hard for me to make important decisions.

___ 6. I do not feel that I have a drinking problem.

___ 7. I try to keep to myself how much I really drink.

___ 8. I can stop drinking any time I want to.

___ 9. I just can't seem to accept help when I need it.

___ 10. I do not think of myself as a person with a drinking problem.

___ 11. Most people simply do not understand me.

___ 12. Only a weakling admits he is powerless over alcohol.

___ 13. I would rather not go any place if someone has to drive me.

___ 14. All an alcoholic needs is a little will power to control his drinking behavior.

___ 15. For some reason I feel uncomfortable in the presence of an AA member.

___ 16. It makes me angry when people try to do things for me that I can do myself.

___ 17. I can take criticism better than most people.

___ 18. It is a sign of weakness to admit defeat.

___ 19. Just because I might drink too much people think they can tell me what to do.

___ 20. I do not want or need any help from anybody.

___ 21. I feel that people are prying into my private affairs when they question me about my drinking behavior.

___ 22. My drinking behavior doesn't really hurt me all that much.

___ 23. It upsets me when someone opens a door for me.

___ 24. Nobody is affected by my drinking but me.

___ 25. I envy non-alcoholics because they can do so much more than I can do.

___ 26. I wish people wouldn't look at me like I've got two heads or something.

___ 27. Even when no offense is intended, it bothers me to be called an alcoholic.

___ 28. I do not like to be shown how to do things.

___ 29. It makes me feel sad when I cannot join others in certain social activities.

___ 30. My drinking habits are my business and my business alone.

___ 31. My drinking habits haven't caused anybody any trouble.

___ 32. I am no different from anyone else.

___ 33. I am not understood by anyone.

___ 34. In spite of my drinking habits, I can still be a successful person.

___ 35. I just can't believe that I am an alcoholic.

___ 36. I do not like to be told I am going to have to stop drinking.

___ 37. If I really wanted to, I could stop drinking by myself.

___ 38. I can control my drinking behavior when I really want to.

___ 39. Somehow it is difficult for me to take advice about my drinking behavior.

___ 40. It makes me feel anxious when the subject of alcoholism is discussed.

APPENDIX B

Attitude Scale

No. ______________________ Date ______________

A number of statements concerning alcohol and its use are listed below. Please indicate your agreement or disagreement with each statement by encircling the word, to the left of each statement, which best describes your feeling. Make a decision for every statement. Encircle only one letter for each statement. A = agree D = disagree.

A____ D___ 1. A national organization similar to the Cancer Society should be established and supported for treatment of alcoholism.

A____ D___ 2. Nova Scotia should establish more treatment facilities for alcoholics.

A____ D___ 3. For successful treatment of alcoholism both medical and psychological techniques should be used.

A____ D___ 4. The most successful treatment of alcoholism attempts to help the individual regain his will power.

A____ D___ 5. The Provincial Commission on Alcoholism is a waste of the taxpayers money.

A____ D___ 6. Money spent for research on alcoholism would be better spent on other things.

A____ D___ 7. The Provincial Commission on Alcoholism is an organization of vital importance to all.

A____ D___ 8. Individual psychological counseling is the most effective way of treating the alcoholic.

A____ D___ 9. Science has no real hope of finding a cure for alcoholism

A____ D___ 10. The wholesale treatment of alcoholics is impractical.

A____ D___ 11. It is impractical to offer treatment to all alcoholics who might want it.

A___ D___ 12. The treatment of alcoholism should be undertaken only by the individual's own family and friends.

A___ D___ 13. Public education is an integral part of the treatment of alcoholism as a social problem.

A___ D___ 14. Alcoholism should be as widely and as freely discussed among the general public as cancer or heart disease.

A___ D___ 15. Cooperative community effort is needed to provide the facts about alcohol.

A___ D___ 16. Public educational programs concerning alcoholism are useless.

A___ D___ 17. It is impractical to attempt to educate the public concerning the facts of alcoholism.

A___ D___ 18. There is no real need for a specific educational program on alcoholism in Nova Scotia.

A___ D___ 19. The public could do with less emphasis on the problem of alcoholism.

A___ D___ 20. Literature concerning alcoholism should not be freely available to the general public.

A___ D___ 21. More information should be available to the general public regarding alcoholism.

A___ D___ 22. Information concerning alcoholism should be restricted to those directly involved.

A___ D___ 23. The public deserves to be kept informed regarding the topic of alcoholism.

A___ D___ 24. The Provincial Commission on Alcoholism should distribute more information among the general public.

A___ D___ 25. Drinking is OK as a business courtesy.

A___ D___ 26. Drinking is itself as bad as any improper behavior which may result.

A___ D___ 27. Public drinking is more to be frowned upon than drinking in the home.

A___ D___ 28. Taking a cocktail before dinner is the first step toward alcoholism.

A___ D___ 29. Parents who drink in front of their children would do better to flog them daily.

A___ D___ 30. Social drinking adds to our relaxation and pleasure.

A___ D___ 31. Moderate drinking should be regarded as neither good nor evil.

A___ D___ 32. Whether or not a person drinks has nothing to do with his will power or emotional health.

A___ D___ 33. Even moderate drinking eventually produces harmful consequences.

A___ D___ 34. Alcohol in moderation has no real effect upon a person's personality.

A___ D___ 35. A few drinks are quite relaxing after a hard day's work.

A___ D___ 36. A job applicant who drinks at all is probably a bad prospect.

A___ D___ 37. The alcoholic deserves the same consideration as any other sick person.

A___ D___ 38. The alcoholic has only himself to blame for his problems.

A___ D___ 39. The alcoholic is simply a sick person who needs care and sympathy.

A___ D___ 40. Alcoholism can only exist in a general atmosphere of greed.

A___ D___ 41. The alcoholic is more to be envied than pitied.

A___ D___ 42. Alcoholism is a disease and should be treated as such.

A___ D___ 43. Alcoholism is a condition which is best ignored.

A___ D___ 44. The alcoholic basically enjoys the attention which he usually gets.

A___ D___ 45. Only an exceedingly selfish and unthinking person becomes an alcoholic.

A___ D___ 46. Alcoholism is a deliberate crime against society.

A___ D___ 47. The alcoholic should be treated as the criminal which he is.

A___ D___ 48. Most alcoholics would resent an offer of free treatment for their condition.

No. ____________________ Date ________________

A number of statements concerning alcohol and its use are listed below. Please indicate your agreement or disagreement with each statement by encircling the word, to the left of each statement, which best describes your feeling. Make a decision for every statement. Encircle only one word for each statement.

A___ D___ 1. Alcoholics Anonymous is a wondrous organization.

A___ D___ 2. The families of alcoholics should encourage them to seek expert treatment for their condition.

A___ D___ 3. Private treatment facilities should be available to alcoholics.

A___ D___ 4. Treatment of alcoholism should be a specialty within the medical profession.

A___ D___ 5. Tremendous research programs are needed in the area of alcoholism.

A___ D___ 6. Grants should be readily available to any professional person for research in the area of alcoholism.

A___ D___ 7. Doctors who spend their time treating alcoholics are wasting their time.

A___ D___ 8. Neither state nor federal funds should be used for the treatment of alcoholism.

A___ D___ 9. General hospitals should not accept alcoholics for treatment as such.

A___ D___ 10. If an alcoholic wanted to be cured, he could accomplish the matter himself.

A___ D___ 11. Even if alcoholics could be cured by proper treatment, the cost would be unwarranted.

A___ D___ 12. The counsellor who attempts to treat an alcoholic is wasting his time.

A___ D___ 13. Newspapers should be willing to contribute space for publicizing the problem of alcoholism.

A___ D___ 14. The facts of alcoholism should be extensively taught in every high school in Canada.

A___ D___ 15. Popular literature on alcoholism should be available to any citizen who has the interest to write for it.

A___ D___ 16. Every dollar spent toward educating the public regarding alcoholism is a dollar exceptionally well spent.

A___ D___ 17. The more extensive efforts to "educate the public" regarding alcoholism probably serve simply to increase alcoholism.

A___ D___ 18. The facts of alcoholism are generally unknown to the public.

A___ D___ 19. Public education concerning alcoholism is a waste of time and money.

A___ D___ 20. The general public is already sufficiently informed about the facts of alcoholism.

A___ D___ 21. Publicity concerning the problem of alcoholism simply adds to the confusion already rampant in the public mind.

A___ D___ 22. The public has heard enough about alcoholism.

A___ D___ 23. Only such professional persons as physicans, social workers, and the like, should receive extensive information concerning alcoholism.

A___ D___ 24. More interest in the problem of alcoholism should be aroused among the general public.

A___ D___ 25. A person who has had the equivalent of one highball should not be allowed to drive an automobile.

A___ D___ 26. Despite the fact that many millions to use alcoholic beverages, their use is degrading.

A___ D___ 27. An individual with no emotional problems has no need for alcohol.

A___ D___ 28. The "Social drinker" is probably basically disturbed emotionally.

A___ D___ 29. Alcoholic beverages are harmless when used in moderation.

A___ D___ 30. The use of alcohol is a custom which should be abandoned by society.

A___ D___ 31. It is all right for women to engage in moderate social drinking.

A___ D___ 32. Drinking of alcoholic beverages should be classed with the illegal use of dope.

A___ D___ 33. The habit of a before-dinner cocktail is neither beneficial nor harmful.

A___ D___ 34. Social drinking is all right if, and only if, it is done with moderation.

A___ D___ 35. One should drink if he enjoys the taste of alcoholic beverages.

A___ D___ 36. Drinking on some social occasions should be done if it helps the inficidual to fit in with others.

A___ D___ 37. The alcoholic is basically an insincere person.

A___ D___ 38. Alcoholism is the direct result of a sick and decadent society.

A___ D___ 39. Conditions within the individual as well as external to the individual contribute to the development of alcoholism.

A___ D___ 40. No one should presume to criticize the alcoholic without knowing why he drinks.

A___ D___ 41. Alcoholism should be treated as a misdemeanor.

A___ D___ 42. In combating alcoholism as a disease the effect should be as great as the effort expended in combating any other disease.

A___ D___ 43. Only a person who is basically quite malicious could become alcoholic.

A___ D___ 44. The alcoholic has no one to blame for his troubles but himself.

A___ D___ 45. Alcoholism should be treated as a felony.

A___ D___ 46. Alcoholism begins as the sin of drinking and ends as a sinful habit.

A___ D___ 47. The alcoholic suffers from a severe illness and needs treatment to a much greater degree than the usual medical complaints.

A___ D___ 48. All alcoholics are human wrecks found in dives.

APPENDIX C

Distribution of Demographic Variables and Proportion of Improved and Non-Improved Cases

	ATTITUDE SCALE		B.A.S.A.		
	Improved Score	Non-Improved Score	Improved Score	Non-Improved Score	Totals
	No. %	No. %	No. %	No. %	No. %
A.R.F. Group					
1. Employment					
Employment	7 (58%)	2 (33%)	5 (55%)	4 (45%)	9 (50%)
Unemployment	5 (42%)	4 (67%)	4 (45%)	5 (55%)	9 (50%)
Totals	12 (100%)	6 (100%)	9 (100%)	9 (100%)	18 (100%)
2. Marital Status					
Single	2 (17%)	3 (50%)	3 (33%)	2 (22%)	5 (28%)
Married	6 (50%)	1 (17%)	3 (33%)	4 (45%)	7 (39%)
Separated	4 (33%)	2 (33%)	3 (33%)	3 (33%)	6 (33%)
Totals	12 (100%)	6 (100%)	9 (100%)	9 (100%)	18 (100%)
3. Referral Type					
Voluntary	9 (75%)	3 (50%)	7 (78%)	5 (55%)	12 (67%)
Forced Compliance	3 (25%)	3 (50%)	2 (22%)	4 (45%)	6 (33%)
	12 (100%)	6 (100%)	9 (100%)	9 (100%)	18 (100%)
4. Age					
21-35	2 (17%)	2 (33%)	3 (33%)	1 (11%)	4 (22%)
36-50	7 (58%)	2 (33%)	6 (67%)	3 (33%)	9 (50%)
51-65	3 (25%)	2 (33%)	0 (00%)	5 (56%)	5 (28%)
Totals	12 (100%)	6 (100%)	9 (100%)	9 (100%)	18 (100%)
5. Education					
Primary	3 (25%)	1 (17%)	2 (22%)	2 (22%)	4 (22%)
Junior High	6 (50%)	2 (33%)	5 (55%)	3 (33%)	8 (45%)
Senior High	3 (25%)	3 (50%)	2 (22%)	4 (45%)	6 (33%)
Totals	12 (100%)	6 (100%)	9 (100%)	9 (100%)	18 (100%)

	ATTITUDE SCALE		B.A.S.A.		
	Improved Score	Non-Improved Score	Improved Score	Non-Improved Score	Totals
	No. %	No. %	No. %	No. %	No. %
N.S.H. Group					
1. Employment					
Employed	16 (59%)	3 (33%)	15 (58%)	4 (40%)	19 (53%)
Unemployed	11 (41%)	6 (67%)	11 (42%)	6 (60%)	17 (47%)
Totals	27 (100%)	9 (100%)	26 (100%)	10 (100%)	36 (100%)
2. Marital Status					
Single	10 (37%)	3 (33%)	9 (35%)	4 (40%)	13 (36%)
Married	13 (48%)	3 (33%)	14 (53%)	2 (20%)	16 (44%)
Separated	4 (15%)	3 (33%)	3 (12%)	4 (40%)	7 (20%)
Totals	27 (100%)	9 (100%)	26 (100%)	10 (100%)	36 (100%)
3. Referral Type					
Voluntary	19 (70%)	8 (89%)	18 (69%)	9 (90%)	27 (75%)
Forced Compliance	8 (30%)	1 (11%)	8 (31%)	1 (10%)	9 (25%)
Totals	27 (100%)	9 (100%)	26 (100%)	10 (100%)	36 (100%)
4. Age					
21-35	10 (37%)	4 (44%)	9 (35%)	5 (50%)	14 (39%)
36-50	10 (37%)	3 (33%)	11 (42%)	3 (30%)	14 (39%)
51-65	7 (26%)	2 (23%)	6 (23%)	2 (20%)	8 (22%)
Totals	27 (100%)	9 (100%)	26 (100%)	10 (100%)	36 (100%)
5. Education					
Primary	7 (26%)	3 (33%)	7 (27%)	3 (30%)	10 (28%)
Junior High	9 (33%)	3 (33%)	9 (35%)	3 (30%)	12 (33%)
Senior High	11 (41%)	3 (33%)	10 (38%)	4 (40%)	14 (39%)
Totals	27 (100%)	9 (100%)	26 (100%)	10 (100%)	36 (100%)

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