A SURVEY OF ATTITUDES OF OUTPATIENT TREATMENT THERAPISTS IN CLINICS TOWARD THEIR ALCOHOLIC CLIENTS

by

Charlotte Anne Susanka Lissy, R.N., B.S.N.

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APPROVED:

[redacted]

Florence F. Hardesty, Ph.D., Associate Professor, Thesis Advisor

[redacted]

May E. Rawlinson, Ph.D., Professor, First Reader

[redacted]

Mary Lu Love, M.S., Assistant Professor, Second Reader

[redacted]

Patricia S. Tomlinson, M.S., Associate Professor, Third Reader

[redacted]

Carol A. Lindeman, Ph.D., Dean, School of Nursing

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DEDICATION

This study is dedicated to my family.

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CHAPTER I

INTRODUCTION

Alcoholism is a disease which physically and emotionally destroys or degrades the lives of millions of its victims in the United States. It also causes severe problems for family members as well as for others who are close to the problem drinker. The serious nature of this insidious disease makes it imperative that health care professionals recognize and better understand the alcoholic and confront the problems of alcoholism. With understanding, treatment becomes less difficult.

Throughout recorded history women as well as men have used and enjoyed alcohol; and, as with men, many women have abused it. In the past, drinking problems of women have been neglected, ridiculed, denied, or, at best, lumped together with those of men. The assumption that the typical alcoholic is male has become increasingly incorrect in recent times due to the fact that there has been a rise in the number of female problem drinkers (Glatt, 1979). Figures provided by the National Clearinghouse on Alcohol Information also indicate that alcoholism is increasing among women (Oregon State Plan, 1977-1978). A recent conservative estimate of the number of female alcoholics in the United States is 900,000 (Beckman, 1976).

The increased awareness of the incidence of alcoholism in females in the United States is pointed out by Herzog and Wilson (1979) in a study of personality characteristics of female alcoholics. These same authors further mention that most research has focused on the male alcoholic and little is known about the female who has a drinking problem.

Oregon's 1977-1978 State Plan for Alcohol Problems declares that although 32% to 50% of persons with alcohol problems are women, the percentage of persons in treatment who are women varies from 10% to 25%. The cause of this discrepancy in numbers has not been determined, but it is of great concern on both state and federal levels because of the magnitude of the problem. The most significantly underserved target population in the State of Oregon is women (State Plan, 1977-1978).

This study addresses the question of why alcoholic women do not seek treatment for their drinking problem as readily as their male counterparts. Gomberg (1974) suggests that the attitude of the therapist toward the alcoholic client, as well as the enthusiasm and interest shown, were more related to outcome of treatment than the technique used. If therapists' attitudes toward women alcoholics is less favorable, then treatment would be less successful. This would tend to discourage women from entering or completing treatment. The purpose of this study is to explore the therapists' attitudes as related to the sex of the client.

Review of the Literature

Alcoholism, somewhat like ulcers and heart disease, has traditionally been considered a "man's" disease. As a result, nearly all research on alcohol problems and treatment efforts have been directed toward the male population. Studies focusing on alcoholism in women are scant. In a 1972 review of the literature Schuckit counted only 28 English language studies on women and alcoholism between 1929 and 1970. Frequently researchers ignore the alcoholic women entirely or simply assume that alcoholism is the same, regardless of the sex of the sufferer (Curlee,

1971). In a recent study Mulford (1977) pointed out that much of our knowledge about alcoholics comes from the tip of the iceberg -- men alcoholics in hospitals and jails who tend to be in advanced stages of the alcoholic process.

The reason for the neglect of the woman with an alcohol problem is unclear. It has been suggested by Wilsnack (1973) that the bias may reflect that men are more visible with regard to their drinking and hence more accessible for study. Wilsnack describes a moralistic attitude in our society which views the female drinker in a more negative light than the male drinker. This may result in the drinking problem of a woman being overlooked or denied by society.

In a review of the literature to follow, the major and minor criteria for diagnosing alcoholism will be noted. The epidemiology of alcoholism in women will be examined. Differences between male and female alcoholics will be discussed. The status of women with a drinking problem in today's society will then be explored. Finally, the implications of therapists' attitudes will be considered.

Criteria for Diagnosing Alcoholism

The National Council on Alcoholism established a committee that was charged with the responsibility of establishing guidelines for the proper diagnosis and evaluation of "alcoholism". (Throughout this paper the terms "alcoholism" and "problem drinking" will be used interchangeably). The diagnostic criteria aid in detection, establish uniform nomenclature, prevent over-diagnosis, and help to set treatment purposes. These criteria are used as a basis for assessment in alcohol treatment clinics.

The major and minor criteria are outlined in brief below. A more complete outline can be found in the appendix. An individual who meets any one or more of the major criteria, or several of the minor ones, is classified as an alcoholic. One should search for both major and minor criteria in diagnosing an individual suspected of alcoholism and include a history and physical examination as well as laboratory evidence.

Major Criteria

Physiological and Clinical

A. Physiological dependency
   1. Manifested by withdrawal syndrome
   2. Evidence of tolerance to effects of alcohol
   3. Alcoholic "blackouts"

B. Clinical: Major alcohol-associated illness
   1. Liver disorders
   2. Gastrointestinal disorders
   3. Hematological disorders
   4. Neurological disorders
   5. Cardiovascular disorders
   6. Nutritional disorders

Behavioral, Psychological, and Attitudinal

1. Drinking despite strong medical contraindication known to patient
2. Drinking despite strong, identified social contraindication (job loss for intoxication, marriage disruption, arrest for driving while intoxicated)
3. Subjective complaint of loss of control in terms of alcohol consumption

Minor Criteria

Physiological and Clinical

A. Direct effect
   1. Early
      Odor of alcohol on breath at time of medical appointment
   2. Middle
      Various physiological symptoms
   3. Late
      Same as Major Criteria B

B. Indirect effects
   1. Early
      Tachycardia
      Flushed face
      Nocturnal diaphoresis
   2. Middle
      Ecchymosis on legs, arms, or chest
      Cigarette burns on hands or chest
      Hyperreflexia or if drinking heavily, hyporeflexia
   3. Late
      Decreased tolerance

C. Laboratory tests
   1. Direct
      Blood level at any time of more than 300mg/100ml
   2. Indirect
      Serum osmolarity: every 22.4 increase over 200mOsm/litre reflects 50mg/100ml of alcohol in blood

      Result of alcohol ingestion seen in certain physiological tests
      Blood test abnormalities
      Liver function test indicating abnormalities
      Urine test abnormalities
      ECG abnormalities
      EEG abnormalities
      Decreased immune response

Behavioral, Psychological, and Attitudinal

A. Behavioral
   1. Direct effects
      Early
      Gulping drinks
      Surreptitious drinking
      Moring drinks
      Middle
      Repeated conscious attempt at abstinence
      Late
      Blatant indiscriminate use of alcohol
      Skid Row or equivalent social level
   2. Indirect effects
      Early
      Missing work
      Change in companions and activities with emphasis on drinking
      Late
      Various forms of disturbed or inappropriate behavior

B. Psychological and Attitudinal
   1. Direct effects
      Early
       Frequent reference to alcohol
      Middle
       Drinking for relief of tension
      Late
       Symptoms of chronic organic brain syndrome
   2. Indirect effects
      Early
       Unexplained disruptive changes in family, social, and business relationships
      Late
       Overt expression of regressive defense mechanisms
       Resentment, jealousy, paranoid attitudes
       Symptoms of depression, isolation, suicidal preoccupation
       Feeling of "losing mind"

Epidemiology of Alcohol in Women

Alcoholism is the fourth major health problem in the United States today (Heinneman & Smith-Deyulio, 1977). A subgroup of the alcoholic population that is rising rapidly in number is women. The estimate made by Lisansky (1957) of 5.5 men alcoholics for every woman alcoholic has changed considerably in recent years. While the ratio of males to female in state hospitals is often 6:1, it has been reported to be 1:1 for patients seen by physicians privately (Glatt, 1979). A recent Alcoholics Anonymous survey noted by Sandmaier (1977) showed the proportions of women AA members nationally had jumped from 22% in 1968 to 28% in 1974. The survey also noted that fully 31% of AA's new members in the past 3 years have been women.

President Carter's Commission on Mental Health found that one in three people with an alcohol problem is a woman (Kazicks, 1977). Many who specialize in alcoholism treatment believe that half of the nation's alcoholics are women, but simply are less visible because of a greater fear of exposure. A recent study conducted for the National Institute

on Drug Abuse reports findings which are in agreement with this belief. It is noted that half of the presumed 10 million Americans who are alcoholics are women (Kuhn, 1978). Although the number of alcoholic women in this country is an approximation it does seem clear that alcoholism among women is a widespread, much misunderstood and still largely ignored national problem.

Differences Between Male and Female Alcoholics

Physiological. The literature points out differences in men and women alcoholics. The sexes are dissimiliar in their physiological and psychological responses to alcohol consumption. Women are not a homogenous group and have widely varing socioeconomic levels, cultural and racial backgrounds and lifestyles which produce different stresses that may trigger an alcohol problem. There are, however, some common elements shared by women who develop a problem with alcohol that are different, as a rule, than in the development of alcoholism in men.

As early as 1957 differences between the male and female alcoholic were reported. A study was done by Lisansky in that year which looked at 55 male and 55 female alcoholics in an outpatient treatment facility. Her findings revealed that twice as many women as men reported onset of drinking after a stressful life experience such as a parent's death, a divorce, an unhappy love affair or post partum depression. This study further reported that the female subjects took their first drink at a later age than the male subjects and a shorter time elapsed between the first drink and the onset of problem drinking for the women as compared to men.

The "telescoping" or rapid onset of symptoms for women as reported by Lisansky (1957) has been confirmed in other studies throughout the years. Recently Mulford (1977), revealed a shorter period of time between the first drink and the onset of problem drinking for women. In 1979 Ashley, Olin, Harding, leRoche, Kornaczwski, Schmidt, DeJur and Rankin (1979) compared the physical disease profile of alcoholic inpatients and found that the average duration of hazardous drinking and the first recorded occurrence of almost all resultant illnesses was shorter in women than in men.

Two studies which also corroborate the early findings of Lisansky were reported in the literature recently. Interviews with members of Alcoholics Anonymous report that the prodromal drinking period for men averages 2.8 years and for women 1.1 years (Heinneman et al., 1977). In a 1975 study Sclere found that women usually begin their drinking careers at a later age than men. The mean age for women to initiate alcohol use being 34 compared to 26 for males.

Some of the early signs of alcoholism as noted in the Criteria for the Diagnosis of Alcoholism mentioned earlier in this paper that are seen in men are not seen in women. The female problem drinker is not "sneaking" or "gulping" drinks until later in the progression of the development of problem drinking. Prodromal-stage drinking in women appears to consist of a desire or search for change in mood which is not reported regularly in the early stages of drinking in men.

Another early stage development in women which is not reported by men is unexplained bruises (Gomberg, 1972). It can be speculated that these may be a result of accidents, poor nutrition, or perhaps physical

abuse all of which could be associated with drinking. Also noted in Gomberg's review of the literature were early signs of alcoholism reported by men but not by women include sudden aggressiveness and grandiosity.

Lindbeck (1972) reviewed the literature and concluded that while non-alcoholic women as a group drink smaller amounts than men, alcoholic women drink as much as alcoholic men. However, it is thought that alcoholic women drink to insensibility more frequently than do their male counterparts.

Though the evidence is slight there is a suggestion based on two studies done by Spain (1945) and Tokuhata, Digon and Ramaswamy (1971) that other things being equal, women develop cirrhotic problems and complications more readily than do men. Ashley et al. (1977) looked at morbidity in alcoholics for ulcer surgery, gastrointestinal hemorrhage, fatty liver, hypertension, obesity, anemia and malnutrition, the sex differences were statistically significant. In every case the average duration was shorter in women. Chronic obstructive lung disease and esophageal varices were reported to be found more often in men.

Although there were no significant differences between the sexes in the average daily consumption per kilogram of body weight found in the study by Ashley et al., the frequency of cirrhosis of the liver in women was double that in men, suggesting that consumption requirements for the occurrence of this disease may be lower in women. It has been postulated that hormonal factors might account for the increased hepotoxic reaction.

Another finding in the study by Ashley et al. which points to differences of women based on hormonal factors concerns the blood-

alcohol level. Given the same amount of alcohol, there is a variability in the level reported to occur at different points in the menstrual cycle. The role of hormonal interaction with alcohol remains to be explored.

Family Backgrounds. There is a great deal of attention to the study of family backgrounds of the alcoholic found in the literature. It is suggested that there is a pattern in the parental history of alcoholic women. In her review of the literature, Homiler (1977) concludes that alcoholic women are more likely to have alcoholic parents, siblings, or spouses than alcoholic men.

Although both male and female alcoholics appear to have experienced a high incidence of deprivation and disruptive emotional behavior as children, women alcoholics experienced more deprivation such as loss of a parent by divorce, desertion, or death (Sclare, 1970). Sandmaier (1977) concludes from a literature review that parents of alcoholic women have made unrealistic demands on them and that training in the acceptable use of alcohol was either absent or ambivalent.

In a study by Kinsey (1966) it is reported that female alcoholics perceive themselves to have cold, domineering mothers and warm, gentle, although often alcoholic fathers. Alcoholic women tend to choose cold, domineering husbands and resort to drinking patterned after their fathers' drinking, or they married men who, like their fathers, were also alcoholic (Beckman, 1976).

Another interesting difference noted by Gomberg (1977) is evidence of transmission of alcoholism much more frequently from the men to women than from women to men. Women report drinking with spouses more than

alcoholic men report sharing drinking bouts with wives.

An important point mentioned earlier in this paper, concerns the frequent occurrence of women alcoholics being married to an alcoholic spouse. Glatt (1977) found that 51% of alcoholic women have an alcoholic spouse compared to 13% of alcoholic men. Wilsnack (1974) points out that men use denial of wife's drinking more frequently than his female counterpart. This may reflect a "double standard" adopted by society toward female heavy drinking. He may abandon his wife, though some husbands, like wives of alcoholic men, may react like martyrs or try to control their wife's drinking.

In a review of the literature, Fraser (1973) points out that for every 10 wives who remain with an alcoholic husband, only one husband remains with an alcoholic wife. This author further notes that two-thirds of alcoholic women are divorced, a rate not matched by the male segment of the alcoholic population.

Psychological. The literature points out that there is a clear relationship between alcoholism and affective disorders. A study by Winokur and Clayton (1968) found that women alcoholics are more likely to have affective disorders, while men alcoholics are more likely to be sociopathic. They further reported that more women had a concurrent and independent depressive illness as well as suicidal thoughts and delusions.

These findings are reinforced by a more recent study in which a group of researchers attempted to determine how men and women alcoholics respond to conflict through various defense mechanisms (Sugerman, Sheldon & Roth, (1975). They found that men had significantly higher "Turning Against Others" scores, while women had significantly higher

"Turning Against Self" scores.

In another study the author reports findings that indicate 30% of the women and no men suffered from depressive disorders needing treatment before the onset of problem drinking. It is further reported that 36% of the women, compared to 6% of the men had a history of suicidal attempts (Rathod, 1971). The relationship between early deprivation and affective disorders has not yet been established. Some work suggests that a relationship does in fact exist, and may account, in part, for why so many women alcoholics suffer from depression independent of their drinking. One might speculate that these women may experience alcoholism as a secondary phenomenon superimposed on a tendency to severe depression.

Sociological. The lawbooks in ancient Rome included a statute ordering the death penalty for women who drank alcohol and who were adulterous. The law clearly reflected certain societal attitudes about women and alcohol: first,that drinking and immorality went hand in hand; and second, that female drinking was considered intolerable enough to be punished by death. The law was stringently inforced throughout Rome.

The laws have changed, but the underlying attitudes in many instances have not. Alcoholism is still considered a moral problem by many. Since there is still a double-standard of morality for women and men, women with drinking problem are judged harshly. In her review of the literature, Badiet (1976) states that while the excessive drinker is still looked down upon by even the most developed society, present day society will not tolerate a drunken woman.

Alcoholic men are considered to be weak-willed by many, but alcoholic women are frequently branded as immoral, promiscuous, even unnatural. As a result, many women avoid seeking help to protect themselves from society's hostility and censure (Sandmaier, 1977). If therapists working with alcoholic clients accept this viewpoint concerning women, it may well put women with a drinking problem at a disadvantage if she does seek treatment.

The conclusion that society will not tolerate a drunken woman is corroborated in a 1974 study by Clarke. Her findings indicate that our society has a general opinion that women alcoholics are more dissolute than men alcoholics. It can be speculated that this stigma might well be a result of the strategic place women have traditionally held in the family as wives and mothers. As a result of her study,Lisansky (1958) concluded that a female problem drinker breaks a strong taboo. This drinking runs counter to the American ideal of self-controlled, lady-like behavior. One author points out that because woman's role has been equated with the stabilizing functions of wife and mother, the drunken woman seems to be a special threat. "No one likes to believe that the hand that rocks the cradle might by a shaky one" (Curlee, 1967, p. 155).

As mentioned earlier in this paper, depression is frequently seen in the female alcoholic. It has been documented throughout mental health literature that groups in our society who are devalued or lack control over their lives are particularly prone to depression and other emotional problems. Sandmaier (1977) observes that studies show that women are a group who have been designated and treated as inferior throughout history and suffer much more emotional illness than do men. Alcohol may be one

among many mechanisms women use to cope with a reaction to their subordinate status in society.

Coping mechanisms are used by women with alcoholism to conceal their drinking problem. In a study Curlee (1970) compared male and female alcoholics. As a result of this study she suggests that social disapproval causes the woman with a drinking problem to use the defense mechanisms of repression and denial more frequently than a man with the same problem.

Interest and concern about women alcoholics appears to be growing. In a recent newspaper article a journalist notes that while society tends to accept the fact of alcoholism and drug abuse in men, women's drug problems are neither acceptable nor tolerated. A woman is labeled instead, as unfit, deviant, weak, "fallen" -- often by herself as well as by society. Consequently, a woman tends to ignore or hide her drug problem. The stigma attached to the use of drugs or alcohol by women makes it difficult for them to admit their problem, seek help, be rehabilitated and then accepted by society (Kuhn, 1978).

Another reported difference between the drinking pattern of the sexes is that women are more likely to drink alone and secretively. A woman with an alcohol problem feels lonely. She tends to accept society's evaluation that she is deviant. It is probable that the greater self condemnation, fear of ostracism, and guilt suffered by the female alcoholic adds to the concealment of her alcohol problem.

It is reported frequently in the literature that lonliness of the woman with a drinking problem is paired with feelings of no longer being needed and that no one cares (Glatt, 1979). The female alcoholic is often widowed or divorced. As mentioned earlier problem drinking often

occurs later in a woman's life than in a man and the children have often grown up and left home. This "empty nest syndrome" is often accompanied by boredom.

Alcoholism is a lonely and painful illness. Lindbeck (1972) suggests that it is unlikely that a woman with an alcohol problem would bear difficulties such as guilt, isolation, and emotional discomfort entirely alone. The same author feels that it is more likely that these women do seek help but focus on physical, emotional, or familial problems while the drinking goes unmentioned. It is possible that they go to social agencies seeking help with marital, financial, or parent-child problems; to the clergy, to family physicians, internists, psychiatrists, and possibly gynecologists.

A study done recently by Fisher, Kesley, Mason and Fisher (1975) which looked at physicians and factors affecting attitudes toward alcoholics revealed findings which indicate little help for a woman going to a private physician. Alcoholics were seen by the doctors as being weaker and more hopeless and aimless than the average person. These results suggest that, in addition to a medical evaluation, the alcoholic is being judged by moralistic criteria.

Drug advertising may play an important role in what happens to a woman going to a physician seeking assistance with her stated problem. An increasing number of researchers are questioning the influence of drug advertising of the medical profession and the way doctors prescribe (Badiet, 1976). In her review of the literature, this author concludes that overprescribing by physicians and attitudes physicians hold toward women, have been influenced by drug advertising. Women are almost always

portrayed as the weaker and sicker sex and physicians are dismissing women's symptoms as neurotic or as "normal" female problems.

The drinking problem often remains undiagnosed when a women goes to a physician. The result of the visits for the woman may be a diagnosis of emotional illness and a prescription for tranquilizers (Johnson, 1965). This method of dealing with the alcoholic woman not only masks the drinking problem but it adds the problem of poly-drug use. According go Kuhn (1978) women's overdependency on prescription drugs and alcohol is reaching epidemic proportions.

Badiet (1976) reported that doctors believe they have a responsibility to discuss problem drinking with patients, but many fail to do so for fear of harming the relationship. This same author concludes that women who chronically complain of depression, tension, anxiety or vague physical complaints should not receive a prescription for tranquilizers but rather help in confronting the reason for the problem.

The woman with an alcohol problem has a great deal of assistance in hiding the fact that she drinks too much. Gomberg (1976) reported that women tend to drink at home and alone much more often than men do. The role of the housewife makes concealment easier. She has more opportunity to drink secretly. It is possible that a woman could conceal her problem for a number of years. One might speculate that rather than a telescoping of the drinking problem (as described earlier in this paper) perhaps the early stages were simply hidden.

After reviewing the literature, Lindbeck (1972) suggests that when husbands finally realize the problem, they frequently use denial, as do their wives, because of the stigma. They may keep their knowledge secret

for fear disclosure will reflect on their ability to "control" their wife's behavior and also on their masculinity (Trice and Roman, 1972).

An interesting cultural phenomenon was observed by researcher in Boston which highlights how women are indirectly aided by society in ignoring their drinking problem. The results of the Boston Alcohol Safety Action Project found results relating to the attitude of the police toward women who were driving while intoxicated. According to this study a documented reluctance of police officers to arrest women for driving while intoxicated even after having detected and stopped them. Women are only rarely arrested for driving under the influence of alcohol and generally there are other factors accompanying intoxication which mandate arrests. The potential of early identification of problem drinking by means of the driving while intoxicated arrest is certainly diminished under these circumstances. The unequal treatment of women and men by the police may appear to be favorable to women. Angeriou and Paulino (1976) point out that in the long run, this type of police behavior may well be deleterious if it results in aiding problem drinkers to keep their problem hidden.

Therapists' Attitudes. The attitude of society, which generally seems to be negative toward the alcoholic woman, is seen in clinicians who work in alcoholic treatment clinics. A study done by Levy and Doyle in 1974 of a therapeutic program found a greater number of males on the general clinical staff, and a total absence of females on the executive staff. They concluded the absence of women at the administrative and policy making level appears to bias the system to male clients at the outset.

According to Glatt (1979) most observers have found that the prognosis for alcoholic women in treatment is less hopeful than for men. The Levy and Doyle (1974) study found the clinicians viewed women as more emotional, more sensitive, limited by their biology, needing to please men, and implicitly "sicker" than men. Male staff members' behavior tended to suppress the aspirations of women and to disregard some of the unique problems of women in our society as a whole. As a result of their study, the authors recommended that attitudes of therapists should be taken into account when looking at women and alcohol problems. The present author feels that, based on the Levy et al (1974), as well as the other studies, the sex of the therapist should also be considered in studying male and female alcoholics.

The importance of how the therapist views the client is pointed out in an interesting way by Rossi and Filstead (1976) in their review of the literature. They concluded that psychiatric diagnoses made by professionals are little more than translations of stereotypes and prejudgements about other people, and the diagnoses tell us nothing about the recipients of the diagnostic labels but instead reveal a great deal about those who apply them and the society they serve.

A study done by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) is mentioned frequently in the literature. It was determined by them that actively functioning clinicians strongly agree as to the attributes characterizing healthy adult men, healthy adult women, and healthy adults, sex unspecified. They claim that this agreement, furthermore, holds for both men and women clinicians. The results of this study also support the hypotheses that (a) clinicians have different concepts of health for men and women, and (b) these differences parallel the sex-role stereotypes prevalent in our society.

In their discussion Broverman et al. pointed out their findings that clinicians' concepts of a healthy, mature man do not differ significantly from their concepts of a healthy adult. These same clinicians' concepts of a mature healthy woman do, however, differ significantly from their adult health concepts. Speculation, based on these findings along with the reported negative attitude of society toward the alcoholic woman, might lead one to conclude that a woman with a drinking problem would be assessed more negatively by clinicians than a man with the same problem.

Broverman et al. conclude that though there is a dilemma for women at a treatment facility it is not one that is posed by the clinicians. They feel it is a reflection of the sex-role stereotyping, and the differing valuations of the stereotypes, prevalent in our society that are seen in the judgements of the clinicians used in the sample. These authors explain that the study does provide evidence that clinicians do accept these sex-role stereotypes, at least implicitly, and, by doing so, help to perpetuate the stereotypes.

These authors further conclude that therapists should be concerned about whether the influence of the sex-role stereotypes on their professional activities acts to reinforce social and intrapsychic conflict. They indicate that clinicians undoubtedly exert an influence on social standards and attitudes beyond that of other groups. This influence arises not only from their effect on many individuals through conventional clinical functioning, but also out of their role as "expert" which leads to consultation to governmental and private agencies of all kinds, as well as guidance of the general public.

In summary, the literature reviewed has dealt with the criteria for diagnosing alcoholism. Additionally, the differences between male and female alcoholics were considered based on family background, physiological, psychological, and sociological perspective, as well as therapists.

In conclusion, this review can be summarized by these statements: (1) Use of an established criteria for diagnosing alcoholism is valuable for those in the health care field in enabling them to recognize and work more effectively with that problem. (2) There are important physiological, psychological and sociological differences between men alcoholics and women alcoholics which may affect their treatment. (3) Society has a negative view of the alcoholic woman and she, in turn, denies her problem and is aided in this by family and others who might help her to confront her problem. (4) Therapists working with alcoholic clients may mirror society's negative view of the alcoholic woman and this may impede treatment.

Statement of the Problem

Though alcoholism is being reported as increasing, the rate of women appearing for treatment has not changed noticeably from the 1950's. Alcoholism is generally considered a man's disease and women are more likely to incur social costs for drinking than men.

Society views the alcoholic woman as more dissolute and deviant than her male counterpart. For this reason a woman with a drinking problem loathes to disclose it. She denies her problem both to herself and others. Usually her family, especially her spouse, helps her to hide her problem because of the stigma attached to alcoholism in women. He often

tries to control her drinking and may leave her when the problem becomes too severe. The alcoholic woman is often alone, lonely, depressed and may be suicidal.

Others in society, for example physicians and police also aid the alcoholic woman in hiding her problem by protecting her from the realistic consequences of her drinking. For reasons which are as yet unclear her drinking becomes a serious problem much more quickly than a man and her physiological problems progress rapidly. She frequently does not seek treatment for her alcoholism directly, but may claim other physical and emotional problems. When a physician is seen by the woman with a drinking problem, she usually receives a tranquilizer. This adds the problem of poly-drug abuse.

She may not become a statistic at an alcohol treatment center until confronted by a crisis that forces her to seek help. When she does reach an alcohol treatment clinic she may be faced with negative attitudes of therapists who see her as more neurotic and sicker than the alcoholic man. The therapists often reflect the attitude of society and in turn may reinforce the negative attitude since they are seen as experts in the field of mental health.

Hypotheses and Secondary Purpose of Study

Based on information obtained through a review of the literature, the following hypotheses were formulated:

(1) All therapists will have different attitudes toward client of different sexes.

(2) All therapists will have more negative attitudes toward female clients than toward male clients.

Secondary purpose of the study is to explore the effects of demographic characteristics of the therapist with their attitudes toward their clients.

Justification for the Study

From the review of literature, the differences between male and female alcoholics seem clear. The importance of early recognition and treatment of alcoholism in women seems to be even more imperative than in men due to the reported telescoping of symptoms in women, a tendency toward severe depression and suicidal tendencies. The number of alcoholic women in the United States is rising rapidly according to recent reports and yet, the number of women being treated for the problem is not increasing at the same rate.

The reason or reasons for alcoholic women not seeking treatment is unclear, however, suppositions based on a review of the literature can be made. Since society views the alcoholic woman more negatively than the alcoholic man, it is difficult for a woman to admit she has a drinking problem and seek treatment. The negative attitude of society has been seen in clinicians working in mental health clinics. The attitude of therapists has been pointed out as being important in the treatment of clients. A negative attitude on the part of the clinician working with alcoholic clients would make it difficult, indeed, for an alcoholic woman to enter treatment for her problem.

This study is designed to assess if there are, in fact, differences in the therapists' attitudes toward men and women clients and if the reported more negative feelings of society toward women alcoholics are shared by those who treat them.

CHAPTER II

METHODS

Subjects and Setting

The 39 subjects for this study were male and female therapists, working with alcoholic clients in six outpatient treatment clinics for the State of Oregon. These programs offer a variety of services. Included are both individual and group approaches to therapy and rehabilitation. Specific approaches to overcoming alcohol problems range from controlled drinking plans to total abstinence. Medications such as psychotropic drugs and antabuse are given under supervision to some clients.

All therapists on the staff of these six outpatient clinics participated in the study. These mental health clinics are located in five Oregon counties: Multnomah, Washington, Clackamas, Columbia and Benton. The clinics were selected because they were geographically close and accessible to the researcher.

Design and Procedure

The design of this study is descriptive and comparative. The aim of the study is to explore the relation between attitude of the therapists and sex of the client.

Each clinic director was contacted by phone. After briefly explaining the study they presented the request for participation to the staff members at their staff meeting.

The researcher met with the therapists at each of the clinics during a staff meeting. Signatures of the subjects were obtained on a consent form. Subjects filled out a personal information questionnaire, and the attitude scales with instruction for administration. The questionnaire and the attitude scale were filled out at that time.

Data and Data-gathering Instrument

The data for this study were collected by means of attitude scales. The scales incorporated a semantic differential technique which was constructed by the researcher. A personal information sheet was included to gather demographic data. (See appendix for copy of complete booklet).

The semantic differential was developed by Osgood, Succi, and Tannenbaum (1957) to observe and measure the psychological meaning of stimuli, usually concepts, and is uniquely suited to assess attitudes. Attitudes are described by Osgood et al. as learned implicit processes having reciprocally antagonistic or potentially bipolar properties of varying intensity and mediate evaluative behavior. If attitude is some portion of the internal mediational activity, it is, by inference, part of the semantic structure of an individual, and may be correspondingly indexed.

This instrument consists of a number of scales, each of which is a bipolar adjective. These are rated, together with the concepts chosen for the specific study to be rated with the scales. The concepts are chosen to elicit different reactions by people holding different attitudes and to cover the assumed semantic space covered by those concepts (Kerlinger, 1965).

Each attitude scale is selected to measure the basic dimension, or factor underlying the scale and for its relevance to the concepts. Through research, Osgood et al. have found that, when analyzed, adjective pairs fall into factors or clusters. Three basic dimensions of importance are evaluative, potency, and activity (Osgood, et al., 1957). There are a

number of other clusters of varying importance.

According to Osgood et al. (1957), the semantic differential shows satisfactory reliability. Test and retest scores of 100 subjects and 40 items, producing an N of 4,000, resulted in a coefficient of .85. A study by Tannenbaum which shows additional test-retest reliability is reported by Osgood et al. Each of six concepts were judged, in a study by Tannenbaum, against six evaluative scales by 135 subjects on two occasions separated by five weeks. The test-retest coefficients ranged from .87 to .93.

In regard to validity, the semantic differential displays reasonable face validity as a measure of attitude. This instrument has been tested against other independently devised and well-known attitude measuring instruments, the Thurstone and the Guttman scales. The validity coefficients were .90 and .78 respectively.

Measurement of the Dependent Variable

In evaluating the semantic differential for the present study concepts were chosen for relevance to the research purposes. Six concepts were selected to test the relation between therapist attitude and sex of the client, namely: alcoholic man, alcoholic woman, alcoholic mother, alcoholic father, man and woman.

The concepts alcoholic mother and alcoholic father were chosen since the role of the parents is seen as important in our society. The literature mentions the deleterious effects on children of parents who are alcoholics. However, there is no research reported which compares society's attitude toward alcoholics who are parents and alcoholics in general. The concepts of man and woman were used to contrast the attitudes toward the gender of the person in the general population with attitudes toward

alcoholics.

Ten pairs of adjectives were chosen that would be representative of the following four factors: evaluative, potency, morality and accountability and for their relevance to the concepts previously mentioned. Five of these scales had high loadings on the evaluative scale (good-bad, sweet-sour, honest-dishonest, hopeful-hopeless, and selfish-unselfish). Two pairs of the adjectives chosen had high loadings on the potency scale (strong-weak, masculine-feminine). The adjectives chosen from the morality scale were respectable-not respectable. A final choice was responsible-irresponsible which had high loadings on the accountability scale.

The order of the adjective pairs and the polarity on the scoring sheets given to the subjects was varied for each concept in order to avoid response bias tendencies. The scores are simply the numbers 1 through 7 assigned as follows:

good 7: 6: 5: 4: 3: 2: 1 bad

That is, if an individual checks the adjective pair good-bad between the first and second set of dots at the left, a 6 is assigned. The first adjective represents the favorable pole of the continuum and the second adjective, the unfavorable pole. Other checked points are assigned to the other numerals. A score of 6 is a bit less favorable than 7. A score of 5 is close to neutral and a score of 4 is neutral. A score of 3 is less favorable than the neutral score and 2 is close to the unfavorable pole. Therefore, on each side, scores may range from 1 (least favorable)to 7 (most favorable); each concept may vary from 10 (least favorable) to 70 (most favorable). (See Appendix E for copy of instrument).

Personal Information Sheet

To explore the attitudes of the therapists toward clients as related to demographic data, a questionnaire was given to the subjects. Specifically, seven questions were asked which include sex, educational background, including field in which credential was received, number of years as therapist working with alcoholics and whether or not the therapist worked exclusively with alcoholic clients and members of their families. (See Appendix C for Personal Information Questionnaire).

Analysis of Data

To test the hypotheses of the present study, a two factor analysis of variance (ANOVA) with repeated measures on the second factor was conducted. The first factor was the sex of the therapist and the second, the sex of the client. The Newman-Keuls test was used when significant differences were found.

Separate tables are used to report the demographic data for each of the seven questions from the personal information sheet. The subjects' attitudinal scale mean scores are shown on each table. A comparison of the mean scores with the demographic information is used to further explore therapists attitudes toward their clients.

A chi square test was used to assure that the age distribution of the sample fits the age distribution curve of the population of the United States (U.S. Department of Commerce, 1973). With a confidence level of .01 the distribution was seen to be a good fit. Purpose of the test was to eliminate the possibility of age bias skewing results of the survey. (Data for chis square test are shown in Appendix G).

CHAPTER III

RESULTS AND DISCUSSION

Description of the Sample

The division of male and female therapists in this study is nearly equal, as shown in Table I. Educational background was divided into 5 categories as follows: doctoral, masters, baccalaureate, and associate degree and high school diploma levels. The field in which each degree was received varies and includes both liberal arts and science. One female therapist did not disclose her specific field and it is listed as unknown in Table I.

Fourteen of the subjects had received training in alcoholism counseling in addition to their specified educational background. Thirteen of this group had been involved in mental health training other than alcoholism counseling as a specialty. The remaining 12 subjects had not studied in a formal setting beyond the highest credential received. The two subjects with high school diplomas had received further training in order to prepare for their work. One of these was trained in alcohol counseling in a college setting. The second female therapist in this category was a college senior, majoring in psychology. In addition, she was employed as a counselor in a local nursing home as well as at the mental health facility. Based on the reported training, the therapists appear, as a group, to be interested in increasing their expertise as therapists.

The largest single age group was made up of 15 subjects with an age range of 30 to 39 years. A majority (26) of the total group of subjects held a masters' or doctoral degree. The fields in which 25 subjects had specialized were Psychology, Social Work and Sociology. Eighteen of the 39 subjects had worked 1 to 5 years as a therapist working with

TABLE I

Characteristics of Subjects

Characteristic	Number	
	Male (N = 20)	Female (N = 19)
Age		
20-29	1	6
30-39	8	7
40-49	5	5
50-59	6	1
Sex	20	19
Educational background		
Doctoral degree	6	3
Masters degree	12	5
Baccalaureate degree	2	6
Associate degree	--	3
High school diploma	--	2
Field of credential		
Education/English/Accounting	2	1
Counseling/Mental Health/Theology	2	3
Psychology/Social Work/Sociology	16	9
Nursing	--	2
Biology	--	1
High school diploma	--	2
Unknown	--	1
Other Training		
Alcoholism counseling	4	10
Other types mental health training	9	4
None	7	5
Number of years as therapist working with alcoholic clients		
Less than 1 year	2	5
6-10 years	8	10
11-15 years	5	3
16-20 years	1	--
over 20 years	2	--
Work exclusively with alcoholics		
Yes	4	5
No	16	14

alcoholic clients. Seven of the subjects had worked less than 1 year and 14 had worked more than 5 years as seen in Table I. Only 9 of the 39 subjects work exclusively with alcoholics. Although the subjects come from diverse backgrounds, the majority of therapists have a high level of education and a great deal of work experience.

Overall Analysis of Data

The analysis of variance revealed no significant difference in the attitudes of all therapists toward all clients when considered as a group. There was a significant difference in these same attitudes when the clients were separated according to the sex of the client. There was no significant difference in how the individual therapists viewed the client based on the sex of the client. (See Table II). Based on the finding the first hypotheses of the study was accepted. The Newman-Keuls test was used to determine the specific difference in attitude of the therapists based on concepts of the instrument. This parametric statistical test was chosen since it tests differences between all possible pairs of means (Winer, 1962).

An analysis of the overall scores of the subjects revealed significant differences at the .01 level in attitudes toward the alcoholic mother when compared to alcoholic men, alcoholic women and alcoholic fathers. The attitude of the therapists toward the alcoholic mother was more positive than toward those clients in the other three categories as seen in Table III.

The second hypothesis of the study was rejected since all therapists did not have more negative attitudes toward female clients than toward male clients.

Analysis of the Bipolar Adjective Pairs

Analysis of variance was used to determine specifically which of the 10 bipolar adjective pairs of the attitude scale across all concepts were

TABLE II

Analysis of Variance

of Therapists' Attitudes

	SS	df	MS	F
Total	5224.93	155		
Between Subjects	4225.93	38		
Sex of therapist	216.08	1	216.08	1.99
Subjects within groups	4009.85	37	108.37	
Within subjects	999.00	117		
Sex of client	168.57	3	56.19	7.56*
Therapists		3	1.99	.13
Client x subject within group	824.46	111	7.43	

* p =< .01

TABLE III

Newman-Keuls Test F Scores

Differences Between Pairs of Means

Concept Mean Scores	Alcoholic Woman 33.72	Alcoholic Father 33.95	Alcoholic Man 34.44	Alcoholic Mother 36.36
Alcoholic Woman 33.72	-	.23	.72	2.64*
Alcoholic Father 33.95		-	.49	2.41*
Alcoholic Man 34.44			-	1.92*
Alcoholic Mother 36.36				

* p = .01

A score potency can vary from 10 (least favorable) to 70 (most favorable).

significantly different. Five of the ten scales used in the data collecting instrument had significant differences at the .01 level. These bipolar adjective pairs were from the evaluative and morality scales. Mean scores of the bipolar adjective pairs which were significantly different were tested using the Newman-Keuls test.

Three pairs of bipolar adjectives which showed significant differences were from the evaluating scale. Alcoholic mothers were rated significantly higher on the good-bad scale than alcoholic fathers, alcoholic men, and alcoholic women. Alcoholic mothers and women were viewed as more sweet than alcoholic men and alcoholic fathers on the sweet-sour scale. On the hopeful-hopeless scale the subjects viewed alcoholic mothers as significantly more hopeful than alcoholic fathers, men, or women as shown in Table IV.

The respectable-not respectable bipolar adjective pair from the morality scale indicated that alcoholic mothers were viewed as significantly higher on the respectable pole than alcoholic fathers, men and women. The moral-immoral bipolar adjective pair showed that alcoholic mothers were considered to be more moral than alcoholic fathers. No significant difference was seen in regard to this bipolar adjective pair for the concepts alcoholic woman and alcoholic man.

There were no significant differences found in the unselfish-selfish or honest-dishonest bipolar adjective pairs of the evaluative scale. There were no statistically significant differences found in the masculine-feminine or strong-weak bipolar adjective pairs of the potency scale as seen in Table V. The bipolar adjective pair, responsible-not responsible, chosen from the accountability scale showed no significant differences.

TABLE IV

Mean Scores of Attitudinal Scales

In Which Significant Differences Were Found

	Alcoholic Mother	Alcoholic Father	Alcoholic Man	Alcoholic Woman
Evaluative Scale				
1. Good/Bad	4.13*	3.59	3.67	3.74
2. Sweet/Sour	3.67*	3.26	3.41	3.62*
3. Hopeful/Hopeless	4.20*	3.61	3.54	3.69
Morality Scale				
1. Respectable/ Not Respectable	3.97*	3.46	3.36	3.40
2. Moral/Immoral	4.02*	3.56	3.69	3.72

* $p = < .01$

TABLE V

Mean Scores of Attitudinal Scales

In Which Significant Differences Were Not Found

	Alcoholic Mother	Alcoholic Father	Alcoholic Man	Alcoholic Woman
Evaluative Scale				
1. Unselfish/ Selfish	3.21	2.85	2.93	2.62
2. Honest/ Dishonest	3.13	2.97	2.90	2.92
Potency Scale				
1. Masculine/ Feminine	4.36	4.59	4.57	4.46
2. Strong/Weak	3.06	3.20	3.26	3.16
Accountability Scale				
1. Responsible/Not Responsible	2.59	2.77	2.67	2.82

Personal Information Sheet Responses

Subjects responses to the bipolar adjectives of the attitude scale were compared to the demographic data of the personal information sheet. Averages were computed for these except for the sex of the therapist which was analyzed and reported earlier.

Question 1 dealing with age group of the therapist was answered by 7 individuals in the 20-29 year old category. This group was made up of 1 male and 6 females. Eight male and 7 female therapists were in the 30-39 year old group. Of the 10 subjects in the 40-49 year old category 5 were male and 5 female. The 50 and above group had 6 men and 1 woman.

Mothers were rated higher of the positive poles in the four scales which considered alcoholic individuals, by male and female therapists. However, this was not the case for males in the 40-49 age range and females of 50 and over. The men 40-49 rated alcoholic fathers more positively. The over-50 female subject rated alcoholic fathers and women more positively as seen in Table VI.

Unlabeled women were rated more positively as seen in the mean scores shown in Table VI by all subjects except males in the 30-39 category and males in the 40-49 age group. The over-50 female age group rated unlabeled men and women equally.

Question 2 of the personal information sheet asks if the therapist is male or female. This data was analyzed statistically.

Question 3 of the personal information sheet deals with the educational background of the subjects. Results of this question can be seen in Table VII. The therapists viewed alcoholic mothers more favorably than the other three concepts dealing with alcoholism. Unlabeled

TABLE VI

Comparison of Attitudinal Scale Mean Scores

With Age Group of Therapists

Age Group	Subjects	Alcoholic Mother	Alcoholic Father	Alcoholic Man	Alcoholic Woman	Man	Woman
20-29	Male	40.00	39.00	37.00	35.00	49.00	52.00
	Female	36.50	32.17	33.00	34.33	45.17	47.50
30-30	Male	36.88	33.13	35.25	36.13	44.63	44.38
	Female	33.86	31.57	33.00	32.14	42.43	47.86
40-49	Male	35.40	35.60	31.80	32.80	47.60	43.40
	Female	35.40	34.20	31.40	31.40	45.00	46.60
50-59	Male	39.67	36.50	35.67	38.17	44.67	48.67
	Female	34.00	38.00	37.00	38.00	40.00	40.00

Scale potency range from 10 (least favorable) to 70 (most favorable).

TABLE VII

Comparison of Attitudinal Scale Mean Scores

With Educational Background of Therapists

Background	Subjects	Alcoholic Mother	Alcoholic Father	Alcoholic Man	Alcoholic Woman	Man	Woman
Doctoral	Male	35.83	33.00	34.17	35.17	47.00	50.83
	Female	30.00	28.33	29.67	30.00	44.33	45.00
Masters	Male	36.33	34.67	33.58	34.58	46.00	44.75
	Female	32.80	30.20	30.20	31.00	45.00	49.60
Baccalaureate	Male	42.00	33.50	35.50	34.33	46.33	48.33
	Female	36.33	33.00	35.17	35.17	40.67	46.00
Associate Degree	Male	-	-	-	-	-	-
	Female	40.33	38.67	35.33	34.33	46.33	48.33
High School Diploma	Male	-	-	-	-	-	-
	Female	37.00	36.50	33.00	33.50	41.00	44.00

Scale potency range from 10 (least favorable) to 70 (most favorable).

women received higher scores than unlabeled men. Inspection of the data seemed to indicate no relationship between education and attitude.

The fourth question on the personal information sheet asked subjects to identify the field in which their credential was received if a degree above a high school diploma was earned. Twenty males and 16 females answered.

The males included in the group who received their credential in education, English and accounting, rated alcoholic mothers above alcoholic fathers, alcoholic men and alcoholic women. Unlabeled women were rated more favorably than unlabeled men by this group. The only female subject who received her credential in this category rated alcoholic mothers lowest of the alcoholic individuals. She rated unlabeled men and women equally.

Males and females who received their credential in counseling, mental health, theology, psychology, and sociology rated alcoholic mothers highest of those labeled alcoholic as can be seen in Table VIII. Unlabeled men were rated more favorably by the male therapists than were unlabeled women. The female therapists, however, rated unlabeled women more favorably than unlabeled men.

The therapists who received their credential in nursing or biology rated alcoholic men higher than the other 3 alcoholic categories. The unlabeled men and women were rated equally by the nurse therapists. Unlabeled women were rated more favorably than unlabeled men by those who received their credential in biology.

Question 5 of the personal information sheet contributes information about additional training the subjects may have had relating to their

TABLE VIII

Comparison of Attitudinal Scale Mean Scores

With Field of Credential of Therapists

Credential Category	Subjects	Alcoholic Mother	Alcoholic Father	Alcoholic Man	Alcoholic Woman	Man	Woman
Education, English, Accounting	Male	42.00	33.50	35.50	39.50	40.00	42.50
	Female	34.00	38.00	37.00	38.00	40.00	40.00
Counseling, Mental Health, Theology	Male	42.00	35.00	32.00	37.00	43.00	42.50
	Female	38.50	35.75	33.25	35.00	47.25	52.50
Psychology, Social Work, Sociology	Male	36.38	35.25	34.87	35.25	46.63	46.63
	Female	33.25	28.88	30.14	30.38	42.50	46.13
Nursing	Male	-	-	-	-	-	-
	Female	36.50	37.50	39.00	36.00	43.00	43.00
Biology	Male	-	-	-	-	-	-
	Female	27.00	24.00	28.00	26.00	54.00	57.00

Scales potency range from 10 (least favorable) to 70 (most favorable).

profession. Four male subjects and 10 female therapists received training in alcoholism counseling. Mental health training other than alcoholism counseling was received by 9 of the male subjects and 4 of the female subjects. Twelve therapists have not been involved in formal training beyond their reported credentials as seen in Table IX.

All therapists gave higher scores to the alcoholic women who were mothers than the other three alcoholic concepts. The unlabeled men were viewed less favorably than the unlabeled women by all except the male therapists who had received additional mental health training. These therapists who received additional training in alcoholism counseling had mean scores which were equal for unlabeled men and unlabeled women.

The attitude of the therapists toward their alcoholic clients compared with the number of years of working with alcoholic clients was dealt with by Question 6 of the personal information sheet. An overall look at the results can be seen in Table X. Alcoholic mothers were viewed more favorably than alcoholic fathers, alcoholic men and alcoholic women categories except in two instances. Female therapists who have worked with alcoholic clients 6 to 10 years rated alcoholic men more favorably than the other groups of clients. The single male therapist in the 16 to 20 year category rated alcoholic fathers higher. Unlabeled women were viewed more favorably by all the therapists with the exception of male therapists in the 16 to 20 year group.

The final question of the personal information sheet asks whether the therapist works exclusively with alcoholic clients or not. The results of the attitude of the male and female therapists when compared with this question is seen in Table XI.

TABLE IX

Comparison of Attitudinal Scale Mean Scores

With Additional Training of Therapists

Additional Training	Subjects	Alcoholic Mother	Alcoholic Father	Alcoholic Man	Alcoholic Woman	Man	Woman
Alcoholic Counseling	Male	36.00	32.75	31.25	33.50	48.75	48.75
	Female	36.70	33.70	34.20	34.50	44.10	46.10
Mental Health Training	Male	37.44	33.67	34.33	35.89	46.44	46.22
	Female	34.25	33.75	32.75	32.25	47.50	50.75
No Additional Training	Male	38.43	38.14	36.86	40.00	42.71	43.57
	Female	32.60	30.20	30.00	30.40	40.40	45.60

Scales potency range from 10 (least favorable) to 70 (most favorable).

TABLE X

Comparison of Attitudinal Scale Mean Scores

With Number of Years as Therapist With Alcoholic Clients

Number of Years	Subjects	Alcoholic Mother	Alcoholic Father	Alcoholic Man	Alcoholic Woman	Man	Woman
Less than 1 year	Male	36.50	33.50	35.50	36.00	45.00	45.50
	Female	35.20	34.00	34.40	33.40	45.60	48.60
1 to 5 years	Male	37.25	33.00	34.88	35.88	45.38	47.00
	Female	35.40	33.40	32.00	33.10	44.30	46.80
6 to 10 years	Male	37.75	36.75	33.50	34.50	42.50	43.25
	Female	35.50	35.50	36.50	35.00	43.00	43.50
11 to 15 years	Male	40.00	39.00	35.67	38.00	46.33	48.00
	Female	27.50	20.50	22.00	22.50	42.00	47.50
16 to 20 years	Male	31.00	36.00	31.00	31.00	58.00	30.00
	Female	-	-	-	-	-	-
Over 20 years	Male	38.50	35.00	35.00	37.50	46.00	51.00
	Female	-	-	-	-	-	-

Scales potency score range from 10 (least favorable) to 70 (most favorable).

TABLE XI

Comparison of Attitudinal Scale Mean Scores

With Therapists Exclusive Work With Alcoholic Clients

Exclusive Work	Subjects	Alcoholic Mother	Alcoholic Father	Alcoholic Man	Alcoholic Woman	Man	Woman
Yes	Male	37.00	32.00	33.25	35.50	44.50	48.00
	Female	39.20	38.40	35.80	36.00	42.60	44.80
No	Male	37.63	35.81	34.94	35.94	45.88	45.25
	Female	33.64	30.79	31.71	31.86	44.29	47.71

Scales potency range from 10 (least favorable) to 70 (most favorable).

The alcoholic mother was viewed more favorably than the other alcoholic categories by therapists working exclusively with alcoholic clients and those who work with other types of clients as well. The unlabeled women were viewed more favorably by all therapists with the exception of the male therapists who do not work exclusively with alcoholic clients.

In order to explore the outcome of this study it is necessary to recall the hypotheses formulated. The first of these stated that all will have different attitudes toward clients of different sexes. A statistically significant difference was found which support that hypothesis that the sex of the client will make a difference in the therapists' attitudes toward the clients. A Newman-Keuls test was conducted which determined the specific concept influencing the statistical difference.

It will be recalled that the second hypothesis states that all therapists will have more negative attitudes toward female clients than toward male clients. The results of this study did not support this hypothesis. The Newman-Keuls test, mentioned above, indicated that the alcoholic mother was viewed more favorably at a statistically significant level by the male and female therapists. This significant difference was seen on three of the evaluative scales and two of the morality scales as mentioned earlier.

The alcoholic mother was seen by the therapist as significantly more good and more hopeful than alcoholic men, alcoholic fathers, or alcoholic women on the respective bipolar scales. Alcoholic mothers and women were seen as significantly sweeter than alcoholic men and fathers. The alcoholic mother is also seen as more respectable than alcoholic fathers, alcoholic men and alcoholic women and more moral than alcoholic fathers.

The findings in the present study seem to indicate that the climate at a mental health clinic might well be very supportive toward alcoholic women who come in for treatment of their drinking problem, especially if the client is also a female parent. Based on the results found here, the question concerning the reason for the discrepancy in the number of women in treatment for an alcohol problem and the reported increase in women alcoholics remains unanswered. Speculation concerning this question seems appropriate.

While the attitude which seems to be in evidence in this study is one of acceptance for the alcoholic woman who is a mother, the literature strongly suggests this may not be generalized to society as a whole. Social prejudices might well discourage women from admitting their problem and seeking help according to Badiet (1976). This same author points out that 70% of women alcoholics in the United States are hidden drinkers.

The self perception of the alcoholic woman influences strongly, whether she seeks treatment for her drinking problem. Badiet (1976) points out that women have historically been the guardians of social values. Admission of alcohol abuse may be seen by the female problem drinker as a threat to family stability. A result of this thinking might well be a factor in denial that a problem with alcohol exists.

According to Curlee (1970) society finds it easier to recognize a woman as mentally ill than as an alcoholic. The same author points out that it is also easier for a husband to decide that his wife is mentally ill and send her to a psychiatrist than to decide she is an "inebriate" and send her for treatment for alcoholism. The woman with a drinking

problem may well feel a sense of disgust or self-loathing because of the increased use of alcohol. These feelings may influence her to accept society's view and avoid treatment for alcoholism but seek help for other concurrent problems which often include anxiety, depression or a harmless physical ailment.

A study by Johnson (1965) pointed out that only 4% of 500 women studied went to a physician specifically because of a drinking problem and concluded that the doctor has an important role to play in uncovering the problem. Many of the doctors in the study believed they had a responsibility to discuss the drinking problem with the patient, but many failed to do so, believing it would harm the relationship. According to the author of the study, treatment for alcoholism would often be delayed or ignored as doctors do not know when or how to approach the patient. The woman who comes in to a doctor complaining of depression, tension, or anxiety is given a prescription for medication for these problems and has no help in confronting a problem with alcohol.

Trice and Roman (1972) found that supervisors in an industrial setting who had a negative attitude toward alcoholics were more likely to confront those with a drinking problem, resulting in earlier identification and treatment. Alcoholic women who remain at home are safe from this kind of confrontation and therefore may not seek treatment. This protection from the reality of the drinking problem and need for treatment may well be reinforced by husbands who deny the problem.

The attitude of the therapist does seem to be a vital issue in the outcome of treatment in a mental health setting. Homiler (1977) points out that the majority of research studies examining treatment effective-

ness do not distinguish between outcome rates and/or success criteria in men and women alcoholics. The few that have made this distinction, however, generally reported a poorer prognosis and a lower treatment effectiveness rate in women than in men.

The therapists who took part in the present study apparently perceive the alcoholic mother and woman in a more favorable way than the alcoholic man and alcoholic father. One might speculate that the protective attitude which occurs in society toward the alcoholic woman may be mirrored by therapists, based on the lower treatment effectiveness rate mentioned earlier. This could result in unrealistic assessment of the drinking problems of the female client and influence the attitude of the therapist to be more favorable toward her.

A final point that should be considered when speculating about the number of women in treatment for alcoholism concerns the actual number of women with a drinking problem. The statistics regarding women with an alcohol problem are based, in most instances, on assumptions and approximations. It is a possibility that the increase of this problem has been less than speculative thought reported and that there are, in fact, fewer than supposed alcoholic women.

Limitations of the Study

Therapists who comprise the sample for the present study are from the State of Oregon. This geographical limitation should be considered when speculating about the results reported. Since the therapists live in counties of close proximity, the cultural influence might effect their perception of the client which would lead to similarity of attitude.

The number of clinics chosen for the study was small (6) and were all State run agencies. This implies a strong possibility that a similar basic philosophy existed among these clinics and influence attitudes of therapists toward their clients.

The simplicity of the semantic differential may be seen as a limitation. The concepts and adjectives may not have touched the real differences. A further consideration is that the researcher's intent may have been clear to the population tested which could cause the subjects to answer less than honestly.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

There has been concern at both federal and state level that the number of alcoholic women is increasing much more rapidly than the number who go into treatment clinics for an alcohol problem. The purpose of this study was to look at an aspect of the treatment setting to determine one possible factor in the decision by the alcoholic woman to enter a clinic for help with a drinking problem. The attitude of the therapist working with alcoholic clients was considered.

The data were collected by means of a semantic differential scale from 39 therapists working in 6 alcohol treatment clinics in 5 counties in the State of Oregon. Data were analyzed statistically by analysis of variance and statistically significant differences by the Neuman-Keuls test.

Statistically significant differences were found to be more positive attitudes toward the alcoholic mother when compared to alcoholic men, women and fathers. Significant differences were seen in the evaluative and morality scales when analyzing the bipolar adjectives used in the semantic differential.

The evaluative scale revealed that alcoholic mothers were perceived as significantly more positive on the good-bad scale than alcoholic fathers, men and women. Alcoholic mothers and women were seen as sweeter than alcoholic fathers and men. The alcoholic mothers were seen as significantly more hopeful than alcoholic fathers, men or women.

The morality scale indicated that alcoholic mothers were perceived as significantly more respectable than alcoholic fathers, alcoholic men and alcoholic women. Alcoholic mothers were also considered to be significantly more moral than alcoholic fathers.

Conclusions

The attitude survey indicates that the therapists were receptive to the alcoholic woman, especially the alcoholic mother. There was no instance in which the attitude of the therapist favored the male alcoholic over the female alcoholic at a statistically significant level.

The findings of this study are contrary to what might be expected based on reports in the literature review.

The attitudes of society noted in the studies are unfavorable toward the alcoholic woman. She is labeled deviant. She is seen as immoral and is often a target of society's hostility (Sandmaier, 1977). It might be expected that the attitude of therapists would reflect society's reported negative attitude.

However, findings of this study are not in line with society's negative view of the alcoholic woman. There is then a need to look further to determine why alcoholic women do not readily enter treatment for their drinking problem.

Recommendations

1. Interview women in treatment for alcoholism to explore what barriers they see toward seeking help for the problem.

2. Replicate this study on a state-wide basis to compare responses of therapists from counties further from a large metropolitan setting.

3. Survey nurses in community health and hospital settings to determine whether they recognize signs and symptoms of alcoholism and

are willing to confront clients with this problem when noted.

4. Look at records in alcohol treatment centers to actually determine the percentage of women compared to men in treatment for a drinking problem.

5. A look at alcohol treatment programs in the state to determine if the special needs of women are considered.

6. A study which looks at women in treatment and what helped them to make a decision to enter treatment as a means of determining approaches to the problem that might be utilized by health care workers to encourage other women to enter treatment for a drinking problem.

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APPENDICES

APPENDIX A

Permission to Conduct Study Form

I, _____, Clinic Director of _____

_____, give permission to Charlotte Lissy to contact therapists at this facility to ask them to take part in an attitudinal survey she is conducting.

APPENDIX B

Informed Consent Form

Informed Consent Form

I, _____, herewith
(First Name) (Middle Name) (Last Name)
agree to serve as a subject in the study "A Survey of Attitudes of Outpatient Treatment Therapists in Clinics Toward Their Alcoholic Clients", by Charlotte A. Lissy, R.N., B.S.N., under the supervision of Florence Hardesty, R.N., Ph.D. I will be asked to give some identifying information about myself such as age, sex, and educational background and to fill out an attitudinal scale. Approximately 15 minutes of my time will be required. The information will be kept confidential. My name will not appear on the records and anonymity will be insured by the use of code numbers. The code key will be kept separate from other research data and in a locked file. Though I may not see an immediate benefit from my participation in this study, I understand it will increase our knowledge of the alcoholic client's treatment experience.

Charlotte Lissy has offered to answer any questions that I might have regarding my participation in the study. I understand I am free to refuse to participate or withdraw from participation in the study at any time if I so desire without its affecting my relationship with my employer nor with the University of Oregon Health Sciences Center.

I have read the foregoing.

_____ _____
(Date) (Subject's Signature)

_____
(Witness' Signature)

APPENDIX C

Personal Information Sheet

Questionnaire

Personal Information Sheet

Questionnaire

1. Age group to which you belong (circle appropriate letter)
   a. 20 to 29
   b. 30 to 39
   c. 40 to 49
   d. 50 years or over
2. Sex (circle appropriate letter)
   a. Female
   b. Male
3. Educational background (circle appropriate letter adjacent to highest credential received)
   a. Doctoral degree
   b. Master's degree
   c. Baccalaureate degree
   d. Associate degree
   e. High School diploma
4. Field in which above credential was received if one of letters a through d was circled _____
5. Other professional training; describe _____

   _____

   _____
6. Number of years employed as therapist working with alcoholic clients (circle appropriate letter)

a. Less than one year

b. 1 to 5 years

c. 6 to 10 years

d. 11 to 15 years

e. 16 to 20 years

f. Over 20 years

7. Do you work exclusively with alcoholic clients or members of their family (circle appropriate letter)

a. Yes

b. No

APPENDIX D

Instructions for Use of Attitude Scale

Instructions For Use of Attitude Scale

The purpose of this study is to measure the meanings of certain things to various people by having them judge them against a series of descriptive scales. In taking this test, please make your judgements on the basis of what these things mean to you. On each page of this booklet you will find a different concept to be judged and beneath it a set of scales in order. Here is how you are to use these scales:

If you feel that the concept at the top of the page is very closely related to one end of the scale, you should place your check-mark as follows:

Fair: X : ___: ___: ___: ___: ___: ___Unfair

OR

Fair:___: ___: ___: ___: ___: ___: X Unfair

If you feel that the concept is quite closely related to one or the other end of the scale (but not extremely), you should place your check-mark as follows:

Fair:___: X : ___: ___: ___: ___: ___Unfair

OR

Fair:___: ___: ___: ___: ___: X : ___Unfair

If the concept seems only slightly related to one side as opposed to the other side (but is not really neutral), then you should check as follows:

Slow:___: ___: X : ___: ___: ___: ___Fast

OR

Slow:___: ___: ___: ___: X : ___: ___Fast

The direction toward which you check, of course, depends upon which of the two ends of the scale seem most characteristic of the thing you're judging.

If you consider the concept to be neutral on the scale, both sides of the scale equally associated with the concept, or if the scale is completely irrelevant, unrelated to the concept, then you should place your check-mark in the middle space.

Safe:___: ___: ___: X : ___: ___: ___Dangerous

IMPORTANT: (1) Place your check-marks in the middle of spaces, not on the boundaries:

THIS : X : ___: NOT THIS ___X___

(2) Be sure you check every scale for every concept - do not omit any.

(3) Never put more than one check-mark on a single scale.

Sometimes you may feel as though you've had the same item before on the test. This will not be the case, so do not look back and forth through the items. Do not try to remember how you checked similar items earlier in the test -- make each item a separate and independent judgment. Work fairly fast. Do not worry or puzzle over individual items. It is your first impressions we want. On the other hand, do not be careless, because we want your true impressions.

APPENDIX E

Attitude Scale

Attitude Scale

Table I

Alcoholic Mother

Respectable:___: ___: ___: ___: ___: ___: ___Not Respectable

Selfish: ___: ___: ___: ___: ___: ___: ___Unselfish

Hopeful: ___: ___: ___: ___: ___: ___: ___Hopeless

Masculine: ___: ___: ___: ___: ___: ___: ___Feminine

Bad: ___: ___: ___: ___: ___: ___: ___Good

Sweet: ___: ___: ___: ___: ___: ___: ___Sour

Strong: ___: ___: ___: ___: ___: ___: ___Weak

Dishonest: ___: ___: ___: ___: ___: ___: ___Honest

Immoral: ___: ___: ___: ___: ___: ___: ___Moral

Responsible:___: ___: ___: ___: ___: ___: ___Irresponsible

Attitude Scale

Table II

Alcoholic Father

Good:	___:	___:	___:	___:	___:	___:	___	Bad
Sweet:	___:	___:	___:	___:	___:	___:	___	Sour
Honest:	___:	___:	___:	___:	___:	___:	___	Dishonest
Moral:	___:	___:	___:	___:	___:	___:	___	Immoral
Hopeless:	___:	___:	___:	___:	___:	___:	___	Hopeful
Feminine:	___:	___:	___:	___:	___:	___:	___	Masculine
Responsible:	___:	___:	___:	___:	___:	___:	___	Irresponsible
Weak:	___:	___:	___:	___:	___:	___:	___	Strong
Selfish:	___:	___:	___:	___:	___:	___:	___	Unselfish
Respectable:	___:	___:	___:	___:	___:	___:	___	Not Respectable

Attitude Scale

Table III

Alcoholic Man

Responsible:___: ___: ___: ___: ___: ___: ___Irresponsible

Good: ___: ___: ___: ___: ___: ___: ___Bad

Respectable:___: ___: ___: ___: ___: ___: ___Not Respectable

Weak: ___: ___: ___: ___: ___: ___: ___Strong

Sour: ___: ___: ___: ___: ___: ___: ___Sweet

Unselfish: ___: ___: ___: ___: ___: ___: ___Selfish

Masculine: ___: ___: ___: ___: ___: ___: ___Feminine

Hopeful: ___: ___: ___: ___: ___: ___: ___Hopeless

Moral: ___: ___: ___: ___: ___: ___: ___Immoral

Dishonest: ___: ___: ___: ___: ___: ___: ___Honest

Attitude Scale

Table IV

Alcoholic Woman

Hopeful:	___:	___:	___:	___:	___:	___:	___Hopeless
Good:	___:	___:	___:	___:	___:	___:	___Bad
Masculine:	___:	___:	___:	___:	___:	___:	___Feminine
Respectable:	___:	___:	___:	___:	___:	___:	___Not Respectable
Weak:	___:	___:	___:	___:	___:	___:	___Strong
Sweet:	___:	___:	___:	___:	___:	___:	___Sour
Responsible:	___:	___:	___:	___:	___:	___:	___Irresponsible
Immoral:	___:	___:	___:	___:	___:	___:	___Moral
Selfish:	___:	___:	___:	___:	___:	___:	___Unselfish
Honest:	___:	___:	___:	___:	___:	___:	___Dishonest

Attitude Scale

Table V

Man

Honest:	___	: ___	: ___	: ___	: ___	: ___	: ___	Dishonest
Sweet:	___	: ___	: ___	: ___	: ___	: ___	: ___	Sour
Responsible:	___	: ___	: ___	: ___	: ___	: ___	: ___	Irresponsible
Strong:	___	: ___	: ___	: ___	: ___	: ___	: ___	Weak
Respectable:	___	: ___	: ___	: ___	: ___	: ___	: ___	Not Respectable
Hopeless:	___	: ___	: ___	: ___	: ___	: ___	: ___	Hopeful
Good:	___	: ___	: ___	: ___	: ___	: ___	: ___	Bad
Masculine:	___	: ___	: ___	: ___	: ___	: ___	: ___	Feminine
Immoral:	___	: ___	: ___	: ___	: ___	: ___	: ___	Moral
Selfish:	___	: ___	: ___	: ___	: ___	: ___	: ___	Unselfish

Attitude Scale

Table VI

Woman

Hopeless:	___:	___:	___:	___:	___:	___:	___Hopeful
Unselfish:	___:	___:	___:	___:	___:	___:	___Selfish
Strong:	___:	___:	___:	___:	___:	___:	___Weak
Honest:	___:	___:	___:	___:	___:	___:	___Dishonest
Sweet:	___:	___:	___:	___:	___:	___:	___Sour
Bad:	___:	___:	___:	___:	___:	___:	___Good
Masculine:	___:	___:	___:	___:	___:	___:	___Feminine
Responsible:	___:	___:	___:	___:	___:	___:	___Irresponsible
Respectable:	___:	___:	___:	___:	___:	___:	___Not Respectable
Moral:	___:	___:	___:	___:	___:	___:	___Immoral

APPENDIX F

National Council on Alcoholism

Criteria for Diagnosing Alcoholism

Criteria for Diagnosing Alcoholism

Major Criteria

Physiological and Clinical

A. Physiological dependency

1. Manifested by withdrawal syndrome
2. Evidence of tolerance to the effects of alcohol
3. Alcoholic "blackout" periods

B. Clinical: Major Alcohol-associated Illnesses

1. Fatty degeneration of liver
2. Alcoholic hepatitis
3. Laennec's cirrhosis
4. Pancreatitis in the absence of cholelithiasis
5. Chronic gastritis
6. Hematological disorders
7. Wernicke-Korsakoff syndrome
8. Alcoholic cerebellar degeneration
9. Cerebral degeneration in absence of Alzheimer's disease or arteriosclerosis
10. Peripheral neuropathy
11. Toxic amblyopia
12. Alcohol myopathy
13. Alcoholic cardiomyopathy
14. Beriberi
15. Pellagra

Behavioral, Psychological, and Attitudinal

1. Drinking despite strong medical contraindication known to patient

2. Drinking despite strong, identified social contraindication (job loss for intoxication, marriage disruption, arrest for driving while intoxicated)

3. Subjective complaint of loss of control in terms of alcohol consumption

Minor Criteria

Physiological and Clinical

A. Direct effect

1. Early

Odor of alcohol on breath at time of medical appointment

2. Middle

Alcoholic facies

Vascular engorgement of face

Toxic amblyopia

Increased incidence of infection

Cardiac arrhythmias

Peripheral neuropathy

3. Late

Same as major criteria B

B. Indirect effects

1. Early

Tachycardia

Flushed face

Nocturnal diaphoresis

2. Middle

Ecchymosis on lower extremities, arms, or chest

Cigarette burns on hands or chest

Hyperreflexia or if drinking heavily, hyporeflexia

3. Late

Decreased tolerance

C. Laboratory tests

1. Direct

Blood level at any time of more than 300 mg/100 ml or level of more than 100 mg/ml in routine examination

2. Indirect

Serum osmolarity: every 22.4 increase over 200 mOsm/litre reflects 50 mg/100 ml of alcohol in blood

Result of alcohol ingestion:

Hypoglycemia

Hypochloremic alkalosis

Low magnesium level

Lactic acid elevation

Transient uric acid elevation

Potassium depletion

Indications of liver abnormality:

SGPT elevation

SGOT elevation

BSP elevation

Bilirubin elevation

Urinary urobilinogen elevation

Serum A/G ratio reversal

Blood and clotting:

Anemia

Clotting disorders

ECG abnormalities:

Cardiac arrhythmias

Tachycardia

Atrial fibrilation

Premature ventricular contractions

Abnormal P waves

EEG abnormalities:

Decrease or increased REM sleep

Loss of Delta sleep

Decreased immune response

Decreased response to Synachthem test

Chromosomal damage from alcoholism

Behavioral, Psychological, and Attitudinal

A. Behavioral

1. Direct effects

Early

Medical excuses from work

Shifting from one alcoholic beverage to another

Preference for drinking companions, bars and taverns

Loss of interest in activities not directly associated with drinking

Late

Choose employment that facilitates drinking

Frequent automobile accidents

History of family member undergoing psychiatric treatment; school and behavioral problems of children

Frequent residence change for poorly defined reasons

Anxiety relieving mechanism, such as telephone calls inappropriate in time

APPENDIX G

Data For Chi Square Test of Age Distribution

DATA FOR CHI SQUARE TEST OF AGE DISTRIBUTION

Age Groups of Therapists	Number of Therapists in Each Age Group	From Population Table % in Each Age Group	# of People Expected Out of 39 Subjects in Each Age Range
20-29	7	29.9	12.09
30-39	15	22.5	8.97
40-49	10	24.1	9.75
50-59	7	21.1	8.58

x^2 = 6.49 (not significant)

df = 3

AN ABSTRACT OF THE THESIS OF

CHARLOTTE ANNE SUSANKA LISSY

For the MASTER OF NURSING

Date of Receiving this Degree: June, 1980

Title: A SURVEY OF ATTITUDES OF OUTPATIENT TREATMENT THERAPISTS IN CLINICS TOWARD THEIR ALCOHOLIC CLIENTS

Approved: [redacted]
Florence Hardesty, Ph.D., Thesis Advisor

This study was a survey of attitudes of therapists working with alcoholic clients in 6 outpatient treatment clinics in 5 counties in the state of Oregon. The purpose of the study was to determine a difference in those attitudes depending on the sex of the client.

At the time of the survey, the therapists were given a booklet containing an attitude scale and a personal information questionnaire. The attitude scale was a modified semantic differential which consisted of 10 bipolar adjectives. The bipolar adjectives were rated, together with concepts chosen for the study.

The results were analyzed by a two factor analysis of variance with repeated measures on the second measure. The first factor was the sex of the therapist and the second, the sex of the client. The Newman-Keuls, a parametric statistical test was used to test all possible pairs of means when significant differences were found.

No significant difference was found in the way the male and female therapists viewed their alcoholic clients. However, an analysis of the overall scores of the subjects revealed a significant difference at the .01 level in attitudes toward the alcoholic mother when compared to alcoholic men, alcoholic women and alcoholic fathers. The attitude toward the alcoholic mother was more favorable than those toward clients in the other three groups.

The personal information sheet responses were compared with attitudinal scale responses as an additional dimension. It seemed clear that the therapists, generally, had a favorable attitude toward the alcoholic mother.