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ALCOHOLICS IN THE MENTAL HOSPITAL: THE
EFFECT OF ADMISSION PATH

by

Arthur Anderson

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Master of Arts

Western Michigan University
Kalamazoo, Michigan
April 1976

ACKNOWLEDGEMENTS

I would like to thank the members of my thesis committee: Dr. Morton Wagenfeld, Dr. Stanley Robin and Dr. Thomas Williams. In particular, it has been through my interaction with Dr. Wagenfeld and Dr. Robin that I have learned much more than exhibited in these pages. A special note of thanks to Dr. Williams and the S. P. A. D. A. staff who initially stimulated my interest and guided my study of substance abuse.

I would also like to thank the Battle Creek Veterans Administration Hospital for their complete cooperation. I am extremely indebted to Dr. Joann Sinclair and Lynn Becker of January House for allowing me to explore and learn. Appreciation also goes to the entire January House staff for their valuable comments to never-ending questions.

A host of individuals provided that ever-important emotional support. Among them are: Bob King, Caren Wesson, Ron and Linda Krol, Mike Nusbaumer and Alan Pearl.

Finally, the greatest impetus for the completion of this study came from New Jersey and Pennsylvania. Alright--alright--it is done.

Arthur Anderson

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ANDERSON, Arthur Thomas
ALCOHOLICS IN THE MENTAL HOSPITAL:
THE EFFECT OF ADMISSION PATH.

Western Michigan University, M.A., 1976
Sociology, general

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CHAPTER I

THEORETICAL FRAMEWORK

Introduction

This is a study of alcoholics in a mental hospital. Through the exposure to the generally negative conceptions of mental illness existent in our society, the alcoholic develops a stigmatized attitude toward psychiatric hospitalization. When treated among nonalcoholic patients, these attitudes may be translated into uncooperative and resistive behavior. Ideally, as the alcoholic is socialized to the patient role he will increase his willingness to accept treatment and cooperate with staff. Realistically, socialization is not always successful and the alcoholic may remain uncooperative or leave treatment. The obtainment of the alcoholic's cooperation and his acceptance of the mental hospital as a help source is a problematic issue for hospital administrators.

This is a study of socialization and length of stay in treatment. The sample consists of veterans who participated in the alcoholism treatment program offered at a Veterans Administration psychiatric hospital. Two socialization experiences are considered: the alcoholic is socialized to the hospital among non-alcoholic patients on a functional ward, and socialization occurs

on a ward designated as an alcoholism treatment ward, housing only alcoholics. It is hypothesized that the socialization of alcoholics among nonalcoholic patients arouses stereotyped conceptions of psychiatric hospitalization and will adversely affect length of stay.

Theory

Historically, social scientists have been concerned with discovering how individuals learn to participate in social interaction. The diversity among groups concerning the degree of effective social functioning has challenged the imagination of various disciplines. Carrying their respective theoretical baggage anthropology, psychology, and sociology have contributed to the development of the concept of socialization. Anthropology developed the broader cultural perspective which outlined the overall boundaries of the socialization experience. Psychology focused upon the development of individual characteristics and the basic processes through which behavioral tendencies are learned. Finally, sociology examined the groups and institutions in which socialization occurs and the common social skills acquired by individuals in varying contexts (Goslin, 1969).

For this study, socialization is discussed from the sociological perspective, individual differences and cultural factors are omitted, not to discount their importance but to highlight the

sociological level of analysis.

The majority of research in the area of socialization has focused upon child development. By comparison, studies of adult socialization are a clear minority (Brim & Wheeler, 1966). However, this paucity of research does not reflect the utility of applying the concept to adults.

Early socialization experiences are often not suited to meet the new and changing expectations that arise during the life cycle. Consequently, childhood experiences are not adequate in fulfilling the demands of adult reality. Therefore, to participate as effective members of their society or group, adults undergo socialization:

Adult socialization is the process of inculcating new values and behavior appropriate to adult positions and group memberships. These changes are normally internalized in the course of induction or training procedures, whether formal or informal. They result in new images, expectations, skills, and norms as the person defines himself and others view him (Roscow, 1974:31).

The standards of the socialization process are drawn from the norms of the target system. Target systems include: a specific role, a particular group, or the values of broad social categories (Roscow, 1974).

Organizations contain positions which require indoctrination of the novice prior to adequate position functioning. Consequently, organizations are common target systems of adult socialization.

In the late thirties, organization analysts considered the

mental hospital as a complex organization (Etzioni, 1973). Since that time this perspective has fathered a number of organizational critiques of the mental hospital (Caudill, 1958; Greenblatt, Levinson & Williams, 1957; Stanton & Schwartz, 1954). In addition, the mental hospital has appeared in a number of organizational typologies (Blau & Scott, 1962; Brim & Wheeler, 1966; Etzioni, 1961).

In his discussion of the mental hospital as an organization, Parsons (1957) notes that the overall goal of the mental hospital is, ". . . to cope with the consequences for the individual patient and for patients as a social group, of a condition of mental illness (1957:109)." This broad definition gains specificity if the hospital's goal is considered as a complex of social responsibilities. Parsons lists four components that constitute the hospital's overall goal. These responsibilities are: custody, protection, socialization, and therapy.

The custodial function requires that the hospital cater to the needs of the patient during his illness. The protective responsibility provides for the safety of the community and patient from any injurious acts the patient may perform. Third, the therapeutic responsibility consists of the complex of processes oriented toward the recovery of the patient.

Prior to any therapeutic endeavors, the patient must become a "full member" of the hospital organization. The process through

which membership occurs is the fourth responsibility of the hospital-socialization (Parsons, 1957:110). Parsons notes that the most important aspect of the socialization process is the internalization of the hospital's values. These values are rooted in the social value system concerning the definitions of health versus illness and somatic versus mental illness. The problem for the hospital socializing agents is twofold: the hospital must justify a patient's condition as mental illness, and foster acceptance of the "patient role" (Parsons, 1957:111).

The transition from health to illness characteristically involves anxiety and apprehension (Lederer, 1958). The transition from health to mental illness poses increased problems because of certain social characteristics unique to mental illness.

The public conception of mental illness is generally negative. During their attempts to change a community's conception of mental illness, the Cummings (1957) note that the community was rejecting of those it recognized as mental patients. The phrase, "once a mental patient, always a mental patient" was an exercised belief.

Nunnally notes:

Old people and young people, highly educated people and people with little formal training all tend to regard the mentally ill as relatively dangerous, dirty, unpredictable, and worthless (Nunnally, 1961:51).

More recently, Rabkin (1972) reports that studies have underscored the generally rejecting attitudes of most Americans concerning

mental illness. Although the literature does present conflicting findings, support for nonrejecting opinions concerning mental illness is minimal. Guided by these conceptions, the public stigmatizes the mentally ill and, "By definition, of course, we believe that a person with a stigma is not quite human (Goffman, 1963:5)."

The general community response to stigma is rejection:

Not only have social workers told us that the reintegration of the patient with his family and community is the most difficult part of their job, but discussions with patients in mental hospitals and even in psychiatric wards of a general hospital have revealed that the patients themselves are acutely sensitive to the rejection which they feel awaits them upon their return home (Cumming & Cumming, 1957:6-7).

Consequently, compared to physical illness, the extreme negative value associated with mental illness, its treatment, and victims increases the task of justifying a condition as lying within the realm of mental illness.

This justification becomes more problematic for mental hospital staff who must convince recruits in an environment which traditionally treats the extreme cases--the truly ill. Phillips (1963) has shown that social rejection of those with a mental problem is associated with the help source utilized. As individuals move along the continuum of clergyman, physician, psychiatrist, mental hospital they increase in the degree of social rejection. In this case, rejection increases as the individual is seen to have

a problem which requires serious help. Thus, the public has come to recognize the mental hospital as a last alternative--a validation of a serious mental illness (Erikson, 1957; Cumming & Cumming, 1957). The disclosure of Senator Eagleton's history of psychiatric treatment and his subsequent removal as presidential running mate demonstrates the power stigma can have in overriding past achievements.

Many new psychiatric patients harbor fears and stereotyped conceptions of mental hospitals. Anxiety concerning fear of losing one's mind, of being raped, of masturbation, of brutality from personnel and other patients is expressed by new arrivals (Stanton & Schwartz; 1954; Greenblatt, York & Brown, 1955; Levinson & Gallagher, 1964). A study of the Massachusetts state hospitals revealed that new patients were so preoccupied with their fear of personnel and patients that they had no time to worry about their treatment plan (Greenblatt, et al., 1955:46).

The job of convincing new patients to accept the mental hospital as a treatment source would be enhanced if the patient was a "tabula rasa"--free of misconceptions, doubts and fears. The undoing of these barriers is a requirement that must be met before therapy can proceed; it is one aspect of the socialization process.

The second aspect of the socialization process is the indoctrination of the patient to the patient's role within the hospital. It

has long been recognized that a sick person occupies a special position in our society. The nature of this adjusted position was not explicitly formulated until Parsons (1951) set forth the ideal conception of the sick role. According to Parsons, illness is an incapacity of the individual to perform within his normally expected role.

Under this general framework, there are four specific features of the role of the sick person: 1) The incapacity is viewed as beyond the individual's ability to overcome it by will or decision, therefore, he cannot be held responsible for the condition. 2) The incapacity resulting from the illness is interpreted as a legitimate basis of exemption from normal role responsibility. 3) To be in a state of illness is to be in an undesirable condition. Therefore, the sick person is obligated to try to get well as soon as possible and to cooperate with others to reach this end. 4) It is the obligation of the sick person and those responsible for his welfare to "seek competent help" and to cooperate with this help source (Parsons, 1951: 436-439).

The negative value of mental illness and its associated stigma raises the question as to the appropriateness of the medical sick role for the mental patient. Examining paths to the mental hospital and staff prediction of the patient's role, Denzin and Spitzer (1966) hypothesized that as patient entry status moved away from the typical medical status, staff prediction of patient behavior would tend

toward nonconformity. The finding that involuntary, court referred patients did not consistently receive poor behavioral ratings led the authors to believe that:

Because of certain unique characteristics of the situation and experiences of the mental patient the medical sick role may be inadequate for predicting psychiatric role behavior (p. 270).

The uncertainty in etiology, diagnosis, and treatment of mental disorders has created a public which has questioned the appropriateness of assigning the rights and duties of the medical sick role to the mental patient (Cumming & Cumming, 1957; Erikson, 1957). The framing of mental disorder as a medical enterprise and the reluctance of the public to recognize mental illness as legitimate for the rights and duties of the sick role has created a dilemma for the psychiatric patient. The dilemma is the rather undefined role arising from the lack of consensus, between psychiatry and the community, concerning the role of the mental patient.

Although the public generally accepts the physician's verbal certificate as indication of legitimate physical sickness, it continues to doubt the medical legitimacy of many forms of mental illness and often fails to accept the mental patient as a qualified candidate for the sick role (Erikson, 1957:268-269).

Confusion as to the nature of the psychiatric patient's role also exists in the doctor-patient relationship. Sobell and Ingall (1968) report that certain types of resistance to psychotherapy may result from discrepancies between doctor and patient concerning the patient role. They report that hospitalized psychiatric patients

tend to visualize their role as submissive, dependent, helpless, and passive while psychiatrists characterized the patient role as independent, active, and self-directed.

The nebulous nature of mental illness has not only caused a dilemma for the patient; it has created an identity crisis for psychiatry. An editorial in the Journal of the American Medical Association (1973) notes the diversity that has grown within psychiatry and the criticism that has been levied concerning psychiatry's place among the sciences. It is suggested that psychiatry return to medicine before the psychiatric discipline becomes a questionable enterprise.

The confusion, as Seigler and Osmond (1974) see it, arises out of the introduction of various models into the once medically oriented psychiatry. Comparing the present state of psychiatry to the confusion surrounding the construction of the legendary Tower of Babel, the authors note:

What we have in psychiatry is worse; each person uses a hodgepodge of bits and pieces of ideas, theories, notions, and ideologies in order to engage in a supposedly common enterprise with others similarly confused (p. 11).

In their attempt to resolve this "model muddlement," Seigler and Osmond construct eight models and compare them along twelve dimensions. Consequently, to speak of an ideal patient role for the mentally ill, as Parsons has done for medical illness, is rather problematic. Any discussion of the rights and duties of the

mental patient is dependent upon the model utilized by the therapist. Although generalization is difficult, the mental hospital still has the task of socializing the new patient and specifying those things it expects of him.

The general indoctrination of the new patient to the mental hospital is best characterized by Parsons'(1951) "patient role. " This role calls for the patient to accept his new surroundings, to cooperate with staff, and to participate in therapeutic endeavors. Stanton and Schwartz (1954) describe the nature of the patient role:

A patient has to learn, and in some way to conform to, the rules, restrictions, and freedoms of the hospital. He has to accept, at least externally, his removal from society upon the basis of the judgment of others and without his consent. He has to act in accordance with the knowledge that he is entirely dependent upon strangers for the fulfillment of his needs. He must submit in some way to the power of the staff, who order and regulate his life perhaps down to minute detail in accordance with their conception of what is "therapeutic" for him (p. 170).

A similar set of role behaviors was identified by Caudill, Redlich, Gilmore and Brody (1952) and by Smith and Thrasher (1968) during their investigations of the patient subculture. Caudill notes that the role of the patient is constructed around a set of values which act to shape and guide patient attitudes and behaviors. The general themes of this patient role are: acceptance of the reality of being in a mental hospital, a cooperative nature toward staff, and a supportive attitude toward other patients. Conformity to these

stipulations is enhanced by a system of positive and negative sanctions exercised by both the staff and established patients. These efforts are aimed at gaining conformity to a set of expectations which minimize conflict and foster smooth ward functioning.

However, in spite of these pressures, inmates of total institutions employ a variety of adaptive techniques. Goffman (1961:65) notes that, "Each tact represents a way of managing the tension between the home world and the institutional world." These tactics range from demonstration of behaviors and attitudes which characterize the "perfect inmate" to refusal to cooperate with staff.

Speaking specifically of the mental hospital, Dembo and Hanfmann (1935) identify six major adaptations employed by new recruits. During their first week of hospitalization, patients exhibited: a primitive drive out of the hospital, insight into the basic factors of hospitalization, refusal to accept the reality of the hospital situation, preoccupation with psychosis, a belief that the hospital is a place of refuge, and a narrowed conception of the hospital situation. Braginsky, Holzberg, Ridley and Braginsky (1968) also examined patient adaptation to the mental hospital. Patient "styles" were categorized into three major types: number of hours spent on the wards (warders), the number of hours spent off the ward in informal social activities (mobile socializers). Based upon data from a 100-patient sample, the authors conclude:

1. Mental patients differ in their styles of adaptation to the hospital.
2. Styles of adaptation are significantly related to the kinds of information patients acquire about the mental hospital.
3. Styles of adaptation are significantly related to patient attitudes concerning the mental hospital, mental illness and patienthood.
4. Styles of adaptation are significantly related to the length of hospitalization.
5. Styles of adaptation are not related to indices of the patient's pathological status or to putative differential hospital demands.
6. Styles of adaptation are significantly related to the patient's therapeutic involvement in the hospital (Braginsky, et al., 1968:284-285).

If the mental hospital is considered from Parsons organizational perspective, Braginsky's fourth conclusion is of particular importance. The socialization process must override individual "styles" of adaptation if such adjustments lie outside the boundaries of the patient role. Such action is necessary if patients are to remain for treatment. The mental hospital cannot allow great numbers of patients to disrupt its program or leave the hospital prematurely. If the hospital cannot adequately socialize its members, the therapeutic responsibility is relinquished and the hospital performs merely custodial functions.

The consequences that arise, for the institution, from the unsuccessful socialization of new recruits have been discussed. However, the development of treatment alternatives raises the question as to magnitude of the population currently served by psychiatric hospitalization. The movement toward community-

based centers for the treatment of psychiatric disorders markedly reduced the roles of inpatient facilities. The percentage of inpatient care for psychiatric illness decreased from 77 percent of all psychiatric episodes¹ in 1955 to 42 percent in 1971. Nevertheless, regardless of burgeoning treatment modalities, in 1971 there were still nearly 2 million inpatients (Ozarin & Taube, 1974).

The mental hospital is an accepted source of treatment for a number of conditions. Among the three leading diagnoses of all admissions to inpatient facilities is alcohol disorder. In addition, alcohol disorder was the prominent diagnosis among men aged 35 to 64 in public mental hospitals (Ozarin & Taube, 1974:99).

"Alcoholism, like schizophrenia and drug addiction, is a disputed ailment (Seigler & Osmond, 1974:243)." In order to solve this "dispute," students of alcoholism have devised a number of definitions and etiological schemes. Part of the difficulty, in studying alcoholism, arises out of a general willingness of most people to forsake their approach when it fails and to employ a model constructed by many approaches. In sorting out etiological

¹Patient care episodes are defined as the number of residents in inpatient facilities at the beginning of the year or the number of persons on the rolls of noninpatient facilities plus the total additions to these facilities during the year. Patient care episodes are thus a duplicated count of the number of persons under care during the year (Ozarin & Taube, 1974:98).

perspectives, Roebuck and Kessler (1972) suggest three rough models of analysis: the constitutional, the psychological, and the sociological. In an attempt to deal with this same issue, Siegler and Osmond (1974) present eight models and describe them along twelve dimensions. In summing up their paper they note, "The plurality of viable models, and the inconsistency with which they are used, suggests that the problem of alcoholism has not yet been solved to everyone's satisfaction (Siegler & Osmond, 1974:265)."

Alcoholism was first described as an illness in the late 18th and early 19th centuries by the American Surgeon General Dr. Benjamin Rush and the British physician Dr. Thomas Trotter. Early attempts at popularizing this perspective failed and the "inebriety as illness" movement was muffled. After the repeal of the 18th Amendment, research into the various aspects of alcoholism increased and the conception of "alcoholism as illness" permeated public and professional circles (Jellinek, 1960).

The official declaration of "alcoholism as illness" was made by the American Medical Association in a resolution headed, "Hospitalization of Patients with Alcoholism":

Among the numerous personality disorders encountered in the general population, it has long been recognized that a vast number of such disorders are characterized by the outstanding sign of excessive use of alcohol. All excessive users of alcohol are not diagnosed as alcoholics, but all alcoholics are excessive users. When, in addition to this excessive use, there are certain signs and symptoms of

behavioral, personality and physical disorder or of their development, the syndrome of alcoholism is achieved. The intoxication and some of the other possible complications manifested in this syndrome often make treatment difficult. However, alcoholism must be regarded as within the purview of medical practice (1956:750).

This recommendation is followed by a call to general hospital administrators to open their doors and accept alcoholics as legitimate medical concerns.

Although the AMA's statement links alcoholism with personality disorder, the Diagnostic and Statistical Manual II (1968) of the American Psychiatric Association explicitly lists alcoholism as a type of personality disorder. Matkom (1965) identifies two rationales for such a classification:

1. Heavy drinking is considered to be a symptom of an underlying basic personality disorder.
2. The underlying factors of alcoholism are not particularly different from those of other mental disorders.

The placement of alcoholism in the realm of psychiatric conditions legitimized the utilization of the mental hospital as a treatment setting. Those with an alcoholism diagnosis entered the hospital, lived in the hospital, and received treatment in the same fashion as "mental patients." This procedure permitted hospital staff to legitimately apply the prescriptions of the patient role to alcoholic patients and thus to expect conformity.

It has been reported that alcoholics are particularly resistant to treatment among "mental patients." Camps (1970) notes that

the dislike of being associated with mental patients creates problems in persuading alcoholics to enter the mental hospital. The National Health Service has reserved beds for the treatment of alcoholism in hospitals, but many alcoholics do not believe they have an alcohol problem. Matkom clearly states the situation:

The alcoholic, in fact, can readily see that he is in much better mental health than the nonalcoholic patients which encourages him to dispose of his problems by rationalizing that he is really not sick. He resents identification with other mental patients and refuses to assume the role of a mental-hospital patient. The fact that the staff does not differentiate between him and the "sick" makes him feel he is not understood; thus he does not expect to be helped (1965:501).

A vicious cycle appears to have developed regarding staff attitude toward alcoholics and patient behavior. Examining staff perceptions of hospitalized alcoholics, Reinehr (1969) reports that over 70 percent of the staff characterize the alcoholic as complaining, demanding, hostile, impatient, and resentful. The staff reaction to the alcoholic's "unwillingness" to "cooperate" is irritation:

They (the staff) feel that the alcoholic patients are not making use of professional skills and other resources offered by the hospital and are just taking a rest cure at the public's expense. The alcoholic patients easily sense that they are disliked by the staff and they react in the way anyone would in a hostile atmosphere (Matkom, 1965:501).

The importance of adequate socialization was pointed out by Parsons. Disruptive ward behavior, noncooperative patients, and irritated staff are obstacles which prevent the hospital from

fulfilling its therapeutic responsibility and which deprive the patient of sound efforts at recovery. The formulation of a successful socialization process is an issue that must be confronted by hospital administrators.

Statement of the Problem

The responsibility most commonly associated with mental hospitals is the treatment of the mentally ill. The declaration by the American Medical Association in 1956 that alcoholism is a legitimate medical concern, and the explicit listing of alcoholism as a type of personality disorder in the Diagnostic and Statistical Manual II, has established the mental hospital as an appropriate treatment setting for alcoholism.

Prior to therapy, the mental hospital is responsible for the socialization of new patients to the patient role. This role calls for the patient's cooperation with staff, participation in therapy, and observance of ward rules. The socialization process is problematic for hospital staff since new patients may demonstrate a resistance toward assuming the patient role and recognizing the mental hospital as a treatment center. This resistance is rooted in our society's negative conceptions of mental illness and the stigma associated with patienthood and mental hospitalization.

Although the mental hospital is a recognized treatment center for alcoholism, alcoholics have demonstrated a pronounced

unwillingness to assume the patient role. They resent other patients and any association of themselves with mental illness. Conversely, the hospital staff becomes irritated by these attitudes and behaviors, thus nuturing the tension between the two groups.

This vicious cycle has negative consequences for the alcoholic and the mental hospital. If the alcoholic does not assume the patient role, he may relinquish therapy and thus leave the hospital prematurely. For the mental hospital, early discharge reflects an inability to fulfill its socialization responsibility and consequently its therapeutic responsibility.

This is a study of alcoholics receiving treatment for alcoholism at a psychiatric hospital. Two socialization experiences to the hospital are considered.

- 1) The alcoholic is socialized to the hospital on a ward among psychiatric patients. He is not differentiated from the other patients and is expected, like all the other patients, to assume the patient role.
- 2) The alcoholic is socialized to the hospital in a separate ward designed for alcoholics and housing only those with substance abuse problems. He is considered different from mental patients and his hospitalization is not associated with mental illness. Although he is expected to accept the patient role and cooperate with staff, he is not

considered mentally ill.

Considering these two socialization experiences, the following hypothesis has been generated:

Alcoholics socialized to the patient role in a psychiatric ward among psychiatric patients will exhibit significantly shorter lengths of stay in the hospital than those alcoholics socialized to the patient role apart from the psychiatric ward.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This chapter reviews the literature which examines the relationship between the characteristics of alcoholics and length of stay in treatment or post treatment drinking behavior.

First the literature, regardless of treatment modality, is presented which focuses upon length of stay in treatment. The literature is directed to the theory and hypothesis of this study. Special attention is given to subject characteristics related to longer lengths of stay in treatment.

Secondly this chapter utilizes the research presented in this section plus the research examining post treatment populations. This literature is presented as support for the selection of nine other independent variables. These additional variables are selected in order to consider the relative position of the hypothesized independent variable (differential socialization experience, operationalized as admission path) among variables previously shown to be characteristic of longer stay or improved drinking behavior populations.

It must be stressed that the literature reviewed applies specifically to the theory and hypothesis of this study. The review,

although not directed to the hypothesis, does provide a framework in which to further examine the hypothesized independent variable.

The Literature

Research examining alcohol treatment programs has focused upon two major areas. Dominating the literature are studies aimed at assessing program effectiveness by examining past program participants. Second, through similar methodology, researchers have compiled demographic and psychological characteristics of "abstained" or "improved" groups and formulated prognostic indices for the selection of low risk treatment populations. The research concerning program completion or length of stay in treatment is minimal.

Two studies have focused on psychological test characteristics and length of stay in treatment. Wilkinson, Prado and Schnadt (1971) administered nine psychological tests and a biographical data sheet to 132 admissions to the 90-day inpatient program at an Arkansas VA Hospital. The authors note that among the psychological tests administered, those variables which enhance an opportunity for self-disclosure, especially about how a person perceives and feels about himself and others, are more promising predictors than items which are of a cognitive or intellectual level. From the biographical data, completors began drinking at an older age and exhibited stable marital and job histories. In contrast,

Heilbrun (1971), studying chronic court case alcoholics involved in the Emory University Rehabilitation Project, reports that IQ, education and two scales of the MMPI are indicative of length of time in program. Finally, Gross and Nerviano (1973) studied the results of three tests (Sixteen Personality Factor Questionnaire, Edwards Personality Preference Schedule, Personality Research Form) which were administered to patients of the Lexington Kentucky VA Hospital. The authors conclude:

It seems unavoidable to conclude that the personality dimensions alone, as measured by these inventories, are not sufficient to predict which alcoholics will discontinue treatment (p. 515).

Outpatient clinics have been the site of several studies which examine the tendency of clients to continue clinical contact. Feeney, Mindlin, Minear and Short compared a group of residents at an outpatient clinic to residents at an inpatient "workhouse" program. The authors conclude that among the characteristics which distinguish those who maintain outpatient visits from early terminators are: intelligence, motivation, and present social resources. Two other studies have focused on outpatients. Zax and Biggs (1961) studied 250 white male alcoholics who applied for outpatient treatment in Rochester, New York, emerging as the only significant variable related to continued treatment was marital stability. However, the authors do note that those referred by wife or family appear more motivated to continue treatment than those

referred by an impersonal source. Examining an outpatient program in a Boston ghetto, Gertler, Raynes and Harris (1973) report nonsignificant differences between attenders and dropouts on the demographic and biographic variables they examined. The one variable which differentiates attenders was at least one year period of abstinence prior to seeking treatment.

Canter (1972) reports that among the hospitalized patients he studied, motivation was a significant indicator of participation in the treatment program. He notes that patients "seeking" help participate better in treatment than those who wish to escape or placate family members. In addition, motivation is enhanced when there is consensus among patient, family, and therapist concerning treatment goals.

In sum, researchers have largely neglected the relationship between alcoholics and length of stay in treatment. The research that has been conducted considered a variety of treatment settings, populations, and variables. These differences and the absence of replicated findings lead this author to conclude that no one variable or cluster of variables can be substantiated as characteristic of alcoholics who demonstrate longer lengths of stay in treatment.

Selection of Variables

In order to further examine the hypothesized independent variable, nine additional independent variables are studied. The

selection of these nine variables is based upon three rationales: the reliability of the hospital data gathering system, the nature of secondary data, and the literature.

Hospital records are completed by a variety of personnel: doctors, nurses, social workers, administrative personnel, therapists, etc. Since the recording of data is dependent upon the particular individual or combination of recorders, data at intake is neither consistently nor adequately recorded.

The source of data for this study is the Screening Form employed at the time of admission to the alcohol program. The questions on the form are administered by one admission officer (separate officer for night admissions) who is a staff member of the alcohol program. Since the questions on this form are clearly outlined and the number of intake personnel reduced, the probability of obtaining complete data is enhanced.

The reliance upon secondary data is an additional force which guides variable selection. Since data will not be collected specifically for this study, variable selection is confined to the pool of data collected on the Screening Form.

The research presented in support of variables reflects both program completion material and follow up study results. The research presented for each variable is intended to demonstrate that the variable has been shown to be of some value in alcohol program

research. There is no intention of highlighting some variables more than others or suggest any hypotheses. Priority is given to those studies which deal with program completion or length of stay in mental hospital treatment programs. As much as possible, studies concerning different treatment settings, approaches, or are of a follow up nature are given a secondary role.

Age

Age as a prognostic indicator of termination of treatment has been neglected in alcohol program research. However, follow up studies have examined the relationship between age and improved drinking behavior.

Glatt (1958), in a follow up study of 350 male and female patients who received treatment at the Warlington Park Hospital, reports that between two and four and one-half years after treatment older patients fared more favorably than younger ones. In another study, at the same hospital, Rathod, Gregory and Thomas (1966) reported that seven out of eight patients between 20 and 30 years of age had relapsed after completing the 90-day inpatient program. Supporting the findings of Warlington Park are Selzer and Holloway (1957) who found that among the committed alcoholics of the Ypsilanti State Hospital younger patients (mean age 38.8) remained unimproved when compared to the older alcoholics (mean age 48.8).

Increased age and improved drinking behavior has also been reported by research examining nonhospitalized populations.

Rudfeld (1958) found that in a program of counseling and anti-abuse, alcoholics above 35 improved the most. Wolf and Holland (1964) also note that after a three-week inpatient program coupled with outpatient meetings, those over 45 were most successful in remaining abstinent. Similarly, Bateman and Peterson (1971) report that among those variables associated with abstinence among completors of a 25-28 day inpatient program was age (45 or older).

Finally, Kissin, Rosenblatt and Machover (1968) report that in all of their treatment groups (inpatient rehabilitation ward, drug therapy, psychotherapy, control) a favorable prognostic indicator was age (over 40).

Race

This variable has been neglected in the literature concerning program completion or length of stay in treatment.

Mindlin (1960) has reported that at follow up of those treated at a 90-day inpatient setting, race was one variable which distinguished the improved from the unimproved. Her findings indicate that blacks did significantly better than whites in this type of treatment modality. Contrary to this, Kissin, et al., found that when all four treatment modalities (inpatient rehabilitation, drug therapy, psychotherapy, control group) are considered, whites do significantly

better than blacks. He attributes the discrepancy between his study and Mindlin's to the fact that her black sample was socially stable, while the characteristics of his black sample correlated highly with poorer indices of social adjustment and thus constituted a poorer prognostic group.

Education

Education has been found to be of prognostic value in determining length of stay in treatment and improvement of drinking behavior among chronic court case alcoholics. Heilbrun (1971) reports that 12 years or more of schooling was one variable indicative of prolonged contact with outpatient therapy.

Several follow up studies have linked higher levels of education to improved drinking patterns. Mindlin (1960) reports that after a 90-day inpatient program, nonsignificant differences were found between the improved and unimproved groups at the lower levels of education. However, among the college educated, significantly more alcoholics improved. Higher educational levels and improvement was also noted by Gills and Keet (1969) in their follow up of hospitalized alcoholics in South Africa and by Meyerson and Mayer (1969) during their follow up of "skid row" alcoholics after half-way house treatment. These findings are in agreement with the work of Kissin, et al. (1968), who found that alcoholics with some college have a more favorable prognosis.

In an outpatient setting, Goldfried (1969) notes that higher education is a good prognostic indicator of improvement. In contrast, Haberman (1966) found that in psychoanalytically-oriented therapy conducted with alcoholics the improved patients had less often attended college.

Marital Status

The literature tends to support the belief that alcoholics who are married are good candidates for treatment. Mindlin (1959) reports that being married and living with one's spouse was positively related to improvement in both outpatients and inpatients. Concurring with Mindlin are Davis, Shepherd, and Myers (1956) who studied 50 patients receiving inpatient treatment. They note that two-thirds of the patients in the two best prognostic groups were married, in contrast to six of ten in the worst prognostic group who were either single or divorces.

Marital status as a valuable prognostic indicator, particularly married, is well supported in the literature (Kish & Herman, 1971; Rudfield, 1958; Myerson, 1966; Zimberg, 1974).

Referral Source

Neuman and Tamerin (1971) studied alcoholics and drug addicts who had been treated together in an inpatient program at a psychiatric hospital. Among the alcohol patients, the majority of whom

were middle and upper class adults, the successful group was largely self-referred. The authors note fear of losing one's economic holdings often motivates these patients into treatment.

Current Employment

The literature presents evidence that treatment success is associated with current employment. Kish and Herman (1971), in their three, six and twelve month follow up of veterans who completed an eight-week therapy program, report that characteristic of their successful group was a job. In England, McCance and McCance (1969) report that steady employment at admission to the hospital was significant in predicting favorable outcome.

In their work at an inpatient alcoholism clinic, Bateman and Peterson (1971) report that among the six variables associated with abstinence is full time employment.

Steady employment as indicative of improved drinking behavior has also been reported by several other follow up studies which have been carried out at a number of different treatment settings (Fox & Smith, 1959; Goldfried, 1969; Kissin, et al., 1968; Rudfeld, 1958; Zimberg, 1974).

Diagnosis

Both Mindlin (1959) and Fiddes (1956) have included diagnosis in their prognostic indices. Mindlin (1959) notes that the Obsessive

Compulsive classification appeared in 28 percent of the successful outpatient group and was nearly absent in the other groups. Fiddes (1956) suggests physicians be cautious in accepting alcoholics for treatment who demonstrate a serious underlying disorder, especially psychosis.

Performing a 15-month follow up of patients receiving alcoholism treatment at the Crickton Naval Hospital, Pemberton (1967) notes that among the successful group (abstinent or rarely taking a drink) 14 of 18 men and all 10 women were diagnosed neurotic. Several other studies report similar findings. They note that psychopaths benefit less from alcoholism treatment than those who demonstrate neurotic or mild personality disorders (Pokorny, Miller & Cleveland, 1968; Walton, Ritson & Kennedy, 1966; Ritson, 1971).

In contrast, Rossie, Stack and Bradley (1963), in a follow up study performed on alcoholics treated at a mental hospital, report that prognostic variables increased the rate of improvement from 32 percent to 56 percent. Among the prognostic variables indicative of the improved group was the absence of a functional diagnosis with alcoholism.

Previous Admissions to Program

The literature is inconsistent concerning the relationship between admissions to treatment and treatment outcomes.

Trice, Roman and Belasco (1969), in their follow up study of alcoholics who underwent treatment at a Maryland state hospital, considered the predictive value of 81 variables concerning post hospital adjustment. Among the 16 significant variables, few or no previous state hospitalizations ranked as the fourth most powerful predictor. Davis, Shepherd and Myers (1956) report similar findings, and note that an indication of favorable outcome is first admission for treatment.

Contrary to these findings are the results of a study performed by Davis (1966) at a Texas state hospital. He notes that a significant prognostic factor associated with sobriety is the number of admissions to the hospital. Those who had fewer admissions were less likely to report improvement. Gills and Keet (1969) also report that among their hospitalized alcoholics in Capetown, South Africa, readmittances were doing better at follow up than those admitted only once.

Hospitalization History

The reader will recall the theoretical framework of this study in which it was stressed that for first admissions to the psychiatric hospital stereotype conceptions of the mental hospitalization may impede the acceptance of the patient role and interfere with treatment. Alcoholics who have previously entered treatment in a psychiatric hospital for alcoholism or psychiatric disorder have encountered the patient role and mental hospital milieu. From

available data, it is neither possible to record the patient's response to his previous encounters with mental hospitalizations nor anticipate the patient's perceptual set molded by these earlier experiences. Whether this previous experience will hinder or enhance the alcoholic's functioning in the hospital is unknown.

Consequently, in order to consider the relationship of previous psychiatric hospitalizations to length of stay in treatment, psychiatric hospitalizations are considered independent from other types of treatment modalities.

The previous variable, "previous admissions to program," closely resembles the nature of this variable. However, in this case, all previous treatments are considered, regardless of setting. Such a distinction is not present in the literature.

Admission Path

In the statement of the problem, two possible socialization experiences to the mental hospital are presented. The variable "admission path" is the operationalization of the two socialization experiences. The socialization experience occurring on the functional unit is the transfer or indirect path. Socialization occurring apart from the functional unit and other psychiatric patients is defined as the direct path.

The closest the literature comes in discussing "admission path" is referral source. The affect of hospital routing upon treatment

outcomes has not been discussed.

Two admission paths are possible to January House. Direct admission involves the referral of the veteran from the admissions building directly to January House. The veteran is screened by the admitting officer of the alcohol program and is admitted directly into the program. The veteran does not enter any functional or medical unit of the hospital.

Transfer admission is basically the same procedure as direct admission, however, the veteran is not initially accepted to January House. The veteran may be referred from January House to a different unit in the hospital for "stabilization." Stabilization is the detoxification of intoxicated veterans and the dissipation of any physical conditions or psychological problems (depression, suicidal ideations, hallucinations) which may interfere with treatment.

When the staff of the stabilization ward feel the veteran is now suitable for the January House program they refer him back to the alcoholism program for rescreening. If the veteran now appears suitable for treatment he will be admitted into the program offered by January House.

Although those admitted directly to January House are living in a mental hospital and must reconcile their new social status with their old, stabilization treatment places the alcoholic in a bona fide functional ward. While on this ward the alcoholic is undifferentiated

from the other patients and is expected to abide by established ward regulations. Unlike January House, where alcoholism and mental illness are presented as two distinct conditions, in the functional units the alcoholic is viewed as a psychiatric patient.

In summary of this section, the availability of reliable data and the findings of previous research have guided the selection of nine independent variables (age, race, education, marital status, referral source, current employment, diagnosis, previous admissions to program and hospitalization history). The addition of the hypothesized independent variable creates a pool of ten independent variables for study. The analysis of these variables will be exploratory in nature; knowledge gained about the dependent variable through admission path will be examined relative to the nine variables outlined in this section of Chapter II.

CHAPTER III

METHODS

Introduction

This chapter is divided into four sections. Section one is a description of the setting for this study. The structure and functioning of the program under study are discussed. Section two is a discussion of the population and rationales for the chosen sampling procedure. Section three concerns the data-gathering devices utilized in this study. Finally, section four deals with the nature of the analyses of the data.

Setting

Prior to 1964, it was the VA's policy to disallow treatment for alcoholism, considering the condition to be nonservice connected, noncompensable and an act of misconduct. However, cases of alcohol psychosis or secondary alcoholism symptomatic of an established neuropsychiatric disorder were accepted for treatment (Wenger, 1955).

In the 1960's, the Veterans Administration made two policy changes which marked a new, more liberal approach to the treatment of alcoholism. The first change, in August 1964, removed from the category of misconduct organic disablement resulting from

alcohol. The second change, in January 1967, ruled that requests for the treatment of alcoholism be processed as any other request for treatment (Cantor, 1974). As a result of such changes, the number of veterans hospitalized in the VA system with an alcohol diagnosis doubled from 1965 to 1969. In addition, during the period of July 1972 to June 1973 Veterans Administration hospitals reported treating over 92 thousand veterans with a principal or associated diagnosis of alcoholism (Cantor, 1974).

The Battle Creek VA hospital is one of 25 psychiatric hospitals of the VA system. Battle Creek offers a combined drug and alcohol program with a total bed capacity of 136; 100 beds for alcoholics and 36 for veterans with other drug problems. At January House (the program is named after the Roman god Janus--the god who symbolized the start of something new), the substance abuse program is housed separately from the rest of the hospital wards and maintains its own recreational program, ceramics shop, and dining hall. However, January House is not completely autonomous, dependence upon the rest of the hospital is guaranteed because of administrative requirements and a lack of staff and facilities. Such ties lie in the area of recreational facilities, medical, and detoxification treatment.

These are two efforts undertaken by January House staff to calm any fears and doubts new patients may have about treatment at a mental hospital. The term "patient" is replaced with the designa-

tion "resident." In addition, introductory remarks highlight the program's separation from other hospital wards and focus on alcoholism.

The treatment program is approximately nine weeks long and consists of a core of confrontation group therapy supplemented with individualized counseling. AA meetings are presented once a week requiring attendance by all alcoholic residents. Veterans who have previously completed the program enter Readmission Group. The length of stay in this group varies with the needs of the veteran, and the usual stay is three to four weeks.

Initially the veteran enters "Pre-Group" which is usually a one week long process. The exact length of stay in Pre-Group is determined by the veteran's participation in group and assignments, the therapists perception of motivation, and the available openings in core group. Pre-Group is a get-acquainted week for both resident and staff, confrontation therapy is not practiced during these early sessions. Residents are watched as they spend these initial days without alcohol and encouraged to continue in the program.

The program offered by January House is structured to provide different learning experiences and different services at various points in the program. For this reason, in order to become exposed to all program components, veterans are encouraged to complete the entire program.

Population and Sample

Veterans who have entered the core group treatment program at January House comprise the population of this study. The sample consists of all veterans treated between February 1, 1975 and June 30, 1975. Those entering Readmission Group are not included in this study. This sampling process was developed because of the following circumstances unique to January House and requirements of this study. Prior to February, program staff were assigned to the screening process on a rotating basis. Consequently, under these conditions there are no controls for interviewer bias. The screening procedure instigated in February reduced cross interviewer bias by specifying one officer (separate officer for night admissions) as the sole admission personnel. The second program change was the introduction of a more complete and standardized screening form. Thus, with fewer intake officers and a more concise primary data gathering instrument,¹ the screening process obtained more consistency in both data gathering and program participant selection.

Three practical restrictions limited the choice of sampling

¹The screening form is designated as the "prime data gathering" instrument because data on all but three variables is collected by this form. Data concerning length of stay, diagnosis and admission path is collected on two other standardized forms of the veteran's clinical record.

procedures. First, the new screening process excluded sample selection prior to February 1975. Second, the number of variables under study excluded any sampling procedure which would decrease sample size and, consequently, hinder analysis. Third, the gathering of data is not possible until the entire nine-week program is completed. In order to retain a reasonable completion date for this study, June 30, 1975 was accepted as the cut-off point for the sample. Therefore, all veterans entering the program during this time period comprised the sample.

Data Collection

All data for this study were obtained from the veterans clinical record as compiled and maintained by the Veterans Administration.

The primary data-gathering device was the January House Screening Form. This device is completed by the program screening officer at the time the veteran applies for admission to the alcohol program. Data of length of stay at January House and diagnosis was extracted from the Discharge Summary Form, completed by the veteran's therapist after the veteran is discharged from the hospital. Finally, admission path was obtained from the Doctors Orders form which documents the veteran's routing through the hospital.

In sum, all data for this study were obtained from three

sources, all of which are required components of the veteran's clinical record.

Analysis

The final concern of this chapter is a discussion of the nature of the analysis of this study. The analysis is presented in three sections.

Section one is a descriptive analysis of the total research sample and two subsamples created by a division of the total sample by admission path. One subsample consists of those admitted directly to January House, the other subsample contains those who enter January House via the indirect route. Frequency distributions and measure of central tendency are the techniques chosen to analyze all three groups.

Section two of the analysis concerns the hypothesis of this study. Socialization to the hospital is the independent variable which is operationalized as admission path. The direct admission path does not require the veteran to spend any time on a functional ward. The veteran enters January House directly and is explicitly told that his problem concerns alcohol, not mental illness. Indirect admission is that path which entails a period of "stabilization" on a functional ward of the hospital. While on the ward, the alcoholic is not differentiated from other patients and is expected to conform to ward rules. There is no distinct identification of a patient as

being admitted for alcoholism or mental illness on the functional ward.

The null hypothesis to be tested is:

H_0 : Alcoholics socialized to the patient role in a psychiatric ward among psychiatric patients will not exhibit different lengths of stay in the hospital than those alcoholics socialized to the patient role apart from the psychiatric ward.

Below is the substantive hypothesis associated with the null hypothesis:

H_1 : Alcoholics socialized to the patient role in a psychiatric ward among psychiatric patients will exhibit significantly shorter lengths of stay in the hospital than those alcoholics socialized to the patient role apart from the psychiatric ward.

Comparisons of length of stay are based upon the number of days in the January House program.

In order to test the null hypothesis, the t test of mean differences will be used to test for a significant difference in mean length of stay at January House between those entering via the direct and indirect route of admissions. The prediction that direct admissions will demonstrate significantly longer periods of stay in the program justifies the utilization of a one-tailed test. The .05 level of significance will be used throughout the analysis.

The third section of the analysis calls for the examination of the relationship of independent variables to a dependent variable. In addition, six of the independent variables are of nominal measurement. These two requirements suggest a multivariate technique

which can utilize predictor variables of no better than nominal measurement. Fulfilling these requirements is Multiple Classification Analysis.

"Multiple Classification Analysis (MCA) is a technique for examining the interrelationships between several predictor variables and a dependent variable within the context of an additive model (Andrews, Morgan & Sonquist, 1967:8)." In essence, MCA demonstrates the relationship of each predictor variable to a dependent variable, both before and after adjusting for the effects of other predictors.

The statistical model of this technique is presented below:

$$Y_{ijk} = \bar{Y} + a_i + b_j + \dots + e_{ijk}$$

(Where: Y_{ijk} . . . = the score (on the dependent variable) of individual k who falls in category i of predictor A, category j of predictor B, etc.

\bar{Y} = grand mean on the dependent variable

a_i = the "effect" of membership in the i^{th} category of predictor A

b_j = the "effect" of membership in the j^{th} category of predictor B

e_{ijk} = error term of this individual
(Andrews, et al., 1967:103)

MCA is essentially multiple regression using dummy variables, however, three advantages of MCA have been pointed out. First,

MCA does not require the transformation of nominal measures.

Second, MCA output focuses on sets of predictors, such as various referral sources. Finally, this technique reports the extent and direction of adjustments due to intercorrelations among predictors (Andrews, et al., 1967:10).

MCA makes an important assumption with regard to the data of the analysis. This procedure assumes that the phenomenon being studied can be understood through the use of an additive model. The additive model is insensitive to interaction and assumes that the average score on the dependent variable is predictable by summing the effects of several predictor variables. If there is no interaction among predictors, MCA can be carried out without concern. However, in this study the extent and nature of interaction is unknown. Interaction will be examined through the comparison of actual average subgroup value with expected subgroup value. Comparing these values indicates whether there is more than solely additive effects in the analysis. Where indicated, interaction terms will be created and included in the analysis.

MCA reports the nature of the relationship of classes of predictors, complete predictors, and all predictors together to the dependent variable. Below is a description of MCA output which will be presented in the next chapter:

- . . . For each category of each predictor:
 - . . Deviation of raw mean for the category from the grand mean (this indicates the gross or unadjusted effect of the predictor)
 - . . Deviation of category mean from grand mean after adjusting for effects of other predictors, i. e., all other predictors have been "held constant"
- . . . For each predictor:
 - . . Eta and Eta^2 : Eta is the correlation ratio and indicates the ability of the predictor, using the categories given, to explain variation in the dependent variable. Eta^2 indicates the proportion of the total sum of squares explainable by the predictor.
 - . . Beta and Beta^2 : these are directly analogous to Eta statistics, but are based on the adjusted means rather than the raw means. Beta provides a measure of the ability of the predictor to explain variation in the dependent variable after adjusting for the effects of all other predictors. This is not in terms of percent of variance explained
- . . . For all predictors considered together:
 - . . A multiple correlation coefficient (adjusted for degrees of freedom). This coefficient (when squared) indicates the proportion of variance in the dependent variable explained by all predictors together (after adjusting for degrees of freedom). (Andrews, et al., 1967: 21-22)

Andrews, et al. (1967:117-119) note that the beta reported in MCA when squared does not indicate the percent of variance explained. Thus the beta coefficients must be interpreted with caution and are useful only for indicating the relative importance of the various predictors. The percent of variance explained for each predictor is available by performing multiple runs of the program and observing the decrease in the total explained sum of squares.

This procedure will be performed for each variable, and the percent of variance explained recorded.

Thus, by selecting MCA as the technique for analysis for section three, greater insight as to the relationship of admission path to length of stay at January House is obtained. In addition, an examination of the relationship of nine additional variables to length of stay in treatment is also possible.

In sum, this chapter has described the program under study, population and sample, data collection devices, and methods of analysis. The stage is now set for the presentation of the findings.

CHAPTER IV

FINDINGS

Introduction

This chapter discusses the distribution of the total research sample and two subsamples (direct admission and indirect admission) among the 11 independent variables and the dependent variable. It will focus upon the hypothesis and present hypothesis testing results. Finally the exploratory section of this study examines the nature of the relationship between the 10 independent variables to length of stay at January House.

Characterization of the Sample

Each frequency distribution table considers the total sample (N=228) and two subsamples created from the dichotomized admission path variable, direct admission (N=177) and indirect admission (N=51). The distributions are presented in this fashion in order to consider the entire sample, compare subsamples, and consider the deviation of each subsample from the sample as a whole. It should be noted that small frequencies in some categories, particularly within the indirect admission subsample, may make generalization tenuous.

Age

In general the majority of the research sample is middle aged. The mean age is 42.4 years and the modal category is the 38-47 age group. The frequency of veterans in each category increases with age up to the modal group, with frequencies declining as age increases. The combination of the modal category with its adjacent age groups creates an age group (28-37) which contains 84.4% of the total sample. The youngest (18-27) and older (58 or greater) age groups contain relatively small percentages of the sample, 9.5% and 6.0% respectively.

TABLE 4. 1. --Distribution by age of total research sample and direct and indirect admission subsamples

Sample	Respondents										Total		
	18-27		28-37		38-47		48-57		58-67			68+	
	N	%	N	%	N	%	N	%	N	%		N	%
Total	22	9.5	51	22.6	73	31.9	68	29.9	13	5.6	1	0.4	228
Direct Admission	19	10.9	42	23.7	56	31.7	49	27.7	10	6.2	1	0.6	177
Indirect Admission	3	6.0	9	17.8	17	33.4	19	37.4	3	6.0	0	0.0	51

The direct admission subsample demonstrates the same age distribution pattern and nearly identical percentages as the total research sample. The mean age for this subsample is 41.9 and again the modal age group is the 38-47 age bracket. That this sub-

sample is slightly younger than the indirect admission group is indicated by the higher percentage of veterans found in the two youngest age groups.

The indirect admission subsample tends to be slightly older than the total research sample and the direct admission subsample. The mean age for this subsample is 44.0 and the modal age group has shifted to the 48-57 age bracket. The percentage of veterans in the lower two age groups (18-27 and 28-37) is smaller than the previously discussed groups, while the two proceeding age groups (38-47 and 48-57) have higher percentages than the other two samples.

The distributions of the total research sample and the two subsamples, by race, are strikingly consistent. Slightly over 84% of all three groups are white and nearly 16% are nonwhite. According to the racial categorization presented here, there does not appear to be any admission routing bias based upon the veteran's racial background.

Education

The mean educational level of the total sample is 12.1 years of schooling. Although the modal educational category contains those with a high school diploma, 44.3% of the sample has not completed high school. In addition, 13.6% of the sample reports schooling after high school.

TABLE 4. 2. --Distribution by race* of total research sample and direct and indirect admission subsamples

Sample	Respondent's Race				Totals
	White		Nonwhite		
	N	%	N	%	
Total	192	84.2	36	15.8	228
Direct Admission	149	84.2	28	15.8	177
Indirect Admission	43	84.3	8	15.7	51

*The categorization of white and nonwhite is the racial classification utilized by the VA. Nonwhite includes all racial groups except Caucasians.

TABLE 4. 3. --Distribution by education of total research sample and direct and indirect admission subsamples

Sample	Respondent's Highest Completed Grade										Total		
	0-8		9-11		12		13-15		16+			N. R.	
	N	%	N	%	N	%	N	%	N	%		N	%
Total	31	13.6	70	30.7	93	40.8	27	11.9	4	1.7	3	1.3	228
Direct Admission	25	14.1	52	29.4	76	42.9	20	11.3	2	1.2	2	1.1	177
Indirect Admission	6	11.8	18	35.3	17	33.3	7	13.7	2	4.0	1	2.0	51

The direct admission subsample exhibits a slight deviation from the total sample. The mean education level of this subsample is 12.0 years and the mode is the high school diploma category. This subsample also has a substantial percentage (43.5%) of veterans with less than a high school diploma and 12.5% with post high school education.

The indirect admission subsample also shows some slight deviation from the pattern just described. The mean for this group is 12.7, however, the mode has moved to the category of some high school (9-11 grade). Consequently, the percentage (47.1) of this sample with less than a high school diploma is greater than the direct admission group or the total research sample. In addition, only one-third of this subsample has finished high school compared to 42.9% of the direct admission group. The increased percentages in the upper educational levels are responsible for the indirect admission's high mean educational level.

Referral Source

Referral source is defined as any individual or agency which recommended Battle Creek VA hospital as a source of treatment.

The sample members have been referred to the hospital by a variety of referral sources. Most of the veterans were self-referred. Over 20% of the sample reported that they were not referred to the hospital by another person or by any agency.

TABLE 4. 4. --Distribution by referral source of total research sample and direct and indirect admission subsamples

Sample	Respondent's Referral Source											
	Self ¹		Spouse		Friend		Relative		Physician		Employer	
	N	%	N	%	N	%	N	%	N	%	N	%
Total	52	22.8	5	2.2	25	11.0	14	6.1	8	3.5	9	3.9
Direct Admission	35	19.8	4	2.3	24	13.6	7	4.0	5	2.8	8	4.5
Indirect Admission	17	33.3	1	2.0	1	2.0	7	13.7	3	5.9	1	2.0

Sample	Legal ²		Other VA Hospital		General Hospital	
	N	%	N	%	N	%
Total	10	4.4	50	21.9	13	5.7
Direct Admission	10	5.6	35	19.8	11	6.2
Indirect Admission	0	0.0	15	29.4	2	3.9

Sample	Alcoholism Treatment Program ³		Other Source ⁴		N. R.		Total
	N	%	N	%	N	%	
Total	23	10.1	17	7.5	2	0.9	228
Direct Admission	21	11.9	16	9.0	1	0.6	177
Indirect Admission	2	3.9	1	2.0	1	2.0	51

¹ These veterans note that they came to the hospital based upon their own decision, without any outside encouragement.

² Included under this heading are: courts, lawyers and police departments.

³ This category is composed of alcoholism treatment programs not affiliated with any VA hospital, psychiatric or general hospital.

⁴ Community sources not specifically designated as alcoholism treatment centers.

Individuals within the veteran's social group (friends, relative, spouse) referred 19.2% of all subjects, a referral by a friend being the most frequent among these three sources. Medical referral sources (physician, other VA hospital, general hospital) referred 31.1% of the sample, other VA hospitals alone referred 21.9% of the total sample. Community alcoholism programs and other community services have referred 17.6% of the sample. Slightly more (10.1%) veterans report a specific alcoholism program as their source of referral to Battle Creek. Finally, employers and legal sources are referring relatively small numbers of veterans to the hospital.

The direct admission subsample reveals two modal referral sources: self-referrals and other VA hospitals. The pattern within the spouse, friend, relative group is the same as that for the total sample. Friends remain as the most common referral source among those three sources. Within the medical referral (physician, other VA hospital, and general hospital), other VA hospitals are the most frequently reported referral source, physicians the least. Among other alcoholism programs and other community sources, alcoholism programs are sending slightly more (11.9%) veterans for treatment. Finally, legal sources and employers have referred 5.6% and 4.5% of the direct admission subsample.

Similar to the two previous groups is the finding that the

modal referral class for indirect admissions was the self-referred group. However, the indirect admission subsample distribution differs from the pattern of referral sources reported for the other two samples. Among friends, spouse, and relative, the modal group has shifted from friend to relative. There is also a change within the medical referral sources, general hospitals have replaced physicians as the least likely medical referral source. It is interesting to note that other VA hospitals continue to refer the most veterans among the three medical sources. Only 5.9% of the indirect admission subsample was referred by another alcoholism program or community service organization. Finally, one (20%) veteran of the indirect admission subsample was referred by his employer and no veteran reported having been referred by a legal source.

Marital Status

Nearly one-third of the total research sample is married and nearly one-third is divorced. Fifty-seven percent of the sample reports disrupted marital relationships (divorced, widowed, separated). Only 14.9% of the sample is single.

The situation just described for the total sample holds for the direct admission subsample. All the widowed veterans are in the direct admission subsample. Compared to the total sample, this subsample has fewer married veterans and more single and separated veterans.

TABLE 4. 5. --Distribution by marital status of total research sample and direct and indirect admission subsamples

Sample	Respondents Marital Status										Totals
	Single		Married		Separated		Divorced		Widowed		
	N	%	N	%	N	%	N	%	N	%	
Total	34	14.9	74	32.5	38	16.7	75	32.9	7	3.1	228
Direct Admission	27	15.3	54	30.5	31	17.5	58	32.8	7	4.0	177
Indirect Admission	7	13.7	20	39.2	7	13.7	17	33.3	0	0.0	51

Finally, the indirect admission subsample has the highest percentage of married veterans (39.2%) of all the samples and the lowest with disrupted marital relations (47.0%). This sample also has the lowest percentage (13.7%) of single veterans.

The majority (64.0%) of the research sample is unemployed. Similarly high rates of unemployment characterize the direct and indirect subsample.

TABLE 4. 6. --Distribution by employment status of total research sample and direct and indirect admission subsamples

Source	Respondents Current Employment Status						Total
	Employed		Unemployed		N. R.		
	N	%	N	%	N	%	
Total	81	35.5	146	64.0	1	0.6	228
Direct Admission	63	35.6	113	63.8	1	0.6	177
Indirect Admission	18	35.3	33	64.7	0	0.0	51

Previous Admissions to January House

The majority (78.1%) of the sample has no previous admissions to January House. Nearly all the sample (94.3%) has one or fewer admissions; no one who entered the regular group program reported more than four previous admissions.

TABLE 4. 7. --Distribution by previous admissions to January House of total research sample and direct and indirect admission subsamples

Sample	Respondents Previous Admissions										Total
	0		1		2		3		4		
	N	%	N	%	N	%	N	%	N	%	
Total	178	78.1	37	16.2	8	3.5	3	1.3	2	0.9	228
Direct Admission	13	76.8	30	16.9	8	4.5	2	1.1	1	0.6	177
Indirect Admission	42	82.4	7	13.7	0	0.0	1	2.0	1	2.0	51

A similar pattern exists for the direct admission and indirect admission subsamples. The majority of both subsamples have no previous admissions with over 90% of each group having one or less previous admission. Low frequencies for more than one prior admission characterize each subsample.

The two subsamples and, consequently, the entire sample average less than one prior admission to January House.

As might be anticipated for participants of an alcoholism program, nearly all (93.4%) received a primary diagnosis of alcoholism.

The frequency of other diagnoses is low. This same pattern characterizes both subsamples.

TABLE 4. 8. --Distribution by primary diagnosis of total research sample and direct and indirect admission subsamples

Sample	Respondents Primary Diagnosis									
	Alcoholic Psychosis		Schizophrenia		Other Psychosis		Neuroses		Alcoholism	
	N	%	N	%	N	%	N	%	N	%
Total	1	0.4	4	1.8	1	0.4	1	0.4	213	93.4
Direct Admission	1	0.6	2	1.1	0	0.0	0	0.0	167	94.4
Indirect Admission	0	0.0	2	3.9	1	2.0	1	2.0	46	90.2
	Drug Dependence		Personality Disorder		Physical Ailments		Mental Retard.		Total	
	N	%	N	%	N	%	N	%		
Total	5	2.2	1	0.4	1	0.4	1	0.4	228	
Direct Admission	4	2.3	1	0.6	1	0.6	1	0.6	177	
Indirect Admission	1	2.0	0	0.0	0	0.0	0	0.0	51	

Secondary Diagnosis

Slightly over half (52.2%) of the sample was not assigned a secondary diagnosis. Of the diagnoses, some type of physical ailment emerged as the most frequent secondary diagnosis. A greater variety of diagnostic categories are utilized as secondary diagnoses;

however, low frequencies are reported in the functional disorder categories.

TABLE 4. 9. --Distribution by secondary diagnosis of total research sample and direct and indirect admission subsamples

Sample	Respondents Secondary Diagnosis							
	Alcoholic Psychosis		Nonpsychotic Brain Syndromes		Organic Syndromes		Schizophrenia	
	N	%	N	%	N	%	N	%
Total	1	0.4	1	0.4	3	1.3	8	3.5
Direct Admission	1	0.6	1	0.4	2	1.1	5	2.9
Indirect Admission	0	0.0	0	0.0	1	2.0	3	5.9
Sample	Alcoholism		Drug Dependence		Other Pers. Disorders		Special Symptoms	
	N	%	N	%	N	%	N	%
	N	%	N	%	N	%	N	%
Total	12	5.3	6	2.6	3	1.3	2	0.9
Direct Admission	8	4.5	5	2.8	2	1.1	2	1.1
Indirect Admission	4	7.8	1	2.0	1	2.0	0	0.0
Sample	Physical Ailments		No Secondary Diagnosis					
	N	%	N	%				
	N	%	N	%				
Total	73	32.0	119	52.2				
Direct Admission	58	32.8	93	52.5				
Indirect Admission	15	29.4	26	51.0				

Secondary diagnoses of the direct admission and indirect admission subsamples are identical to total sample distribution. Over half of each subsample has no secondary diagnoses, while 32.8% of direct admissions and 29.4% of the indirect admissions are given a physical ailment diagnosis. Compared to primary diagnosis, there is an increase in the percentage of veterans with a secondary diagnosis of neurosis.

Previous Admissions to Psychiatric Hospital

The mean number of previous psychiatric hospitalizations for the total sample is 1.2. As was the case for previous admissions to January House, the majority (63.5%) of the sample was never admitted to a psychiatric hospital. In addition, over 80% of the veterans have never been admitted more than once. In this case, 17.0% of the sample reported more than two previous admissions, and some veterans had been to a psychiatric hospital five times previously.

The direct admission group averages less than one (0.7) previous admission. This group has the highest percentage of veterans with no previous hospitalizations and the highest percentage with no more than one admission. The percentage of veterans with two or more prior admissions is the lowest of any sample.

The indirect admission group has the highest average (3.0) of prior psychiatric hospitalizations. This group also has the smallest percentages of veterans with no previous admissions (58.8%) and with

no more than one admission (74.5%). The higher percentages in the category of two previous admissions (13.7%) and five or more admissions (6.0%) are the two main diversions of the indirect admission group from the direct admission subsample.

TABLE 4. 10. --Distribution by number of previous admissions to a psychiatric hospital* of total research sample and direct and indirect admission subsamples

Respondents Number of Admissions to a Psychiatric Hospital															
Sample	0		1		2		3		4		5+		N. R.		Total
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total	145	63.6	43	18.9	17	7.5	10	4.4	5	2.2	7	2.9	1	0.4	228
Direct															
Admis.	115	65.0	35	19.8	10	5.6	9	2.3	4	2.3	4	0.0	0	0.0	177
Indirect															
Admis.	30	58.8	8	15.7	7	13.7	1	2.0	1	2.0	3	6.0	1	2.0	51

*A previous admission to January House or any mental hospital is counted as a previous admission to a psychiatric hospital.

TABLE 4. 11. --Distribution by general treatments for alcoholism* of total research sample and direct and indirect admission subsamples

Respondents Number of Treatments															
Sample	0		1		2		3		4		5+		N. R.	Total	
	N	%	N	%	N	%	N	%	N	%	N	%			
Total	103	45.2	55	24.1	35	15.4	18	7.9	6	2.6	8	3.5	3	1.3	228
Direct															
Admis.	82	46.3	46	26.0	28	15.8	10	5.6	4	2.3	6	3.5	1	0.6	177
Indirect															
Admis.	21	41.2	9	17.6	7	13.7	8	15.7	2	3.9	2	4.0	2	3.9	51

*Included in this class are all treatments for alcoholism not functioning on the grounds of a psychiatric hospital.

General Alcoholism Treatments

The average number of treatments for the entire sample is 2.6. Nearly one-half (45.2%) of the total sample has not undergone a general treatment for alcoholism. Once again, a majority (69.3%) of the veterans have not entered more than one treatment program. The broad definition of general treatment has increased the likelihood that a veteran has undergone treatment. This is supported by the finding that 15.4% of the total sample reported at least two previous treatments and 14% have reported at least three or more treatments.

The direct admission group demonstrates the same pattern as the total sample. The mean number of treatments for this group is 1.8.

The indirect admission subsample is slightly below the direct admission group in percentage of veterans with no previous treatments or with one or two previous treatments. This subsample demonstrates a tendency to have undergone more treatments for alcoholism, the mean of this subsample being 5.4. The higher percentage of veterans reporting three or more treatments, in particular 15.7% reporting three previous treatments, accounts for the high mean of this group.

Length of Stay

The mean length of stay for the total sample is 45.6 days or

within the sixth week of the program. The mode is the eighth week of core group therapy. In order to accommodate individuals who stay over one week in Pre-Group or who require additional services (employment or housing placement) beyond the last week of group, the ninth week is considered as within the usual length of stay boundary. Considering these two groups together, 41.5% of the total sample did not require any extensive assistance beyond the usual time structure. The dropout pattern of the sample is not surprising, the highest percentage of dropout occurring during the first week. The percentage of veterans leaving declines over time as the veterans continue in core group. The increased dropout rate at week five can be explained through an understanding of a program component which operates at the end of week four. At this point the veteran meets with his therapist in Progress Clinic. The purpose of this clinic is to discuss the veteran's progress in group and to plan for the remaining weeks. The increase in the dropout rate for week five may result from veterans choosing to leave after this review and planning session. It is interesting to note that 9.5% of the sample stayed beyond the usual length of stay. There are several reasons for staying beyond eight or nine weeks: the veteran needs additional time in group therapy and is assigned to post group, additional time is needed to arrange community placement or the veteran broke a program regulation and was sent back to Pre-Group.

TABLE 4. 12. --Distribution by length of stay at January House of total research sample and direct and indirect admission subsamples

Sample	Respondents Number of Days at January House											
	Pre-Group		Week 1		Week 2		Week 3		Week 4		Week 5	
	0-7		8-14		15-21		22-28		29-35		36-42	
	N	%	N	%	N	%	N	%	N	%	N	%
Total	35	15.4	20	8.7	15	6.5	5	2.2	8	3.4	15	6.6
Direct Admission	26	14.7	16	9.0	14	8.0	5	2.8	6	3.4	13	7.4
Indirect Admission	9	17.7	4	8.0	1	2.0	0	0.0	2	4.0	2	4.0
	Week 6		Week 7		Week 8		Week 9		71+			
	43-49		50-56		57-63		64-70					
	N	%	N	%	N	%	N	%	N	%	N	%
Total	5	2.1	8	3.3	53	23.4	41	18.1	23	9.5		
Direct Admission	5	2.9	6	3.0	45	25.3	28	15.8	13	7.7		
Indirect Admission	0	0.0	2	4.0	8	15.7	13	25.5	10	19.9		

The direct admission group has a mean stay of 43.7 days and the mode is the eighth week of core group. Consistent with the sample as a whole is the finding that 41.1% of the veterans left after completing eight or nine weeks. The dropout rate during Pre-Group is the lowest for the directly admitted but the dropout rate during the first six weeks is generally higher for this subsample. This subsample also has the greatest percentage (25.3%) of veterans leaving during the eighth week and the smallest percentage (7.7%) requiring a stay of greater than

nine weeks.

The mean length of stay in the indirect subsample is 52.0 days, eight days higher than the direct admission group. The modal category has shifted from the eighth to ninth week. Termination during Pre-Group is highest (17.7%) for this subsample although termination is less likely as the weeks go by. Considering the eighth and ninth week together, this subsample releases about 41% of its subjects. However, unlike the direct admission group, more veterans are discharged from the ninth than the eighth week. The tendency to remain in treatment is further highlighted by the finding of nearly 20% of the veterans remaining beyond the ninth week.

Summary of Descriptive Characteristics

The total research sample tended to be middle aged, the mean being slightly over 42. Over 80% of the sample is white with no formal education beyond high school. Approximately one-third of the sample was married at the time of admission and one-third divorced. It is interesting that two-thirds of the veterans were either divorced, widowed or separated. Considering our country's current economic situation, it is not surprising that two-thirds of the sample reports being out of a job.

Most of this sample had never been to January House before and over 90% report one or fewer admissions. According to the distribution

of this sample among the diagnostic categories, these veterans are relatively free of functional disorders. Perusal of the secondary diagnosis distribution indicates that many veterans have physical complaints in addition to their drinking problems. The mean number of admissions to a psychiatric hospital is slightly over one, and only seven veterans had been hospitalized more than four times. However, more than 80% report no more than one admission to a psychiatric hospital. This sample demonstrates a higher mean (26) of general alcoholism treatments. Only 40% of the veterans report one or no prior general treatments for alcoholism. Finally, the average length of stay at January House falls within the sixth week of the program. Forty percent of the sample stayed eight to nine weeks; a substantial percentage (15.9%) left during the Pre-Group stage and approximately 10% stayed longer than nine weeks.

In general, the direct admission subsample and the indirect admission subsample demonstrate minor deviations from each other. The indirect sample is somewhat older, less educated, and married. The interesting differences concern the number of previous treatments for alcoholism. Both groups average less than one admission to January House but the indirect subsample reports three times the number of psychiatric hospitalizations and nearly three times the number of general alcoholism treatments. In addition, the indirect admission group has an average length of stay of nearly ten days

greater than the mean for the direct admission subsample.

Test of Hypothesis

It was stated in the first chapter that alcoholism is only one type of condition treated at a mental hospital. The hospital under study, January House, specializes in treating alcoholism, functional wards treat organic and functional disorders, and the medical ward attends to physical ailments.

The philosophy of January House states that the veteran should be free of psychological or physical conditions which may interfere with his alcoholism treatment. The functional and medical wards (indirect path) operate to minimize these problems and enhance the veteran's chances of gaining admission to January House. There are eight veterans in the research sample who were transferred to a functional ward and three who were sent to medical wards while involved in the January House program. This study considers length of stay at January House and doesn't attempt to evaluate motives for leaving treatment. However, these 11 men presented pressing problems which interfered with the January House treatment plan. These conditions did not result in the termination of treatment but necessitated a change in the priority of treatment. Since these veterans continued to utilize the hospital as a help source, the consideration of their length of stay at January House would be inappropriate.

Therefore, since these cases are atypical of the January House population they are omitted from the sample. The total sample size for this section of the analysis is 217.

The hypothesis is:

Alcoholics socialized to the patient role in a psychiatric ward among psychiatric patients will exhibit significantly shorter lengths of stay in the hospital than those alcoholics socialized to the patient role apart from the psychiatric ward.

The independent variable is socialization experience to the patient role, operationalized as type of admission path. The direct path allows socialization to proceed in a building designated as an alcoholism treatment center which houses only alcoholics. The indirect path provides a functional ward as the setting for socialization of the alcoholic.

Findings comparing the mean length of stay at January House, by admission path, are presented in Table 4.13.

TABLE 4. 13. --Mean length of stay at January House, direct and indirect admission paths--all subjects

	N	Mean	Standard Deviation	t
Direct Path	167	45.51	28.17	1.201*
Indirect Path	50	51.22	33.61	

*not significant at .05 level

No significant difference exists between the two admission paths; the null hypothesis cannot be rejected. The substantive hypothesis is not supported.

In Chapter II it was suggested that prior admissions to a psychiatric hospital may affect the veteran's current adjustment to the patient role. In order to control for possible effect of previous hospitalization experience, a subsample consisting of veterans with no previous psychiatric hospitalization is analyzed. Table 4. 14 compares the mean length of stay for this subsample by path.

TABLE 4. 14. --Mean length of stay at January House, direct and indirect admission paths for subjects with no previous psychiatric hospitalization

	N	Mean	Standard Deviation	t
Direct Path	110	45. 56	28. 24	. 8803*
Indirect Path	30	50. 97	35. 03	

*not significant at . 05 level

Controlling for previous psychiatric hospitalizations has not resulted in a significant difference of means in the length of stay between direct and indirect admission patients.

In Chapter II hospitalization history is dichotomized into treatments for alcoholism in a psychiatric setting and general alcoholism treatments. In order to consider the effect of general

treatments to length of stay and the effect of all treatments (general treatments and psychiatric setting) two additional t tests were performed.

TABLE 4. 15. --Mean length of stay at January House, direct and indirect admission paths for subjects with no previous general alcoholism treatments

	N	Mean	Standard Deviation	t
Direct Path	77	49.83	27.68	-.1533*
Indirect Path	21	48.71	35.95	

*not significant at .05 level

Considering those with no previous general alcoholism treatments has not resulted in a significant difference of means between the groups.

TABLE 4. 16. --Mean length of stay at January House, direct and indirect admission paths for subjects with no previous treatments for alcoholism

	N	Mean	Standard Deviation	t
Direct Path	42	51.57	27.70	.0498*
Indirect Path	15	52.00	31.06	

*not significant at .05 level

If veterans with no previous treatments for alcoholism are considered, both groups have nearly identical means. The t value

for the novice group is not significant.

Discussion

The mean lengths of stay for all groups tested are very similar. In all cases, the range falls within the sixth and seventh week of core group. In order to satisfy the assumption of homogeneous variance, a test of homogeneity of variance was performed for each t test. The findings indicate that this assumption is satisfied in all cases.

The theory used in this study states that the stigma associated with psychiatric hospitalization will affect an alcoholic's willingness to accept the hospital as a source of treatment and affect his willingness to assume the patient role. Two socialization experiences are considered in this study. In the first case, the alcoholic is socialized to the patient role on a functional ward and is not differentiated from the other patients. The second socialization experience introduces the alcoholic to the hospital on a ward designated as the alcoholism treatment ward and recognized as treatment of substance abuses only. The hypothesis of this study states:

Alcoholics socialized to the patient role in a psychiatric ward among psychiatric patients will exhibit significantly shorter lengths of stay in hospital than those alcoholics socialized to the patient role apart from the psychiatric ward.

The findings (Table 4. 13) indicate that socialization experience does not significantly affect length of stay in treatment. The hypothesis of this study cannot be accepted.

It was stated in Chapter I that psychiatric hospitalization requires the individual to make some adjustment to his new environment. In order to control for the effects of adaptations initiated during previous hospitalizations, subjects with no previous hospitalizations were considered. The findings (Table 4. 14) indicate that the length of stay means of the two admission paths are not significantly altered when prior hospitalizations are controlled. It is concluded that this variable does not significantly affect length of stay of either admission group.

Chapter II presented hospitalization history as a variable: psychiatric treatment setting versus general alcoholism treatment setting. Adaptations to psychiatric hospitalization have been discussed. However, treatments in nonpsychiatric settings may also require individual adaptation. Treatment is one social validation that a drinking problem exists. The individual requesting treatment must confront the concept of alcoholism and the label alcoholic. If a lack of consensus exists between individual and the treatment team concerning his drinking, a great deal of individual adjustment may result from entering treatment. In order to control for adaptations formulated in nonpsychiatric treatment settings, a test of means of subjects with no prior general alcoholism treatments was performed. The findings of Table 4. 15 indicate that controlling for this variable does not significantly affect length of stay.

Finally, the novice to alcoholism treatment was considered. The results (Table 4.16) indicate no significant difference in mean length of stay between admission path.

In conclusion, the null hypothesis has not been disproved, by any of the tests performed, and cannot be rejected. In addition, previous treatments have been excluded as a variable significantly affecting length of stay. These findings are discussed further in the next chapter.

Exploratory Analysis

The findings of the previous section indicate that path of admission is not significantly related to length of stay in treatment. The question becomes, What is the nature of the relationship between these two variables? This final section presents the findings of the Multiple Classification Analysis which examines this relationship and the relationship of nine other variables to the dependent variable (Appendix A). The variables included in this section are: age, race, education, marital status, employment status, referral source, previous admissions to January House, previous admissions to psychiatric hospitals, previous general alcoholism treatments and path of admission. A discussion of each variable, in relation to alcoholism treatment, appears in Chapter II.

Two alterations were made in the data in order to obtain stable results. First, missing data (5 cases) were omitted from the analysis

in order to avoid the affect of "unknown" classes upon the predictor's overall relationship to the dependent variable. Second, Andrews, et al. (1967:20) note that there should be more cases in the predictive model than degrees of freedom (d.f. = sum of number of categories - total number of predictors). In order to meet this assumption, it was necessary to collapse categories of several predictors. The total number of cases for this section of the analysis is 212.

The multiple correlation coefficient (R) indicates a low degree of predictability of length of stay, considering all ten independent variables ($R = 0.14425$). In addition, the coefficient of determination (R^2) reveals that only 2 percent of the total variance is accounted for by all ten independent variables. Based upon these findings, it is concluded that the variables studied have little relation to length of stay. Since MCA is structured within an additive model, interaction between variables is not reported. In this study, the small relationship between the independent variables and length of stay excludes the necessity of searching for interaction among the variables.

Although the gross relationship of the predictive model to length of stay is small, MCA allows for the examination of individual variables and patterns within variables. Eta and beta coefficients provide information concerning the relationship of a predictor variable to the dependent variable, and the unadjusted and adjusted coefficients indicate a pattern within predictors.

Entire variables will be considered first, the statistics of importance are eta and beta.

Only four variables (age, education, number of general alcoholism treatments and referral source) have an eta of at least .10. The remaining variables report eta's ranging from .01 to .07. Controlling for the effects of variables (beta) also demonstrates a low degree of relationship (.03 to .18).

In sum, ten independent variables have explained only 2% of the variance in the dependent variable. All of the variables report an eta or beta of less than .20. Three variables explain 65% of total explained variance (2%): referral (24.5%), general alcoholism treatments (21.1%), and education (19.4%). The following discussion focuses upon these variables.

Education

A linear relationship exists between education and length of stay in treatment. Deviations from the grand mean indicate that lower educational levels are characteristic of veterans with shorter lengths of stay. The greatest change in stay occurs between those who have completed high school and those veterans with some advanced training.

Considering only the effect of educational level reveals a similar pattern with differing magnitudes. High school graduates now are

above the grand mean and those with advanced schooling have moved closer to the grand mean. Other variables characteristic of the higher educational level are obviously responsible for boosting the unadjusted deviation of this higher education group.

Referral Source

The variety of referral sources has been grouped into six categories. Veterans who note their seeking of treatment as a self-initiated behavior fall into the category of self-referral. Individuals within the veteran's social group (spouse, friend, relative) formulate the group of personalized referral sources. Third, medical oriented sources (physician, other VA hospital, general hospital) are grouped together. Fourth, alcoholism treatment centers and community services not specifically designated for alcoholism treatment are combined into another class. Finally, two sources could not be justifiably included in any class or combined to form a class. Legal and employer referrals are considered independently, the small N's of these two classes make interpretation tenuous.

Three sources have a mean stay less than the grand mean (self, personalized, and other sources). Veterans referred by a medical or legal source, or their employer, remain over the mean. Controlling for the effects of other variables results in each referral group, except legal referrals, staying less time in treatment.

General Alcoholism Treatment Admissions

This variable is trichotomized into: no admissions, one admission, and two or more admissions. This variable demonstrates a curvilinear relationship to the dependent variable. The veteran with no prior treatments for alcoholism is the only group above the grand mean. Veterans reporting only one prior treatment experience are leaving the soonest of all the groups.

This pattern is evident among the adjusted coefficients, however, the difference between groups is increased.

In sum, the ten independent variables studied could explain only 2% of the variance in the dependent variable. The analysis has also demonstrated that admission path is of little value in predicting length of stay in treatment.

The findings of this chapter have not provided support for the hypothesis.

Further examination of admission path was performed by MCA. The findings add additional support to the claim that admission path has little relationship to length of stay. Referral source, previous general alcoholism treatments, and education emerge as the most promising variables.

CHAPTER V

CONCLUSIONS AND IMPLICATIONS

This chapter discusses the findings of the hypothesis and exploratory analysis, focusing upon their theoretical and practical implications.

Hypothesis

The substantive hypothesis has not been accepted:

Alcoholics socialized to the patient role in a psychiatric ward among psychiatric patients will exhibit different lengths of stay in the hospital than those alcoholics socialized to the patient role apart from the psychiatric ward.

The question is, What factors may account for this finding? Theoretical and methodological factors are explored for possible explanations to this question.

This study posited that stereotyped conceptions of mental illness, patients, and hospitalization would decrease an alcoholic's willingness to accept the patient role. Central to the theory was the concept of individual adaptation to the rights and duties constituting this role. Adaptations range from complete rejection of the help source to strict conformity to role prescriptions.

Only one type of adaptation was dealt with in this study--term-

ination from treatment. Comparatively, neither experience fostered the selection of this type of adaptation. However, the relationship of socialization experience to the more subtle styles of adaptation remains to be investigated. Support for such an approach is provided by the work of Mechanic (1961) in which he notes that treatment atmosphere affects patient attitude toward treatment.

The findings also stimulated a critical review of the methods utilized in this study. The restriction of subjects to January House participants neglects a group of alcoholics who never enter the program. This study obtained no information concerning the nature of the adaptations assumed by those alcoholics on the functional ward. There is no record of the number of veterans who decide that a mental hospital is an inappropriate help source and who chose to terminate treatment prior to coming to January House. These earliest terminators never reached January House and, consequently, were not contained in the sample.

It is suggested, for a replication of this study, that veterans seeking admission to January House be followed through from the admission office. Days spent on the functional ward should be included as part of length of stay. In addition, those who leave the hospital from the functional ward should be considered as part of the sample. With such an approach, length of stay in treatment replaces length of stay at January House.

The question remains, Why didn't the transfer admissions to January House exhibit anticipated shorter stays? An answer to this question is presented in two parts.

The indirect admission procedure can be conceptualized as a "prescreening" device, removing the marginal and retaining veterans who demonstrate by their stay a willingness for treatment. Thus, by remaining on the functional ward these veterans behaviorally demonstrate a commitment for treatment. From this perspective, the indirect admission group is partially cleansed of its short-term treatment subjects while retaining, for January House, those more committed to treatment. It may be that this desire for treatment and the anticipation of transfer are sufficient enough to postpone any decision about leaving until transfer to January House.

Once accepted, transferred alcoholics no longer encounter associations with mental illness. At January House, friendships develop with men of similar background, interests and concern--alcoholism. It has been observed that the alcoholics dichotomize the patient population of Battle Creek into psychiatric patients and alcoholic residents. The alcoholics do not view themselves as occupying the same position in the hospital as other patients; they see themselves as a separate and distinct group, occupying a position somewhere between patient and staff. It is quite possible that the newly-transferred veteran welcomes this comradeship and is

quite anxious to remove the robe of patient and don the gown of resident. Under such circumstances, the finding that socialization experience does not affect January House participation is understandable.

Since exposure to patienthood requires the development of adaptive behaviors, previous psychiatric hospitalizations was considered to be an intervening variable. The novices to psychiatric hospitalization were considered in order to exclude possible confounding effects of previous encounters with patienthood. The findings reveal no significant difference between the two admission groups. Several factors prevent it from being confidently stated that previous psychiatric hospitalizations do not affect length of stay at January House for veterans seeking alcoholism treatment.

Examination reveals that controlling for previous psychiatric hospitalizations considers prior encounters with the patient role for direct admissions but not indirect admissions. By definition, indirect admissions spend time at the hospital away from January House, a time requiring them to accept their hospitalization, take a place among patients, obey staff--to assume the patient role. Therefore, the most recent and perhaps most critical adaptation may occur immediately prior to admission to January House. The restriction of sample to January House participants makes it impossible to assess the overall affect of functional ward socialization. The lack of

information concerning those who chose to terminate treatment because of this current exposure to patienthood restricts generalization of this finding. It can be stated that among those accepted to January House previous psychiatric hospitalizations do not affect length of stay.

In order to consider possible confounding effects of general treatments and all treatments, two additional t tests were performed. It should be noted that the small n's of the indirect admission groups questions the stability of the findings.

Controlling for possible effects of previous general treatments has not altered length of stay. It is suggested that the broad definition of this category may be overshadowing possible results. Assumed under this heading are all treatments not carried out at a psychiatric hospital: hospital detoxifications, AA meetings, outpatient, inpatient, etc. A more refined classification of treatments may prove valuable. For example, a greater amount of learning generalization may follow from previous experience in programs of similar structure and philosophy. Under such conditions, prior treatment experience is more likely to affect current program participation. However, the current findings point out that the removal of possible affects of all these treatments does not affect length of stay.

Those veterans with no prior treatments for alcoholism were expected to be the greatest affected by socialization experience. It

was anticipated that novices housed on the functional ward would demonstrate the shortest length of stay. The findings did not support this contention; socialization experience did not significantly alter length of stay of the novice group.

It is believed that the prior discussion of design, dynamics of the functional ward and in-group atmosphere at January House offer one tenable explanation of this finding. In addition, this finding about novices questions the assumption that the novice would be most negatively affected by functional ward socialization and exhibit a shorter length of stay. Instead, the novices are affected similarly by both socialization experiences. Several studies have highlighted that the novice is well motivated and a sound treatment risk (Trice, Roman & Belasco, 1969; Davis, et al., 1956). It may be that the novice, free of past treatment failures, accepts temporary housing on a functional ward in order to give his first treatment effort his best try.

In sum, future research should consider: 1) a broader approach to treatment which considers all veterans seeking alcoholism treatment and which conceptualizes the entire hospital as a treatment setting, 2) other types of adaptation (i. e., participation in therapy, adherence to schedule, attitudes toward hospital, treatment, and patients, etc.) as dependent variables, 3) factors which enhance the adoption of particular modes of adaptation (i. e., setting, modality,

population characteristics, etc.), 4) the classification of previous treatments by number and type in order to ascertain the affects of specific treatments upon current therapeutic involvement, 5) factors which enhance motivation for treatment (i. e., family, legal, employer pressure, physical ailments, etc.).

Analysis

The findings of the exploratory section are conspicuous by the ability to explain less than three percent of the variance. The following discussion is restricted to the three variables (referral source, education, general alcoholism treatments) which account for 65 percent of the total explained variance.

Referral source emerges as the most promising variable, particularly legal and employer referrals. It may be that the sanctions initiated by the law or one's employer, upon early termination of treatment, foster prolonged stays. Thus, a veteran may decide that remaining in treatment is a better alternative to jail or unemployment. This finding concerning severity of sanctions is similar to that of Neuman and Tamerin (1971) who reported that fear of losing one's economic standing often motivates patients into treatment. In addition, concern with damage to one's social standing may also encourage entrance into treatment.

The findings also indicate that education beyond high school is characteristic of those who remain in treatment. This finding is

well supported in the literature. Heilbrun (1971) found that among court case alcoholics, 12 or more years of schooling was indicative of prolonged outpatient clinic contact. In addition, higher educational levels was found to be characteristic of improved drinking behavior in a number of follow-up studies (Mindlin, 1960; Gills and Keet, 1969; Myerson & Mayer, 1966; Kissin, 1968).

General alcoholism treatments has emerged as the third prominent variable. The interpretation of this finding must proceed with caution because of the dicotomization of previous treatments into psychiatric hospitalizations and general alcoholism treatments. The findings indicate that the novice is the best treatment risk.

In general, the findings of this exploratory analysis are consistent with but not strongly supportive of studies of this nature. Findings will be specific to treatment setting, modality, and program structure. A discussion of possible program characteristics responsible for this finding is presented in the practical implications section.

Theoretical Implications

Socialization was presented as a process through which individuals learn to participate in social interaction. The effect of this process is the development of individuals who function effectively in society of their specific group. The standards of effectiveness arise from the target system. The target system of this study was the mental hospital, the selected measure of socialization

effectiveness--length of stay in treatment.

This study operationalized optimal socialization as a length of stay of eight to nine weeks in the program. By this study's measure, the findings indicate that neither socialization experience fulfilled this optimal requirement. Does this indicate that all of the alcoholics were hampered in treatment that both experiences were "ineffective"? Obviously not, rather these findings point out a danger in utilizing partial definitions. As Roscow (1975) noted, socialization is a multi-dimensional process involving the internalization of new values, behavior, images, skills, and norms. The findings suggest that a narrow conception of socialization loses the full import of the concept and may lead to faulty conclusions.

The theory conceptualized the mental hospital as a type of organization with four responsibilities: custody, protection, socialization and therapy. As Parsons (1957) stressed, adequate socialization must precede therapy.

The findings indicate that both socialization experiences retain patients for equivalent periods of time. These findings question an important theoretical assumption: therapeutic process is largely dependent upon prior socialization. The issue deals with the locus of responsibility, when is therapeutic involvement attributed to prior socialization, when to therapeutic regime?

The conceptualization of socialization as an inoculation against

therapeutic interference may be an oversimplification of the relationship between socialization and therapy. The finding that neither socialization experience significantly altered length of stay suggests that socialization may be a continuous process, not just an introduction to therapy. The dichotomy utilized in this study neglected the responsibility of therapeutic agents to demonstrate to patients that their approach is effective and warrants participation and cooperation. It is suggested that the current dichotomy be replaced by one concept. Roscow's (1975) definition of socialization appears adequate in stating the functions of both socialization and therapy.

It was emphasized that the transition from health to illness is filled with apprehension. The transition to mental illness is accompanied by increased anxiety because of social stigma associated with mental disorder. The resolution of these fears and doubts is one aspect of the socialization process. The second aspect of socialization involves the acceptance of hospitalization and development of a cooperative attitude toward staff--acceptance of the patient role.

The substantive hypothesis was not accepted; socializing alcoholics among nonalcoholic patients did not significantly affect length of stay. It is not suggested that this theoretical stance be abandoned, rather that it be expanded. The positive as well as negative aspects of this type of socialization experience should be noted. For example, it has been observed that mental patients

provide a negative model for some alcoholics, with possible positive impact. In this case, housing among mental patients encourages treatment by suggesting possible effects of long-term drinking (i. e., mental or emotional illness). This calls for theorists to dispel their own negative feelings about psychiatric hospitalization and to take on a broader approach. For such a perspective, the value of such an experience can be fully evaluated.

The theory also attributed a great deal of power to stigma. The findings do not support this contention, alcoholics temporarily living on a functional ward did not prematurely terminate treatment. Even novices do not exhibit a significantly shorter stay. Theoretically, this suggests that perhaps the stigma associated with psychiatric hospitals is not as potent as anticipated. Perhaps our society is beginning to recognize the mental hospital as a legitimate treatment center. If this is the case, adaptation may not be a question of acceptance or rejection but the adoption of more subtle styles of adjustment. Perhaps the stigma of mental illness is not held strongly by those who are also stigmatized, albeit in a differing way as alcoholics.

The theory also discussed the uncertainty that has arisen concerning the application of the sick role to mental patients. Siegler and Osmond (1974) pointed out that this uncertainty resulted from the introduction of various models into the once purely medically

oriented psychiatry. Alcoholism is plagued with the same uncertainty and proliferation of models which characterize mental illness.

On the treatment level, models define conditions, guide treatment, and shape relationships. By design, the model embraced by the program under study is nonmedical. A specific model of alcoholism is not explicitly outlined, consequently therapists tend to use a combination of various approaches in treatment.

The findings have an important implication for the present eclectic approach. The fact that patients are aborting treatment prior to the recommended termination date indicates that the current approach lacks power over patient behavior. Power, in this case, refers to the ability to motivate patients to stay for the complete program. A model which enlists the patient's full cooperation and dedication to treatment is needed. This contention supports the position of Seigler and Osmond (1974) which finds therapy characterized with "model muddlement" without the social recognition and support which enhances the power of the healer.

Finally, the theory discussed the formation of a vicious cycle between alcoholic and ward staff which culminates in treatment termination. Again, the findings discount the possibility of this resulting in treatment termination but not other aspects of treatment relations.

In sum, the substantive hypothesis was not accepted; relatively,

the stigma associated with mental illness did not encourage alcoholics to increased rejection of treatment. This may indicate that our society may be changing to a less negative conception of the mental patient and the mental hospital. Recognizing this, perhaps the theory overstated the importance of socialization at the expense of neglecting the importance of therapy. It is suggested that the functions of socialization are continuous and overlap with the responsibilities of therapy. The uniting of these two concepts does away with an unnecessary distinction and in part deals with the negative findings of this research.

Finally, therapy was conceptualized as the implementation of perspectives, ideologies, or models. The findings provide support for the contention that when model muddlement prevails healers are not granted complete social sanction and are deprived of power to control patient behavior.

Practical Implications

The findings of this study were presented in three sections: distribution of subjects among the 11 independent and the dependent variable, test of the hypothesis, and the exploratory examination of the nature of the relationship of the 10 independent variables to the dependent variable. This section discusses the implications of these findings regarding program policy.

Demographic Characteristics

In addition to hypothesis testing, this study gathered data concerning a number of demographic characteristics. Besides providing data for comparing the direct and indirect subsamples, demographic information provides the program administrators with information concerning veteran characteristics which can serve as baseline for a review of program-participant congruence. Also, such information specifies current areas of veteran need which can be met by the program.

The veterans of this study tended not to be in the younger age brackets (Table 4.1); 90% of those studied were over 27 and 62% were in the 38-57 age group. A report to the Congress entitled "Alcohol and Health (1974)" reports the following:

The highest proportion of drinkers are found among those aged 21-24 years, but "heavier" drinking among men is more frequent in the 18-20 year group than in the 21-24 year group. (Chafetz, 1974:10)

This report also points out that a 1970 survey of young men, one year after graduation from high school, indicates that the military sample exhibited higher rates of drinking than those enrolled in college.

The implication is that January House may not be treating younger veterans with drinking problems. The case may be that only after years of drinking, deterioration of social relationships and physical soundness veterans seek treatment. It seems appropriate for therapeutic intervention prior to the development of these problems.

The development of a short-term treatment program may prove to be a valuable primary prevention measure, rather than the remedial function the current program now attempts to serve. With regard to current program functioning, policy makers should consider the age of their treatment population when establishing behavioral contingencies.¹

The findings (Table 4.2) indicate that January House is receiving relatively few nonwhite veterans (84.2% white and 15.8% nonwhite). It may be that information concerning January House is not reaching those areas occupied by nonwhite groups, consequently, these individuals may be misinformed or uninformed about the program. Also, literature which is distributed should be reviewed for prejudicial material which may discourage the nonwhite veteran from coming to Battle Creek.

There are two occasions where interviewer bias may be operating to remove nonwhite veterans from treatment at January House. Veterans of the indirect route undergo an additional screening by the functional ward staff. The purpose of this screening is to ascertain the veteran's stability for January House. The first is an application

¹ Recently those who break a program regulation are required to spend at least one day in pajamas, no street clothes. Such a measure brought negative responses, particularly from older veterans. The program was accused of neglecting the fact that the veterans are "grown men." A careful selection of rewards and punishments can only strengthen desired behavior.

for admission to the hospital; the second is the screening procedure to January House. A study of the racial composition of veterans at these two points would address the issue of racial prejudice and admission to treatment.

The educational level (Table 4.3) of the veterans of this study is relatively low; 44.3% do not have a high school diploma and a relatively small percentage (13.6%) have advanced schooling. The January House program has a component designed for familiarizing the veteran with the bodily effects and damage incurred from excessive alcohol consumption. When selecting literature or preparing presentations for this educational component program, planners should consider the educational level of the alcoholic. Materials gauged at an advanced level may have little meaning to its audience. Attention should be given to the sequence and timing of material presentation; planners should present materials in stride with therapeutic progress.

Group therapy requires a great deal of the verbalization of feelings and life experiences. A lack of education can restrict the development of communication skills. The implication is that for those veterans not active in therapy, the lack of participation may not be in an "unwillingness" but in an inability to effectively communicate.

Finally, the findings, by recognizing that a number of veterans are without a high school diploma, lend support for the continuance

of the high school equivalency program offered to January House residents.

The findings (Table 4.4) indicate that among the eleven referral sources, two (self, other VA hospitals) are referring 44.7% of the veterans.

A community program may not be referring veterans because: it receives few veterans, it lacks information about January House, it prefers to treat rather than refer, veterans do not choose to come to Battle Creek, etc. Whatever the circumstances, greater community exposure and increased communication with other programs may not only resolve some of the current problems of community referral but also expose more veterans to the treatment offered at January House.

The percentage of veterans referred by individuals (friend and relative: 17.1%) indicates that a potentially large source of referral is not being exploited by January House program graduates. During their daily routines these veterans are likely to interact with other veterans with alcohol problems and to discuss their treatment experience. A personal talk from a program participant may prove more convincing than a printed VA document.

Among the medical referral sources, other VA hospitals are sending the majority of veterans. It may be that public hospitals and private physicians prefer to deal with detoxification and physical

ailments rather than long-term therapy. January House should inquire into the number of veterans serviced by general hospitals and private physicians and convey knowledge to these sources about veteran referral.

Another characteristic of January House may be affecting the degree of non-VA affiliated referrals to Battle Creek. This concerns the length of the program. Particularly in the case of employers, nine weeks may be too long a period of time to grant medical leave. A shorter inpatient or a sound outpatient program could be viewed as reasonable alternate treatment modalities.

Finally, it may prove fruitful to examine the reasons why veterans do come to January House for treatment and to capitalize on these points in the program literature. The fact that all services are free to the veteran may pan out to be an important inducement.

The findings (Table 4.5) indicate that over half (52%) of the sample report a disruptive marital status. Whether the veteran entered treatment as a measure to resolve his marital difficulties cannot be ascertained by this data. However, the data do indicate the existence of a sizeable population which could possibly benefit from some sort of marriage counseling. Counseling in this area should consider: restoration of current relationship, family therapy, crisis intervention, social readjustment, and legal advice.

Even though nearly two-thirds (64%) of the veterans entering

January House are unemployed (Table 4.6), the nine week program may be discouraging the employed (35.5%) from leaving the job or remaining for the entire program. Current program length may not be such a critical variable for the unemployed. As mentioned previously, treatment alternatives more suitable to the working man's schedule may attract a greater number of employed veterans.

Program administrators should be sensitive to the large number of veterans without jobs. There is certainly a need for sessions concerning resume preparation, job hunting and interview skills.

Perusal of the diagnoses (Table 4.7) indicates that a majority (93.4%) of the veterans received a primary diagnosis of alcoholism. Nearly one-third (32.0%) of the veterans were diagnosed as having a secondary problem of a physical nature, while over half (52.2%) did not receive a secondary diagnosis. This finding indicates a restricted utilization of diagnostic classifications. This finding may be a reflection of program policy restricting admission to veterans who are psychologically and physically sound or it may be a function of diagnostician. For those veterans in January House, diagnoses are made by the program therapist. Although January House staff are free to assign any classification listed in the Diagnostic and Statistical Manual (DSM II), an alcoholism orientation may lead the therapist to attribute behavior to alcoholism and not to one of the more subtle distinctions of the DSM II. Diagnosticians outside January House may

be more likely to assign other diagnostic categories. The findings also indicate that January House is not providing treatment for those veterans with problems in addition to drinking. The implication is that by ignoring these veterans January House is selecting the less seriously impaired veterans--a more favorable treatment population. The critical question concerns alcoholism treatment being offered to those veterans not entering January House. Since these veterans were seen as inappropriate for the nine-week program, they should not be considered inappropriate for any specific alcoholism treatment. In order to serve all veterans with a drinking problem, the philosophy of neglect should be replaced with a variety of treatment alternatives which could accommodate those veterans rejected from the core group program. These treatment programs could be implemented on the functional ward and become part of the veterans' overall treatment plan.

Nearly one quarter of the veterans entering January House have previously participated in the program (Table 4.8). The majority of these recidivists report one prior admission. It may be that veterans aren't seeking readmission or that after two admissions veterans are completing the program and do not require further attention. From the program's perspective, the small number of recidivist admissions may be a reflection of the program's philosophy. The philosophy states that veterans not completing the program after repeated

admissions are poor treatment risks and should be encouraged to seek other types of treatment. In order to test this assumption, it is suggested that studies of a follow-up nature should be conducted.

This approach hampers what Pittman and Gordon (1958) have termed the "revolving door." Studying chronic police case alcoholics, they note:

They represent a hard core of individuals who are involved in a circular process of arrest, incarceration, release and rearrest for public intoxication, and a group for whom the penal sanctions of the society have failed with the existent community resources for rehabilitation (p. 3).

This concept can also be applied to those alcoholics who incorporate treatment into their lifestyle without altering their drinking behavior. In this case, readmission to treatment constitutes the basis of the revolving door. Although some veterans are deemed inappropriate for readmission to January House, a sound treatment alternative should be offered. Pittman and Gordon (1958) suggest a treatment plan containing medical and physical rehabilitation, psychological rehabilitation, and social rehabilitation. Although the January House program contains these elements, research into the characteristics of these chronic cases may prove valuable in reconstructing these elements into a treatment plan that better suits the needs of these veterans.

A more complete account of recidivism is available from the previous psychiatric hospitalizations data and general alcoholism treatments distributions. The findings (Table 4.9 and 4.10) indicate

that many veterans have participated in some type of treatment experience; only 25% of those applying to January House have never been involved in treatment. Thus, although January House can control the degree of recidivist admissions to its program, three-fourths of the January House population have undergone treatment. From this broader perspective, the program is serving a segment of veterans who view treatment as a revolving door, and program content should reflect this fact.

It was mentioned in Chapter III that indirect admissions average nearly three times the number of general alcoholism treatments and three times the number of psychiatric hospitalizations than direct admissions. This suggests that those with greater treatment histories are being selected for the functional ward. These alcoholics are treatment repeaters who benefit from medical care and the short period of abstinence offered by treatment, but who do not demonstrate changed drinking behavior. Thus, as the frustrations of treatment mount and alcoholism continues to deteriorate their health, social relationships and resources, they are likely to seek hospitalization while intoxicated, in need of shelter or medical attention. Consequently, those veterans come to Battle Creek with needs in addition to alcoholism which require the close supervision of a functional unit.

The admission process acts to dichotomize admissions, routing

chronic cases to the functional ward while directing those less familiar with treatment to January House. As previously discussed, an alcoholism treatment program implemented on the functional unit may better serve the needs of these veterans than the nine-week program or portions of the program offered at January House.

The January House program is structured to introduce different learning experiences at different times in the program. In order to gain exposure to all program components, veterans are encouraged to complete the entire nine-week schedule.

This sample exhibited a mean stay two weeks less than that required by the program. Less than half (41.5%) demonstrate a length of stay within the acceptable time boundary and nearly 10% required extended treatment. These findings have important implications for the structure of the present rehabilitation program.

There are many possible explanations of the veterans' premature termination of treatment: medical problems have been resolved, pressure from family or employer, maximum benefit from the program has been achieved, veteran desires a drink or desires to be reinstated in the community, etc.; whatever a veteran's constellation of factors, January House has not been able to retain nearly half of those seeking treatment.

One alternative involves increased socialization of new admissions to the nine-week program structure. From this perspective,

veterans would be informed about the necessity of remaining in the program for nine weeks and the anti-therapeutic effects of early termination from treatment. Motivating factors outside the hospital could also be recruited to foster the veteran's decision to stay. This approach is based upon the program's belief that valuable experiences are presented during the last three weeks of the program. Although in theory a nine-week program appears sound, in practice the findings suggest that a veteran's need may not require staying more than five weeks.

The second alternative considers program change based upon the needs of the served population:

Undoubtedly, treatment programs could maximize their effectiveness by clearly identifying the type of alcoholic population they propose to serve, the goals most feasible for that population, and what methods can be expected most nearly to achieve those goals. Undoubtedly, success rates could be maximized if the expectations of a group of patients are sensibly matched to the helping source (Chafetz, 1974:11).

The present study indicates that a nine-week program is not utilized by nearly half of the veterans entering January House. It is suggested program administrators review present program structure and evaluate program components. It may prove that a substantial amount of change is initiated during the initial five weeks and veterans are prepared to leave the hospital. The inclusion of the components of the last three weeks of the program into the initial five weeks of group would expose most veterans to the entire treatment plan. This

shorter, more intensive program may better serve the veteran and be in harmony with those elements which encourage his return to the community.

Hypothesis Testing

This study has focused upon the relationship between admission path and length of stay. The findings indicate that among those who enter January House, admission path does not significantly affect length of stay. In other words, the utilization of functional units for the stabilization of alcoholics does not adversely affect stay in the program.

On the surface, this finding can be interpreted as support for the contention that functional units have no affect upon veterans seeking alcoholism treatment and can continue to be utilized as part of the January House program. However, mere number of days in treatment does not provide information concerning drop-outs, non-referrals, or resistant patients. There is no information concerning the anti-therapeutic or therapeutic experiences encountered on the functional ward even though the number and variety of wards, personnel, and perspectives currently involved with stabilization could confound the study.

The findings highlight the fact that the two paths are equally ineffective in retaining patients. The inclusion of the stabilization process at January House, however, could simplify program

functioning and centralize authority. Under such a structure, administrators can consider all veterans needing alcoholism treatment, carry on research to locate faulty program components, and make program changes which fit the needs of the veteran without the extraneous effects of indirect admission.

Summary

Unfortunately, this study was unable to provide January House with a prognostic device which could differentiate program completors from early terminators. In order to assist future research, a discussion of possible factors responsible for the present findings is presented.

First, being part of the VA system, the services offered by January House are free to all veterans. In addition, free medical and dental care are available to participants of the program. Consequently, the desire for alcoholism treatment may be confounded with the attraction of free medical benefits. The restoration of physical health may correlate very highly with termination of treatment.

Once at January House, a veteran is isolated from the community and is absorbed by the program. The program is highly structured and veterans are expected to conform to their prepared schedules. Treatment plans are standardized and a veteran is required to complete the nine-week program. Such a rigid format may be responsible for masking the predictive potential of the variables examined in this study. For example, although friends and family are encouraged to visit on

weekends, long distances discourage many visits to Battle Creek. Therefore, the opportunity for interaction with family and friends is restricted to mail and telephone. Under such circumstances, program policy restricts the involvement of significant others, which may be helpful to treatment.

The lack of relationship between the demographic variables and length of stay may be a reflection of the isolation and nondiscriminatory approach to treatment characteristic of this program. The findings suggest that January House does not have the flexibility to capitalize on individual characteristics which enhance treatment. For example, Cantor (1972) notes that consensus among patient, family, and therapist concerning treatment goals enhances motivation and increases participation in therapy. Under current program structure, therapist-family interaction is minimal, consequently a potentially powerful treatment enhancement is lost.

Although further research into the development of a predictive index is encouraged, policy changes for current structure are recommended. This study adopted the stance that length of stay is an important treatment variable. Although it may be of theoretical importance, realistically successful treatment outcomes are not automatically achieved by fulfilling time requirements. The changes proposed here are based upon the perspective that alcoholics entering January House are social beings, having differing community involvements, varying

degrees of motivation, and individualized treatment goals. From this position, veterans should not be plugged into a rigid treatment structure but evaluated for placement into an appropriate treatment regimen. This would involve not only the development of different treatment tracks (detoxification, short-term inpatient therapy, outpatient, long-term inpatient individual treatment plans with individualized treatment goals) but also a focus upon different treatment outcomes. The designation of pretreatment goals and their posttreatment attainment can be used in evaluation research only when specified in the program. Once specified they could replace the less sophisticated measure of duration of program involvement for both program development and assessment.

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APPENDIX MULTIPLE CLASSIFICATION ANALYSIS

Dependent Variable = Length of Stay in Treatment; Grand Mean = 6.77*

	<u>N</u>	<u>Deviation</u>	<u>Adjusted</u> <u>Coefficient</u>
AGE			
18-30	(38)	-0.80	-0.84
31-43	(70)	+0.11	+0.02
44-56	(91)	+0.26	+0.36
Over 56	(13)	-0.08	-0.14
Eta = 0.11	Beta = 0.12	% Variance Explained = 9.3	
RACE			
White	(179)	-0.11	-0.12
Non White	(33)	+0.62	+0.64
Eta = 0.07	Beta = 0.08	% Variance Explained = 4.4	
EDUCATION			
0-8	(28)	-0.84	-1.09
9-11	(63)	-0.14	-0.16
12	(88)	-0.12	+0.08
Over 12	(33)	+1.32	+1.02
Eta = 0.17	Beta = 0.16	% Variance Explained = 19.4	
REFERRAL			
Self	(47)	-0.37	-0.43
Social Group	(42)	-0.30	-0.31
Medical	(66)	+0.26	+0.22
Alcoholism Program, Community Service	(38)	-0.40	-0.44
Legal	(10)	+0.93	+1.69
Employer	(9)	+2.12	+2.06
Eta = 0.16	Beta = 0.18	% Variance Explained = 24.6	

	<u>N</u>	<u>Deviation</u>	<u>Adjusted Coefficient</u>
MARITAL STATUS			
Married	(70)	-0.04	+0.14
Single	(31)	-0.13	-0.22
Disruptive	(111)	-0.01	-0.03
Eta = 0.02		Beta = 0.03	% Variance Explained = 0.8
EMPLOYMENT STATUS			
Employed	(79)	-0.29	-0.49
Unemployed	(133)	+0.17	+0.29
Eta = 0.06		Beta = 0.10	% Variance Explained = 7.5
PREVIOUS JANUARY HOUSE ADMISSIONS			
None	(166)	+0.17	+0.26
One or More	(46)	-0.49	-0.94
Eta = 0.07		Beta = 0.12	% Variance Explained = 6.4
PREVIOUS PSYCHIATRIC HOSPITALIZATIONS			
None	(139)	+0.02	-0.24
1	(39)	+0.35	+0.84
Over 1	(34)	-0.51	0.00
Eta = 0.07		Beta = 0.12	% Variance Explained = 7.1
PATH			
Direct	(164)	-0.12	-0.08
Indirect	(48)	+0.39	+0.28
Eta = 0.06		Beta = 0.04	% Variance Explained = 1.3
PREVIOUS GENERAL ALCOHOLISM TREATMENTS			
None	(97)	+0.43	+0.56
1	(52)	-0.74	-0.91
Over 1	(63)	-0.06	-0.11
Eta = 0.13		Beta = 0.17	% Variance Explained = 21.1
Multiple R = 0.14			
Multiple R ² = 0.02			
*Unit of measure is a week			