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Factors of motivation related to maintenance of casework contact by patients treated for alcoholism.

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

FACTORS OF MOTIVATION RELATED TO
MAINTENANCE OF CASEWORK CONTACT BY
PATIENTS TREATED FOR ALCOHOLISM

A thesis

Submitted by

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(B.S., Simmons College, 1950)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1957

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CHAPTER I
INTRODUCTION

Purpose of the Study

This is a study of factors of motivation as they relate to the maintenance of casework contact by alcoholic patients. Many of the alcoholics that start in casework treatment withdraw after much time and effort has been spent on them. It is felt that one of the major reasons for the lack of success is insufficient motivation on the part of the patient to give up his symptom of drinking.¹ This often results in his premature withdrawal from treatment. It would be important to know early in the relationship whether a patient is capable of sustaining a casework or psychotherapeutic relationship so that appropriate treatment plans may be made. One of the most promising areas of research, then, would be one that would give a better understanding of the critical variables associated with motivation for maintaining treatment.

Treatment of alcoholics has been considered an all-or-none proposition. Either the alcoholic must conform to the casework techniques that have been evolved for other less severe disorders or he gets no treatment. Efforts are being made to alter the treatment situation to meet the special ego deficits of the alcoholic. It is felt that a more thorough

1. Jean V. Sapir, "Relationship Factors in the Treatment of the Alcoholic," Journal of Social Casework, July, 1953., pp. 297-303.

knowledge of the factors that relate to the maintenance of treatment contact would permit a more systematic alteration of the treatment method.

Scope, Sources of Data and Method of Procedure

In order to more clearly delineate the factors of motivation most pertinent to maintenance of treatment contact, a group of patients who were able to maintain contact with a caseworker was compared with a group who were not. The data for the study were obtained from case records of outpatients at the Washingtonian Hospital. Two groups of ten cases each were selected. One group consisted of cases which were known to be "successful" and the other group is known as "unsuccessful". Success in this instance is being defined as maintenance of treatment for at least six months' regular contact. This definition is based on the assumption that maintenance of treatment is generally an initial and important step in the achievement of abstinence. Those cases selected in the group "unsuccessful" were patients who had shown some interest in treatment but who had dropped out at a critical point, having had a minimum of six and a maximum of eighteen interviews.

Since the purpose of this study is to evaluate motivation as seen in initial contacts, the number of interviews studied in all cases was limited to a maximum of three plus a psychiatric evaluation when available.

Limitations of the Study

Since the majority of patients studied were recruited from the inpatient population,² the sample is not homogeneous as regards external source of referral, nor is it typical of most outpatient clinics where the initiative for beginning treatment is taken by the patient.

The writer would like to emphasize the fact that in this study maintenance of treatment is being related only to questions pertaining to the patient's motivation. It is recognized that other factors must also contribute to a continued treatment relationship, such as the worker's skill, his ability to meet the patient's needs, transference phenomena.

In order to know to what degree maintenance of treatment is a valid gauge of the patient's ability to overcome his drinking problem, a follow-up of both groups would be required. At this point we have no way of knowing what became of those in the "unsuccessful" group who dropped out after brief contact, and therefore we cannot assess what help they have gained from their contact or how successfully they have coped with their problem on their own or by some other method. Similarly, further study would be required in order to correlate more exactly maintenance of treatment with progress made with the problem of drinking.

2. For explanation see Chapter II, "The Setting."

This study was necessarily limited by the lack of material in some of the case records.

CHAPTER II.

HISTORY AND RELATED LITERATURE

The Setting

The Washingtonian Hospital . . . is the oldest hospital in the country devoted exclusively to the treatment of alcoholism. It was incorporated in 1859 as the Washingtonian Home; it was promoted and financed by the Washingtonian Movement, which was a nineteenth century society of men and women who came together, signed abstinence pledges, and proselytized its cause. . . . The home survived the movement itself, which disappeared after eight or nine years of existence. The hospital changed locations several times.¹ [It moved to its current location in Forest Hills in February, 1955.]

The institution was licensed by the Department of Mental Health in 1939, and shortly thereafter a social service department and an outpatient department were established. A night-hospitalization program was instituted which offered interested patients an opportunity to live in the sheltered atmosphere of the hospital while working outside. In 1942, Dr. Joseph Thimann, the present director, began the conditioned response treatment which develops an aversion to alcohol in the patient by subjecting him simultaneously to alcohol and nausea.

The staff consists of the medical director, two staff physicians, seven part-time outpatient psychiatrists, the

1. Arthur Schwartz, "A Study of Casework with Twenty-five Patients Treated with Antabuse at the Washingtonian Hospital from 1950-1952." Unpublished Master's Thesis, Boston University School of Social Work, Boston, 1953, p. 7.

social service director, a full-time caseworker, two student caseworkers, a registered nurse, a dietician and auxiliary personnel. Financial support is derived from the Community Chest, private trust and endowment funds, payments by individual patients, payments by referring social agencies both public and private, and from the Massachusetts Department of Public Health, Division of Alcoholism.²

Recovery from acute intoxication may be accomplished by treatment of seven to fourteen days' duration. The more far-sighted individual who is interested in rehabilitation may avail himself of medical, psychiatric or casework services applied singly or in combination, according to individual needs.³

Theoretically, the social service department is active on all patients who come to the hospital. However, because of shortages of staff, about 75 per cent of the inpatients are actually seen by a social worker. Cases that become active with social service may involve contact on admission to the hospital: 1) patients who cannot afford the cost of hospitalization and for whom state funds are recommended by the director of social service, and 2) cases referred to the social service department by other social agencies. Another group of cases is called to the attention of social service by the staff physicians. These people may seem like good

2. Bernice Rosenbaum, "Married Women Alcoholics at the Washingtonian Hospital." Unpublished Master's Thesis, Boston University School of Social Work, Boston, 1956.

3. Ibid., p. 6.

outpatient treatment candidates because of such factors as an expressed interest in treatment by the patient, a marital problem, a short drinking history, or a good job history. Some cases are referred for a specific, short-term service which the patient is requesting, or which the doctor feels is indicated. In addition to the foregoing, records of new hospital admissions are reviewed weekly by a member of the social service department with a view toward selecting cases that might benefit from casework or psychotherapy.⁴

Potential outpatient candidates are interviewed by a member of the social service staff who tries to establish a relationship with the patient while he is in the hospital. His interest in attending the outpatient clinic is explored, and in most cases a psychiatric evaluation is performed by a psychiatrist, who sees the patient directly for one or more interviews. About 90 per cent of the patients attending the outpatient clinic are drawn from the inpatient population in this manner, while approximately 10 per cent apply directly as outpatients. On the basis of the psychiatrist's recommendation, the patient may be referred for outpatient psychotherapy, casework, or for consideration of a medical regime.

The medical therapies such as the conditioned response treatment and antabuse are found to be appropriate and suc-

⁴. Discussion with G. M. Price, Director of Social Service.

cessful with selected cases. The major treatment approach is psychoanalytically oriented psychotherapy and casework, wherein an attempt is made to cure the symptom of drinking by resolving in some measure the underlying emotional conflicts.

In 1956, 234 patients were seen for psychiatric evaluation, and 149 (64 per cent) were accepted for psychotherapy or casework. Of the number accepted for treatment, 53 per cent failed to return after three interviews or less, while 32 per cent came for more than three interviews but less than six months. Fifteen per cent of the number accepted for treatment remained in treatment for more than six months.

Theoretical Background

Society is of late concerning itself more and more with the rehabilitative treatment of the alcoholic. The atmosphere of degradation, immorality, and hopelessness for so long surrounding the alcoholic is beginning to drop away. Increasingly, alcoholism is being seen as a symptom of an emotional disorder that is at least theoretically amenable to therapeutic assistance. However, the alcoholic himself does not always share this enlightened view, but, on the contrary, often persists in regarding himself in the same harsh, unflattering light as does his most bitter critic. Thus he is often loath to expose himself to the threat of treatment. If the ordinary neurotic is dubious about relinquishing the gratifications offered by his neurotic symptoms, the alcoholic

is infinitely more reluctant to part with his major form of solace. Nor does the physical distress suffered in giving up an addiction serve to strengthen his motivation toward abstinence. Thus the addictive drinker who gets as far as a clinic often comes on a very tentative basis. The literature has emphasized the importance of the therapist's response to the patient in initial contact as being a decisive factor in determining whether treatment will take place.

The only approach that seems to have value is one that includes a frank meeting, in so far as possible, of presenting needs. This should be utilized as a planned approach for clients who are endeavoring to 'run away' literally or figuratively in one way or another; it is the only one to which they can respond. . . . The physician-caseworker team, by handling realistically the emergency problems presented, can offer an effective initial response to the addictive drinker's conflicted 'cry for help.' His motivation for crossing our threshold is usually a gun at his back in the form of real disaster--social, physical, or mental. Building up a creative rapport between the clinic and this conflicted, fearful, evasive, and above all tentative new patient is possible only if there is clear recognition of the real crisis in his affairs which brings him to us.⁵

The alcoholic's resistance to therapy is probably the biggest hurdle we have to overcome in the initial phases of treatment.

Whereas traditionally the patient with symptoms and difficulties is aware of the purpose of treatment and acknowledges his disabilities, the alcoholic often denies that he is in trouble with his drinking. The wish for recovery in him would seem for a long time buried by a campaign of denial, rationalization and

5. J. V. Sapir, "Relationship Factors in the Treatment of the Alcoholic," Social Casework, July, 1953, pp. 298-99.

projection upon others for the unworkability of his present life pattern.⁶

It has been seen that the question of whether or not treatment will take place often rests upon the therapist's ability to establish quick rapport with the patient by meeting his initial need. However, there is still the question, in this writer's opinion, of whether this is enough to sustain a poorly motivated patient beyond the initial phases of treatment. It has been this writer's experience that often the patient has been "seduced" into treatment by the worker's ability to form a quick relationship with the patient, or perhaps to capitalize on his need to put the problem in someone else's hands, another means of denying his own part in the process and avoiding the painful realization that considerable effort and sacrifice will be required of him if the outcome is to be successful. The impulse-neurotic, as alcoholics have been classified, sometimes tends to have magical expectations of treatment. When his dreams don't come true, when somehow he is not cured overnight, he then withdraws from treatment in bitter frustration and disappointment.

Even the most competent therapist can do little with a patient who is totally unable to face his problem and admit the need for help; or the patient who having faced and asked, cannot participate in a "talking cure" because of his wish for

6. Anthony Zappala, M.D., "Motivation of the Alcoholic Patient Towards Therapy," Unpublished paper, 1956.

a quick, painless cure which, like a magical potion, will obviate the necessity of any further pain or effort on his part.

At the Washingtonian Hospital it has been found that the majority of outpatients drop out before having had three interviews. Some of them will return months later when their difficulties have become so great as to supply the impetus to seek help that they lacked before.

There is another large and more baffling group who remains in treatment beyond the initial phase, only to drop out at a further critical point. Some of the patients included in this group seem to be fairly promising candidates who do not evidence to a marked degree the common signs and symptoms of a tenuous treatment risk. Others of this group include those who have shown some signs of poor motivation, but who have apparently been sustained by relational factors to the point where motivational deficiencies, difficulties of treatment and/or the tax of abstinence prove a greater force than the emotional tie with the therapist.

It is this group who gets beyond the initial stages of treatment before "breaking" that is the subject of this study. Much therapeutic time and effort is expended on their behalf. Although it is possible that they may receive some lasting benefit from their incomplete clinic contact, it is probably insufficient to justify the therapeutic investment made in them.

One of the important functions of intake at the Washingtonian Hospital is to assess the patient's motivation for treatment and his capacity to undergo and benefit from casework or psychotherapy. The purpose of this study is to give a more detailed examination to the factors that comprise motivation to maintain treatment. It is hoped that the findings will help in a better early assessment of the patient's ability to sustain a casework or psychotherapeutic relationship so that an optimal form of treatment may be chosen.

Review of the Literature

A survey of the literature yielded little material directly related to motivation for treatment maintenance. There have been several unpublished theses undertaken in child guidance or adult psychiatric clinics which concern themselves with motivation and/or maintenance of treatment.

A study by Belson sought to determine whether differences could be found in the way groups of successfully and unsuccessfully treated mothers initially present their problem. Significant differences were not found, but it was suggested that various factors may have inhibited their appearance.⁷

Gerstenfeld explored common factors in a group of cases who had applied and failed to return for treatment at a psy-

7. Barbara Belson, "Seeking Determinants of Treatability." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, Massachusetts, 1955.

shiatric outpatient clinic. She found that 90 per cent of these cases were referred upon instigation of others, that 60 per cent saw their problems as physical instead of psychogenic. She concluded that the motivation for therapy was poor because precipitating factors were external rather than intrapsychic. The attitude was a search for a "wonder drug." The majority viewed therapy as a threat and therefore were unable to establish meaningful relationships in intake interview.⁸

Studies by Mills and Ritterskamp in child guidance settings substantiate the finding that treatment is successful only when parents have some real desire for it, and that lack of desire for treatment can usually be identified in the first interview if the parents are left free to express their feelings about coming to the clinic and to decide whether they want the kind of service the clinic has to offer.

Typical responses of parents who do not want treatment were found to be an inability or unwillingness to see anything amiss in their children's behavior, or the placing of blame on other persons or situations.^{9, 10}

8. Esther Gerstenfeld, "Common Factors in Patients Who Withdrew from Treatment After Acceptance at a Psychiatric Clinic." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, Massachusetts, 1955.

9. Harriet Mills, "The Prognostic Value of the First Interview." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, Massachusetts, 1937.

10. Louise Ritterskamp, "The First Interview As a Guide to Treatment." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, Massachusetts, 1937.

Dowden, in a study comparing short-term (one interview) and long-term alcoholic patients in outpatient treatment, found that the short-term patients appeared to be more limited in education, were unemployed when applying for treatment although they did not exhibit any less stable work histories than long-term patients. It was found that short-term patients feel under pressure from other people to seek treatment rather than coming out of an inner need. The short-term patients' attitudes toward treatment appear negative. They deny drinking is a problem. They present more concrete problems, often indirectly expressed.

There was no significant difference found between the two groups as to age, sex, marital status, living conditions, self-image and degree of alcoholism, thus these factors were concluded to be non-determinant in acceptance or rejection of treatment. The author felt that insufficient material prevented any definite conclusions. There was variation in both groups regarding family constellation, parental attitudes toward drinking and attitude toward parents. Short-term patients were found to have more unstable relationship with their spouses which diminished their chances for successful treatment by default of a supporting relationship.¹¹

11. Sylvia Dowden, "Deflection from Treatment in Alcoholics." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, Massachusetts, 1956.

Theoretical Justification of the Study

This study differs from Dowden's in that the comparison here involves short-term patients who have had a minimum of six interviews rather than a single interview. One would suspect that the short-term group ("unsuccessful") of this study would represent a somewhat different type of patient--namely, one who undertakes treatment more seriously than the single-interview patient whose initial ambivalence is probably more apparent and who does not, by virtue of his single interview, involve as great a loss of therapeutic time.

The focus of the current study is also somewhat different from Dowden's with the concentration placed on those particular factors thought to comprise motivation for treatment maintenance. In this regard, certain areas have been selected as being critical in the determination of a patient's motivation for treatment maintenance. In this section each of these component areas will be justified separately.

Maintaining treatment presupposes that the patient has initiated treatment, and that he has had some reason for so doing. Thus it would seem important to know what his reasons are, and whether they would provide some clue to the degree of his motivation to endure in treatment. The literature has demonstrated that not all patients who ask for treatment do so because they sincerely and whole-heartedly want to stop drinking, but that often they are prompted to apply for help because of external pressures and threats, or even if they do apply for "internal" reasons, their resolutions are subject

to great vacillation. Moreover, since approximately 90 per cent of the patients ultimately receiving clinic treatment are inpatients at the time of their initial interviews, their primary purpose in coming to the hospital is for medical help in drying out; therefore, their wish to stop drinking cannot be taken for granted.

Thus, one of the purposes of initial interviews is to assess the patient's motivation to stop drinking. One of the ways this can be done is to note the way in which he presents his problem. It is legend among alcoholics and those who work with them that alcoholics cannot stop drinking without help. Thus, a desire for help is considered to be an essential ingredient to a sincere wish for abstinence, and is being taken into consideration in evaluating the initial presentation of the problem.

The patient's initial presentation of his problem will then be correlated with the other pertinent areas selected for study.

The second area of study will be a consideration of the length of time it took the patient to apply for treatment after initial referral. (This factor can be used only in regard to patients who come into outpatient clinic directly from the outside, and who were not inpatients.) Since promptness can probably be interpreted as eagerness (in a situation where a patient is free to make a choice) or conversely, delay as

resistance, an evaluation of this factor was thought to have some bearing in gauging a patient's motivation.

The patient's concept of who is responsible for his drinking is the third area of consideration. Attitudes ranging from projection to a masochistic self-blame are encountered. It would seem reasonable to expect that a patient who sees himself appropriately responsible for his drinking would stand a better chance of taking responsibility for stopping than either the one who projects or the one who blames himself too much. The one who projects does not see himself as responsible in the first place, and thus will not feel moved to remedy the situation, while the patient who overly blames himself uses the drinking in the service of his feelings of worthlessness which he tends to see as his immutable fate.

The fourth area concerns the question of what aspects of his life the patient feels are interfered with by his drinking. It is possible that the two groups might see different aspects of their life interfered with, and that this, therefore, might prove an area of prognostic value.

The fifth area under observation is that of the patient's awareness of the emotional roots of his drinking problem. It is felt that patients who have some understanding that their drinking is related to emotional problems will, at least intellectually, have some understanding of the purpose of treatment and will have more chance of being able to discuss their problems in a relatively meaningful way. Conversely,

the patient who initially has no insight about the reasons for his drinking will be less able to discuss his meaningful relationships and feelings because he is not oriented toward introspection. It sometimes happens that patients have never heard of the connection between drinking and underlying problems, but generally they have encountered this idea somewhere, with the result that their acceptance or denial of the connection is indicative of their real attitudes. This is not to say that a limited intellectual understanding necessarily augurs well. It also happens that a patient who ostensibly has no insight is carried through to success by a positive relationship, with the worker supporting his wish to abstain.

A review of a patient's past efforts to stop drinking might serve as an index by which to measure the seriousness of his current effort. One might expect, for example, that a very long list of short-lived past efforts would indicate poor depth of motivation; hence probably this patient would be a poorer risk on this occasion.

The reality of the patient's expectations from treatment is examined, as this should have an important bearing on his ability to remain in treatment. With alcoholic patients there are frequently some very unrealistic ideas as to what treatment will provide, and when these unrealistic expectations are not immediately met or confirmed, the patient may feel discouraged and unhelped and often drops out. Unclear or

erroneous as his ideas may be, however, it is sometimes not possible for him to comprehend an intellectual explanation because treatment is largely an experience which must be felt to be understood. Nevertheless, superficial misconceptions can sometimes be cleared up when known, and the patient thus salvaged. Initial anxieties about the relationship with the worker, and misconceptions or bewilderment as to the purpose of casework, often combine to make treatment seem pointless or intolerable to the patient. Thus it is seen that if the patient's expectations from treatment are known, they will possibly provide a prognostic clue.

The quality of the relationship with the worker should be a crucial factor in determining a patient's ability to stay in treatment. One of the major questions asked in this study was whether a good relationship could carry a patient through a treatment situation for which his motivation is otherwise poor. It will therefore be of interest to see to what extent a positive relationship can offset poor motivation for treatment, or conversely, to what extent a negative relationship can thwart an otherwise promising treatment situation.

CHAPTER III.
DATA FINDINGS

General Characteristics of the Population

The purpose of this study is to examine the various factors thought to comprise motivation for maintaining treatment. Recordings of the first three interviews the social worker had with the patient plus a psychiatric evaluation where it is included in the case record, are being examined in each of twenty cases. Ten of the patients have been in treatment with a social worker for a minimum of six months, coming to the outpatient department at regular weekly or bi-weekly intervals. This group is being called "successful" in that they have maintained treatment beyond the six months' minimum time here defined as success. The other ten patients had from six to eighteen interviews, and are to be referred to as "unsuccessful" because they did not succeed in having six months of interviews.

Cases were selected to meet the criteria for success and unsuccess and were taken from the file of cases active within the past year. Information about age, occupation, marital status, religion, race, education, financial status, drinking patterns and number of years drinking was taken from the face sheet of the medical record on inpatients. Diagnosis was taken from the psychiatric evaluation. In the cases of patients who came directly to the outpatient department and

who therefore do not have inpatient records, this information was taken from applications for outpatient treatment or from outpatient case records.

Age

TABLE I.

AGE

	30-40	41-50	51-60	Total
Successful	7	2	1	10
Unsuccessful	6	4	0	10

The majority of patients in both groups are between the ages of thirty and forty.

Employment Status

The employment status of both groups is roughly equivalent. The occupations tend to be unskilled to skilled manual and clerical work. The successful group includes one nursery school teacher and one person employed in electronics, which are the highest employment status represented. (See Appendix, Table XXII.)

Marital Status

In the successful group, there are seven married, one divorced, one separated and one widowed; in the unsuccessful group there are seven married, two separated, one single. Thus, the marital status of the two groups is seen to be quite

similar.

Sex

There are seven males and three females in the successful group; nine males and one female in the unsuccessful group.

Religion

There are four Protestants and six Catholics in the successful group; three Protestants and seven Catholics in the unsuccessful group.

Race

There are nine white persons and one Negro in the successful group; ten white persons in the unsuccessful group.

Education

TABLE II.

EDUCATION

Grades Completed	8	9	10	11	12	13	14	15	16	17	Unknown
Successful		1	2	3	2		2				
Unsuccessful	2	1	1	2	1					1	2

As seen in Table II, except for one person in the unsuccessful group who had seventeen years of education (college and one year of graduate school), the successful group tends to be very slightly better educated than the unsuccessful group.

Financial Status

TABLE III.

FINANCIAL STATUS

Income Per Week	Wel- fare	\$40-50	51-60	61-70	71-80	81-90	91 or more	Un- known
Successful	1		2	1	1	1	1	3
Unsuccessful	1	2		3	2			2

The unsuccessful group tends to cluster around the middle range of income, while the successful group is distributed more evenly throughout the ranges, progressing to a higher level of income.

Length of Time Drinking

TABLE IV.

LENGTH OF TIME DRINKING

Years	1-5	6-10	11-15	16-20	21-25	Total
Successful	1	5	1	3		10
Unsuccessful	4		1	3	2	10

If the number of cases falling within the medium ranges (six to twenty years) is totaled for each group, it is seen that nine successful cases fall within this range compared to only four unsuccessful cases. If the number of cases falling within the combined extreme ranges is totaled (one to five years and twenty-one to twenty-five years) the number of successful

compared to the number of unsuccessful cases is one to six. Thus, there is a strong trend for the successful cases to have been drinking from six to twenty years, while the unsuccessful cases tend to have been drinking less than five years or more than twenty years.

Drinking Patterns

In the following table, steady drinkers are defined as those who drink daily or at intervals of less than a week. Periodic drinkers drink at intervals ranging from a week to several months.

TABLE V.
DRINKING PATTERNS

	Steady	Periodic
Successful	6	4
Unsuccessful	5	5

The sample is thus seen to be quite evenly matched in regard to drinking patterns.

Diagnosis (see Table VI.)

There is some difference in the classification systems used by the different psychiatrists which may account at least in part for the abundance of diagnoses. In the successful group there are two cases listed as being extremely disturbed (borderline psychotic). Likewise, in the unsuccessful group there are two very disturbed (one borderline and one

schizophrenic). There is some similarity of diagnosis, but the diagnoses of the successful group tend to indicate less pathology. In two cases there is a more temporary kind of pathology (delayed grief reaction and involuntional depression) than in the unsuccessful group where in two cases it would seem that the disorder is more pervasive and disabling (hysterical personality and inadequate personality).

TABLE VI.

DIAGNOSIS

	Successful	Unsuccessful
Delayed grief reaction	1	
Involuntional depression	1	
Anxiety reaction	1	
Anxiety neurosis	1	
Character disorder	2	3
Hysterical personality		1
Inadequate personality		2
Borderline psychotic	2	1
Schizophrenic		1

Origin of Hospital Contact

TABLE VII.

ORIGIN OF HOSPITAL CONTACT

	Originated as Inpatient	Originated as Outpatient
Successful	7	3
Unsuccessful	6	4

The groups are quite evenly matched as to origin of hospital contact.

Night Hospitalization

Two of the successful group are night-hospitalized patients; three of the unsuccessful group are night-hospitalized patients.

Basic Data

The areas thought to comprise motivation to maintain treatment will be examined in this section.

Evident Motivation

The first area is that of the patient's initial presentation of his problem. This is alternatively called his "evident motivation," and will be referred to as such subsequently.

Motivational attitudes are gauged on a two-point scale ranging from high to low. The following definitions are used:

High

1. Patient expressed his eagerness to stop drinking, the knowledge he is an alcoholic, and his wish for help.
2. Although not overtly expressed by patient, worker commented that patient seemed well motivated and sincere in his interest.
3. Alcoholism not denied although positive motivation neither expressed by patient or noted by worker; however patient seemed willing to continue outpatient department contacts when offered them.

Low

1. Patient says he wants to stop drinking but can do it

alone. (These are not outpatients but inpatients being interviewed for possibility of initiating outpatient treatment.)

2. Patient overtly tentative or ambivalent in attitude toward stopping drinking or receiving help. This may be inferred through patient's failure to keep initial appointments or undue changes or postponements of appointment time.
3. Patient denies drinking is a problem or that he needs help, but nevertheless responds to worker's offer of a relationship.
4. Patient expresses no feelings about drinking or wanting help, but accepts night hospitalization largely to solve a living problem.
5. Patient shows minimal interest of his own in receiving help but comes mainly at the insistence or pleasure of someone else, such as a spouse or parole officer.

TABLE VIII.

EVIDENT MOTIVATION

	High	Low
Successful	7	3
Unsuccessful	4	6

There is a clear tendency for the successful individual to show higher evident motivation than for the unsuccessful individual. If an individual shows high evident motivation, in seven out of eleven cases he will be successful in maintaining treatment.

Length of Time it took patient to get here after referral or initial consideration

Since seven of the successful group and six of the

unsuccessful group started as inpatients, they are necessarily excluded from the sample regarding this item under the reasoning that their hospitalizations were primarily for purposes of "drying out" and dictated by purely physiological considerations. The remaining outpatients may be classified as follows:

TABLE IX.

LENGTH OF TIME

	Within A Week	Within A Month	One Year Or More	Unknown
Successful	2	1	0	
Unsuccessful	1	0	1	1

One additional unsuccessful patient came only after his wife called and came first.

There is a tendency for the successful patient to be more prompt in coming in for outpatient treatment after first having considered it.

Patient's Concept of Who is Responsible for His Drinking

The following definitions will be used:

Self-blame: Patient is extravagant in blaming himself for his drinking, often with a moral tinge. This patient may displace all his difficulties onto the fact that he drinks, which he sees as an indication of his intrinsic worthlessness.

Realistic appraisal: Patient sees himself as responsible for his drinking; he can identify situations or relationships that are tension-creating, thus precipitating drinking episodes.

Projection: Patient blames his drinking on someone else--e.g., "It's my wife's fault that I drink; she drives me to it."

TABLE X.
RESPONSIBILITY FOR DRINKING

	Self-blame	Realistic Appraisal	Projection	Unknown
Successful	1	5	1	2
Unsuccessful	1	3	2	4

The two in the successful group who did not consider drinking a problem, also did not give evidence of having considered this question, and are therefore not included. There was not enough information available to make any conclusion regarding four in the unsuccessful group.

Aspects of Life Interfered with by Drinking

The patient may see his drinking as interfering with one or several aspects of his life, such as his work, his relationship with his wife and/or children, his physical health; or he may object to being an alcoholic on general principle without mentioning disturbances in specific areas. Furthermore, he may perceive these disturbances as unsatisfactory to himself or to someone else, or both (internally disapproved and/or externally disapproved). Thus a patient may feel his drinking interferes with his work in that it causes him to be absent too much, something which he feels badly

about (internally disapproved) or he may feel that his absences are getting him into trouble because his employer objects to them (externally disapproved). These two classifications are of course not necessarily mutually exclusive, but are being used here to express the patient's dominant point of view.

TABLE XI.

ASPECTS OF LIFE INTERFERED WITH BY DRINKING*

	Internally Disapproved		Externally Disapproved	
	Unsuccessful	Successful	Unsuccessful	Successful
Work	5	1	3	
Spouse	1	5	4	4
Children	2	1		
Physical health	1			
Mental functioning	2			
General		1		

* This area was coded by response rather than by individual. Thus one individual may give responses in several aspects.

There is a large tendency for the unsuccessful group to see their work interfered with (five to one) whereas the successful group tends to see the interference in the area of the marital relationship (five to one). The successful group gives a larger number of internal-disapproval than external-disapproval responses, and in no instance is there an externally disapproved response alone (projection). In contrast, the unsuccessful group gives four externally disapproved

responses and only one internally disapproved response in the area of relationship with the spouse, thus tending strongly to deny and project the difficulty by saying that it is the spouse who objects to the drinking.

Seven internally-disapproved responses were given by successful patients, while eleven were given by unsuccessful patients. Thus, fewer aspects of life are felt to be interfered with by the successful group whose dissatisfaction with drinking is therefore more general and less focused on specific areas. The unsuccessful group gives a larger number of externally disapproved responses (seven, as compared to four given by the successful group).

Awareness of Emotional Causation of Drinking

Degrees of awareness are divided into two groups.

The following definitions are being used:

High

1. High degree of awareness of emotional roots of drinking and ability to accept the concept of change through casework. Such a patient might say, "I know my problems are in my head, and that's what I need help with."
2. Awareness that drinking is caused by tensions, but less understanding of his own personality as contributory to the tensions. This patient might say, "I drink because of pressure on my job."
3. Patient is beginning to see that drinking is emotionally caused.

Low

1. Patient talks about pressures on him without making any overt connection between his difficulties and

his drinking. Such a patient might say that he had a fight with his wife last Sunday. Later he says that he got drunk Sunday night. When asked if he was upset about anything Sunday night, he flatly denies that he was.

2. Patient feels everything in his life is fine, or if there are troubles they are projected or otherwise attributed to external causes; e.g., "I just get the urge to drink every once in a while--no, nothing ever bothers me."

TABLE XII.

AWARENESS OF EMOTIONAL CAUSATION OF DRINKING

	High	Low	Unknown
Successful	7	3	
Unsuccessful	5	4	1

The tendency is for successful patients to evidence slightly better "awareness" than unsuccessful patients. Note that the majority of unsuccessful patients nevertheless does fall into the "high" category.

Past Efforts to Stop Drinking

The following two-point table utilizes these definitions:

Great effort: The patient has made seemingly serious attempts to stop drinking such as attendance at meetings of Alcoholics Anonymous, abstinence for three months or longer, voluntary psychotherapy or casework help of more than nominal nature.

Poor effort: Brief A.A. contact, less than three months' abstinence, drying out hospitalizations, brief attempts at psychotherapy or casework. Also

included in this category is no previous effort at abstinence and no effort to get help.

TABLE XIII.
PAST EFFORTS TO STOP DRINKING

	Great Effort	Poor Effort	Unknown
Successful	3	7	
Unsuccessful	4	5	1

It can be seen that a large majority of successful patients made a poor effort to stop drinking in the past (this includes three who made no effort). The unsuccessful patients made a somewhat better effort to stop their drinking. (this includes two who made no effort). A smaller majority of unsuccessful patients made a poor past effort to stop drinking.

Expectations from Treatment

An examination of treatment expectations of both groups of patients follows with these definitions:

Realistic: Patient shows understanding of the purpose of treatment, seems to accept the notion that discussion of his problems with a caseworker will help him to become a more stable person with the consequent alleviation of his need to drink.

Limited: Patient shows less realistic understanding of purpose of treatment. He may have some magical notions, such as that coming for a certain number of appointments will "cure" him, or he may see the interview only as a place to "blow off steam," or that someday something will "click" and he'll be well.

Vague: Patient is frankly confused as to the purpose of treatment and doesn't understand why he is coming.

Unrealistic: Patient has strong convictions that are illogical and unrealistic, e.g., being in treatment means he is "crazy," or the only thing that can help him is pills, or that treatment will bring about some drastic change in his spouse.

This must necessarily be a somewhat artificial categorization because there is always a mixture of feelings and expectations. A patient may be predominantly realistic in his verbalized, intellectual understanding of the purposes of treatment, but may nevertheless maintain magical expectations on a less conscious level. Predominant, conscious attitudes are used in this table.

TABLE XIV.

EXPECTATIONS FROM TREATMENT

	Realistic	Limited	Vague	Unrealistic	Unknown
Successful	2	3	1	1	3
Unsuccessful	1	2	1	1	5

Of those listed as unknown, one unsuccessful and three successful patients had not accepted treatment by the third interview, thus could not be classified. The successful patients tended to be somewhat more realistic in their expectations than the unsuccessful, but there is no information available on so many cases that the results here must be considered inconclusive. Note that even within the successful group there are more

"limited" than "realistic" expectations.

Feelings about the Therapist

The definitions used are as follows:

Positive: Seductive, dependent, appropriately positive feelings.

Ambivalent: Visibly mixed feelings of a positive and negative nature.

Negative: Hostile, mistrustful, fearful, aloof, or affectless feelings.

"Feelings" refers to the dominant feeling in the patient detected by the worker or expressed by the patient. It is axiomatic that all sorts of combinations of feelings exist in a person, and the underlying feelings may be quite discrepant with those manifested in this initial period.

TABLE XV.

FEELINGS ABOUT THE THERAPIST

	Positive	Ambivalent	Negative	Unknown
Successful	4	3	1	2
Unsuccessful	4	2	2	2

This table shows the two groups to be quite similar in their initial manifest feeling about the therapist.

Relationship between Identifying Data and Factors of Motivation

In this section, some of the identifying data will be correlated with some of the basic areas of study just pre-

sented. Also, some of the basic tables will be correlated with each other.

Evident Motivation Correlated with Periodicity

In the successful group, all the periodic drinkers were highly motivated, whereas the steady group was evenly distributed through all degrees of motivation. In the unsuccessful group, the findings are more equivocal. Periodicity doesn't seem related to motivation, but steady drinkers seem to have low motivation. Thus, if the successful and unsuccessful groups are compared with respect to motivation, it is seen that the motivation of the steady unsuccessful drinker appears low, while the periodic successful drinker has the highest motivation.

TABLE XVI.

EVIDENT MOTIVATION CORRELATED WITH PERIODICITY

	High	Low
Steady	3 S* 1 U**	3 S 4 U
Periodic	4 S 3 U	0 S 2 U

* Successful

** Unsuccessful

TABLE XVII.

EVIDENT MOTIVATION RELATED TO YEARS DRINKING

Years Drinking	Evident Motivation	
	High	Low
1 - 5	0 S	1 S
	1 U	3 U
6 - 10	4 S	1 S
	0 U	0 U
11 - 15	1 S	0 S
	1 U	0 U
16 - 20	2 S	1 S
	1 U	2 U
21 - 25	0 S	0 S
	1 U	1 U

When evident motivation is related to number of years drinking, it is seen that by far the highest concentration of successful cases falls within the range of six to ten years drinking, with the next highest concentration in the range of ten to twenty years drinking. These individuals are highly motivated. Seven of the ten successful cases thus have been drinking from six to twenty years. Only one of the successful cases has been drinking one to five years, none for more than twenty years. Persons drinking one to five years or more than twenty years were all but one unsuccessful regardless of motivation.

Awareness Related to Years Drinking

The configuration was similar to that of the preceding

comparison. The highly aware successful cases fell within the medium range of years drinking while the unsuccessful cases tended toward the extremes of few years drinking and many years drinking. (see Appendix, Table XXIII)

Awareness Related to Evident Motivation

TABLE XVIII.

AWARENESS RELATED TO EVIDENT MOTIVATION

Evident Motivation	Awareness	
	High	Low
High	7 S 2 U	0 S 2 U
Low	0 S 3 U	3 S 3 U

A high correlation was found to exist in successful cases. Of the successful cases seven were highly motivated and highly aware, three poorly motivated and of low awareness. There was little correlation among the unsuccessful cases. High awareness alone is not necessarily associated with success. There must be a combination of high awareness and good motivation.

Evident Motivation Related to Responsibility for Drinking
(see Table XIX on the following page)

It is seen that of the successful group six out of seven cases are highly motivated and also realistic in their appraisal of responsibility for drinking. The seventh successful case tended to self-blame. None of the successful patients

projected the responsibility for drinking.

TABLE XIX.

EVIDENT MOTIVATION RELATED TO RESPONSIBILITY FOR DRINKING

Responsibility for Drinking	Evident Motivation		
	High	Unknown*	Low
Self-blame	1 S		0 S
	1 U		0 U
Realistic appraisal	6 S		0 S
	2 U		1 U
Projection	0 S		0 S
	0 U		2 U

* 3 S; 4 U.

Past Efforts to Abstain Related to Motivation

TABLE XX.

PAST EFFORTS TO ABSTAIN RELATED TO MOTIVATION

Past Effort	Evident Motivation		
	High	Unknown*	Low
Great	3 S		0 S
	3 U		1 U
Poor	4 S		3 S
	0 U		5 U

* 1 U.

Having made an effort to abstain by itself is not necessarily associated with success or unsuccess. But if motivation is low, having made a poor past effort to abstain reduces the probability of success this time. If motivation is high,

having made a poor past effort greatly increases the chances of success this time.

Years Drinking Related to Past Efforts to Abstain

There appears to be no relationship between these two factors (see Appendix, Table XXIV).

Age Related to Years Drinking

There is very little relationship between these two factors. There is a slight tendency for older people to have been drinking somewhat longer. (see Appendix, Table XXV).

Evident Motivation Related to Expectations from Treatment

It was seen that successful cases tended to be more realistic in their expectations as well as high in motivation (see Appendix, Table XXVI). There is not enough information, particularly on the unsuccessful cases, to draw any final conclusions.

Awareness Related to Expectations from Treatment

There was a trend for the successful cases to be both highly aware and limited to realistic in their expectations (see Appendix, Table XXVII). Again, there was not enough information available, particularly on the unsuccessful cases, to draw any final conclusions.

Relationship as Compared with Evident Motivation (see Table XXI on the following page)

The highest number of successes occur when the evident motivation is high and the relationship is positive. When

evident motivation is poor, relationship seems to have little bearing in determining success.

TABLE XXI.

RELATIONSHIP AS COMPARED WITH EVIDENT MOTIVATION

Relationship	Evident Motivation		
	High	Unknown*	Low
Positive	3 S 1 U		1 S 3 U
Ambivalent	2 S 0 U		1 S 2 U
Negative	0 S 1 U		1 S 1 U

CHAPTER IV.

SUMMARY AND CONCLUSIONS

This was a study of factors of motivation as they relate to the maintenance of casework contact by alcoholic patients. The subject was considered important because of the large number of cases who have established themselves in treatment relationships beyond the initial phase, only to drop out prematurely at a further point with a resultant loss for the patient who was probably not helped by this form of treatment, and for the therapist whose time was not used to best advantage. In 1956, 85 per cent of patients accepted for outpatient treatment with a social worker or psychiatrist at the Washington Hospital failed to return within a period of six months. Of these, 32 per cent came for more than three interviews, having thus passed an initial "critical point."

In order to more clearly delineate the factors of motivation most pertinent to maintenance of treatment contact, a group of patients who were able to maintain contact with a caseworker was compared with a group who were not. The two groups consisted of ten patients each. One group was successful in maintaining six months' contact, and the other group was unsuccessful in sustaining this contact, having had a minimum of six and a maximum of eighteen interviews.

The two groups were described and compared in regard to general characteristics of the population. They were found

to be quite similar as to employment status, marital status, religion, race, and educational status. Financial status was found to be slightly higher for the successful group. The ratio of females to males was also slightly higher in the successful group (factors relating to these women will be further discussed). Drinking patterns, inpatient-outpatient origin of hospital contact, and number of patients on night-hospitalization was very similar in both groups. Personality disturbance tended to be more serious for a number of the unsuccessful patients.. Some of the successful cases showed a temporary reactive type of pathology of a less pervasive nature. The major descriptive difference in the two groups was in regard to length of time drinking. There was a trend for the successful cases to have been drinking between six and twenty years, while the unsuccessful cases tend to have been drinking one to five and twenty to twenty-five years. It can be speculated that the reason for the lack of success in the one to five year period is that it takes a while for a person to have experienced enough dissatisfaction from his drinking to really want to do something about it. Those drinking heavily for more than twenty years are likely to be too disintegrated, poor in ego strength, and accustomed to their straitened social circumstances to promise much hope of rehabilitation.

The areas thought to comprise motivation ~~were~~ examined with respect to the two groups. There was a tendency for more

of the successful individuals to show high evident motivation. That some unsuccessful cases also rated high in evident motivation might be explained by the fact that many alcoholics are facile in their talk and are motivated by a desire to please and be well thought of rather than by a real internalization of motivation for abstinence. Of more interest is the small group of successful patients who rated low in evident motivation. These patients, all women, seem to have been sustained in treatment by some other factor. Upon investigation it was found that two took the totally passive-receptive position of night-hospitalized patients when alternative living arrangements collapsed. The other had a strongly libidinized, initial reaction to the worker which outweighed her ambivalence toward abstinence.

The next area considered was the length of time it took the patient to apply for treatment after referral or initial consideration. From the small number of cases on which there was information, it appeared that the successful group tends to come earlier after referral. However, this is inconclusive.

In the areas of concept of responsibility for drinking and expectations from treatment there was no significant difference between the two groups, although in both cases the successful group tended to be more realistic. However, in both groups expectations of treatment tended to be more limited than realistic. This points up the prevalence of initial

misconceptions as to the purpose and methods of treatment among alcoholics in general, without regard to success.

It was found that the unsuccessful patients felt that drinking interfered with more aspects of life, and they were more prone to project the dissatisfaction. This multiplicity of complaints on the part of the unsuccessful group attests to a more pervasive feeling of deprivation and suggests a poorer general integration. The successful group, who give fewer areas of difficulty, may feel a more abstract, internalized dissatisfaction with their drinking, which represents a higher level of integration and need to abstain.

The successful patients saw the difficulty in the area of their marriage, while the unsuccessful patients felt most of the difficulty with their work. Since the groups are evenly matched as to number of married persons, this difference must reflect a real difference in attitude. The successful patient feels more concern about close emotional relationships. He is concerned about his ability to relate and thus may be more likely to bear the anxieties that develop in his relationship with the worker without recourse to flight.

Dowden¹ in her study comparing long and short term alcoholic patients found that her long-term patients had better marital relationships than did the short-term patients. She specu-

1. Sylvia Dowden, "Deflection from Treatment in Alcoholics." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, Massachusetts, 1956.

lated that this supportive relationship was a factor in the success. The findings herein are not necessarily contradictory of Dowden's study, but may be reconciled by the explanation that successful patients do not have poorer marital relationships than unsuccessful patients, but that they are more concerned about the difficulty and thus, perhaps, more willing to explore their own contribution in treatment.

In the area of awareness of emotional causation of drinking, the successful group shows slightly better awareness. The fairly large number of "highly aware" unsuccessful cases attests again, perhaps, to the prevalence of an ability of the alcoholic to be intellectually familiar with certain facts of alcoholism to which he can pay lip service with great facility. The three "low" successful cases are the same cases that were low in evident motivation and who had not really accepted treatment within the three-interview-period studied, but were sustained for other reasons previously discussed on page forty-four.

A fairly large majority of successful patients made a poor effort to stop drinking in the past as compared to a small majority of unsuccessful patients. The fact that unsuccessful patients made a better effort to abstain might be interpreted from several points of view. One could reason that the greater the past effort which ended in failure, the poorer the ability of the individual to deal with the problem and the poorer his present prognosis. A poor past effort or

none could suggest that the individual has not yet put forth his full potential into the effort to stop and therefore has not yet been put to the test. However, a large number of poor past efforts on the part of one individual might indicate poor depth of motivation and unless there were a particular reason for a change in attitude on the current occasion, one would have little reason to expect different results. More specific clarification is apparent when this is correlated with motivation.

The initial manifest feelings about the therapist were found to be surprisingly similar for the two groups and taken alone, therefore, would have little relationship to success. It will be seen subsequently that relationship is relevant when seen in conjunction with other attributes. It is important to remember that this study concerns itself only with initial relationships, with which alcoholics have a great deal of difficulty. It would be of interest to examine the changes in relationship that occur in the course of treatment with respect to the successful and unsuccessful groups, as one would wonder whether there would not have to be a higher correlation between relationship and success during the later phases of treatment.

Some of the basic data above was correlated with descriptive characteristics. In the successful group, all the periodic drinkers were highly motivated, whereas the steady successful drinkers were of both high and low motivation. There

was no relationship in the unsuccessful group.

As previously discussed, by far the highest concentration of successful cases fell within the range of six to ten years' drinking, with the next highest range of success within the period of ten to twenty-years. These individuals seemed highly motivated. Those drinking one to five years or more than twenty years are not likely to be successful, and their motivation is generally not good.

It was seen in correlating past efforts to stop with evident motivation that if evident motivation is low, having made poor past effort to stop reduces the probability of success this time, but if evident motivation is high, poor past effort greatly increases the chances of success this time. This can be explained by the hypothesis that a poorly motivated person may make a number of meaningless nominal efforts to stop, possibly because of external pressure. Furthermore, if a person has made many unsuccessful efforts to abstain and has had unrewarding personal relationships associated with these efforts, he will be apt to be discouraged and less likely to invest much of himself in the current therapeutic situation. If a highly motivated person has made few or no past efforts there is more likelihood of success on this occasion because his motives may be internal, and he has not been discouraged by a string of failures.

There appeared to be no relationship between the length of time drinking and past efforts to stop, contrary to what

one might expect. All that can be said about this is that it is not time that is of the essence. There was also little relationship between age and number of years drinking.

It was found that in successful cases there was a tendency in the direction of a combination of high evident motivation and fairly realistic expectations from treatment. (This was inconclusive, particularly in regard to unsuccessful cases because of insufficient information.)

There was a high correlation in successful cases between high evident motivation and awareness of the emotional nature of the problem. There was little correlation in unsuccessful cases.

There was a definite correlation in successful cases between high evident motivation and realistic appraisal of responsibility for drinking, again with little correlation in unsuccessful cases. (This also must be considered inconclusive because of insufficient information.)

There was also found to exist in successful cases a combination of high awareness of the emotional roots of drinking and limited to realistic expectations from treatment, though there was not enough information available for a conclusive statement.

When relationship was compared with evident motivation it was found that the highest number of successes occurred when the motivation was high and the relationship positive. When motivation was low, relationship seemed to have little

bearing in determining success. It would be pertinent to examine the two groups in regard to their respective ability to survive a change in worker during the course of treatment. From what this author has observed (unsystematically) an untimely change in worker can often be fatal to a continued treatment relationship for these very frightened, overly-sensitive people.

In conclusion, as seen in the early interviews, successful maintenance of treatment contact by an alcoholic seems related to a combination of many factors. No single factor stands clear as a basic requirement. The following constellations seem most highly associated with success.

1. Six to ten years drinking and high evident motivation.
2. High awareness of emotional causation and high evident motivation to abstain.
3. Realistic appraisal of responsibility for drinking and high evident motivation to abstain.
4. High evident motivation and poor past effort to abstain.
5. High awareness and limited to realistic expectations from treatment.
6. High evident motivation and a positive relationship with worker.
7. Few aspects of life felt to be interfered with by drinking; disturbance felt in the marital relationship rather than in work; internal rather than external dissatisfaction over the disturbed areas.

*accepted by
Maxwell J. Schliefer Ph.D.
May 1957*

BIBLIOGRAPHY

- Belson, Barbara, "Seeking Determinants of Treatability." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, 1955.
- Dowden, Sylvia, "Deflection from Treatment in Alcoholics." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, Massachusetts, 1956.
- Gerstenfeld, Esther, "Common Factors in Patients Who Withdrew from Treatment after Acceptance at a Psychiatric Clinic." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, 1955.
- Kovar, Leo, M.D., Manuscript of speech given at the Washingtonian Hospital, Forest Hills, April, 1957.
- Mills, Harriet, "The Prognostic Value of the First Interview." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, 1937.
- Ritterskampf, Louise, "The First Interview as a Guide to Treatment." Unpublished Master's Thesis, Smith College School for Social Work, Northampton, 1937.
- Rosenbaum, Bernice, "Married Women Alcoholics at the Washingtonian Hospital." Unpublished Master's Thesis, Boston University School of Social Work, Boston, 1956.
- Sapir, Jean V., "Relationship Factors in the Treatment of the Alcoholic," Social Casework, July, 1953.
- Schwartz, Arthur, "A Study of Casework with Twenty-five patients Treated with Antabuse at the Washingtonian Hospital from 1950 - 1956." Unpublished Master's Thesis, Boston University School of Social Work, Boston, 1953.
- Zappala, Anthony, M.D., "Motivation of the Alcoholic Patient Towards Therapy," Unpublished paper, Washington, D.C., 1956.

A P P E N D I X

TABLE XXII.
EMPLOYMENT STATUS

Unsuccessful	
Bus driver	Clerical work (2)
Houseman (unemployed)	Electrician
Housewife	Barber
Shipping clerk	Nursery school teacher
Brokerage house clerk	Electronics worker
Punch press operator	Domestic
Ash barrell handler	Plumber
State auditor (temporary)	Letter carrier
Milk man	Housewife
Shoe worker	

TABLE XXIII.
AWARENESS RELATED TO YEARS DRINKING

Awareness	Years Drinking				
	1-5	6-10	11-15	16-20	21-25
High	0 S	4 S	1 S	2 S	0 S
	3 U	0 U	1 U	0 U	1 U
Low	1 S	1 S		1 S	0 S
	1 U	0 U		3 U	1 U

TABLE XXIV.
PAST EFFORT TO ABSTAIN RELATED TO YEARS DRINKING

Past Effort	Years Drinking*				
	1-5	6-10	11-15	16-20	21-25
Great	0 S	2 S	1 S		0 S
	2 U	0 U	1 U		1 U
Poor	1 S	3 S		3 S	0 S
	2 U	0 U		2 U	1 U

* Unknown: 1 U

TABLE XXV.
AGE RELATED TO YEARS DRINKING

Age	Years Drinking				
	1-5	6-10	11-15	16-20	21-25
30-39	0 S	4 S	0 S	3 S	
	3 U	0 U	1 U	2 U	
40-49	1 S		1 S	0 S	0 S
	1 U		0 U	1 U	2 U
50-59		1 S			
		0 U			

TABLE XXVI.

EVIDENT MOTIVATION RELATED TO
EXPECTATIONS FROM TREATMENT*

Evident Motivation	Expectations			
	Realistic	Limited	Vague	Unrealistic
High	2 S 1 U	3 S 1 U	1 S 0 U	0 S 1 U
Low	0 S 0 U	0 S 1 U	0 S 1 U	1 S 0 U

* Unknown: 3 S, 5 U.

TABLE XXVII.

AWARENESS RELATED TO EXPECTATIONS FROM TREATMENT

Awareness	Expectations			
	Realistic	Limited	Vague	Unrealistic
High	2 S 1 U	4 S 1 U	0 S 1 U	0 S 1 U
Low				1 S 0 U

* Unknown: 3 S, 5 U.

SCHEDULE

I. IDENTIFYING DATA

Age	Home setup
Occupation	Length of time drinking
Education	Drinking Patterns
Financial Status	
Marital Status	
No. Children	
Religion	
Diagnosis	
Degree of illness	

II. MOTIVATION

1. Does patient come in because he wants to or because someone else wishes it.
2. How long did it take him to get here after first considering it?
3. To what extent does he see his drinking as interfering with his life?

Work

Recreation

Family

Who is it a problem to:

Wife
Employer
Family
Self

4. What awareness does he have of connection between drinking and underlying problems?
5. What effort has he made in the past to do something about his drinking; with what success?
6. What are his expectations re treatment? (Does he see it as pills, magical cures, etc.)
7. What are his feelings about being in treatment?