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DISPOSITIONAL ASSESSMENT WITH ALCOHOLICS

by

Jonathan Meyer

A DISSERTATION

Presented to the Faculty of

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In Partial Fulfillment of Requirements

For the Degree of Doctor of Philosophy

Department of Psychology

Under the Supervision of Associate Professor P. Clayton Rivers
and Associate Professor John Berman

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TITLE

DISPOSITIONAL ASSESSMENT

WITH ALCOHOLICS

BY

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--For my father, who made this dream possible.

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A dissertation is but a first step in a lifelong process of growth and development. Its completion marks the beginning of a professional career and, as such, is a momentous occasion. The author would like to thank the following for helping him to take this first step: his advisors, Dr. P. Clayton Rivers and Dr. John Berman, for their guidance and patience; his readers, Dr. Herbert Howe and Dr. Gerald Weinberger, for their time and interest; the Nebraska State Division on Alcoholism and the Department of Psychology at the University of Nebraska-Lincoln, for financial support; the staff and patients of Lincoln General Hospital's Independence Center, for their support, encouragement and participation.

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

Alcoholism is perhaps the greatest mental health problem confronting our society at the present time. As such, it is not surprising that treatment attempts have shown a marked increase within the recent past. However, prospects were not always this optimistic as most of the history of rehabilitation has been marked by a flat rejection of the individual with an alcohol abuse problem. Alcoholics, for the most part, have been viewed as being moral degenerates who neither wanted, nor could benefit from, help. These attitudes, in turn, have made it difficult for treatment givers to accept the possibility of treating the alcoholic individual. Indeed, the battle to identify alcoholism as a problem worthy of attention has been a long and difficult one, involving many professional and cultural obstacles. Yet, alcoholism is treatable.

Given that alcoholics have only recently won their "right to treatment," rehabilitation strategies at present reflect the confusion and constant flux of any process in its infancy. Presently, treatment attempts range from simple detoxification to those dealing solely with the physical consequences of addiction (i.e., Chronic Brain Syndrome, etc.), to attempts to change an individual's entire style of living through social and psychological therapies. This plethora of treatment approaches reflects the multi-dimensional nature of alcoholism. Alcoholics come into facilities while sober or in the throes of delirium tremens. They come of their own free will,

or under pressure from a variety of sources. They need understanding and support, yet confrontation and direction. To take into account this multi-dimensionality, there is general agreement that treatment has to be broad-based in approach. However, the question of its most appropriate and efficient usages remains unanswered.

In an effort to deal with this question, recent workers in the field have indicated the desirability of adopting a rehabilitative approach in which client is matched with therapeutic modality. Such an approach has been termed dispositional assessment (based upon the work of Cole and Magnusson, 1966), and is ultimately concerned with the prediction of outcome from client characteristics in conjunction with specified treatments. As a result, it enables the service provider to specify which individuals, given certain characteristics, should be placed in what treatment regimens to bring about the most appropriate (and successful) outcomes. Of course, not only does this approach have great potential for clarifying the confusion surrounding alcoholism treatment, but it has great practical value for an agency in that it generates very specific treatment actions. Yet, in practice, dispositional assessment has been put to little use. Perhaps the major reason for this is that evidence relating client, treatment and outcome is not definitive enough to permit practical applications. Thus, while researchers see the need for this approach, they do not have the means to implement it. The present study is an initial attempt to remedy this situation. It will involve an analysis of outcome data based upon a comprehensive

dispositional assessment model of alcoholism.

To begin with, let us consider in more detail the exact nature of a dispositional assessment approach to treatment. From a very general perspective, such an approach assumes that any information obtained from a client will be used as a basis for selecting the most appropriate treatment for that client. Thus, the client's characteristics dictate the modality to be used and the outcomes to be attained. Inherent within this conceptualization are two basic properties. The first involves the fact that the client (his characteristics), type of treatment and those areas where the client needs improvement (his outcome needs) are all important components in any rehabilitation planning. Such a property is too obvious to require explanation. The second concerns the notion that these components do not comprise unitary phenomena, but are multi-dimensional. This implication corresponds to Howe's (1977) concept of "potential" within the client-treatment context and reflects the fact that dispositional assessment could not take place with uni-dimensional components because prediction requires variation. Thus, any adequate dispositional assessment model must view client, treatment and outcome as variable factors which significantly influence rehabilitation. In what ways are these components important for treatment?

The first component, that of client characteristics, derives its importance because of the tremendous amount of variability from alcoholic to alcoholic. One need only consider the vast differences

between the "skid row" and "upper class" alcohol abuser to see that treatment and outcome would take very different forms in each. Obviously, this heterogeneity of characteristics generates different rehabilitation and outcome needs, depending upon the client, and thus can dictate the form of treatment. In general, client characteristics can be broken down into two categories: psychological and life-ecology. The psychological traits include the personality dynamics which motivate the client, as well as the more transitory feelings and thoughts he has upon entering treatment. The life-ecology traits include demographic, drinking and life situation information. They give a more general picture of the client's life style and history. Although both of these factors influence treatment and outcome by dictating the stage of the illness, personal resources and readiness to accept help, the life-ecology variables have been shown to be much more important in this regard (Edwards, 1966; Trice, Roman, & Belasco, 1969). Given this fact (in addition to the general observation that psychological variables have lower reliability), the present study will concern itself only with life-ecology characteristics as the source of dispositional statements.

How does the component of treatment modality exert its influence? As mentioned before, clients enter facilities with a certain set of predispositions based upon their own personal life ecology: they are jobless or employed, have a family or live alone, have been drinking for two or twenty years. If the nature of treatment

does not complement the client's present living situation, or if the philosophy does not fit his life style, treatment will most likely have limited effect and could even be detrimental. In essence, a variety of modalities must be made available to allow for population selectivity. One rehabilitation regimen could never work on all clients as treatment is not potent enough to overcome client differences (Trice et al., 1969). Therefore, the choice of a treatment scheme intimately involves the characteristics of clients and, as these are variable, multiple treatments too become an intricate facet of any rehabilitation planning.

Before leaving this second component, one final point needs to be discussed; this is the distinction between treatment and therapy. According to Trice et al. (1969), therapy refers to an aspect of treatment which is primarily aimed at the cessation of a specific pathological behavior. This includes such approaches as behavior modification and chemo-therapy which seek to make very limited and select changes. Treatment, on the other hand, refers to the total process of rehabilitation and aims at much more broad and comprehensive changes in the individual. Included here would be entire programs. As rehabilitation clearly seems to be the most effective approach to take with alcoholism and, as it fits quite well with the theoretical model now being advanced, the present study will concentrate solely on treatment as opposed to specific therapies. In particular, the primary focus will be on in-patient and out-patient programs, since these are very common among current approaches.

Of the three components comprising a dispositional assessment model, the final one of outcome seems to be surrounded by the greatest amount of controversy. Traditionally, the sole dimension by which treatment effectiveness has been judged has involved the client's drinking behavior. This situation, according to Trice et al. (1969), has arisen because of two assumptions held by workers in the field: (a) An alcoholic's only outcome need is the control of his drinking; and (b) This control will result in healthy functioning in other life areas. Both of these assumptions have been spawned in a pool of ambivalence towards alcoholics and alcoholism. This explains their power to remain such potent dicta in the field (Pattison, Coe, & Rhodes, 1969). The result has been that multi-dimensional outcomes have not been considered relevant end products by many service providers and it is this conception that has had an important impact upon rehabilitation. Let us now consider the nature of this impact.

In general, both of the above assumptions have conspired to limit the scope and meaningfulness of rehabilitation attempts. As a result of the first one, treatment is rendered less meaningful because the client is encouraged to change only in the limited area of drinking. One need only consider the outcome needs of the skid row alcoholic, to see the meaninglessness of a program which adopts the sole goal of returning these individuals to sobriety. Obviously, alcoholics have many needs, of which drinking cessation is only one. The second assumption operates to severely limit the scope of treatment. In this way, if clients are expected to automatically change

in other life areas once drinking ceases, why bother to make remedial attempts in such other areas? Although many studies (e.g., Clancy, 1965; Emrick, 1975; Skoloda, Alterman, Cornelison, & Gottheil, 1975) have found changes in drinking behavior to be positively related to other life changes, the correlational nature of these data make any concrete statements at present premature. Therefore, abstinence cannot be considered the sole need of an alcoholic or the sine qua non of health. Given this, plus the fact that such a position has detrimental effects upon treatment, one is forced to assume multi-dimensional outcome needs in any treatment planning. As this strategy is congruent with the model now being advanced, and has obvious importance for treatment, it will be incorporated into the present study.

We have examined, in some detail, the precise nature of a dispositional assessment approach to treatment. At this point, it seems appropriate to discuss why such an approach is so important. To begin with, there is the issue of treatment effectiveness and efficiency. It has been shown that the client, his outcome needs, and treatment are all variable phenomena. If this factor is not taken into account in treatment planning, it is the client that is hurt because the service provider would be treating that which is variable as uniform. In this way, the approach would not fit the patient and it is probably this failure to match client to modality, in terms of outcome, that has led to treatment looking less than adequate in the past (Bergin, 1971). Moreover, this failure has generated a situation in which all

clients sample all modalities with no sense of which are wasted efforts. Given the vast shortages in manpower and funds, such inefficiency can scarcely be afforded. The present treatment model, then, has important implications for rehabilitation effectiveness and efficiency.

On the basis of these above considerations, the question of implementing a dispositional assessment approach becomes almost an ethical issue. If it is true that matching client and treatment has a positive effect upon outcome, then it would be ethically questionable to proceed in any other way. Clients have both a legal and moral right to the best possible care. Moreover, this approach helps to circumvent the questionable practice of prescribing standard goals for every client, rather than attempting to meet the needs of the individual. Such a situation is nowhere better brought out than in the previously discussed practice of using abstinence as the only treatment goal. This may be true for most alcoholics; but if there are individuals for whom other outcomes are more appropriate, then it seems almost unethical to impose an arbitrary standard upon them. Such a procedure is the norm in a more traditional treatment model. It should be obvious from the above that a dispositional treatment approach has grave importance for treatment, and that it merits careful study.

Recognizing this importance, researchers in the field of alcoholism have made numerous attempts to ferret out the particulars of a dispositional assessment model. At least in theory, this task has been approached through the following question: What client

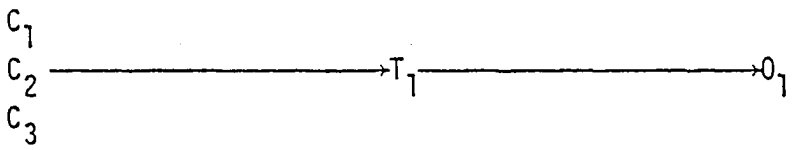
characteristics, in what type of treatment, predict what type of outcome? Although this question, on the face of it, appears simple, a reading of the literature reveals the true complexity of the issue. This is nowhere better illustrated than in the fact that so many research strategies have been utilized in providing an answer. In general, these strategies can be broken into four basic models, depending upon which variables researchers have assumed to be multidimensional and interactive. These models are presented in Table 1, and represent a modification of those reported by Pattison et al. (1969).

In the following paragraphs, a discussion of the literature, which is organized around these four models, is presented. The primary focus of this discussion will concern the findings that have been generated with regard to client characteristics, treatment modalities and outcomes. In terms of client characteristics, only those findings which have received support in two or more studies will be reported. This will help to produce consistency in the compilation of results. As for treatment modality, given that the present research will look at both in-patient and out-patient rehabilitation, findings which involve these two appraoches will be the primary concern. Lastly, only that research which uses "life-ecology" outcomes (i.e., drinking behavior, work status, etc.) will be presented. In this way, outcome indices such as length of stay in treatment or termination status will not be considered, as it is felt that they have less significance with regard to "real life" situations.

TABLE 1

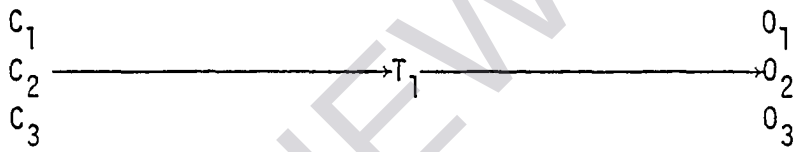
RESEARCH MODELS

Model 1: Single Factor



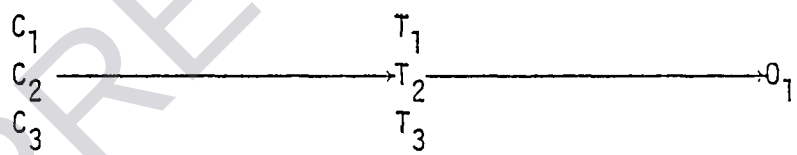
Heterogeneous Clients	Homogeneous Treatments	Homogeneous Outcomes

Model 2: Two Factor



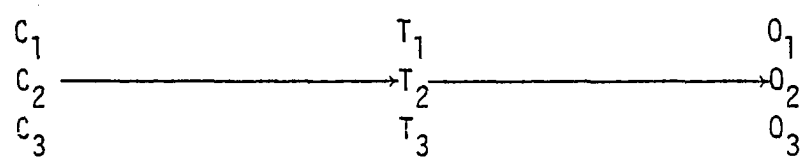
Heterogeneous Clients	Homogeneous Treatments	Heterogenous Outcomes

Model 3: Two Factor Interaction



Heterogeneous Clients	Heterogeneous Treatments	Homogeneous Outcomes

Model 4: Three Factor Interaction



Heterogeneous Clients	Heterogeneous Treatments	Heterogeneous Outcomes

Single Factor Studies

In Single Factor research, only the multi-dimensionality of clients is assumed. These studies generally comprise the more traditional attempts to generate dispositional information and, as such, have provided the groundwork for more sophisticated efforts. In particular, studies in this model have suggested relevant life-ecology variables for subsequent investigations. All Single Factor research is characterized by the use of drinking behavior as the sole outcome dimension, and all have involved either in-patient or out-patient treatment. Of course, studies in this category are the weakest of all the models because of the predictive limitations imposed by considering only one multi-leveled variable. Yet, such studies do have great practical value if carried out in a particular setting and applied to that setting. Moreoever, the simplicity of Single Factor research allows for an easier understanding of the basics of a dispositional assessment approach; an understanding which provides the treatment giver with at least some basis for decision-making. Let us now turn to a consideration of the relationships that have been discovered through research in this category.

In terms of in-patient treatment, investigations involving this modality far outweigh those concerning out-patient. This probably reflects the more favorable attitude, held by service providers, towards in-patient programs. Research here has looked at males and females, as well as a large variety of client populations and therapeutic approaches. In general, premorbid characteristics

found to be predictive of abstinence in in-patient families are: higher social stability (i.e., married, living with spouse and maintaining a household, older than forty-five, less arrests and steady employment), higher social status (i.e., high education and occupation), and a less severe alcohol problem (i.e., less hospitalizations and physical complications, AA affiliation, prior abstinence and an intermittent drinking pattern) (Bateman & Petersen, 1971, 1972; Davies, Shepherd & Myers, 1956; Pemberton, 1967; Selzer & Holloway, 1957; Willems, Letemendia & Arroyave, 1973; Wolff & Holland, 1964). It can be seen that there is a high degree of agreement between these studies, resulting in a fairly stable picture of who will remain abstinent after completing in-patient treatment.

As for out-patient rehabilitation, research focusing on this modality has also involved many different client populations and therapeutic approaches. Life-ecology variables found to be predictive of abstinence in these facilities are: higher social stability (i.e., married and living with spouse, steady work, less convictions), lower social status (i.e., less education and occupation) and a less severe drinking problem (i.e., prior abstinence and AA affiliation) (Haberman, 1975; Madden & Kenyon, 1975; Mayer & Myerson, 1970; Zimberg, 1974). As with the in-patient studies, there is a high degree of agreement in research involving out-patient programs. However, while the general picture of the abstinent out-patient is somewhat similar to that of the abstinent in-patient, there are still important differences between the two groups. This centers primarily around the

finding that high status predicts abstinence for in-patients, while low status predicts it for out-patients.

Two Factor Studies

In Two Factor research, two of the three variables relevant for a dispositional assessment model are considered to be multi-dimensional. While research in this category could potentially be carried out according to two approaches (i.e., one in which the client and outcome are assumed to be multi-dimensional, and one in which the client and treatment are assumed to be such) in practice, studies here only assume the multi-dimensionality of client and outcome. Apparently, when multiple treatments are involved, researchers find it necessary to look at interactions as well. This practice, of course, moves such investigations into the realm of the next model. For the most part, Two Factor research uses as its outcome criterion a single global rating of improvement. This global rating is generally based upon a consideration of drinking, social and work behavior and for this reason, must be considered multi-dimensional. However, because of the fact that it is only a single index that is ultimately used, these studies have little more predictive value than those of the previous model. Thus, both models share the same weakness in terms of their predictive limitations. Yet, more weight still can be given to the results of Two Factor research, as their multi-leveled outcome measures provide a more comprehensive picture of post-treatment adjustment.

As with the previous model, in-patient research in this category outweighs that of out-patient. However, research here has concentrated solely on the male alcoholic. This factor, no doubt, explains the higher percentage of chronic/skid row types found in these studies. In general, factors identified as being predictive of "global adjustment" after completion of in-patient treatment are: higher social stability (i.e., married and living with spouse, steady work and no arrests), higher social status (i.e., high education and occupation) and a less severe alcohol problem (i.e., prior sobriety, less hospitalizations, and a continuous or periodic, but not mixed, drinking pattern) (Mindlin, 1960; Moore & Ramseur, 1960; Trice et al., 1969; Vallance, 1965). It should be noted that these findings are characterized by the same high degree of agreement as was the case with Single Factor in-patient research, and that they are also very consistent with the findings of that research. Such consistency, perhaps, might arise as a function of the fact that in both instances it is a single index or improved versus not-improved that is being predicted. Given this high degree of abstraction, and the fact that the same modality is involved in both cases, this may operate to equate client characteristics that are found to be predictive.

In terms of the out-patient studies in this category, unlike in-patient research, both males and females have been examined, as well as a much less chronically ill population. Factors found to be predictive of "global success" in out-patient treatment are: higher social stability (i.e., married and living with family, steady

work or income and less arrests) and higher social status (i.e., higher education and occupation) (Goldfried, 1969; Mindlin, 1959; Wattenberg & Moir, 1954). In reading these results, it can be seen that, while they are characterized by a high degree of agreement, they are inconsistent with those generated by Single Factor out-patient research. In particular, addiction severity has ceased to be predictive and it is high, as opposed to low, status that relates to outcome. In attempting to explain this inconsistency, one must consider the client populations treated in the two modalities. In general, out-patients are a better functioning group than in-patients, and with this healthier functioning comes a greater variability of needs and behavior (Fisher, 1956). Such variability could very likely result in greater inconsistency from out-patient study to out-patient study. Yet, both findings could still be valid and suggest important dispositional "links."

Two Factor Interaction Studies

In Two Factor Interaction studies, it is assumed that two variables are multi-dimensional and that these variables interact. It is at this point that research increases in complexity and that an adequate dispositional assessment model begins to be approached. While these studies are a relatively new development, they do not represent any great departure from previous models in terms of approach or methodology; rather, they are a conceptual refinement. From a predictive point of view, research in this category is much stronger than that in the previous two models in that it can generate

very specific treatment statements. Such specificity, of course, enables this research to have the greatest practical value of all models discussed thus far. Although Two Factor Interaction studies can be classified into variants (i.e., CLIENT X TREATMENT versus CLIENT X OUTCOME), it is only the CLIENT X TREATMENT option that has received any consideration. Let us now turn to a discussion of this variant and see what relationships have been generated through research.

The CLIENT X TREATMENT option is simply a Two Factor approach with multiple treatment modalities; again, the adding of multiple treatments seems to necessitate looking at interactions. As mentioned before, this variant is the only one that has received any consideration in the literature. This probably reflects its greater practical applications. Thus, on the basis of the information obtained through this approach, the service provider can take certain therapeutic actions because he can specify the most appropriate treatment for a client. This is opposed to information generated through the CLIENT X OUTCOME option, from which one can only specify the general effects that treatment is going to have upon a particular client. It therefore provides a weaker basis for action-taking and as a result, has less practical value. To date, only one study can be classified as falling into the present category. This research was conducted by Ritson (1968) and involved both male and female clients compared in in-patient versus out-patient treatment. The outcome measure was a simple drinking scale ranging from abstinent to unimproved.