San Fernando Valley State College

RESPONSES TO AN ALCOHOLISM QUESTIONNAIRE

A Thesis submitted in partial satisfaction of the requirements for the degree of Masters of Science in Health Science

by

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August, 1969
The thesis of Eileen Joyce Nagle is approved:

Committee Chairman

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August, 1969
DEDICATION

TO

MARTIN EDWARD NAGLE

AND

TWO VERY SPECIAL DAUGHTERS

KITTY AND SUZY
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ABSTRACT

Responses to an Alcoholism Questionnaire

by

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The responses to an alcoholism questionnaire administered to the pilot class on Counseling on Alcoholism and Related Disorders at University Extension of the University of California at Los Angeles have been measured. The variations of responses were compared within five groups among the nine factor items examined.

In comparing the responses among the five groups it was found that there was disagreement among the groups on the nine factors examined. The degree of difference, however, was not significant at the five percent level of the critical ratio (1.96) and, therefore, did not indicate a significant change in attitudes. The five groups analyzed were: "Significant Others", "Wants to Help", "Professionals and Counselors", "Recovered Alcoholics", and "Alcoholics Anonymous". "Significant Others" and the "Recovered Alcoholics" had the least amount of change, followed by the "Alcoholics Anonymous", "Wants to Help"
and "professionals and Counselors", the last two groups having the same amount of change were not significant.

This questionnaire measured attitudes, and the results indicated that the educational experience had no significant effect on the attitudes to elicit a change. This study supports the premise that "It is more difficult to change attitudes than to increase knowledge". (44)
CHAPTER I

INTRODUCTION

The majority of the adult Americans drink some type of alcoholic beverage, but the amount used and frequency of use varies greatly by population and geographic areas. In a 1960 Iowa study of the drinking practices of an adult sample, Mulford and Miller (43) found that 40 percent were abstainers, while the remaining 60 percent were classified as users. They further divided the alcohol users into percentages; 48 percent were categorized as light drinkers, 36 percent as moderate drinkers, and 16 percent as heavy drinkers. A California survey in 1961 by Krupfer (34) indicated that in an adult sample the respondents classified themselves as only 13 percent abstainers, while the remainder were users. The results of these two surveys, and others as well, may have pointed out differences that amount and frequency of drinking vary with the sociocultural attributes of age, sex education, residence, and religion; or strikingly different criteria of geographic location, or mobility, social status, occupation, and lifestyle.

As viewed in this statement:

Each culture reflects a general ethos or feeling tone about the place of alcoholic beverages within its social system, and ascribes social psychological functions to the drinking of alcohol in reference to specified social situations. (48)
Attitudes vary from culture to culture toward consumers of alcohol and change from acceptance to tolerance to rejection but even with these variables the consumers increase the frequency and amount of alcohol. More specifically, cultural attitudes tend to dictate the treatment, policies and practices for the alcoholism within a society.

For example, in Western societies of the United States and Great Britain, treatment resources in the community available for the alcoholic have generally lagged far behind those available for the mentally ill. This discrepancy can be understood only in terms of ambivalent cultural attitudes towards drinking and alcoholism in these countries. (48)

National estimates indicate that, of the approximately eighty million users of alcoholic beverages in America, over six million are excessive users and may be classified as problem drinkers. Of the latter group, approximately one million are excessive users and may be classified as chronic alcoholics. (47) The alcoholic's problem is not an isolated one as can be shown when it is "expressed in terms of people involved, in traffic accidents, manpower losses, juvenile delinquency, deaths and financial burdens to the community." (1)

The studies mentioned emphasize the scope of this problem of alcoholism in the United States, and the complexity and confusion of trying to define the condition of alcoholism. Many observers of the American social scene are convinced that drinking pathologies in the
society are perpetuated by the cultural attitudes that veer toward either asceticism or hedonism. Myers (44) has used the phrase "Social Ambivalence" in reference to American attitudes toward drinking and it restricts the meaning of drinking to one of hedonism and insulates drinking practices from social controls. Thus, drinking becomes an extreme and uncontrolled form of behavior for many. Some verification is found for this position in Skolnick's (59) study in which he states:

Total abstinence teaching which impounds and implants a repugnance to drinking and inebriety tends to identify the act of drinking with personal and social disorganization. Thus, it inadvertently suggests an inebriety pattern of drinking and encourages behavior it most deplores.

By this Skolnick is suggesting that individuals from this type of background may use excessive drinking as a means of rebellion against background.

Pittman (49) suggests that,

a complimentary notion to that of social ambivalence is that, if drinking were more thoroughly integrated into American social custom and routine, the competing attitudes (abstinence and hedonism) would be neutralized along with the more extreme pathology of alcoholism.

To support this position, reference is made to the low alcoholism rates among Jewish (60) and Italian (36) subcultural groups and to conversely high rates among Irish and Scandinavian (49) groups. The latter two groups have the same ambivalence that is found in the American cultural attitudes toward drinking. There is
no uniformity and "social ambivalence"is reinforced by the conflict between the drinking and abstinence sentiments co-existing in many countries. (48)

Abstinence groups are characteristically composed of ascetic Protestant groups who believe the use of alcohol is sinful and who, therefore, see little difference between the occasional social drinker and the chronic inebriate, for the former is the beginning stage for the latter. (48)

What has been called the "Puritan ethic" in American culture is cause for the child to learn other social values. (68)

There is substantial rejection of the developing child's sensual, organic being, by home, church, and neighborhood. In contrast, his intellectual development receives great emphasis, along with economic success, unselfishness, love, and equality. Having deeply internalized these social values, specified personalities may be particularly attracted to excitement, anger, and immediate gratification of bodily needs. (64)

However, the effect of the "Puritan ethic" will vary on each individual but have a collective effect on society.

These cultural attitudes, described have long been considered a deterrent to the treatment, rehabilitation, and legal control of the alcoholic. Professional workers in the field of alcoholism carry with them, into the therapy relationship attitudes toward alcohol and alcoholism that originated in their earlier family and group environments. Many of these attitudes toward alcoholism are deeply rooted in Western culture and reflect both punitive and moralistic sentiments and will affect the therapist's behavior towards the alcoholic, unless he is
aware of them and makes a conscious effort to change them into more accepting and understanding attitudes. These attitudes also influence the community's definition of the type of services that should be offered to the alcoholic and his family.

A study by Pittman and Sterne (49) of community agency attitudes and their impact on treatment services for alcoholism in one large American community in 1962 documents this position adequately. Their study indicates that among 115 health and welfare personnel at 31 agencies or semi-autonomous divisions of agencies, 26 hospitals, and 5 law enforcement agencies, many respondents were marked by ambivalence, moralism, and a pessimism regarding the alcoholic and his treatability; further, these data indicate a significant relationship between the perception of alcoholics as presenting problems for the treatment and the respondent's unwillingness to accept them as clients. For example, resistance to treating alcoholics is often engendered by the fact that the alcoholic's behavior violates the norm of the treatment personnel: i.e., the alcoholic may be aggressive while intoxicated, too dependent when sober, financially irresponsible, and uncooperative concerning treatment plans. Consequently, many professionals have a pessimistic, even defeatist, attitude toward the treatment of alcoholism. Sources of pessimism derive from the perplexity as to mode of treatment.
Unfortunately, these attitudes of pessimism are automatically registered into any treatment situation, which, of course, has negative implications for the therapist-patient relationship and outcome. (49) Research suggests that this pessimism in itself, may lead to ineffectiveness of treatment: i.e., Rosenthal's "Self-fulfilling prophecy.' (52) These attitudes contribute to inadequacies in the formation of services for the American alcoholic.

These same attitudes can serve as a convenient rationale for the failure to examine and modify current policies and practices so as to serve the alcoholic more effectively. (49)

Attitudes of counselors of alcoholics are particularly crucial. This study is concerned with a training program for counselors of alcoholism and related disorders. At the present time there is uncertainty as to what constitutes the specific constructive attitudes toward alcoholics. However, we are gaining some understanding into what constitutes constructive attitudes toward people in general. Eventually we would like to be able to develop a program which would inculcate potential counselors with a set of beliefs and attitudes towards the alcoholic or specifically constructive for him, a set of attitudes, beliefs, and behavior toward people. As a start in this direction this program is concerned with two questions. What are some of the typical attitudes of counselors toward alcoholics? Secondly do these attitudes change during an educational experience? The writer of these
later studies will have questions of how specifically to modify these attitudes and what constitutes constructive attitudes toward the alcoholic.

Constructive attitudes may include acceptance of the alcoholic as a human being with a problem in need of help. This attitude may result in earlier treatment for the alcoholic, for his family, and reduce the destruction associated with alcoholism. The need for counselors who can accept the alcoholic in this way is acute and hopefully this type of educational program will begin to meet this great need.

THE PROBLEM

Purpose of the study

The purpose of this study is to measure and compare responses to an alcoholism questionnaire administered during the first and last meetings of the Fall quarter on September 17, 1968 and December 10, 1968, to a pilot class on Counseling on Alcoholism and Related Disorders offered by the University Extension of the University of California at Los Angeles.

Statement of the hypothesis

Considering the factors involved in attitude change and knowing it is more difficult to change attitudes than
it is to increase knowledge, the following null hypothesis and alternative hypothesis was developed for testing:

1. There will be no significant change in response to the alcoholism questionnaire from September 17, 1968 to December 10, 1968.
2. The subgroups will have no significant difference in the pre and post measure or in degree of change within the nine factors measured.

IMPORTANCE OF THE PROBLEM AND NEED FOR RESEARCH

The problem of the alcoholic and the attitudes of the public and professionals toward him have established his degraded spot in our society. The importance of the problem is paramount to those involved with the alcoholic, and to the alcoholic as well.

Society discriminates and makes certain problems of human beings socially acceptable and thus affords him greater opportunity of treatment, rehabilitation, and possibly prevention. However, once a problem has the connotation of being morally wrong, according to the dogma of the church, the opportunity for help with the problem to the person and his family is negligible.

Perhaps if we remove the label of "alcoholic" and see him as a human being with a problem in need of help
we may begin to change attitudes. Frankel (19), Nunnally (45), and Glasser (20) have discussed the harm that can be done by labeling. This is also supported by Rosenthal (52). The label of "disease" that now exists when referring to alcoholism changes the approach to the alcoholic from punitive control and moralistic shunning to seeing him as a "sick" person with an incurable disease. He is again labeled, and although this may be acceptable to the American public, as medical opinion carries much influence, the ultimate help to the alcoholic except in the area of obtaining grants for research and in the instigation and granting of state and national programs is questionable to the individual alcoholic. By labeling a person, the prescribed attitude of the day will have many negative effects on him. Labels are difficult to erase and certain behavior is excused and expected because of them.

Attitudes toward the alcoholic have been detrimental to him not only in society but in the therapy setting as well. Our knowledge on the most effective ways of changing destructive attitudes to constructive attitudes allows for much needed research in this area. There is some uncertainty as to what constitutes specific constructive attitudes toward the alcoholic. Research has gained some knowledge and understanding as to what constitutes constructive attitudes toward people - which, of course, alcoholics are.
Since accurate empathy, non-possession warmth and genuineness appear to be central ingredients (common to a wide variety of theories and even more central to effective practice in counseling and psychotherapy), training programs should at least initially focus most of their attention on the understanding and implementation of these therapeutic conditions. (55)

and should be stressed in both lay and professional training programs. Bergin and Solomon (1963) found evidence to support this. (7)

Truax (65) noted that the success of the client-therapist relationship is greatly dependent upon the therapist's expectations and attitudes. In a situation where the relationship has a high degree of accurate empathy, nonpossession warmth, and genuineness a greater opportunity for effectiveness is present.

The need for counselors of alcoholism and related disorders has been evident for some time. Pearson (46), in discussing an economic study of alcoholism in Los Angeles County, indicates that,

although this is a valuable study on costs it emphasizes the need for further precise studies to assist agencies in adequate and appropriate planning in working with this gigantic problem. ...the need for further training programs on alcoholism in medical schools, as well as other professional schools is evident.

Presnell (50) made note of this in his statement,

If only ten percent of the untreated alcoholics in the United States volunteered suddenly tomorrow to seek treatment, many of them would be unable to secure help from qualified counselors, either lay or professional.
Industry is becoming more receptive to the use of counselors. Dorris and Lindley (14) state, "Business must realize that in treating the alcoholic not only is the life of the individual saved but the company itself stands to gain."

The importance of the problem has long been known by professionals and lay people interested in the field of alcoholism. The pilot class examined is a result of that concern. Further studies can be made as the class will be offered again at several universities and will eventually be offered nationwide. In time, effectiveness of the counselors trained by this program can be measured.

With training programs such as this, perhaps in time the knowledge and understanding of alcoholism will be more uniform and lead to more effective ways of helping the alcoholic. This may also have an effect on existing attitudes and help to evolve them toward validity and flexibility.

DEFINITION OF TERMS

In order to insure equal understanding of the terms used in this study the following definitions are offered to indicate the meanings used in this study.

Alcoholic: An alcoholic is anyone whose drinking interferes frequently or continuously with any of
his important life adjustments and interpersonal relationships. (13)

Counselor: One who helps the client to come to see who he really is, and what he has and what he does not have; what he can do easily, what he can do with difficulty, and what he probably cannot do at all. (5)

Attitudes: A relatively enduring system of affective evaluation reactions based upon and reflecting the evaluative concepts or beliefs which have been learned about the characteristics of a social objective or class of social objective. (58)

Alcoholism: ...a chronic illness that manifests itself as a disorder of behavior. It is characterized by the repeated usage of alcoholic beverages to the extent that it exceeds customary dietary use or compliance with social customs of the community and that interferes with the drinker's health or his economic or social functioning. (1)

Significant Other: Class member with close relative or friend who is an alcoholic.

Wants to Help: Member of class who is interested in the problem of alcoholism but has no personal involvement.
Recovered Alcoholic: Member of class who is an alcoholic and now considers himself recovered. Method of recovery may or may not have been mentioned, but it would not have been A.A. as these were placed in a separate group.

A.A.: Member of class who is an alcoholic and is now on the Alcoholic Anonymous recovery program.

Empathy: Expression of understanding and acceptance to the client within the client's frame of reference and reality. (5)

Lay Counselor: Professionally untrained but one who has had experiences with a particular problem and has been successful and is now in the process of helping others with similar problems. For example, A.A. members.

Non-Possessive Warmth: For client means accepting him as a person with human potentialities. (65)

Accurate Empathy Scale: Measures degrees of therapist accuracy in the perception of client feelings and the ability to communicate understanding. (65)

Galvanic Skin Response: The apparent diminution of the electrical resistance of the skin, due in reality to the production of an electrical resistance of the skin, resulting from mental activity. (15)
Information: Used here to refer to verifiable statements such as, "There are more men than women in mental hospitals. The terms opinion and knowledge will be used synonymously with information." (45)

Mean Factor Score: For a group is the average of the factor scores obtained by all the individuals in the group. The three stages in the computation are:
1. Compute the sum of the four defining items for each person.
2. Obtain the total of these sums for all persons in the group.
3. Divide this figure by the number of items, (four), times the number of persons. (63)

Factor Analysis: "A mathematical procedure for grouping items so that the items in each group show a relatively high correlation with one another and a relatively low correlation with items in other groups." (45)

Genuineness: Being real; natural; true; pure; not spurious, false, or adulterated.
DEFINITIONS OF ALCOHOLISM

To illustrate extremes in attitudes and knowledge and understanding on alcoholism, great differences are encountered even in the definitions of alcoholism. Various opinions of alcoholism continue to appear in both lay and professional writings. Typical of the quotations from the literature emphasizing psychological characteristics are the following:

1. Alcoholism is a type of abnormal mental reaction; alcohol has been found to be an antidote for some obsessions or emotional depressions. (22)

2. Alcoholism is a "habit of uncontrolled drinking which shows the characteristics of 'malignancy' of a tumor in relation to the physical organism." (66)

3. To Menninger (1938) alcohol addiction is a form of self-destruction, deriving from elements of aggressiveness excited by thwarting, ungratified eroticism, and the feeling of a need for punishment from a sense of guilt relative to the aggressiveness.

Meninger also points out that the accomplishment of the self destruction occurs "inspite of and at the same time by means of the very device used by the sufferer to relieve his pain and avert this feared destruction." (42)
4. Knight's definition presents alcoholism as a psychogenic symptom of a serious personality disorder. (32)

5. In contrast, Isikowitz (24) defines alcoholism as a "limited pathogenic symptom of a serious personality disorder."

The sociologist emphasizes the social aspect of alcoholism as the following statements show:

1. Seliger, in 1941 (57) described alcoholics as people who do not stop drinking either because they are unable or they do not wish to do so, and whose behavior consequently interferes with their life activities.

2. Ernest (1933) noted that alcoholism is not an isolated unitary disease but a symptom of a general personality and social disturbance. (18)

3. Writing in 1948, Simmel (58) defined the social drinker, the reactive drinker, the neurotic drinker and the alcoholic addict. For the social and reactive drinker, he sees alcohol defending the ego against the mental impact of external circumstances. For the neurotic and addict, alcohol defends the ego against the threat of inner unconscious conflicts which only secondarily impair the ego's capacity for coping with reality.
4. Berne (1964) stated:

in game analysis there is no such thing as alcoholism or an 'alcoholic', but there is a role called the Alcoholic in a certain type of game. If a biochemical or physiological abnormality is the prime mover in excessive drinking, and that is still open to some question, then its study belongs in the field of internal medicine. Game analysis is interested in something quite different, the kinds of social transactions that are related to such excesses. Hence the game 'Alcoholic'." (9)

The medical and health professions approach alcoholism within their own frames of reference and explain it in the following ways:

1. American Medical Association (A.M.A.) (1956)

Alcoholism is a disease which is characterized by a compulsive drinking of alcohol in some form. It is an addiction to alcohol. The drinking of alcohol produces continuing or repeated problems in the patient's life. (3)

2. World Health Organization (W.H.O.) (1951)

A chronic illness that manifests itself as a disorder of behavior. It is characterized by the repeated usage of alcoholic beverages to an extent that exceeds customary dietary use of compliance with social customs of the community and that interferes with the drinker's health or his economic or social functioning." (1)


Alcoholism is a chronic disease, or disorder of behavior, characterized by repeated drinking of alcoholic beverages
to an extent that exceeds customary dietary use or ordinary compliance with the social drinking customs of the community, and which interferes with the drinker's health, interpersonal relations or economic functioning."

4. Dorris and Lindley (1968) strongly suggest that the following definition of alcoholism be adopted by all industries:

An illness in which an employee's consumption of any alcoholic beverage seriously and repeatedly interferes with his job performance. (15)

Definitions of alcoholism would not be complete without citing the classification of alcoholics as developed by Jellinek (1946) which list Alpha, Beta, Gamma, Delta and Epsilon alcoholism. (25)

1. **Alpha alcoholism**: a purely psychological continual reliance on the effect of alcohol to relieve bodily or emotional pain. Although the Alpha alcoholic exceeds the bounds of society, he still has the ability to control his drinking and to abstain. Signs of progression are not evident.

2. **Beta alcoholism**: represents to Jellinek that species

in which such alcoholic complications as polyneuropathy, gastritis and cirrhosis of the liver may occur without either physical or psychological dependence upon alcohol.
3. Gamma alcoholism: is described as

"a. acquired increased tissue tolerance to alcohol,

b. adaptive cell metabolism,

c. withdrawal symptoms and 'craving'
   i.e. ... physical dependence and,

d. loss of control."

Whereas Alpha and Beta alcoholism might not progress,

in Gamma alcoholism there is a definite progression from destructive, personally and socially, and is typical of the patients seen in American clinics and in Alcoholics Anonymous (A.A.) groups.

4. Delta alcoholism: included the first three characteristics described in Gamma alcoholism as well as a marked form of the fourth characteristic instead of loss of control there is inability to abstain. "Alcoholics who can control the amount of intake but cannot abstain." Alcoholics who can control the amount of intake but cannot abstain are common in the wine drinking countries, such as France.

5. Epsilon alcoholism: described by Jellinek as periodic alcoholism. He further states that whether it is

a disease per se or the symptom of an underlying disease cannot be asserted at our present state of knowledge. Pseudoperiodic alcoholism or pseudoepsilon alcoholism is a relapse into a disease,
but... the occasion for the relapse is a voluntary one and does not form a part of the disease process, except perhaps in a psychopathological sense.

Chafetz and Morris (12) pointed out that

although Jellinek's study of alcoholism definitions is scholastically valuable, it perpetuates the trend to categorize alcoholics into static groups. ... it is more important to visualize alcoholism as arising from multiple and varied components which overlap.
CHAPTER II

REVIEW OF THE LITERATURE

Attitudes toward alcoholism and the alcoholic

The study of alcoholism is complicated by a lack of understanding and knowledge. As pointed out in the preceding chapter there is not even agreement as to the definition of alcoholism. The etiology of it presents as many various opinions. The following paragraphs are presented in an attempt to convey to the reader some of the history in the treatment of alcoholism. By the history the reader will be able to understand the attitudes that were present. The attitudes toward alcoholism are undergoing a metamorphosis; the attitudes that exist have been damaging to the alcoholic and his family and have retarded rehabilitation and earlier treatment. Damage is usually extensive before society reacts. Alcoholics have been shunned, many times by the medical profession, morally condemned, and punitively treated. The evolution toward more humane, empathetic understanding and acceptance of the alcoholic as a human being in need of help, is in process. Changing attitudes, as studies have indicated, is most difficult and this will be discussed more thoroughly later in this chapter. The attitude of the public toward alcoholism has been reflected in the laws
attempting to control the alcoholic, and in the medical treatment prescribed for the alcoholic. Some of the earlier laws in United States history dealing with the use of alcohol mentioned by Gordon (21) include the following:

the early reasons for legislature regulations regarding liquor were mainly for revenues, then later, to encourage sobriety among the Indians, then the Negroes, then the working class.

Friends in Pennsylvania and New Jersey adopted a resolution against intemperance in 1650.

Probably the strongest impetus given to the founding of the organized temperance movement was caused by the publication, The Effects of Ardent Spirits Upon the Human Mind and Body, written by Dr. Benjamin Rush of Philadelphia, the only physician to sign the Declaration of Independence. Many medical men as well as thousands of the laity were converted to the temperance ideal through the publication of this essay in 1785. (53)

The first national recognition by Congress of the United States regarding alcoholic liquors was brought to light through the enactment of a law giving every soldier in the army one-fourth pint of rum, brandy, whisky, daily as an established ration in 1790. (21)

During the Civil War period (1869), alcoholic consumption increased which also increased post war agitation on the subject. It was during the Civil War that Dr. Leslie Keeley became interested in investigating the effects of alcohol on various individuals. He became
convinced that alcoholism was a disease. Soon after settling in Dwight, Illinois he began searching for a cure. (28)

In 1836 The American Temperance Society was merged into the American Temperance Union which took the stand of total abstinence, and in reality should have changed its name to the American Abstinence Union.

Up to 1940, the opinion among many was that nothing could be done for the drunkard. Therefore, the goal of the Union was to keep the non-alcoholics from becoming alcoholic. The implied indifference to the alcoholic was epitomized by Edwards (1822) "Keep the temperate people temperate; the drunkards will soon die and the land will be free." (38)

1840: The Washington Temperance Society was formed and remained strong until 1845 when the decline of the movement became evident.

1870: Association for the Study of Inebriety was organized.

1930: The Research Council of Problems of Alcoholism was formed.

1930: Specific program of studies on alcohol at Yale developed.

1935: Founding of Alcoholics Anonymous
The attitudes reflected throughout history, toward the alcoholic, of a moralistic and punitive nature are still present even though measures are being taken to understand the true nature of alcoholism and attempts to educate the public to this are in progress. The change toward therapeutic attitudes is slow and will continue to be so. However, with the increasing number of alcoholics and the courts' increasing awareness that the alcoholic is not a legal problem and the attempts made to change the laws, perhaps then the alcoholic will be treated as a human being in need of help. Perhaps then society will try to provide the help he needs rather than morally shun him and alienate him from society.

Lyndon B. Johnson in his message to Congress in March 1966 made the following statement which greatly aided the therapeutic approach to alcoholism.

The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment. Even with the present limited state of our knowledge, much can be done to reduce the untold suffering and uncounted waste caused by this affliction. I have instructed the Secretary of Health, Education and Welfare to:

Appoint an advisory committee on alcoholism. Establish in the Public Health Service a center for research on the cause, prevention, control and treatment of alcoholism. Develop an educational program in order to foster public understanding based on scientific fact. Work with public and private agencies on the state and local level, to include this disease in a comprehensive health program. (26)
The problem of alcoholism in California is quite large, being the tenth leading cause of death at all ages and accounts for one-fifth of all admissions to State Hospitals. After several years experience with pilot programs, California developed a long range plan for the prevention, treatment and control of alcoholism. With the support of Governor Brown, it was enacted into law in 1965 by a forward looking legislature as the McAteer-Rumford-Marks Act. (10)

The law recognizes the State Department of Public Health as the responsible State alcoholism program agency through the Division of Alcoholism. It provides for comprehensive, community alcoholism programs offering a wide range of services to individuals and communities. (10)

Individuals with drinking problems may receive diagnosis, evaluation and referral services; medical care and counseling, both emergency and long range care, rehabilitation and employment. The community has continuing measurements of local alcohol programs and resources; development and coordination of local programs; consultation with other agencies and groups, and public information and education in the community. (40)

With the development of these types of programs and the education of the public with the correct information on alcoholism, hopefully in time the attitudes will be changed toward the alcoholic and the road to recovery will begin before Jellinek's Gamma phase is reached,
However, the review of the literature on attitudes and attitude change indicates the many variables and mediators that influence attitudes and makes changing them quite difficult.

Attitude and attitude change

The responses to this Alcoholism Questionnaire are based on attitude. Research on attitudes and attitude change indicate the following information.

In order to understand what is meant by an attitude, a discussion of definitions may help to clarify. Shaw and Wright (57) suggest the following definitions:

1. An enduring system of plus or minus evaluations, emotional feelings, and pro and con action tendencies with respect to a social object.

2. A mental and neural state of readiness organized through experience exerting a directive or dynamic influence upon the individual's response to all objects and situations to which it's related.

3. Attitude ... the evaluative dimension of a concept.

4. Attitude ... a relatively enduring system of affective evaluation reactions based upon and reflecting the valuative concepts or beliefs which have been learned about the characteristics of a social objective or class of social objectives. As an affective reaction, it is covert or implicit response.

Nunnally (44) suggested that "widespread 'bad' attitudes are not held because of existing information, but rather because of lack of it." Mcguire (51)
investigated the assumptions underlying the "socratic method" of persuasion, namely, that merely eliciting a person's beliefs in the direction of greater consistency.

1. Querying the individual's opinions on logically related issues as in the socratic method, results in a greater consistency of beliefs.

2. Individuals are more highly persuaded by messages arguing in a direction which increases consistency and are more resistant to those arguing in a direction which increases inconsistency of beliefs.

3. Changes produced through reduction of inconsistency on derivative unmentioned issues, while significant, are less than the amount to be expected from the logical method. Since any given belief is related to other beliefs, a message which leads a person to change his mind on one issue would, to the extent he is motivated to be consistent, change his mind on logically related but not explicitly mentioned issues. It seems reasonable, however, to predict that this effect will not be as strong as a change brought about by an explicit communication.

4. The preferred solution to a belief dilemma is one involving the least effortful path.
5. In resolving cognitive discrepancies, subjects seek not only the attainment of balance and consistency but also the solution that maximizes potential gain and minimizes potential loss.

Shaw and Wright (57) presented the dimensions of attitudes in these ways:

1. Attitudes are based upon evaluative concepts regarding the characteristics of the referent object and give rise to motivated behavior.

2. Attitudes are construed as varying in quality and intensity (or strength) on a continuum from positive through neutral to negative.

3. Attitudes are learned, rather than being innate or a result of constitutional development and maturation.

4. Attitudes have specific social referent or specific classes thereof.

5. Attitudes possess varying degrees of interrelatedness to one another.

6. Attitudes are relatively stable and enduring.

A relationship between attitudes and attitude change on the Galvanic skin response (G.S.R.) score was shown by Becker (6). He stated,

G.S.R. scores showed more relationship to attitude change than to retention. ... It indicates that G.S.R. may be a means of further exploring problems involved in persuasive communications and most especially, the relationship of dissonance to attitude change from communication.
For the purpose of transmitting new information, Nunnally (45) stated that,

strategy is not an important consideration. The type of information given to people will very much affect the attitudes that they hold, and consequently, the choice of information to communicate becomes an important aspect of attitude change and strategy.

Kendall (30) presented data on two factors affecting stability of response; namely, conflict and mood. Attitudes are learned through a combination of underlying predispositions and their consequences for action constitute an individual's orientations. Campbell (11) stated that "These orientations represent clusters of phenomenally related social attitudes with their component beliefs, feelings, values, standards, and performance." Kendall (30) also found that psychological conflict is created by the question in tests and surveys.

The respondents appear to experience certain questions as requesting a choice between beliefs held with equal firmness or between values considered sacred. Such requests are obviously difficult to fill.

Suchman (62) noted

there is a curvilinear relationship between position on an attitude continuum and the intensity with which the attitude position is held. This relationship is U-shaped: those at the extremes of the continuum hold the attitude with greater intensity than do those in a middle position.

Kendall's (30) finding suggests,

there is a curvilinear relationship between position on an attitude continuum and stability of response. But the relationship
is exactly opposite to the intensity curve. We expect that those who are at the extremes will be most stable, while those in a middle position will be least so.

The two findings might be considered to be complimentary.

If private attitudes and public ideology do not agree, a conflict situation seems to arise. Kendall (30) considers this a variant of goal conflict in the sense that the individual wants to conform to the social norms specified in the ideology; but he wants at the same time to behave in the way implied by his attitudes. Elmira (17) studied the effect of conflicting loyalties on attitudes. Individuals who find themselves pulled in different directions have a difficult time deciding definitely how to respond; their intentions are not stable. Kendall (29) reported respondents can express their difficulties in a variety of ways. One such way is in certain forms of behavior, as the length of time it takes him to choose between the alternatives; vacillation between alternatives; erasure marks; refusal to answer a question; insistence on giving qualified answers.

Expressions of opinion or attitudes evaluated in the light of different levels of interest or information need also to be evaluated with other variables in mind. Investigators have become aware of the influence of seasonal variations, among other, in opinion on various issues. Recently, awareness of the effect of these mood
changes in the respondent at the time of the interview or test is gaining in importance among clinical workers. We are all aware of the mood changes that we experience and sometimes are even aware of the effect they have on us. Optimism is usually present if we are in a good mood and the converse is usually true if we are in a "foul" mood. This variable was undoubtedly present with some of the respondents to the alcoholic questionnaire in this study. For example, the following question, "Most alcoholics have no desire to stop drinking" could have produced various responses to it by the same person at the pre and post test. At the pre test if the spouse of a practicing alcoholic (continued to drink) read this question after a rather unpleasant encounter with the alcoholic spouse who has been unable to stop drinking and who does not register any positive action to try and stop drinking, there is a good chance that the non alcoholic spouse may answer the "agree" side. On the other hand if a spouse has recently seen the alcoholic spouse experience withdrawal and vigorously attempt to function in society and home and is no longer hostile but loving and kind, then the response would most likely to be placed on the "disagree" side. In support of this, Kendall (30) has found

mood is an effective internal pressure bringing about changes in attitude. Moods are not usually generated, however, if we could trace them back we would usually find that a bad mood develops as the result of some external event.
Communication mediators

Hovland (23) and his associates found that mood changes can distort experimental results, especially when the individual serves as his own control. As they explain, further possible difficulty with using each man as his own control is that obtained shifts in response due to transient mood changes may be correlated with evaluations of the film, giving rise to a spurious factor in the analysis.

It would appear according to both Kendall (30) and Hovland (23) that a pleasant mood will produce associative responses having positive attitudes; and unpleasant mood will produce associative responses having negative attitudes.

An additional dimension to be included on attitudes is the effect the interest and concern of the respondent will have on his attitude. The person without interest is likely to give perfunctory responses. If he has not given previous thought to the topic about which he is questioned, it is very unlikely that he has any real answers at all that can be considered a response to the situation than to the specific question. It is not difficult to see that perfunctory responses are unstable. (30) This emphasizes the importance of interest and concern also known as the "selective process." Klapper's (31) studies on mass communication and attitudes, mentioned the mediating factors that are involved in the effect of mass communication on attitudes. He mentions as the most basic of these mediators audience "predispositions" and their
tendency toward or against some view of some mode of behavior. Selective processes can be divided into three groups; selective exposure, selective retention, and selective perception.

Selective exposure is the process of exposing oneself, if given the choice, to mass communication, lectures, and meetings that is in accord with their interests and views rather than not in accord with them. Berelson, Lazarsfeld, and McPhee (8) found that during political campaigns partisans chose much more frequently to expose themselves to communication from the candidate or party of their choice rather than the opposition. Various other studies by Schramm and Carter (54), Star and Hughes (61) provide confirmatory findings.

Recall or retention of communication is also influenced by selectivity: frequently people were found to recall material they were in agreement with more efficiently than the material with which they disagreed. It was also found that unsympathetic material was more easily forgotten. Levine and Murphy (35) studied this tendency in 1943 and were followed by a reinforcing study by Zimmerman and Bauer (69) in 1956.

Selective retention according to Klapper (31) demonstrates how "selectivity functions in a way that increases the likelihood of its serving a conversion of even a corrosive function."
Klapper (31) indicates that the term selective perception is somewhat of a misnomer, since it refers in fact to what people make of what they recall from what they see or hear. A better term would be reinforceive interpretation, but whatever the term it refers to a simple fact that is perennially startling: people tend to misperceive and misinterpret unsympathetic communications material in such a way that it becomes for them a statement in support of their own view.

This was documented in the classic study of Allport and Postman in 1945 (2) on rumor and its social transmission. Among the most significant findings of their study was a picture of an altercation between a white and black man. The white man was holding an open razor. As the picture was described by person after person in a chain, only the first of whom has seen the picture, the razor shifted to the hand of the black man.

A more recent study by Katz and Feldman (27) noted among viewers of the Kennedy-Nixon debates that viewers had a tendency to ascribe recalled statements with which they disagreed to the candidate they opposed even if he is not the one who made the statement. Again, selective perception influences the effect of mass communication as does selective exposure and selective retention, by a reinforceive function and less likely as a conversion function.

These three selective processes are, of course, external to the communication but are imposed upon the
According to Klapper (31) they modify the communication process by mediating the effect of the communication upon the attitude of the beholder, and they do so, as has been indicated, in such a way as ordinarily to render mass communication an agent of reinforcement rather than an agent of conversion.

Social mediators

Two other mediators which are social in origin are: (1) groups and group norms, and (2) the process of opinion leadership or personal influence.

Group-engendered attitudes derive, in fact, from group norms, and the group opinion, thus directing the selective processes through which the individual reacts to mass communication. (31)

Lazarsfeld, Berelson, and Gaudet (34) conducted a study in 1948, now considered a classic in this area, The People's Choice, dealing with how the voter made up his mind for whom to vote in the presidential election. This study offered an excellent example of the political homogeneity when at the end of the election campaign of 1940, absolute homogeneity reigned in 96 percent of the families of respondents who voted. Of 413 such persons, only 17 reported that any member of his family voted differently than he did. In 396 cases, the family managed to resolve all differences it may have had during the campaign. Less overwhelming, but nevertheless marked homogeneity was observed among co-workers and among members of formal organizations. Both formal and informal
group exposure intensified selective exposure by making the members aware of sympathetic communications and serve as a secondary arena for transmission of the contents of such communication.

Drifters from the group return to the "field" when the group and the communication redefine the group norms. McKeachie (1954) has demonstrated, for example, that group discussions of controversial communications will lead members to attitude changes that can best be described as a return from the periphery to the center of sanctioned opinions - a kind of canceling out of the minor attitude changes short of conversion. (41)

The mediator of personal influence or opinion leadership according to Klapper (31) lie in the fact that in reference to decisions in various areas of attitude and behavior people have been found to be influenced by specific individuals as strongly or more strongly than they have been influenced by mass communication.

Lazarsfeld, Berelson, and Gaudet (34) cite this concept in The People's Choice. Where opinion leadership exists, it has been found typically much involved with mass communication. Klapper (31) also found that the opinion leader is also typically an embodiment of the group norms. His very success as an opinion leader lay in the fact that his advice paid off; it provided the followers satisfaction in terms of shared values of the informal groups to which both leader and follower belonged.
Mass communication usually reinforces rather than converts, however; when conditions of a typical situation exist or mediating factors break down, the reverse of direction of mediation may be found. And then conversion takes place. Studies confirming this were conducted by Schramm and Riley (55), and Annis and Meier (4).

**Implications for this study**

Review of the literature on attitudes for this study on Changes in Response to an Alcoholism Questionnaire, both pre and post test, is beneficial in alerting the investigator to the many variables present within the population and the effects which these variables may have on the responses of the members of the class. Whether the communication be considered mass, lecture, informative, or group, the mediating factors will be present and the selective responses will function. This study will measure change only in nine factor areas of the forty question test. The communication to the population of this study was in the form of lecture, (informative, authorative, and personal) films, group discussions, role playing, and opinion leaders. Many of the members were exposed to communication on alcoholism outside the experimental milieu through Alcoholics Anonymous, C.A.R.D., social work, rehabilitation homes, hospitals, rehabilitation programs, television programs, and newspaper and magazine articles—
all of these factors influencing the attitudes of the members or being instrumental in the formation of attitudes.
CHAPTER III

DESIGN OF THE STUDY

The population studied

The sample study consisted of 313 members of the pilot class on Counseling on Alcoholism and Related Disorders (Public Health X 420.1) offered through University Extension Division of the University of California, Los Angeles during the Fall Quarter, September 17, 1968 to December 10, 1968.

This class was selected because it was the first class of this type ever given. In addition, the class instructor was willing to make the alcoholism questionnaire results available to the author who was also a member of the class.

The pre test was administered September 17, 1968 and the post test was administered December 10, 1968.

Each member of the class was asked to explain in detail on the last attached page of the pre test, "Why you are or wish to be a counselor on alcoholism and related disorders." From this explanation the class was grouped into categories. (See Table I)
### TABLE I

**COMPOSITION OF CLASS**

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gave no information</td>
<td>5</td>
</tr>
<tr>
<td>Recovered alcoholic</td>
<td>221</td>
</tr>
<tr>
<td>Cure attributed to A.A.</td>
<td>155</td>
</tr>
<tr>
<td>Cure attributed to conditioned reflex</td>
<td>1</td>
</tr>
<tr>
<td>Cure attributed to psychoanalysis</td>
<td>1</td>
</tr>
<tr>
<td>Method not mentioned</td>
<td>64</td>
</tr>
<tr>
<td>Alcoholic in family</td>
<td>26</td>
</tr>
<tr>
<td>No experience with alcoholism</td>
<td>91</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>343</td>
</tr>
</tbody>
</table>

(30 did not continue the class and therefore were not used in this study as they did not take the post test)

Further information of the class composition is as follows:

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wants to help, no formal training</td>
<td>189</td>
</tr>
<tr>
<td>Have unused college degree</td>
<td>30</td>
</tr>
<tr>
<td>Now working as a counselor with the following agencies</td>
<td>134</td>
</tr>
<tr>
<td>Teen Post Program high school, college</td>
<td>9</td>
</tr>
<tr>
<td>Employee counselor</td>
<td>27</td>
</tr>
<tr>
<td>Probation, welfare, courts, jail</td>
<td>15</td>
</tr>
<tr>
<td>Acute hospital</td>
<td>10</td>
</tr>
<tr>
<td>Out patient</td>
<td>6</td>
</tr>
<tr>
<td>Recovery hospital</td>
<td>11</td>
</tr>
<tr>
<td>Job placement</td>
<td>9</td>
</tr>
<tr>
<td>Health agency</td>
<td>9</td>
</tr>
<tr>
<td>Performs some individual counseling as part of professional role</td>
<td>32</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>7</td>
</tr>
<tr>
<td>Medical Doctor</td>
<td>4</td>
</tr>
<tr>
<td>Clergy</td>
<td>10</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>3</td>
</tr>
<tr>
<td>Marriage counselor</td>
<td>3</td>
</tr>
<tr>
<td>Hypnotist</td>
<td>2</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Public educator</td>
<td>3</td>
</tr>
</tbody>
</table>
Methodology

For the purpose of this study, data were obtained from the pre and post test responses to the Alcoholism Questionnaire. This questionnaire is the outcome of a factor analytic study of opinions about alcoholism developed by Marcus (36). As a result of that study, nine "areas of opinion" were isolated and these were considered to represent the major dimensions of popular opinion about alcoholism. Four items were selected to define each of these dimensions and, with four additional items, these comprise the final 40-item revision of the Alcoholism Questionnaire. The last four additional items were deleted from consideration in this present study. The factors, defining items, and interpretation of the Alcoholism Questionnaire are explained in Table II. (65)

<table>
<thead>
<tr>
<th>IDENTIFICATION WITH ALCOHOLISM</th>
<th>NUMBER</th>
<th>PERCENT OF TOTAL GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Significant Other</td>
<td>23</td>
<td>7.3</td>
</tr>
<tr>
<td>2. Wants to Help</td>
<td>24</td>
<td>7.7</td>
</tr>
<tr>
<td>3. Professional Counselors</td>
<td>57</td>
<td>18.0</td>
</tr>
<tr>
<td>4. Recovered Alcoholic</td>
<td>59</td>
<td>18.8</td>
</tr>
<tr>
<td>5. Alcoholics Anonymous</td>
<td>149</td>
<td>47.6</td>
</tr>
</tbody>
</table>
The class was arranged into five groups. The members classified themselves and the composition of the groups as defined on page 41. The responses to the pre and post questionnaire were tabulated and the changes within the group to the nine factors were compared. The five groups were then compared in the same way in relation to each other.

The critical ratio of 1.96 at the five percent level was used to determine whether or not there was a significant difference in the t test score for each group in each factor. Biostatistical measurements used are found in Basic Statistics by Dunn. (16)

Administration of the questionnaire

Each member of the class received a copy of the Alcoholism Questionnaire, as they entered, on the first meeting of the class. The standardized instructions were administered to the class as a whole. (See Appendix A.)

No major problems were encountered in administering the questionnaire. However, some persons had difficulty in understanding the "scale." They were instructed to re-read that portion of the instructions which explained the seven choices; this range of choices gives the respondent an opportunity to express his opinion more accurately than would be possible with the typical
"agree-disagree" form. They were instructed to "Answer the question in terms of what you think it most probably means." Under no circumstances did the instructor try to interpret an item for the respondent. Any question was answered by referring to the appropriate part of the instruction.

Total time for the administration of the questionnaire was 15-30 minutes.

Scoring

An individual could obtain a score of from 1 to 7 on each of the forty items. If he completely disagreed with an item he would mark "1"; "2" if he mostly disagreed with it and so on. The four items used to measure each of the factors are shown in Table II (column 2). (62) The total score for each factor was arrived at in the following way:

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>DEFINING ITEMS</th>
<th>RESPONSES PRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>7, 19, 28, 36</td>
<td>6, 6, 2, 3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>RESPONSES POST</td>
<td>TOTAL DIFFERENCE</td>
</tr>
<tr>
<td>17</td>
<td>6, 7, 5, 5</td>
<td>23 +6</td>
</tr>
</tbody>
</table>

Recording the data

The factor scores for each individual were tabulated in the order in which they appear on the questionnaire.
This was done on both the pre and post test. The difference between the pre and post test was also recorded.

For example:

GROUP I

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>PRE TEST SCORE</th>
<th>POST TEST SCORE</th>
<th>DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>17</td>
<td>23</td>
<td>-6</td>
</tr>
<tr>
<td>2.</td>
<td>27</td>
<td>18</td>
<td>+9</td>
</tr>
</tbody>
</table>

If the pre test score was more than the post test score the difference would carry a minus sign. This applied to all factors. A data sheet was prepared for each factor, and the responses were then recorded. These were then key punched onto separate cards for each individual and then collated into the five groups. The statistical mean, standard deviation, and t test score was then computed for all groups. These results are presented in Table III, IV and V.

Presentation of the data

The items used in this type of questionnaire are definitely opinion (and not information) statements; there are no "right" or "wrong" answers. Different groups in the population will show different degrees of agreement and disagreement with the factors. For this reason, the factor scores for any group become meaningful only
in comparison with some other group or possibly with respect to an arbitrary criterion of "what we would like people to believe." It may be interesting to compare a group of average adults with a group of "experts"; in comparing professional groups; and in comparing groups having different kinds of exposure to alcohol education; and so on. (38) This is in essence what was done in this study. However, keeping in mind that the selection criteria was up to the individual, the groups are not pure. Individuals may have been able to fit into several groups. For example, a professional may be placed in the "Significant Other" group if he failed to mention that he had a profession. Table IV presents the pre and post mean factor scores for five groups of people from whom data was obtained.
Limitations in this method of investigation

The study employed a standardized opinion attitude questionnaire. Therefore, it has the same advantages and disadvantages of other studies using this type of instrument.

One advantage of using this type of methodology is the availability of the instrument. Also, "each subject acts as his own control and consequently, the power of statistical tests is high." (45)

The disadvantages include the probability that "the before-after design probably sensitizes the subjects to certain features of the communication." (45) A second weakness mentioned by Nunnally (45) is that subjects tend to remember their "before" response and the "after" response is affected by it.

The subject may change his responses on the "after" questionnaire just to help the experimenter, or if he is recalcitrant, he may not change his response even if the communication was effective. (45)

Another limitation of this study was the problem of the selection criteria being too broad. The instructor of the class would not permit use of a background information form. Administration of a background information form, he felt, may act as a threat to some of the class members. Names were given on the pre and post test but were removed by the time this investigator received the matched pre and post test data.
The variety of background and experience of the population being measured, presented many variables. For example, the groups measured were 23 Significant Others, 24 Wants to Help and No Information, 57 Professional and Counselors, 59 Recovered Alcoholics (who may or may not belong to A.A.) and 149 A.A. The members of the groups were placed in the group according to the most predominant label they gave to themselves. They may be placed in Significant Other group and also be able to fit into the Professional and Counselor group. The fact that they attended the class is an assumption that they Want to Help. Other uncontrolled variables, as far as the grouping, include sex, age, race, experience with the problem of alcoholism. Another varied exposure which took place within the educational milieu was small group experience. After the lecture part of the class, everyone reported to their group meeting. An attempt was made by the instructor to include in the group an A.A., Recovered Alcoholic, Professional, Significant Other, Wants to Help and a leader chosen by the class instructor. Most of the groups had a larger number of A.A. members, and the leaders would many times have to try and prevent the meetings from turning into A.A. meetings.

Another problem was that some of the respondents missed marking some of the questions. In a few cases a
whole page was skipped. Any question not answered was recorded as "0".

It was assumed that the same degree of interpretative error probably existed in both the pre and post test responses.
CHAPTER IV

ANALYSIS OF THE DATA

Pre and post test responses to an Alcoholism Questionnaire designed by A.M. Marcus (37) were selected to determine if an educational experience in this area would elicit a change in attitudes toward alcoholics and alcoholism. The purpose of this study was to examine the null hypothesis: there will be no significant change in response to the alcoholism questionnaire from September 17, 1968 to December 10, 1968 and the alternate hypothesis: the subgroups will have no significant difference in the pre and post measure or in degree of change within the nine factors measured.

Analysis of the pre and post test responses showed no significant difference of the critical ratio 1.96 at the five percent level. Subgroups showed no significant differences in the pre and post measures nor in degree of change within the nine factors measured, see Table II. (12) However, of the 313 statistically applied tests examined, only five were significant at the five percent level again at 1.96 critical ratio. It was assumed that the ratio (5/313) could occur as a result of error. Reasons for these five changes could be due to:

1. Misinterpretation of test instructions by the students.
2. Mood changes which may distort experimental results, especially when the individual serves as his own control.
3. Selective exposure as discussed in the review of the literature.
4. Various communication and social mediators which were also discussed in the review of the literature.

These five changes occurred within the groups in the factors in the following way:

1. Significant Other - no significant change in any of the nine factors.
2. Wants to Help - showed change in factors 3 and 8.
3. Professional and Counselor - showed change in factors 6 and 8.
4. Recovered Alcoholic - showed no significant change in the nine factors.
5. Alcoholics Anonymous - showed change in factor 3.

Two of the groups had differences in factors 3 and 8 and one showed a difference in factor 6. Factor 3 concerns prognosis for recovery. A high score indicates the belief that most alcoholics do not and cannot be helped to recover from alcoholism. Factor 6 deals with the social status of the alcoholic. A high score indicates
the belief that alcoholics come from the lower socio-economic strata of society. Factor 8 deals with alcoholism as a harmless voluntary indulgence. A high score indicates the belief that the alcoholic is a harmless heavy drinker whose drinking is motivated only by his fondness for alcohol. See Table III for more information on the t test scores. Table II explains the factors, while Table IV shows mean scores, and Table V shows the standard deviations of test responses. (62)

Follow-up studies on future classes on Counseling on Alcoholism and Related Disorders may produce differing results if selection criteria for groupings of the class populations are more precise. The various uncontrolled variables such as various prior exposures undoubtedly had an effect on the results. Another possibility for a study with a class such as this, would be to review, in a few years, the effectiveness of counselors trained in this type of educational program.
### TABLE III (63)

**SCORING KEY FOR THE ALCOHOLISM QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>DEFINING ITEMS</th>
<th>INTERPRETATION</th>
<th>EXPERTS' POSITION*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotional difficulties as causes of alcoholism</td>
<td>7, 19, 28, 36</td>
<td>A high score indicates the belief that emotional difficulties or psychological problems are an important contributing factor in the development of alcoholism.</td>
<td>High</td>
</tr>
<tr>
<td>2. Loss of control</td>
<td>6, 16, 27, 32</td>
<td>A high score indicates the belief that the alcoholic is unable to control his drinking behaviour.</td>
<td>High</td>
</tr>
<tr>
<td>3. Prognosis for recovery</td>
<td>9, 12, 30, 37</td>
<td>A high score indicates the belief that most alcoholics do not, and cannot be helped to recover from alcoholism.</td>
<td>Low</td>
</tr>
<tr>
<td>4. The alcoholic as a steady drinker</td>
<td>1, 11, 25, 35</td>
<td>A high score indicates the belief that periodic excessive drinkers can be alcoholics. A low score indicates the belief that a person must be a chronic excessive drinker in order to be classified as an alcoholic.</td>
<td>High</td>
</tr>
<tr>
<td>5. Alcoholism and character defect</td>
<td>2, 18, 26, 34</td>
<td>A high score indicates the belief that the alcoholic is a weak-willed person.</td>
<td>Low</td>
</tr>
</tbody>
</table>

*Professionals working in the field of alcoholism*
### TABLE III

**SCORING KEY FOR THE ALCOHOLISM QUESTIONNAIRE (cont'd)**

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>DEFINING ITEMS</th>
<th>INTERPRETATION</th>
<th>EXPERTS' POSITION*</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Social status of the alcoholic</td>
<td>4,14,22,31</td>
<td>A high score indicates the belief that alcoholics come from the lower socioeconomic strata of society.</td>
<td>Low</td>
</tr>
<tr>
<td>7. Alcoholism as an illness</td>
<td>8,13,29,38</td>
<td>A high score indicates the belief that alcoholism is not an illness.</td>
<td>Low</td>
</tr>
<tr>
<td>8. Harmless voluntary indulgence</td>
<td>3,15,21,33</td>
<td>A high score indicates the belief that the alcoholic is a harmless heavy drinker whose drinking is motivated only by his fondness for alcohol.</td>
<td>Low</td>
</tr>
<tr>
<td>9. Addiction liability</td>
<td>10,20,24,40</td>
<td>A high score indicates the belief that alcohol is a highly addicting substance</td>
<td>High</td>
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</table>

Additional items: Not measured in this study

*Professionals working in the field of alcoholism*
TABLE IV
T-TEST
DIFFERENCE BETWEEN PRE AND POST

CRITICAL RATIO
1.96 @ 5% LEVEL

<table>
<thead>
<tr>
<th></th>
<th>V1</th>
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<th>V6</th>
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<th>V8</th>
<th>V9</th>
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<td>-0.59</td>
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<td></td>
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<tr>
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### TABLE V

**MEAN FACTOR SCORES FOR FIVE SAMPLES**

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TABLE V
MEAN FACTOR SCORES FOR FIVE SAMPLES

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<td>N = 149</td>
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CHAPTER V
SUMMARY AND CONCLUSION

This study was an investigation of the pre and post test responses to an Alcoholism Questionnaire administered to 313 members of a pilot class on Counseling on Alcoholism and Related Disorders offered through the University of California, Los Angeles, Extension Division. The investigation had as its premise, that an educational experience would not have any effect on changing attitudes toward alcoholism.

To determine whether or not any change occurred, 313 pre and post test responses to an Alcoholism Questionnaire were compared using the t test. Results showed there were no significant changes at the five percent level of the critical ratio of 1.96, between the pre and post test responses. Out of 313 tests, only five were significant at the five percent level of 1.96 critical ratio; two in factors three and eight, and one in factor six. It was assumed that this ratio, 5/313 could occur as a result of error or by chance. The following are the five changes found among groups. (See Table II, Column 1 for explanation of factors.)

1. "Significant Other" - no significant change in any of the nine factors.
2. "Wants to Help" - showed change in factors 3 and 8.
3. "Professional and Counselor" - showed change in factors 6 and 8.
4. "Recovered Alcoholic" - showed no significant change among the nine factors.
5. "Alcoholics Anonymous" - showed change only in factor 3.

At this time there is no basis for specifying lack of significant differences between pre and post test responses. These findings raise the crucial question of why no change occurred or no differences existed between the groups. One would imagine that a learning experience such as this pilot program would create more differences in the pre and post test responses but many factors may have prevented this, such as:

1. Biases on the part of the instructor and some class members. The instructor appeared to exhibit strong biases toward some of the professionals who spoke to the class. Invariably he would point out the weaknesses of the professionals who spoke to the class and more often than not register approval of the lay speakers. The instructor also admitted that he was in the embryonic stage of knowledge on alcoholism and group and sensitivity
encounter groups. His first group experience was with this class. This point is made to clarify the point that some of the instructor's biases may have been conveyed to the class members.

2. Prior knowledge of the subject of alcoholism. The class was composed largely of people who have been interested, professionally or personally, in the field of alcoholism for many years. This interest was acquired in many ways: some were recovered alcoholics who have worked in the field of alcoholism control, some had spouses who motivated their interest in alcoholism, while others were professionals who specialized in counseling, treatment, and rehabilitation of alcoholics.

3. There was no attempt to stress change except in open-mindedness toward methods of treatment. The instructor stressed the need for the class members to recognize other currently available and experimental methods of treatment. Many biases were noted and rigidity of attitude appeared especially strong among members of Alcoholics Anonymous. However, more open-mindedness was noted among many of the members in the last quarter.
4. Stress and reinforcement of particular approaches to the study and treatment of alcoholism: although open-mindedness was stressed, there still appeared to be more support offered to the Alcoholics Anonymous method. One of the class members, who carried an aura of influence in the field of alcoholism and who was a strong guiding force in this class, still appeared to carry biases for the Alcoholics Anonymous approach.

5. The method used for group selection would prevent future groups from being pure and thus effecting the group results. Group selection was based on the label the class member assigned to himself.

As with most pilot programs, much was learned by the instructor and those responsible for the planning of this course. One of the areas that this pilot program established was which subjects to include and which to delete. The course was generally considered a success and did appear to meet one of its goals by combining efforts of lay and professional groups in creating more open-mindedness within each group and between the two large groups concerned with alcoholism.
This study supports Nunnally's (44) statement that it is more difficult to change attitudes than to increase knowledge.
BIBLIOGRAPHY


26. Johnson, Lyndon B.: Message to the Congress. Delivered as a part of the President's Annual Health and Education Message to the Congress of the United States of America on March 1, 1966, in Alcohol and Alcoholism, Public Health Service Publication 1640.


40. McAteer, Rumford, Marks Act: Senate Bill 1279; California State Legislature, 1965 Session.


63. The Alcoholism Questionnaire: Administration, Scoring, and Interpretation from Schoettlin; Charles, 1968.


INSTRUCTIONS

On the following pages you will find a number of statements about alcoholism. We want to know how much you agree or disagree with each of the statements. To the right of each statement you can find a rating scale:

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

The points along the scale (1,2,3, . . . 7) can be interpreted as follows:

1. Completely disagree
2. Mostly disagree
3. Disagree more than agree
4. Neutral
5. Agree more than disagree
6. Mostly agree
7. Completely agree

The use of the scale can be illustrated with the following statement:

"There are very few female alcoholics".

If you agreed completely with this statement, you would place a mark in column 7. If you agreed slightly with the statement, you would place a mark in column 5. If you mostly disagreed with the statement, you would place a mark in column 2. In this manner you can indicate the extent to which you agree or disagree with each of the statements on the following pages.

Like everyone else, you will probably feel that you do not know the answer to some of the statements. When this occurs please make the best guess you can.
Please make your marks inside the agreement or disagreement boxes of the scales. Do it like this:

<table>
<thead>
<tr>
<th>Disagree</th>
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<tbody>
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Do not do it like this:

<table>
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<th>Disagree</th>
<th>Agree</th>
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<tr>
<td>6</td>
<td>7</td>
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</table>

Please make sure that you make a mark for each statement. Leave none of the statements blank and make only one mark for each. You should not spend more than a few seconds marking each statement. If it is difficult for you to make up your mind, make the best guess that you can and go on to the next one.
SAMPLE OF ALCOHOLISM QUESTIONNAIRE

Name ____________________________

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<tr>
<td>2.</td>
<td>Most alcoholics have no desire to stop drinking.</td>
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</tr>
<tr>
<td>3.</td>
<td>The average alcoholic is usually unemployed</td>
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<td>4.</td>
<td>A person can inherit a weakness for alcohol.</td>
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<td>5.</td>
<td>The alcoholic is helpless to control the amount of alcohol he drinks.</td>
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<td>Alcoholics usually have severe emotional difficulties.</td>
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<td>7.</td>
<td>The alcoholic drinks excessively mainly because he enjoys drinking.</td>
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