Alcoholism and Self-Concept

A Research Paper

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Table of Contents

Introduction

Much of the previous research on alcoholism has dealt largely with the disease concept of alcoholism (Mann, 1975, pp. 3-4). It seems that the relationship between alcoholism and self-concept has not been explored until recent times.

Before discussing alcoholism and self-concept, these terms must be defined. An alcoholic is a person suffering from a chronic disease caused by the ingestion of large quantities of the chemical alcohol over a long period of time (Walles, 1969, p. 19). The drinking of alcohol impairs, in varying degress, the person's life adjustment in terms of health, personal relationships, and/or occupational functioning (Coleman, 1976, p. 414). Valles states that the symptoms of the disease are: a need for alcohol, an inability to stop drinking after taking a drink, needing alcohol upon arising or to finish work, and withdrawal symptoms when one stops drinking, e.g., "the shakes". This "need" for alcohol seems to be physiological because it develops into what may be termed an "addictive need". This physiological need is intertwined in its psychological expression (Valles, 1969, p. 31).

Alcoholism is a unique disease. Schuster (1968) says:

> It is obviously not a disease in the same sense in which ulcers, diabetes, pneumonia, or scarlet fever are diseases; the doctor cannot put a bacillus under the microscope or take x-rays to "prove" his diagnosis to the patient.

He provides three reasons for this distinction. First, the patient usually does not seek treatment, in fact, he usually

rejects it. Secondly, there is no medicine or antibiotic as such for an alcoholic. Thirdly, friends and relatives often will not discover themselves that the person is an alcoholic. Alcoholism is not purely a physiological disease, nor is it purely a psychological diease, like a mental illness. Alcoholism is a "psycho-physical illness", to use Schuster's terminology.

Self-concept refers to the various images an individual has of himself. These images are derived from himself and his interactions with others. Eventually, the individual joins these many self-images into an overall, single idea called self-concept (Wilson, 1973, p. 8). These many self-images are classified by Middlebrooks as the five components of self-concept (1968, p. 103). They are: the material self, the actual or psychological self, the self as thinking and emotional process, the social self, and the ideal self. The material self consists of our physical body, and those possessions that are uniquely ours. The actual or psychological self is what one thinks of oneself when analyzing one's thoughts and ideas. The self as thinking and emotional process is one's own perception of of the process of experiencing. The social self is the self defined in one's interactions with others. The ideal self is the self one would like to be.

Middlebrooks also mentions five characteristics of self-concept (1974, p. 103). They are: the self is organized and consistent, the self is seen as the origin of behavior, the

self is separate and unique, the self evaluates the self, and the self seeks actualization. All of these characteristics and components previously mentioned are all part of the single overall idea called self-concept. This unitary idea is projected by the individual throughout his life. Middlebrooks (1974) supports this by saying, "The normal self, after all, is a cohesive whole fuctioning as a single unit and presenting a single image to those who view it at any given time" (p. 63). The term self-concept used in this paper will be more oriented to the social self and ideal self. Therefore, this paper will be concerned with the self in relation to interactions with others and in relation to the self one would like to be.

Is self-concept involved with alcoholism? This position can be seen clearly in the tenets of Alcoholics Anonymous (A.A.). A.A. points out that there is a power greater than self and that a favorable relationship with this power is discovered through "hitting bottom" and "surrender" (Bateson, 1971). "Hitting bottom" can be equated with a very low or poor self-concept and when it is low or poor enough, then the alcoholic is ready for help. This is illustrated by Ronald Terry (1976), an alcoholic, in his book The Long Suffering. He states:

> The one thing besides the need for money that inspires an alcoholic to give up drinking is the very thing that makes alcoholism such a sorry business to begin with. Sooner or later the serious drinker is going to come to the realization that he is a bum. (p.31).

Once this very low or poor self-concept has emerged for the alcoholic, he then "surrenders". He does so because he cannot tolerate himself and feels a compulsion to change. This process of "hitting bottom" and "surrender" occured to Bill W. in 1935. At that time he and Dr. Bob founded A.A. Since that time, self-concept is typically included in discussions of alcoholism.

If the above discussion on self-concept is correct, the question arises: Does motivation play a role in alcoholism? Motivation, for the alcoholic, will be understood to mean an inclination toward treatment (Robson, Paulus, Clark, 1965). This concept of motivation can be correlated with self-concept.

Again, if the above discussion on self-concept is correct, then a low or poor self-concept would imply that an alcoholic's motivation for treatment would be high. The alcoholic would have a favorable attitude, or positive motivation toward treatment. A high or good self-concept would imply that an alcoholic's motivation for treatment would be low or poor.

The hypothesis of this paper is that the self-concept of alcoholics who seek or accept help for their alcoholism is more negative and lower than those of alcoholics who do not seek or accept help. Mindlin, in 1964, conducted a study of alcoholism that will permit an exploration of this hypothesis. She stated that those alcoholics labeled as seeking or accepting help are distinguished by their involvement in A.A. and psychiatrically oriented clinics or hospital treatment cen-

ters. The self-concept of those alcoholics who do not seek or accept help for their alcoholism is more positive and higher than those who do. Mindlin furhter stated that those labeled as not seeking or accepting help are distinguished by the fact that they have had no prior involvement in A.A.

There are three implications of my hypothesis. First, an alcoholic must "hit bottom" and "surrender" before alcoholism can be controlled. Bateson (1971) lists many kinds of disasters which may cause an alcoholic to "hit Bottom" and cause "surrender". Among these are "...rejection by wife, loss of job, hopeless diagnosis...". All of these can be seen as destructive of the integrated self-concept. This disintegration is all the more plausible when one considers these events in light of Abraham Maslow's hierarchy of needs.(Zimbardo, 1976, p. 258). The previously mentioned disasters affect the physiological, safety, love, and esteem needs. This destruction of the self-concept would seem to enhance the alcoholic's motivation to seek help.

Secondly, alcoholics who volunteer for help in controlling alcoholism and admit that their drinking is out of control, are most successful in treatment programs. A final implication is that a treatment program, to be maximally effective, should try to improve the alcoholic's self-concept, along with eliminating his dependence on alcohol.

Logically, then, there should be a connection between self-concept and alcoholism. There does appear to be empiri-

cal evidence supporting a relationship between the two.

In a study conducted by Matefy, Kalish, and Cantor (1971), it was found that among alcoholics offered a rehabilitation program, help-acceptors exhibited a lower degree of self-acceptance on an adjective rating scale than help-rejectors. This study involved 65 male subjects who were members of a rehabilitational program for alcoholism at a Veterans Administration hospital. All of the subjects had a history of drinking problems. There were 33 subjects in the help-acceptor group and 32 in the help-rejector group. The instrument used to measure the degree of self-acceptance was a 52-item rating scale of self-descriptive adjectives, called the Index of Self-Acceptance. From this instrument a self-ideal discrepancy score was obtained. The mean self-ideal discrepancy score of help-acceptors was 62.2 and for the help-rejectors, it was 41.3.

Another study, conducted by Gross (1971), investigated whether significant changes in self-concept occured in 60 male alcoholic subjects. Self-concept was measured by the Tennessee Self-Concept Scale (TSCS). All of the subjects voluntarily participated in a 60-day rehabilitational program. The TSCS was given as a pretest and postest. Hatelling's modification of variance ratio for multivariate data was used to test for a significant difference between pretest and posttest means. Then a t-value was determined for each of the 11 subscales between the two groups (See Table 1 for results).

Insert Table 1 about here

Gross' conclusion was that the self-concept improved after treatment. The type of self-concept that changed was from a negative view of self to a more positive view. This was the type of change that should take place after treatment for the treatment program to be maximally effective.

In a third study conducted by Mindlin (1964), a newly developed 137-item attitude questionnaire was given to 155 non-psychotic alcoholics. This questionnaire was composed of sub-tests on motivation, attitude toward drinking and alcoholism, self-esteem, depencency, and social isolation. All the subjects were committed to one of two California hospitals for treatment of alcoholism. Those who had previously undergone psychotherapy, those who had previous A.A. experience, and those who had neither (the no-help group), were compared. Self-esteem was highest in the no-help group and lowest in the therapy group. Mindlin (1964) makes the following observation concerning the no-help group's higher self-esteem: "The no-help group's higher self-esteem (not supported by higher achievement) is seen as a factor militating against help."

These three studies, then, do support my hypothesis. They do so because in all three studies, some form of the self-concept was tested in relation to treatment for alcoholism. In all three, the perception of self was seen as being lower for help-acceptors than help-rejectors. No matter what

type of test of self-concept was used, this conclusion was obtained.

In the next chapter of this paper, studies, not dealing specifically with alcoholism and self-concept will be reviewed for the purpose of examining more closely my hypothesis and its implications. To accomplish this, most of the studies will be follow-up studies of alcoholics who have undergone treatment. In these follow-up studies, the major focus will be on the type of subject (help-seekers or acceptors as opposed to non-help seekers or acceptors), which type of subject was successful in treatment programs, and did self-concept improve after treatment. In addition, two studies dealing with the issue of motivation and alcoholism treatment programs, will also be reviewed. The purpose of this will be to determine to what extent motivation is involved with self-concept and also treatment programs. Hopefully, after reviewing a number of studies, a concensus opinion can be drawn to support the hypothesis and its implications.

Review

The next section of this paper entails a review of follow-up studies of the treatment of alcoholism. It must be remembered, from the previous section, what specifically this paper is seeking to demonstrate. In all the studies, the degree of their usefullness in this paper varies. Most will lend some support to my hypothesis and its implications. Most will also just deal with the treatment of alcoholics and a follow-up treatment. However, two studies to be reviewed will deal with the role of motivation in treatment.

Before beginning the actual reviewing, it would be helpful to examine the general structure of typical follow-up studies of alcoholism treatment. Most studies use some sort of alcoholism treatment program connected with a hospital, and tend to use males, the number of subjects varying. Many do not use a control group. Instead, the research centers around patients who have already been admitted to the hospital. There is usually a screening process, as all the patients cannot be used. Psychotic or neurotic patients are usually rejected. Before treatment begins some sort of pretest is given. These vary, but typically involve a preliminary diagnosis of the alcoholic's condition, classification of alcoholics, or some type of predictive measure concerning success or failure potential. An example of one type of test used is the Tennessee Self-Concept Scale developed by Fitts (1965). After the pretest, treatment follows. Treatment may involve the use of drugs,

such as disulfiram, or an antabuse. Both cause an alcoholic to become sick to his stomach upon alcohol intake. Treatment also may consist of individual or group psychotherapy, or A.A. In many, some sort of combination of the above mentioned forms of treatment are used. After treatment, the follow-up begins. The time interval between the conclusion of treatment and the beginning of the follow-up may vary. It can be anywhere from a couple of months to a few years. Some may even conduct follow-ups yearly or semi-yearly. To see how the structure of the follow-ups actually works, it would be helpful to examine one in detail.

The study to be examined was conducted by Norvig and Nielsen (1956). The subjects in this study consisted of 221 alcohol addicts admitted to the men's division of the Sanct Hans Hospital in the period from July 1, 1948 to December 31, 1950. They were admitted after treatment with disulfiram having been initiated.

Subjects were divided into three groups for the follow-up. Group I consisted of 42 patients who died during the study. Group II consisted of 40 patients about whom no follow-up data could be obtained. Group III consisted of 114 patients about whom satisfactory follow-up information was obtained.

The next section of the study involved a comparison with an earlier study conducted by Ellermann (1948). The results of the Norvig and Nielsen study were classified into three categories. The "good" post-treatment represented patients who showed no overindulgence in alcohol and were considered

socially rehabilitated.. "Fair" represented patients who were no longer addicted to alcohol, but were not considered socially rehabilitated. "Poor" represented patients who over-indulged in alcohol. The overall result was that 63 per cent of the patients showed positive results. They were classified as the "good" and "fair" groups. Nowig and Nielsen centered their discussion around disulfiram. It was supposed that disulfiram opened a new era in alcoholism treatment. This study will not be discussed in relation to the hypothesis and its implications, but was used to describe the general structure of alcoholism follow-up studies. The following studies will be reviewed with emphasis on those aspects pertaining to my hypothesis and its implications.

The first of these studies to be reviewed was conducted by Kish and Hermann (1971). This study involved a follow-up of 173 male alcoholics at three, six, and twelve month intervals after an eight week treatment program at a Veterans Administration (V.A.) hospital. The subjects were both committed and non-committed (voluntary) patients.

In the results, A.A. attendance did seem to affect improvement. Frequent A.A. attendance by the patients corresponded with a very high probability of his being in the much improved category. It was also found that group therapy had no significant effect on improvement rates. The most interesting finding, however, was that there was no difference between the results of the committed and non-committed patients.

This is the most interesting finding because it is contradictory to the hypothesis that voluntary help-acceptors would be more likely to be successfully treated.

The second study to be reviewed was conducted by Pokorny, Byron, Miller, and Cleveland (1968). The study was conducted over a three year period. The results showed that the best successes (those subjects who had remained abstinent from alcohol) had low self-esteems. The abstinent subjects also possessed neurotic and psychotic symptoms to a greater degree. This result is not seen as unusual because it is compatible with the opinion that "neurotic" subjects respond well to therapy (Pokorny, et. al., 1968).

The third study to be reviewed was conducted by Fitzgerald, Pasewark, and Clark (1971). The study consisted of a 16-week minimum treatment requirement inpatient program. The subjects were 392 men and 139 women who participated in the program from 1961-1965. They were not all voluntary patients. Some were self referrals, while others were referred by physicians, community agency, or committed by the courts.

The conclusion that pertains most to this paper was a speculation "that program completion itself could serve as a crude measure of an individual's motivation to control or overcome his addiction and distinguishes the well motivated from the poorly motivated" (Fitzgerald, et. al., 1971). This, is also similar to findings in other studies.

Contrary to the other studies, this study found no essen-

tial difference between men and women in posthospital adjustment. There was, however, a difference in the rates of completing treatment between the two sexes. Fitzgerald et. al. (1971) suggested that a higher drop-out rate among women can be anticipated during the first try at treatment. This drop-out rate does not have the same significance for men. For men, noncompletion on first admission for treatment is a rough prediction of non-completion in a second treatment attempt. Possible reasons for this were hypothesized by the authors. One hypothesis that is most interesting is that the treatment program itself has a masculine bias or aura that does not consider unique female needs. It would be interesting to further study this question to determine if this bias is present in other treatment programs, especially considering that most studies dealing in alcoholism treatment follow-up programs use all male subjects.

A fourth study to be reviewed was conducted by Davies, Shepherd, and Myers (1956). The subjects were 50 alcohol addicts, 39 were men and 11 were women. The study was principally concerned with determining the sociomedical prognosis of the alcohol addicts. All of the subjects participated voluntarily. Most of those accepting help became inpatients.

The idea of alcoholics accepting help was emphasized and discussed in this study. This is seen in a statement found on the first page of the study that declares: "Moreover, acceptance of inpatient treatment is often a measure of the patient's

resolve to be helped, so that a greater degree of cooperation on the patient's part might be ensured by this means" (Davies et. al.,1956). This is supported by the fact that as part of the treatment program, A.A. membership was offered to all patients. Those who expressed the most interest in A.A., were members of the most successful treatment group. Those who expressed the least interest, were members of the least successful treatment group. This seems to support the idea that alcoholics who volunteer for help, and admit that their drinking is out of control, are most successful in treatment programs. It also seems to imply that motivation may be involved in determining success or failure of alcoholics in treatment.

Davies et. al. (1956) call motivation "an underlying factor common to the acceptance of disulfiram and A.A." They also claim that motivation was the main reason for differences in a study by Wallace (1952). From the Davies et. al. study, it seems that one can posit the conclusion that motivation does partly determine the success or failure of the patient in the treatment of alcoholism. If the motivation is high, then treatment should succeed. If it is low, then treatment should fail.

A fifth study to be reviewed was conducted by Robson, Paulus, and Clarke (1965). There were 200 subjects in the study. They were divided into an experimental group, consisting of 100 patients, and a control group consisting of the same amount of subjects. Both groups consisted of all males,

and were similar in age, marital status, occupation, employment status, education, religion, and time elapsed since intake interview. Six areas of behavior were used in the evaluation of the rehabilitation program. They were: drinking behavior, health (physical and emotional), work, family relationships, social functioning, and insight. The experimental group was distinguished by having an average of 16 sessions of treatments, whereas the control group had an average of only 2.5 sessions of treatment. Of these 100 subjects, follow-up interviews were conducted with 155 of the 200. These were conducted between 10 and 46 months after the patient's first session.

Robson et al's results showed that the experimental group was better motivated and acknowledged more serious drinking problems. This group also showed more involvement with A.A. after attending the clinic. Percentage wise, 50% of the 155 subjects showed some overall improvement in their behavior. The percentage for the experimental group was 60%, while it was 42% for the control group. The researchers found that 7 % of this higher rate of rehabilitation among those who received treatment was due to both their greater motivation and to the fact that a greater number regularly attended A.A. meetings. This finding deserves further explanation.

In the Robson et al study the 7% figure was arrived at by an analysis used to determine if the 20% difference in im-

provement between the experimental group and the control group could legitimately be attributed to the treatment. In the analysis, the rehabilitation rates were compared, controlling the other differences between the two groups. It was found in the analysis that motivation and attendance at A.A. meetings did affect rehabilitation, but the patient's perception of his problem did not. Motivation in this analysis was measured by the patients attitude toward treatment as assessed during an interview. (For the results of this analysis, see Table 2).

Insert Table 2 about here

From these results, it is obvious that the largest percentage of improvement came from those alcoholics with a realistic attitude toward treatment. This study fails to define or explain what is meant by a "realistic" attitude. Therefore, a conjecture will be made that it means the alcoholic feels treatment can be of benefit to him because he has tried unsuccessfully by himself to quit drinking. In other words, he realizes that he cannot do it by himself. This, however, is purely conjecture, as there does not appear to be any supporting evidence in this study. This conjecture is therefore made, based on previous evidence mentioned already. Since the alcoholic does desire to cease drinking, but realizes he can-

not do it by himself, he seeks help. He does so because of a poor or negative self-concept. In A.A. terminology, he has "hit bottom". He cannot stand himself any longer. He also realizes that treatment cannot harm him any more than alcoholism already has. It can also be pointed out that the results of the Robson et al analysis demonstrated that more frequent attendance at A.A. meetings is associated with greater chance of improvement.

To conclude my discusiion of this study, note that the study supports my hypothesis and its implicactions. However, since this study does not deal directly with self-concept, it cannot be determined if it improved after treatments. However, it can be speculated from the results of the family and social functioning indices that the self-concept would improve after treatment because 60% of the experimental group and 49% of the control group showed improvement on these indices. This seems to support the contention that self-concept would improve, especially in relation to the social aspects of the self.

Before drawing conclusions from the studies reviewed so far, it seems that an investigation into the role motivation plays in alcoholism treatment is in order. This seems necessary because the issue of motivation was present in most of the studies reviewed thus far, it seems that a requirement for treatment programs is that the patient desire help. This is the case for A.A. also. The question then arises concerning

the reason for treatment programs and A.A.'s success. Is it due to treatment, or is it due to motivation?

In a study conducted by Orford and Hawker (1974), the question of client motivation was explored. The hypothesis tested was that relatively low levels of motivation for change were responsible for the link between youth, or early complicated alcoholism, and premature departure from residence at an alcoholism halfway house. Two types of test were given to the subjects. The first one consisted of asking the residents four questions concerning drinking and alcoholism. The second test was a sentence completion test. Two forms were used. Both intended to elicit pro-drinking and anti-drinking statements. The sujects were 56 male residents of a halfway house. The results did not confirm the hypothesis. The importance of this study is that it seriously questioned the normative ideas of previous studies on the importance of motivation determining the success or failure of treatment. The normative idea of motivation would have predicted that a low level of motivation for change would have been responsible for the link between youth or early-complicated alcoholism, and premature departure from residence at an alcoholism halfway house. However, this was not found in this study.

In aother study conducted by Sterne and Pittman (1965), the concept of motivation was explored from the angle of the treaters instead of the patients. This examination of motivation was part of a study of attitudes and treatment services

in the area of alcoholism in St. Louis. The aspect of the significance to this paper is the extent to which the alcoholic's motivation was believed crucial to his recovery. This was measured by an attitudinal questionnaire and interviews. The study involved a nonrandom sample of 115 administrative and nonadministrative personnel working in hospitals and agencies. Also, 75 persons working in the hospitals and agencies who were not interviewed, were given questionnaires. The results showed that the majority of the respondents took the position that motivation is crucial to success in treatment. Sterne and Pittman (1965) stated that: "Three quaters of those completing the questionnaire were assigned scale scores indicative of some committments to the importance of motivation to recovery from alcoholism." (A satisfactory unidimensional scale was not derived, but Guttman criteria for a quasi-scale were met. C.R.=86.4%. Error was randomly distributed). Also, of the 86 persons interviewed on the meaning of the alcoholic's "motivation" to recover, 81% commented on current behavior in relation to alcoholism. This included the alcoholic's admitting of his problem, stating the desire to remedy it, taking the initiative to undergo treatment, performance in treatment, and curtailing or quitting drinking.

These findings are important because they hint at a type of built-in experimenter bias on the part of those people performing the actual treatment of alcoholics. It seems as if most treatment programs do not even allow the poorly motivated

alcoholic a chance at treatment. This seems to be an injustice, especially since Orford and Hawker concluded that low levels of motivation for change were not responsible for the link between youth or early-complicated alcoholism, and premature departure for residence at an alcoholism halfway house.

Conclusion

In the introduction of this paper, a hypothesis was stated that the self-concept of alcoholic's who seek or accept help for their alcoholism is more negative and lower than tose alcoholics tho do not seek or accept help. This paper supported it. Studies by Matefy et al (1971), Gross (1971), Mindlin (1964), and Pokorny et al (1968) all supported the hypothesis. These studies dealt specifically with self-concept or some similar term (i.e. self-esteem).

The first implication drawn from the hypothesis was that an alcoholic must "hit bottom" and "surrender" before alcoholism can be controlled. This implication did not seem to be adequately proven because of the various ways these terms can be explained and applied. There was not a set definition for "hitting bottom" or "surrender".

The second implication was that alcoholics who volunteer for help in controlling alcoholism and admit that their drinking is out of control are most successful in treatment programs. This did seem to be supported in the paper, however, I would like to raise a serious question concerning the reason for this being true. My question involves the concept of motivation for treatment. It seems to me that the reason volunteers are most successful in treatment programs is because most treatment programs only deal with volunteers. All the doctors, psychiatrists, psychologists, social workers, and A.A. leaders are working under the assumption that the alco-

holic believes he has a problem and wants to solve it. These people seem to exclude even the possibility of curing an alcoholic who does not show a high level of motivation for treatment. It seems to me that insufficient research has been conducted in exploring this possibility and that research is needed in this area. In fact, the Orford and Hawker study says that the level of motivation is not linked to predicting success or failure in treatment.

The third implication was that a treatment program should improve the alcoholic's self-concept. This implication was supported, but only through data from the Robson et al. study. From this data, a conjecture was made, which can be questioned because of a lack of studies that used a test for self-concept in follow-up studies. What is really needed to better support this implication is more studies using a self-concept test (i.e. the TSCS) before and after treatment in follow-up studies.

Most of the studies reviewed used predominantly all males or a majority of males. This seems to be a serious procedural flaw because it prevents a truly random sample. It seems that there is not adequate screening to achieve a balance of males and females in the studies. Most studies just use the alcoholic patients who are in the hospital for treatment at the time the study is conducted. Most studies also did not have any outpatients involved at all. There is also a need in the follow-up studies for some type of untreated control group,

similar to the one in the Robson, et al study. This idea could be further developed. Generally, I think that future studies in this area should concern themselves with a random sample and also the issue of motivation in treatment program.

As a result of my investigations, I would say that the success or failure of treatment of alcoholics depends upon the concept of motivation. From the traditional view, high levels of motivation of alcoholics results in successful treatment. Low levels of motivation would result in the failure of treatment. However, Orford and Hawker have shown that motivation need not be the criterion of success or failure. The criterion can be the treatment itself. For motivation not to be the criterion, the traditional view of motivation in treatment must be recognized as faulty. The traditional view is faulty because it presupposes a high level of motivation. As long as treatment programs uphold this traditional view of the concept of motivation, treatment programs, such as A.A., will continue to be the most successful. It should be remembered though, that programs not presupposing a high level of motivation could possibly work. Research should be attempted in which the traditional view of the concept of motivation is not used. Until it is, we may never know for sure if motivation is a prerequisite for successful treatment.

Until that time comes, I would use the findings of my investigations to help alcoholics by trying to enhance their motivation to stop drinking. I think that the way to do this

would be by pointing out to the alcoholic what his drinking is doing to affect the people around him and his relationship with these people. If you could show the alcoholic that people are concerned about him, then maybe he would be concerned about himself. This seems how self-concept is involved in alcoholism. Hopefully, my findings have some significance for the treatment of alcoholism.

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Table 1

Gross' Results: A Comparison of Alcoholic Pre- and Posttest Means with the Standardization Means On 11 Aspects of Self-Concept as Measured by the Tennessee Self Concept Scale

Subscale	Norm Mean	Pre-test	Post-test	t
Self-criticism	35.5	38.7	38.1	- .66
Total Positive	345.6	286.2	290.9	1.17
Identity	127.1	109.4	110.8	1.11
Self-satisfaction	103.7	83.0	84.6	.88
Behavior	115.0	93.8	95.3	1.01
Physical Self	71.8	58.6	61.8	3.28*
Moral-Ethical Self	70.3	54.5	55.4	.88
Personal Self	64.6	52.7	55.0	2.34**
Family Self	70.8	57.1	57.7	.50
Social Self	68.1	62.4	60.9	-1.46
Variability	48.5	58.0	55.3	-1.69

* Significant at the .01 level.
** Significant at the .05 level.

Note. From "Self-Concepts of Alcoholics Before and After Treatment" by W.F. Gross, Journal of Clinical Psychology, 1971, 27, 539-541.

Table 2

Percentage Comparison Between Experimental (E) and Control (C) Groups on Over-all Change according to Attitude toward Treatment and on Number of Alcoholics Anonymous Meetings Attended after Initial Visit*

	Improved		No Change		Deteriorated		N Cases	
	E	C	E	C	E	C	E	C
Attitude								
Realistic	74	64	14	18	12	18	35	11
Neutral	61	53	17	26	21	21	28	19
Unrealistic or manipulative	50	30	17	43	33	27	24	33
A.A. Meetings								
Over 10	71	70	7	15	22	15	31	13
Under 11	57	37	21	37	22	26	58	49

*All "no answer" responses have been excluded, therefore percentages add up to 100.

Note. From "An Evaluation of the Effect of a Clinic Treatment Program on the Rehabilitation of Alcoholic patients" by Reginald Robson, Ingeborg Paulus, and G. Grant Clarke, Quarterly Journal of Studies on Alcohol, 1965, 26, 264-278.