A COMPARISON OF HOSPITAL AND PRISON ALCOHOLICS

CHRISTOPHER P. J. ROSS
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   Date
A COMPARISON OF HOSPITAL AND PRISON ALCOHOLICS

Christopher F.J. Ross

M.Sc.
University of Edinburgh
1969
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CHAPTER 1

INTRODUCTION

The literature on alcoholism is large, and covers a wide range of topics: that part devoted to psychological aspects of alcoholism, while considerable in size, contains comparatively few studies that have included standardised psychological tests, and of those that have, in many cases, the test used was the MMPI (Hampton, 1951; Hoyt and Sedlacek, 1958; Macandrew, 1965) which has been widely criticised on the grounds that its scales are a mixture of signs and symptoms of psychological disturbance on the one hand, and of personality traits and attitudes on the other (Foulds, 1959; Kasselbaum, 1959; Gocka and Marks, 1961; Corah, 1964). The subjects in most of the psychological investigations have been alcoholics receiving treatment as in-patients or out-patients at a psychiatric hospital or unit. By comparison the alcoholic in prison has been neglected. There have been some excellent descriptive studies of the Skid Row drinker (Edwards, 1966; Straus, 1946, 1952; Myerson, 1956, 1966); these studies have shown that the majority of these drinkers are dealt with by the police, courts and prison service, rather than by hospitals. Comparative studies, however, are required to determine the differences between the two groups which may account for this marked discrepancy in the manner of their disposal. Some comparative studies have been made (Feeney, 1957; Jones, 1963; Lisansky, 1957), but no such investigation has been carried out in Scotland.

Observed differences in the drinking behaviour of alcoholics have given rise to a discussion of the 'pattern of drinking' in alcoholics.
One of the distinctions most commonly made in this context is that between 'loss of control' and 'inability to abstain' drinking. Little work, however, has been carried out on the reliability with which this distinction can be made, and there is confusion as to the nature of the distinction - whether 'loss of control' and 'inability to abstain' are just two of many forms that alcoholism might take, or a general dimension of 'pattern of drinking', which might be more widely applied. A study using questionnaire procedures may elucidate these problems.

The relation of age to alcoholism has seldom been directly investigated. Recent studies, however (Cramer, 1965; Hassall, 1968; Foulds and Hassall, 1969; Rosenberg, 1969), have found differences between young and old alcoholics, and those with early or late onset of alcoholism. Some of the findings, however, conflict and further replication studies are required.

The purpose of the present study may be expressed in three aims:

(i) To compare two groups of alcoholics, differentiated in terms of their disposal by society: one receiving treatment for alcoholism, the other undergoing imprisonment for drunkenness.

(ii) To investigate the classification of the drinking behaviour of alcoholics in terms of the loss of control/inability to abstain distinction.

(iii) To investigate the relation of the age at which alcoholism develops to the degree of disturbance in the person.

The psychological tests used in the study are all standardised and of well established reliability. They were selected because they have been widely used in studies of psychiatric patients and other
groups who show other signs of psychological disturbance. The study is predominantly descriptive but some explanatory hypotheses have been made. It was necessary to develop some original instruments to investigate this field, and so conclusions from the results obtained can only be tentative.
CHAPTER 2 (i)

ALCOHOLISM IN SCOTLAND

Alcoholism affects the physiological, psychological, and social functioning of the individual. This fact is recognised by the World Health Organisation (WHO, 1952) in its definition of the alcoholic. "Alcoholics are those excessive drinkers whose dependence on alcohol has attained such a degree that they show noticeable mental disturbance or interference with mental and bodily health, their interpersonal relations and smooth social and economic functioning; or who show prodromal signs of such developments. They therefore require treatment."

A person becomes an alcoholic in a particular society with its own complex of rules and sanctions which govern those pieces of social behaviour called 'drinking', which together constitute the 'drinking culture'. This will affect not only the amount of alcoholism, but the form it takes in a given society. Blane (1963) and Jellinek (1960) have shown that the diagnosis is in part determined by social factors.

The importance of social factors operating upon alcoholism has been stressed in relation to: the increasing prevalence of alcoholism in Scotland, the higher prevalence of alcoholism compared to England, and finally the variation in prevalence between regions in Scotland.

The extent of Alcoholism in Scotland and its increase

Using Jellinek's formula for estimating the incidence of alcoholism from the number of deaths from cirrhosis of the liver, the World Health
Organisation (Jellinek, 1960) has placed Scotland in the middle range of 30 countries ranked in order of incidence of alcoholism. The recent report on alcoholism in Scotland, *Alcoholics: Health Services for their Treatment and Rehabilitation* (Macrae, 1965) discarded this method of estimating incidence because it was found at two hospital centres in Scotland that the number of deaths caused by the physical sequelae of alcoholism was small. A number of different methods were therefore used. One of these was the number of admissions per year to mental hospitals:

<table>
<thead>
<tr>
<th>Year</th>
<th>Alcoholic Admissions</th>
<th>Total Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1959</td>
<td>921</td>
<td>12,592</td>
<td>7.3</td>
</tr>
<tr>
<td>1960</td>
<td>1,091</td>
<td>12,892</td>
<td>8.5</td>
</tr>
<tr>
<td>1961</td>
<td>1,350</td>
<td>13,686</td>
<td>9.9</td>
</tr>
<tr>
<td>1962</td>
<td>1,617</td>
<td>14,724</td>
<td>10.9</td>
</tr>
</tbody>
</table>

These figures show an absolute increase in the number of alcoholics admitted to mental hospital and an increase in the proportion of alcoholics to total admissions.

Another indication of the increase in alcoholism is the increased number of convictions for public drunkenness. In the period 1954-1958 there were 65,400 convictions and in the period 1959-1963 there were 71,500. Ratcliffe (1966) reports that a high proportion of these are alcoholics.

The increasing incidence of alcoholism, estimated in this way, might be explained in a number of ways: the recognition by both the mental hospital and the alcoholic that treatment in a psychiatric facility is appropriate; the movement of alcoholics between the psychiatric facilities may inflate the overall admission figures, or alternatively it may be that a rise in prosperity in this culture leads to an increase in social drinking which increases the population at risk.
The higher incidence of Alcoholism in Scotland, compared to England

Morrison (1964) has shown that there are marked differences in the incidence of alcoholism between Scotland, and England and Wales taken together. Compared to England and Wales, in Scotland first admissions for alcoholism are seven times as high for men, and five times as high for women. For first admissions for alcoholic psychosis Scotland has three times as many men, but there are an equal number of admissions of women. The proportion of alcoholic admissions (to all other admissions) to mental hospital is higher: alcoholics constitute 31% of total admissions in Scottish mental hospitals and 7% in English ones.

The problem of interpreting these differences is that it is possible, though unlikely, that they may not indicate a real difference in the incidence of alcoholism in Scotland. The Scottish figures quoted refer to 1961, whereas the English ones refer to 1957. The difference quoted, however, is too great to be explained entirely in terms of an increase between these years. An alternative explanation is that there is a different diagnostic practice in Scotland: more patients admitted to mental hospitals are diagnosed as alcoholics, whereas in England they would be put into another psychiatric category. This, however, is probably not the case since the rates for other diagnoses are roughly the same. It is true that there is an overall higher rate of admissions to mental hospitals in Scotland but this excess is largely made up of the greater number of alcoholics. Morrison invokes a further possible explanation, that there is a different admissions policy in Scotland - a higher proportion of alcoholics in the community are admitted to a mental hospital.

Having considered these alternative explanations Morrison concludes that there is a prima facia case for the proposition that the prevalence
of alcoholism in Scotland is considerably higher than in England. Morrison's study includes a description of the characteristics of the alcoholic admitted to a mental hospital in Scotland. It is based on hospital statistics obtained from the Scottish Home and Health Department, which are the most comprehensive figures available.*

Age: The peak age for first admission for alcoholism was 54 years, while for alcoholic psychosis there was a more even distribution over an age range of 35-64.

Marital status: The first admission rates were similar for 'ever married' (married, divorced or separated) and single people until the age of 44 years, after which single men were a higher risk. Readmission rates for single men were higher irrespective of age; this has been found to apply to other categories of psychiatric illness.

Length of stay in hospital: The commonest period was 1-3 weeks. The average length, however, was longer because a quarter of the alcoholics stay for 8 weeks or more. The length of stay varies only slightly with age. Those who have been admitted three or more times have a shorter average length of stay - 5-7 weeks, compared to 6-7 weeks for those with less than three admissions. Those with multiple admissions spend less time out of hospital between admissions. Six months after discharge is the time of greatest risk of readmission.

*Note: The Scottish prison alcoholic is described separately in chapter 4II.
Social class: Morrison found that social classes I and II were over-represented in alcoholic first admissions compared to the general population. This could be a function of the hospitals selective admission policy, or reflect the social class distribution of alcoholism in Scotland as a whole. Evidence for the latter interpretation is that deaths as a result of cirrhosis of the liver have a similar distribution. If hospital admissions were biased in favour of social classes I and II they should include milder cases, and would therefore have a short stay in hospital and a low admission rate. In fact no difference was found between social classes I and II and social classes III, IV and V on either of these measures. This, however, could be a result of hospitals keeping those from social classes I and II in hospital longer irrespective of severity because they were more 'suitable for treatment'. It is not certain, therefore, that there is a higher incidence of alcoholism among social classes I and II in Scotland.

Regional differences in the incidence of Alcoholism within Scotland, and their relation to social factors:

The incidence in the Northern region is four times that in the rest of Scotland:

- Northern region: 76 alcoholics per 100,000
- Other regions: 18 alcoholics per 100,000

Morrison suggests that the factors accounting for the higher incidence in Scotland as a whole may be more clearly seen in the Northern region which has an even higher incidence. Kessel and Walton (1965), in their discussion of social factors contributing to alcoholism, divided them into three categories - example, opportunity and incitement. An explanation of the higher incidence of alcoholism may be considered in these terms.
The importance of parental example has been emphasised by many authors. Morrison (1964) noted that a disproportionate number of parents of Scottish alcoholics had either adopted an extreme puritanical attitude to drinking or had themselves experienced serious drinking problems. The presence of numerous distilleries as sources of employment and profit provide not merely opportunity for employees to drink, but also contribute to the strong association between the 'health' of the licensed trade and the general economic wellbeing of Scotland. This tends to discourage serious appraisal and expression of the socially undesirable effects of heavy drinking. Incitement is a less well defined category ranging from the direct persuasive techniques of advertising, which associate alcohol consumption with 'manliness', to the more general 'mystique' which develops around a particular alcoholic beverage. Certainly in Northern Scotland the reputation of whisky for 'keeping out the cold', and the absence of alternative means of relief constitute a considerable incitement to drink whisky. Moreover whisky is a spirit, and in this form a large amount of alcohol can be ingested with greater ease than for example in the form of English 'best bitter'.

The social factors described are difficult to measure accurately, but Morrison has brought forward evidence for the importance of early family example. He argues that if this is important, then immigrants from Northern Scotland living in other parts of Britain should have a higher incidence. This has been found to be the case.
Summary

On the basis of first admissions to mental hospital it is evident that there has been a real increase in the prevalence of alcoholism in Scotland over the last decade, and that alcoholism is more prevalent in Scotland than in England, while within Scotland alcoholism is more prevalent in the North. These findings were discussed as examples of the effect of social and cultural determinants on alcoholism.

A number of factors may be particularly related to variations in prevalence: the effect in the family of a parent who was either an alcoholic or had very strong views against alcohol; the economic importance of the distilling industry; the 'mystique' surrounding whisky, and the lack of activities alternative to 'drinking'.
CHAPTER 2 (ii)

THE TREATMENT OF ALCOHOLICS
AND THE FACILITIES IN SCOTLAND

The World Health Organisation concludes its definition of the alcoholic 'he therefore requires treatment'. In chapter 6 the existence of two basic methods of dealing with the alcoholic was mentioned - treatment in hospital and confinement in prison. These will now be discussed in relation to Scotland. The Macrae Report on Alcoholism (1965) provides an account of the various kinds of treatment facilities for alcoholics offered in Scotland. They may be classified in the following way:

a) In general hospitals:
   (i) general medical ward
   (ii) psychiatric unit

b) In psychiatric hospitals:
   (i) acute admission ward
   (ii) special treatment for alcoholics but with no separate residence
   (iii) an alcoholism unit with separate residence and special treatment for alcoholics

The types of treatment available vary with the type of medical establishment. The group of alcoholics admitted to one type of establishment may also differ as a group from alcoholics admitted to another treatment facility. The medical or surgical wards of most general hospitals contain some alcoholics who are being treated for one of the physical illnesses associated with alcoholism, but no attempt is made
to treat alcoholism itself. In 1965 there were only four general hospitals in Scotland with psychiatric units - the three general hospitals in Glasgow and Maryfield Hospital, Dundee. The three Glasgow units admit large numbers of alcoholics - more than 200 in 1962. Their average length of stay, however, was short - 17 days in one unit. The results of treatment have on the whole been poor. The Macrae Report attributes this partly to the lack of staff for intensive treatment, and to the type of patients admitted: "One hospital reported that upwards of 40% would be unsuitable for intensive treatment because of gross character disorder or low intelligence".

Smith and Scare (1964) studied 100 alcoholic admissions to a psychiatric unit of a general hospital in Glasgow. Table 2.1 shows the problems they presented with.

**TABLE 2.1**

The presenting problems of alcoholics admitted to the psychiatric unit of a general hospital (Glasgow)

<table>
<thead>
<tr>
<th>Problem</th>
<th>No. of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social or family distress</td>
<td>51</td>
</tr>
<tr>
<td>Marital breakdown</td>
<td>18</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>13</td>
</tr>
<tr>
<td>Police charge</td>
<td>11</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>4</td>
</tr>
<tr>
<td>Delirium tremens</td>
<td>3</td>
</tr>
</tbody>
</table>

N=100

Eighty-nine of the admissions were male, and 11 were female. Most cases were in the 35-49 age range, with a drinking history of 5-15 years. There was a rapid decline in the admissions of alcoholics over 50 years.
of age. There are three possible explanations for this: alcoholics tend to die before they reach 50 years of age; after 50 years alcoholics will tend to go to the medical and surgical wards with the physical symptoms of chronic alcoholism; there may be less social pressure for alcoholics over 50 years of age to seek treatment, or alternatively spontaneous remittance may occur after this age.

In accounting for the only limited success of treating alcoholics in a general hospital psychiatric unit, Smith and Sclare noted that patients "tend to use a hospital as a port of call during a storm rather than as a convenient site for major repairs". An indication of this was the failure of most patients to keep out-patient appointments after discharge. Vallance (1965) reports similar disappointing results with alcoholics from another Glasgow hospital where out of 65 male alcoholics only 25% improved and 30% suffered further deterioration.

In addition to the attitude of the alcoholic to the hospital, the psychiatric unit may have to contend with the attitudes of the general medical staff to the alcoholic. Blane (1963) investigated the selection of patients by the chief medical officer, a physician, for treatment in a special alcoholism unit in the general hospital. He found that a significant number of alcoholics had been 'missed' and that those alcoholics who had been recognised scored lower on a seven-point index of social integration. Blane suggests that this indicates physicians consider alcoholism only occurs in those who are socially deteriorated. In addition those 'missed' alcoholics tended to have more general medical pathology, and Blane considers this as evidence of the physician's practice of preferring diagnosis of a physical disease, when there are
some physical symptoms present, to that of alcoholism with its social
and psychological implications.

Smith and Solare in discussing alternative treatment facilities
emphasise the need for the expansion of out-patient clinics. They
draw attention to the expense of special 'alcoholism units', and refer
to the problem of transferring what is learnt in a residential unit to
the life situation outside.

The Alcoholism Unit attached to the Royal Edinburgh Hospital is
the first of its type in Scotland. The assumption underlying the
building of a special unit is that, while alcoholics may share problems
with other patients who are mentally ill, there are a number of problems
which are peculiar to alcoholics which are best dealt with by them
living and being treated together. A number of studies have been
made in this unit. Ritson's study (1968) of the features associated
with favourable outcome, is of particular interest in the present con-
text. He found that only slightly better results were obtained with
in-patients than with out-patients. Better results were obtained with
'loss of control' than with the 'inability to abstain' type of alcoholic.
Both higher social class and older age were associated with good prognosis.
There was also a positive correlation between employment after 6 months
and abstinence, and between progress after 6 months and progress after
12 months. Ritson constructed a profile of the out-patient with a good
prognosis: loss of control drinking, mild personality disorder, a long
history of addiction as measured by time elapsed since the first experience
of withdrawal symptoms, previous experience with the A.A., good marital
relations, and evidence of abstinence several days before first attendance.
The following features were associated with successful outcome by inpatient treatment: extant marriage, no history of arrest for being drunk and a late start to heavy drinking. The 20% who had attempted suicide had a poor outcome.

The results of Ritson's study are most usefully considered along with a study by McCance and McCance (1969). Most alcoholics in Scottish mental hospitals are not dealt with in a special unit, but are treated in the acute admission wards. McCance and McCance investigated alcoholic patients admitted to the two main psychiatric hospitals in Aberdeen - Cornhill and Kingseat. Initially they compared three groups receiving different treatments: one group received aversion therapy, one group therapy twice a week, and the third just participated in the ward routine of weekly ward meetings and occupational therapy. There were five categories of outcome, similar to those used by Myerson in his programme for Skid Row alcoholics and based both on the person's drinking behaviour and his personal ability to lead an independent life.

The most interesting finding was that there was no difference in outcome between the three conditions, but there was a large difference in outcome between the two hospitals, with Kingseat having relatively fewer successes, even though the treatments in the two hospitals were similar. McCance and McCance inferred from this that the difference was due to Kingseat admitting more alcoholics with poorer prognostic characteristics. Table 2.2 shows the characteristics that differentiated significantly between the two hospitals and were associated with poor prognosis.
TABLE 2.2

Characteristics differentiating the alcoholic admissions of two mental hospitals (Aberdeen) and associated with poor prognosis

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Probability of obtaining value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of D.T.s</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>Heavy drinking subculture</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>Living alone</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>Low social class</td>
<td>p&lt;.01</td>
</tr>
<tr>
<td>Marital instability</td>
<td>p&lt;.01</td>
</tr>
<tr>
<td>Cheap wine</td>
<td>p&lt;.01</td>
</tr>
<tr>
<td>(rather than beer and whisky)</td>
<td>p&lt;.01</td>
</tr>
<tr>
<td>Police convictions</td>
<td>p&lt;.02</td>
</tr>
<tr>
<td>Declining occupational status</td>
<td>p&lt;.02</td>
</tr>
<tr>
<td>Duration of drinking</td>
<td>p&lt;.05</td>
</tr>
</tbody>
</table>

Using these findings the following profile can be constructed of the alcoholic at Kingseat Hospital: he tends to live alone and have had D.T.s, he is part of a subculture of heavy drinking and from the lower social classes; he is less likely to have a stable marriage and more likely to drink cheap wine, have police convictions, and have been drinking longer.

It is evident from the profile of the alcoholic with a good prognosis which emerged from Ritson's study and the features that McCance and McCance found to be associated with unsuccessful treatment, that the alcoholic who fails in psychiatric treatment shows many of the social characteristics associated with the Skid Row drinker: low social class, no family, decline in occupational status, drinking cheap wine, and police arrests for drunkenness. McCance and McCance suggest that it may not be the treatment received which determines the outcome of alcoholism, but the presence or absence of these factors. The favourable
record of results obtained by the Royal Edinburgh Hospital Alcoholism Unit (Walton, 1966) and by the Cornhill Hospital may be because these establishments are only used by those with good prognostic factors who may have done as well with ordinary hospital routine.

**TABLE 2.3**

<table>
<thead>
<tr>
<th>Percentage of Alcoholics Abstinent after hospital treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Alcoholism Unit, R.E.H.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Cornhill Hospital, Aberdeen</td>
</tr>
</tbody>
</table>

McCance and McCance conclude that there is a need to establish centres for those with less favourable features. Such centres should provide a protected environment where the alcoholic could take the first steps to obtaining a job. Tolerance of failures would be necessary. Some alcoholics, however, are so deteriorated that permanent care may be required.

Discussion of the needs of the 'failed' hospital alcoholic is related to the question of treatment for the Skid Row or prison alcoholic, for they have many features in common. Ratcliff (1966) using the official prison records for Scotland has outlined some characteristics of those imprisoned by primarily alcoholic offences. The total number of convictions for 1965 was 1180. Table 4.4 shows the convictions distributed by age.
TABLE 2.4

Convictions for alcohol offences distributed by age (Scotland 1965)

<table>
<thead>
<tr>
<th>No. of convictions</th>
<th>Age range in years</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>0-19</td>
</tr>
<tr>
<td>97</td>
<td>20-29</td>
</tr>
<tr>
<td>218</td>
<td>30-39</td>
</tr>
<tr>
<td>357</td>
<td>40-49</td>
</tr>
<tr>
<td>350</td>
<td>50-59</td>
</tr>
<tr>
<td>15</td>
<td>60+</td>
</tr>
</tbody>
</table>

As with other alcoholic populations the age of peak incidence is during the forties and fifties. Over 80% of the imprisonments were men between 30 years and 60 years. The remaining 20% were equally divided among the old and young. The average sentence was under 30 days - 97% were sentenced to 30 days or less. The vast majority were imprisoned for being drunk, in most cases for being 'drunk and incapable' but some times for being 'drunk and disorderly'. In terms of occupation most (96%) were unskilled but literate. The main kind of occupation of this group was labouring although a few were seamen, or factory or farm workers. The remaining 4% was made up of vagrants (18), clerks, farmers and shop assistants (18) while ten cases were unclassified.

The indirect evidence for regarding most of the individuals that contribute to the 1180 convictions as alcoholics of the Skid Row type is that the prison records show it was most likely to be the person's seventh conviction. A person's life outside must be quite deteriorated for him to prefer imprisonment to a small fine. He probably has no job, home, or personal contacts to provide a reason for not going to prison.
In addition 410 first attendances were made to the prison medical officer for alcoholism.

The large number of readmissions indicate that imprisonment construed as a deterrent to drunkenness or as a treatment for alcoholism is ineffective. It is reported, however, that prison alcoholics do not take up alternative treatment when it is offered. The evidence suggests (McCance and McCance, 1969; Ritson, 1967) that the treatment offered, however, is inappropriate to their condition. Edwards (1966) has reported that many in fact said that they would take up treatment if it was offered and argues that some form of treatment should be devised since, if this group has elected to return to an institution for a month rather than pay a fine, then they might be persuaded to attend a non-penal institution and return to it for observation, assessment and treatment.

An alternative approach to the chronic drunkenness offender is compulsory treatment. This has been the subject of much discussion in the U.S.A. Bourne (1966) has shown that conventional treatment techniques like antabuse therapy if carefully administered and accompanied by assistance from other social agencies, can be used to stop the 'revolving door' pattern of the prison alcoholic's behaviour. In Bourne's study 32 out of 64 in the voluntary, and 61 out of 132 in the compulsory group (i.e., those receiving treatment as an alternative to a prison sentence) were abstinent after 9 months.

Chafetz (1965) explains the difference between a prison sentence and compulsory treatment in a hospital. The former is basically a punishment for an offence; the latter is a coercive measure but is intended as a form of pressure to increase motivation for treatment. Chafetz argues for the
implementation of the World Health Organisation's recommendation that laws should be introduced for the compulsory treatment of alcoholics adjudged dangerous to themselves or others. If compulsory treatment is introduced the question is raised whether it should be handled by the courts, or whether there should be a law as there is for mentally ill patients generally whereby a person can be compulsorily detained. Chafetz emphasises, along with Terhune (1966) and Ratcliff (1966), that alcoholic offenders would have to be committed for treatment for a longer period than the current length of goal sentence. The alcoholic offender, therefore, should always be allowed to choose the goal sentence if he prefers.

The practice of committing alcoholics to having treatment in some States in the U.S.A. is not only changing medical practice but is bringing about a corresponding change in the legal status of the alcoholic who offends the law. In the case of Driver v Hinnant reported by Curran (1966) a federal court reversed a previous decision which had imprisoned the defendant for drunkenness, on the grounds that to punish criminally for public drunkenness a patient who was admitted to have chronic alcoholism would be a violation of the 8th amendment of the U.S. Constitution which prevents 'cruel and unusual punishment'. The conclusion of the federal court's report provides hope for the development of a new approach to the chronic drunkenness offender: "Although his misdoing objectively comprises the physical elements of a crime, nevertheless no crime has been committed because the conduct was neither actuated by an evil intent nor accompanied with consciousness of wrongdoing, which are indispensable ingredients of crime". This means that
an alcoholic can be sent for compulsory treatment, and not be considered a criminal. This, however, raises a further question, whether alcoholism can be used to show that other apparent offences of the law are not criminal acts. If this is the case, then a commonly agreed definition of alcoholism is even more urgently needed.

Bewley (1967) takes a different attitude to the question of a new approach to the offending Skid Row alcoholic. He argues that it is unnecessary to change the law in order to bring those alcoholics in prison into the hospital for treatment. It would already be possible to do this in most cases under sections 25, 26, 29 and 60 of the 1959 Mental Health Act, and section 4 of the 1948 Criminal Justice Act which states that it is wrong to punish a person for acts which are the results of his having a disease. As long ago as 1878 the Inebriates Act recognised that such people had special needs, and made provisions for them to be committed to 'retreats' but these became defunct as the expense for them fell on local rates. A leading article in the British Medical Journal (B.M.J. 1968) quotes the 1967 Criminal Justice Act which states that if sufficient suitable accommodation is available for the care and treatment of persons convicted of being drunk and disorderly these persons shall be helped rather than punished. Bewley concludes that if this law already provides for the care of the alcoholic offender, then what is required is a change in the attitude of those in control of admissions to mental hospitals. The B.M.J. leader poses the question of where the money required to develop forms of treatment appropriate to the alcoholic offender is to come from. The money involved would hardly be more than what is currently expended in the arrest, conviction and imprisonment of these men. The B.M.J. leader
makes a case for the establishment of a government department which would take responsibility for co-ordinating work on the interrelated problems of chronic drunkenness and vagrancy. A Home Office Working Party on the Chronic Drunkenness Offender was set up in 1967, but the report is still awaited.

Bewley contends that even within the prison more could be done for alcoholics. While the expectation of a cure would be unrealistic these are not the only ends of treatment. Competent case work with an adequate case history and diagnosis are preparatory to the provisions of any service. Simple advice could be given and arrangement made for referral to another agency. A small number might be put in contact with Alcoholics Anonymous. Basic chemotherapy – vitamins, tranquillisers and sedatives could be used to deal with the physical complications of their condition. Antabase therapy has been effectively employed with alcoholics of this type (Bourne, 1966). The more elaborate treatments of aversion and group therapy have not even been extensively tried on this group.

Researchers, both in Britain and U.S.A. maintain that, while treatments which are available to alcoholics in hospital may be usefully incorporated into a treatment programme for the Skid Row alcoholic, nevertheless the Skid Row alcoholic does present particular problems that are less prominent or altogether absent in most hospital alcoholics. The Skid Row alcoholic is invariably without a home, a permanent job, and has no close personal contacts. Therefore the usual basic network of social relations around which a person's life can usually be developed are not present for the Skid Row drinker. Instead he is a member of a
separate drinking subculture. Any treatment programme must tackle these factors if it is to be successful.

Most attempts to devise a special treatment programme for Skid Row alcoholics have been based on the idea of a 'half-way house'. Rubington (1958, 1967) regards the patterns of living in such an establishment would help to reverse the effects of 'industrialisation, urbanisation and bureaucratisation' which he considers to be the contributing factors to the Skid Row subculture. Rubington maintains that the 'half-way house' should be a small size and have simple rules. It should be non-hierarchically structured with status differences reduced. It is hoped that in this informal residence the men would be encouraged to interact and communicate, while the homelike atmosphere would induce them to stay, and provide a protective and supportive environment from which to resume social relations which had lapsed. It is important that each residence elaborates its own 'rationale', so that its apparent lack of formal structure does not lead to it becoming a 'dumping ground' for other social agencies. Another problem encountered in the running of such a residence is that the amount of power exercised by the house director inhibits the development of group solidarity. Experience has also shown that the role of counselling must be separate from that of administering. Another difficulty that has emerged is the tendency for counsellors who are former alcoholics to develop dependency relationships with the men they were counselling.

Edwards (1966a), in his account of the hazards of setting up such a residence in Camberwell, agrees with Rubington in the need for simple rules so that people will know exactly what will happen if they start
drinking. He considers that they should be dismissed but told that readmission will not be refused. He believes that the alcoholic's dependency on the staff can be usefully encouraged at times. Other programmes of a similar kind are Myerson's rehabilitation programme for 101 homeless alcoholics attached to hospital which showed many features of the 'half-way house' system. The results obtained were encouraging: 12 kept off drink for 3 years and restored themselves to their families, 20 kept sober for 3 years but used the hospital as their home; 22 had just 2 or 3 drinking episodes a year; while in 47 cases there was no improvement.

A large section of this chapter on treatment has been devoted to the question of the treatment of the Skid Row alcoholic. Skid Row alcoholics are the only group in society that are considered by the majority of the medical profession to be suffering a disease but who are nevertheless held criminally responsible for offences which are the result of that disease, and disposed of accordingly. The rationale of the half-way house and the difficulties encountered in its running have been described in detail because they represent an attempt to tackle the problems of homelessness, occupational instability and personal isolation which characterise not only the alcoholic in prison but are associated with failure of hospital treatment.

Summary

There are two basic methods of dealing with the alcoholic in Scotland - treatment in hospital and confinement in prison. The treatment an alcoholic receives in hospital varies with the kind of hospital. In a medical ward of
a general hospital he receives treatment for the physical ill effects of chronic alcoholism. Alcoholics also form an important group in the admissions to the psychiatric units of general hospitals. Studies of such units in Glasgow do not show a high success rate with alcoholics. These units may have to contend with the negative attitude of the general medical staff to alcoholism, as well as the patient's tendency 'to use a hospital as a port of call during a storm rather than as a convenient site for major repairs'. Their work is also hampered by insufficient trained staff for intensive treatment. A specialised 'Alcoholism Unit' where alcoholics both live and receive treatment in a separate unit, is less likely to have these particular difficulties. Follow-up studies of the unit attached to the Royal Edinburgh Hospital show that 60% were abstinent after 18 months. Most alcoholics in Scottish mental hospitals, however, are treated in the acute admission wards. McCance and McCance (1969), from a comparison of the effects of psychotherapy, aversion therapy and ward routine, suggest these are less important in relation to outcome than certain characteristics which individual alcoholics have. The better success rates enjoyed by some hospitals may be a function of this. McCance and McCance found poor outcome was associated, among other factors, with the alcoholic who belonged to a heavy drinking subculture, lived alone, drank cheap wine, had unstable marital relations and police convictions, and was of low social class.

The situation of the Skid Row alcoholic is unique as they are held responsible and punished for acts which most of the medical profession would consider to be the result of a disease. Compulsory treatment has been offered as an alternative in some States in U.S.A. and has met with
some success. The particular characteristics of this group—occupational instability, homelessness and personal isolation, however, must be considered in the development of an appropriate treatment. The establishment of 'half-way houses' which have simple but firm rules and are run on 'communal' lines is an attempt to provide a place where the Skid Row alcoholic can start to interact and resume social relations that have lapsed. Schemes attempting to return the Skid Row alcoholic to an independent life without resort to alcohol are particularly important because the Skid Row alcoholic shows many of the characteristics which occur in those who fail to benefit from hospital treatment.
Falkey (1957) has suggested that while alcoholics have some common characteristics, important differences may be found between different kinds of alcoholics. Jellinek (1960) has differentiated alcoholics in terms of their drinking pattern. Different types of explanations have been offered for variations in the pattern of drinking: sociological (Ullman, 1958), physiological (Jellinek, 1960) and psychological (Storm, 1965). Walton (1968), however, has taken the strongest position in relation to the psychological causes of pattern of drinking; this is reflected in the title of his paper on the subject 'Personality as a determinant of the form of alcoholism'. Before an adequate evaluation of these different theories can be made an adequate description of the drinking patterns is required.

Jellinek (1960) distinguished five types of alcoholism. The drinking pattern types which have received most attention in the literature are the two which Jellinek considers constitute a disease process where the person is addicted to alcohol in the sense of physical dependence. These two types of alcoholism with their associated drinking patterns are Loss of Control alcoholism and Inability to Abstain alcoholism. Some writers refer to these types of drinkers as 'compulsive' and 'inveterate' respectively. Jellinek uses the Greek letters 'Gamma' and 'Delta' to refer to Loss of Control and Inability to Abstain alcoholism respectively. Jellinek and Walton have described both types of alcoholics, and from these descriptions a 'profile' of each type has been constructed:-
The 'Loss of Control' or Gamma Alcoholic

The Gamma alcoholic has a drinking pattern in which the level of alcohol intake fluctuates: he may not have a drink for some time but once he starts drinking, control over the amount he drinks is lost, and he goes on drinking, often at an increasing rate, until he has to stop either because of the physical ill effects, an accident, or because available supplies of drink or money are exhausted. A brief period of abstinence follows when he deliberately tries to keep off alcohol.

Craving, 'the shakes' or 'tremors' may occur with reduction or cessation of drinking. Black-outs occur in which the person fails to remember what happened to him, for example, for part of the previous evening. A person with this type of alcoholism knows that his drinking is abnormal: he has episodes of drunkenness which antagonise people he comes in contact with, and so his drinking disrupts his social and family life, and interferes with his work.
The 'Inability to Abstain' or Delta Alcoholic

The Delta alcoholic has a less socially conspicuous pattern of drinking. He has a steady excessive level of alcohol consumption. In the context of his excessive intake, he can control how much he drinks at any one time. However, he cannot remain for any length of time without a drink; i.e. he has no periods of abstinence. His excessive drinking is less noticeable because his public behaviour is seldom disorganised through drinking too much. He is often in a social milieu where a high level of drinking is required or approved. His social and family life is less disrupted and his work may not be affected. Because of this, physical symptoms of alcoholism or withdrawal symptoms due to enforced abstinence (e.g. when undergoing hospitalisation) may be the first sign that the person is an alcoholic.

Jellinek clearly states in his book 'The Disease Concept of Alcoholism' (1960) that Gamma and Delta alcoholism constitute a disease process. "The current majority opinion to which this author subscribes is that anomalous forms of the ingestion of narcotics and alcohol such as drinking with loss of control and physical dependence are causes by physiopathological processes and constitutes a disease."

Jellinek mentions three physiological changes which indicate that alcoholism in these forms is a disease:
(i) Increased tissue tolerance
(ii) Adaptation of cell metabolism
(iii) Withdrawal symptoms following the reduction or cessation of alcohol, which result in either:
(a) craving and 'loss of control' or
(b) 'inability to abstain'.

Jellinek's criteria for considering alcoholism a disease are physiological. He does, however, stress the importance of psychological and social variables which may not only be affected by the course of alcoholism, but may determine who becomes an alcoholic and what form the alcoholism takes. Jellinek maintains that with the physiological changes a psychopathological condition develops which differs from any possible pre-alcoholic psychopathology.

Many people drink alcohol for its tension reducing properties, but addiction to alcohol in a pharmacological sense develops only in 3/4% to 10% of alcohol drinkers. The reason for this low percentage may be the relatively small number of people who have the urgent motivation to take alcohol in the quantity and frequency that is required to bring about physical dependence. This is to say that only persons with certain personality characteristics and in a particular social situation are likely to become addicted.

That social and cultural factors may affect the drinking culture and hence the incidence and form of alcoholism was mentioned in chapter 2. Jellinek stresses the following social factors: the availability of alcohol, the economic importance of the alcohol industry, and the attitudes towards drinking and drunkenness. He also maintains that in some societies the psychological factors are more important, while in others the social factors are more important. He describes two types of drinking culture, one which
produces a predominance of Gamma alcoholics, where individual psychological factors are important, while the other produces a predominance of Delta alcoholics, where social variables are the more important factors.

The social conditions associated with Delta alcoholics are:

(i) approval of a high average intake of alcohol
(ii) the availability of alcohol throughout the day
(iii) the existence of an alcohol industry which is of great economic importance

These social conditions prevail in France, which has a correspondingly high number of Delta alcoholics. The reason that Jellinek gives for this is that in France many people normally drink large amounts of alcohol but these are spread throughout the day, so that while the level in the blood is never so high as to produce intoxication, the body is never free from alcohol. The consequence of this is, therefore, that it requires only a small vulnerability, whether psychological or physical, to expose the person to the risk of addiction.

Gamma alcoholism occurs predominantly in cultures which only accept drinking on certain occasions and in approved amounts, i.e. there is a definite 'when, where, and how much' rule which regulates drinking behaviour. The result of these restrictions is that drinking is concentrated into limited periods. Britain and the U.S.A. have this kind of drinking culture.

Jellinek maintains that where the intake of large amounts of alcohol is not accepted those exposed to the risk of addiction will be those with high psychological vulnerability which induces them to offend social
standards, and a common feature of alcoholics in Britain (Walton, 1968) and the U.S.A. (Fuller, 1966) is a low tolerance of tension, and an inability to cope with psychological stress.

Though the descriptions given above show how the relative importance of social and psychological factors can vary from country to country, nevertheless the large and frequent use of alcohol is the crucial factor in increasing the risk of addiction in a pharmacological sense.

The nature and cause of loss of control (Gamma) alcoholism

Because loss of control or Gamma alcoholism is more socially conspicuous and more common in Britain, it has been the subject for more investigation and debate than the inability to abstain or Delta alcoholism. Indeed, the Gamma drinker is often the only drinker who is accepted as an 'alcoholic'. The A.A. definition only applies to this one type of alcoholism. Jellinek is careful to delineate the exact characteristics of loss of control drinking. Loss of control is "the stage in the development of alcoholic drinking when ingestion of one drink sets up a chain reaction so that they (the alcoholics) are unable to adhere to their original intention to have one or two drinks only, but continue to ingest more and more, often with quite some difficulty and disgust, and contrary to their own volition". Loss of control does not occur suddenly, but develops progressively, becoming fully established several years after the first intoxication. Loss of control drinking should be distinguished from 'undisciplined' or 'uncontrolled' drinking which is characterised by a deliberate transgression of social rules governing amount, time, occasions and locales for drinking; the essential difference from loss of control
drinking is that there is no deprivation of choice. Undisciplined drinking may occur in the early stages of Gamma alcoholism but as loss of control establishes itself, deliberate undisciplined drinking diminishes for fear of the consequences of showing loss of control in certain situations. Later on, however, attempts to control the occasions fail.

From direct observation Jellinek describes the behaviour of the Gamma alcoholic in a drinking bout. There is an ebb and flow of withdrawal symptoms even within the drinking period. As a result the Gamma alcoholic demands more drink. He becomes anxious and may reach panic state with the failure of the alcohol to give the expected euphoric effect. The craving which the Gamma alcoholic experiences is not directly for alcohol which may be ingested only with difficulty but for the psychological relief it gives to the effects of the withdrawal symptoms.

'Craving' is used by Jellinek in relation to the Gamma alcoholic in a quite specific way. By craving is meant "an urgent and overpowering desire to drink alcoholic beverages" (Mardones, 1955). The 'urgency of desire' is a passive condition that is perceived by the alcoholic. 'Overpowering' is taken by Jellinek to mean 'inducing an active attitude directed to surmount the obstacles opposing the desire'. This is what is noticed by other people when the alcoholic breaks the social rules regulating drinking.

Jellinek makes what he considers to be an important distinction between (i) the factors that lead the Gamma alcoholic to start drinking and (ii) the factors which cause the continuation of drinking once the bout has started. The Gamma alcoholic starts drinking not because of a craving but for the tension-reducing effects of alcohol, i.e. because
he wants to feel 'different', to effect some change in his state of consciousness. At the outset he has the obsessive belief that he will be able to stop after two or three drinks once he has obtained a euphoric state or a state of relief and relaxation. Craving, according to Jellinek, only occurs with the continuation of drinking as a result of the desire to relieve the withdrawal symptoms. Craving is not a specific appetite for alcohol as postulated by proponents of the nutritional and endocrine aetiologies, for during periods of enforced abstinence the Gamma alcoholic displays none of the behaviour or symptoms which occur if he had stopped drinking when intoxicated.

A physiological theory is offered by Jellinek to explain what he considers to be the essential feature of loss of control - the insatiability of the desire once drinking has started. Vogel (1953) and Straus (1951) maintain that this is based on the occurrence of minor withdrawal symptoms even when alcohol is still in the blood stream, and the inability to maintain the desired euphoria for more than a few minutes. Jellinek invokes two physiological concepts to explain this - 'increased tissue tolerance', whereby more alcohol is required to obtain the same amount of euphoria, and 'short term accommodation', whereby the same amount of alcohol has less effect in the descending phase after the peak concentration of alcohol in the blood has been reached, than in the ascending phase. The combined effect of these two physiological changes is that in the descending phase the effect of alcohol is markedly reduced and withdrawal symptoms quickly reappear. The detailed workings of these two physiological processes are not described by Jellinek, and his theory awaits confirmation.
An evaluation of Jellinek's description of loss of control alcoholism

While no studies have been made to directly examine Jellinek's physiological concept of short term accommodation, studies have been made which suggest that certain clarifications or modifications to Jellinek's original description of loss of control are required.

Blume and Sheppard (1967) have shown that a definite change occurs in the effect that alcohol has on a drinker who has a long record of excessive drinking. They asked 53 male alcoholics to rate themselves at two stages: (i) when they were about the age of 22, and (ii) just before admission, and in two conditions: (i) when sober, (ii) when drunk. There was little difference between the two sober states - at both stages they acknowledged poor self-confidence, tension, difficulty in expressing anger, and were oversensitive. There was, however, a difference in the drunken states at the two stages: at 22 years the effect of drinking was to reverse the feelings they had when sober, but at the later stage the effect of drinking was different - they experienced instead increased depression, a reduction in general activity, ambition, and sexual activity, and made more extreme responses with greater variability in their behaviour. Blume and Sheppard concluded that the changes in the effect of alcohol could only be explained in part by personality changes with increase in age, and that prolonged intoxication may result in alcohol having a different effect on the central nervous system.

McNamee (1968) showed by an experimental analysis of drinking pattern that in certain circumstances it may require more than a single drink to start the chain response and craving characteristic of Gamma alcoholism. Twelve volunteer alcoholic patients were placed in a drinking situation
where they received 86% proof whisky for the performance of a simple operant task. This was continued for seven days. Psychiatric ratings for mood, thought, and social behaviour were made before, during, and after the experiment. Two results are relevant here: nine subjects had an increase in anxiety and depression with drinking which may be evidence for a psychological or physiological change in reaction to alcohol. No subject, however, experienced craving after the first drink; the expression of increased desire occurred only during the last days.

The implications of McNamee's findings are more clearly seen in a study by Glatt (1967) who reports that there are situations in which an alcoholic can drink and not lose control. These situations included when the person was on holiday, free from business or domestic worries, or following removal to a situation where heavy drinking is less socially accepted or expected. Glatt infers from this that there exists a critical threshold for certain alcoholics below which they can drink and maintain control, and that this threshold will vary with changes in the drinker's motivation.

The studies of McNamee and Glatt may be regarded as further support for Jellinek's view that physical craving does not occur at the outset of drinking but develops with its continuation. Alternatively the fact that 'the chain response' of loss of control does not invariably occur may be interpreted as undermining Jellinek's theory that a distinct physiological change has occurred in the Gamma alcoholic - for if he can in certain circumstances exercise control, then the distinction from the 'undisciplined drinker' becomes less clear. This is the position taken
by Merry in his interpretation of the results of an experiment with nine Gamma alcoholics. Without their knowledge they were given a mixture containing 1 fluid oz. of vodka, alternating it with a placebo for 18 days. Subjects had to rate their craving afterwards on a five point scale. No difference was found between the vodka and placebo in the total number of craving points. On the 18th day when 2 fluid oz. of vodka was given, again without their knowledge, all nine patients reported craving.

Merry claims that his own results show that loss of control drinking does not constitute a disease in which a small amount of alcohol is able to trigger off a biochemical chain reaction. Merry's findings, however, do not necessarily discredit Jellinek's category of the loss of control alcoholic. They may be interpreted to show that (i) it is not a matter of one drink, but of a critical threshold of alcohol concentration in the blood above which control is lost, and that (ii) environmental and psychological factors are important in determining the threshold. This is further supported by Merry's additional finding that the stronger mixture produced craving in all nine subjects.

One method of evaluating the usefulness of Jellinek's distinction between loss of control and inability to abstain alcoholics is to examine criterion groups of such drinkers for differences on other important variables. Stein (1968) using this method has shown several features to be associated with Gamma alcoholism. He gave a questionnaire to 271 male alcoholic admissions, and differentiated 'loss of control' from 'controlled drinkers' by their answer to this question, "After taking one or two drinks can you usually stop drinking". He found that loss of
control (Gamma) drinkers tended to suffer more from the physiological effects of alcohol, and have longer and more frequent blackouts, more frequent D.T.s, shakes and vague fears and phobias associated with prolonged drinking. There was also more evidence of psychological disturbance: (i) they were often in conflict with authority, e.g. cutting classes at school, dislike of the teacher, involved with the police; (ii) their family was more disturbed - another member of the family was more likely to have had a drinking problem, and also to have been hospitalised for mental illness; (iii) they showed more antisocial and impulsive behaviour, e.g. temper tantrums, a record of conflict with the police.

Stein argues that these differences cannot be explained by saying that the loss of control drinker is at a more advanced stage of alcoholism since they do not differ in their present age, age when drinking started, or age at first intoxication, nor in the number of hospital admissions. Stein, therefore, concludes that the differences are a reflection of a difference in type or form of alcoholism. He concludes that the collective features known as loss of control are 'multi-determined'. The 'causes' he mentioned include differences in conditionability and the presence of a personality disorder.

Storm (1965) suggests that loss of control may be understood in terms of learning theory. He introduces the concept of dissociation which is similar to that of stimulus generalisation. To illustrate this he gives accounts of experiments which have shown that responses learnt in a drugged state are not transferred to the non-drugged state and vice versa. Storm suggests that blackouts are a case of complete
dissociation. His conclusion for the treatment of loss of control drinkers is that relearning - not to go on drinking - will only be completely successful if it is carried out in the appropriate state, i.e. when he is mildly intoxicated. These deductions from the concepts of learning theory make testable predictions but the appropriate studies have not yet been carried out.

Stein mentioned personality disorder as one of the causes of loss of control alcoholism. Walton (1968) investigated the personality of 38 alcoholics using Cattell's 16 Personality Factor Questionnaire. He categorised his subjects as Gamma or Delta types, and compared their personality profiles. Compared to the Delta alcoholic, the Gamma type was less emotionally stable (C-), more shy and timid (H-), more reticent and depressed (F-), more self-sufficient and preferring his own company (Q4+) and less likely to distort answers to give a favourable impression. Walton claims that the profiles of the Gamma alcoholics generally resemble those of neurotics, while those of the Delta alcoholics resemble both neurotics and personality disorders. He comments that Gamma alcoholics tend to have a more marked symptom development - for instance they tend to be more timid and show anxiety in social situations (H-). Gamma alcoholics also scored significantly higher than Delta alcoholics on the Character Disorder scale of the SSI. Many of the items on the scale relate to impulses which they view as a threat to their own security. They also obtained higher scores on the General Hostility scale of the Hostility and Direction of Hostility Questionnaire, the HDHQ (Caine, Foulds and Hope, 1967). Walton regards these differences as an indication of the association of personality with the pattern of drinking. The differences,
however, may be the results of the Gamma alcoholic's experience of the loss of control over his drinking.

Utilising the findings of Hassall (1968) that alcoholics under 30 years have a very high hostility score, Foulds (1968) re-analysed Walton's data, and using a four-fold classification ranked the groups according to the degree of psychopathy shown. The General Hostility score of the HDHQ and factors G (weak super-ego strength) and Q3 (undiisciplined self-conflict) were used as measures of psychopathy.* It was suggested that Gamma alcoholics who develop alcoholism before 30 years would be the most disturbed in this respect followed by Gamma alcoholics developing alcoholism after 30 years. The inability to abstain alcoholic would obtain a lower score regardless of the age of onset of alcoholism.

**Typological and methodological problems in the classification of alcoholics according to pattern of drinking.**

Although the terms 'loss of control' and 'inability to abstain' are widely used, the actual differentiation of alcoholics according to these patterns of drinking has been the subject of only a small number of studies. It raises familiar problems of typology and classification which are frequently encountered in psychiatry as a whole. These may be summarised as:

1. **The reliability of the classification.** No inter-rater reliability studies have been carried out, and there is a need for replication studies to see if this classification can be consistently applied to all alcoholic populations - to those in prison as well as

* The measure of psychopathy has subsequently been revised (Foulds and Hassall, 1969).
those in a mental hospital. An important question in considering reliability is whether the classification can be investigated by questionnaire methods. The development of such a questionnaire would greatly facilitate replication studies.

2. The question of validity. Whether the alcoholic is assigned to a point on a scale of drinking pattern or obtains a score on a questionnaire, the question arises whether the loss of control/ inability to abstain distinction resembles a personality dimension in the sense that all alcoholics 'a priori' occupy some position on the scale, or whether 'loss of control' and 'inability to abstain' should be regarded as diagnostic categories characterised by signs or symptoms. If the latter is the case then it would be expected that an alcoholic might fall into neither category, and the extent to which an alcoholic had signs of loss of control could vary independently of the signs of inability to abstain. Jellinek's writings indicate that he regards the loss of control/inability to abstain distinction as resembling the diagnostic rather than the trait model. Further clarification, however, of these issues is needed.

3. Aetiology. Social, psychological and physiological theories have been developed to explain different patterns of drinking in alcoholics. Stein, however, claims that the cause is 'multi-dimensional' and it is reasonable to suppose, considering the complicated nature of alcoholism as a whole, that drinking pattern is not the function of a single cause or even of a single type of cause. If this is the case then the nature of the interaction of the different determinants must be investigated.
4. The generality of the loss of control/inability to abstain distinction. The important question raised here is whether the same distinction can be applied to non-pathological drinkers. Cahalan and Cisin (1969) distinguished those who take small daily amounts from those who drink spasmodically. He found that given the same total amount those who never have more than five drinks on one occasion were older and in a higher social class, better adapted to their environment, less likely to be worried about their drinking and less dependent on alcohol to cope with their problems.

Summary

Two forms of alcohol addiction have been described by Jellinek. The Gamma or loss of control alcoholic is characterised by his inability to stop drinking voluntarily once he has started. He is eventually forced to stop because of the physical ill effects, an accident, or because available supplies of drink or money are exhausted. A brief period of abstinence occurs between drinking bouts. These, however, disrupt the rest of his life: he experiences craving and has withdrawal symptoms, and knows his drinking is abnormal.

The Delta or inability to abstain alcoholic is characterised by a steady excessive level of alcohol consumption. Because he can control the amount he drinks on any one occasion his excessive drinking is less conspicuous especially as this form of alcoholic addiction often occurs in a social milieu where a high level of drinking is required or approved. Nevertheless he is unable to function adequately for any length of time without a drink. Jellinek maintains that Delta alcoholism will predominate
in countries like France which generally approve of and facilitate the routine consumption of large amounts of alcohol. In this situation only a small physical or psychological vulnerability is required to produce addiction. By contrast Gamma alcoholism predominates in countries like Britain and the U.S.A. where there are both laws and social conventions controlling the consumption of alcohol. Consequently a more considerable 'psychological vulnerability' is required to produce addiction.

'Loss of control' addiction has received more attention in the literature and complex psychological and physiological explanations have been offered. An important question is whether Gamma and Delta drinking patterns are just two of a number of forms that alcoholism may take, or whether they represent two poles of a 'pattern of drinking' dimension on which all alcoholics can be placed.

There is also a need for replication studies to investigate whether this classification can be reliably applied to other alcoholic populations. The use of questionnaire methods may help in the elucidation of these problems.
CHAPTER 3 (ii)

AGE AND ALCOHOLISM

Most studies of alcoholism report at least the mean age of the sample. There have been, however, few studies that have investigated the relation of alcoholism to age as such. Community surveys and studies of first admissions to mental hospitals for alcoholism suggest that middle-age is the highest risk period for alcoholism. Similarly, Skid Row drinkers and prison alcoholics (Feeney, 1955; Myerson, 1966) are usually in their forties. Those studies which attend specifically to the relation of age to alcoholism tend to focus on young alcoholics, or on comparisons between groups of young and old alcoholics. If there are particular factors inducing tensions in middle-age which precipitate alcoholism, then those who become alcoholics at an earlier age may be more disordered in terms of personality, or be subject to more factors predisposing to alcoholism.

Hassall (1968) investigated a group of 40 alcoholics under 30 years of age, referred for treatment at a number of centres in Scotland. She found that the young alcoholics obtained significantly higher scores on the General Hostility scale of the HDHQ when compared with their matched controls and a group of undifferentiated young neurotics. They were also more hostile than other alcoholic groups. Philip (1969) has suggested that the total hostility score is an undifferentiated measure of psychiatric disturbance.
**TABLE 3.1**

The General Hostility scores of alcoholic groups on the HDHQ

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<th>Mean</th>
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<td>1. Hassall (1968)</td>
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<tr>
<td></td>
<td>Young male alcoholics (N=40)</td>
<td>27.65</td>
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<tr>
<td></td>
<td>Matched controls</td>
<td>17.37</td>
</tr>
<tr>
<td>2. Walton (1968)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-patients of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcoholism Unit (N=38)</td>
<td>20.66</td>
</tr>
<tr>
<td></td>
<td>Gamma type</td>
<td>23.81</td>
</tr>
<tr>
<td></td>
<td>Delta type</td>
<td>18.36</td>
</tr>
<tr>
<td>3. Philip (unpublished data)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcoholics (N=23)</td>
<td>21.65</td>
</tr>
</tbody>
</table>

Young alcoholics are also differentiated from other groups in terms of their drinking history. Hassall's group started drinking at 15.5 years which is two years earlier than most other groups of alcoholics. Rosenberg (1969) in his study comparing alcoholics under 30 with those over that age, found the younger alcoholics were drunk at an earlier age and took less time to lose complete control over their drinking. In addition, once alcoholism had developed the younger alcoholics had fewer periods of abstinence, and were more likely to have taken other drugs. Both Rosenberg and Hassall found that young alcoholics were higher in social class as estimated by current occupation - Rosenberg found that 50% were in social class III. The most probable reason for this is that the young alcoholics have had less time to deteriorate in their occupational skills.
There is disagreement over whether the family background of the young alcoholic is more or less disordered. In Hassall's group there was a much lower incidence of alcoholism among relatives, but Rosenberg found that significantly more of the alcoholics below 30 years had fathers who were alcoholics or heavy drinkers; they were also more likely to have been separated from their fathers for long periods. Cramer (1963) divided a group of female alcoholics in prison into those whose problem drinking started before they were 25, and those who started after that age. The 'early starters' in comparison to the 'late starters' were more likely to come from disorganised homes where they felt the victims of parental dislike; their parents were more likely to have been problem drinkers themselves and were seen as severe and inconsistent parent figures. The life history of the 'late starters' shows that they had a variety of disturbances in childhood, but that their families were not disorganised to the same extent. Cramer suggests that the comparatively less disorganisation accounts for the delay in onset. In this group alcoholism developed in response to pressures experienced at a later stage, after a period of normal social drinking. This is in contrast to the 'early starters' with their grossly disorganised family background who appear to have had a much shorter period of 'normal' drinking.

Rosenberg found that young alcoholics obtained higher scores on the neuroticism scale of the Eysenck Personality Inventory (Eysenck and Eysenck, 1964) and on Factor Q4 (ergic tension) of the IPAT Anxiety Test (Cattell and Scheier, 1963). In terms of the Direction of Hostility scale of the HDHQ, Hassall found paradoxically that those who had prison
convictions were more intropunitive, and those who had attempted suicide were more extrapunitive!

**Summary**

Young alcoholics when compared with older alcoholics are more disordered in terms of their drinking history, the degree of family disturbance, and their current psychological state. Foulds (1968, 1969) has suggested that it is not age 'per se' that accounts for the differences but the age of onset of drinking as a problem. The number of studies directly investigating the relationship of age to alcoholism is small, and there have been discrepant findings.
CHAPTER 4 (i)

INVESTIGATIONS AND PROBLEMS IN THE STUDY OF
THE PERSONALITY CHARACTERISTICS OF ALCOHOLICS

The W.H.O. definition quoted in chapter 2 refers to the effect of alcoholism on the mental state of the individual. Much research, however, has been carried out to see if there are psychological factors associated with the etiology of alcoholism as well as with its effects. Early studies were preoccupied with 'the search for the alcoholic personality' (Armstrong, 1958). Such attempts to isolate a particular kind of personality associated with alcoholism have been unsuccessful. Sutherland (1950) in a review of 37 reports concludes that there is 'no satisfactory evidence to justify a conclusion that persons of one type are more likely to become alcoholics than persons of another type.

Many of the early investigations were made using projective techniques. Syme (1957) however, in a review of twelve such studies reports that even where research methods were adequate and key 'signs' were isolated, subsequent attempts at replication often produced contradictory results. The reason for this lies in the nature of projective techniques where in the attempt to ascertain the 'basic personality structure' from the subject's response the clinician has to make his own inferences which are subject to distortion.

Non-projective studies have focussed on the identification of alcoholics using items and scales largely drawn from the MMPI. Hampton (1951) claimed that his scale not only differentiated alcoholics from non-alcoholics but
primary from secondary, and weekend from social family drinkers. Macandrew (1964) gave this scale with two other scales derived from the MMPI to 300 male alcoholic out-patients and 300 non-alcoholic psychiatric patients. Correlations between the three scales after items explicitly referring to alcohol had been removed were very low, .17, .22 and .21. The three scales together contained 191 different items and only seven items were common to all three. Since the items had been selected on their ability to discriminate alcoholics from non-alcoholics, and yet failed to do this in a psychiatric population, Macandrew concluded the scales were measures of general psychological disturbance on which a variety of psychiatric patients score high.

Some scales, however, were based on comparisons of alcoholics with other psychiatric groups. Macandrew (1965) derived a 49 item scale from the MMPI, a cut-off point was determined from the standardisation samples, and in a cross-validation study it correctly allocated 81% of the patients. Haertzen (1967) constructed a 74 item psychopathic scale, and found alcoholics intermediate between drug addicts and criminals. During withdrawal addicts and alcoholics are more similar - they are both tense, anxious, and socially and intellectually inefficient, but after the withdrawal phase addicts move towards the criminal group on the scale.

The potential value of these scales is that they may isolate certain psychological characteristics which distinguish alcoholics from non-alcoholics. They may be useful as screening instruments but the items do not provide an overall view of the person's personality. The requirement for this task is a well standardised questionnaire which covers a wide range of behaviour and personality factors. Cattell's 16 Personality
Factor Questionnaire, the '16PF', is suitable for this purpose (Cattell and Eber, 1965).

Walton (1968) and Fuller (1966) have used the 16PF to study the personality of alcoholics, while the Institute of Personality and Aptitude Testing have accumulated 122 profiles of alcoholics. Holt (1965) administered the 16PF to 84 prisoners convicted for 'drunk and disorderly behaviour', and mainly drawn from Melbourne's 'Skid Row'. In comparison with normals the alcoholics in all four studies were 'serious', 'taciturn' and 'introspective' (F-). They experienced an unusually high degree of tension and frustration (Q4+) and their high score on the second order factor of anxiety indicates an acknowledged inability to release tensions effectively or control them - this may well be a factor in their recourse to alcohol. They also showed unpredictable emotionality (C-) referred to as 'weak ego-strength'. This has been found to typify adolescent attitudes - Fuller argues that this indicates difficulty in assuming mature social roles. The alcoholics in the samples of Walton, Fuller and Holt were more inhibited and diffident (H-), while IPAT, Holt's and Fuller's group were 'guilt prone' and 'apprehensive', feeling unable to meet the demands of everyday life (O+).

It is evident from these findings that alcoholics differ from normals on a number of important personality dimensions. This, however, is not evidence for 'the alcoholic personality'. Fuller found in fact that the profile of his alcoholics correlated .6 with 122 neurotics; within that category the alcoholics resembled most closely a group of 76 depressives. There was a small negative correlation with psychopaths and sociopaths.

Walton, using McAllister's 16PF norms for psychiatric groups (1968), found that the alcoholics resembled most closely neurotic and personality disorder groups.
Syme (1957) criticises the use of questionnaire techniques in the study of alcoholics on the grounds that a subject's response to questionnaire items reflects the subject's self-perception and with alcoholics this perception will already have been altered by their recognition and disposal as an alcoholic. Syme's contention is not confined to the value of personality questionnaires, but raises a general question of the extent to which the alcoholic's present condition is a function of his years of excessive drinking. This has been the source of much debate, but remains an unsolved problem. For it is clear that the 'pre-alcoholic' personality cannot be directly assessed in a concurrent study. The approach, however, taken in this study is that there is value in investigating the personality of the alcoholic after years of excessive drinking for this is the condition in which they present for treatment. Moreover it is possible to disentangle cause and effect to some extent in the case of the 16PF where some factors are known to be stable over time, whereas some change with treatment.

The only research method which avoids the problem of whether personality features are the result of alcoholism is the prospective longitudinal or cohort study. There are only two studies of this kind which contain information on alcoholics. These are the Oakland Growth Study (Jones, 1968) and the Cambridge-Sommerville Youth Study (McCord and McCord, 1959, 1962).

In the Oakland study 66 men in their mid-forties were classified on the basis of their drinking behaviour into five groups, ranging from total abstinence to problem drinking. They had been assessed using the California 'Q' test at three previous stages - junior high and senior high
school level, and later in their thirties. Those who were classed as problem drinkers differed from normals on ratings of: interest in opposite sex, enjoyment of sensuality, eroticism, the direct expression of hostility, and rebelliousness. Jones (1968) argues that those characteristics which were present before drinking started indicate a self-indulgent, undercontrolled, impulsive personality.

The Cambridge-Sommerville study consisted of 29 boys who later became alcoholics. The measures were derived from ratings carried out by trained social workers. McCord and McCord (1959) used the data to test certain currently held psychoanalytical theories of alcoholism by comparing the 29 in the sample with 159 non-alcoholic and non-criminal controls.

(i) Alcoholism as a sign of self-destruction

Menninger's theory was that when a baby the alcoholic was led to expect more oral gratification than he received; this led to oral frustration and a wish to destroy his love objects - his parents. The rage against the parent was repressed because of guilt and turned against the self giving rise to feelings of worthlessness and inferiority. If alcoholism is a sign of powerful self-destructive tendencies, then the prediction is that there should be more suicide attempts among alcoholics preceding their alcoholism. This was found to be the case, but the numbers were small and the difference failed to reach statistical significance.

(ii) Alcoholism as a sign of oral fixation

Fenichel claimed the alcoholic was fixated at the oral stage. The prediction from this is that the alcoholic should show more oral tendencies which may be expressed in excessive smoking, thumb sucking, eating orgies and 'playing with the mouth'. This prediction was not confirmed.
(iii) Alcoholism as a sign of latent homosexuality

Ferenczi and Abraham claim that the alcoholic had experienced severe frustration at the oral stage, and so turned against mother and over-identifies with father. Alcoholism is a substitute for overt homosexuality - the male camaraderie of the bar and disinhibiting effect of alcohol allows the satisfaction of inhibited homosexual motives. The prediction is that there will be a higher proportion of covert homosexuals among alcoholics. This was not confirmed, and in fact the proportion of covert homosexuals - those with some feminine characteristics - who became alcoholic was lower than for overt homosexuals and normals.

(iv) Alcoholism as an attempt to remove feelings of inferiority

According to Adler's theory of personality those with a conscious feeling of inferiority or who were extremely self confident would be more likely to become alcoholic. This prediction was not confirmed and in fact there was a lower incidence of alcoholism among those who consciously expressed feelings of inferiority. There was no difference between alcoholics and non-alcoholics in the amount of pampering and dependence encouraged by their mothers.

While none of the psychoanalytic theories were confirmed McCord and McCord noted two associations that emerged: (i) a person with marked suicidal tendencies is more likely to be alcoholic; (ii) boys with strong, consciously expressed inferiority feelings are less likely to become alcoholics.

A particularly valuable feature of the McCords' work is that in addition to the 29 boys who later became alcoholics, 89 fathers who were currently alcoholics were studied. A comparison between the pre-alcoholic
boys and alcoholic fathers may elucidate the aetiological problem of which personality characteristics precede alcoholism and which develop after its onset. From this comparison it is possible to infer a certain pattern of change.

The pre-alcoholic boys differed from normals on the following characteristics:

(i) disapproval of mother
(ii) indifference towards siblings
(iii) a tendency to deny 'dependency', be self-sufficient, and to be active rather than passive
(iv) less likely to be disturbed by normal fears
(v) more expression of unrestrained aggression
(vi) tendency to be preoccupied with sexual fears

The personality of the pre-alcoholic boy is characterised according to the McCords as 'a facade of intense masculinity which occurs in early adolescence'. In comparison to normals the alcoholic father showed the following characteristics:

(i) a tendency to reject their sons
(ii) a tendency to play a passive role in the family, or else be a 'dictator'
(iii) involvement in intense family conflict
(iv) discipline of the son is erratically punitive or lax
(v) tendency to feel victimised by society and have grandiose ideas of his potential capabilities
(vi) tendency to exhibit unrestrained aggression
(vii) openly dependent
(viii) a tendency to place enjoyment above other values
The relationship between the personality features of the pre-alcoholic boy and alcoholic adult. Although the pre-alcoholic boys and alcoholic adults had two personality features in common – excessive aggression and rejection of their immediate family, they differed on a large number of features. In an earlier study McCord (1960) found that alcoholics in childhood were subjected to experiences that might lead to intensified dependency needs, and to a confusion in self-image: (i) alcoholics tended to have been raised in conflict ridden homes, by emotionally erratic and unstable mothers; (ii) paternal alcoholism and paternal rejection were found to predispose the son to alcoholism.

McCord (1962) uses these earlier findings to infer a process which accounts for the differences between the pre-alcoholic boy and the alcoholic adult: the conflict in the home with an unstable mother leads to intensified dependency needs which the boy deals with, in the absence of an adequate model provided by his father, by fastening on to the most readily available self-image of manhood – the indifferent, independent, aggressive 'man'. Thus in childhood his fear of dependency is concealed by his apparent self sufficiency. In adulthood alcoholism supplies a compromise for, while he is initially attracted to the 'masculine' image of drinking, his alcoholism allows him to become dependent.

A clearer picture of the personality of the pre-alcoholic emerges if the findings of the two longitudinal studies are considered together. Gomberg (1968) in her review of these two studies isolates two personality features which are present before alcoholism develops:

(i) Inadequate control over aggression: the alcoholic may not only have more aggression but have less control over its overt expression.
(ii) Dependency conflict characterised in childhood by a denial of dependency and an overplaying of the 'masculine role'.

For a fuller description of the personality of the alcoholic at the time of his seeking treatment the 16PF data should be added. Compared to normals they are solemn and taciturn (F-), apprehensive (O+) and tense (Q4+) with unpredictable affective reactions (C-). These features would be expected to be shown by a general psychiatric population at the time of admission. Hence the difficulty noted by Macandrew (1960) of devising a discriminating scale. Walton, however, found that compared to neurotics alcoholics were more shy and timid (H-). Both McCord (1962) and Jones (1968) found that alcoholics place greater value on immediate enjoyment than do normals. If this were the case then lower scores might be expected on 16PF factors Q3 (follows own urges) and G (weak super-ego). These differences were not found.

Summary

Concurrent studies of alcoholics show that they differ in terms of personality from normals, and less clearly that alcoholics differ in certain respects from other psychiatric groups: compared with normals alcoholics are more anxious and less emotionally stable; compared with neurotics they are more timid and shy. Concurrent studies, however, raise one important methodological problem - the extent to which the measure obtained of the alcoholic's personality is a reflection, not of his pre-alcoholic personality, but of the effects of years of excessive drinking. A prospective longitudinal study is the only research method which avoids this problem. Only two such studies have contained information about alcoholics.
In certain respects the measures used were unsatisfactory. Two personality features, however, were found to be present before alcoholism developed: the lack of control over aggressive drives, and a dependency conflict characterised in adolescence by a 'facade of intense masculinity'. Early research attempted to isolate 'the alcoholic personality' but no such personality has been found. Authors, however, are agreed that personality variables are important. It is reasonable to suppose that alcoholism may represent a 'final common pathway' for people with a variety of physical or psychological 'vulnerabilities'. The literature suggests that three ways of differentiating alcoholics may be particularly important - the type of pattern of drinking, the age of onset of alcoholism, and the method of disposal by society. These are discussed in the following chapters.
The continued breach of social conventions and the law is usually taken to indicate mental incapacity or criminality which requires punishment, treatment or seclusion. Although alcoholics are regarded by most of the medical profession as suffering from a disease, some alcoholics are handled not by social or medical services but by the police, the courts, and the prison service. They are repeatedly arrested on the charges of 'drunk and disorderly' and 'drunk and incapable'. They are usually fined a small amount, but finish up in prison because they are either unable or unwilling to pay the fine. They are called by various names, 'chronic drunkenness offenders' (Guze, 1962), 'inebriate offenders' (Jones, 1963), 'Skid Row drinkers' (Myerson), or 'homeless drinkers' (Straus, 1946). Though 'Skid Row drinkers' and 'chronic drunkenness offenders' are defined in different ways, in practice the terms apply on the whole to the same population, since most alcoholics found in prison are 'Skid Row drinkers' while most drinkers on Skid Row have been in prison because of their drinking. This is the case both in Britain and in the U.S.A. Myerson in his survey of Skid Row drinkers (1966) found that 93% had been arrested more than 24 times, 65% averaged more than one arrest every two years, while 7% had a record of 100 or more arrests. Edwards (1966) in his survey of 57 men attending a soup kitchen in Stepney, London, found that all but 6 were alcoholics, and that 47 of the remaining 51 had been arrested for drunkenness. Nineteen of these had been arrested
more than 10 times. He also found 96% of the alcoholics were of the loss of control type, as defined by Jellinek.

One of the problems in this field is that in some studies of 'chronic drunkenness offenders' and 'Skid Row drinkers' the exact proportion of the group who are alcoholics is not stated. Since 'chronic drunkenness offenders' and 'Skid Row drinkers' have been found to be drawn from the same population, for the purpose of this study they will be dealt with together, and the terms 'chronic drunkenness offender' and 'Skid Row drinker' regarded as equivalent.

**The size of the problem**

The chronic drunkenness offender constitutes a problem in a large number of countries, and a leading article in the B.M.J. on this subject referred to special procedures that have been developed in Austria and Poland. In Britain they constitute a very large problem. Fifty percent of the prison admissions for England and Wales (B.M.J. 1968) are composed of persons on drunkenness charges. In 1967 in England and Wales there were 70,499 arrests for drunkenness or 19 per 10,000 of the population over 15 years. The range was from 26 per 10,000 in Pembrokeshire to 1.4 per 10,000 in Norfolk. The situation in Scotland has been well described in a paper by Ratcliff (1966) which is more fully reviewed in chapter 7 on the treatment of alcoholics. Ratcliff records that there were 1,180 occasions in Scotland in 1965 when a man was actually imprisoned as a result of a drinking offence.

The repetitive cycle of drunkenness - police arrest - court appearance - prison sentence - release - drunkenness has been termed in the United States
'the revolving door'. It forms a considerable burden on the courts and prisons, and the social services (Myerson, 1956). Gath (1968), as a part of the Maudsley Alcohol Impact Project interviewed 157 persons charged with drunkenness immediately before their court appearances. The extent to which this group is an alcoholic population was demonstrated by the 50% who showed signs of chemical dependence. Only 6% of these were sentenced to prison, and so are in this respect a less socially deviant group than one composed entirely of alcoholics in prison. Gath observed an alarming amount of pathology - medical, psychological and social - 8% had attempted suicide; 32% had a serious accident as a result of drinking; 26% had a head injury as a result of drinking; 58% had never married; 17% were living with their wives; 55% had had no contact with either their parents or siblings in the last 12 months; 42% had slept in a reception centre; 51% had slept 'rough'; 32% had pawned clothes; 24% had either stolen or borrowed money. A significant number showed the revolving door process of repeated arrests: 51% had been convicted of a similar offence in the last 12 months; 30% had been convicted 3 times in that period, while 24% had been convicted once or more in the past 4 months.

The pathology found in these 151 cases indicates the size of the problem - Gath estimates that the figure of 70,499 arrests for drunkenness in 1967 represents 35,000 individuals.

Some characteristics of the Skid Row Drinker

The Skid Row drinker has been the subject of many investigations by psychologists (Lisansky, 1957; Feeney, 1955), psychiatrists (Myerson, 1956; Edwards, 1966, 1968) and sociologists (Rubington, 1958; Straus, 1946).
Age: The average age of the drinker was found to be in the 'forties'.

**TABLE 4.1**

Average age in years of the Skid Row drinker

<table>
<thead>
<tr>
<th>Drinkers</th>
<th>Average Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edwards (1966)</td>
<td>44.7</td>
</tr>
<tr>
<td>Feeney (1955)</td>
<td>41</td>
</tr>
<tr>
<td>Myerson (1966)</td>
<td>46 (median age)</td>
</tr>
<tr>
<td>Pittman (1958)</td>
<td>47.7</td>
</tr>
<tr>
<td>Straus (1951)</td>
<td>51.3 (whites)</td>
</tr>
</tbody>
</table>

Marital status: Most Skid Row drinkers are either single, or else separated or divorced from their wives.

**TABLE 4.2**

Marital Status of Skid Row alcoholics by per cent

<table>
<thead>
<tr>
<th>Drinkers</th>
<th>Married</th>
<th>Divorced</th>
<th>Separated</th>
<th>Widowed</th>
<th>Ever Married</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeney (1955)</td>
<td>4</td>
<td>32</td>
<td>33</td>
<td>26</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>Straus (1951)</td>
<td>5</td>
<td>33</td>
<td></td>
<td>12</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Pittman (1958)</td>
<td>5</td>
<td></td>
<td>36</td>
<td>64</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Edwards (1966)</td>
<td>17</td>
<td>11</td>
<td>11</td>
<td>3</td>
<td>58</td>
<td>58</td>
</tr>
</tbody>
</table>

The table shows that a far higher percentage of those who become Skid Row drinkers never marry compared to 13% for the general population (in the U.S.A.). Of those Skid Row drinkers who have married a comparatively higher proportion are divorced or separated - Pittman (1958) found that 96% of those who had married did not live with their wives, compared with
the expected 11% for the general population. The English group has the lowest percentage of those who married.

Social class: Most studies have used the occupational status of the alcoholic to estimate his social class.

**TABLE 4.3**

<table>
<thead>
<tr>
<th>Study</th>
<th>Percentage of Skid Row drinkers in Class V (unskilled labour)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeney (1955)</td>
<td>84</td>
</tr>
<tr>
<td>Straus (1951)</td>
<td>63</td>
</tr>
<tr>
<td>Myerson (1966)</td>
<td>32 (those in half-way house)</td>
</tr>
<tr>
<td>Edwards (1966)</td>
<td>60 (those refusing treatment)</td>
</tr>
<tr>
<td>Gath (1968)</td>
<td>48</td>
</tr>
</tbody>
</table>

**Parental Loss:**

**TABLE 4.4**

<table>
<thead>
<tr>
<th>Study</th>
<th>Percentage of Skid Row drinkers with Parental Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeney (1955)</td>
<td>39% lost father before 20 years old</td>
</tr>
<tr>
<td></td>
<td>28% lost mother</td>
</tr>
<tr>
<td></td>
<td>18% lost both parents before 20 years old</td>
</tr>
<tr>
<td>Edwards (1966)</td>
<td>58% with one or both parents for 3 years or more, before the age of 13</td>
</tr>
</tbody>
</table>

These figures indicate Skid Row drinkers both in the U.S.A. and in Britain are more likely to have suffered some kind of parental loss or extended absence, in comparison with a normal population.
Psychiatric Diagnosis:

TABLE 4.5

<table>
<thead>
<tr>
<th>Psychiatric Illness</th>
<th>Feeney (1955)</th>
<th>Myerson (1956)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overt psychosis</td>
<td>30</td>
<td>6</td>
</tr>
<tr>
<td>Pre-psychotic</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>Sociopath</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Passive dependent</td>
<td>-</td>
<td>55</td>
</tr>
<tr>
<td>Neurotic</td>
<td>20</td>
<td>-</td>
</tr>
</tbody>
</table>

Myerson comments on the fact that Feeney's group had more psychotics and organic patients, and contends that his own group was more atypical because his group was composed of those who accepted the 'half-way house' programme and who were, therefore, more likely to possess strong dependency needs.

Summary

From this short survey (of the personal data that has been collected in a number of studies conducted in either the U.S.A. or Britain) a picture emerges of the typical Skid Row drinker as a man in his forties, with a disrupted home background. He is occupationally unskilled and is either single or else living apart from his wife, showing an inability to either establish or maintain close personal relations. This long standing 'disturbance of the person' (Foulds, 1965) is indicated by the high proportion who can be placed in a category of psychiatric disorder.

Although most studies contain information on the basic characteristics considered above, many investigate particular aspects of the life of Skid
Row drinkers, and its causes. These require separate presentation. Some of the more important aspects will be considered below.

Possible differences between the Skid Row drinker of the U.S.A. and Britain

Most of the studies of the Skid Row alcoholic have been conducted in the U.S.A. or Britain. The question, therefore, of the comparability of findings between the two countries is an important one - how similar is the 'wino' of New York's Skid Row to the homeless drinker of Edinburgh's Grassmarket?

A particularly important question is whether the Skid Row drinkers in both countries are alcohol addicts. Edwards (1966) in his study in London of 50 'bombed site' drinkers found that 49 were 'chemically dependent'. In a study of vagrants using a Reception Centre in Camberwell he found 25% were chemically addicted; 45%, however, had been arrested by drunkenness and half of these said that they had had 'the shakes', so that a number of these may be on the way to becoming fully addicted to alcohol.

Crude spirit drinkers

Edwards also found a high proportion, 58%, of crude spirit drinkers. These drinkers had more severe morning symptoms of nausea, 'the shakes', sweats, craving and blackouts, and more frequent day time amnesias. Seventy-two per cent of the crude spirit drinkers, compared with 43% of the other drinkers, had auditory hallucinations. They usually started drinking crude spirits when they were offered some by another person at a time when they were needing alcohol to relieve the withdrawal symptoms but had no money for cider or wine. Seven of the 29 who drank crude
spirits preferred them to any other form of alcohol, and all but one said that crude spirits had a 'special effect'.

Straus, in two studies in the United States, one of 203 drinkers admitted to a Salvation Army Hostel in New Haven, Connecticut (1946) and the other of 444 men using a day time shelter and recreation centre in the Bowery in New York (1951), has raised the question whether most Skid Row drinkers are alcoholic in the sense of being chemically addicted. He estimated that only half were alcoholics. The criteria he used were: (i) persistent and repetitive drinking which is progressively destructive of the person's psychological and social function; (ii) episodic or spree drinking, where once the alcoholic starts drinking, control is lost. Straus distinguishes drinkers who show these features from what he calls 'pathological drinkers' who are not addicted. The characteristics of this group were: (i) the interference of alcohol with health and personal relations; (ii) the reduction of efficiency and dependability at work as a result of alcohol; (iii) 'a state of discomfort' in the drinker, but (iv) he exhibits control and planning over his drinking to obtain a limited effect for as long as possible. In contrast to the 'addicted' group, these drinkers do not necessarily buy the cheapest drink in terms of alcoholic content. Sufficient information on this group has not been gathered to state conclusively that on Skid Row there are two groups, one addicted and one not. An alternative interpretation is that Straus' dichotomy resembles Jellinek's Gamma/Delta classification and that the group of non-addicted pathological drinkers contains many who in different social circumstances would be called Delta or inability to abstain alcoholics. The different proportions of alcohol addicts among Skid Row
drinkers between British and American studies may be a reflection not of national differences in the two Skid Row cultures, but may be the result of the kind of hostel or service centre at which the Skid Row drinkers were interviewed. The discrepancy in the proportion of alcoholics in Edwards' two London studies, supports this interpretation.

Straus' studies, however, are interesting in the emphasis that is put on the consideration of social factors, not only in the cause of Skid Row drinking but in its maintenance. Straus argues that heavy drinking for these people is in part an adjustment to reality - a way of coping with their low status. Rubington (1958) criticises the 'individualistic approach' to the Skid Row drinker and homeless alcoholic, which explains the person's current behaviour in terms of the possession of particular attributes. He claims that this approach is inadequate because many people who never develop alcoholism show the personality features characteristic of the alcoholic. It also neglects the social forces that serve to sustain a 'Skid Row culture'. It may attract people with a variety of different characteristics, but offers them a common subculture which they can be a part of, and which has its own particular patterning. Rooney's (1961) investigation of group processes among Skid Row drinkers supports this view. Edwards found that communal drinking is common especially among crude spirit drinkers. Myerson (1956) describes how groups of men would prepare 'Sterno' (canned heat) — one of the men with a steadier hand would bottle feed those who were particularly tremulous and shaky.

These drinkers, however, regard 'Skid Row' with ambivalence. Many talk about how it is the only place that accepts them and that 'Somebody will always give you a drink if you need it'. Jones (1963), however,
observes 'When off their guard they clearly display their dissatisfaction with this life of begging and jail sentences, of flop houses and missions, of personal relationships that are marked by generosity with alcohol but egocentric selfishness and violence in almost about everything else'.

If there are social relations on Skid Row which are both coherent in themselves and yet deviant in relation to the rest of society, then an important question is the process by which persons become a part of this subculture. Even though it may be the case that there is a higher proportion of alcohol addicts in Britain compared to the U.S.A., studies in both countries have revealed a similar course of events which lead up to the person's presence on Skid Row. Perhaps the three features which most clearly differentiate the life pattern of the Skid Row are occupational instability, residential mobility and the repetitive cycle of drinking, arrest, and imprisonment. Myerson (1966) and Feeney (1955) in the United States and Edwards (1966) in Britain have been concerned to explain the development of these three features. Studies undertaken by them reveal in the Skid Row drinker a long history of failure to attain and sustain close personal contacts, and a tendency to irritability and restlessness. Edwards argues that the cause of their social restlessness is not excessive drinking itself, but a damaged personality, often traceable to childhood. This is indicated by a large proportion who lose one or both parents, or suffer separation from them for long periods.

A number of other people, however, have the same personality characteristics and so talk of a Skid Row personality is not justified. A more appropriate approach is the investigation of the social conditions which may interact with these personality features. Edwards observes that the
majority come from large working class families which may be more tolerant of social deviance and make fewer attempts than a middle class family to recover a person from the vicious spiral of uncontrolled drinking and loss of job. Myerson found that 70% of Skid Row drinkers came from families who were unable in some way to cope, and had recourse to some 'social agency'. A common source of stress in these families was the presence of an alcoholic father. Straus describes the family and social conditions, associated with a person becoming a member of Skid Row, in terms of 'under-socialisation'. He maintains that people are normally conditioned by the sanctions and prohibitions which facilitate interaction and the sharing of experiences. For those who have not learnt these basic social skills associating with other people is difficult. A vicious circle is set up because the person then becomes even more remote from the usual socialising agencies of the family, school and work place. Straus' theory of under-socialisation has been criticised by Jones (1963) on the grounds that the study by Rooney of group processes in Skid Row alcoholics does not indicate a general deficiency in social and interpersonal skills. It is reasonable to suppose, however, that the instability of his family and its failure to cope has an effect on the children's ability to manage their own lives. The education record of these alcoholics (Jones, 1963) reflects a general failure to follow through any sustained course of action. At adolescence they fail to acquire any work skills and soon develop the repetitive pattern of drunkenness and arrest. As control over drinking is lost the types of employment open to these men is diminished and so a critical stage is reached when they are unable to pay the court fine, or else prefer to go to prison because they have already become homeless. The age when this
decisive point is reached is usually associated with the final break-
down of marriage, or else the death of the alcoholic's mother if he has
remained single. Myerson found that 49% came into Skid Row after their
wives had left them, and 37% when their mothers had died. The two
critical events, therefore, which finally bring the person on to Skid
Row are: (i) loss of the only close personal contact; (ii) the first
imprisonment. The order in which they occur may vary - in some cases
the first prison sentence may be the final blow to the marriage. By
this stage, however, the person is a 'full member' of Skid Row: he has
no steady job, no home of his own and is involved in the cycle of drunken-
ness - arrest - prison.

Straus (1946) found no differences between those for whom heavy
drinking preceded homelessness and those for whom the order was reversed.
He did, however, discover differences between those who had married at
some stage, and those who had always been single. The 'ex-marrieds'
started heavy drinking later in that twice as many as the 'non-marrieds'
started after 30 years. The 'ex-marrieds' also tended to have started
in better jobs - only 6% compared to 25% 'non-marrieds' had started in
lowest status jobs. There was no difference between their drinking habits.
The reason for this may be that occupational instability and homelessness
of Skid Row encourage excessive drinking irrespective of marital experience.
There was no difference in the amount of residential mobility. This may
be more a function of the size of the town: Straus in New York, and
Edwards in London found the average length of stay was three years.
However, in a smaller town, New Haven, Connecticut, Myerson found 50%
had been in the State for a week or less.
Life on Skid Row itself has been fully described by Myerson (1956). He states that life for the Skid Row drinker revolves around three key people: the barman or grocer who provides what he wants – alcohol in exchange for money; the policeman who arrests him functions almost as a protector as it interferes with his continuous drinking; the employer – the Skid Row drinker may perform his job quite adequately, but is unreliable because he invariably leaves when he has earned sufficient money to become drunk. The relationship to his employer is the only one which corresponds to a relationship which ordinary citizens have. All the relationships the Skid Row drinker has, however, are determined by his desire for alcohol. He demands satisfaction of his needs – those who supply them are his 'friends', but as soon as they refuse they become 'enemies'. He feels loved only as long as his insatiable demands are met. The effect of this on the other person is eventually to reject him. The demanding aspect of the personality of these men was noted by Myerson when those drinkers who had participated in the rehabilitation programme tried to restore family contacts. They expected that because they had laid off drink for six months, their family would automatically take them back. They were on the whole unable to see that the problem was not just one of drinking. The significance of the drinking, however, was that it prevented them from being in a condition in which they could face their personality difficulties. Instead the 'revolving door' continues – while in prison the Skid Row drinker has time to contemplate his failure in life and his isolation, and then, when he goes out, he drinks in order to forget this fact. Alternatively he may deny that he has a problem, refuse help, only later to face his grim situation alone in a lodging house. The result is the same – he starts drinking again.
The studies dealt with so far have been primarily descriptive. Their value is that together they provide a detailed picture of the Skid Row drinker, his current pattern of living, and social and family conditions which preceded. The limitation of these types of studies is that they are basically comparisons with the general population. Unfortunately there are only a few studies which compare Skid Row drinkers or chronic drunkenness offenders with other groups of alcoholics. Three studies have been found, however, which give full accounts of the characteristics on which Skid Row drinkers differ from other alcoholics. Guze (1962) interviewed 233 criminals convicted consecutively in a particular jurisdiction of Missouri State. Using Jellinek's criteria of alcoholism he found that 43% of the criminals were alcoholic. The following features were significantly associated with the alcoholic prisoners in comparison to those who were not alcoholic: their families tended to have a history of alcoholism and suicide; the alcoholic prisoners themselves were more likely to have anxiety neurosis, and tended to have been arrested ten or more times; they had records of more frequent fighting before the age of eighteen. The alcoholics also tended to have had two or more jobs in the preceding two years, to have been discharged from military service, and to have been wandering around the country. The percentage of those who were alcoholics rose with age - under 21 years 39% were alcoholics, 21-30 years - 55%, and over 30 years 64% were found to be alcoholic. Guze says that this could be explained in three ways: (i) alcoholism may be easier to diagnose in older people; (ii) the risk of becoming an alcoholic increases with the length of time in a criminal career; (iii) alcoholics are more
likely to continue in a criminal career. Pittman (1962) found in his study of the criminal careers of the chronic drunkenness offenders that when young they tended to be arrested for offences other than drunkenness, but after 35 years most of their convictions were for drunkenness.

Holt (1965) compared the profiles obtained by 34 prison alcoholics on Cattell's 16PF with those of 67 undifferentiated prisoners. The alcoholics deviated from normals on the same factors as did the undifferentiated prison group, but they tended to obtain even more extreme scores. They scored particularly highly on the second order factor of Anxiety and on the following related first order factors: 'ergic tension' (Q4+), 'emotional instability' (C-) and 'apprehensive and guilt prone' (O+). They were also more submissive (E-), glum and silent (I-), more expedient (G-), timid and shy (H-), suspecting and jealous (L-), and more wrapped up in their own concerns (M-).

An important factor in considering the question of the appropriate treatment for alcoholics at present in prison is the extent to which they resemble alcoholics who are already receiving psychiatric treatment. Howard Jones compared 36 alcoholics in prison with 36 alcoholics receiving in-patient psychiatric treatment. The prison group differed significantly from the patient group on a number of features. Fewer of them had been married and, if they had, then the risk of separation or divorce was higher. They tended to come from larger families and from families in which the father had an occupation of lower status. They also spent far less time in education and were geographically more mobile. They did not, however, experience any more 'emotional deprivation' or 'social insecurity' as children. It is evident from this that prison alcoholics differ from
hospital alcoholics on the same factors, primarily social, which differentiate them from normals. Jones, in discussing the contrast between prison and hospital alcoholics comments that 'it is not difficult to understand why alcoholics who are not so strikingly different in their basic motivation should end by displaying such very different patterns of social behaviour as matured alcoholics. The jailed alcoholics have so many fewer footholds in society that it is bound to be they, if any, who will fall into the abyss'.

Similar conclusion can be drawn from a study by Feeney (1955). He found that the prison alcoholics tended to be lower in intelligence and educational and occupational level, have more siblings, and far fewer of them are married. The prison alcoholic is more likely to have brain damage or a deformity and to be less well motivated in psychotherapy and to have a poorer prognosis than the alcoholic who attends the alcoholic unit. There were also differences between the two groups in psychiatric diagnosis: the prison alcoholic group included more psychotics and sociopaths and fewer neurotics. There were no differences on current age of onset, duration of alcoholism or parental drinking habits. Lisansky (1957) in a similar study with female alcoholics found that the prison group alcoholics were less likely to bring up their own children; they are younger (average age 37.5 years; of out-patients 41.3) and lose control over their drinking more quickly. The studies of Lisansky and Feeney show that the Skid Row drinker or prison alcoholic is not just at a later stage of alcoholism compared with the alcoholics in hospital, but represents a different kind of alcoholic problem. This does not mean that the prison and hospital alcoholic necessarily differ in terms of their personality.
features before becoming alcoholics. What these studies do imply is that the social conditions associated with the development of the Skid Row drinker and prison alcoholic involve additional factors which must be considered in the development of appropriate treatment facilities.

Summary

Chronic drunkenness offenders and Skid Row drinkers appear to be drawn from the same population. The exact proportion in the groups studied of those who are addicted to alcohol varies but seldom falls below 50%. These pathological drinkers, whether chemically addicted or not, are primarily distinguished from both the normal population and from other alcoholic groups by social variables. They come from larger families which are of lower social status in terms of their father's occupation. They make little progress at school, leave early and fail to develop occupational skills in adolescence. At this age they start drinking. Their failure to establish or maintain close personal relations becomes more evident, and the pattern of drunkenness and arrest develops. The final events which precipitate their arrival on Skid Row is the first imprisonment for drunkenness and the break up of the one close relationship they may have had, with the death of mother or the departure of wife. The three features which, according to Edwards (1966) characterise the Skid Row drinker are now evident:

(i) A life long personality disorder signified by a continued failure to establish or maintain close personal contact;

(ii) An acquired chemical disease of alcohol addiction;

(iii) Pathological social adjustment, characterised by residential mobility and occupational instability.
It is the third characteristic which mainly distinguishes the prison from the hospital alcoholic. The implications of this for the treatment of the prison alcoholic are considered in Chapter 2II.
CHAPTER 5 (i)

REVIEW AND DISCUSSION OF THE TESTS AND MEASURES USED IN THE STUDY

The tests and measures used in the study may be divided into two classes: The Hostility and Direction of Hostility Questionnaire, or HDHQ, the Symptom Sign Inventory, or SSI and the Sixteen Personality Factor Questionnaire, or 16PF are well standardised tests of established reliability. They have also been used on a variety of groups so that the comparisons can be made between these groups and those investigated in the present study. The Pattern of Drinking Questionnaire, the Drinking Behaviour Questionnaire, the Psychiatric Rating Form, and the Personal History Inventory, were all especially constructed for this study. In view of their early stage of development the results they produce must be interpreted with caution. The Drinking Behaviour Questionnaire was developed to obtain detailed information on which an accurate description of the behaviour of the alcoholic could be based. The 'Pattern of Drinking Questionnaire' was an attempt to provide a standard replicable procedure for differentiating Gamma and Delta alcoholics. In the 'Psychiatric Rating Form' the psychiatrist provides a clinical rating of the same dimension of 'Pattern of Drinking'. The 'Personal History Inventory' contains items relating to the subject's family and basic information about the person's history and background: it includes a three-fold estimate of social class derived from estimates of previous residence, occupational status, and level of education.
The seven tests and measures used in the study are more fully described in the following sections of this chapter.

1. **Personal History Inventory**

Page (1) **Social class estimates:** Alcoholism develops in the context of a general drinking culture. The relation of alcoholism to the general drinking culture of a society was discussed in chapter 2 with reference to Scotland. Kessel and Walton (1965) in their discussion of social and cultural theories of causation of alcoholism, identify three factors: incitement, opportunity and example. A common approach to the investigation of social factors is to classify the subjects studied in terms of social class. The concept of social class as such is used in a variety of senses. However, the Registrar General's classification of occupations (1966) on a five-point scale remains the most widely used estimate of social class. But such a simplistic approach fails to differentiate between social class origin, social class functioning - past and present - and social class 'status'.

Jones (1963) preferred the occupational status of father as an estimate, for this provides an estimate of social class origins. Graffar (1956) has constructed a measure which is more sensitive to environmental influence, but it is cumbersome for survey work (Henderson, 1967). Consequently, for the purposes of this study a compromise was made, and a number of estimates were used, including those sensitive to current environmental influences. The four estimates were occupation of father, educational level, subject's own occupation and the last place of residence. A five-point scale was used in each case, and the categories are laid out
in a copy of the Personal History Inventory in the appendix:

(i) occupation of father provides an estimate of social class origins;
(ii) educational level provides an estimate of the subject's social class before drinking; (iii) subject's last occupation provides an estimate of current social function; (iv) last place of residence is another index of present social functioning, but is included because a person who is still living in an ordinary working area is likely to differ in important ways from a person moving around in cheap lodging houses.

Page (2) Personal Data Form: This consists of three sections:

(i) The occurrence of problem drinking in the alcoholic's family and relations: the higher incidence of problem drinking among the relatives of alcoholics is a widely reported finding (Kessel and Walton, 1965).
(ii) Previous hospitalisation for alcoholism: information in this section includes the number of hospital admissions and the treatment received.
(iii) Legal record: this covers the total number of convictions and fines received for offences associated with drinking, which may indicate how far advanced the subject is in his alcoholism. Information collected under sections 2 and 3 provides an estimate of the extent to which the prison and hospital samples of alcoholics overlap.
2. The Drinking Behaviour Questionnaire

This record form, which was filled in by the investigator after close questioning of each subject, covers a wide range of drinking behaviour. The detailed nature of the enquiry makes it extremely difficult for the subject to distort the information required. Three areas of information are obtained, relating to onset of drinking, drinking in the previous 12 months and drinking in the 3 months prior to admission or arrest, under the following headings:

1. Age at start of drinking
2. Age when drinking recognised as a problem
3. Places in which drinking occurred
4. Alcohol Types
5. General weekly pattern (which days are different and which equivalent)
6. Periods
7. No. of hours
8. Amount of alcohol
9. Place
10. % of hours drinking alone
11. Rate of consumption (amount drunk in an hour)
12. No. of days in a month when drinking is <25% of average amount
13. Abstinence period of more than 2 weeks in past 12 months
14. Continuous drinking in past 12 months

Some of the copious information obtained using this instrument has not been analysed for inclusion in this study.
3. **The Psychiatric Rating Form**

This form has three sections: clinical criteria for the diagnosis of alcoholism; clinical assessment of the pattern of drinking; associated psychiatric diagnosis. A copy of the form is contained in the appendix.

**Clinical criteria for alcoholism:** The psychiatrist was asked to indicate those criteria of alcoholism which the patient met. The four criteria were derived from Kessel and Walton's (1965) definitive description of the alcoholic, and are the same as those used by C. Hassall (1967) in her study of young alcoholics. The criteria are listed below:

(i) the inability to spontaneously give up drink for any length of time (failure to intend drinking behaviour);

(ii) the inability to function normally, i.e. cope with routine tasks, without recourse to alcohol (psychological dependence);

(iii) the occurrence of withdrawal symptoms such as the 'shakes', fears, and tremors when drinking stops or is reduced; these symptoms are usually dispelled by the resumption of drinking (physical addiction);

(iv) the disruption of a major segment of a person's life - physical health, work, social or home life (social disorganisation).

**Clinical assessment of the pattern of drinking:** The psychiatrist was asked to rate each patient in the hospital group on a 6-point scale, with 'loss of control' at one end and 'inability to abstain' at the other. The psychiatrist was given a list of the 16 criteria which were considered to differentiate 'loss of control' and 'inability to abstain' alcoholics. A clinical assessment of pattern of drinking was included in order that a comparison could be made with the 'Drinking Pattern Questionnaire'. This is discussed in the following section.
Associated psychiatric diagnosis: The psychiatrist completing the rating scale was asked to record the presence of any other psychiatric disorder, and indicate its severity.

4. The Pattern of Drinking Questionnaire

The literature in the pattern of drinking was reviewed in a previous section. The questionnaire was constructed on the basis of features derived from the definitive descriptions of Gamma (loss of control) and Delta (inability to abstain) alcoholics by Jellinek (1952, 1960), Kessel and Walton (1965) and Walton (1968). The original questionnaire covered twelve differentiating characteristics expressed in questions of an alternative kind, for example:

"Did you keep drinking fairly steadily, or were there times when you laid off drinking for a short while".

There were two questions for each differentiating characteristic in the questionnaire with the order of the alternatives reversed in the second question. This feature was included in the questionnaire in order to control for 'positive response set' ('yea-saying') but was omitted in the final version, since no inconsistencies were ascertained in the trial administration and the repetition proved to be a source of irritation to the subjects. Questions covering four more differentiating characteristics were added to the final version making a total of sixteen questions.

Dr. H.J. Walton was consulted at each stage in the development of this instrument, and in the final version he indicated the 'key features' and so made possible two methods of scoring, providing a weighted and unweighted score.
The questionnaire was given orally and the subject was required to choose one of the alternative statements. Ambiguous responses were explored until a decision could be reached.

The classification of the pattern of drinking in terms of these two forms of alcoholism may be such a complex process that it cannot be resolved into even a large number of questionnaire items, and only established in a clinical interview. However, the position taken in this study is that in so far as the rational basis of the clinical interview can be made explicit, its elements can be expressed in the form of a questionnaire.

The Standardised Tests used in the study

Two of the tests, the HDHQ and 16PF, are self-administered questionnaires. This type of test has been critcised on the grounds that the scores obtained are affected by response bias. In particular Edwards (1957) has claimed that most of the variance on scales derived from personality tests of this type is accounted for by a factor he has termed 'social desirability'. Those critical of questionnaire techniques have interpreted this as demonstrating that the subject distorts his reply, consciously or not, to give a favourable impression. Scott (1963), however, argues that what is considered 'socially desirable' will vary with the individual. Consequently the view expressed by Syme (1957) in his review of personality studies of alcoholism seems more balanced: he concludes that the limitation of questionnaires is that they are in part a reflection of the subject's current self conceptions. Philip (1968) in a full review of the criticisms made of self administered questionnaires
observes that most of the studies demonstrating marked response bias have used a single personality questionnaire, the MMPI, while the subjects have been mainly students who would be expected to differ from groups investigated in most psychiatric studies. Philip concludes "In the absence of strong evidence to the contrary there is no reason to doubt the majority of patients are well motivated to be co-operative and truthful in their response to questionnaires and inventories".

5. The Sixteen Personality Factor Questionnaire (16PF)

The 16PF is an objectively scorable test covering a wide range of personality traits. These are coherently related by Cattell in a general theory of personality, described most fully in his book 'The Scientific Analysis of Personality' (1965). Each personality factor corresponds to and has been validated against a primary personality trait found in extensive factor analytic studies. The split half consistency coefficients vary from .90 for Factor A to .71 for Factor Q1. It is surprising, therefore, in view of the extensive research involved in the validation of these factors, and their impressive reliability, that Cattell's contribution to personality measurement has only recently been acknowledged (Holtzman, 1965). His complex factor analytical techniques, and proclivity for neologism may account in part for this delay.

The 16PF has been used in a large number of studies and its reliability and validity has been established over a wide cross section of the population. Full details on the reliability and validity of the factors are given in the 'Handbook for the Sixteen Personality Factor Questionnaire' (Cattell and Eber, 1965), which also provides a full description of each of the
16 obliquely related first order factors and the 4 second order factors, and an account of the scoring procedure by which raw scores are converted into 'sten scores'. A brief description of the 16 bi-polar first orders is provided below.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Low score</th>
<th>High score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Aloof</td>
<td>Warm, outgoing</td>
</tr>
<tr>
<td>B</td>
<td>Unintelligent</td>
<td>Intelligent</td>
</tr>
<tr>
<td>C</td>
<td>Emotionally unstable</td>
<td>Mature, stable</td>
</tr>
<tr>
<td>E</td>
<td>Submissive</td>
<td>Dominant</td>
</tr>
<tr>
<td>F</td>
<td>Reticent</td>
<td>Enthusiastic</td>
</tr>
<tr>
<td>G</td>
<td>Expedient</td>
<td>Conscientious</td>
</tr>
<tr>
<td>H</td>
<td>Shy</td>
<td>Venturesome</td>
</tr>
<tr>
<td>I</td>
<td>Tough-minded</td>
<td>Sensitive</td>
</tr>
<tr>
<td>L</td>
<td>Trustful</td>
<td>Suspecting</td>
</tr>
<tr>
<td>M</td>
<td>Practical</td>
<td>Self-absorbed</td>
</tr>
<tr>
<td>N</td>
<td>Simple</td>
<td>Sophisticated</td>
</tr>
<tr>
<td>O</td>
<td>Confident</td>
<td>Apprehensive</td>
</tr>
<tr>
<td>Q1</td>
<td>Conservative</td>
<td>Radical</td>
</tr>
<tr>
<td>Q2</td>
<td>Group dependent</td>
<td>Self-sufficient</td>
</tr>
<tr>
<td>Q3</td>
<td>Uncontrolled</td>
<td>Self-controlled</td>
</tr>
<tr>
<td>Q4</td>
<td>Relaxed</td>
<td>Tense</td>
</tr>
</tbody>
</table>

The second order factors of Anxiety and Introversion-Extroversion are obtained by applying the formulae set out in the Handbook for the Sixteen Personality Factor Questionnaire (Cattell and Eber, 1965). These formulae are as follows:

\[
\text{Anxiety} = 3.7 - 0.2C - 0.2H + 0.2L + 0.30 - 0.2Q3 + 0.4Q4 \\
\text{Introversion-Extroversion} = 0.2A + 0.2E + 0.4F + 0.5H - 0.2Q2 - 1.1
\]
Clinical and research findings using the 16PF are published in an 'Information Bulletin' by the Institute of Personality and Ability Testing. A bulletin has been produced on alcoholism (Fuller, 1966) including the 16PF profiles of 696 alcoholics from Willmar Hospital and a further 122 profiles from other sources. Walton (1968) has 16PF profiles from 38 in-patients of an alcoholism unit, and Holt (1965) from 84 alcoholics in prison. All these studies have been reviewed in chapter

Administration procedure

The 16PF Form E (low literate) was given to all subjects, because it was thought that Forms A, B or C, where the subject has to choose between three alternative answers for each question would be too difficult for some of the prisoners. In Form E the subject just has to choose between two contrasting statements. The Form E version has only recently been prepared: the standardisation is based on 306 cases, and each factor has been validated against the corresponding factor on Form C.

It was necessary because of the shortage of time, especially at the prison, to tell some of the subjects what they had to do, rather than leave them to read the instructions.

6. The Symptom Sign Inventory (SSI) and the Hostility and Direction of Hostility Questionnaire (HDHQ)

Both the SSI and the HDHQ have been developed within Foulks' theory of personality, elaborated in his book 'Personality and Personal Illness' (1965). In this book he emphasises the distinction between symptoms and signs, and attitudes and traits, which any psychological measure or theory
of psychopathology should observe. Traits and attitudes are universal in the sense that people differ only in the degree to which they have the trait or attitude; they do not differ on whether they have it or not. Symptoms, however, are only possessed by a small number of people, so that the important difference is not in the extent to which the symptom is expressed, but whether the symptom is present or absent. Traits and attitudes are also more enduring than symptoms. There is evidence for this from a number of studies (Coppen, 1965; Foulds, 1958; Mayo, 1967a) where measures of symptomatology were found to be significantly different before and after treatment, whereas measures of traits and attitudes were less affected. Finally, traits and attitudes are ego-syntonic, i.e. they are integrated into a person's behaviour and life pattern, whereas symptoms are ego-dystonic, interfering with the person's life and causing distress.

Many psychological measures used clinically and in research, such as the MMPI and MPI (Corah, 1964; Gocka and Marks, 1961; Kasselbaum, 1959) do not observe the distinction. The SSI, the HDHQ and the HOC, therefore, have been developed to cover the need to measure separately symptoms, and personality traits and attitudes. Because the HDHQ and SSI are comparatively new tests, and less well established than the 16PF, a fuller description of these tests and the associated research has been provided.

7. The HDHQ

According to the Manual of the HDHQ (Caine, Foulds and Hope, 1967), it is designed to sample a wide range of possible manifestations of aggression, hostility or punitiveness. The test was constructed with
five subscales, on the assumption that, while hostility may be a unitary factor it can be expressed in a variety of ways. This assumption and the development of the measures has been fully discussed by Foulds in 'Personality and Personal Illness' (1965). There were three extrapunitive scales: acting out hostility (AH), criticism of others (CO) and delusional hostility (DH), and two intropunitive scales: self criticism (SC) and delusional guilt (G) (Foulds, Caine and Creasy, 1960). All five scales were positively correlated, which is evidence for their being a general factor of hostility. The patterns of correlation confirmed that the extrapunitive subscales were measuring something different from the intropunitive ones. These assumptions were confirmed by Hope's (1963) principal component analysis. The first component was unipolar with all five sub-tests represented, and since no criterion measure of amount of hostility was available, this was taken to approximate such a measure. The second component contrasted the intropunitive scales with the extrapunitive ones, and was assumed to be a measure of the direction of hostility, either outwards against other people, or inwards against the self. Further validation was provided by the method of criterion groups. The validation of the first component by this method rests on the assumption that psychotics have more aggression than neurotics, who in turn have more than normals. This order is predicted by Foulds' theory of a continuum of Personal Illness (1965). The second component is more securely validated. It was predicted that melancholics (psychotic depressives) would be more intropunitive, and paranoids more extrapunitive, while hysteroid personalities would be more critical of others. These predictions were confirmed except for one group of paranoids who were no more extrapunitive than normals.
Psychopaths did not score more highly on the 'acting out of aggression scale' and so Hope renamed it 'the urge to act out hostility'.

Hope (1963) from studies in South-East England found that the component structure was the same for neurotics and for normals. This was replicated by Philip (1968a) on a comparable population in North-East Scotland. Philip found that in his sample normals scored more highly on general hostility and were more intropunitive. This has not been explained, but in a subsequent paper Philip (1969) notes the need for more extensive norms. He also argues that it may be more useful to treat intropunitive and extrapunitive scales separately. He terms these Sum I and Sum E respectively. In normals the Sum E score is higher, but in neurotics Sum I is increased so that both scales are approximately equal. For hospitalised psychopaths there is an increase in both Sum E and Sum I. Sum I has been found to vary over time more than Sum E. Philip suggests an alternative interpretation of the component structure: in this Sum I would become a measure of Personal Disturbance (Foulds, 1965) manifested in the form of self blame and psychiatric symptomatology; Sum E would be related to psychopathy; Sum I + Sum E, corresponding to Hope's first principal component, would be an undifferentiated indicator of Personal Disturbance which increases with progress along the continuum of personal illness (Foulds, 1965).

The reliability of the measure has been estimated from the test-retest correlation coefficients. The reliability was .75 for the General Hostility scale and .51 for the Direction of Hostility scale. Philip (1968) concludes that test-retest figures are adequate when compared with the reliability coefficients of personality tests in general.
Many of the studies which have used the HDHQ have been investigating the relationship between personality traits and symptoms in subjects with different types of social or psychological pathology. Neurotics (Caine, 1965) and depressives (Foulds, 1965; Mayo, 1967a) show a reduction in General Hostility as their psychological state improves. Mayo (1967b) showed that those who have neurotic symptoms but do not seek treatment are less intropunitive than neurotics who do seek treatment. They are, however, more extrapunitive than normals. In this case higher extrapunitive may be a substitute for a psychiatric 'breakdown'. Foulds (1966) found that when patients were divided in terms of whether their symptoms were psychic or somatic, those with somatic symptoms scored lower on General Hostility and were less intropunitive. Foulds notes that the somatisation of symptoms may be an expression of hostility which is not measured by the HDHQ. This is further support for the claim that the HDHQ measures only the amount of hostility which is allowed to enter the respondent's consciousness.

Foulds (1967) found that those classified as Character Disordered on the SSI obtained General Hostility scores two standard deviations higher than neurotics, but did not differ on Direction of Hostility. In a comparison of prisoners and non-psychotic psychiatric patients the prison 'normals' and 'neurotics' scored more highly on General Hostility than their hospital counterparts on General Hostility, while the two Character Disorder groups were not significantly different.

In the HDHQ Manual, Foulds is careful to point out that although significant differences have been found between different psychiatric groups, the HDHQ remains primarily a descriptive, rather than a discriminating,
device. The means and standard deviations for the five different psychiatric groups and normals show that on average one group may be more hostile than another, but this does not entail that every member of 'x' diagnostic category has more hostility than a member of 'y'. Foulds recommends that it should be used in conjunction with the diagnostic instrument of the SSI. This was the manner of its use in the present study.

Administration and scoring

The HDHQ was administered according to the instructions in the Manual. The questionnaire consists of a set of statements which the subject is asked to circle as 'true' or 'false' according to whether he feels they apply to him or not. In the present study three of the subjects in the prison had to be given the test orally due to reading difficulties. The scores for the subscale are calculated using a keyed set of stencils. The General Hostility and Direction of Hostility are calculated according to the formula given by Hope (1963). In addition the two scales described by Philip (1968) were calculated:

\[
\begin{align*}
\text{Sum E (extrapunitiveness)} &= AH + CO + DH \\
\text{Sum I (intropunitiveness)} &= SC + G
\end{align*}
\]

The SSI

The purpose of the SSI is described by Foulds in the Manual (Foulds and Hope, 1968), "The SSI has been compiled as an aid to the differential diagnosis of the mentally ill". The SSI uses the eight commonly accepted categories of mental illness: four neurotic - anxiety state, hysteria, obsessional neurosis and neurotic depression, and four psychotic - melancholia (psychotic depression), mania, paranoid and non-paranoid schizophrenia.
Recent research (Kreitman, 1960) has shown diagnosis based on the traditional psychiatric categories is more reliable than was previously thought, and so Foulds considers it is defensible to develop a psychological instrument within that framework. Foulds, however, observes, from descriptions in the standard psychiatry textbooks, that some symptoms were mentioned as characterising two different syndromes. This showed there was a need to isolate symptoms which differentiate psychiatric categories, since it is the presence or absence of these symptoms which should lead the psychiatrist to prefer one diagnostic category to another. The SSI was developed to serve this function - the 80 items do not constitute an exhaustive checklist of psychiatric symptoms, but provide a selection of symptoms and signs which are important in discriminating one psychiatric class from another. It covers a wide range of psychopathology and so clinically it is a useful adjunct to the psychiatric interview which may tend to focus on a particular set of symptoms. In research it provides a standardised instrument for diagnosis which is a prerequisite for meaningful comparisons between groups in different studies. A full account of the construction of the 'a priori' scales and the selection of particular items is contained in the Manual (Foulds and Hope, 1968). In the present study all the 80 items of the SSI were given, but only the Personal Disturbance and Character Disorder scales were used.

The Personal Disturbance (PD) Scale

The PD scale is a general measure which differentiates those who are psychiatrically disturbed in some way from those who are not. It consists of 20 items which were selected for their power to differentiate a sample
of normal females from at least seven of the male or female diagnostic categories. This accords with Foulds' view that there are symptoms which are shared by all psychiatric diagnostic categories. The name of the scale requires some explanation: 'Personal' is preferred to 'mental' because it avoids resuscitating the 'mind-body' problem. The Personal Disturbance scale is an improved version of the Personal Illness scale. The Personal Disturbance scale, however, contains fewer items from the 'a priori' anxiety scale and more from the neurotic depressive and obsessional scale. A study by Mayo (1967b) revealed a group of normals who had many of the symptoms contained in the Personal Illness scale. As they were 'coping' with their symptoms and did not seek treatment it was not appropriate to classify them as 'Personally Ill', and so the scale was renamed the Personal Disturbance scale. The SSI Manual does not contain a clear definition of the scale, but Philip (1968) provides a full description, "The scale distinguishes people who experience or are observed to manifest difficulty in interpersonal relations, this difficulty being so distressing to many of them or to their intimates that help is sought to alleviate their problems".

The items comprising the PD scale are listed below:

A9 Are you afraid of going out alone?
B2 Have you lost interest in almost everything?
B4 Is the simplest task too much of an effort?
B6 Have you found it difficult to concentrate recently?
B7 Does the future seem pointless?
B9 Are you slower recently in everything you do than you used to be?
D1 Are people talking about you and criticising you through no fault of your own?

E1 Are you distressed by silly, pointless thoughts that keep coming into your mind against your will?

E3 Are you unnecessarily careful in carrying out even simple everyday tasks, like folding up clothes, reading notices, etc?

E6 Do distressing thoughts about sex or religion come into your mind against your will?

E7 Do you feel you just have to check things again and again - like turning off taps or lights, shutting windows at night, etc. - although you know there is really no need to?

E8 Have you an unreasonable fear that some careless act of yours might have very serious consequences?

E10 Do you have an uneasy feeling that if you don't do something in a certain order, or a certain number of times, something might go wrong?

F1 Do you feel that there is some sort of barrier between you and other people so that you can't really understand them?

F5 Do you think other people regard you as very odd?

F6 Do you feel that you cannot communicate with other people because you don't seem to be on the same wave-length?

F9 Do you have very strange and peculiar thoughts at times?

G4 Do you ever lose all feeling in any part of your skin, so that you would not be able to feel a pin-prick, or do you ever have burning or tingling sensations under your skin?

H7 Are you ever so low in spirits that you just sit for hours on end?

The distribution of PD scores obtained by normal women and psychiatric patients of both sexes is shown in the following table.
### DISTRIBUTION OF SCORES ON PERSONAL DISTURBANCE SCALE

<table>
<thead>
<tr>
<th>PD Score</th>
<th>Normal Women</th>
<th>Psychiatric Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>4</td>
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<td>17</td>
<td></td>
<td>8</td>
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<tr>
<td>16</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>34</td>
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<tr>
<td>11</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>41</td>
</tr>
<tr>
<td>9</td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td></td>
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<td>7</td>
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<td>41</td>
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<tr>
<td>5</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>1</td>
<td>10</td>
<td>34</td>
</tr>
<tr>
<td>0</td>
<td>52</td>
<td>22</td>
</tr>
</tbody>
</table>

\[ n = 69 \quad n = 562 \]

The PI and PD scales have been used in many studies. In some of these (Foulds and Mayo, 1967; Mayo, 1967a; Philip and McCulloch, 1967b, 1968) comparisons have been made between the mean scores of different groups while the SSI Manual also contains means and standard deviations for various groups on the PD scale. This has been criticised by Philip, and so the interpretation of PD scores, especially the use of mean scores, requires some comment. The items of the PD scale refer to symptoms and signs, and not to traits or attitudes. One of the differences is that symptoms and signs occur on only a small number of people and as would be expected, the distribution of scores on the PD scale is markedly skewed.
This casts doubt on the use of means as the basis for meaningful comparison. The second comment relates to the nature of the construction of the SSI: it has been developed as an instrument which places individuals into categories that carry with them implications for clinical treatment. If scores of 5 and above on the PD scale are taken as indicating Personal Disturbance, then a subject with a score of 5 is considered Personally Disturbed, as is a person with a score of 10. Philip comments, "The latter cannot be considered to be twice as disturbed as the former; all we can say is that he displays twice as many signs and symptoms of Personal Disturbance, and the probability of his being correctly allocated to the Personally Disturbed category is greater than if he displayed fewer symptoms". The system of scoring used by Philip was adopted:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>Normal</td>
</tr>
<tr>
<td>2, 3, 4</td>
<td>Borderline</td>
</tr>
<tr>
<td>5+</td>
<td>Personally Disturbed</td>
</tr>
</tbody>
</table>

The Character Disorder Scale (CD) differs from the other scales of the SSI in that it is validated against a group that had been classified primarily in terms of personality characteristics and not in terms of symptoms.

The eight items of the scale were initially selected on the basis of their ability to discriminate clinically diagnosed character disorders from other psychiatric categories. The items comprising the CD scale are listed below.
A1 Does your hand often shake when you try to do something?

B5 Are you depressed because of some particular loss or disappointment?

E5 Are you afraid you might do something seriously wrong against your will?

E8 Have you an unreasonable fear that some careless act of yours might have very serious consequences?

H1 Are you worried about having said things that have injured others?

H6 Because of things you have done wrong, are people talking about you and criticising you?

H8 Do you cause harm to people because of what you are?

H10 Do you ever go to bed feeling you wouldn't care if you never woke up again?

For women, using a cutting score between 3 and 4 with high scores as being indicative of character disorder, good discrimination between character disorders and other psychiatric states was achieved. Foulds found better results were obtained for men when item H10 was omitted, items A1, H6 and H8 were given double weightings, and a cutting score between 4 and 5 was used.

The CD scale has been most fully described by Foulds (1967) in a study which investigates the difference between neurotics and character disorders. The notion of character disorder as measured by this scale, however, has not yet been adequately defined, but approximates the definition given by Robin (1965) to hysterical psychopaths. These are characterised by:

(i) a continuous and chronic disability in personal relations
(ii) shallow emotional reactivity with recurrent explosions
In the discussion of the aims of the study in chapter 1 the absence of a study directly comparing prison and hospital alcoholics in Scotland was noted. The review of the literature has shown the need for such a comparative study, for at the moment the two groups are treated in a markedly different way, and it is important to know the extent to which this may be due to their different social or psychological characteristics. The importance of relating this difference to other variables was also seen, in particular the relation of age and alcoholism, and drinking pattern and alcoholism. And so in the present study a variety of social and psychological measures have been included which may help to elucidate these relations, or at least provide a fuller description of those features on which prison and hospital alcoholics differ, and those which are held in common. In addition, however, it was considered useful to formulate a number of specific hypotheses. Obviously in a preliminary study of this kind the hypotheses are to an extent speculative: many possible hypotheses are suggested from the literature, and so the selection of a small number for a single study is necessarily somewhat arbitrary. In most cases the hypotheses selected are related to studies made in Edinburgh (Mayo, 1967b; Philip, 1968; Walton, 1968) of a variety of 'pathological' groups using those standardised measures described in the review of the method in chapter 8. The five hypotheses which have been formulated are presented below with a short explanatory note on each.
Hypothesis 1. Alcoholics in prison will be of lower social class than those in hospital.

This is what would be expected in the view of the many investigations that indicate the extent of the overlap between prison alcoholics and Skid Row alcoholics, who on most definitions of social class are ranked low. Indeed the more general descriptions of the prison alcoholic are often in terms which differ dramatically from those used to describe hospital alcoholics.

Hypothesis 2. There are two types of alcoholics: Gamma or 'loss of control' alcoholics and Delta or 'inability to abstain' alcoholics.

This has been fully dealt with in the review of the literature and the review of the method. It was noted there that, though good clinical descriptions of Gamma and Delta alcoholism exist, this classification of drinking pattern has not been studied by more replicable methods using questionnaires.

Hypothesis 3. There will be a higher proportion of alcoholics of the Gamma type in prison.

This prediction follows from the clinical description of the Gamma alcoholic who, by definition, is unable to control the amount he drinks on any one occasion, and so is more likely to be arrested on such charges as 'drunk and incapable' and 'drunk and disorderly'. Furthermore, Gamma drinking has been described as socially more disruptive to the person's work, social and home life, and so would be expected from studies of prison alcoholics to occur more frequently in that population.
Hypothesis 4. Those who become alcoholics before 30 years old ('early starters') will have higher total hostility and may be more character disordered than those who become alcoholics after 30 years ('late starters').

This prediction was derived from the findings of Foulds and Hassall (1969) who, in a study of 181 male alcoholics, found that the 'early starters', in addition to having more police convictions and prison sentences and a higher rate of attempted suicide, also had higher General Hostility while 80% were diagnosed as personality disorders against only one in three of the 'late starters'.

Hypothesis 5. The prison alcoholics will be more Character Disordered according to the SSI than hospital alcoholics.

This is a speculative hypothesis suggested by clinical observations of those who score as Character Disordered on the SSI: they are usually found to display much social pathology - a history of violent outbursts or drug offences, and are admitted at the time of a social crisis. These characteristics would be expected to be found among prison alcoholics. Foulds and Hassall (1969) found that the 'early starters' were both more often diagnosed as personality disorders and had more prison sentences.

**SELECTION OF PATIENTS**

**Hospital Alcoholics**

The hospital sample of 40 alcoholics consisted of 39 consecutive admissions and one alcoholic who was referred but not admitted to the Alcoholism Unit of the Royal Edinburgh Hospital. It was originally intended to take referrals to the Unit but administrative problems made
this impractical. The hospital sample was seen in the period from 1st January to 9th May, 1969. The hospital group was made up in the following way: 26 were admitted for treatment by group therapy; 13 were admitted to the 'drying out unit' for assessment. Of these 6 had received intensive group therapy on a previous admission. One alcoholic included in this study was referred to the unit but was not admitted.

**Prison Alcoholics**

The prison sample of 18 consisted of prisoners who were in prison for offences directly associated with drinking, and known to be alcoholics by the Chief Nursing Officer. This was considered to be a reliable procedure since only a person of the Skid Row drinker type as described in chapter 6 is likely to be sent to prison for a drinking offence, or prefer prison to a small fine. Moreover, only those who showed a recurrent pattern of drunkenness and imprisonment were seen. The range was from 4 to 200 convictions. A final screening occurred with the administration of the Drinking Behaviour Questionnaire: from the replies of two prisoners to this questionnaire it was doubtful that they were alcoholic - both were accordingly excluded. The problem of obtaining co-operation in the prison was considerable. A proportion of those thought to be alcoholic refused to attend, and it did not prove possible to go and explain to them the nature of the study in the prison itself.

This group of refusers does raise the question of bias in the sample studied. However, in terms of social deviance those who agreed to be seen are less extreme and so significant differences obtained by comparison with the hospital would remain valid.
PROCEDURE

The Hospital

The patient was told by the nurse on duty, "The psychologist would like to see you". The patient was then seen either in a side office or the small discussion room of the unit. This was done as soon after his admission as was consistent with his health. In one case, however, the patient was seen in bed.

The Prison

The alcoholics in prison were seen by the psychologist in a private office in the prison hospital. After the first session certain of the prisoners refused to be seen. The practice was then changed so that prisoners saw the psychologist as soon as they came in before those who had refused influenced the new admissions to take the same position. It was evident from the replies of some of the prisoners that they regarded this as a new piece of prison routine which had been introduced. The point was made that those in prison for a drinking offence were being seen as a part of a special study. In some cases further information was given: that the group here was being compared with alcoholics in hospital, and that one of the possible results of the research may be the development of a service to alcoholics in prison. Most of the subjects who were told this expressed surprise, indicating that they had accepted that nothing could be done for them.

The Testing Session in Prison and Hospital

After the initial explanation and assurance of confidentiality the battery of tests were given. The order of presentation was as tabulated below.
<table>
<thead>
<tr>
<th>Approximate time for administration in minutes</th>
<th>Name of Test</th>
<th>Mode of Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-10</td>
<td>Social and Personal Data Sheet</td>
<td>Orally presented</td>
</tr>
<tr>
<td>5-15</td>
<td>Drinking Behaviour Questionnaire</td>
<td>&quot;</td>
</tr>
<tr>
<td>7</td>
<td>Pattern of Drinking</td>
<td>&quot;</td>
</tr>
<tr>
<td>15-20</td>
<td>Symptom Sign Inventory</td>
<td>&quot;</td>
</tr>
<tr>
<td>25-35</td>
<td>Cattell's 16 Personality Factor Questionnaire</td>
<td>Self administered</td>
</tr>
<tr>
<td>10-15</td>
<td>Hostility and Direction of Hostility Questionnaire</td>
<td>&quot;</td>
</tr>
</tbody>
</table>

When the administration of the SSI had been completed the subject was told, "I have some tests which I want you to do yourself". The psychologist supervised the subject until it was clear that he understood what was required and then left the room to allow the patient to complete it alone. The forms were scrutinised after their completion to check that they had been filled in correctly.

At the prison the same general procedure was followed but modifications were made in certain cases in order to fit in with the routine at the prison. When two or three prisoners were seen in a morning or afternoon session the prisoners who were waiting were asked to fill in the 16PF and HDHQ first. In chapter 8 it was noted that in some cases these two tests had to be given orally because of illiteracy or the loss or breakage of the subject's glasses.
This group is identified on the SSI CD scale by acknowledging 'symptoms' which characterise psychotics rather than neurotics. In the case of character disorders these 'symptoms' are not pathognomonic of a particular syndrome, but are signs of a disorder of the personality. Foulds explains the particular pattern of symptoms acknowledged by the character disordered patient in terms of his desire to evoke pity. Foulds also notes that the use of the CD scale reduces the number of people who might otherwise have been diagnosed by the SSI as psychotic depressives.

The administration

The SSI was given orally according to the instructions contained in the Manual. Specific problems of interpretation arose, however, with this population since a number of the signs and symptoms could be the specific result of excessive drinking. Where this problem arose the item was only scored if the subject claimed that he was generally distressed by the symptom and not just when he had been drinking heavily. This problem arose with the following items:

- **C1** Do you ever feel so confident and successful that there is nothing you can't achieve?
- **C3** Are you ever so cheerful that you want to laugh and joke with everyone?
- **F2** Do you ever see visions, or people, animals or things around you that other people don't seem to see?
- **F4** Do you ever have very strange and peculiar experiences?
- **G2** Do you ever have fits or difficulty in keeping your balance?
- **H1** Are you worried about having said things that have injured others?
- **H2** Are you an unworthy person in your own eyes?
- **H8** Do you cause harm to people because of what you are?
CHAPTER 6

RESULTS

The results are presented in two sections: section I contains those that directly relate to the hypotheses. Section II contains a general comparison between hospital and prison subjects on those characteristics investigated in this study.

SECTION I

Hypothesis 1. Alcoholics in prison will be of lower social class than those in hospital.

TABLE 6.1

OCCUPATIONAL STATUS OF ALCOHOLICS*
(using the Registrar General's Classification)

<table>
<thead>
<tr>
<th>Classes</th>
<th>Hospital</th>
<th>Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II, III</td>
<td>31</td>
<td>2</td>
</tr>
<tr>
<td>IV, V</td>
<td>9</td>
<td>16</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 22.31, \ p < .001 \]

* Frequencies presented in the tables have not been expressed as percentages as well because with small numbers the difference in proportion may be exaggerated.
FIGURE 6.1

OCCUPATIONAL STATUS. THE DISTRIBUTION AMONG PRISON AND HOSPITAL ALCOHOLICS

* In some tables and figures the letters 'H' and 'P' appear; these refer to the hospital and prison groups of alcoholics respectively.
TABLE 6.2

EDUCATIONAL LEVEL OF ALCOHOLICS

<table>
<thead>
<tr>
<th>Classes</th>
<th>Hospital</th>
<th>Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II, III</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>IV, V</td>
<td>12</td>
<td>17</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 20.62, \ p < .001 \]

FIGURE 6.2

EDUCATIONAL LEVEL: THE DISTRIBUTION AMONG HOSPITAL AND PRISON ALCOHOLICS
TABLE 6.3

RESIDENTIAL STATUS OF ALCOHOLICS

<table>
<thead>
<tr>
<th>Classes</th>
<th>Hospital</th>
<th>Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II, III</td>
<td>34</td>
<td>2</td>
</tr>
<tr>
<td>IV, V</td>
<td>6</td>
<td>16</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 28.79, \ p < .001 \]

FIGURE 6.3

RESIDENTIAL STATUS: DISTRIBUTION AMONG HOSPITAL AND PRISON ALCOHOLICS
TABLE 6.4

OCCUPATIONAL STATUS OF THE FATHERS OF ALCOHOLICS
(using the Registrar General's Classification)

<table>
<thead>
<tr>
<th>Classes</th>
<th>Hospital</th>
<th>Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II, III</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>IV, V</td>
<td>13</td>
<td>6</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 1.154, \text{ n.s.} \]

FIGURE 6.4

OCCUPATIONAL STATUS: THE DISTRIBUTION AMONG
THE FATHERS OF HOSPITAL AND PRISON ALCOHOLICS
TABLE 6.5

SOCIAL DRIFT: COMPARISON BETWEEN THE OCCUPATIONAL
STATUS OF ALCOHOLIC AND ALCOHOLIC'S FATHER

(i) Prison

<table>
<thead>
<tr>
<th>Classes</th>
<th>Alcoholic</th>
<th>Father of Alcoholic</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II, III</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>IV, V</td>
<td>9</td>
<td>6</td>
</tr>
</tbody>
</table>

χ² = 1.06, n.s.

(ii) Hospital

<table>
<thead>
<tr>
<th>Classes</th>
<th>Alcoholic</th>
<th>Father of Alcoholic</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II, III</td>
<td>26</td>
<td>19</td>
</tr>
<tr>
<td>IV, V</td>
<td>6</td>
<td>13</td>
</tr>
</tbody>
</table>

χ² = 2.69, n.s.

Tables 6.1 to 6.5 show that prison alcoholics are significantly lower in social class when this is estimated by alcoholic's occupational status, educational level and residential status; but is not when father's occupational status is taken as an index. The occupational status of alcoholics and that of their fathers is not significantly lower.
Hypothesis 2. There are two types of alcoholics - 'loss of control' or Gamma alcoholics and 'inability to abstain' or Delta alcoholics.

A. The Pattern of Drinking Questionnaire

FIGURE 6.5

DISTRIBUTION OF HOSPITAL AND PRISON SCORES ON THE PATTERN OF DRINKING QUESTIONNAIRE (PDQ)

Note: The relative frequency is the real frequency expressed as a percentage of N.
The distribution of these scores gives no evidence of bimodality which would be expected if there were two types of alcoholic.

B. The psychiatric rating of pattern of drinking on hospital alcoholics

**FIGURE 6.6**

THE FREQUENCY DISTRIBUTION OF PSYCHIATRIC RATING OF PATTERN OF DRINKING ON HOSPITAL ALCOHOLICS

Inability to Abstain  
Loss of Control
TABLE 6.6

THE FREQUENCY DISTRIBUTION OF PSYCHIATRIC RATING
OF PATTERN OF DRINKING ON HOSPITAL ALCOHOLICS

<table>
<thead>
<tr>
<th></th>
<th>DELTA</th>
<th>GAMMA</th>
<th>N=38 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Clearly some features</td>
<td>Some features</td>
<td>Total F</td>
</tr>
<tr>
<td></td>
<td>Mainly</td>
<td>Mainly</td>
<td>48</td>
</tr>
<tr>
<td>0</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>14</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>

Only the hospital alcoholics were rated for pattern of drinking by a psychiatrist. For practical reasons two patients were not rated. It was intended that the pattern of drinking scale should be used as a single scale with each alcoholic allocated to one of six places according to the degree to which he showed inability to abstain or loss of control features. The clinician, using the scale, however, used each half of the scale separately so that one alcoholic might be considered clearly loss of control but also show some inability to abstain features. This explains why the total number of frequencies (F) exceeds the number of individuals rated.

Because the distribution of psychiatrists' ratings is so skewed, with just two patients showing only inability to abstain features, the following analysis was made.
TABLE 6.7

THE PDQ SCORES* OF THOSE RATED PSYCHIATRICALLY AS SHOWING NO SIGNS OF DELTA DRINKING COMPARED TO THOSE WHO SHOVED AT LEAST SOME SIGNS

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Delta Features</td>
<td>28</td>
<td>13.46</td>
<td>5.85</td>
</tr>
<tr>
<td>Some Delta Features</td>
<td>10</td>
<td>16.1</td>
<td>4.63</td>
</tr>
</tbody>
</table>

\[ t = 1.2855, \text{n.s.} \]

If the 'Pattern of Drinking Questionnaire' (PDQ) and the 'Psychiatric Rating of Drinking Pattern' were measuring the same dimension of drinking pattern then it would be expected that those who showed no signs of Delta drinking, i.e. only loss of control drinking would score significantly higher on the PDQ. As this was not found to be the case and since the distribution of the PDQ was unimodal, and appeared to be normally distributed an analysis was undertaken to see with what other variables PDQ might correlate. The coefficient calculated was Pearson's product moment coefficient.

* The means and standard deviations in this chapter have been rounded to two decimal places. The statistical calculations, however, were performed with the unrounded figures.
TABLE 6.8

CORRELATIONS BETWEEN PDQ AND FIVE OTHER VARIABLES OF DRINKING BEHAVIOUR

<table>
<thead>
<tr>
<th>Amount of Alcohol per week</th>
<th>Hours spent Drinking per week</th>
<th>Years of Social Drinking</th>
<th>Years of Problem Drinking</th>
<th>Present Age</th>
<th>Age of Onset of Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>.43</td>
<td>.33</td>
<td>-.37</td>
<td>.46</td>
<td>-.03</td>
<td>-.16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- .44 Hospital</td>
</tr>
</tbody>
</table>

These results show that the more features of Gamma drinking that an alcoholic shows the more he will drink in terms of grams of absolute alcohol and the more time he will spend drinking. He will also be more likely to have had a shorter period of social drinking and have been drinking excessively for a longer length of time. Age as such appears to be unrelated to pattern of drinking.

TABLE 6.9

CORRELATION BETWEEN DURATION OF SOCIAL DRINKING AND AGE AT ONSET OF (i) SOCIAL DRINKING, AND (ii) PROBLEM DRINKING

<table>
<thead>
<tr>
<th>Duration of Social Drinking</th>
<th>Age at onset of Social Drinking</th>
<th>Age at onset of Problem Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-.089</td>
<td>.92</td>
</tr>
</tbody>
</table>

A high correlation was expected with one of these two factors since the duration of social drinking is the difference between age at which the
person first drank and the age at which drinking became a problem. As age of onset of social drinking does not vary much — most people start to drink in their late teens — it would be expected that the variance in the duration of social drinking would be largely due to how long it was before drinking became a problem.

**TABLE 6.10**

**CORRELATION OF AGE WITH HOURS SPENT DRINKING PER WEEK AND DURATION OF PROBLEM DRINKING**

<table>
<thead>
<tr>
<th>Hours spent Drinking per week</th>
<th>Duration of Problem Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.06</td>
</tr>
</tbody>
</table>

Age is comparatively unrelated to the time that is spent drinking. The older the person is, however, the longer he is likely to have had a drinking problem. It would be expected on 'a priori' grounds that if a person has lived longer he is more likely to have been drinking longer. Where it was suspected 'a priori' that age might affect the correlation between the two other variables, partial correlations were made.

**TABLE 6.11**

**PARTIAL CORRELATIONS OF PDQ WITH OTHER VARIABLES OF DRINKING BEHAVIOUR**

<table>
<thead>
<tr>
<th>Hours spent drinking</th>
<th>Duration of Problem Drinking</th>
<th>Age</th>
<th>PDQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>partiailling the effect of age</td>
<td>partiailling the effect of age</td>
<td>partiailling the effect of duration of problem drinking</td>
<td>.33</td>
</tr>
<tr>
<td>.51</td>
<td>-.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The correlation between PDQ and hours spent drinking is unaffected by age. However, the relation of Gamma features of alcoholism to the duration of problem drinking is stronger when age is held constant. The last partial correlation is more difficult to express – if the number of years of problem drinking is held constant, then younger alcoholics are slightly more likely than older ones to show signs of 'Gamma alcoholism'.

**TABLE 6.12**

**CORRELATIONS OF PDQ WITH SELECTED FACTORS FROM SCALES OF THE 16PF, HDHQ AND SSI**

(i) Correlations of PDQ with 16PF factors and General Hostility (HDHQ)

<table>
<thead>
<tr>
<th>Factor</th>
<th>C</th>
<th>F</th>
<th>H</th>
<th>Q2</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDQ</td>
<td>-.20</td>
<td>.05</td>
<td>-.22</td>
<td>.16</td>
<td>.26</td>
<td>.07</td>
</tr>
</tbody>
</table>

The drinking pattern seems unrelated to either Factor 2 (extraversion) or Factor F (enthusiasm).

(ii) Correlations of PDQ with General Hostility (HDHQ) and SSI Personal Disturbance and Character Disorder Scales, and 16PF Anxiety, and some intercorrelations

<table>
<thead>
<tr>
<th>PD</th>
<th>General Hostility</th>
<th>CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDQ</td>
<td>.16</td>
<td>.49</td>
</tr>
<tr>
<td>PD</td>
<td>.37</td>
<td>(.60 Prison)</td>
</tr>
<tr>
<td>16PF Anxiety</td>
<td>.45</td>
<td>.56</td>
</tr>
</tbody>
</table>
There appears to be a slight tendency for those with Gamma features to be more self-sufficient (Q2+). They are also more likely to be emotionally unstable (C-) and to be shy and reticent (H-). Gamma drinking, however, is most strongly related to General Hostility.

Hypothesis 3. There will be a higher proportion of alcoholics of the Gamma type in prison.

Because the PDQ scores were not bimodally distributed it was not considered appropriate to classify patients into Gamma and Delta types on the basis of their PDQ scores. It was not possible therefore to test this hypothesis by comparing the proportion of each drinking type in the hospital and prison samples. A 't' test, however, comparing the mean score on the PDQ for prison and hospital groups was possible.

**TABLE 6.13**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>40</td>
<td>14.05</td>
<td>5.53</td>
</tr>
<tr>
<td>Prison</td>
<td>18</td>
<td>19.44</td>
<td>4.15</td>
</tr>
</tbody>
</table>

\[ t = 3.69, \quad p < .001 \]

Table 6.13 shows that the prison alcoholics show significantly more features of Gamma drinking than hospital alcoholics.
FIGURE 6.7
THE FREQUENCY OF DISTRIBUTION OF PDQ SCORE
PRESENT BY (i) HOSPITAL (ii) PRISON

Note: The relative frequency is the real frequency expressed as a percentage of N.
Hypothesis 4. Those whose alcoholism started before 30 years (early starters will have higher total hostility, and may be more Character Disordered.

TABLE 6.14

COMPARISON OF SCORES OF 'EARLY' AND 'LATE' STARTERS ON TOTAL HOSTILITY SCALE OF THE HDHQ

(i) Hospital

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting under 30 years</td>
<td>18</td>
<td>23.2</td>
<td>7.16</td>
</tr>
<tr>
<td>Starting over 30 years</td>
<td>22</td>
<td>22.6</td>
<td>7.78</td>
</tr>
</tbody>
</table>

\[ t = 0.2514, \text{n.s.} \]

(ii) Prison

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting under 30 years</td>
<td>9</td>
<td>27.12</td>
<td>10.89</td>
</tr>
<tr>
<td>Starting over 30 years</td>
<td>9</td>
<td>26.5</td>
<td>8.42</td>
</tr>
</tbody>
</table>

\[ t = 0.1351, \text{n.s.} \]

(iii) Hospital and Prison

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting under 30 years</td>
<td>27</td>
<td>24.6</td>
<td>8.56</td>
</tr>
<tr>
<td>Starting over 30 years</td>
<td>31</td>
<td>23.4</td>
<td>8.37</td>
</tr>
</tbody>
</table>

\[ t = 0.53, \text{n.s.} \]
TABLE 6.15

COMPARISON OF MEAN TOTAL HOSTILITY SCORES OF THOSE ALCOHOLICS
OVER 30 YEARS (OLD) AND THOSE UNDER 30 YEARS (YOUNG)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young</td>
<td>4</td>
<td>29.25</td>
<td>6.89</td>
</tr>
<tr>
<td>Old</td>
<td>36</td>
<td>21.85</td>
<td>6.65</td>
</tr>
</tbody>
</table>

\[ t = 2.105, \ p < .05 \]

Note: There were no young alcoholics in the prison sample.

Tables 6.14 and 6.15 show that those for whom drinking is a problem
before 30 years are not significantly different on any of the HDHQ
measures of punitiveness from those whose problem drinking starts after
this age; however, those alcoholics who were under 30 years when tested,
were significantly more hostile than those over 30 years.

TABLE 6.16

FREQUENCIES OF 'CHARACTER DISORDERS' (CD)
AMONG 'EARLY' AND 'LATE' STARTERS

<table>
<thead>
<tr>
<th></th>
<th>CD</th>
<th>Non</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>Late starters</td>
<td>5</td>
<td>26</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.044, \ n.s. \]
Table 6.17 shows that there are no more Character Disorders among the early starters than among the late starters. Table 6.17 shows that those alcoholics who are Character Disorders did not start problem drinking significantly younger.

Although Tables 6.18 to 6.24 do not relate directly with hypothesis 4 it was considered appropriate to include them here.

### Table 6.17

**Age of Onset of Problem Drinking for Character Disorders and Non-Character Disorders**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD</td>
<td>8</td>
<td>29.62</td>
<td>9.07</td>
</tr>
<tr>
<td>Non CD</td>
<td>50</td>
<td>32.76</td>
<td>10.37</td>
</tr>
</tbody>
</table>

\[ t = 0.807, \text{n.s.} \]

### Table 6.18

**Comparison of the Mean Scores of Early and Late Starters on the PDQ Both for Hospital and Prison Groups**

#### (i) Hospital Alcoholics

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean PDQ Score</th>
<th>S.D.</th>
<th>t</th>
<th>p&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>18</td>
<td>15.94</td>
<td>5.69</td>
<td>2.16</td>
<td>.05</td>
</tr>
<tr>
<td>Late starters</td>
<td>22</td>
<td>12.5</td>
<td>5.01</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### (ii) Prison Alcoholics

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean PDQ Score</th>
<th>S.D.</th>
<th>t</th>
<th>p&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>9</td>
<td>19.11</td>
<td>4.93</td>
<td>0.33</td>
<td>n.s.</td>
</tr>
<tr>
<td>Late starters</td>
<td>9</td>
<td>19.77</td>
<td>4.44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6.18 shows that for the group of hospital alcoholics the early starters have higher PDQ scores than the late starters. This difference, however, was not found among the prison alcoholics.

**TABLE 6.19**

**COMPARISON OF THE DURATION OF SOCIAL DRINKING AMONG**

(i) **EARLY AND LATE STARTERS AND (ii) YOUNG AND OLD ALCOHOLICS**

(i) **Early and Late starters**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean duration of Social Drinking</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>27</td>
<td>6.15</td>
<td>2.93</td>
</tr>
<tr>
<td>Late starters</td>
<td>31</td>
<td>20.03</td>
<td>8.85</td>
</tr>
</tbody>
</table>

\[ t = 7.79, \quad p < .001 \]

(ii) **Young and Old Hospital Alcoholics**

(those whose present age was under 30 years and over 30 years respectively)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean duration of Social Drinking</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young Alcoholics</td>
<td>4</td>
<td>6.75</td>
<td>3.59</td>
</tr>
<tr>
<td>Old Alcoholics</td>
<td>36</td>
<td>15.17</td>
<td>10.53</td>
</tr>
</tbody>
</table>

\[ t = 1.62, \quad n.s. \]

Table 6.19 shows that alcoholics whose drinking problem started before 30 years have a shorter period of social drinking compared with those whose drinking problem started later. If the hospital alcoholics are divided in terms of present age, rather than onset of problem, the
difference in the duration of social drinking fails to reach significance. This may, however, be due to the small number in the young group.

Comparisons between early and late starters on social and family characteristics

<table>
<thead>
<tr>
<th>TABLE 6.20</th>
</tr>
</thead>
</table>

**ATTEMPTED MARRIAGE AMONG EARLY AND LATE STARTERS**

(i) **Hospital Alcoholics**

<table>
<thead>
<tr>
<th></th>
<th>Attempting Marriage</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Late starters</td>
<td>17</td>
<td>5</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.000, \quad \text{n.s.} \]

(ii) **Prison Alcoholics**

<table>
<thead>
<tr>
<th></th>
<th>Attempting Marriage</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Late starters</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.000, \quad \text{n.s.} \]

(iii) **Hospital and Prison Alcoholics**

<table>
<thead>
<tr>
<th></th>
<th>Attempting Marriage</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>Late starters</td>
<td>21</td>
<td>10</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.0075, \quad \text{n.s.} \]
### Table 6.21

**Stability of Marriage Among Early and Late Starters**

(i) **Hospital Alcoholics**

<table>
<thead>
<tr>
<th></th>
<th>Intact</th>
<th>Broken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Late starters</td>
<td>13</td>
<td>3</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.10, \text{ n.s.} \]

(ii) **Prison Alcoholics**

<table>
<thead>
<tr>
<th></th>
<th>Intact</th>
<th>Broken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Late starters</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.000, \text{ n.s.} \]

(iii) **Hospital and Prison Alcoholics**

<table>
<thead>
<tr>
<th></th>
<th>Intact</th>
<th>Broken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Late starters</td>
<td>13</td>
<td>7</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.007, \text{ n.s.} \]

Tables 6.20 and 6.21 show that there are no significant differences between early and late starters in the proportion who either attempt marriage or have broken marriages.
### TABLE 6.22

**ATTEMPTED SUICIDE AMONG EARLY AND LATE STARTERS**

(i) **Hospital Alcoholics**

<table>
<thead>
<tr>
<th></th>
<th>Attempted Suicide</th>
<th>No Suicide Attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Late starters</td>
<td>5</td>
<td>17</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.12, \text{ n.s.} \]

(ii) **Prison Alcoholics**

<table>
<thead>
<tr>
<th></th>
<th>Attempted Suicide</th>
<th>No Suicide Attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Late starters</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.004, \text{ n.s.} \]

(iii) **Prison and Hospital Alcoholics**

<table>
<thead>
<tr>
<th></th>
<th>Attempted Suicide</th>
<th>No Suicide Attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Late starters</td>
<td>7</td>
<td>24</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.006, \text{ n.s.} \]

### TABLE 6.23

**HOSPITAL ALCOHOLICS ARRESTED FOR DRUNKENNESS: EARLY AND LATE STARTERS COMPARED**

<table>
<thead>
<tr>
<th></th>
<th>Arrest</th>
<th>No Arrests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Late starters</td>
<td>10</td>
<td>12</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 1.32 \]
Table 6.22 shows that there is no significant difference in the proportion of early and late starters who attempt suicide. Table 6.23 shows that among hospital alcoholics there is no difference in the number of early and late starters who are arrested for drunkenness.

**Table 6.24**

**The Incidence of Problem Drinking Among the Relatives of Early and Late Starters**

(i) Hospital Alcoholics

<table>
<thead>
<tr>
<th></th>
<th>Problem Drinking</th>
<th>No Problem Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Late starters</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

\[ \chi^2 = .61, \text{ n.s.} \]

(ii) Prison Alcoholics

<table>
<thead>
<tr>
<th></th>
<th>Problem Drinking</th>
<th>No Problem Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Late starters</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 1.00, \text{ n.s.} \]

(iii) Hospital and Prison Alcoholics

<table>
<thead>
<tr>
<th></th>
<th>Problem Drinking</th>
<th>No Problem Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early starters</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Late starters</td>
<td>19</td>
<td>12</td>
</tr>
</tbody>
</table>

\[ \chi^2 = .02, \text{ n.s.} \]
Table 6.24 shows that there is no significant difference in the incidence of problem drinking among the relatives of early and late starters.

Hypothesis 5. The prison alcoholics will be more Character Disordered than the hospital alcoholics.

<table>
<thead>
<tr>
<th></th>
<th>CD</th>
<th>Non</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>6</td>
<td>34</td>
</tr>
<tr>
<td>Prison</td>
<td>2</td>
<td>16</td>
</tr>
</tbody>
</table>

\[X^2 = 0.16, \text{n.s.}\]

This result fails to show that significantly more of the prison alcoholics are Character Disordered.
SECTION II: COMPARISONS BETWEEN PRISON AND HOSPITAL ALCOHOLICS

Social and Family Characteristics *

TABLE 6.26

THE INCIDENCE OF PROBLEM DRINKING AMONG THE FATHERS AND RELATIONS OF ALCOHOLICS

(i) Alcoholics whose fathers are problem drinkers

<table>
<thead>
<tr>
<th></th>
<th>Problem Drinking</th>
<th>No Problem Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Prison</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.28, \text{ n.s.} \]

(ii) Alcoholics whose relations (except father) are problem drinkers

<table>
<thead>
<tr>
<th></th>
<th>Problem Drinking</th>
<th>No Problem Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Prison</td>
<td>3</td>
<td>15</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.006, \text{ n.s.} \]

(iii) Alcoholics whose relations (including father) are problem drinkers

<table>
<thead>
<tr>
<th></th>
<th>Problem Drinking</th>
<th>No Problem Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>Prison</td>
<td>12</td>
<td>6</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.23, \text{ n.s.} \]

These results indicate that the incidence of problem drinking among the fathers and relatives is not significantly different for hospital and prison alcoholics.

* Social class measures appear under Hypothesis 1 in Section I.
TABLE 6.27

FREQUENCIES OF ATTEMPTED SUICIDES AMONG HOSPITAL AND PRISON ALCOHOLICS

<table>
<thead>
<tr>
<th></th>
<th>Suicide Attempt</th>
<th>No Suicide Attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>9</td>
<td>31</td>
</tr>
<tr>
<td>Prison</td>
<td>3</td>
<td>15</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.04, \text{ n.s.} \]

Table 6.27 shows that the frequency of attempted suicide is not significantly different for prison and hospital alcoholics.

TABLE 6.28

ALCOHOLICS AND MARRIAGE

(i) General Marital Status

<table>
<thead>
<tr>
<th></th>
<th>Married</th>
<th>Widowed</th>
<th>Separated</th>
<th>Divorced</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>25</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Prison</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

(ii) Attempted Marriage

<table>
<thead>
<tr>
<th></th>
<th>Attempting Marriage</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Prison</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 3.52, \text{ n.s. (p < .1, two tail; p < .05, one tail)} \]
Table 6.28 shows that the marriages attempted by prison alcoholics are more likely to fail than those by hospital alcoholics. The difference between the frequency of those who attempt marriage among hospital and prison alcoholics just fails to reach the .05 level of significance.

**TABLE 6.28 (contd.)**

(iii) **Stability of Marriage**

<table>
<thead>
<tr>
<th></th>
<th>Broken</th>
<th>Intact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Prison</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 20.02, \ p<.001 \]

**TABLE 6.29**

**PREVIOUS CONTACTS WITH HOSPITAL AND COURTS AS A RESULT OF DRINKING**

(i) **Previous Arrests as a result of drinking**

<table>
<thead>
<tr>
<th></th>
<th>Previous Arrests</th>
<th>No Previous Arrests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Prison</td>
<td>18</td>
<td>0</td>
</tr>
</tbody>
</table>

(ii) **Previous hospitalisations as a result of drinking**

<table>
<thead>
<tr>
<th></th>
<th>Previous Hospitalisation</th>
<th>No Previous Hospitalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>Prison</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 0.80, \ n.s. \]
Table 6.29 shows that prison alcoholics are more likely to have been previously arrested than hospital alcoholics; the corresponding tendency for hospital alcoholics to have been in hospital is not demonstrated.

**TABLE 6.30**

**AGE, THE ONSET OF SOCIAL AND PROBLEM DRINKING, AND THEIR DURATION**

(Hospital, N=40; Prison, N=16)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>S.D.</th>
<th>t value</th>
<th>p&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital (H)</td>
<td>42</td>
<td>8.9</td>
<td>3.38</td>
<td>.01</td>
</tr>
<tr>
<td>Prison (P)</td>
<td>50</td>
<td>6.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of Onset of Social Drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital (H)</td>
<td>18.7</td>
<td>3.81</td>
<td>0.17</td>
<td>n.s.</td>
</tr>
<tr>
<td>Prison (P)</td>
<td>18.8</td>
<td>4.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of Onset of Problem Drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital (H)</td>
<td>33.12</td>
<td>10.88</td>
<td>0.88</td>
<td>n.s.</td>
</tr>
<tr>
<td>Prison (P)</td>
<td>30.55</td>
<td>8.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of Social Drinking and Problem Drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital (H)</td>
<td>23.45</td>
<td>8.49</td>
<td>3.16</td>
<td>.01</td>
</tr>
<tr>
<td>Prison (P)</td>
<td>31.00</td>
<td>8.23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of Problem Drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital (H)</td>
<td>8.625</td>
<td>6.56</td>
<td>5.30</td>
<td>.001</td>
</tr>
<tr>
<td>Prison (P)</td>
<td>18.94</td>
<td>7.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of Social Drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital (H)</td>
<td>14.42</td>
<td>10.23</td>
<td>1.00</td>
<td>n.s.</td>
</tr>
<tr>
<td>Prison (P)</td>
<td>11.67</td>
<td>8.31</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE 6.31

THE FREQUENCIES OF EARLY AND LATE STARTERS
AMONG HOSPITAL AND PRISON ALCOHOLICS

<table>
<thead>
<tr>
<th></th>
<th>Early Starters</th>
<th>Late Starters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>Prison</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

$\chi^2 = .1247$, n.s.

Tables 6.30 and 6.31 show that the prison alcoholics were on average 8 years older than the hospital alcoholics, and tended to have been drinking for 8 years longer. The difference is increased to 10 years if the period spent drinking socially is subtracted and the duration of problem drinking is compared.

C. Comparisons of measures of drinking behaviour

TABLE 6.32

HOURS AND AMOUNT PER WEEK
(Hospital, N=40; Prison, N=18)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>S.D.</th>
<th>t value</th>
<th>P&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of absolute</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>alcohol per week</td>
<td>H 1401</td>
<td>543</td>
<td>3.3195</td>
<td>.01</td>
</tr>
<tr>
<td></td>
<td>P 2105</td>
<td>1061</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours spent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>drinking per week</td>
<td>H 37</td>
<td>19.6</td>
<td>2.17</td>
<td>.05</td>
</tr>
<tr>
<td></td>
<td>P 51</td>
<td>28.7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 6.33

**FLUCTUATION LEVEL OF DRINKING:** THOSE WHOSE DRINKING DURING A MONTH NEVER DROPPED BELOW THEIR AVERAGE LEVEL (A); THOSE SHOWING FLUCTUATION IN DRINKING LEVEL (B)

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Prison</td>
<td>3</td>
<td>13</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 4.61, \ p < .05 \]

### TABLE 6.34

**TYPE OF DRINK**

(i) Beer Spirits Cheap Wine

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Spirits</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Cheap Wine</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 16.5117, \ p < .001 \]

(ii) Beer and Spirits Wine

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer and Spirits</td>
<td>35</td>
<td>6</td>
</tr>
<tr>
<td>Wine</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 13.68, \ p < .001 \]
TABLE 6.35

DRINKING ALONE

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>19</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Prison</td>
<td>5</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>

$\chi^2 = 3.7, p=n.s.$

Tables 6.32, 6.33 and 6.34 show that prison alcoholics drink more alcohol and spend more time drinking than the hospital alcoholics. The former also tend to drink cheap wine, the latter beer and spirits. Prison alcoholics may drink more on their own and have a more fluctuating level of drinking.

PSYCHOLOGICAL MEASURES

TABLE 6.36

COMPARISON OF THE MEAN SCORES ON THE PERSONAL DISTURBANCE (PD) AND CHARACTER DISORDER (CD) SCALES OF THE SSI

(Hospital, N=40; Prison, N=16)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>S.D.</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD</td>
<td>H</td>
<td>2.67</td>
<td>2.05</td>
<td>1.19</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>2.00</td>
<td>1.85</td>
<td></td>
</tr>
<tr>
<td>PD</td>
<td>H</td>
<td>4.65</td>
<td>3.62</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>4.66</td>
<td>3.14</td>
<td></td>
</tr>
</tbody>
</table>
TABLE 6.37

THE FREQUENCIES OF PERSONAL DISTURBANCE
IN HOSPITAL AND PRISON ALCOHOLICS

<table>
<thead>
<tr>
<th></th>
<th>PD</th>
<th>Borderline</th>
<th>non PD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>12</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Prison</td>
<td>8</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 1.26, \text{ n.s.} \]

Tables 6.36 and 6.37 show no significant difference between hospital and prison alcoholics on either the PD or CD scales of the SSI.

TABLE 6.38

COMPARISONS OF MEAN SCORES ON THE HDHQ
(Hospital, N=40; Prison, N=16)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>S.D.</th>
<th>t</th>
<th>p&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>H</td>
<td>22.67</td>
<td>7.43</td>
<td>1.74</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>26.81</td>
<td>9.41</td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
<td>H</td>
<td>2.9</td>
<td>7.04</td>
<td>0.95</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>0.87</td>
<td>7.53</td>
<td></td>
</tr>
<tr>
<td>Direction of</td>
<td>H</td>
<td>15.97</td>
<td>6.49</td>
<td>0.87</td>
</tr>
<tr>
<td>Hostility</td>
<td>P</td>
<td>17.69</td>
<td>7.15</td>
<td></td>
</tr>
<tr>
<td>Intropunitiveness</td>
<td>H</td>
<td>13.05</td>
<td>5.19</td>
<td>1.53</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>15.5</td>
<td>5.98</td>
<td></td>
</tr>
<tr>
<td>Extrapunitiveness</td>
<td>H</td>
<td>17.69</td>
<td>7.15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>15.5</td>
<td>5.98</td>
<td></td>
</tr>
</tbody>
</table>
Table 6.38 indicates that no significant differences were found between hospital and prison alcoholics on any of the HDHQ scales.

**Table 6.39**

**MEAN SCORES AND STANDARD DEVIATIONS OF THE GENERAL HOSTILITY: COMPARISONS OF HOSPITAL AND PRISON ALCOHOLICS (PRESENT STUDY) WITH NORMALS, NEUROTICS, ATTEMPTED SUICIDES AND TWO OTHER GROUPS OF ALCOHOLICS**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>S.D.</th>
<th>t value for comparison with means of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hospital</td>
</tr>
<tr>
<td>Normals</td>
<td>240</td>
<td>15.17</td>
<td>6.91</td>
<td>6.3 +++</td>
</tr>
<tr>
<td>Neurotics</td>
<td>103</td>
<td>18.04</td>
<td>8.05</td>
<td>3.1 ++</td>
</tr>
<tr>
<td>Young Alcoholics (Hassall, 1967)</td>
<td>40</td>
<td>27.65</td>
<td>7.0</td>
<td>3.1 ++</td>
</tr>
<tr>
<td>Alcoholics (Walton, 1968)</td>
<td>38</td>
<td>20.66</td>
<td>8.44</td>
<td>1.1 n.s.</td>
</tr>
<tr>
<td>Attempted Suicides (Philip, 1968)</td>
<td>100</td>
<td>25.93</td>
<td>8.99</td>
<td>2.1 +</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prison</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normals</td>
<td>240</td>
<td>15.17</td>
<td>6.91</td>
<td>6.4 +++</td>
</tr>
<tr>
<td>Neurotics</td>
<td>103</td>
<td>18.04</td>
<td>8.05</td>
<td>4.0 +++</td>
</tr>
<tr>
<td>Young Alcoholics (Hassall, 1967)</td>
<td>40</td>
<td>27.65</td>
<td>7.0</td>
<td>0.4 n.s.</td>
</tr>
<tr>
<td>Alcoholics (Walton, 1968)</td>
<td>38</td>
<td>20.66</td>
<td>8.44</td>
<td>2.4 +</td>
</tr>
<tr>
<td>Attempted Suicides (Philip, 1968)</td>
<td>100</td>
<td>25.93</td>
<td>8.99</td>
<td>0.4 n.s.</td>
</tr>
</tbody>
</table>

+++ Significant at .001 level
++  Significant at .01 level
+   Significant at .1 level
n.s. Not significant

Table 6.39 shows that both hospital and prison alcoholics are significantly more hostile than neurotics and normals. Hospital alcoholics are significantly less hostile than attempted suicides and a group of selected young alcoholics. Prison alcoholics are more hostile than Walton's group of hospital alcoholics.
## Table 6.40

### COMPARISON OF SCORES ON CATTELL’S 16PF

(Hospital, N=40; Prison, N=16)

<table>
<thead>
<tr>
<th>(i) First order Factors</th>
<th>Mean</th>
<th>S.D.</th>
<th>t</th>
<th>p&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> (outgoing)</td>
<td>H</td>
<td>5.27</td>
<td>1.96</td>
<td>.51</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>5.00</td>
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<tr>
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<td>1.94</td>
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<td>P</td>
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<td>1.56</td>
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<td></td>
<td>P</td>
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<tr>
<td><strong>D</strong> (dominant)</td>
<td>H</td>
<td>5.02</td>
<td>2.14</td>
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<tr>
<td></td>
<td>P</td>
<td>4.12</td>
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<tr>
<td><strong>E</strong> (enthusiastic)</td>
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<td>3.9</td>
<td>2.16</td>
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<td></td>
<td>P</td>
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<td><strong>I</strong> (sensitive)</td>
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<td></td>
<td>P</td>
<td>7.31</td>
<td>2.33</td>
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<td><strong>L</strong> (suspecting)</td>
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<td>6.65</td>
<td>1.87</td>
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<td></td>
<td>P</td>
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<td><strong>M</strong> (self absorbed)</td>
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<td>4.9</td>
<td>1.99</td>
<td>0.96</td>
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<td></td>
<td>P</td>
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<td><strong>N</strong> (sophisticated)</td>
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<td>6.97</td>
<td>1.79</td>
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<td></td>
<td>P</td>
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<tr>
<td><strong>O</strong> (apprehensive)</td>
<td>H</td>
<td>7.56</td>
<td>1.96</td>
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<td></td>
<td>P</td>
<td>7.75</td>
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<td></td>
<td>P</td>
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<tr>
<td><strong>Q2</strong> (self sufficient)</td>
<td>H</td>
<td>7.67</td>
<td>2.23</td>
<td>1.28</td>
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<td></td>
<td>P</td>
<td>8.50</td>
<td>2.00</td>
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<tr>
<td><strong>Q3</strong> (self controlled)</td>
<td>H</td>
<td>3.62</td>
<td>1.99</td>
<td>0.86</td>
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<tr>
<td></td>
<td>P</td>
<td>4.12</td>
<td>1.86</td>
<td></td>
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<tr>
<td><strong>Q4</strong> (tense)</td>
<td>H</td>
<td>8.9</td>
<td>1.56</td>
<td>0.88</td>
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<td></td>
<td>P</td>
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<th>(ii) Second order Factors</th>
<th>Mean</th>
<th>S.D.</th>
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<tr>
<td><strong>I</strong> (anxiety)</td>
<td>H</td>
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<tr>
<td></td>
<td>P</td>
<td>8.81</td>
<td>1.58</td>
<td></td>
</tr>
<tr>
<td><strong>II</strong> (extraversion)</td>
<td>H</td>
<td>2.94</td>
<td>2.12</td>
<td>1.84</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>1.88</td>
<td>1.39</td>
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</table>
Table 6.40 indicates that no significant differences were found between
the hospital and prison alcoholics on any of the 16 first order factors
or two second order factors. There was some indication that the prison
alcoholics may be less intelligent and more introverted and reticent.

**TABLE 6.41**

**COMPARISON OF 16PF MEAN PROFILES OF THE HOSPITAL AND PRISON ALCOHOLICS
IN THE PRESENT STUDY WITH NEUROTICS AND OTHER STUDIES OF ALCOHOLICS USING
THE 'PATTERN SIMILARITY COEFFICIENT "r_p"' (CATTELL, 1949; HORN, 1961)**

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<tbody>
<tr>
<td>Hospital</td>
<td>N=40</td>
<td>N=84</td>
<td>N=38</td>
<td>N=16</td>
</tr>
<tr>
<td>Neurotics</td>
<td>.69</td>
<td>-</td>
<td>.74</td>
<td>.91</td>
</tr>
<tr>
<td>Prison Alcohol</td>
<td>N=16</td>
<td>.62</td>
<td>.53</td>
<td>-</td>
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</table>

Table 6.41 shows the very close similarity between the 16PF profiles of
the hospital and prison alcoholics in the present study. Both groups
display an overall similarity to a mixed group of neurotics. The
hospital group shows a close resemblance to a similar group of alcoholics
studied by Walton. The pattern similarity coefficient, however, between
the present group of prison alcoholics and those investigated by Holt is
somewhat lower.
SUMMARY

I. Hypotheses Section

Hypothesis 1.

The prison alcoholics were found to be lower in social class compared to hospital alcoholics where the occupation, education and recent residence is taken as an index. The occupational status of the fathers of the two groups of alcoholics were not significantly different.

There was no significant difference between the occupational status of the alcoholics and their fathers.

Hypothesis 2.

The distribution of the Pattern of Drinking Questionnaire scores appears to be unimodal for the prison and hospital groups. A division of the hospital group into those who showed at least some signs of Delta alcoholism and those who showed only Gamma features did not produce a significant difference in the mean scores of these two groups on the PDQ.

The PDQ was found to correlate with some other variables of drinking behaviour, 'Amount of absolute alcohol per week' (0.43), 'Hours spent drinking per week' (0.33) and 'Years of problem drinking' (0.51), when the effect of present age is partialled out.

PDQ was correlated 0.49 with HDHQ 'General Hostility'. Of Cattell's 16PF factors PDQ correlated -0.20 with C (emotional stability), -0.22 with H (venturesome) and 0.16 with Q2 (self sufficiency).

Hypothesis 3.

The distribution of scores on the PDQ appeared to be normally distributed for both prison and hospital alcoholics. It was decided,
therefore, that a comparison of the mean scores of the two groups on the PDQ would be more meaningful than a comparison of the frequencies for prison and hospital of those arbitrarily allocated to the Gamma or Delta category on the basis of the PDQ score obtained. The prison alcoholics were accordingly found to show more Gamma features than the hospital alcoholics.

**Hypothesis 4.**

There were no significant differences on either General Hostility or the SSI Character Disorder scale between those whose problem drinking started before 30 years and those whose problem drinking started after 30 years. A significant difference was found on General Hostility between those hospital alcoholics under 30 years and those over 30 years of age. In terms of drinking variables the early starters were found to have had a shorter period of social drinking (an average of 6 years) between starting drinking and its development into a problem, in contrast to the late starter who on average had been drinking 20 years before it became a problem. Among the hospital alcoholics the early starters showed more signs of Gamma alcoholism. No corresponding difference was found among the prison alcoholics. Early and late starters were not differentiated in terms of their social and family characteristics: the variables on which the two groups were compared were attempted marriage and proportion of broken marriages, the frequency of suicide, and arrests for drunkenness, and the incidence of problem drinking among the relatives of the alcoholic.
II. Comparison of prison and hospital alcoholics on psychological variables and drinking behaviour

A. Social and drinking variables

No significant differences were found between the two groups in the proportion who had fathers or other family relatives who were problem drinkers. There was no significant difference in the proportions in each group who had attempted suicide. The prison alcoholics, however, were significantly older and had had a drinking problem for a correspondingly longer time. They also drank more, both in terms of grams of absolute alcohol ingested and the hours spent drinking. The level of drinking fluctuated significantly more among prison alcoholics. The two groups also differed in the type of drink that was taken: most of the prison alcoholics drank cheap wine; most hospital alcoholics drank either spirits (mainly whisky) or beer.

B. Psychological variables

1. Symptom Sign Inventory (SSI)

No significant differences were found on the Personal Disturbance or Character Disorder scale of the SSI.

2. The Hostility and Direction of Hostility Questionnaire (HDHQ)

There were no significant differences on the four measures of hostility from the HDHQ – General Hostility, Direction of Hostility, intropunitiveness (Sum I) and extrapunitiveness (Sum E).

3. Cattell's 16PF

There were no significant differences between the mean score on any of the 16 first order factors, or on the second order factors of anxiety and extraversion. There was evidence that the prison alcoholics may be less intelligent and more introverted and reticent.
CHAPTER 7

DISCUSSION

Those hypotheses which relate to differences between hospital and prison alcoholics are discussed in the General Comparison of Hospital and Prison Alcoholics in Section II. The remaining hypotheses are discussed under the headings of Pattern of Drinking and Age and Alcoholism in Section I.

SECTION I

Pattern of Drinking among Hospital and Prison Alcoholics

If most alcoholics could be classed as Gamma or Delta alcoholics, then the scores of alcoholics on a questionnaire designed to differentiate between the two types would be expected to show a distribution in which there is a clustering of subjects at one end obtaining very high scores (Gamma) and another at the other end obtaining very low scores (Delta). Figure 6.5 shows the distribution of the scores of both hospital and prison alcoholics on the PDQ, and as far as can be judged with this number of subjects the scores are on the whole normally distributed, with a slight skew to the higher end of the scale. In Figure 6.7 the distribution of scores is plotted separately for the prison and hospital groups. Figure 6.7 (i) shows that the scores of the alcoholics in hospital are normally distributed while Figure 6.7 (ii) shows that the distribution of scores for prison alcoholics are definitely skewed to the higher (Gamma) end of the scale. Thus in none of the three distributions is there evidence of clustering at both ends of the scale. These results indicate that though there may be some
alcoholics who obtain extreme scores, and may closely correspond with Delta or Gamma types described in the literature, there are nevertheless a large proportion of alcoholics who show a mixture of both features. It may be more appropriate, therefore, to consider alcoholics as varying in the number of features of Gamma or Delta drinking they have, rather than to categorise them into those of the Gamma or Delta type. The fact that the psychiatrist who rated the subjects on drinking pattern used the Gamma and Delta scales independently indicates the difficulty of assigning an alcoholic to one category or the other. Further investigation into the relation between clinical ratings and questionnaire measures of drinking patterns is required since in this study those who were rated clinically as having no Delta features at all scored no higher on the PDQ than those who were rated as having at least some Delta features.

Tables 6.8 to 6.12 show that the number of Gamma or Delta features an alcoholic may show is related to other factors. The correlations listed in Table 6.12 suggest an alternative interpretation of the PDQ - it may be a measure of the severity of alcoholism, for the presence of a large number of Gamma features is associated with more hours spent drinking per week, and a higher weekly consumption in terms of the number of grams of absolute alcohol ingested. An alcoholic with these features tends to have had a drinking problem for a longer time and a shorter period of social drinking, i.e. it took less time for a drinking problem to develop. These correlations suggest that those features which are claimed as signs of loss of control as opposed to inability to abstain drinking may in fact be an indication of the severity of alcoholism; thus a low score on the PDQ may not indicate that the alcoholism is of
the inability to abstain type, but that it is (in certain respects) less severe. The large number of negatively defined features of inability to abstain drinking (the differentiae of Gamma and Delta Alcoholism are listed in the Appendix) adds support to this view, and raises doubts as to the appropriateness of a generally applied bipolar dimension of drinking pattern. This problem requires further investigation.

General Hostility is the only measure of psychological disturbance or personality factor that is strongly related to the presence of 'loss of control' features (Table 6.12). This scale of the HDHQ has been described as a general measure of egocentricity or the degree of failure to maintain or establish mutual personal relationships, which is the defining feature of those described by Foulds (1965) as 'Personally Ill'. The Personal Disturbance scale of the SSI is regarded as a measure of Personal Illness as manifested in the production of symptoms. This measure, however, is only very slightly related to the presence of features of loss of control. The 16PF second order factor of Anxiety has been regarded as a general measure of 'emotional upset' (Adcock, 1965), and Philip (1968) in a study of attempted suicides found that it was correlated highly with General Hostility, .615 for men and .827 for women. In the present study there was a clear, though slightly weaker, relation between 16PF Anxiety and General Hostility for both hospital and prison alcoholics (Table 6.12). 16PF Anxiety, however, was not strongly related to the presence of loss of control features.

It appears from these correlations that loss of control over drinking may be related to a failure to maintain mutual personal relations. This failure moreover is manifest in the development of hostile attitudes both
towards the self and others, rather than in the development of more anxiety or a greater number of symptoms. The association between loss of control drinking and General Hostility certainly accords with clinical impressions that the intensive intake of alcohol is used by the 'loss of control' drinker to help express his aggression; these drinking bouts result in further disruption of personal relations, especially in the family.

Age and Alcoholism

The hypothesis that those who become alcoholics before the age of 30 years would be more hostile and Character Disordered was not confirmed (Tables 6.14, 6.16 and 6.17). A subsequent study by Foulds (1969) of alcoholics in Scotland and Canada has also failed to confirm the original findings of Foulds and Hassall (1969). The four young alcoholics (those under 30 years of age when tested), however, were significantly more hostile than the rest of the hospital group (Table 6.15). Their mean General Hostility score of 29 is 7 points higher than Philip's group of young neurotics. Hostility, however, appears to be higher in young people generally - Kapur (unpublished data) found that adolescents obtained high scores on General Hostility, and so it may be that young people, in the various groups of normals, neurotics and alcoholics that have been tested, and perhaps in other psychiatric groups, are more hostile than the older members of those groups.

Early and late starters have been found to differ on a number of social and family variables. Foulds and Hassall (1969) report that early starters in comparison to late starters were more likely to have
attempted suicide, and to have been arrested and imprisoned, and less likely to have attempted marriage, or if they had, to have failed in this. In the present study early and late starters differed significantly on none of these variables (Tables 6.20 to 6.25). Cramer (1963) and Rosenberg (1969) report a higher incidence of problem drinking in the relations of young alcoholics while Hassall reports a lower incidence. In the present study no significant difference was found at all (Table 6.24). Rosenberg's finding that young alcoholics have a shorter period of social drinking was confirmed: early starters were on average social drinkers for six years, whereas the late starters remained social drinkers or just heavy drinkers for an average of 20 years. This is what would be expected if the sample is divided in terms of age of onset of problem drinking since the age when ordinary drinking usually starts is in the late 'teens', and varies little. The difference in the length of social drinking is marked, and suggests the presence of a precipitating factor, but no significant differences were found on a number of social and psychological variables. Cramer suggests that it is the degree of disorganisation in the alcoholic's family which precipitates the early onset.

Differences in terms of the pattern of drinking were found: there was a slight tendency for the presence of loss of control features to be found in those of a younger age, when the effect of the duration of problem drinking was held constant (Table 6.11). The early starters in the hospital group had significantly more features of loss of control drinking; this difference was not found
in the prison group. The relation of these findings to other differences between hospital and prison alcoholics will be discussed in the following section. Discrepancies in the findings of the very small number of existing studies of the young alcoholics indicate that the selection of the groups for study should be more closely investigated. Other aspects of the relation of age to alcoholism may illuminate the present anomalies.

SECTION II

General comparison of hospital and prison alcoholics

Social and family variables

Large social class differences were found between hospital and prison alcoholics. Although social classes I and II were over-represented in the hospital group, the majority in that group were in social class III, whether this was estimated by their educational level, or occupational or residential status (Tables 6.1 to 6.4; Figures 6.1 to 6.4). By contrast, using the Registrar General's classification of occupations all but one of the prison group were in classes IV and V, and all but one had either left school at or before the minimum school leaving age. The largest differences, however, were in terms of residential status (Figure 6.3) where 72% were in lodging houses. This would be expected since residential status is probably the closest estimate of current social functioning for occupational status may be more affected by previous educational level and father's occupational status. In fact no significant difference was found in the occupational status of the alcoholics' fathers between hospital and prison groups. Therefore
prison alcoholics appear to be less different in terms of their social class origins from hospital alcoholics, but have deteriorated more. One measure of this downward social drift is the difference between the occupational status of the alcoholic and his father. No significant difference, however, was found for either prison or hospital groups. Nevertheless the significantly lower educational level of the prison alcoholics shows that at an early age they perform less well in comparison to hospital alcoholics: only 1 out of 18 stayed on at school after 14 years, while 6 had left school before that age or had received special schooling (Table 6.2). This may indicate two characteristics of the prison alcoholics: (i) their lack of perseverance in any social situation; (ii) their failure to acquire an occupational skill. The failure to acquire an occupational skill will have its effect later when the person starts drinking heavily as many unskilled jobs are less secure, and so an alcoholic is more likely to be dismissed. In the case of labouring a person may have to travel around seeking employment. Such occupational instability will also make the establishment of a 'settled home' more difficult, and may explain the results in Table 6.28 which show a trend for fewer prison alcoholics to have attempted marriage than hospital alcoholics, or if they have the probability of it breaking up is much higher. For hospital alcoholics the relations in the marriage may be very strained, but this less often results in a complete breakdown. In certain respects, therefore, the prison alcoholics may be said to show more features of social pathology. One feature, however, that both groups share is a high rate of suicide: Table 6.21 shows that 1 in 3 of the hospital alcoholics and 1 in 5 of the prison alcoholics have
attempted suicide. Kessel has commented on the relationship between alcoholic and suicidal behaviour.

**Psychiatric disturbance and personality factors in prison and hospital alcoholics.**

The hospital and prison alcoholics in the present study were not differentiated by any of the personality factors or measures of psychiatric disturbance. This part of the discussion will therefore largely consist of a description of the psychological features which the two alcoholic groups share in contrast to normals, and other groups showing pathological social adjustment.

a) The SSI

The hypothesis that there would be more Character Disorders among the prison alcoholics was not confirmed (Table 6.25). There was no significant difference between the groups in the numbers who were neurotics (PD), Character Disordered (CD), or normals according to the SSI (Table 6.37). There was also no significant difference between their mean scores on the CD or PD scales (Table 6.36). Foulds (1968) in a study of unselected male prisoners and non-psychotic patients found that according to the SSI there were more neurotics in the hospital sample, with a few more character disorders in the prison. It appears from a comparison of the present findings with those of Foulds' study that far fewer Character Disorders and more 'normals' were found among hospital alcoholics compared to other non-psychotic hospital patients, while the group of prison alcoholics contained far more neurotics, fewer normals and character disorders when compared with a group of unselected prisoners.
These differences are not all in the expected direction, and a replication study is required using both the SSI and psychiatric interviewing procedures.

The mean score of both hospital and prison alcoholics on the PD and CD scales are lower than expected, both when they are compared to the original norms (Foulds and Hope, 1968; Foulds, 1967) and to the scores on the CD and PI scales obtained by Walton's group of alcoholics. The difference may be in part due to the strict scoring procedure referred to in chapter 8 whereby positive items due to the specific effects of the excessive intake of alcohol were not scored.

Thus in terms of the two SSI scales fewer alcoholics than expected in the present study are character disordered or show symptoms of personal disturbance.

b) The HDHQ

No significant differences were found between the hospital and prison alcoholics on any of the four scales of the HDHQ - General Hostility, Direction of Hostility, Intropunitiveness and Extrapunitiveness (Table 6.38). Both groups were significantly more hostile than neurotics and normals: the hospital alcoholics exceed the neurotics by 4 points and the normals by 9; the prison alcoholics exceed these groups by 8 and 13 points respectively (Table 6.39). The high hostility may be the result of the years of excessive drinking but in the two longitudinal studies of alcoholics, McCord and McCord (1962) and Jones (1968) found the personalities of those who later became alcoholics were characterised by inadequate control over aggression.
Although the prison and hospital alcoholics do not differ significantly from one another in terms of hostility, they do differ in their relationships to other groups on this variable (Table 6.39). The prison alcoholics are closer to Hassall's group of young alcoholics, and the hospital alcoholics to Walton's group of alcoholics (both groups of alcoholics were drawn from the Alcoholism Unit of the Royal Edinburgh Hospital). Philip's group of 100 attempted suicides are intermediate between the two alcoholic groups - the attempted suicides are significantly more hostile than the hospital alcoholics but are not significantly different from the prison ones. In common with Walton's alcoholics the two present groups score slightly towards the intro-punitive end of the Direction of Hostility scale. Philip (1968), however, has suggested that extrapunitiveness and intro-punitiveness should be treated separately as Sum E and Sum I respectively. In normals Sum E is usually larger but Sum I increases with Personal Disturbance and in the present study for both prison and hospital alcoholics the Sum I score exceeded the Sum E score by two points.

c) The 16PF

No significant differences were found between the hospital and prison alcoholics on any of the sixteen first order factors or the two second order factors of Anxiety (1) and Introversion-Extraversion (2). On three factors the differences just fail to reach the .05 level of significance. These results suggest that the prison alcoholics are less intelligent (E-) which would be expected from the differences found on social class variables. They also tend to be shyer (H-) and more introverted (Factor 2-). Both groups, however, are markedly deviant from normals
on the two personality factors, and so such small differences between the groups are unlikely to be important.

The overall similarity between hospital and prison alcoholics on the 16PF is shown by the close correspondence between the personality profiles of the two groups, as measured by the pattern similarity coefficient \( r_p = .91 \), Table 6.41. The profiles of the two groups accord well with previous 16PF studies of alcoholics. In common with Fuller's study a pattern similarity coefficient of .6 was found between neurotics and hospital and prison alcoholics. The two groups differed from normals in the five factors on which McAllister (1968) found neurotics diverged from normal. Thus in common with neurotics they were less emotionally stable (C-), more expedient (G-), more apprehensive (Q+), less integrated (Q3-) and more tense (Q4+). The low G and high Q3 scores provide indirect support for the findings of McCord (1962) and Jones (1968) that alcoholics place more value on immediate satisfaction but McAllister's study shows that this applies to neurotics as well. In addition hospital and prison alcoholics are more reticent (F-) and markedly shyer (R-) than normals. They are also more sensitive (I+), suspicious (L+), radical (Q1+) and less group dependent (Q2+) than normals. On the Q2 whereas neurotics are more group dependent than normals, the alcoholics of the present study differ from normals in the opposite direction, being more self-sufficient. This is particularly the case with the prison group, and is consistent with the social isolation which characterises the Skid Row drinker. When the hospital and prison alcoholics of the present study are compared to the 16PF profiles of other groups of alcoholics a close resemblance obtains between the present
hospital alcoholics and those studied by Walton. His finding that alcoholics are shyer than neurotics was confirmed. A much weaker resemblance, however, holds between the present group of prison alcoholics and those studied by Holt ($r_p = .5$) but in view of the close similarity of the present group of prison alcoholics to hospital alcoholics it would appear that it is the personality profile of Holt's group that is the less 'typical'.

**The drinking behaviour of hospital and prison alcoholics**

Hospital and prison alcoholics both start to drink at about the age of 18. The hospital alcoholics have a slightly longer period of social drinking but this just fails to reach the .05 level of significance (Table 6.30). The average number of years required for drinking to develop into a problem varies widely, but on average it is about 12 years. This is contrary to Lisansky's finding (1957) with female alcoholics that those in prison 'lost control' of their drinking more quickly than those alcoholics attending an out-patient clinic. Feeney (1955) found that the mean age of onset of problem drinking was not significantly different for hospital and prison alcoholics. This was replicated in the present study - the mean age of onset was in the early thirties for both hospital and prison alcoholics. There were no differences in the proportions of early and late starters between the two groups. Feeney's finding that there were no differences in the parental drinking habits was confirmed in the present study in that no significant difference was found between hospital and prison groups in the proportion of alcoholics who had a father with a drinking problem - 50% of the prison group and 42% of the
hospital group (Table 6.26). Both Lisansky and Feeney found no difference in the duration of alcoholism and concluded from this that prison alcoholics are not in a later stage of alcoholism than hospital ones. In the present study, however, the prison alcoholics were found to be on average 8 years older and to have had a drinking problem for 10 years longer than those alcoholics in hospital. This suggests that the prison alcoholics may in some sense be in a later stage of alcoholism. This, however, does not imply that all the hospital alcoholics will later become alcoholics in prison – the good social characteristics of the group as a whole, e.g. job stability and an intact marriage, will prevent most of them from entering the vicious circle of public drunkenness and imprisonment which characterise the prison sample. However, the present results may be interpreted to suggest that a number of those currently in hospital – probably those with a broken marriage and insecure employment – will later find themselves in prison. Further evidence in favour of this interpretation is that nearly one in three of the prison alcoholics had previously been in hospital because of their alcoholism (Table 6.29). A longitudinal or longterm follow-up study, however, is required.

The greater age and longer duration of problem drinking among alcoholics who are in prison may be explained in a number of ways. It is likely, however, that the large social class differences between hospital and prison alcoholics interact with these observed age differences in accounting for the different disposal methods applied to them by society. It may be that the hospitals are not referred, or do not admit alcoholics of very low social class (unskilled, unemployed or homeless) who are also of an older age and have a longer history of alcoholism. At the same time such
an alcoholic, if he is homeless and also old, is more likely to be found 'drunk and incapable' in the street, and be arrested by the police, especially if he is 'known' by the local police because of his long drinking history. Prison alcoholics differ from social drinkers both in the amount and form of alcohol they consume. Hospital alcoholics mainly drink beer or whisky, or a combination of the two, whereas alcoholics in prison drink mainly cheap wine (Table 6.34). In contrast to studies of London's Skid Row (Edwards, 1966) only a small number ever drank crude spirits, but in no case was this the predominant form in which alcohol was taken. Prison alcoholics had an average weekly intake of 2105 grams of absolute alcohol, which is the equivalent of 18 bottles of cheap wine, 6 bottles of whisky, or 105 pints of beer (Table 6.32). The hospital alcoholics had an average weekly intake of 1401 grams of absolute alcohol which is equivalent to 12 bottles of cheap wine, 5 bottles of whisky or 70 pints of beer. Thus prison alcoholics consume significantly more alcohol than hospital alcoholics and also spend a greater part of their time drinking - 51 hours per week compared to 37 hours. This may be because they have no alternative activity to drinking since they do not have a steady job or a home. Their relatively greater social disorganisation will make them more 'conspicuous' to the police, and less likely to be accepted as 'suitable' for treatment by the hospital.

The relation of Drinking Pattern to Hospital and Prison Alcoholics

Table 6.13 shows that the prison alcoholics have significantly more features of loss of control drinking. It was noted earlier that
they also drink more, and as the amount drunk is correlated .43 with scores on the PDQ the extent to which this difference in 'drinking pattern' is due to a difference in the amount drunk is unclear. It may be that both variables are a function of a more general psychological factor, but it is unlikely that this explains the presence of more features of loss of control drinking among prison alcoholics for, although PDQ is .48 with General Hostility, no significant difference was found between the two groups on this latter variable. There is a similar problem in interpreting the effect that the prison alcoholics' having a drinking problem for a longer time may have on the observed differences between hospital and prison alcoholics on the PDQ. An analysis of covariance design may help to elucidate this relationship.

The fact that the PDQ is related to total alcohol intake, time spent drinking, and the duration of problem drinking, and the more socially disorganised group - the prison alcoholics - have more loss of control features, raises the question again of whether PDQ is not a measure of the severity of alcoholism. The distribution of PDQ scores (Figure 6.7) shows that no prison alcoholic has a predominance of Delta features. This agrees with Edwards' study in London where 98% of 'bombed site' drinkers met Jellinek's criteria for loss of control addiction. Straus (1951), from his studies of Skid Row drinkers in the United States, has distinguished the non-addicted or 'plateau' from addicted or 'peak' drinker. No evidence has been brought forward to suggest this distinction can be made among Skid Row drinkers in Britain. Some doubts too have been raised about the application of the Gamma/Delta to Skid Row drinkers. The skew distribution of the prison
alcoholic's PDQ scores, compared to the normal distribution for the hospital alcoholics (Figure 6.7) suggests that this dimension of pattern of drinking may only be applicable to hospital alcoholics. Further evidence for this view may be the finding that, whereas for hospital alcoholics those who are early starters have more loss of control features than those who start after 30 years, this difference was not found among the prison alcoholics.

**Conclusion**

The results of the present study suggest that it may be more appropriate to consider that alcoholics vary in the number of features of loss of control (Gamma) or inability to abstain (Delta) drinking they show, than to allocate them to one category or the other. It may be that the two halves of the Gamma/Delta pattern of drinking dimension should be treated separately. Most alcoholics are likely to vary on the loss of control (Gamma) dimension, which may be regarded as a measure of severity because of its positive correlations with General Hostility, total intake of alcohol, the time spent drinking, the duration of the problem and the swiftness with which it developed. Inability to abstain drinking is less clearly defined - it has few positive features. This type of drinking may apply to a smaller proportion of the alcoholic population, and so should not be generally regarded as the necessary 'opposite' of loss of control drinking.

Alcoholics whose drinking problem started before 30 years were no more likely to be Character Disordered or more hostile than those alcoholics whose drinking problem started after that age. No differences were found
between these 'early' and 'late' starters on a number of social variables. The alcoholics under 30 years were more hostile. Studies of the relation of age to alcoholism, however, should be extended from the current comparisons of young and old alcoholics and early and late starters to longitudinal studies of the changing effects of alcoholism with increase in age and the duration of alcoholism.

The prison and hospital groups did not differ in the degree of psychiatric disturbance: the high 16PF Anxiety and HDSQ General Hostility scores obtained by both hospital and prison alcoholics indicate a high degree of 'emotional upset' and disturbance of personal relations, manifest in a lack of confidence, sense of guilt and worthlessness, dependency, irritability, tenseness, and hostility towards and suspicion of others. The prison alcoholics, however, were clearly differentiated from those in hospital in terms of social class. These findings should be considered along with the study by McCance and McCance of the outcome of treatment for alcoholics in Scotland (1969). They found that those alcoholics who did poorly were those who showed such characteristics as being single, having no home or steady job, and a record of police arrests and drinking cheap wine. These are the very characteristics which describe the prison alcoholic. These factors, moreover, were found to be more important than the type of treatment that was given. This indicates the need for the development of other methods of treatment and disposal than those presently in use.

The case for a review of current techniques of treatment and a revision of the present disposal of alcoholics in prison can be summarised in three points:
(i) The alcoholic in prison is in as great a need of treatment as the hospital alcoholic: they show a similar degree of psychological disturbance.

(ii) The present procedure for dealing with prison alcoholics is costly and ineffective. One alcoholic who had had 100 imprisonments was described as being "on life sentence without remittance since 1945".

(iii) The hospital treatment for alcoholics showing the same features as prison alcoholics is ineffective.

For the 'problem of the chronic drunkenness offender' to be tackled a change is required in both the medical practice of admission to treatment and the legal procedure for dealing with drunkards. A large scale reallocation of economic resources, however, is necessary for the development of an effective alternative to imprisonment.
SUMMARY OF THESIS

A COMPARISON OF HOSPITAL AND PRISON ALCOHOLICS

The principal aim of the study was to compare two groups of alcoholics who were differentiated in terms of their disposal by society: one receiving treatment for alcoholism, the other undergoing imprisonment for drunkenness. A study of this kind has not been carried out in Scotland before. Forty male alcoholics referred to the Alcoholism Unit of the Royal Edinburgh Hospital and 18 male alcoholics in H.M. Prison, Saughton, were seen individually. A battery of standardised tests and special schedules (some self administered, others presented orally) was completed for each subject. The measures used covered a wide range of social and personality variables and various aspects of drinking behaviour. The effect of age on alcoholism, and the nature of the distinction between 'loss of control' and 'inability to abstain' drinking were investigated.

The main findings were as follows:

1. Alcoholics were found to vary in the number of features of 'loss of control' and 'inability to abstain' they displayed, but the existence of two clearly differentiated types of alcoholics was not confirmed. It is possible that the number of loss of control features may in fact be an indication of the severity of alcoholism.

2. The age of onset of alcoholism was not associated with any of the social and psychological variables used in the study.

3. Hospital and prison alcoholics did not differ in the degree of psychiatric disturbance: the high scores obtained by both groups on
measures of hostility, anxiety and introversion indicate a marked degree of 'emotional upset' and disturbance of personal relations.

4. The alcoholics in prison were of lower social class than those in hospital. The prison alcoholics showed the same characteristics of low occupational status, homelessness and social isolation that have been found with Skid Row drinkers.

5. Compared to hospital alcoholics, alcoholics in prison were older and had had a drinking problem for a longer time. They had a higher intake of alcohol and spent more of their time drinking. They also showed more features of 'loss of control' drinking.

These findings were discussed in relation to a study showing the failure of treatment with hospital alcoholics who had similar features to those in prison. A case was made for the development of an appropriate treatment for those alcoholics who are at present imprisoned.
ACKNOWLEDGEMENTS

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REFERENCES


APPENDIX A

Items of the standardised tests used in the study

Sixteen Personality Factor Questionnaire, Form E.

Hostility and Direction of Hostility Questionnaire.

Symptom Sign Inventory.
WHAT TO DO: Some tests tell us what you can do best, but this one helps us know you better. Since no two people are the same, there are no right or wrong answers to most of these questions, but only what is true for you. You have a separate answer sheet. On the ANSWER SHEET, there is a number for each question and by the number there are two little boxes, like this: □ □. Mark your answer for each question by putting an X in one of the boxes to show the side that fits you better, LIKE THIS:

EXAMPLES:

1. Would you rather play baseball or go fishing
   If you would rather play baseball, mark the first box, the left one, like this: X □. If you would rather go fishing, mark the second box, the right-hand one, like this: □ X.

2. Do you like to play jokes on people or do you not like to do that
   If you like to play jokes on people, mark the first box, the left one, like this: X □. If you do not like to play jokes, mark the second box, the right-hand one, like this: □ X.

3. After 2, 3, 4, 5, does 6 come next or does 7 come next
   In this last example, there is a right answer. It is the one on the left. But there are very few questions like this.

Inside there are more questions like these. When you are told to, start with number 1 and answer the questions. Keep these three things in mind:

1. Give only true answers about yourself. It will help you more to say what you really think.

2. You may have as much time as you need, but go fairly fast. Give the first answer that comes to you and do not spend too much time on any question.

3. Do not skip any questions. Answer every question one way or the other.
1. Would you rather help children play games or help fix watches
2. Is \( \frac{1}{2} \) of 7 closer to 3 or closer to 5
3. Do you always feel like doing what you planned or do you ever plan things and then not feel like doing them
4. Is it fun to tell an obvious lie with a straight face or could you never do that
5. Do you like to tell jokes or do you not like to do that
6. Are you a strict person who does everything as well as possible or do you do some things just well enough to get by
7. Do you show up well in social things or would you rather stay quietly out of the way
8. Would you rather be an artist or a mechanic
9. Do you make smart remarks that hurt people’s feelings when they deserve it or do you never do that
10. If you were good at both would you rather bowl or play chess
11. After a busy day do you fall asleep easily or do ideas keep running through your mind
12. Do you have times when you feel sorry for yourself or does that never happen to you
13. If you had a lot of money to give away would you give it to science research or would you give it to a church
14. When you are on a train or bus would you rather look out of the window or talk to people
15. If a man wears a beard and dresses sloppily would you stay away from him or might he be nice to know
16. When someone is bad tempered toward you, do you get over it quickly or does it bother you for some time
17. In an office would you rather see people or draw house plans
18. After 3, 5, 7, 9, does 11 come next or does 10 come next
19. When people don’t listen to you, do you get impatient or does it not bother you
20. Most of the time would you rather “play it safe” or take a chance
21. Would you rather spend an evening quietly at home or at a lively party
22. Do you avoid saying things that bother people or do you sometimes like to
23. Are you the one who gets the party going or do you wait for someone else to do it
24. Are you always glad to fix mechanical things or would you rather sit around and talk
25. Do you think that most people tell the truth even if it might hurt them or do they tell the truth only when it won’t hurt them
26. When there is hard work to do, do you try to take rest breaks more than most people or less than most people
27. Can you stand things to be all mixed up or does it bother you
28. Do you ever feel that there is danger without any good reason or do you never feel that way
29. Would it be better if everyone went to church regularly or is that not too important
30. Do you like to take an active part in social things and committee work or are you most interested in things that you can do by yourself
31. Do your friends sometimes think your mind is not on what you are doing or do they never think that
32. Are you almost never jealous or are you often jealous
33. Does it bother you to be the center of interest in a group of people or do you like it

34. If John is taller than Bill and Mike is shorter than Bill, is Bill the tallest or is John the tallest

35. Do people misunderstand you when you mean well or does that never happen

36. Do you sometimes speak angrily to your parents or is it wrong to do that

37. Do you like things to be quiet or do you always like exciting things

38. Do you think people need to observe the rules more strictly or that they need to have greater freedom

39. Do you feel shy in front of people when you need to talk or can you usually stand right up and talk

40. Would you rather be a good musician or a good soldier

41. When people are unreasonable do you keep quiet or do you feel a strong dislike for them

42. Would you rather be a bookkeeper or an artist

43. Does it bother you if people think you are odd or strange or does it not bother you at all

44. Even in the middle of a group of people do you sometimes feel lonely and worthless or do you almost always feel good

45. Do we need more attention to old well-tried ideas about social matters or more calm thinking of a new kind

46. Are you always glad to get together with a group of people or would you rather do things your own way when you want to

47. Do you often jump into things too fast or do you take your time

48. Do you get very sad about little things or is that never a problem for you
49. Would you rather take care of trees in a forest or teach children in a school
50. Does little mean the same as thin or the same as small
51. Do you often get angry with people too quickly or are you slow to get angry
52. Would you rather do without something than put a waiter to a lot of extra trouble or do you feel that extra trouble is part of his job
53. Do you like to be serious most of the time or are you happy and laughing most of the time
54. Do you just ignore messy streets or do they bother you
55. Would you rather have a job where you work by yourself or a job where you had to go to one meeting after another
56. Would you rather be a school-teacher or a great hunter
57. When a person is not doing the right thing do you show him up even if it takes some trouble or do you just let it go
58. Would you rather hire workers to run machines or fix the machines when they break down
59. Should we live more by the rules of the group or by our own ideas
60. Are you afraid of something for no particular reason or do you never feel that way
61. Do you think that new ideas make old-time preachers look silly or are the new ideas silly
62. Would you rather spend a holiday in a quiet place or in a resort
63. Is it all right to leave beds unmade for a day or two or do they need to be made every day
64. Do you have dreams that disturb your sleep or do you not dream very much
65. Would you rather have a house alone in the deep woods or where lots of people live
66. After 2, 4, 6, 8, does 10 come next or does 9 come next
67. Do little things get on your nerves a lot or are little things not important
68. Do you sometimes say things that hurt people's feelings or do you try very hard never to do that
69. Do you like to make people laugh with funny stories or do you not like to do that
70. Is it very important to follow all rules or are there some rules you should not follow
71. Is it easy to go up and meet an important person or would you rather not
72. In a play would you rather be a jet pilot or a famous writer
73. When someone is unreasonable and narrow-minded, are you still polite or do you show him up
74. Can people change your mind by appeals to your feelings or do your feelings not have anything much to do with what you think
75. When someone corrects you or blames you for something, do you try to show you are right or do you accept the blame
76. Would you rather be the one in charge of a group of people or just be one of the group
77. Do you like thinking games better or do you like sports better
78. Can you spend a whole morning without wanting to speak to anybody or would you never feel like that
79. Are you a practical person or more of a dreamer
80. Do you feel comfortable and calm or are you often upset

GO RIGHT ON TO THE NEXT PAGE
81. Would you rather teach children about their own feelings or build a new building
82. After N, P, R, T, V, does X come next or does W come next
83. Do your feelings usually come from what is going on around you or do you get strong feelings that come without any real cause
84. If you have to tell someone a lie do you have to look away or can you look at him
85. Do you really enjoy all large groups of people such as parties or dances or would you rather be alone much of the time
86. Do you usually do what you want to do or what will be best for other people
87. When you join a new group does it take some time to fit in or do you fit in right away
88. Would you rather have a job writing children's books or fixing electrical machines
89. Do you think that most people are honest only because they are afraid of getting caught or that most people would be honest anyway
90. Can you take either side in an argument just to be sure that all sides are thought about or would you not want to take the side you didn't believe in
91. Are you always careful to believe only half of what you read or can you depend upon the things you read
92. When someone fusses at you in public does it not bother you too much or do you get very embarrassed and upset
93. Do you think we need stricter laws about Sunday or more freedom to do what we like
94. Would you rather paint pictures or run a social club
95. Do you like to make plans so that you will not waste time between jobs or do you take things as they come
96. Do you have many problems or are you getting along well
97. Do people say you talk too much or are you quiet

98. After 3, 6, 12, 24, does 36 come next or does 48 come next

99. When you get upset do you cool down again very quickly or does it take a while to calm down

100. In a strange city would you stay away from the parts of town that people say are dangerous or would you walk any place you wanted

101. Do people say that you are a serious person or that you are happy-go-lucky

102. Do you feel that some jobs do not need doing so well as others or that any job should be done as well as you can

103. Do you find it hard to speak to a large group of people or do you like it

104. Would you rather read about battles and war or about people’s feelings

105. If someone gets mad and yells at you, do you stay quiet and calm or do you yell back

106. Do you like to tackle problems that other people have made a mess of or would you rather start from the beginning

107. Do you think we should be very slow to lose the wisdom of the past or should we move faster to try new things

108. Do your friends think you have many new ideas or that you are good at following the ideas of others

109. If you had more money than you need, would you keep it in case you need it later or would you give some to a church

110. Would you rather work with a committee or on your own

111. Are you a person who gets things done or a dreamer

112. When you are going to catch a train or a bus do you get tense and nervous or do you feel you have enough time
113. In your spare time would you rather join a hiking club or a club that helps people
114. Is red more like blue or more like orange
115. Do you always have lots of energy when you need it or do you often feel too tired
116. Are you critical of other people’s work or are you not like that
117. Do people say you are lively or do they say you are quiet
118. Do you think that most people take life too seriously or not seriously enough
119. Do you speak your mind no matter how many people are around or do you hold back when a lot of people are around
120. Would you rather fix machines that don’t work or think about what life means
121. If a neighbor cheats you in some small thing, would you rather show him up or just let it go
122. Would you like to be a writer about music and plays or would you not like that kind of work
123. Would you rather ride in a car with someone else driving or do you like to drive a car
124. When the teacher calls your name are you glad to show what you can do or are you afraid you have done something wrong
125. Do you think our country should keep its army strong or that we should depend on good will among all countries
126. Do you like to be active in social things or would you rather be alone
127. If someone gets mad at you would you get upset too or would you try to calm him down
128. Do you usually feel good no matter how many troubles there are or do you get to feeling low
INSTRUCTIONS

Mark your answers in the boxes below.
Be sure the number is the same as the question you are answering in the test booklet.
Make each mark VERY DARK. Fill in the whole box if you want.
PERSONALITY QUESTIONNAIRE (HDHQ)

1. Most people make friends because friends are likely to be useful to them. True False
2. I do not blame a person for taking advantage of someone who lays himself open to it. True False
3. I usually expect to succeed in things I do. True False
4. I have no enemies who really wish to harm me. True False
5. I wish I could get over worrying about things I have said that may have injured other people's feelings. True False
6. I think nearly anyone would tell a lie to keep out of trouble. True False
7. I don't blame anyone for trying to grab everything he can get in this world. True False
8. My hardest battles are with myself. True False
9. I know who, apart from myself, is responsible for most of my troubles. True False
10. Some people are so bossy that I feel like doing the opposite of what they request, even though I know they are right. True False
11. Some of my family have habits that bother and annoy me very much. True False
12. I believe my sins are unpardonable. True False
13. I have very few quarrels with members of my family. True False
14. I have often lost out on things because I couldn't make up my mind soon enough. True False
15. I can easily make other people afraid of me, and sometimes do for the fun of it. True False
16. I believe I am a condemned person. True False
17. In school I was sometimes sent to the principal for misbehaving. True False
18. I have at times stood in the way of people who were trying to do something, not because it amounted to much but because of the principle of the thing. True False

19. Most people are honest chiefly through fear of being caught. True False

20. Sometimes I enjoy hurting persons I love. True False

21. I have not lived the right kind of life. True False

22. Sometimes I feel as if I must injure either myself or someone else. True False

23. I seem to be about as capable and clever as most others around me. True False

24. I sometimes tease animals. True False

25. I get angry sometimes. True False

26. I am entirely self-confident. True False

27. Often I can't understand why I have been so cross and grouchy. True False

28. I shrink from facing a crisis or difficulty. True False

29. I think most people would lie to get ahead. True False

30. I have sometimes felt that difficulties were piling up so high that I could not overcome them. True False

31. If people had not had it in for me I would have been much more successful. True False

32. I have often found people jealous of my good ideas, just because they had not thought of them first. True False

33. Much of the time I feel as if I have done something wrong or evil. True False

34. I have several times given up doing a thing because I thought too little of my ability. True False

35. Someone has it in for me. True False

36. When someone does me a wrong I feel I should pay him back if I can, just for the principle of the thing. True False
37. I am sure I get a raw deal from life.    True  False
38. I believe I am being followed.        True  False
39. At times I have a strong urge to do something harmful or shocking. True  False
40. I am easily downed in an argument.   True  False
41. It is safer to trust nobody.         True  False
42. I easily become impatient with people. True  False
43. At times I think I am no good at all. True  False
44. I commonly wonder what hidden reason another person may have for doing something nice for me. True  False
45. I get angry easily and then get over it soon. True  False
46. At times I feel like smashing things. True  False
47. I believe I am being plotted against. True  False
48. I certainly feel useless at times.    True  False
49. At times I feel like picking a fist fight with someone. True  False
50. Someone has been trying to rob me.   True  False
51. I am certainly lacking in self-confidence. True  False
THE SYMPTOM SIGN INVENTORY

SET A

1. Does your hand often shake when you try to do something?
2. Do you sweat very easily even on cool days?
3. Do you suffer from palpitations or breathlessness?
4. Are there times when you feel anxious without knowing the reason?
5. Are you afraid of being in a wide-open space or in an enclosed place?
6. Are you afraid that you might be going insane?
7. Have you a pain, or feeling of tension, in the back of your neck?
8. Have you difficulty in getting off to sleep (without sleeping pills)?
9. Are you afraid of going out alone?
10. Have you any particular fear not mentioned so far?

SET B

1. Do you cry rather easily?
2. Have you lost interest in almost everything?
3. Have you ever attempted to do away with yourself?
4. Is the simplest task too much of an effort?
5. Are you depressed because of some particular loss or disappointment?
6. Have you found it difficult to concentrate recently?
7. Does the future seem pointless?
8. Are you more absent-minded recently than you used to be?
9. Are you slower recently in everything you do than you used to be?
10. Do you ever seriously think of doing away with yourself because you can no longer cope with your difficulties?
SET C

1. Do you ever feel so confident and successful that there is nothing you can't achieve?

2. Do you ever become very excitedly happy at times for no special reason?

3. Are you ever so cheerful that you want to laugh and joke with everyone?

4. Are there times when exciting new ideas and schemes occur to you one after the other?

5. Are you ever so full of pep and energy that you carry on doing things indefinitely?

6. Do you ever become so excited that your thoughts race ahead faster than you can express them?

7. Are you ever so cheerful that you want to wear lots of gay things, like button-holes, flowers, bright ties, jewellery, etc?

8. When you get bored, do you like to stir up some excitement?

9. Do you ever feel so full of energy and ideas that you don't want to go to bed?

10. Are you a much more important person than most people seem to think?

SET D

1. Are people talking about you and criticizing you through no fault of your own?

2. Have you an important mission to carry out?

3. Are there people who are trying to harm you through no fault of your own?

4. Is someone trying to poison you, or make you ill in some way?

5. Have you some special power, ability or influence which is not recognized by other people?

6. Is someone, other than yourself, deliberately causing most of your troubles?

7. Are people plotting against you through no fault of your own?
8. Do you ever take strong action against an evil person for the sake of a principle?

9. Do you ever see someone do or say something which most people don't take much notice of, but which you know has a special meaning?

10. Can people read your thoughts and make you do things against your will by a sort of hypnotism?

**SET E**

1. Are you distressed by silly, pointless thoughts that keep coming into your mind against your will?

2. Are you compelled to think over abstract problems again and again until you can't leave them alone?

3. Are you unnecessarily careful in carrying out even simple everyday tasks like folding clothes, reading notices, etc?

4. Are you unable to prevent yourself from doing pointless things - like tapping lamp-posts, touching things, counting windows, uttering phrases, etc?

5. Are you afraid you might do something seriously wrong against your will?

6. Do distressing thoughts about sex or religion come into your mind against your will?

7. Do you feel you just have to check things again and again, like turning off taps or lights, shutting windows at night, etc. - although you know there is really no need?

8. Have you an unreasonable fear that some careless act of yours might have very serious consequences?

9. Are you excessively concerned about cleanliness?

10. Do you have an uneasy feeling that if you don't do something in a certain order, or a certain number of times, something might go wrong?
SET F

1. Do you feel that there is some sort of barrier between you and other people so that you can't really understand them?

2. Do you ever see visions, or people, animals or things around you that other people don't seem to see?

3. Do you often wonder who you really are?

4. Do you ever have very strange and peculiar experiences?

5. Do you think other people regard you as very odd?

6. Do you often feel puzzled, as if something has gone wrong either with you or with the world, without knowing just what it is?

7. Do you ever hear voices without knowing where they come from?

8. Do you feel that you cannot communicate with other people because you don't seem to be on the same "wave-length"?

9. Do you ever have very strange and peculiar thoughts?

10. Is there something unusual about your body, like one side being different from the other and meaning something different?

SET G

1. Do you ever lose the use of an arm or leg or face muscle?

2. Do you ever have fits, or have difficulty in keeping your balance?

3. Do you ever completely lose your voice (except from a cold)?

4. Do you ever lose all feeling in any part of your skin, so that you wouldn't be able to feel a pin prick; or do you ever have burning or tingling sensations?

5. Do you ever have "black outs", dizzy spells or faints?

6. Have you been in poor health during most of the past few years?

7. Do you often suffer from blurring of vision, or any other difficulty with your sight which no one seems able to put right?

8. Are you often bothered with pains over your heart or in your chest or in your back?

9. Do you ever do things in a dream-like state without remembering afterwards what you have been doing?

10. Are you worried about your physical health?
SET H

1. Are you worried about having said things that have injured others?
2. Are you an unworthy person in your own eyes?
3. Have you some bodily condition which you find disgusting?
4. Are you a condemned person because of your sins?
5. Are you troubled by waking in the early hours and being able to get off to sleep again (without sleeping pills)?
6. Because of things you have done wrong, are people talking about you and criticizing you?
7. Are you ever so low in spirits that you just sit for hours on end?
8. Do you cause harm to people because of what you are?
9. Are you ever so "worked up" that you pace about wringing your hands?
10. Do you ever go to bed feeling you wouldn't care if you never woke up again?
APPENDIX B

Instruments developed for the study

Inventory of Personal Data.

Drinking Behaviour Form.

Psychiatric Rating Form, and Differentiae of Gamma and Delta Drinking.

Pattern of Drinking Questionnaire.
INVENTORY OF PERSONAL DATA

No. ..........  Date of testing ..............  Group  P  AU  0
Date of arrest/admission  .................

Name ...........................................  Age ......
Address ...........................................  Marital Status:

A. Occupation:
   Description.
   Supervisory capacity
   If self employed
   With employees
   Occupation of father

B. Education:
   1. University or professional level
   2. Higher/Ordinary Certificate or O.N.C.
   3. Complete schooling to 15 yrs. at grammar school
   4. Complete schooling to 15 yrs. at junior secondary
   5. Incomplete or special schooling
   Further information:

C. Housing:
   1. Owned; detached house; superior quality; good area
   2. Owned; det/semi/flat; good quality; good area
   3. Owned/rented/council; det/semi/terr; sound quality
      working area
   4. Owned/rented/council; det/semi/terr; poor quality
      working area
   5. Transient dwelling/hostel accommodation; poor area
   Description:
D. Problem drinking in the family:
   - Wife
   - Father
   - Mother
   - Wife's father
   Further information:

E. Previous hospitalisation:
   - Number of occasions
   - Names of hospitals
   - Type of treatment
   - Details

F. Legal record:
   - Number of arrests
   - Type of charges
     - Drunk and incapable
     - Drunk and disorderly
     - Driving offence
     - Other categories
   - Number of convictions
   - Number of fines
   - Total value of fines £
   - Number of sentences
   - Total length of sentences
   Further information:
DRINKING BEHAVIOUR FORM

1. Age at start of drinking
2. Age when drinking recognised as a problem
3. Places in which drinking occurred
4. Alcohol Types
5. General weekly pattern (which days are different and which equivalent)
6. Periods
7. No. of hours
8. Amount of alcohol
9. Place
10. % of hours drinking alone
11. Rate of consumption (amount drunk in an hour)
12. No. of days in a month when drinking is <25% of average amount
13. Abstinence period of more than 2 weeks in past 12 months
14. Continuous drinking in past 12 months
PSYCHIATRIC RATING FORM
(Pattern of Drinking)

No. .......................... Date of assessment ..........................
Subject's Name .......................... Name of Psychiatrist ..........................

1a. Is this subject an alcohol addict? Yes [ ] No [ ]
1b. Indicate, by a 'X' in the right hand box, which of these criteria of alcoholism the subject satisfies:
   (i) He cannot spontaneously give up drinking for any length of time.
   (ii) He cannot function normally, i.e. cope with routine tasks without a drink.
   (iii) Withdrawal symptoms such as the 'shakes', fears and terror, marked restlessness, are experienced when drinking is stopped; these are usually dispelled by taking a drink.
   (iv) Excessive drinking is disrupting a major area of the person's life, e.g. health, work, social or home life.

2. Assign the subject to a position on this dimension of Loss of Control/Inability to abstain drinking pattern, as defined by the summary profiles and list of criteria.
   Indicate the subject's position with a 'X'.

   Loss of Control          Inability to Abstain
   Clearly          Mainly          Same features          Same features          Mainly          Clearly
   ..........................  ..........          ........          ........          ..........          ..........          ........

3a. What is the subject's associated psychiatric diagnosis?

   ..................................................

3b. Indicate whether it is -
   Mild [ ] Moderate [ ] Severe [ ]

3c. Brief description:
DIFFERENTIAE OF GAMMA AND DELTA DRINKING

'Loss of Control' alcoholic (Gamma type)

1. Rise in the amount of drink taken as drinking rises to a peak.
2. Brief periods when the person deliberately abstains.
3. A craving for alcohol.
4. Intoxication with uncontrolled behaviour in public.
5. The person drinks to a point of being incapacitated so that, for example, he is unable to go to work or perform adequately when there.
6. Associates disapprove of person's drinking.
7. Recognition that alcohol is needed in order to carry out routine tasks.
8. The occurrence of withdrawal symptoms which are relieved by taking a drink.
9. Blackouts of awareness when the alcoholic is unable to recall what he did.
10. The person realises that his drinking is abnormal before any physical symptoms occur.
11. Person knows that his drinking is abnormal before his alcoholism is diagnosed.

'Inability-to-abstain' alcoholic (Delta type)

1. Amount of drink maintained at a steady level.
2. Person is unable to remain without a drink for any length of time: no periods of voluntary abstinence.
3. Lack of craving for alcohol.
4. No disturbance of social behaviour in public.
5. Not incapacitated to any degree by drinking.
6. Associates do not disapprove of person's drinking.
7. Alcohol is not recognised as necessary to control stress.
8. No withdrawal symptoms under normal circumstances.
9. No blackouts of awareness.
10. Drinking is not recognised as abnormal before serious physical consequences occur.
11. Person does not know his drinking is abnormal before his alcoholism is diagnosed.
Gamma type (cont'd.)

12. Inability to control the amount drunk at any one time so that he is unable to keep reserve supplies in the house or spends all the money he has with him on drink in the pub.

13. Drinks because of a personal need.

Delta type (cont'd.)

12. Able to moderate drinking and to keep reserves of drink at home.

13. Drinks because of the company of others who drink a lot.
DRINKING PATTERN QUESTIONNAIRE

1. G Have there been times when you could not remember something that you had done, for example, for part of the previous evening? OR D Has your memory not been affected like this?

2. D Was it only when you were told, that you realised that you had a drinking problem? OR G Did you realise this before you were given this opinion?

* 3. G Did you tend to upset people in public when you had been drinking? OR D Did you manage to avoid upsetting them?

* 4. D Did you keep drinking fairly steadily? OR G Were there times when you deliberately laid off drink for a short while?

* 5. G In the three months before admission/arrest did you sometimes crave for a drink? OR D Did you have no such longing?

6. D Were you able to keep drink in the house? OR G Did you use up all available supplies when drinking?

7. G Did you often have trembling, etc. in the morning which you could put right with a drink? OR D Did you not normally get like this?

* 8. D Has your drinking on the whole not prevented you from missing work? OR G Have you missed work because of your drinking?

* 9. G Did you often think that unless you had a drink, you could not face up to what you had to do, such as to go out in the evening or to do a particular job at work? OR D Did this not particularly occur to you?

Items with an * are scored with two points.
* 10. D Did you find that your work was not affected by your drinking?
    OR
    G Did your drinking affect your work?

* 11. G Have you ever had the shakes and feelings of terror?
    OR
    D Did you normally experience them (except as a result of enforced withdrawals)?

12. D Did you enjoy drinking in company?
    OR
    G Were you content to drink alone?

* 13. G Did the people around you openly object to your drinking?
    OR
    D Did they not mind?

* 14. Have you had feelings of nausea and wanting to vomit or tingling sensations in your fingers?
    D Did you only realise that your drinking was abnormal after these feelings?
    OR
    G Did you know it was abnormal before these things occurred?

* 15. G Did you find that once you started drinking the amount you drank increased to a peak?
    OR
    D Did the amount you drank stay the same?

16. D Did you moderate your drinking?
    OR
    G Did you go on drinking until your money was finished?

Items with an * are scored with two points.