CHARACTERISTICS AND HELP-SEEKING PATTERNS OF ATTENDERS AT A COMMUNITY BASED VOLUNTARY AGENCY AND AN ALCOHOL TREATMENT UNIT

By

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Thesis submitted for
Degree of Ph. D.
Faculty of Medicine
University of Glasgow
July 1992

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ACKNOWLEDGEMENTS

I would like to thank Professor D. N. Brooks for his help and advice throughout the preparation of this thesis. My thanks also to Dr. J. G. Greene for comments and criticisms. I am grateful for the continued support and interest of Dr. P.W. Kershaw and also for access to his patients. I would also like to thank Mr. J. Cuthbert (Manager) and counsellors of Glasgow Council on Alcohol for access to their clients and the Executive Committee of GCA for supporting the project by financing a part-time research assistant.

I am grateful to P. McColm and A. Miller for assistance with data collection and preparation and to Christine Mathieson for helping to type the manuscript. Thanks also to Christine Puckering for statistical advice and to Mrs Sheila Neilson and Miss Beatrice Shaw for their tolerance. Finally thanks to my husband Bill for his support and encouragement.

LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
ANOVA	Analysis of Variance
ASP	Anti-social Personality Disorder
ATU	Alcohol Treatment Unit
BAL	Blood Alcohol Level
CAT	Community Alcohol Team
CNS	Central Nervous System
DIS	Diagnostic Interview Schedule
DF	Degrees of Freedom
D.T.s	Delirium Tremens
GCA	Glasgow Council on Alcohol
GGT	Gamma-glutamyl Transpeptidase
GP	General Practitioner
MCV	Mean Corpuscular Volume
NHS	National Health Service
P	Probability
RDC	Research Diagnostic Criteria
SADQ	Severity of Alcohol Dependence Questionnaire
SADS	Schedule for Affective Disorders
SAS	Social Adjustment Scale
SCA	Scottish Council on Alcohol
SD	Standard Deviation
SPSSX	Statistical Package for the Social Sciences
VAS	Visual Analogue Scale
WHO	World Health Organisation

ABSTRACT

A consecutive series of 112 problem drinkers attending a community based voluntary agency were followed up over a six month period, in order to measure their compliance with treatment. In common with many other agencies attrition rates were high and this was especially true for self-referrals. Those coming through the usual referral channels attended more frequently. Clients attending from the Courts, hostels and from employers attained the highest rates of compliance.

A second study examined a representative sample of fifty clients attending a Council on Alcohol and fifty patients attending an Alcohol Treatment Unit. The assumption that clients using community-based facilities have less serious alcohol problems uncomplicated by the physical, social and psychological difficulties found in those attending Alcohol Treatment Units was not confirmed. Attenders at both agencies, women as well as men, had help seeking patterns similar to those described for other populations which were discontinuous and unco-ordinated and featured multiple contacts and simultaneous use of different services.

One fifth of clients attending a community based voluntary agency presented for treatment with an alcohol problem complicated by affective disorder, phobic anxiety or personality disorder. A similar levels of formal psychiatric disorder was also identified in the ATU sample , except for a small group of women. One quarter of women in this group were phobic with some overlap of affective disorder. Rates of psychological symptoms as opposed to

psychiatric disorder were high in both samples and appeared to be associated with severity of dependence on alcohol. No sex differences were apparent in the rates of psychological symptoms. The need for co-ordination was discussed in the light of the improved outcome which can be expected given appropriate matching of clients to treatment. Some suggestions as to how this might be achieved were discussed.

DECLARATION

I declare that this thesis is entirely my own work. The work has not been submitted for any other degree either at this institution or elsewhere.

Carole A. Allan

INTRODUCTION

Councils on Alcohol, and Glasgow Council (GCA) in particular, make a significant contribution to the network of alcohol services. In Scotland alone 4,000 clients per annum are seen by voluntary counsellors in these agencies. Local Councils on Alcohol aim to provide an easily accessible, non-medical response to the problem drinker. Despite an impressive record of expansion over the last twenty years encompassing the development of 26 Councils, there has been no systematic evaluation of the work of these agencies.

The following research is based on two separate studies and will examine some of the key features about clients attending voluntary agencies in the form of Councils on Alcohol. The aim of the first study will be to define the socio-demographic characteristics of this population and to monitor and identify factors associated with compliance with treatment. The second study will involve a detailed examination of the social, psychological and clinical features of this population as well as their use of services and patterns of seeking help. For purposes of comparison, a sample of patients attending an Alcohol and Drug Treatment Unit will be assessed using the same criteria in order to identify the nature of the populations served by these two very different treatment facilities.

CHAPTER ONE ALCOHOL PROBLEMS AND THEIR TREATMENT

The excessive use of alcohol has been associated with a wide range of physical and social problems which have been increasing over the last twenty years. This has led the Royal College of Psychiatrists (1986) in their report on alcohol abuse to say, "Alcohol is the major public health issue of our time, overshadowing even that of tobacco and dwarfing the problems of illicit drug abuse". In this chapter the scale and extent of alcohol-related problems will be described as well as the development of treatment services that evolved in response to these problems. Some of these changes have resulted from disenchantment with conventional in-patient treatment as well as a radical shift in the way alcohol problems were viewed. This has laid the groundwork for other treatment agencies to flourish; in particular community based voluntary agencies in the form of Councils on Alcohol.

There is now a large amount of data that indicates that alcohol misuse is a causal factor in a wide range of difficulties. As with other psychoactive substances, the harm that can occur from the use of alcohol can be categorised into three main types. These are problems relating to intoxication, to heavy regular use and to dependence (Thorley, 1985).

THE EXTENT OF ALCOHOL RELATED PROBLEMS

Alcohol is a mood altering drug and its intoxicating action on the central nervous system is the main reason for its widespread use and popularity. Generally speaking, the higher the concentration of alcohol in the blood the more intoxicating effect there is on the

brain. Because alcoholic beverages vary widely in their concentration of alcohol the following system will be used to provide some consistency of measurement. A "standard" drink is referred to as a "unit" and contains 8 gms pure alcohol. A half pint of beer, a glass of wine and a single measure of spirits are considered to be roughly equivalent in alcoholic strength. Consumption of a unit of alcohol raises the blood alcohol level (BAL) by approximately 15mg.% (Royal College of Psychiatrists, 1986). The first recognisable changes in mood and behaviour appear at modest levels of consumption. After drinking 2 or 3 units of alcohol, most individuals report subjective feelings of mild euphoria and a loosening of inhibitions. As the blood alcohol level rises, progressively more functions of the brain are affected. Driving skills are adversely affected at 80mg per cent, and clumsiness and impaired judgement follow at 100mg per cent. At concentrations of 300mg per cent most individuals are grossly intoxicated. The fatal concentrations lie between 500mg per cent and 800mg per cent (Saunders and Paton, 1981).

There are many legal problems typically associated with episodes of acute intoxication. In 1985 there were over 100,000 convictions for drunk driving in the UK (Scottish Council on Alcohol, 1988). A recent report indicated that one third of people killed on the roads in England and Wales had blood alcohol levels exceeding the legal limit. More than 1200 people, half of them below the age of 25, are killed annually as the result of drinking and driving (Dunbar, 1985).

Alcohol intoxication was directly responsible for 96,000 convictions per annum for drunkenness in the U.K. (Brewers Society, 1986). It is also implicated in more serious types of crime. In the West of

Scotland more than half of those found guilty of murder were intoxicated at the time of the offence. A similar proportion of the victims had also been drinking (Gillies, 1976). Alcohol consumption is also an important contributory factor in about one third of domestic accidents (Taylor, 1981) and 15% of drownings (McNeil, 1983).

Apart from the effects of acute intoxication, heavy regular consumption is associated with a variety of other difficulties. It is generally accepted that very high levels of alcohol consumption (in excess of 56 units per week) can adversely affect health (Pequignot, Tuyns and Berta, 1978). What is less well recognised is that alcohol can cause illness when consumed at much lower levels than were previously thought harmful. The Royal College of Physicians (1987) has suggested that regular consumption of between 21-49 units per week for men and 14-35 units per week for women is associated with an increasing risk of a wide range of physical damage. This includes gastrointestinal disorder in the form of chronic diarrhoea, gastritis, peptic ulcer, pancreatitis, hepatitis and diseases of the liver including cirrhosis and cancer. Other disorders typically associated with heavy drinking are neurological and include Korsakoff's syndrome, cerebellar damage and alcoholic dementia (Marsden, 1977). As many as one in five men in a medical ward will have physical problems related to their alcohol use (Lloyd, Chick and Crombie, 1982).

Estimates of the total number of deaths from alcohol-related conditions have ranged from 5,000 to 10,000 per year (Taylor, 1981). Even this high figure has been considered to be an underestimate by some authorities and the Royal College of General Practitioners

(1986) has suggested that the number of deaths from alcohol-related conditions may be as high as 40,000 per year.

Alcohol belongs to that class of drug which if used frequently and heavily can induce dependence. Among this dependent group are people who have traditionally been described as alcoholic. Physical dependence usually takes many years to develop, and the critical quantities of alcohol involved are thought to be about 16 units per day and above (Thorley, 1982). Withdrawal symptoms occur when blood alcohol levels begin to fall, typically after a period of sleep when the drinker is unable to top up his alcohol levels. The commonest withdrawal symptoms are mood disturbance, tremor, nausea and sweating (Sillanpaa, 1982). More severe withdrawal phenomena which include withdrawal seizures, hallucinations and delirium tremens usually require prompt medical help. The Royal College of Psychiatrists (1986) estimates that there are over 300,000 people in Britain who have severe alcohol problems of this type. Community surveys in England and Scotland have shown that 5% of men and between 1-2% of women have alcohol problems requiring intervention (Edwards et al., 1973; Saunders and Kershaw, 1979). These high rates of problems are reflected in the number of admissions to psychiatric hospitals for alcohol treatment which have increased 25 fold in the last 25 years (Royal College of Psychiatrists, 1986). In Scotland, one in three of all male psychiatric admissions to hospital are for alcohol-related problems (Scottish Home and Health Department, 1985).

CHANGES IN CONSUMPTION AND PROBLEMS

The sheer scale of alcohol-related harm has prompted strong comments and the resulting sum of damage has been described as "an appalling

insult to the nation's health, a cause of untold personal and family misery and a cost to the country of thousands of millions of pounds each year" (Royal College of Psychiatrists, 1986). There are a number of possible explanations for the the major increase in alcohol problems. Many commentators have noted that per capita consumption of alcohol virtually doubled between 1959 and 1979. This pattern of increase was thought to be related to a fall in the real price of alcohol as a proportion of disposable income and to changes in the availability and distribution of alcohol. Increases in the prevalence of alcohol-related problems have closely followed these trends in the patterns of availability and consumption (Smith, 1981).

The relationship between per capita consumption and levels of harm has been described before. During the First World War, when the availability of alcohol was reduced by licensing laws there was a significant decline in alcoholic mortality and drunkenness (Wilson, 1939). Similar changes were noted during the Prohibition era in the United States (Smith, 1981). A formal link between consumption and problems was first proposed by Ledermann (1964) who suggested that a population's consumption would always be distributed in the same way. The majority consuming relatively small amounts of alcohol and successively less drinkers consuming larger and larger quantities. The theory was further elaborated by De Lint and Schmidt (1971) who concluded that there was an invariant relationship between overall consumption and rates of problems. There is now a great deal of evidence to support the general principles of this theory although the details have been heavily criticised (Smith, 1981).

Consumption levels are unlikely to be determined solely by economic variables but are influenced by social and cultural factors. There has been speculation that because consumption was relatively modest during the First World War, a generation grew up with no personal experience of the results of unfettered consumption of alcohol. This produced a more relaxed attitude towards alcohol and a loosening of the strong restrictions that used to govern its use, leading to a period of heavy and problematic use (Smith, 1981). This most recent period has seen a relaxation of licensing hours and a huge growth in outlets selling alcohol, leading to heavier consumption (Baggot, 1990).

DEVELOPMENT OF SERVICES

The foundations for the present pattern of services for problem drinkers began to develop after the Second World War in response to the rapid rise in the number of people with alcohol problems. Before this rise, alcoholism treatment was directed towards a relatively small number of patients and was hardly recognised as a legitimate responsibility for the psychiatric services (Orford and Edwards, 1977). Treatment services do not spring from a conceptual vacuum but reflect the prevailing views of the day on the nature of the disorder being treated. When treatment services were first conceived the post-war years were characterised by a fairly strict disease model. At its most simplistic this model postulated a biochemical defect which led the alcoholic to react to alcohol in certain ways. This was characterised by craving and loss of control over drinking once alcohol had been consumed. Total abstinence was considered to arrest the condition but not to cure it and a return to normal drinking was not considered possible.

The first specialised NHS unit for the treatment of alcohol problems was established at Warlingham Park Hospital in Surrey (Glatt, 1955). The model used for Alcoholism Treatment Units (ATU's) was heavily influenced by the work of Jellinek (1960) and characterised by a disease orientation. This was a significant development as it signalled that the NHS was undertaking the treatment and care of alcoholics. In 1962 a Memorandum recommended the establishment of further hospital based units (Ministry of Health, 1962) and between 1962 and 1973 nineteen regional Alcoholism Treatment Units (ATU) were brought into operation to provide improved care for alcoholics. Eventually twenty-nine such units came into operation (Ettore, 1985a).

At the beginning these were specialised in-patient units usually located within psychiatric hospitals and staffed by psychiatric personnel. Treatment was intensive, group orientated and sometimes lasted many months. Patients were strongly encouraged to attend Alcoholics Anonymous (AA) in order to provide them with continued support. However by 1968 the Ministry issued further guidance recommending that the Units should become integrated with community agencies. A further series of policy documents culminating in the issue of the "Pattern and Range of Services for problem drinkers" (Department of Health and Social Services, 1978) stressed that ATU's were not providing care in isolation, but were to be part of a wide range of services available to the problem drinker.

These developments represented a fundamental shift in the way treatment services were viewed. Gradually concepts of alcohol abuse

changed to include much broader perspectives on aetiology, treatment goals and the size of the population at risk. This has been reflected in the changes that have taken place in the services provided by ATU's. Over the years there has been a a substantial rise in day-patient attendances coupled with a shortened stay for in-patients (Ettore, 1988). Many ATU's have acquired strong links with community based agencies, residential hostels and the primary care team (Ettore, 1985b).

This change in emphasis from specialised units with pretensions to monopolise alcoholism treatment, to a centre which was simply part of wider service network, occurred along with a number of other developments. The first was a questioning of the efficacy of treatment, the second was a re-evaluation of the disease concept of alcoholism.

THE EFFECTIVENESS OF TREATMENT

There have been two distinct phases of treatment evaluation studies. During the first phase, research was directed at discovering the main effects of treatment compared to no treatment or to an alternative treatment. The second wave of studies has used a more sophisticated approach and has investigated what has come to be known as "the matching hypothesis". This pre-supposes the existence of interaction effects and suggests that treatment will be more effective if clients with different characteristics are matched with appropriate treatments. This second proposition will be fully discussed in Chapter 5 which examines the qualitative evaluation of treatment services.

In the first instance, when examining the effects of treatment, Emrick (1974) in an extensive review of 271 uncontrolled studies, concluded that two thirds of patients improved with treatment. In a subsequent paper he reviewed 384 treatment outcome studies (Emrick, 1975), in an attempt to examine the relative effectiveness of different types of treatment. Only 72 of these studies used random assignment or matched treatment groups, allowing assessment of treatment differences unconfounded by patient characteristics. In all, only five studies indicated that any one treatment approach was superior. Even with these five studies Emrick expressed reservations as he felt that the results for the control group may have been depressed because patients were disappointed at not being in the experimental group. Therefore until 1975 the research literature had not found that any particular type of treatment to be advantageous. It would also be true to say that the overwhelming majority of studies had severe methodological problems making it difficult to interpret the results with any degree of certainty (Nathan and Lansky, 1978).

Subsequent to this in 1977, Orford and Edwards published an influential study which examined whether a conventional alcoholism treatment regime had any objective advantage over a simpler and less costly approach. This type of issue had been examined before. For example, similar studies had shown that client improvement was unrelated to the length of treatment received in such a unit (Willems, Letemendia and Arroyabe, 1973), and that clients treated in an out-patient basis were as likely to improve as those treated within in-patient units (Ritson, 1968). However, a combination of the prestige of these particular authors and the mood of the times served to make this a landmark study.

The Orford and Edward's study will be described in detail as its results are widely quoted to support often widely discrepant viewpoints. A hundred married male alcoholics received a three hour detailed assessment, which included a psychiatric interview, physical examination and psychological screening. The wife meanwhile was interviewed by a social worker to assess social and marital functioning. At this point the group were randomly assigned to either "advice" or treatment. After the assessment session the advice group received a joint counselling session with clear instructions that responsibility for improvement lay with the patient. The treatment group, after the initial assessment were given access to the full range of in-patient and out-patient care normally provided by a major psychiatric hospital. Both groups received a monthly social work visit to collect news of the patient's progress. At twelve months there were no differences in outcome between the two groups and by twenty-four months approximately 10% of both treatment groups had returned to some form of non-problem drinking and 10% had become abstainers.

This study was noteworthy as it avoided many of the pitfalls that had previously compromised alcohol treatment research. The client group was fully described in terms of drinking status as well as other relevant variables like social support and marital stability. Subjects were randomly allocated to two distinctly different treatments and the follow-up was effectively carried out.

The authors themselves reported their results with the caveat that the project involved a highly selected group of patients; married

male alcoholics referred to one single clinic. A quite different outcome might be expected for unmarried patients of low social stability who may not have readily been able to apply the advice they were given.

In an American context another major and influential study looked at clients attending 45 treatment centres throughout the country (Armor, Polich and Stambul, 1978). Amongst many other findings, they reported no consistent differences in remission rates among different treatment settings such as hospitalisation or out-patient care. These researchers also found small numbers of clients returning to drinking without apparent problems.

CHANGES IN VIEWS ABOUT ALCOHOL PROBLEMS

These types of studies influenced the development of alcohol treatment services by questioning the value of routine admission for alcohol problems whatever their nature or severity. The finding that a relatively brief advice session could be beneficial also lent great impetus to simpler forms of help which rested upon a counselling approach.

As assumptions about the nature of alcoholism underlie most treatment the failure to find that one of the major clinical approaches towards alcohol problems has not proved consistently effective led some researchers to question the underlying theoretical model (Armor et al., 1978). The disease theory predicted that alcoholics would be unable to return to normal drinking although the two previous studies described found evidence to the contrary. Again these type of findings had been reported throughout the research literature before,

but at this juncture received a great deal of attention because of heightened interest in the disease model (Heather and Robertson, 1981).

Outside the clinical field, the pioneering work by Ledermann (1964) described previously had questioned the concept of alcoholism as a discrete entity. This notion was further undermined by researchers studying drinking patterns and problems in the general population. Problems appeared to be more diffuse and sporadic and there was evidence that people moved in and out of problem drinking. Changes in personal circumstances like a new job or getting married appeared in some cases to be more important factors than formal treatment in the successful resolution of a drinking problem (Saunders and Kershaw, 1979).

Underlying this consistent relationship between consumption and problems at a national level there is considerable variation between different groups in the incidence of alcohol-related problems. Sociological studies have made a distinctive contribution to understanding the mechanisms by which this may occur, which includes cultural and occupational factors. Different ethnic groups appear to have varying vulnerabilities to alcohol, for example in the U.K. the Irish and the Scots appear to have high rates of alcohol problems. Findings by O'Connor (1978) have suggested that the basic differences may be due to cultural transmission of drinking behaviour mediated through the family and peer groups.

It has been recognised for many years that people in certain occupations carry a higher risk of developing alcohol-related liver damage. Most at risk are publicans, followed by seamen and barmen

(OPCS, 1986). Other high risk groups include fishermen, authors, writers and journalists. Obviously no single factor can account for the diversity of these findings but easy availability of alcohol has been considered an important factor. Plant (1979) found that within the brewing industry, conditions of employment compound a tendency to higher levels of drinking already apparent at the time of recruitment. On the other hand he found that when workers moved from a high risk job to a low risk job, their level of consumption decreased.

A new departure in experimental method which involved giving alcohol to alcoholics in the laboratory or under controlled conditions began to make a substantial contribution to the research literature. Before this the determinants of drinking behaviour were based on anecdote and the self-report of patients. Mello and Mendelson (1971; 1972) used an operant model to study heavy drinkers and found that in common with other behaviours, drinking could be shaped and maintained by its environmental consequences. Subjects did not display the classic loss of control or craving which had been the key features of earlier definitions of alcoholism. During the experimental period, subjects drank to maintain a fairly high constant BAL rather than to extreme intoxication. This level was maintained by what appeared to be a careful process of titration as subjects did not drink continuously but alternated between starting and stopping drinking. Some subjects were observed to reduce their consumption gradually to avoid withdrawal symptoms at the end of an experimental session. Mello and Mendelson could find little scientific utility in the concept of loss of control and others workers who have carried out similar experiments have rejected it altogether (Merry, 1966; Cohen

et al., 1971).

In essence the weight of evidence from the fields of epidemiology, sociology and psychology were promoting a much wider view of the nature of alcohol problems. The WHO had also revised its definition of alcoholism which was now based on a formulation proposed by Edwards and Gross (1976). The notion of a discrete disease entity had been rejected and was replaced by the alcohol dependence syndrome. The new syndrome was composed of seven separate elements which centred around a drive consume alcohol. Prominence was given to physical dependence and the experience of withdrawal symptoms. In contrast to traditional formulations of alcoholism which had included a wide range of difficulties, it distinguished between alcohol dependence and alcohol related disability. The original formulation in 1976 was described by its authors as provisional but became officially incorporated into the International Classification of Diseases in 1979.

From the outset this formulation attracted much criticism on a number of grounds. By many it was seen as a more sophisticated version of "alcoholism" and lacking in scientific respectability and a reassertion of medical dominance (Shaw et al., 1978). One of the original authors of the first paper in 1976 obviously aware of some of contradictions associated with the formulation attempted to provide a synthesis of the most noteworthy findings from other areas with the notion of a dependence syndrome (Edwards, 1977). He asserted that the syndrome was not all or none but placed drinkers on a continuum of dependence. He reiterated the separation of dependence from disability and highlighted the clinical utility of the syndrome as a means of shared understanding with other professionals outside

the medical profession. Within a clinical context other workers have considered level of dependence to be an important factor in negotiating treatment goals with patients (Hodgson, 1980).

Over the next few years the alcohol dependence model generated a large number of studies and further evidence supporting the basic elements of the syndrome has been succintly described by Hodgson and Stockwell (1985). Despite this there is still a vigorous debate about the scientific and clinical utility of the concept (Heather, Robertson and Davies, 1985). Nevertheless research findings from this and the other areas described has had a number of implications for the way services were to develop. There was general endorsement that the aetiology of alcohol problems was multi-faceted and as such, diverse forms of treatment should be promoted and be available. They have provided a rational basis for contacting and advising those whose problems were less severe, as the possibility of reducing consumption rather than lifelong abstention had become a viable treatment goal. Implicit in this type of formulation is the view that the number of people with alcohol problems is not fixed but varies with the amount of alcohol consumed in a particular society. If there is a link between national consumption, individual consumption and alcohol problems everyone is potentially at risk. This view represents a change of focus from a small deviant group with a pathological condition to viewing alcohol problems as a continuum with many more drinkers potentially at risk.

It had already become clear that the assumption by planners that only a small number of people required help with their drinking problems was ill founded. By 1975 the Department of Health and Social

Security concluded that 400,000 people in England and Wales had a serious drink problem. In the same year less than 14,000 persons were admitted to psychiatric hospitals with alcohol problems (Cartwright, Shaw and Spratley, 1975). Alcohol Treatment Units were logistically not capable of dealing with the sheer numbers of people who required help.

A COMMUNITY RESPONSE TO ALCOHOL PROBLEMS

A number of options were available and Cartwright et al. (1975) in a report to the Department of Health and Social Security argued persuasively that much more effective use should be made of existing resources. The primary health care team was seen as main treatment personnel upon which this community response could be based. They were to be supported in this work by the formation of Community Alcohol Teams (CAT) whose remit was to provide advice, support and training to primary care workers to allow them to carry out their treatment role effectively (Shaw et al., 1978). The original aims of CAT's have been greatly modified over the years as there has been a gradual disenchantment with this approach. Some CAT's have failed to attract continued funding while others have become direct treatment providers as their advisory function has never satisfactorily developed (Clement, 1989). The second option, and the subject of this research was the development of other specialist services, that would be able to make use of simpler and cheaper forms of interventions. This led to the promotion and development of Councils on Alcohol which had begun in embryonic form in 1963.

CHAPTER TWO DEVELOPMENT OF COUNCILS ON ALCOHOL

In this chapter, the particular conditions that have promoted the rapid development of Councils on Alcohol will be highlighted. The structure and proposed function of Councils will be described as well as the characteristics of the volunteers who carry out the work of these agencies. Very little is known about the client group, and the reasons for this will be discussed. Finally the aims of the two separate studies which will form the body of this thesis will be described.

The original idea for Councils on Alcohol came from a recovered female alcoholic called Marty Mann who set up the American Council on Alcoholism in 1942. Her aim was to provide a much more wide ranging service than was available from Alcoholics Anonymous, where she had been a member. She felt that individual counselling should be available and she was concerned that women with alcohol problems should receive appropriate help (Association of Directors of Councils on Alcohol, 1988). Following the success of the American experience, the National Council on Alcohol was established in Britain in 1963 (Edwards et al., 1967). There were parallel developments in Scotland and in 1968, Glasgow Council on Alcohol was established (SCA, 1984). In 1973, when the Scottish Councils on Alcohol (SCA) was inaugurated as a federal organisation there were five local Councils in Scotland. The SCA has adopted a co-ordinating and organisational role and played a leading part in the development of the network. Since these early days there has been an impressive record of expansion which includes the establishment of twenty six local Councils on Alcohol (Allan, 1987).

Councils on Alcohol are now major providers of services to problem drinkers. This research concentrates on Scotland, but other countries in the U.K. and America have very similar organisations. There are now fifty three Councils on Alcohol in England, Wales and Northern Ireland (Association of Directors of Councils, 1988). In Scotland alone, in the year the following studies were carried out 4,000 clients per annum were seen by voluntary counsellors in these agencies (Scottish Council on Alcohol, 1986). Despite the importance of this service empirical information on the nature of this large client group is almost non-existent.

Apart from a major shift in the way alcohol problems are viewed a number of special conditions have favoured the rapid development of Councils. The first involves the long-standing tradition of self-help which exists in the alcohol field. Alcoholics Anonymous (AA) arguably one of the world's most successful self-help groups has provided a model for many such ventures. The second comes directly from the community mental health movement which actively promotes the use of volunteers and non-professionals.

There is sometimes a degree of confusion between AA and Councils on Alcohol. AA has a much longer history and since its beginning in 1935, has grown into a world-wide organisation claiming well over 1,000,000 active members (Robinson, 1979). AA groups are financially self-supporting and no outside donations are accepted. An important part of the movement is for established members is to recruit new comers and to help them to remain sober. By listening to other member's experiences, attending different AA meetings and reading AA literature new members eventually begin to "identify" with the

fellowship. Recovery is effected by contact, not with professional workers but with help from fellow alcoholics. In AA, recovering alcoholics monopolise the therapeutic role. Personal experience of having overcome an alcohol problem rather than training is considered the vital element in the ability to help others. The aim is to persuade the drinker to stop drinking completely as total and lifelong abstinence is considered to be the only effective treatment.

Although Councils have some superficial similarities with AA there are fundamental differences between the two organisations. Councils receive most of their funding from outside bodies, treatment goals are flexible and, perhaps most importantly, having had an alcohol problem is not considered to be a necessary or important experience for consellors. Despite these differences between the two organisations, AA has provided a powerful role model and has stimulated the extensive use of non-professional workers in both the alcohol and drug fields (Ogborne and Glaser, 1982).

Community responses towards alcohol problems have not occurred in isolation and should be placed within the wider context of the community care movement. Proponents of community care feel that insufficient recognition has been given to the positive role played by families, volunteers and self-help organisations (Orford, 1987). Because of this the use of non-professionals is preferred as they are considered to be the most appropriate and effective therapists in the management of dysfunctional community members (Durlak, 1979).

The basic philosophy is that services should be provided as near as possible to people's homes so that regular routines and social ties are disturbed as little as possible. Stigmatised settings like

psychiatric hospitals are to be avoided and residential provision if required should be in small, therapeutic hostels (Otto and Orford, 1978).

Implicit in much of the thinking on community care is the view that early cases can be easily identified and because there is unrestricted access to treatment, can be seen promptly. Less complex treatment in the form of relatively "brief" advice or minimal intervention strategies should be readily available. Because of this, community care strategies are felt to be important in the prevention of major chronic problems. The assumption is that treatment at an early stage of a disorder is likely to be more effective for much less intensive effort (Institute of Medicine, 1990).

Some of these views have found wide application in mental handicap and in the care of chronic psychotic patients (Shepherd, 1987). Some reservations about the application of community care strategies have been expressed from the very beginning and have been reviewed by Hawks (1975). More recently a degree of suspicion has been expressed about the speed with which the radical views about community care have been adopted by government and it has been suggested that economic rather than humanitarian motives may be the dominant force (Sedgewick, 1982). What is perhaps unique in the present climate is the blanket rejection of institutional care and the assumption by funders that community services provide a cheaper and more effective health care option. The application of these views in the alcohol field remains untested and the research to be reported will examine whether the aims of a community based service are being met.

THE STRUCTURE OF COUNCILS ON ALCOHOL

Each local Council has a management structure which consists of a policy making executive committee elected on a yearly basis. In the larger Councils a salaried manager with supporting administrative staff usually oversees the work of the organisation. Funding comes from a variety of sources including the Scottish Office, Health Boards, Social Work Departments and donations from the general public. The bulk of the counselling work of the Council is carried out by unpaid, voluntary counsellors (SCA, 1984).

The model used for the deployment of voluntary alcohol counsellors is that of the "barefoot doctors". These workers received a very basic training and were Mao Tse Tung's response to the gap between the health needs of China and the supply of expensively educated medical specialists (Brown and O'Donnell, 1980). In a similar vein it was felt that voluntary workers would be able to fill the gap between needs and resources in the alcohol treatment field.

Brown (1980) has suggested that "lay" personnel can be equally as effective as professionals in the mental health field. He has also noted that many professional workers acquire a range of unneeded skills which will not be used when counselling problem drinkers. He contends that the necessary skills can be easily imparted to specially selected volunteer counsellors in relatively brief training courses and a period of supervised practice.

Selection criteria for volunteer counsellors are based upon personal attributes and not on formal qualifications. Desired characteristics include "good communication skills, potential for accurate warmth"

and "freedom from gross and crippling personal problems" (Brown, 1980). At this stage trainee counsellors are not required to have either skills in counselling or knowledge of the alcohol field.

Despite the emphasis on the untrained and unskilled element in a study of 290 volunteers trained by the SCA throughout Scotland between 1982 and 1985, Wilson (1986) found that alcohol counsellors were very similar to other voluntary workers. The majority were female, middle-aged and middle-class. Of those in employment (i.e. two thirds of the sample) well over half held upper or lower managerial or professional positions, while only 13% held unskilled posts. One third of candidates described themselves as already in work with an element of counselling e.g. in nursing, social work or health related professions. Therefore even before training, many aspiring counsellors have a great deal of knowledge and experience in the "caring" field. Probably the main difference from other voluntary workers is that about half of the volunteers have had personal experience either as problem drinkers or more frequently as the close relative of a problem drinker.

The counselling style favoured emphasises the personal relationship between the counsellor and client "built up in counselling an individual client over some time". The aim is to allow long term contact to effect positive change in the clients life. The style has been described as "developmental, non-directive and client-centred" (Brown, 1980). There is particular emphasis placed on the quality of relationship between counsellor and client. This has been described in the following way , "counsellors are seen as less likely to behave in any arbitrary, arrogant, bullying or dominating ways as if they

had authority because they have no authority" (Brown, 1980). In Wilson's study the overwhelming majority of counsellors expressed confidence in working with self-referrals, but 41% would be reluctant to work with those who came from non-voluntary sources e.g. courts or employers. She does not comment on the reasons for this but presumably counsellors felt that a strong coercive element might compromise the relationship between counsellor and client.

WHY HAVE COUNCILS NOT BEEN STUDIED BEFORE?

Despite the successful expansion of the Council network there are virtually no studies of the clients who attend these agencies. The literature which is available is in the form of policy documents which concentrate on creating services rather than evaluating them. Understandably, service provision, rather than service evaluation was the priority in the early days.

Another perhaps more important reason rests with the ideological and philosophical roots of volunteer counsellors. Many counsellors identify very closely with their clients and feel allowing access to a researcher may compromise this relationship. Many reject the whole notion of research, and view as self evident that the work they do is effective and valuable. These opinions are also very common among professional workers who are asked to take part in evaluation studies (Suchman, 1967). Such views are harder to deal with among volunteers as they are not paid employees and give their time and often considerable expertise without a cash reward. This ambivalence can create great difficulties for researchers. A demonstration of this sabotage process in action can be seen in the work of Smith (1990). She attempted to obtain a representative sample of fifty women from

an Council on Alcohol which sees about 250 new female clients per year. Despite vigorous attempts to recruit subjects it took eighteen months to obtain a sample of 26 at which point she abandoned the attempt to recruit more clients.

To some extent these problems were overcome in the present research as the author has been involved with the Council on Alcohol network for thirteen years in a number of capacities. Formerly as a selector and trainer for voluntary counsellors throughout Scotland, and latterly as an executive committee member of GCA. This presented a unique opportunity to study the work of a Council on Alcohol. Because of the author's close involvement with the organisation the question of undue bias and lack of objectivity has to be considered. This can be partially answered by stating at the outset that some of the author's views and observations are in conflict with those expressed in the various policy documents available (e.g. SCA, 1984, Brown and O'Donnell, 1980). This research is partly aimed at defining and describing these conflicting views and examining their respective merits.

THE CLIENTS OF COUNCILS ON ALCOHOL

SCA policy documents have defined in precise terms the type of client they were hoping to engage in treatment. They state that they were hoping to cater for "that large and hitherto neglected section of the population of problem drinkers who do not seek contact with professional services, but who do not fit in with the atmosphere and ideology of Alcoholics Anonymous". Problem drinkers without "such intractable problems as single homelessness or liver damage" (SCA,

1984) were the target group for this service. The aim therefore was twofold; to attract the early problem drinker and to extend help to those who were not involved with other services. No indication as to how this target group of problem drinkers was to be located is contained in the policy documents but the assumption appears to have been that they would be largely self-referred.

Evidence on whether these goals have been achieved is sparse. The earliest study on Councils was carried out by Edwards et al. in 1967 when a survey of consecutive attenders at three Councils on Alcohol, including GCA was carried out. The average age of clients was 43, the majority were male and the authors concluded that they were similar to attenders at AA and ATU's but rather different to "Skid Row" alcoholics as they tended to be more socially stable than this group.

A review of clients attending GCA by O'Donnell (1978) during its first nine years from 1968-1977 indicated that Councils were attracting a predominantly middle aged group of male, heavy drinkers. He described a typical client as male, aged 42, married and in regular employment. This confirmed the findings of Edwards et al. (1967) a decade earlier who found essentially similar socio-demographic features. O'Donnell noted an increasing proportion of women; 23% in 1977 compared to 13% in 1967. Referrals came from a variety of sources, the largest group being self-referrals (64%). At this point O' Donnell felt that attracting a younger and earlier problem drinker was a particular challenge for Councils on Alcohol. There was also speculation that women would be using the services to an increasing extent.

No outcome studies have been reported for Councils on Alcohol but Madden and Kenyon (1975) carried out an uncontrolled descriptive study of clients who attended "group counselling" for a minimum of six months with the Merseyside Council on Alcohol. They reported that 64% of subjects had a good outcome. The average age of attenders was 41 and the average duration of alcoholism was 11 years with a range from 2-30 years indicating this sample contained a proportion of drinkers with chronic problems.

Indications from the above authors would suggest that Councils were not attracting a fundamentally different client group from other agencies, although more detailed evidence was not available at this point. A further two unpublished studies which are not in agreement with these findings will be mentioned.

Smith (1990) interviewed women attending different agencies including a Council on Alcohol about their opinions and personal experiences of treatment. She concluded that women attending the Council were younger and at an earlier stage of the disorder than women attending AA or those attending a hospital based facility. Unfortunately she experienced great difficulty in obtaining unbiased samples from all of the agencies involved in the study. For both AA and the hospital based sample, because of difficulties in recruiting subjects, attenders who had been in treatment for a considerable period of time were used in the research. For example, eight of the AA sample had been sober for five or more years at the time of interview and a further twelve had been sober for between one and four years. This protracted period in treatment was not a feature of the Council sample who seemed to be at the beginning of a treatment contact. Crucially, conclusions about general service use can only be drawn

if comparable samples of women are located and interviewed.

The final study to be reviewed involved clients attending Council on Alcohol Information Centres in the Greater Manchester area were who were reported to be younger, more socially deprived and to have less severe alcohol problems than attenders at other agencies within the area (Delahaye and Hore, 1974). This finding is at odds with all of the others described and may reflect idiosyncratic local conditions.

Apart from the few papers described, the author is not aware of any further studies on the clients of Councils although these organisations have developed and flourished. Clearly the process of monitoring and evaluating services has become increasingly important, as economic forces and the growing consumer movement have demanded greater accountability from agencies providing care (Shepherd, 1987). The move towards early intervention and a shift in emphasis away from hospital based services and personnel to community based facilities mirrors developments in other areas of the mental health services. The growth of community care has occurred with little critical appraisal of the results and the findings from this study would have application outside the alcohol field.

Glasgow Council on Alcohol was chosen as the subject of this research for a number of reasons. First of all the author was reasonably confident of obtaining access to clients which has been a difficulty for past researchers. Apart from this, GCA is well established as the oldest and largest Council, accounting for 20% of all referrals to Councils in Scotland and is therefore a natural focus for a study of this type. Finally it has been described as representative of

urban Councils by the parent body the SCA when defining and describing it's services (SCA, 1981). Together with GCA, the other large urban Councils of Edinburgh, Dundee and Aberdeen account for over half of all referrals. It is highly likely that client characteristics and patterns of service use do not differ from these other centres.

Other Councils serve a mixture of rural populations and smaller urban centres. Comparisons on basic socio-demographic indices in terms of age and sex indicate that these centres do not differ in the type of clients seen although more rigorous comparison is not possible because of lack of data (SCA, 1988). This means that the findings from this research would be directly applicable to other Councils and particularly to the large urban centres.

The following research, in the form of two separate studies will examine some of the assumptions about the services provided by voluntary agencies in the form of Councils on Alcohol. The aim of the first study will be to define the socio-demographic characteristics of this population and to examine the relationship between these variables and compliance with treatment. The findings from this initial exercise will be used to provide basic background information for a more intensive study about the nature of community based services.

The second study will examine the strong but untested assumption that clients in the main are early problem drinkers relatively free of the psychiatric, legal, medical and social problems which are present in those attending Alcohol Treatment Units (ATU) located in psychiatric hospitals. A comparison

between clients attending a Local Council on Alcohol and patients attending an Alcohol Treatment Unit (ATU) will be carried out to identify the nature of the populations served by these two very different facilities and establish whether or not there is a match between client needs and treatment services.

Surveys of patients attending ATU's have revealed that the presenting alcohol problem may be complicated by affective disorder, phobic anxiety or personality disorder. The common occurrence of these disorders in conjunction with alcohol problems has led to suggestions that they may be of aetiological significance. Interpretation of these findings has been different for a number of reasons, not the least of which is the almost exclusive focus of research on highly selected groups of patients receiving treatment in units located in psychiatric hospitals. Examinations of a community based sample may generate additional data to clarify the link between psychiatric disorder and alcohol problems. There has been a great deal of discussion about the aetiology, level of severity and appropriate treatment response towards women with alcohol problems. From their earliest days Councils on Alcohol have attracted a growing proportion of women and provide a unique opportunity to examine these key areas of concern.

CHAPTER THREE STUDY ONE
MONITORING THE WORK OF A VOLUNTARY AGENCY

APPROACHES TO EVALUATION

Services seldom develop in a planned and rational way. They are influenced by public opinion, the needs of politicians and are often shaped by the drive and enthusiasm of particular individuals. Because of these factors the services which eventually emerge may not be consistent with the goals, procedures and standards as originally conceived. The author's view is that the services have developed and evolved in ways that were not envisaged. Evaluative research can compare the service as it now stands with the original aims and intentions of the planners. It also provides baseline data for future changes and developments within a particular service.

An evaluation is basically an attempt to to judge the worth or value of a particular procedure or activity. Suchman (1967) has proposed a distinction between evaluation as the general process of judging the worthiness of a particular activity, and evaluative research as the specific use of the scientific method for the purpose of an evaluation. Hyman, Wright and Hopkins (1962) have described evaluation as a form of "applied" research whose major aim is not the production of new basic knowledge but the study of the effectiveness of the application of such knowledge.

There are three major categories of evaluation. The first is an assessment of effort, by which is meant the levels of activity engaged in by the service; numbers of clients seen or personnel operating. This type of approach which concentrates on "input" tends

to focus on client characteristics, physical surroundings, and number of personnel and has something in common with the monitoring approach which will be used in the first study to be carried out. Monitoring is probably the most widely used approach to service evaluation. Relatively simple measures, often of a descriptive or quantitative nature are used to keep a continuous check on aspects of the service. The information required is normally collected on a routine basis by staff. This means, to borrow a term from physical medicine, that monitoring procedures are not invasive and do not involve disruption to the usual routine of an agency. This allows a more typical picture of agency performance to be observed. Monitoring has a feedback function and implies checking outcome, relative to service objectives (Goldberg, 1980). Despite the simplicity of the procedures involved, the information obtained can be used to answer complex questions.

"Process" evaluation refers to the actual nature of the service provided. The aim is to assess the quality of the interaction between client and service provider, to ensure that the client is receiving appropriate and effective treatment. This type of evaluation will be to used to assess the qualitative aspects of service provision and will form the basis of the second study.

The third category contains assessment of treatment outcome which has been considered to be the most effective and objective evaluation of quality of care. This approach was not adopted because at this point the author felt there was a lack of basic information on the exact nature of the client group and the nature and scale of their use of other services. Design of such a study would require more

information than had previously been available.

In practice a wide variety of statistical records, inventories, surveys, testimonials and experimental procedures are classified as evaluative instruments. More recently certain types of evaluation have come into prominence. One widely used strategy described by Suchman (1967) as the "Is everyone happy approach" will be discussed in some detail as it has become very widely used due to the growing interest consumer satisfaction with health and social care.

CLIENT OPINION RESEARCH

This type of study, typically asks clients' opinions about aspects of the care they have received. It is easily carried out, cheap to administer and almost without exception, produces results which are comforting to those evaluating care. This method of evaluation will not be used in the following study but will be discussed to highlight some of the pitfalls involved when applied within both an alcohol and voluntary care setting.

In a review of studies of patient satisfaction (Lebow, 1974) found that most studies reported very high levels of satisfaction with care, often over 85%, for both medical and psychiatric settings. From both personal and clinical experience the validity of such high degrees of satisfaction seems unlikely. This "grateful testimonial" approach to evaluation has a number of serious drawbacks, the most important being the ease with which the results can be manipulated. Campbell (1969) has described a number of ways of doing this. In the first instance he suggests that human courtesy being what it is, consumer satisfaction will be

more favourable if the evaluative meaning of the response measure is clear to the subject. This may be a particular difficulty when clients are being asked to evaluate voluntary workers who after all carry out tasks without payment.

He also maintains that the more the subjects participating in the evaluation are a small, highly selected group, preferably those who have been in contact with the agency for a protracted period of time, the better the results will be. In the alcohol context, depending on the characteristics of populations studied, up to 80% of patients drop out within a month of treatment (Baekland and Lundwall, 1975). Long term attenders are a rarity and therefore unrepresentative of the majority of clients, although these are the group most likely to be asked their opinion. Those who are likely to be critical of services presumably drop out of treatment relatively rapidly.

There may also be a conflict between services that are considered high quality or beneficial by clients but may in fact be considered to be inappropriate by the treating clinician. For example many clients request the prescription of tranquillisers and antidepressants, while they are still drinking heavily. These type of drugs can induce cross dependence or be dangerous in over dose. Refusal of these requests would be good practice in a clinical sense but may be personally upsetting for clients.

Finally many clients do not welcome information that is unpleasant or anxiety provoking, and "denial" of an alcohol problem can create tension between the therapist and client

(Goldsmith and Green, 1988). Some clients are coerced into treatment by their families, the Courts or their employers and feel very pressured by the circumstances surrounding their referral for treatment. Some of the evaluations produced in these circumstances may be critical of therapists or agencies but reflect clients beginning to confront issues that must be resolved before they can begin dealing with their drink problem.

Because of these reasons client opinion research has a limited usefulness in evaluative research (Sainsbury 1987) although it has obvious relevance to other aspects of service provision. For example looking at aspects of quality of care or checking on the accuracy of communications between client and care-giver (Davies, 1981).

EVALUATING SERVICE AIMS AND OBJECTIVES

The following study will examine some of the aims and service objectives of GCA and some of the more general assumptions about community based services. Socio-demographic information will be collected on a consecutive series of clients who will be followed up over a six month period to measure their compliance with treatment.

Basic service objectives have been succinctly put by O'Donnell (1978) who felt that attracting a younger and earlier problem drinker was a priority for Councils on Alcohol. He also speculated that because of more liberal attitudes towards women's use of alcohol they would develop problems more frequently and would be using the treatment services to an increasing extent.

COMPLIANCE WITH TREATMENT

Patients with alcohol problems are notoriously difficult to engage in treatment. Their help-seeking has been characterised as highly ambivalent and depending on the characteristics of the populations studied, between 28% and 80% of patients drop out within a month of beginning treatment (Baekland and Lundwall, 1975). Attrition rates are of interest because there is evidence that dropouts or sporadic attenders have relatively low rates of remission (Armor et al., 1978). Specific studies of patient compliance may also provide information on the quality of the service offered. Ogborne and Gavin (1990) have suggested that services in which drop-out is high are failing to meet minimum quality assurance standards. A behavioural measure of attendance is intrinsically more convincing than an attitude survey ever can be as it demonstrates in a very powerful manner the acceptability of the service to the target group.

Explanations for the failure to keep patients in treatment have varied. Patient variables have been extensively studied but only crude measures of social stability have been reliably associated with premature drop-out (Bander et al., 1983; Jacobson and Rubin, 1981). Proponents of community care have suggested that factors intrinsic to the helping agencies themselves may be influential. Many facilities are based in stigmatised settings like psychiatric hospitals which some patients find embarrassing and unacceptable (Thom, 1986). Long waiting lists for non-urgent appointments (Rees, Beech and Hore, 1984) and no consistent therapist have characterised some treatment settings and have a demonstrable effect on compliance rates (Baekland and Lundwall, 1975). Shaw et al. (1978) have suggested that low morale and poor therapeutic commitment displayed by some

professional workers have communicated themselves to patients with subsequent poor uptake of services. The dominant psychiatric model operating with static models of motivation has been particularly criticised as not conducive or helpful to patients with alcohol problems (Davies, 1981).

Because of the expansion of the voluntary sector in the form of Councils on Alcohol it is now possible to examine compliance rates in another type of service that is in keeping with community mental health initiatives. Specifically, Councils aim to provide an easily accessible and rapid response to the problem drinker in relatively anonymous office premises not associated with Health or Social Services, and located within the client's own community. Typically clients or referral agents contact the agency by telephone and are given appointments within 1-5 days. The counselling work of these agencies is carried out by volunteer workers who tend to be enthusiastic and committed to the care of clients (Wilson, 1986). Facilities are limited in that these agencies cannot normally provide direct access to medical or psychiatric advice. This provides a degree of homogeneity in the treatment offered which is largely individual counselling (SCA, 1984).

Source of referral has been an area neglected by those examining compliance rates and the few studies that have examined this issue have produced conflicting results. Wanberg and Jones (1973) found that self-referrals were less likely to remain in treatment. Other studies have reported the opposite finding, that self- referrals were more likely to follow through with treatment (Pfouts, Wallach and Jenkins, 1963; Raynes and Warren, 1971).

Voluntary agencies advertise their services to the general public and attract a substantial proportion of self-referrals who approach the agency directly without using a referral agent like a General Practitioner. In Wilson's (1986) study the overwhelming majority of counsellors expressed confidence and a preference for working with self-referrals. Almost half of counsellors (41%) expressed a reluctance to work with those who came from non-voluntary sources. Despite this a growing proportion of clients now come from coercive sources like the Courts or through employers (Allan and Cuthbert, 1990), providing the opportunity to examine this whether this aspect has an influence on compliance.

There has been a great deal of speculation about what constitutes an optimal treatment response to women with drink problems. They have been considered to be an especially vulnerable group who are difficult to attract and keep in treatment (Litman, 1986). Councils provide many of the features which have been suggested as particularly appropriate for this group. The majority of counsellors are female (Wilson, 1986) which allows female clients to have access to same sex counsellors which some workers have contended reduces stigma (Otto and Litman, 1976). Councils operate a flexible appointment system for day or evening allowing women with child care responsibilities easy access to services. Finally, the main treatment offered is individual counselling which anecdotal evidence indicates may be suitable for women as they are said to function less well in groups (Thom, 1984). A comparison between male and female attenders would indicate whether these features improve compliance to any significant extent.

In view of the above points, the first study was designed with the following aims.

1. To define the sociodemographic characteristics of a Council population.

2. To examine compliance in a community based agency which uses volunteer counsellors as treatment personnel.

3. To assess the relationship between source of referral and compliance with treatment.

4. To examine women's use of services in relation to features which are said to be particularly designed to hold them in treatment.

METHOD

This study was carried out at Glasgow Council on Alcohol (GCA) which is the largest Council in Scotland (SCA, 1981). GCA receives an average of 600 referrals per year (Glasgow Council on Alcohol, 1986) and is located in office premises in the city centre. Clients or referral agents contact the agency by phone or letter and appointments are usually arranged within 1-5 days.

Subjects

Data were collected on 121 consecutive attenders at GCA during January to March 1986 from the records kept by voluntary workers.

MEASURES - Client Variables

During the first interview, the counsellor collected details of age, sex, marital status and employment. Clients who had contacted the Council directly without going through an intermediary were designated as self-referrals. Other referral categories were those from family doctors, local hospitals, employers and hostels and were designated as agency referrals. A full drinking history was also taken to allow the counsellor to assess whether the client had significant problems with his\her alcohol use. No departure from routine GCA practice was involved as Sutherland, Stockwell and Edwards (1985) have demonstrated that intensive research interviews at this point can distort compliance rates. They boosted attendance from a routine 56% to 95% for a second interview during a research project. This method allows typical agency performance to be documented.

Counsellor Variables

Forty-one counsellors were involved in the study the majority of whom were female (63%). As far as possible female clients were allocated to the same sex counsellor.

Measures of Compliance

All counsellors were required to keep a note of return visits of clients to the Council. These records were monitored on a weekly basis for a period of six months to check on client compliance. A number of measures of outcome were employed. The method used by

Baekland and Lundwall (1975) was adopted and involved the following categories,

1. Immediate dropouts - clients who attended for their initial appointment and then subsequently failed to return. Counsellors are specifically trained in techniques to inhibit drop-out at this crucial point.

2. Rapid dropouts - those who attended more than once, but dropped out within a month of initial attendance.

3. Slow dropouts - those who dropped out within 2 - 5 months.

4. Clinic attenders - those who attended on a long-term basis for 6 months or more. This is based on the notion that sustained attendance over this time period is associated with a more favourable outcome (Kissin, Rosenblatt and Machover, 1968).

Finally, the method of leaving treatment was noted. Many clients disappear abruptly and without warning, and this group were deemed to have left in an "unplanned manner". All clients who failed to attend were followed up by telephone or letter, only after these avenues were exhausted was a client finally discharged. When clients and counsellors mutually agreed on discharge, this was designated as a planned discharge.

CHAPTER FOUR RESULTS

Statistical analysis were carried out by means of SSPSX programmes using the University of Glasgow mainframe computing facilities.

CLIENT CHARACTERISTICS

Nine clients (7%) were excluded from the following analysis, as their main purpose in attending GCA was to seek help on behalf of a relative. All of the 112 clients eventually included in the study were assessed by the counsellor involved as having a drink problem requiring intervention. Just over half of clients were married (52%) with one quarter describing themselves as divorced or separated. A further 21% were single. The majority were employed (60%). The average age was 40 years, with a range from 18 to 65 years. Most clients were male with a sex ratio of 2:1 (Table One).

TABLE 1 Sociodemographic Indicators

	GCA (1986)	Edwards (1967)	ATU (1981)
Married	52%	48%	53%
Single	21%	16%	22%
Separated	11%	24%	10%
Divorced	13%	9%	8%
Widowed	3%	3%	7%
Employed	60%	67%	41%
Unemployed	30%	32%	49%
Retired/housewife	10%	1%	10%
Age (years)	40	43.1	42
Sex Ratio	2:1	7:1	4:1

These figures are similar to those described by Edwards et al. (1967) in a survey of three Councils which included GCA. The major difference in the sex ratio as the percentage of women clients attending Councils in 1986 was over twice as high as in 1967 (x^2=22.98, p<0.001).

In comparison with an Alcohol Treatment Unit in the same city, there were similarities in most socio-demographic indices except for employment status. Sixty per cent of GCA clients were employed as opposed to 41% attending the ATU (x^2=9.94, p<0.01). There were also differences in the proportions of women attending the two different agencies (x^2=4.6, p<0.05).

TABLE 2 Source of Referral

Referral	Males	Females	Total
Self-referral	45% (n=34)	57% (n=21)	49%
GP	13% (n=10)	5% (n= 2)	11%
Hospital	7% (n= 5)	14% (n= 5)	9%
Other *	10% (n= 7)	19% (n= 7)	3%
Courts	4% (n= 3)	0% (n= 0)	7%
Employer	8% (n= 6)	5% (n= 2)	12%
Hostels	13% (n=10)	0% (n= 0)	9%

* Marriage Guidance, Minister of Religion, other voluntary agencies etc.

SOURCE OF REFERRAL

Forty-nine per cent of clients were self-referrals and came directly to GCA. The second group came from a variety of sources with

General Practitioners, Hospitals and other services providing the bulk of what will be described as "agency referrals". The rest were made up of referrals from coercive sources like the Courts, Employers or hostels where the provision of accommodation, continued employment or a delay in the judicial process is made conditional on attendance for counselling (Table Two).

COMPLIANCE WITH TREATMENT

Twenty-seven per cent of the sample attended for one interview and then failed to return. Drop-out continued rapidly with a further 37% of clients leaving over the first 4 weeks. By 6 months a further 29% had left. Long-term attenders in this sample were infrequent with 7% continuing beyond this point (Table Three).

TABLE 3 Drop-out Categories

	Immediate (one interview)	Rapid (< 1 month)	Slow (2-6 months)	Clinic (6 months or more)
Combined (GCA)	27%	37%	29%	7%
Male (GCA)	22%	43%	24%	11%
Female (GCA)	35%	27%	38%	-
Rees (1985)	35%	18%	24%	23%
Rees et al. (1984)	44%	6%	35%	15%

This compared favourably with results published by Rees (1985) and Rees et al. (1984) describing 35% and 44% respectively as the initial drop-out from an ATU. However, as time goes on drop-out continued rapidly with Glasgow Council on Alcohol's figures similar to those described by Silberfield and Glaser (1978). By 3 months 83% of their sample were lost, and by one year, only 5% were still attending. The corresponding figures for this sample were 83% at 3 months, and 7% attending beyond 6 months.

FACTORS AFFECTING COMPLIANCE WITH TREATMENT

Seventy-two per cent of the sample left the Council abruptly and failed to respond to follow up attempts. Twenty-one per cent left after a mutually agreed period of attendance, while the remaining 7% continued to attend beyond six months.

TABLE 4 ANOVA Examining the effect of sex and referral category on number of individual sessions

	Male	Female
Refer1	3.44	3.38
Refer2	5.45	3.00
Refer3	6.26	5.50

	df	F ratio	F prob
Refer	(2,106)	3.17	0.05
Sex	(1,106)	1.55	0.21
2-Way Interactions	(2,106)	1.00	0.37

Both source of referral and sex were examined as factors likely to be important for subsequent attendance. As described previously, source of referral (Refer) was divided into three categories which were designated as self-referrals (Refer1), agency referrals (Refer2) and coercive referrals (Refer3). Using analysis of variance, source of referral had a significant effect on number of sessions attended, and time in treatment. Sex had no statistical effect on compliance with treatment and no interaction effects were noted (Tables 4 and 5).

TABLE 5 ANOVA Examining the effect of sex and referral category on time in treatment

	Male	Female
Refer1	3.59	4.10
Refer2	7.18	5.07
Refer3	9.21	7.50

	df	F ratio	F prob
Refer	(2,106)	3.98	0.05
Sex	(1,106)	0.17	0.67
2-Way Interactions	(2,106)	0.36	0.69

The average self-referral attended for 3.4 sessions over 3.7 weeks, while the average coercive referral visited the agency for 6 sessions over 9 weeks. Eighty per cent of non-coercive referrals left treatment abruptly in an unplanned fashion, but this is less likely to be the case with coercive referrals, where 52% left in this way.

There were some differences between men and women in compliance with treatment although none of the differences reached statistical significance. Over a third of women attended the Council on one occasion (35%) compared to 22% of males. Men attended for an average of 4.7 sessions over an average time of 6 weeks, while women attended for 3.3 sessions over an average time of 4.5 weeks. No woman was a "clinic attender" whereas 11% men attended for 6 months or more (x^2=4.25, NS).

Women were poorly represented among coercive referrals as only two women who were referred by employers fell into this category (Table 2). This may help to explain the lower rates of attendance for women, who in the main were self-referrals or from non-coercive sources. These results indicating almost equal compliance between the sexes do not appear to be attributable to allocating women to female counsellors, who saw 78% of female clients. Using a two-way analysis of variance the sex of the counsellor had no effect on compliance for male or female clients for number of individual sessions or time in treatment (Tables 6 and 7).

TABLE 6 ANOVA Examining the effect of sex and seeing a same sex counsellor on number of individual sessions

	df	F ratio	F prob
Sex	(1,107)	2.81	0.09
Sex of Counsellor	(1,107)	1.16	0.68
2-Way Interactions	(1,107)	0.06	0.80

TABLE 7 ANOVA Examining the effect of sex and seeing a same sex counsellor on time in treatment

	df	F ratio	F prob
Sex	(1,107)	1.11	0.29
Sex of Counsellor	(1,107)	0.09	0.76
2-Way Interactions	(1,107)	1.52	0.22

DISCUSSION

Despite the large increase in numbers of clients attending GCA, very little has changed in the decade since O'Donnell (1978) reported his findings. The majority of clients were male, most were employed and they sought treatment in their early forties. The numbers of females had increased slightly to form 29% of all clients as compared to 23% in 1978. These figures were remarkably similar to those described by Edwards et al. in 1967 during a survey of Councils, including GCA. The major difference appeared in the sex ratio, the as the percentage of women clients attending Councils in 1986 was more than double those seen in 1967.

Some of the findings from the preliminary study were at odds with what had been expected and predicted for Council clients. In particular a rather younger client group might have been expected if the early problem drinker had been successfully targeted. The average age of clients was forty which was the same as a Scottish ATU (Hyslop and Kershaw, 1981).

The relatively high proportion of women attending the Council was an intriguing finding. An excess of young males might have been expected as they are the heaviest consumers of alcohol in the general population (Dight, 1976).

Community based voluntary agencies in common with most other treatment agencies studied had significant numbers of clients whose attendance was very brief. Levels of compliance were comparable with those found in Health Service settings (Rees, 1985; Rees et al., 1984). Realistically, the first session may be the only interview, and it would be unwise to treat this as the prelude to sustained contact allowing a therapeutic relationship to be established. One response would be to concentrate effort in the first session, along the lines suggested by Orford and Edwards (1977). This would involve thorough assessment, coupled with clear recommendations on treatment goals at the earliest stage of counselling.

Contrary to what might have been expected self-referrals were particularly tentative in their help seeking. Those who reached treatment through the more usual routes had better rates of compliance. The culmination of this effect can be seen in the high rates of attendance attained by coercive referrals. Far from being insensitive to the pressures exerted by referral agents, clients appear to be highly responsive, at least as far as attending for counselling is concerned. Wilson (1986) found in her survey of voluntary counsellors that they expressed a preference for working with self-referrals, although these results suggest that they may not be particularly rewarding as far as counselling goes.

The results from this study would endorse subsequent developments which have been occurring in GCA (Allan and Cuthbert, 1990). There have been of a number of projects which have deliberately linked potential clients with the Council. This involves alcohol policies negotiated with employers, whereby employees are given the opportunity of receiving help with drinking problems which have affected their work performance. At the other end of the social spectrum, GCA has developed a project to provide outreach workers for the eight Glasgow District Council hostels for single, homeless men and women. Clients are either counselled in the hostels or are encouraged to attend GCA. Many problem drinkers are convicted of minor alcohol-related offences. In conjunction with the District Court some offenders after assessment receive a deferred sentence on condition that they seek help through GCA. Community based agencies may be particularly appropriate for these types of client where voluntary effort by fellow citizens removes some of the coercive element involved in the operation of such schemes. This type of scheme could be viewed as recreating in an urban setting the powerful social sanctions that operate in smaller communities.

Explanations of women's failure to make use of services have tended to suggest they are somehow "sicker" and more in need of special types of help. Data from this sample on referral sources would tend to suggest that a more mundane explanation may be offered. Women for a variety of social and cultural reasons are less likely to commit offences while intoxicated, be subject to disciplinary procedures at work or become homeless. Because of this they are less likely to be referred from the coercive sources which in varying degrees may have provided the powerful pressures for men to remain in counselling.

In spite of providing many of the service elements considered to enhance compliance with treatment, attendance at a community based agency did not appear to differ substantially from that found in many other treatment settings. Preliminary sociodemographic findings are in agreement with those found in previous published studies and suggest that Councils are not dealing with a highly motivated, early abusing group. There are limiting factors to the conclusions that can be drawn from this study and these will be discussed in detail in the next chapter as well as the aims of the second study.

CHAPTER FIVE QUALITATIVE EVALUATION

THE LIMITS OF MONITORING

In order to augment the information obtained in the first study, a second more detailed study was carried out to examine a number of salient issues. The previous study was basically a descriptive exercise, using relatively simple measures to provide a continuous check on aspects of service. Because of the simplicity and quantitative nature of the measures involved there are limits to the conclusions that can be drawn from this particular exercise.

The monitoring approach used in the first study involved an assessment of effort, and has as one of the criteria of success the quantity of activity that takes place. Preliminary indications suggest that the immediate objective of establishing a flourishing service has been achieved. Over the years there has been a steady rise in the number of clients using GCA (Allan and Cuthbert, 1990). This pattern of increased use of Councils on Alcohol has also been observed throughout Scotland (SCA, 1986) and England (Baggot, 1990). Effort evaluation also assumes that the specific activity taking place is a valid means of reaching higher goals. There is a school of thought which suggests that if the need for a particular service appears to exist then supplying that service in accord with the best available knowledge seems to be sufficient justification in itself (Suchman, 1967). Further evaluation is considered to be unnecessary or simply spurious.

This type of approach is most appropriate in situations where there are few services available or where there is an obvious and overwhelming need. For example the establishment of alcohol and drug services in a large, peripheral housing scheme with poor access to other types of facilities. It is less useful when projects have passed the initial stages of development, when other services may be offering similar treatment or when there is competition for resources. The Council network, now an established resource finds itself in this position. Funding bodies, including the National Health Service are demanding more sophisticated types of evaluation that had been thought necessary in the past.

It can be inferred from the socio-demographic data reported previously that Councils were not attracting early problem drinkers. Clients appeared to be coming for treatment in their early forties, which is a similar age group to that found in Alcohol Treatment Units (Hyslop and Kershaw, 1981). It is possible that older people with a relatively short duration of drinking problems or a much less serious manifestation of the disorder were attending GCA. Qualitative assessment of the drinking problem and its associated difficulties is required to clarify this issue.

Attendance for individual counselling was sporadic and not greatly different from levels of compliance found in other agencies. By four weeks almost two-thirds (64%) of clients had disappeared from counselling. Views about adequate amounts of treatment are derived from helping patients with alcohol problems attending NHS facilities. It may be unrealistic and inappropriate for those with early or less severe problems to remain in treatment for significant lengths of time as this expectation is based on traditional hospital based

treatment systems that have been inherited from the psychiatric context. If clients have minimal problems, perhaps extended contact with counsellors is unnecessary. More detailed assessments of clients' treatment needs are necessary before this can be evaluated.

It should be noted that among strategies for evaluation, a distinction can be drawn between ongoing, continuous monitoring of agency performance and an occasional, more detailed study of a particularly salient issues (Cox, 1982). The previous study was able to provide accurate demographic and service information on clients while highlighting areas that required further exploration. The type of data collected was dictated by the practical demands of the counselling situation and the type of information usually collected by voluntary workers. Basic information was quickly and relatively easily collected with minimal intrusiveness, although this was at the expense of collecting more detailed information. The second study will adopt a much more rigorous approach and use objective assessment procedures to measure client characteristics and level of functioning. The research interviews themselves will be carried out using personnel external to the counselling work of the organisation, namely the author and a research assistant.

IMPLEMENTATION MONITORING

The second study will be undertaken to look at three key areas. Firstly to identify the characteristics of the clients in detail, to see if a distinctive group of problem drinkers have been successfully located. A second but equally important aim is to assess whether there is a match between client needs and treatment resources.

Finally the process by which clients are matched or mismatched to particular types of treatment will be examined.

This type of evaluation has been described as implementation monitoring (Rossi and Freeman, 1982). It involves a systematic attempt to measure programme coverage (the extent to which a programme is reaching its intended target population), and programme process (the extent to which the service being delivered matches what was intended to be delivered). Programme coverage and programme process are often described as programme outputs which are the products and services being delivered to clients. Output should be distinguished from outcome as the latter refers to the effects of outputs on clients.

Service evaluation of this type concentrates on whether and by what means a particular service is working. The questions it asks are: Is the project meeting its stated aims? What is the level and quality of care provided and how does it fit in with the overall aims of service provision within the particular speciality? The aim is to assess the interaction between client and service provider, to see if the client is receiving appropriate and effective treatment (Shepherd, 1987).

There has been an upsurge of interest in evaluative research over the last few years particularly in the United States. Health insurance companies have made it compulsory to measure the quality of care given to individual clients in order to check on the appropriateness, adequacy and effectiveness of care. In addition, priority has been given to controlling the costs of treatment by preventing the overuse of services (Lalonde, 1982). Quality assurance programmes are geared to the clinical care of particular clients usually on a day to day

basis, whereas programme evaluation makes judgements about broader issues that affect the delivery of care to groups of clients. This type of information is more likely to be used by managers and administrators to plan services and make decisions about the allocation of resources (Shepherd, 1987).

Both of these approaches assume that there are accepted methods of treatment for different disorders. In the mental health field there are few explicit criteria for defining indices of acceptable and effective standards of care. Within the area of alcohol treatment field there are many different approaches to helping the problem drinker. These differences reflect legitimate views about the nature of alcohol abuse and its treatment. Historically treatment was based on the premise that there was one population of alcoholics, to be treated by one best method which was usually in-patient programmes combined with attendance at Alcoholics Anonymous, with one therapeutic outcome namely complete abstinence (Pattison, 1982) . This position is no longer tenable and treatments offered vary along many dimensions including intensity, duration and the use of medical or psychosocial interventions, and a wide variety of treatment personnel (Ogborne and Gavin, 1990).

Because of the variety of treatment agencies and approaches now available there is a sense in which the evaluation of a particular agency cannot be carried out in isolation. Services interact, overlap and in today's economic and political climate compete for clients and resources. Historically, Alcohol Treatment Units (ATU) have provided the focus for the NHS response to alcohol problems (Ettore, 1985b) and this service would provide an appropriate comparison group for Councils on Alcohol.

Because of the diversity of treatment approaches available some guide to appropriate treatment must be adopted. Service elements can be derived in two different ways. Firstly they can be deduced from general sets of principles or theoretical constructs. The community mental health movement described previously has guided many aspects of service delivery for Councils on Alcohol, stressing the provision of community based agencies, with the emphasis on volunteer counsellors aiming at a particular section of the treatment population (Orford, 1987). Alcohol treatment research has also indicated the nature of the service that is required for some types of clients and has made some preliminary suggestions for matching them with particular types of treatment (Miller and Hester, 1986a).

THE MATCHING HYPOTHESIS

The matching hypothesis suggests that clients who are matched with appropriate treatment will show improved outcome relative to those who are unmatched or mismatched. Appropriate matching has obvious clinical importance in allowing patients to receive care directed towards their particular needs. Of equal importance is avoiding inappropriate or unnecessary treatment. Enhanced motivation may occur after appropriate matching as patients may be more likely to to accept or comply with treatment that seems relevant to them. There is also a cost-effectiveness issue as an appropriate treatment match would avoid using extra treatment resources.

Miller and Hester (1986b) have speculated that the failure to take matching into account may explain some of the mediocre outcomes in many treatment studies. They have noted that although the typical

alcoholism agency claims to tailor treatment to the individual, in reality this rarely occurs. The best predictor of the treatment a client is likely to receive can be derived from knowledge of the agency he attends, as each programme almost invariably recommends its own services (Hansen and Emrick, 1983).

TREATMENT FOR SEVERE ALCOHOL PROBLEMS

Patients with alcohol problems are a highly diverse group. They include the homeless vagrant and those who despite an alcohol problem continue to be employed and function within a family setting. The most basic problem has been to specify in detail the patient variables and the treatment elements which when matched will produce superior outcomes. A number of schemes have been proposed and have been reviewed by Miller and Hester (1986b).

The specific matching variables that appear promising are related to problem severity. In particular patients with severe dependence on alcohol and extensive and severe alcohol-related problems may derive more benefit from an intensive treatment approach. This scheme has found some support from the research literature. In the "advice versus treatment" study carried out by Orford and Edwards (1977) relatively stable, married male alcoholics responded as well to advice as to intensive treatment. In the same group, a further analysis of the data found that the most highly dependent group, "gamma" alcoholics appeared to benefit from intensive treatment. The pattern was reversed for drinkers without dependence or loss of control as this group did better if not given intensive treatment (Orford, Oppenheimer and Edwards, 1976). In a study extending the

work of Orford and Edwards (1977), Chick et al. (1988) employed the same design but used a more representative sample of patients. They included single and divorced patients of both sexes, which approximates more closely to a typical clinic sample than the socially stable group studied by Orford and Edwards (1977). They found that the patients who were offered extended treatment were functioning better at a two year follow-up. Shaw et al. (1990) in an uncontrolled study of a highly dependent and socially disadvantaged group found that 37% responded to an intensive residential programme with improvements noted in drinking status and social and psychological well-being.

Intensive treatment procedures vary but most contain a common core of items many of which are provided within the setting of an ATU. Helping the problem drinker is seen as at least a two stage process which involves the management of withdrawal from alcohol and secondly attempting to help the drinker bring about changes that will help to maintain longer term sobriety. This includes access to medically supervised detoxification for those who are severely physically dependent on alcohol and have been experiencing the alcohol withdrawal syndrome. Moderate to severe forms of the syndrome include tremulousness, seizures, and hallucinations occurring within 6-48 hours of stopping drinking. A more serious consequence, delirium tremens (D.T.'s), involves confusion, hallucinations and severe nervous system overactivity and typically begins 48-96 hours after the last drink (Victor, 1983).

Recent evidence suggests that it may be important to treat all patients who are suffering from alcohol withdrawal symptoms of any severity. During withdrawal there is an increased production of the

adrenal hormones cortisol and norepinephrine. Both of these hormones can be toxic to nerve cells and cortisol can also cause damage to the hippocampus (Sapolsky, Krey and McEwan, 1983). Untreated or inadequately treated withdrawals may produce future withdrawals of escalating severity (Ballenger and Post, 1978). In a review of pharmacological treatments for withdrawal symptoms, Liskow and Goodwin (1987) concluded that the drugs of choice are the benzodiazepines. Treatment is usually carried out by administering decreasing doses of the drug during the withdrawal period. Hayashida et al. (1989) have demonstrated that out-patient medical detoxification is effective for patients with mild to moderate withdrawal symptoms.

Detoxification is usually carried out on an out-patient or day-patient basis unless the patient has other coexisting disorders or is without adequate social support. In-patient care is usually offered to patients with major physical illness, a past history of severe withdrawal reactions, cognitive impairment or are disabled by severe neurotic or psychotic symptoms. In some instances patients who are living in circumstances that make it very difficult for the to detoxify at home e.g. living with a heavy drinking spouse are offered short in-patient stays.

After the initial phase of detoxification most ATU's run structured programmes usually lasting four to six weeks using a combination of individual and group sessions. The aim is to maintain prolonged sobriety and "broad-sprectrum" interventions incorporating social skills training, stress management and marital and family counselling are typically used (Kershaw, 1982).

Another aspect of severity which has been considered important is the occurrence of psychiatric illness in conjunction with alcohol problems. Clients with anxiety, depression or personality disorder as well as alcohol problems have been considered to be a specially vulnerable group, requiring treatment directed towards the alcohol problem as well as the psychological disorder. These difficulties are generally treated and managed by mental health professionals who are most likely to be found in psychiatric hospitals or in ATUs. The assessment and treatment of these disorders in alcohol dependent patients will be discussed fully in Chapter six.

TREATING LESS SEVERE PROBLEM DRINKERS

The clients who have been considered to be most appropriately helped within a Council setting are those with less severe alcohol problems (Brown, 1980). There are no standard measures to identify the early problem drinker but different researchers have pin-pointed certain key areas of difficulty. Client characteristics considered important have been short duration of problem, absence of medical illness (Berg and Skutle, 1986), evidence of social stability, no psychiatric disorder and low to moderate degrees of dependence on alcohol (Heather, 1986).

Treatment procedures for those with less serious alcohol problems are in some ways harder to specify as most research work has been carried out with more damaged groups. The finding that many people give up addictive habits without lengthy professional contact has provided support for less intensive treatment approaches (Orford and Edwards, 1977). In the main Councils on Alcohol have have used counselling

techniques derived from client-centred therapeutic approaches. For example counsellors are advised to be "positive and directive" about clients drinking, (Brown, 1984). Great emphasis is placed on the process of counselling employing what Truax and Carkhuff (1967) have described as "warmth, genuineness and accurate empathy". No theoretical model of alcoholism or counselling is used as this is considered too restrictive (Brown, 1984). Despite the wide use of this method, to the authors knowledge there have been no trials of its efficacy in helping problem drinkers.

HOW IS MATCHING ACHIEVED?

There is an implicit assumption that clients seeking help from voluntary agencies will have less severe problems. However the process by which patients are matched to particular types of treatment is far from clear. Thom (1984) in a theoretical discussion of the use patients make of alcohol services has suggested a "stages" approach to help-seeking. She envisages that these stages would involve attending one agency at a time, and if this is unsuccessful the patient then discontinues contact and attends another agency which may fulfil his needs. The findings from the few empirical studies on this topic have presented a rather more disorganised picture and indicate that both men and women display highly ambivalent attitudes and behaviour towards engaging in treatment (Thom, 1986).

Workers in Canada have noted that problem drinkers interact with many types of agencies and that the management of these individuals is often discontinuous and unco-ordinated (Ogborne, Rush and Dwyer,

1985). In a British context Delahaye and Hore (1974) examined the use of services of 624 alcoholics, and found that the majority of patients (83%) had attended at least one other agency, other than the one they were currently attending and that many had multiple service contacts. High degrees of crossover were noted between all agencies, with some clients attending agencies concurrently. This kind of service use has implications for service planning, if scarce resources are to be used to maximum effect.

It is probable that today's situation may be even more complex because there has been a general expansion in service provision for those with alcohol problems. In 1973 in England and Wales there were eighteen NHS specialist Units, nine local Councils on Alcohol and twenty-one hostels. In 1986 the numbers had increased to 35 NHS Units, 80 local Councils on Alcohol and 86 hostels (Baggot, 1990). A similar pattern emerges when looking at Scotland where there has been an expansion in all of these types of services (Strathclyde Regional Council, 1989). Given this level of service provision the mechanisms by which individual clients arrive at the most appropriate agency has yet to be specified.

Using a sample of clients attending a Council on Alcohol, and as a comparison group a sample of patients attending an Alcohol and Drug Treatment Unit, the following questions will be examined,

1. Do Councils intervene at an early stage in the problem drinkers career, before he or she is heavily dependent on alcohol or has suffered other forms of alcohol-related harm?

2. Is there a match between treatment resources and and the type of clients who attend Councils?

3. Is help-seeking an essentially rational process, with clients attending a voluntary agency before using other treatment resources? Is this done over a relatively sustained period, involving a single agency at a time?

CHAPTER SIX MEASUREMENT ISSUES

Chapter Five provided a review of the guiding principles that underly the second study. In designing the second study, which will provide a more detailed, qualitative examination of attenders at two different agencies, a number of measurement issues must be considered. Doubts have been expressed about the accuracy of the information provided by alcoholics and the impact this may have on research findings. This will be discussed in some detail, as well as the conceptual changes that have had an impact on the way alcohol problems are measured.

DENIAL OF ALCOHOL PROBLEMS

There has been a great deal of scepticism about the reliance that can be placed in self-reports obtained from alcoholics. The unpopularity of the alcoholic patient is often attributed to the frustrating business of dealing with an individual who despite evidence to the contrary refuses to acknowledge his or her difficulties with alcohol. This process is enshrined in the notion of denial which has been considered one of the major obstacles to the recovery of the alcoholic patient (Goldsmith and Green, 1988). This poses particular problems for the researcher as most of the assessment procedures which are typically used have been described as "direct scale strategies" (Miller, 1976). These are questions which inquire openly and directly about the consequences of heavy drinking and are liable to falsification if the subject so wishes.

It is important to distinguish between denial and the failure to provide accurate information. In two comprehensive reviews of this area Midanik (1982, 1988) concluded that if certain conditions are met, accurate factual information obtained from alcoholic patients can be both valid and reliable. Factors which enhance validity and reliability include collecting information when the patient is alcohol-free, the use of properly structured questionnaires and establishing good rapport with the patient. In support of these claims they cite a number of studies which have looked in detail at these issues. Sobell and Sobell (1978) and Hesselbrock et al. (1983) have reported studies which have verified the accounts given by problem drinkers with public records of arrests and admissions to hospital. They also found that collateral sources like the spouses of heavy drinkers in the main agree with accounts given by drinkers.

Sobell et al. (1979) have found that retrospective self-reports of daily drinking and alcohol-related problems for the previous twelve months can also be highly reliable. The interview method they used was highly structured and required subjects to recall their drinking over specified time periods. Subjects were given a blank calendar for the time period to be reconstructed. Anchor points such as holidays, birthdays and weekends were used to provide a basic framework for drinking behaviour. The method employed has many similarities with that developed by researchers in the life events field (Brown and Harris, 1978). Sobell and Sobell (1978) make the point that alcoholics, like any other group of subjects, may give inaccurate answers depending on the demand characteristics of the task involved, for example if patients believe their answers may not be treated

confidentially.

Many reports of denial have arisen from descriptions of processes occurring within a clinical context. It is important to remember that the purposes of a research and therapeutic interview may differ. The research interview has as its object the gathering of accurate information and frequently does not wish to influence the behaviour of the patient. In Britain, research subjects often do not receive payment and many agree to take part in studies from altruistic motives a factor which may enhance the quality of information obtained.

In contrast, the therapeutic interview may involve a degree of conflict for both patient and therapist. Many practitioners in the alcohol field feel that unless the patient fully accepts the view that his difficulties are alcohol related treatment cannot proceed as compliance will be poor. Some workers have been particularly critical of this approach (Miller, 1983; Miller, Sovereign and Kregg 1988). They have suggested that denial is not a characteristic of alcoholics, but is a product of the confrontational way that therapists interact with patients. He has described this as particularly marked in approaches that seek to persuade the client to recognise that he is an "alcoholic" in an effort to "motivate" him towards accepting treatment which usually involves lifelong abstinence.

DISTORTION OF INFORMATION

Apart from outright "denial", the tendency of some subjects to

"fake good" or present themselves in a socially favourable light has been recognised by those constructing psychological tests for many years (Eysenck and Eysenck, 1966). Within the alcohol and drug context, Davies and Baker (1987) have noted that distortions are more likely to occur when the data are sensitive and have personal significance. This phenomenon has also been noted in a general population study of alcohol consumption where the heaviest consumers had increased "lie scale" scores (Cooke amd Allan, 1983). If "faking good" does occur, differences between interviewers and subjects should be ones of degree rather than extreme discrepancies.

On the other hand denial implies a rather different process from simply failing to give accurate information or "faking good". The term itself is an early psychoanalytic concept used by Freud amongst others to describe one of the psychic defence mechanisms (Hinshelwood, 1989). Weisman (1984) has suggested that the process involves ignoring or severely distorting consequences that are unacceptable to the individual. The popular stereotype of the alcoholic who has ruined his health, lost his job, estranged his family and still claims to be having no difficulties with his alcohol consumption exemplifies the extremes of this behaviour.

HIGH RISK GROUPS FOR DENIAL

Goldsmith and Green (1988) have reported the development of a Denial Rating Scale which they have used to assess a group of young male offenders. Ratings were carried out by an interviewer estimating levels of denial in the patient using written transcripts of interviews. They found that it was pervasive

amongst this group who had been "coerced" into treatment as an alternative to a custodial sentence

At the other end of the spectrum from mandatory treatment, voluntary agencies like Councils on Alcohol encourage clients to contact the agency directly with the aim of targeting a highly motivated group of clients. It is possible that denial is not a particular issue in this type of setting where voluntary counsellors are encouraged to adopt a reflective, non-confrontational counselling style (Brown, 1980). A comparison between attenders at a more traditional treatment facility like an Alcohol Treatment Unit and attenders at a voluntary agency may help clarify the role of agency factors.

Many anecdotal reports of psychiatric populations have suggested that denial is a feature of women with alcohol problems, leading to a reluctance to recognise alcohol as a problem (Sheehan and Watson, 1980). A more detailed analysis would indicate whether women are more likely to adopt a denial strategy.

MEASUREMENT OF DENIAL

Despite the frequent mention of denial in the treatment literature, there appears to be no consensus about its measurement and a variety of ad hoc procedures have been adopted. Most of these rely exclusively on interpreting the verbal behaviour of clients during interviews (Goldsmith and Green, 1988). At its most basic, an operational definition of the term should contain the notion of the drinker refusing to acknowledge or at least

minimising the role of alcohol in his or her difficulties. By implication this requires that there should be evidence of rather more severe difficulties than are being acknowledged, producing a conflict between the perception of the patient and an interviewer about the severity or even presence of a disorder.

Visual analogue scales (VAS) provide a technique for measuring subjective experiences of this type (McCormack, De La Horne and Sheather, 1988). Most VAS studies have been used for self assessment, however several studies have examined their use for observer ratings and have reported significant levels of inter-rater reliability when used in this way (Malpas, Legg and Scott, 1974). This methodology will be used in the following study. It differs from previous studies as the measures employed will allow both the interviewer and subject an opportunity to make an assessment of the contribution of alcohol to the subjects current difficulties using the same scale.

The following issues will be investigated; are subjects willing to acknowledge their use of alcohol as a problem and does this have any relationship to an interviewer's assessment or other measures of alcohol related problems? Does the type of agency attended or sex of the subject have an effect on self or interviewer's rating? Finally can a group be identified who fit the stereotype of the "denying alcoholic" and does this have implications for subsequent compliance with treatment?

BIOLOGICAL MARKERS OF HEAVY DRINKING

The interest in biological indicators of heavy drinking has partly been due to their promise as a way of corroborating verbal reports. More recently there has been increasing attention directed towards the use of biochemical tests as an aid to the diagnosis and treatment of alcohol problems (Babor, Stephens and Marlatt, 1987). The most widely used biological markers of excessive alcohol consumption are mean cell volume (MCV) and gamma-glutamyl transpeptidase (GGT) (Chick, Kreitman and Plant, 1981). However recent research has indicated that both tests are lacking in sufficient sensitivity to be useful as screening instruments. Many alcoholics do not show a rise in GGT and abnormal test results may be produced by drugs, pancreatic disease or non-alcoholic liver disease. Similarly, MCV may be affected by nutritional factors and cigarette smoking (Anderson, Wallace and Jones, 1988).

These tests have been most successfully used as part of a composite measure of alcohol problems combined with clinical data and screening questionnaires (Bernadt et al., 1982). The other major use is in clinical practice to allow patients and therapists to monitor progress (Heather, 1986). In patients who have elevated GGT's, cessation of drinking leads to a return to normal levels within 3-6 weeks for the majority (Chick et al., 1981).

The results of biochemical tests are normally available in hospital units but there are practical problems in arranging for blood tests to be carried out in a non-medical setting. Given the constraints described and the fact that screening for alcohol problems is not a feature of this research this type of information was not collected.

CHANGING VIEW OF ALCOHOL DEPENDENCE

From a methodological point of view the formulation of the alcohol dependence syndrome by Edwards and Gross in 1976 has had a major impact on the way that alcohol problems are measured. Previous descriptions of alcoholism had included a wide range of variables from conceptually distinct domains. These have included physical dependence on the drug, the social and economic consequences of heavy drinking, reasons for drinking and help seeking behaviour (Miller, 1976). One of the contributions of the Edwards and Gross (1976) formulation has been the separation of alcohol dependence from alcohol-related disability. They proposed that the dependence syndrome should be defined in terms of core psychophysiological symptoms which are not to be confused with the secondary consequences of dependence.

The original syndrome proposed contained seven elements which comprised repeated withdrawal symptoms, relief drinking, narrowing of drinking repertoire, salience of drink-seeking behaviour, increasing tolerance, subjective awareness of a compulsion to drink and rapid reinstatement of these elements if drinking takes place after a period of abstinence. Most of these features are self-explanatory except for "narrowing of drinking repertoire" and "subjective awareness of compulsion to drink". Narrowing of repertoire suggests that as the individual becomes more dependent his intake of alcohol becomes increasingly stereotyped and inflexible. He tends to schedule his drinking in much the same way, irrespective of the demands of everyday life. Subjective awareness of compulsion to drink describes

the impairment of control heavily dependent drinkers experience with alcohol. The syndrome is seen as lying along a continuum ranging from mild to severe principally centred around a "drive" to consume alcohol (Stockwell et al., 1979).

In the first instance the provisional nature of the syndrome was stressed (Edwards, 1986) but despite much critical debate and controversy has been widely adopted both within the clinical and research fields (Hodgson and Stockwell, 1985). The notion of separating dependence from disability allows these elements to be separately assessed. Edwards (1977) has speculated that it is possible for a person not to be abnormally dependent on alcohol but to have incurred serious alcohol-related disabilities. Supporting evidence for this view has come from studies of patients identified as heavy drinkers on general medical wards (Corrigan, Webb and Unwin, 1986). Two-thirds of this group showed physical disabilities from excessive alcohol consumption but displayed a range of symptoms of dependence from "minimal or no dependence". The remaining patients tailed into the "mild to moderate" to "severe" dependence categories.

It is possible that problem drinkers attending community agencies do not have the level of physical dependence found among psychiatric patients but have disabilities in other areas of functioning. An important part of the syndrome is the notion of dependence as a continuum. This provides an advantage when individuals who have a wide range of disorder are being assessed, as the emphasis of more traditional approaches has been to make discrete diagnoses rather than to measure degree of dependence.

MEASUREMENT OF ALCOHOL DEPENDENCE

There are a number of self-report scales which are based on the alcohol dependence syndrome. The most frequently used and most rigorously tested is the Severity of Alcohol Dependence Questionnaire (SADQ) which was devised by Stockwell et al. in 1979. The aims of the authors were two fold; firstly to measure the central features of the alcohol dependence syndrome and secondly to validate the scores against a clinician's independent ratings of degree of dependency (Stockwell et al., 1979). There is now substantial accumulated evidence that testifies to the scale's reliability (Stockwell, Murphy and Hodgson, 1983) and validity (Hodgson and Stockwell, 1985).

Most of the early studies with the SADQ were carried out using patients who were severely dependent on alcohol (Stockwell et al., 1979; Stockwell et al., 1983) . In a further study Meehan, Webb and Unwin (1985) validated the scale using admissions to a general psychiatric hospital. This group contained a large proportion of patients who had less severe degrees of dependence. They confirmed the finding of Stockwell et al. (1983) that the SADQ is a valid measure of moderate to severe dependence. They also found that with some reservations it may also distinguish minimal dependence. This is a particularly useful attribute when assessing dependence in a potentially early abusing group like a Council sample.

One of the most consistent criticisms of the SADQ is that it only measures withdrawal symptoms, relief drinking and rapid reinstatement of the syndrome after a period of abstinence, and fails to measure more subtle elements of the alcohol dependence syndrome (Raistrick, Dunbar and Davidson, 1983). Efforts to operationally define concepts

like "impairment of control" and "narrowing of drinking repertoire" have not met with success (Chick, 1980). Because of this they have generally been omitted from questionnaires like the SADQ and no attempt will be made to measure them in this research.

One of the aims of this study is to examine the potential match between clients and treatment. The SADQ has been shown to be useful in decision making about the clinical management of patients not only during the acute phase of withdrawal but also when making decisions about longer term treatment goals. In the short term SADQ scores have been shown to predict withdrawal severity, the quantity of medication prescribed to treat withdrawal symptoms and patients rating of "craving" during this period (Stockwell et al., 1983). Several major reviews (Miller and Hester, 1986a; Heather and Robertson, 1981) have also suggested that degree of dependence is one of several predictors of whether an individual is likely to succeed at controlling his drinking. Degree of dependence may also be a factor in whether an individual will respond to varying intensities of treatment (Orford et al., 1976).

MEASURING ALCOHOL RELATED PROBLEMS

In contrast to the detailed research on the measurement of dependence, the measurement of alcohol related disabilities is relatively unsophisticated. One of the major difficulties is deciding what is and is not an alcohol-related problem. There is a tendency to confuse causes, correlates and consequences (Strang, Bradley and Stockwell, 1989). Deciding at what stage for example the breakdown of marital and social relationships is due to heavy drinking or to an

entirely different process can at times be an arbitrary exercise.

A number of solutions have been proposed to establishing causal connections between drinking and problems. Some authors and clinicians settle for an association between drinking and problems and make the assumption that the two are causally linked. Knupfer (1967) provides a typical view. She suggests "A problem, any problem, connected fairly closely with drinking constitutes a drinking problem". This approach is too inclusive to be useful within a research context. In practice most scales concentrate on questions with high face validity and rely on the patient to acknowledge the link between alcohol use and the problem. For example "Have you had money worries due to or made worse by your drinking?" (Chick et al., 1988).

There are also a number of practical problems in this type of measurement exercise. The variety of alcohol related disability encompasses numerous problem areas. Heavy consumption has been implicated in the development of many diseases, accidents, social, marital and financial problems. No one scale would be suitable to assess the wide range of these difficulties. The solution is to include a variety of measures looking at different areas of disability. This should include social and economic impairment, psychological and psychiatric disturbance and finer aspects of interpersonal adjustment.

Some scales have been developed specifically to assess alcohol related problems like the Problems with Alcohol scale (Chick et al., 1988). However many alcohol researchers have also borrowed measuring instruments from the general field of clinical psychology and

psychiatry. In most cases these instruments are a useful addition to those developed especially for the use of alcohol dependent subjects. For example the study of psychiatric disorder in alcoholics does not require the development of new measuring instruments. What is required is an appreciation and allowance for the potential contaminating effects of alcohol use (Strang et al., 1989). This will be discussed in more detail in Chapter Seven.

Alcoholic patients coming for treatment are a heterogeneous group. Many scales contain items which are not applicable to subjects who are single, divorced or who are unemployed, which makes comparisons between subgroups quite difficult (Drummond, 1990). It also sometimes means that subjects who have had severe alcohol-related problems for extended periods in the past may not score highly on certain items. For example a divorced man, living with other heavy drinkers and without a job may score quite low on many scales as he will no longer experience marital conflict, other heavy drinkers are unlikely to object to his drinking and he will not be in conflict with employers as he does not have a job. However in objective terms he has suffered severe consequences due to his drinking.

Women also constitute a group where difficulties may be encountered in measuring problem areas. Most scales are heavily weighted with items than measure deviant behaviour of different types such as being arrested for drunkenness or drunk-driving offences. These are low frequency behaviours for women whether they have a drink problem or not (Ferrence, 1980). There also tends to be a focus on employment related problems which may not be relevant to many women. Other areas which include finer aspects of interpersonal relationships are not

examined. It has been suggested that these aspects of social functioning may be particularly vulnerable to disruption in women (Clark and Hilton, 1986).

Because of these factors a variety of measures of social function will be included in the research interview to reflect the diversity of disability experienced. This will include two scales previously used with alcoholics which measure social stability (Straus and Bacon, 1951) and social disruption (Smart, 1979). Finally in an attempt to tap finer aspects of interpersonal functioning a rating of social adjustment (Weissman et al., 1971) will be included.

CHAPTER SEVEN ALCOHOL PROBLEMS AND PSYCHIATRIC DISORDER

The possible overlap between alcohol dependence and psychiatric disorder was mentioned briefly in the previous chapter, in the context of matching patients to treatment. There have been a number of reports of high rates of psychiatric disorder amongst alcoholics (Rousanville et al., 1987; Ross, Glaser and Germanson, 1988). In particular, surveys of patients attending for treatment reveal that the presenting alcohol problem may be complicated by affective disorder (O'Sullivan et al., 1983) phobic-anxiety state (Mullaney and Trippet, 1979), or personality disorder (Vaillant, 1983). The common occurrence of these formal psychiatric disorders in conjunction with an alcohol problem has led to the suggestion that such disorders may be of aetiological significance, or be important in the maintenance of heavy drinking (Hesselbrock, Meyer and Keener, 1985).

The interest in alcohol abuse and psychopathology is also fuelled by the hope that the identification and treatment of a coexisting psychiatric disorder in an alcohol dependent patient will improve prognosis and provide a further basis on which to match patients to treatment (Griffin et al., 1987). Patients identified as having a psychiatric condition can receive appropriate treatment directed towards this condition as well as the alcohol problem. Accurate assessment of coexisting disorders in alcoholic patients is of particular importance. More specifically over-reporting can lead to the inappropriate use of medication leading to dependence on prescribed medication as well as alcohol (Allan and Cooke, 1986). Alternatively failure to detect other conditions can deprive patients of potentially helpful treatments in a disorder which in some instances can carry a poor prognosis (Weissman and Myers, 1980).

From a treatment point of view Councils on Alcohol aim to focus mainly on the presenting problem of excessive drinking. Other difficulties outside this area are considered to be uncommon in typical Council clients and not within the competence of counsellors. The SCA (1986) suggest the following role for professional staff "it is better to have these expensive and highly trained people as consultants who can be called in on those rare occasions when their particular professional knowledge and skills are of value, than to waste their skill in routine counselling". The occurrence or otherwise of psychiatric syndromes may have implications for the type of treatment made available to clients.

The belief that alcohol is the "cup that cheers" is widely held among the general population and amongst health professionals. There are also numerous references to this supposed property of alcohol in many forms of literature. However like many forms of "common knowledge" the scientific basis for these beliefs is uncertain, and in many instances there is evidence that drinking increases rather than decreases psychological distress (Stockwell and Bolderston, 1987).

More specifically the view that alcohol problems are linked to psychological dysfunction is drawn from two influential but diverse theoretical traditions namely psychoanalysis and learning theory. The psychoanalytic view suggests that individuals with severe and significant psychopathology are predisposed to develop addictive disorders in an attempt to self-medicate (Khantzian, 1985). Earlier learning theory formulations assumed that alcohol was capable of reducing or eliminating dysphoric emotional states and that this motivated further drinking (Cappell, 1975). This type of formulation

provides the basis for the widespread prescription of anti-depressants and anxiolytics to alcoholic patients (Murray, 1980). The development of heavy drinking in women has been particularly associated with this view (Beckman, 1975) and will be discussed more fully in Chapter eight.

DEPRESSION AND ALCOHOL PROBLEMS

Evidence linking alcohol abuse with depression comes from two main sources. Firstly, when examining alcoholics in treatment, some researchers have reported rates of depressive symptoms as high as 98% (Shaw et al., 1975) although other studies have reported lower rates of between 30% and 70%, depending on the diagnostic criteria employed (Schuckit, 1983). Secondly, drinkers themselves have consistently reported that alcohol has the capacity to improve mood, reduce tension and facilitate social interaction (Mendelson and Mello, 1979).

There have been claims that the presence of depression is a good prognostic indicator. An early study carried out by Schuckit and Winokur (1972), found that female patients with a primary affective disorder and secondary alcoholism had a much better prognosis than women with alcoholism alone. Attempts to carry out similar studies have produced conflicting results. Pottenger et al. (1978) found that alcoholics with depressive symptoms were more likely to have relapsed at follow-up. Rousanville et al. (1987) found that for women having major depression was associated with a better outcome, although for men having an additional diagnosis meant a poorer outcome. McLellan et al. (1983) reported that a global rating of psychiatric severity

was associated with a poorer outcome. O' Sullivan et al., (1988) found that no differences were observed between a depressed and non-depressed group in outcome. Despite these findings the belief that alcoholism is often secondary to an underlying depressive disorder is an enduring feature of a great deal of clinical practice (Murray, 1980).

A number of researchers have been critical of this view and have suggested that depression may be secondary to the alcohol problem. Schuckit and Monteiro (1988) have noted that other processes apart from the occurrence of a pre-existing affective state may be in operation. They have pointed out that alcohol is a central nervous system depressant and is capable of producing intense mood changes and profound feelings of sadness. These emotional states are especially likely to be observed during periods of chronic intoxication or when the blood alcohol level begins to fall (Littleton, 1983). In support of this, observational studies have consistently found that alcoholics become progressively more dysphoric, anxious, agitated and depressed during chronic intoxication (Mendelson and Mello, 1979). These changes in affect may be severe enough to mimic a depressive episode (Mayfield, 1968). In addition to the pharmacological effects of heavy alcohol consumption, many heavy drinkers develop a wide range of physical, social and interpersonal problems, any of which may lead the drinker to be realistically depressed about his situation (Schuckit and Monteiro, 1988). Evaluating these conflicting views has been difficult because of a number of methodological problems in the research. These will be discussed in detail, together with some proposed solutions.

SAMPLING BIAS

Some workers have suggested that the link between depression and alcohol problems is an artefact of the samples usually studied. There has been an almost exclusive focus on highly selected groups of alcoholics receiving treatment in units located in psychiatric hospitals (Murray et al., 1984). Vaillant (1983) has suggested that individuals who frequently seek help from clinics, whatever the nature of the illness tend to be more dependent, more physically ill and more psychologically vulnerable. It would be erroneous to conclude that these characteristics are features of alcoholism when they may occur in many other chronic conditions. It has also been noted that persons with two disorders are more likely to seek treatment, possibly causing a spurious relationship between depression and alcoholism (Weissman and Myers, 1980).

Some evidence on this point has been provided by Woodruff, Guze and Clayton (1973) who compared patients who were treated at a psychiatric clinic with alcoholic relatives who had not sought treatment. There was great similarity between the two groups in terms of severity of drinking problem; the major difference occurred in the presence of depression in the group who sought treatment. These authors have speculated that those who are alcoholic and depressed are more likely to present themselves to doctors for treatment, and therefore be available for study.

On the other hand some workers have felt that psychological disorders are an important correlate of alcohol problems whatever their severity and have built causal hypotheses around this (Weissman, 1977). If drinking to cope with depression or anxiety is important in

the development of an alcohol problem these types of symptoms should be found amongst those whose problems are less severe. Because of this the inclusion of a Council group may provide a population with a wider range of dysfunction to examine this issue.

MEASUREMENT OF DEPRESSION

Many researchers have used widely disparate methods of measuring depression, making comparisons between studies difficult. There are at least three meanings to the term depression; a mood, a symptom and a syndrome. Confusion occurs as different authors use the same term to refer to different aspects of the same conditions. Keeler, Taylor and Miller (1979) using four different measures of depression on the same sample found the percentage of patients considered depressed varied from 8.6%, employing a clinical diagnosis to 69%, using a self-rating scale. The authors concluded that heavy recent drinking can produce signs and symptoms of depression that can invalidate self administered tests used for diagnostic purposes as these simply take into account the presence of symptoms.

Some workers have recognised the limitations of self-report data and have attempted to refine their techniques. In an attempt to improve the validity of the Diagnostic Interview Schedule (DIS) a widely used assessment interview, lay interviewers were instructed to ask the patient whether the symptoms of anxiety and depression they were experiencing are due to medication, drugs or alcohol (Ross et al., 1988). Many commentators are of the opinion that this is a very difficult task even for an experienced clinician to perform (Schuckit and Monteiro, 1988). Keeler et al (1979) favour a structured clinical

interview to arrive at a diagnosis, as this allows the evaluation of qualitative features such as the severity of symptoms, their history and the circumstances surrounding their occurrence. These type of measures will be used in the following research.

The time at which an assessment is carried out may have an effect on diagnosis. Because many patients seek help in a distressed condition and complain of a multiplicity of psychological symptoms, the clinical picture is often unclear. Schuckit (1983) has described the commonest of these symptoms which include anxiety, irritability and feelings of sadness as transient, and which disappear within seven days of abstinence in many patients. These types of symptoms have been noted to decline rapidly during periods of abstinence in young, healthy problems drinkers (Hamm, Major and Brown, 1979) and in primary alcoholics (Schuckit and Monteiro, 1988). Assessment within this time period may produce spuriously elevated scores. Many studies described previously have failed to specify when research assessments have been carried out, or carry them out before the patient has been fully detoxified, leading to over-reporting of depressive illness. To avoid these difficulties, only symptoms occurring during abstinent periods should be used to arrive at a clinical diagnosis.

CHRONOLOGY OF SYMPTOMS

Much of the previous research has been based on the proposition that alcoholics have a depressive disorder which has caused them to drink heavily. In an effort to validate this theoretical position researchers have tried to document the chronology of development of both alcoholism and depression. The procedure adopted has been to take a detailed history from the patient and to note the age of

occurrence of major syndromes; the syndrome which occurs first is considered to be the primary disorder. There has been a gradual disenchantment with this approach for a number of reasons. Often both conditions have been present for many years and frequently the exact chronology of initial symptoms is obscure (Woodruff et al., 1973).

There are also significant difficulties in asking subjects with drinking problems to recall very complex material involving the precise timing of events sometimes many years in the past (Allan and Cooke, 1985). Heavy drinking of even relatively short duration interferes with cognitive and memory functions (Lishman, Ron and Acker 1980) and this may be a factor in inhibiting the accurate recall of events. Poor recall is further compounded by the effects of mood. Many heavy drinkers experience mood disturbance, and Brown and Harris (1978) amongst others have suggested that depression makes individuals more likely to see the past in an unfortunate light and therefore unwittingly provide an unreliable account of the severity and frequency of depressive episodes.

The retrospective identification of onset of alcoholism, which is typified by gradual development may not be easily achieved (Cooke and Allan, 1986). In conditions where there is a rapid change of state, symptomatology or behaviour occurs it is possible to develop a clear, valid and reliable operational definition of onset. With traumatic onset there is a swift transition from low intensity disturbance to a high intensity. This type of onset is more frequently observed in acute schizophrenia and some forms of depression (Brown and Birley, 1968; Brown and Harris, 1978). With gradual onset, which has been described as typical of alcohol

problems, the level of disturbance may increase over an extended period. Vaillant and Milofsky (1982) in describing the results of prospective studies has noted that the progression from asymptomatic drinking to alcohol dependence can take between 3-30 years, indicating very wide individual variation. Because of these factors the attempt to elucidate which came first, depression or the alcohol problem is fraught with difficulties. Because of this the only the occurrence or otherwise of depressive disorder during the previous twelve months will be recorded.

PHOBIC ANXIETY AND ALCOHOL PROBLEMS

Many of the issues already discussed concerning the relationship between alcoholism and depression are relevant to the proposed link between heavy drinking and phobic anxiety states. Because of the similarity, the overlapping areas will be commented upon briefly to avoid duplication.

The association between alcohol use and reduction of severe anxiety have been recognised for many years. Westphal, who first used the term agoraphobia also noted that there was a link between this condition and alcohol consumption as long ago as 1871 (Stockwell and Bolderston, 1987). The first systematic report of phobic anxiety amongst drinkers was made by Mullaney and Trippet in 1979. In a study of in-patient alcoholics, they found that one third of patients had disabling phobic states while a further third had less severe symptoms. Since the publication of this landmark study over a dozen studies have confirmed this initial finding although usually reporting lower rates of disorder. Smail et al. (1984), found that 18% of in-patient alcoholics suffered from a phobic disorder of

clinical severity. Similar findings have been reported by amongst others Bowen et al. (1984) and Hesselbrock, et al. (1985) who found rates of 29% and 27% respectively.

As in the field of depression, a wealth of clinical practice and anecdotal evidence attests to the fact that alcohol is used by patients to reduce anxiety (Murray, 1980). In a study by Wanberg (1969) 93% of alcoholics stated that they used alcohol to reduce anxiety. There have also been reports that a significant proportion of patients with phobic disorders also have alcohol problems. In an early study, Quitkin et al. (1972) described ten case studies of patients with phobic anxiety who abused drugs and sedatives and Bibb and Chambless (1986) found that between 10% and 20% of out-patient agoraphobics had an additional diagnosis of alcoholism depending on the criteria employed. Similar rates have been reported by other workers (Thyer et al., 1986; Cloninger et al., 1981).

As in the case of depression, alternative interpretations have been put forward to account for the association between alcohol problems and anxiety. Observational studies indicate that alcohol-dependent subjects experience feelings of increased tension and anxiety during periods of heavy drinking (Mello and Mendelson, 1979). There have also been a number of methodological problems in the research making evaluation of the opposing viewpoints difficult. As these have already been discussed in detail for depression only those issues relevant to anxiety will be elaborated. Common areas include the almost exclusive study of samples drawn from psychiatric clinics, the use of inappropriate methods of assessment carried out while the patient may be experiencing withdrawal symptoms and a reliance on

retrospective patient self-reports to elicit the chronology of symptoms.

The association between alcohol use and tension reduction has been of particular interest to psychologists because of its theoretical links with learning theory. The "tension reduction hypothesis" is based on two assumptions; firstly that alcohol can reduce tension or anxiety because of its tranquillising effects and secondly that this motivates drinking (Conger, 1956).

The anxiolytic properties of alcohol have been extensively studied on an experimental basis with both humans and animals. Many of these studies which focus on animal experiments and anxiety induced in normal subjects have produced conflicting results (Young, Oei and Knight, 1990). Even when studying the use of alcohol among alcohol dependent patients there is evidence that alcohol can reduce tension (Hodgson, Stockwell and Rankin, 1979) and also evidence that alcohol can can increase it (Mendelson and Mello, 1979; Stockwell, Hodgson and Rankin, 1982).

One of the areas of difficulty has been that the term "tension" has been interpreted rather loosely by many researchers to mean almost any kind of unpleasant mood state which may include fear, irritability, restlessness or anxiety which has probably contributed to some of the contradictory findings in this area. The implication of including all varieties of tension no matter how mild is that the category becomes so overinclusive as to be rendered almost meaningless. To counter this Stockwell and Bolderston (1987) have suggested that concentrating on phobic anxiety states like agoraphobia and social phobia may be more productive. These are

examples of severe anxiety of clinical intensity which have clear subjective, behavioural and physiological components which are measurable using appropriate techniques for assessing phobic states in alcohol-dependent patients (Hodgson and Rachman, 1974). This type of assessment will be carried out in the following research.

ANTISOCIAL PERSONALITY DISORDER AND ALCOHOL PROBLEMS

Apart from phobic anxiety and depression, personality disorder is the other major disorder which frequently overlaps with an alcohol problem. Studies of alcoholic populations have found that the rates for the co-occurrence of these disorders show some variation; from 20% (Penick et al., 1984) to 41% (Hesselbrock, Weideman and Reid, 1985). Some of the variation may be due to the confusion between alcoholism and antisocial personality disorder (ASP) with the two categories sometimes used interchangeably. Presumably this is because alcoholics are likely to engage in antisocial behaviour while intoxicated, and the personality disordered are likely to abuse alcohol as part of a whole spectrum of antisocial behaviour (Schuckit, 1973).

Variations in reported rates may also be due to the use of different diagnostic instruments. A number of the most recent studies have used the Diagnostic Interview Schedule (DIS). This has been demonstrated to diagnose personality disorder seven times more frequently than a clinical assessment using DSM-111 criteria (Griffin et al., 1987). It appears that interviewing instruments like the DIS have difficulty in separating out the sociopath who drinks heavily from the alcohol abuser who commits a limited range of alcohol-related offences.

The association between alcohol problems and this type of disorder may be an artefact of the institutional samples usually studied, as hospitals frequently deal with patients who have a disorganised lifestyle (Vaillant, 1983). Councils on the other hand encourage self-referral and aim to appeal to the more socially stable drinker and because of this possibly attract few clients with antisocial personality disorder.

The link between the two disorders is of theoretical and practical importance. A number of studies have shown that subjects with both diagnoses have a characteristic pattern of onset and prognosis. Alcoholics with an additional diagnosis of ASP tend to begin abusing alcohol at an earlier age (Schuckit, 1973), consume more alcohol (Goodwin and Guze, 1979) abuse other drugs (Hesselbrock, et al., 1985) have an accelerated course of alcoholism (Schuckit, 1985) and have a poorer prognosis (Schuckit, 1973). Because of these factors the presence of patients with both these disorders would have implications for management and treatment, as this group represents a special challenge for treatment programmes (Hesselbrock et al., 1985).

In conclusion, the clarification of the links between psychiatric disorder and alcohol problems has been hampered by the use of inappropriate assessment procedures and the almost exclusive study of highly selected groups of patients attending psychiatric facilities. The following research will answer the following questions;

1. Are Council clients relatively free of the complications of formal psychiatric disorder, in particular affective disorder, phobic anxiety or personality disorder which occur in patients attending an Alcohol and Drug Problem Unit?

2. Can the results from this research which examines a rarely studied population attending a voluntary agency be used to add to current theories about the relationship between psychological symptoms, psychiatric disorder and alcohol problems.

CHAPTER EIGHT WOMEN AND ALCOHOL PROBLEMS

Over the last twenty years there has been an increased interest in the topic of women and alcohol problems. Many factors have contributed to this change of awareness, not the least of which has been an increase in the number of women seeking help for drinking problems and their generally greater visibility in treatment populations (Shaw, 1980). The previous study of GCA clients found that women now form a substantial proportion of attenders. The proportion of women had doubled since 1967 when the agency first began counselling. The impetus of the women's health movement and feminist writers have also encouraged researchers and clinicians to examine all aspects of women's health (Ruzek, 1978). This situation can be contrasted with the 1950's when the focus was firmly on male drinking, and in particular on severely "alcoholic" males (Thom, 1991).

THEORETICAL AND METHODOLOGICAL PROBLEMS

This chapter will examine the major aetiological theories said to account for heavy drinking amongst women. Explanations for women's heavy drinking implicate various types of stress as important causative factors. Because of the social stigma said to be associated with female alcoholism and women's greater susceptibility to the physical effects of alcohol, the clinical course and the consequences of heavy drinking are considered to be more severe for women.

Evaluating some of the supporting evidence for these beliefs about women and alcohol is not easy as much of the writing is anecdotal and speculative and is based on clinical impression rather than the use of more rigorous methods. The main impression created by the research literature on women and alcohol problems is one of confusion and contradiction. Annis (1980) has stated that "the major task facing the serious student of the women alcoholic is that of distilling fact from fancy". The dominant theme has been that alcoholism in females is a much more serious and complex condition with a correspondingly poorer prognosis than it is for men.

Contradictions occur when empirical data are sought to support these conclusions. In many instances the required data does not exist or may in some cases provides support for alternative hypotheses. This state of affairs has probably developed because of the relative absence of heavy and problem drinking in women and has meant that until recently the topic has received little coverage. Because of their small numbers women were frequently dropped from research studies or not studied at all. Smith (1990) estimated that women formed only 7% of subjects examined in treatment outcome studies, although they usually form at least 20% of patients in treatment.

In comparison to the alcohol studies field in general, the number of topics that have been researched are a narrow range, clustering around often contradictory views about women and alcohol problems (Schmidt, Klee and Ames, 1990). A particularly striking example has been noted by Thom (1991). In a recent WHO publication entitled "Alcohol-related problems in high risk groups" epidemiological studies from the six countries involved have consistently found that

women report much lower levels of alcohol consumption and heavy drinking compared to men (Plant, 1990). Yet in each of the countries covered by the WHO publication one of the groups considered to be "high risk" is women. In fact the opposite appears to be true, men appear to be the most vulnerable group since they are more likely to drink heavily and experience alcohol-related problems.

Sampling bias has been a particular problem when looking at women with alcohol problems. There is some evidence that women tend to be under-represented in traditional treatment facilities (Thom, 1984). This is not only a contemporary problem but was noted by early researchers and clinicians. Mason in 1890 noted that many asylums were intended for men and in consequence held a low proportion of women. Even at this early date there was evidence that women sought treatment privately or with personal physicians which kept them out of the public eye and therefore precluded their appearance in prevalence data (Lender, 1981). Simply focusing on traditional treatment settings may have produced distorted results. Inclusion of a sample from a non-psychiatric source like a Council on Alcohol would provide a different type of population for study. From the present research it seems that Councils have been very successful in attracting women to their services. The previous study of GCA clients found that one third of clients attending a Council on Alcohol were female compared to an Alcohol Treatment Unit where women formed only one fifth of patients.

In some of the studies mentioned previously, data are sometimes reported for women alone with the implicit assumption that the results for men would be substantially different. The following research will include a sample of male subjects allowing direct

comparisons to be made. As well as the usual comparisons with male subjects the inclusion of a sample of women from an ATU wil help place the results in a more meaningful social context. For example there are difficulties in comparing the marital and parental functioning of men and women as their roles in these spheres are different. However a comparison with another female group may highlight areas of dysfunction.

AETIOLOGICAL THEORIES

In terms of aetiology, drinking in response to stress has been widely cited as the mechanism by which women develop drink problems (Corrigan, 1980). The suggestion of a stress-related disorder underpinning the more overt drink problem has led to the belief that women with alcohol problems are psychologically more impaired than their male counterparts. Beckman's (1975) view is probably representative; "Alcoholism and heavy drinking in women appear more likely to be linked to psychological stress and a precipitating circumstance or situation than is alcoholism or heavy drinking in men". Women during midlife are thought to be particularly vulnerable (Otto and Litman, 1976) because of the nature of the events they are likely to experience. The events considered to be most important at this time include bereavement, divorce and the "empty nest syndrome" associated with the departure of children from home (Plant, 1980).

There are a number of methodological problems with this approach, most notably the failure to deal with the possibility that heavy drinking could have produced an increased frequency of stressful life

events rather than vice-versa (Allan and Cooke, 1985). A whole range of difficulties; loss of a job, marital disharmony and health problems are just as likely to be the consequence as the cause of heavy drinking. The difficulties of accurately dating onset in a multi-faceted disorder like alcoholism have also been highlighted (Cooke and Allan, 1986). Some of these problems can be avoided by looking at non-clinical samples. When this approach was adopted Cooke and Allan (1984) found no evidence that women in the general population increase their alcohol consumption in response to life events.

Factors relating to changes in the social context of women's lives have been considered to have aetiological significance. A more permissive drinking culture combined with greater economic independence have served to make alcohol use more acceptable and accessible (Shaw, 1980). Some writers have contended that this greater freedom has created role conflict and stress for many women leading to an increase in drinking problems (Beckman, 1975). A frequently quoted observation has been that alcoholism represents the "ransom woman pays for her emancipation" (Massot, Hamel and Deliry, 1956).

Within a clinical framework, of particular importance has been the observation that women are much more likely to exhibit phobic-anxiety and depression in conjunction with alcohol problems than men (Hesselbrock et al., 1985). The links between these disorders and problem drinking have already been discussed in Chapter 6, therefore only points relevant to women will be raised in this chapter. Winokur and Pitts (1965) were among the first authors to relate alcoholism in women to affective disorder. Schuckit et al. (1969) in a study of

seventy female alcoholics found that over half the sample were "primary alcoholics", that is the alcohol problem was not accompanied by other psychiatric illnesses. Of the remaining patients, over a quarter gave a history of depression which was reported as occurring before the onset of alcoholism. These authors suggested that alcohol abuse may have been a symptom of an underlying depressive disorder. Consistent with this hypothesis was the finding that on a three year follow-up, patients who were treated for both disorders had a better prognosis than those with alcoholism alone (Schuckit and Winokur, 1972). In a later study Hesselbrock et al. (1985) found that among women, major depression was the most prevalent disorder (52%) followed by phobia (44%). Amongst men, 32% had an additional diagnosis of depression and 20% had phobic disorders. Mullaney and Trippet (1979) in a study of 102 in-patient alcoholics reported that female alcoholics (n=18) were more likely to be agoraphobic, but that similar proportions of men and women men were found to be socially phobic.

Many of the difficulties in evaluating this type of data have already been described in previous chapters and will not be repeated here. The following research will examine the occurrence of these syndromes in women attending a community based treatment agency to see if they occur with any regularity outwith a psychiatric setting.

CLINICAL ASPECTS OF ALCOHOL PROBLEMS AMONGST WOMEN

Apart from differences in aetiological factors there has been a suggestion that the clinical presentation of alcoholism is different in males and females. Development of problem drinking in women is

said to be particularly rapid, with a "telescoping" of symptoms which in men may take many years to develop (Smart, 1979). Curlee (1980) has specified a time period and has maintained that in women who are experiencing stress, heavy uncontrolled drinking occurs and symptoms characteristic of the later stages of alcoholism develop in a matter of months.

Despite the alleged chronicity and severity of their drinking, anecdotal reports have suggested that denial is particularly strong amongst women, leading to a reluctance to recognise alcohol as a difficulty (Sheehan and Watson, 1980). Explanations for this centre around the greater stigma and shame said to be felt by the alcoholic woman (Gomberg, 1982). Some studies have found that it is difficult for husbands and other family members to define women as alcoholics or as problem drinkers (Thom, 1986). Professional workers have also been reported as reluctant to discuss drinking especially with women and therefore allowing the disorder to continue unchecked (Shaw et al., 1978).

Women who abuse alcohol have also been reported as more likely to abuse prescribed, psychoactive medication (Celentano and McQueen, 1984). There has been speculation that psychotropic drug treatment is prescribed by clinicians in an effort to relieve the stresses thought to underpin the heavy drinking. This in some instances leads to dependence on both drugs and alcohol (Allan and Cooke, 1986). Smart (1979) has noted that the tendency to medicate female patients more than males has been noted outside the alcohol treatment field and may simply be an extension of this practice. Overdoses involving prescribed medication have also been considered a feature of alcoholic women (Schuckit and Morrissey, 1979).

SEVERITY OF PHYSICAL PROBLEMS

The physical consequences of women's alcohol consumption may greater than the consequences for men, as women may be more susceptible to tissue damage (Dunne, 1988) . The most persuasive evidence for this comes from studies of patients with alcoholic liver disease. Women appear to develop more severe liver disease at lower levels of consumption than men and after a shorter duration of problem drinking (Wilkinson, 1980). Women may be placing themselves at risk of liver disease with daily consumption as low as 14 units of alcohol, although the risk is is much greater when consumption rises above this (Norton et al., 1987). In contrast, the recommended safe levels for men are somewhat higher at 21 units per week, and hazardous levels are between 21-49 units per week (Royal College of Physicians, 1987).

Caution has to be exercised when interpreting these findings as severity of liver disease at first treatment contact may simply reflect different patterns of referral. For example men are more likely to be referred as the result of routine screening for insurance or employment purposes at an early stage, whereas women may present much later when symptoms appear (Saunders, Davis and Williams, 1981). A number of other studies have not found any difference in prognosis between male and female patients with liver damage (Hardison and Lee, 1966; Powell and Klatskin, 1968; Rankin, Wilkinson and Santamaria, 1970) suggesting that the disorder may be of equal severity in both sexes.

Some of the sex differences may be accounted for by the lower body weight and differing body composition. On average, women weigh 20% less than men and have a higher proportion of body fat and a correspondingly lower proportion of body water. Alcohol is distributed throughout the body water, which means that the average woman has a significantly smaller volume of distribution for alcohol than the average man. So even if the dose is adjusted for weight, consumption of alcohol may result in higher blood alcohol concentrations in women, and can be expected to cause more liver damage (Plant, 1990).

The female brain has been considered to be more vulnerable to the effects of alcohol. A number of studies have found that in comparisons between male and female alcoholics, women are more impaired on tests of neuropsychological functioning (Hesselbrock et al., 1985; Jacobson, 1986). Other studies have found no major differences in patterns or severity of cognitive impairment (Crawford and Ryder, 1986; Acker, 1985).

SOCIAL CONSEQUENCES OF HEAVY DRINKING

Women are considered to experience more serious social costs from their drinking than men do and this is thought to reflect their subordinate position in the social structure. The consumption of alcohol is influenced by a a wide range of economic and social factors and Fillmore (1987) has suggested that societal norms facilitate drinking in men but often not in women. She considers that women carrying out traditional roles as homemakers or mothers are particularly stigmatised by indulgence in heavy alcohol consumption. Because of this she has speculated that there is a

greater social rejection of the female drinker leading to a more destructive drinking career. This has been reinforced by the public perception of the connection between drinking, sexuality, prostitution and other forms of deviant and criminal activity (Cavan, 1966; Plant et al., 1989). This may cause alcoholic women to be more deteriorated psychologically and socially when they do eventually enter treatment (Gomberg, 1976).

There are very few studies which directly examine the comparative social indices of harm experienced by men and women entering treatment. Smart (1979) found that alcoholic women were more isolated and had fewer social and family contacts when they entered treatment. Other researchers have found that men and women attending an Alcohol Treatment Unit had similar levels of problems (Plant and Plant 1979).

In more general terms, when social indicators of alcohol-related problems are examined there is a clear disparity in rates between the sexes. Women are less likely to be convicted of most types of alcohol related crime including drunkenness offences (Plant, 1990). Large disparities are evident for example, in drunk driving convictions. In 1985 women formed only 5.3% of the 98,000 drivers convicted in England and Wales for this offence (Brewers Society, 1986). The most socially deteriorated and stigmatised alcoholic group are those who are not part of a family group and live in lodging houses or shelters provided by charities or Social Services. Although exact figures are not available for this population, women appear to form only a very small minority of homeless, skid row alcoholics (Otto, 1980).

The husband of the alcoholic female has been said to have a major effect on the course of the disorder (Lindbeck, 1972). As in other areas very little research has been carried out on the spouses of alcoholic women and most studies have produced conflicting results. It has been suggested that women experience more punitive responses from their spouses, are over-protected by their spouses or their spouses collude with them in denying the existence of a problem (Wilson, 1980). Because of the diversity of findings that have been reported no definitive statement can be made on the marital consequences of heavy drinking for women. The most consistent finding has been that these men are often heavy drinkers themselves (Dahlgren 1979).

TREATMENT NEEDS

After many years of neglect, the treatment needs of women attracted widespread interest particularly during the late 1970's and early 1980's. Thom (1991) has traced these developments and pin-pointed the emergence of "advocates" or an "interest constituency" for women with alcohol problems. A key role was played by researchers and service providers who were allied to the Camberwell Council on Alcoholism. This group published a series of articles which highlighted what they considered to be discrimination against women in the provision of treatment services (Camberwell Council on Alcohol, 1980). These are said to reflect the needs of male clients in the type of service offered and the "ambience" of the treatment setting and consequently to be unattractive to women. Sheehan and Watson (1980) have suggested that these barriers to entering treatment mean that women underutilise the treatment services that are available. As a possible solution to this problem it has been suggested that separate

facilities should be provided for women staffed in the main by female counsellors (Ettore, 1990).

As in other areas there are very few empirical studies examining these issues. Of the few that are available Thom (1986) found that on measures of service contact there were no significant differences between men and women. In the study carried out for the first part of this thesis the sex of the counsellor had no effect on compliance for male or female clients, for either time in treatment or number of sessions attended. In terms of eventual outcome there is little evidence to justify the claim that alcoholic women have a poorer prognosis. In a major review of 295 outcome studies, of which only 23 were gender specific there were no sex differences in treatment outcome (Vanicelli, 1984).

To summarise the consequences of having an alcohol problem have been considered to be more severe for women than men, although empirical work on the topic is rare. Samples of women attending psychiatric treatment services have formed the main population for study, and the high rates of psychiatric problems reported may be an artefact of studying this type of population.

The following questions will be examined;

1. Are there significant differences between men and women with alcohol problems, in terms of severity of dependence on alcohol, as well as in numbers of alcohol related problems?

2. Compared to men, do women suffer greater degrees of maladjustment and psychological disturbance, including high levels of denial?

3. Do women attending a community based voluntary agency and those attending an Alcohol Treatment Unit located in a psychiatric hospital, differ in terms of severity of impairment especially in terms of psychiatric problems?

CHAPTER NINE STUDY TWO -A COMPARISON BETWEEN ATTENDERS AT A COUNCIL ON ALCOHOL AND AN ALCOHOL TREATMENT UNIT-METHODOLOGY

SUBJECTS

Two groups of subjects were recruited, the first group were from GCA and the second from an Alcohol Treatment Unit.

a) GCA sample

The subjects were a representative sample of 50 clients attending GCA counsellors for an initial appointment. One day per week was allocated for data collection and all new clients attending the agency on that day were interviewed after they had completed their first counselling session. Clients were new referrals in the sense that they were beginning a new episode of treatment, although a proportion were past attenders. Different days of the week as well as evening counselling appointments were sampled to avoid possible selection bias. For example clients who were in employment often requested evening appointments. Simply including daytime appointments would have erroneously inflated the number of unemployed subjects.

The previous study indicated approximately half of the clients were self-referrals who contacted the Council on their own behalf. The remainder came from a variety of sources including General Practitioners, hospitals and other voluntary agencies within the city of Glasgow. Clients were seen by arrangement and were discouraged from turning up without an appointment. Those who were intoxicated or showing evidence of gross memory impairment were not included in the study, although in fact this happened very infrequently. Fifty-two clients were asked to take part in the study, and two refused. Individual counselling is the main treatment provided by the

Council. It has no resources to help with detoxification or medical or psychiatric emergencies.

b) ATU sample

The second group consisted of a series of 50 patients attending an Alcohol and Drug Treatment Unit (ATU) situated within Gartnavel Royal Hospital, a psychiatric hospital in the west of the city. The hospital serves a socially mixed community, including large areas of both local authority and owner-occupied housing. The area is fairly representative of the city of Glasgow as a whole. The Unit provides in-patient detoxification beds, as well as a range of day and out-patient treatment options, both on an individual and group basis. Staffing is on a multi-disciplinary basis and 500 patients per year are seen in the Unit. Past research has found that the majority of referrals were from G.P.'s, although 20% of attenders were self-referrals (Hyslop and Kershaw, 1981).

Examination of ward records and discussion with staff revealed that entry into the Unit's treatment programme was through two main routes. The majority of patients (60%) were given appointments to attend a weekly multi-disciplinary assessment clinic for new attenders, usually within three weeks of referral. The rest attended the Unit at very short notice or without any prior arrangement.

Both of these routes into the Unit were sampled. Firstly a consecutive series of attenders for prearranged clinic appointments was interviewed after they had seen clinic staff. This group made up 58% of the sample. Secondly patients who attended the Unit as crisis referrals were sampled although they were sometimes not available for immediate interview because of their physical or mental condition.

Interviews with this group took place as soon as possible, usually within two or three days after admission. One day per week was set aside for data collection and new patients available were interviewed by the researchers. Again different days of the week were used to avoid bias. A very small proportion of patients discharged themselves from the unit prematurely and were therefore unavailable for interview. Scrutiny of information obtained by the admitting doctor and case notes indicated that these patients did not differ substantially from those seen for interview. All patients asked agreed to participate in the study. Unlike the Council, the ATU in the study provided care for patients with severe memory impairment. These patients were not included in the study and formed less than 5% of patients attending this agency (Smith, 1991).

The previous study of GCA attenders had already indicated that there were differences in the proportions of men and women attending the two different agencies. Women made up one third of attenders at GCA, but only formed one fifth of attenders at the hospital services. Male and female patients were recruited from the hospital Unit until they were represented in the same ratio as the Council sample. Data collection at both agencies took place between May 1985 and April 1986.

THE INTERVIEW SCHEDULE

In all cases data were collected by direct interview. This was administered by two research workers (the author and a specially trained graduate psychologist) and lasted approximately one hour and a quarter. The interview schedule was pre-tested on a sample of in-patients in the Alcohol Treatment Unit and included the following

measures;

SOCIODEMOGRAPHIC DATA AND USE OF OTHER SERVICES

Details of age, sex, social class (OPCS, 1980), employment and marital status and source of referral were collected.

A checklist containing names of alcohol services in the city and surrounding area was used as a prompt to obtain details of treatment contacts at any time in the past, and in more detail over the last six months. Pilot work had indicated that in practice it was a relatively easy task to get subjects to recall contact with previous treatment agencies. This frequently occurred at times of great personal crisis and subjects often had vivid memories and sometimes amusing anecdotes about their encounters with different agencies and treatment personnel. This type of information can be reliably elicited from alcoholic patients using structured interviewing techniques (Sobell et al., 1979) The following data were sought;

1. Details of specific advice or help from General Practitioners to alter drinking. Only details of first advice session were noted as in practice it was difficult for clients to recall ongoing advice which was often given in the context of other problems.

2. Details of contact with Social Work Department, and details of specific advice on drinking problems.

3. Dates and details of contact with general psychiatric services for help with a drink problem. Attendance at specialist hospital alcohol services, Alcohol and Drug Units and/or use of residential hostels.

4. Dates and details of contact with Alcoholics Anonymous.

5. Dates and details of contact with local Councils on Alcohol.

6. Details of present contact with GCA or the ATU. Attendance at both agencies was monitored using the method described in the previous study which included number of individual sessions and length of time in treatment during a six month period.

MEASURE OF ALCOHOL DEPENDENCE

The Severity of Alcohol Dependence Questionnaire (SADQ) was used to measure physical dependence on alcohol (Stockwell et al., 1983). The SADQ covers the main features of the alcohol dependence syndrome as described by Edwards and Gross (1976) and contains items relating to consumption of alcohol, the physical and affective correlates of withdrawal and the reinstatement of the syndrome after a period of abstinence. The questions refer to a recent period of heavy drinking and subjects are asked to name a particular month to remind them of this. The maximum attainable score is 60. A score of 30 and below indicates mild to moderate dependence, while a cut-off point of 31 and above indicates severe dependence. Councils would aim to intervene before this point is reached as they are unable to provide detoxification facilities or direct access to medical or psychiatric advice (SCA, 1984). This provides a degree of homogeneity in the service offered which in the majority of cases involves individual counselling sessions.

MEASURE OF ALCOHOL PROBLEMS

The Problems with Alcohol Scale was used to measure a range of alcohol-related problems. Many of the items are based on an an earlier scale, the Troubles with Drinking Questionnaire (Edwards et al., 1972). The scale covers some of the major indices of alcohol-related harm which includes the social, marital and health consequences of heavy drinking. It has has been used with in-patient alcoholics (Chick et al., 1988) and patients in general medical wards who have alcohol problems and is of proven inter-rater reliability (Lloyd et al., 1982).

MEASURES OF SOCIAL FUNCTIONING

Councils hope to intervene before social adjustment indices are grossly affected. These were measured using the Straus-Bacon Scale (Straus and Bacon, 1951). This is a four point scale which measures social and occupational integration. A maximum score of 4 indicates a high level of social stability. These type of measures have been demonstrated to be accurate predictors in treatment outcome (Costello, 1980).

A measure of social disruption was also included and this covers occupational, residential, financial and legal stability over the previous 12 months. It is an abbreviated version of a scale used by Smart (1979) for examining the characteristics of male and female alcoholics entering treatment. The maximum score is 24, and more severe disruption is associated with a high score. It is concerned with recent social changes , while the Straus-Bacon Scale

is concerned with more long term breakdown of social stability.

A modified version of the Social Adjustment Scale (Weissman, 1971), which is a semi-structured interview was used to elicit subtle disturbances in the subject's social functioning. It contains items covering five major aspects of functioning: work as an employee, social and leisure activities, relationships with extended family and roles as spouse and parent. Questions in each area fall into the following categories: the subject's performance on expected tasks, the amount of friction he has with people and finer aspects of his interpersonal relationships. The items concerning subjective feelings were omitted as it was felt that these would be adequately covered by the GHQ which was used to measure psychological symptoms.

The scoring for individual items and global ratings ranged from 1 to 5. Ratings were made on the basis of subjects' responses, as well as taking into account all available information, rather than relying purely on self-report. In all cases higher scores reflect poorer adjustment. An overall rating of social adjustment was obtained for each subject taking into account all areas of functioning. The period rated was the previous two months. The SAS has been extensively used with psychiatric patients (Bothwell and Weissman, 1977) as well as alcoholics (Pottenger et al., 1978) and is of proven reliability and validity (Weissman et al., 1971, Paykel et al., 1971).

PRESCRIBED DRUG USE

The number of prescribed drugs received over the previous twelve months was recorded using the following categories; anxiolytics,

hypnotics, antidepressants and analgesics. The aim was to record use rather than abuse of these drugs, as it can be difficult to distinguish dependence on prescribed drugs in a population that is also abusing alcohol. The lifetime occurrence of drug overdoses and those occurring during the previous twelve months were also recorded as these have been described as particularly, high especially amongst alcoholic women (Schuckit and Morrissey, 1979).

ASSESSMENT OF PSYCHOLOGICAL SYMPTOMS

Psychological symptoms were measured using the General Health Questionnaire (GHQ) (Goldberg, 1978). The GHQ is a well validated and widely used screening instrument for the detection of functional psychiatric illness. It has been used in a variety of settings including general practice and community surveys (Tarnopolsky et al., 1979). It exists in four different versions. The 28 item version was selected for this study because it is relatively brief. There are four sub-scales which measure "somatic symptoms", "anxiety and insomnia", "social dysfunction" and "severe depression". A threshold score of 5 and above was used by Goldberg and Hillier (1979) to indicate "a case". There are formidable difficulties in the interpretation of the occurrence of these types of symptoms in alcohol-dependent drinkers because of the likely overlap with withdrawal symptoms. Despite this the GHQ can be interpreted as measuring the levels of psychological distress experienced by patients at the point of entry to these treatment agencies.

ASSESSMENT OF PSYCHIATRIC DISORDER

a) Depressive disorder

Many patients attend treatment facilities in a very distressed condition. However it would be overinclusive to view such people as clinically depressed. The presence of depressive disorder, as distinct from depressive symptoms (which was measured on one of the sub-tests of the GHQ), was assessed using the Schedule for Affective Disorders and Schizophrenia (SADS) (Endicott and Spitzer, 1978). This was used in conjunction with the Research Diagnostic Criteria (RDC) which contains a consistent set of criteria for allocating subjects to diagnostic groups (Spitzer, Endicott and Robins, 1978). The RDC explicitly requires that diagnoses can only be made if there is no known toxic or organic aetiology (including the ingestion of alcohol or drugs) for the symptoms. Because many patients seek treatment after recent periods of heavy drinking the clinical picture is often unclear. Schuckit (1983) has described the commonest of these symptoms as transient, disappearing within seven days of abstinence in many patients. To avoid spuriously elevated scores, patients were assessed if they had been abstinent from alcohol for 7 days. If they had not had an alcohol free period preceding the interview they were asked to recall alcohol free periods during the previous 12 months.

To clarify this all subjects were assisted by the interviewers to complete a drinking history chart which graphed fluctuations in alcohol consumption during this time. Anchor points were identified to provide a framework to prompt subjects' memories. These included holidays, birthdays, times of ritual excess such as Christmas and New Year and the local Glasgow "Fair Holidays". More personal events were also noted such as arrests, hospitalisations, illnesses and entry

into treatment. Subjects were asked to recall their drinking during these times and events. Periods of relatively invariant drinking behaviour were elicited first by asking subjects to recall consecutive days of abstinence. Days of very heavy excessive consumption where subjects "binged" were also elicited. This method has been found to be a reliable technique for obtaining information (Sobell et al., 1979). No attempt was made to sort out the chronology of alcoholism and depression as the aim was simply to quantify the levels of disorder present.

While drawing up their drinking history chart, subjects were asked to indicate their last drinking day. The number of abstinent days before the interview were then recorded. Previous research has indicated that this may have an impact on the severity of psychological symptoms experienced by subjects (Hamm et al., 1979).

b) Phobic states

Clinical rating scales for agoraphobia and social phobia have been developed by Smail et al. (1984) for use in assessing phobic states in alcohol-dependent in-patients. The measures used have clear subjective, behavioural and physiological components and avoid simply focusing on unpleasant mood states, generalised panic, fears of meeting people the morning after a heavy drinking session, withdrawal from many social activities, etc. which are common features in patients who are experiencing the consequences of prolonged heavy drinking. As described previously for depression, only symptoms occurring during periods of abstinence identified on the subjects drinking history chart were included. This method of eliciting phobic symptoms has been used by Stockwell et al., 1984, and they

have presented evidence of high test-retest and inter-rater reliability.

c) Antisocial Personality Disorder

Assessments were also carried out for the occurrence of anti-social personality disorder (ASP). This category requires that subjects exhibit the disorder before the age of fifteen and is characterised by antisocial activities in many areas of life which persists into adulthood. A failure to maintain close, warm and responsible relationships is also a feature of the disorder. RDC criteria require that if the subject has a serious alcohol problem only those manifestations of ASP which cannot be clearly attributed to alcohol are counted towards the diagnosis. This avoids including alcohol abusers who engage in a limited sphere of anti-social acts within this category (Schuckit, 1973).

ACKNOWLEDGING ALCOHOL PROBLEMS

There are no standard measures of "denial" of an alcohol problem but a visual analogue scale (VAS) allows subjects the opportunity to indicate subjective experiences of this type (McCormack et al., 1988). The scale used consisted of a horizontal ten centimetre line anchored at both ends with words descriptive of the maximal and minimal extremes of the dimension being measured. The anchor terms used in this case were "no problems with alcohol" and "problems with alcohol could not be worse". Subjects were asked to indicate their feelings by marking the line at the appropriate point between the two extreme statements. Because "denial" implies a discrepancy between

the perceptions of the patient and therapist or in this case interviewer and subject the interviewers also rated the severity of the subject's problems with alcohol taking into account all the information available to them.

CHAPTER TEN CHARACTERISTICS AND HELP-SEEKING PATTERNS OF ATTENDERS AT GCA AND THE ATU

The focus of this chapter will be to describe in detail the clinical characteristics of attenders at GCA and the ATU and to report on whether there is a match between treatment resources and clients needs. The assumption is that clients with less severe problems are more likely to attend a community based voluntary agency, therefore the main hypothesis to be tested is that;

1. Attenders at GCA will be problem drinkers relatively free of social, marital, occupational and psychological difficulties in comparison to attenders at an ATU. In addition levels of physical dependence on alcohol will be low so that supervised detoxification is not required.

The process by which clients attend the most appropriate agency for their degree of alcohol-related disability will be examined. The suggestion that help-seeking can be viewed as a rational process (Thom, 1984) will be evaluated by testing the hypothesis that;

2. Subjects attend one agency at a time over a relatively sustained time period, and that GCA clients in particular will not have received previous help for their drinking.

Because of the increased stigma and general neglect of services for women they have been considered to face a number of obstacles and barriers when they attempt to seek treatment. It is hypothesised that;

3. In comparison to men, women will have had relatively few treatment contacts.

A recurrent theme in the treatment literature has been the lack of trust that can be placed in the information provided by patients with alcohol problems. It has been suggested there may be differences between groups in their willingness to acknowledge alcohol as a

problem. Attenders at community based agencies which encourages open and early access to services have been considered to be less likely to exhibit denial. On the other hand women have been considered to be a particular high risk group for exhibiting this type of behaviour. Using a visual analogue scale, it was hypothesised that;

4. Differences will be observed between attenders at the two agencies or between males and females in their willingness to acknowledge alcohol as a problem.

The aim was also to identify a group which fitted the stereotype of the "denying alcoholic" i.e. subjects who exhibited a complete failure to acknowledge alcohol as a problem, despite other evidence to the contrary. The implications for subsequent compliance with treatment will also be examined. It was therefore hypothesised that;

5. There is an alcoholic group which has extreme discrepancies between the subjects and interviewer's ratings on the visual analogue scale and that "deniers" comply very poorly with treatment.

The following section will contain a descriptive analysis of the clients attending GCA and the ATU. These indices will be compared with other studies, to establish as far as possible that representative samples of attenders from both agencies have been obtained.

SOCIODEMOGRAPHIC CHARACTERISTICS OF THE TWO GROUPS

The average age of those who attended GCA was 41 years, with a range from 21-65 years. Half of the sample were employed (54%), a further 36% were unemployed, were retired or described themselves as housewives (10%).

TABLE 1 Socio-demographic features of attenders at Glasgow Council on Alcohol (GCA) and an Alcohol Treatment Unit (ATU)

	GCA n=50	ATU n=50
Married	44%	44%
Single	26%	28%
Separated	8%	10%
Divorced	10%	16%
Widowed	12%	2%
Mean Age	40.8	42.0
(SD)	(11.7)	(9.0)
Employed	54%	36%
Unemployed	36%	54%
Retired/ Housewife	10%	10%
% Female Patients	30%	32%

The social class distribution reflected that found in the general population, as over half of clients (58%) came from social class 111. Just under half of clients were married (44%) with 18% either divorced or separated (Table 1).

Clients came to GCA from a variety of sources. The majority were "non-agency" referrals (56%) which are made up of self-referrals (28%) or those who have attended at the suggestion of their family or friends (28%). The rest came from G.P.s (10%) and from employers, hostels, hospitals, social workers and other voluntary agencies etc. (34%). These figures are similar to the socio-demographic characteristics described for a consecutive series of attenders at GCA described in Chapter 4.

Using chi-squared, for marital and occupational status, and Student's t for age, there were no significant differences between GCA and ATU attenders. A larger proportion of ATU patients were unemployed, but the difference was not statistically significant. The pattern of referral to an ATU was different in that the majority of referrals came from General Practitioners (68%) or other agencies (16%), although 16% were self-referrals. This reflects the strong links between hospital services and local General Practitioners.

A previous study in this ATU (Hyslop and Kershaw, 1981) which reported on the socio-demographic characteristics of a consecutive series of referrals to the agency had essentially similar results. This strongly suggests that the aim of obtaining a representative sample of attenders from the ATU has been achieved.

CLINICAL CHARACTERISTICS OF THE TWO GROUPS

In this section the range of alcohol-related disabilities sustained by both groups of attenders will be described. This will include the degree to which subjects are physically dependent on alcohol, the degree of psychological distress experienced and the life problems caused by abuse of alcohol. The two groups will be compared on these indices using chi-squared for categorical variables and Student's t for continuous variables.

On the SADQ, 30% of GCA clients scored above 30 which is the cut-off point indicating severe dependence on alcohol. The average score was 22.4 (SD = 13.2). The ATU patients had a higher average score of 27.1

(SD = 14.7), but a similar proportion of those scoring above 30 i.e. 30%. There were no significant differences in mean SADQ scores, but some differences in subtest scores were apparent with higher rates of affective disturbance ($p<0.05$) and relief drinking ($p<0.05$) in the ATU sample. Therefore contrary to expectations about a third of GCA clients have an established pattern of physical dependence on alcohol (Table 2). Normally some medical assistance is required to detoxify patients at this level of physical dependence.

TABLE 2 Comparison of SADQ scores between Council clients and ATU patients

	GCA n=50 Mean (SD)	ATU n=50 Mean (SD)	t test (sig.)
SADQ Total	22.4 (13.2)	27.1 (14.7)	1.67 NS
Physical Withdrawal	4.1 (3.3)	5.1 (3.6)	1.43 NS
Affective Symptoms	3.8 (3.2)	5.3 (4.2)	1.99 $p<0.05$
Relief Drinking	4.4 (3.3)	6.0 (4.4)	1.99 $p<0.05$
Quantity Drunk	5.6 (2.7)	6.2 (3.8)	0.78 NS
Reinstate-ment	4.4 (3.8)	4.5 (3.6)	0.11 NS

On the GHQ, seventy percent of GCA clients obtained a score of 5 or more (which is the cut off point for caseness) at the time of initial interview, indicating high levels of psychological distress in this sample. The mean score was 10.4 (SD=8.2). A third of the sample (30%) obtained a score of four or more on the depression sub-

scale, and 38% scored above 5 for anxiety, cut-off points suggested by Aylard et al. (1987) to indicate severe dysfunction. The hospital sample had a mean score of 13 (SD=8.1) and a larger proportion of patients reaching "caseness" (86%), as well as larger groups of depressed (34%) and anxious (54%) patients, but none of these differences reached statistical significance. Contrary to prediction a substantial proportion of GCA clients were experiencing psychological symptoms.

TABLE 3 Comparison of alcohol-related problems amongst Council clients and ATU patients

	GCA	ATU	x^2
Ulcers/ Stomach Trouble	8%	30%	$p<0.05$
Liver Problems	20%	30%	NS
Accident	48%	48%	NS
Missed Work	57%	69%	NS
Trouble at Work	60%	54%	NS
Arguments at home	74%	86%	NS
Violent Arguments	20%	16%	NS
Threatened/ Actual Rupture	34%	31%	NS
Money Worries	52%	50%	NS
Police Trouble	44%	32%	NS
Asked to leave a public place	31%	33%	NS

On the "Problems with Alcohol Scale", 20% of GCA clients had been told their liver had been damaged through drinking, and 48% had been involved in an accident when they had been drinking. Many had missed work (57%) and had experienced difficulties while at work (60%).

Marital difficulties were particularly frequent; 74% mentioned arguments at home about drinking, and as an indication of severity 34% had experienced threatened or actual separation. Legal difficulties were common, as 44% described either warnings or arrests by the Police (Table 3). It seems therefore that clients experienced a wide variety of physical, social and marital difficulties as a result of their drinking. Patients attending an ATU had a similar pattern of difficulty, although a higher proportion had physical difficulties in the form of liver and stomach problems ($p<0.05$). Presumably this group with physical sequelae was more likely to be in touch with their G.P.'s and therefore to be referred on to a hospital unit.

A total of six items are applicable to all subjects on this scale and when summed give a "common problems" subscale (Drummond, 1990). These include items relating to physical illness, accidents, behaviour in public, money worries and police involvement. Using Student's t, there were no significant differences between the two groups of attenders on these indices.

Different aspects of alcohol-related, social disability were assessed and measured. A third of clients (36%) were socially stable according to the criteria considered important by Straus and Bacon (1951). However, 10% of the sample were seriously disadvantaged with no job, no stable residence, no wife or family home, characteristics associated with a poor prognosis (Costello, 1980). The rest fell into intermediate categories. There were marginal differences with ATU patients, as the hospital group had a slightly larger group of stable patients (46%) and a slightly smaller group of unstable patients (6%). This may be related to source of referral as unstable,

socially disadvantaged people are often not registered with G.P.'s, making referral to a hospital unit less likely. An examination of the distribution of scores on this scale and also on the measure of social disruption to be discussed in the next paragraph found that they were not normally distributed, therefore a non-parametric statistical test, the Mann-Whitney was used. Overall there were no significant differences between the groups.

The Straus-Bacon scale measures chronic, long term breakdown in social stability. On a measure of recent social disruption (i.e. the previous 12 months) devised by Smart (1979), there were also no significant differences on a measure of residential, financial, occupational and legal status.

On the Social Adjustment Scale (SAS) which is a semi-structured interview designed to elicit more fine-grained changes in subject's social functioning, there were no significant between between attenders at different agencies on a global rating of social adjustment or any of the sub-scales except one. ATU patients were more impaired in relationships with extended family ($t=2.2$, $p<0.05$).

PREVIOUS TREATMENT FOR DRINKING PROBLEMS

Contrary to expectations the majority of Council clients (72%) had been in contact with treatment agencies. This ranged from no previous treatment contact (28%), to contact with three or more agencies (30%), with a mean of 1.8 contacts (Table 4). One very active client managed to become involved with ten separate agencies. After excluding those who have received no previous treatment, clients have

been in contact with an average of 2.5 agencies.

TABLE 4 Number of agency contacts

No. of Agency Contacts	GCA Attenders	ATU Attenders
0	28%	12%
1	32%	28%
2	10%	26%
3	12%	20%
4	6%	4%
5	8%	8%
6	2%	2%
10	2%	0%
Mean	1.8	1.9

A wide variety of agencies were involved in advising about drinking. Nearly half the sample (44%) reported specific advice or treatment from their G.P. aimed at modifying their drinking. Council clients had extensively used hospital based psychiatric services, both as in-patients and out-patients (44%). They had also attended Alcoholics Anonymous (38%), and 18% were past attenders at Glasgow Council on Alcohol. There was therefore a large degree of crossover between different types of services. The hypothesis that clients had not been involved with other helping agencies was not supported.

Not only did clients have many past contacts, some of these had occurred over an extended time scale, in some cases more than ten years ago. More recently, over the previous six months similar

patterns of crossover were noted. This ranged from no treatment contact (38%) to a very active client who had attended five separate agencies. Eighteen per cent of clients had attended three or more agencies. Despite embarking on a new contact with GCA some clients were simultaneously involved with other agencies. For example within the four weeks before attending GCA, 14% of clients attended an AA meeting and 18% attended a hospital based unit.

To see if clients repeated this pattern of tentative contact with other agencies in their current involvement with GCA, compliance was monitored by noting number of individual sessions and recording time in treatment. The results confirmed the previous study that a quarter of clients failed to return for a subsequent appointment, and by six months 96% of clients were no longer attending the agency.

A similar pattern was observed amongst attenders at the ATU. A smaller proportion of patients had received no treatment or had only one treatment contact; 40% as compared to 60% of Council clients. There was crossover to other agencies, but less extensively than that observed in Council clients. Excluding those with one or less treatment contacts, the rest had an average of three contacts. This type of activity was more frequent for Council clients, who had a rate of 3.8 contacts. There was a marked tendency for patients to be past attenders at the ATU ($p<0.01$) suggesting some measure of containment. Direct comparisons in the case of compliance with treatment are probably not meaningful. Councils rely heavily on individual counselling which is easier to quantify than day or in-patient intervention. However in crude terms by six months 12% of patients were still in contact with the ATU (compared to 4% at GCA).

THE USE WOMEN MAKE OF SERVICES

Particular attention was paid to women's use of services, and it was found that there were no differences in the number and variety used by them. Like their male counterparts in both GCA and the ATU they had an average of just under two previous contacts. Despite the barriers proposed for them women appear just as persistent as men in seeking out and receiving treatment.

CHARACTERISTICS OF THOSE WITH VARYING DEGREES OF HELP-SEEKING

Subjects were divided into two groups; those who had received modest amounts of treatment (i.e. one or no previous contact) and those who had between two and ten previous contacts. These frequent users or "help-seekers" were more heavily dependent on alcohol ($p<0.05$), had more alcohol-related problems ($p<0.01$), more severe psychological symptoms ($p<0.05$), were less socially stable ($p<0.01$) and impaired in terms of social adjustment ($p<0.01$). This more severe group were likely to receive more individual sessions and remain in treatment for longer, although these differences did not reach statistical significance. Those with less severe problems, the main target group for Councils remained in counselling for relatively brief periods of time, for an average of 3.5 sessions over a five week period (Table 5).

A similar pattern was found in the ATU sample, with multiple help-seekers likely to have more serious difficulties, although this only reached statistical significance in the number of alcohol-related problems ($t=3.05$, $p<0.01$) and in social disruption ($t=2.5$, $p<0.01$).

TABLE 5 Characteristics of help-seekers attending GCA

	0-1 Previous Contacts n=34	2-10 Previous Contacts n=16	t test (sig.)
	Mean (SD)	Mean (SD)	
GHQ Total	8.8 (7.9)	14 (7.8)	2.16 p<0.05
SADQ Total	20.0 (13.6)	27.6 (10.9)	1.94 p<0.05
Problem Total	1.6 (1.3)	2.8 (1.6)	2.79 p<0.01
Social Stability	3.0 (1.1)	1.9 (1.3)	2.7* p<0.01
Social Disruption	2.8 (4.1)	6.0 (5.0)	2.3* p<0.01
Social Adjustment	3.0 (0.7)	3.8 (0.7)	3.24 p<0.01
Individual Sessions	3.5 (2.6)	5.4 (5.1)	1.43 NS
Time in Treatment	5.0 (5.5)	7.7 (8.5)	1.14 NS

* These variables were tested using the Mann-Whitney and the figures are for z scores.

ACKNOWLEDGING ALCOHOL PROBLEMS

Subjects from both agencies acknowledged a fairly high degree of difficulty with alcohol, with a mean score of 6.8 for GCA attenders, and 7.1 for ATU patients. Using the VAS scale, the interviewers rated GCA attenders at 8.0, while ATU attenders were rated at 8.1. Using Student's t, there were no significant differences between self-assessments carried out by attenders at different agencies, or between the interviewers rating of the

severity of alcohol problems for attenders at different agencies (Table 6).

TABLE 6 A comparison between self and interviewer ratings for attenders at different agencies on the VAS

	GCA n=50 Mean (SD)	ATU n=50 Mean (SD)	t (sig.)
Self Rating	6.8 (2.9)	7.1 (2.2)	0.69 (NS)
Interviewer Rating	8.0 (1.4)	8.1 (0.7)	0.64 (NS)

As agency attended was not an important factor, data were pooled to provide the following descriptive information. Many subjects acknowledged a fairly high degree of difficulty with alcohol. The modal score was 10, and almost a quarter of the group (23%) placed themselves at the extreme end of the scale (Table 7).

TABLE 7 Self and interviewer rating on visual analogue scale

VAS Scale	Self Rating Frequency n=100	Interviewer Rating Frequency n=100
0	6	0
4	6	0
5	19	2
6	4	3
7	17	14
8	19	52
9	6	24
10	23	5

TABLE 8 Differences between interviewer's and subject's scores on the visual analogue scale

Differences	Frequency	Cumulative
-3	2	3
-2	11	14
-1	11	24
0	22	46
1	20	66
2	9	75
3	14	89
4	4	93
5	1	94
7	2	96
8	2	98
9	2	100
	100	

Twenty-two percent of subjects and interviewers arrived at exactly the same rating. Twenty four per cent of subjects rated their problems as more severe than the interviewer did. The rest rated themselves lower than the rater did (54%) (Table 8).

All subjects were assessed by the interviewers as having some degree of difficulty with alcohol . The modal score was 8, which was applied to 52% of the sample. The mean score was 8.08 (SD=1.1). Although many subjects acknowledged quite severe difficulties with alcohol, overall the interviewers assessed these problems as more severe ($t=4.43$, $p<0.001$). When both agencies were examined separately, attenders at the ATU and GCA were willing to acknowledge difficulties with alcohol, but for both

groups the interviewers assessed their problems as more severe (Table 9).

TABLE 9 Comparisons of self and interviewer ratings within agencies

Agency	Self Rating Mean (SD)	Interviewer Rating Mean (SD)	t value
GCA	6.8 (2.9)	8.0 (1.4)	2.94 $p<0.01$
ATU	7.1 (2.2)	8.1 (0.7)	3.55 $p<0.001$

There was a small group of 11 subjects (11%) in which there was a large discrepancy between the subject's and interviewer's assessments. This was computed by subtracting the subject's VAS score from the interviewer's VAS score (Table 8). For the purposes of this study, those subjects whose scores fell one standard deviation below the mean of these differences were considered to be "denying" their alcohol problem. This group rated their problems with alcohol between 4 and 9 points below the point selected by the rater. Contained within the denial group was a very small proportion of subjects (n=6) (6%) who claimed to be having no difficulties at all with alcohol.

There was no evidence of sex differences in denial, as 12% of men and 10% of women were in the denial category. The majority (16%) of deniers attended GCA, while 6% attended the ATU, although using chi-squared this was not statistically significant. Despite rating

themselves as having little in the way of problems on the visual analogue scale, there were no significant differences between the denial group and the rest of the sample on severity of dependence on alcohol, alcohol-related difficulties and indices of social stability. This meant that subjects were quite willing to report a whole range of problems, many of them obviously alcohol-related without acknowledging that alcohol was causing them difficulty.

The "denial" group had a mean score of 1.9 on the VAS, while the interviewer assessed them at 8.1. The difference between these scores was highly significant ($t=9.90$, $p<0.001$). The rest of the sample had a mean score of 7.6 on the VAS, while the interviewers assessed them slightly higher at 8.0. The difference in scores was statistically significant ($t=2.65$, $p<0.01$) (Table 10).

TABLE 10 A comparison between the interviewer and subjects on the VAS according to "denial" status.

	Rater Assessment Mean (SD)	Self Assessment Mean (SD)	df	t (sig)
Non Deniers	8.0 (0.9)	7.6 (1.8)	10	2.65 p<0.01
Deniers	8.1 (0.8)	1.9 (2.2)	89	9.90 p<0.001

There were no differences in compliance with treatment between "deniers" who attended for an average of six weeks, compared to the rest who attended for six and a half weeks. Long term compliance with treatment was poor for both groups as only 9% of "deniers" (n = 1) and 8% of the rest (n = 7) were still attending at

six months. Therefore a failure to acknowledge alcohol as a significant difficulty in the first session did not affect subsequent attendance.

CHAPTER ELEVEN PSYCHIATRIC SYMPTOMS, PSYCHIATRIC DISORDER AND ALCOHOL DEPENDENCE

In Chapter 10 the main hypothesis that clients using community-based facilities in the form of Councils on Alcohol have less serious alcohol problems uncomplicated by the physical, social and psychological difficulties was not confirmed. Both agencies had attenders who were heavily dependent on alcohol and were experiencing a wide range of problems. The main differences were that the Council clients had less physical damage and there was a trend for them to have fewer psychological symptoms.

A major difference between the two samples may be in the occurrence of psychiatric disorder. It has been suggested that Council clients rarely experience the complications of formal psychiatric disorder which has been observed to occur in patients attending an ATU. It is hypothesised that,

6. Council clients will be free of co-existing psychiatric disorder in the form of affective disorder, phobic anxiety and personality disorder.

There is a further implicit assumption that that these disorders may be associated with drinking problems of some severity. It is hypothesised that;

7. There is a link between formal psychiatric disorder and severity of alcohol-related problems and physical dependence.

It is important to maintain the distinction between formal psychiatric disorder which has been diagnosed by specific clinical criteria and self-reported psychological symptoms. In the previous

chapter it was noted that many subjects reported symptoms of anxiety and depression. A number of hypotheses have been proposed to explain their presence. It has been suggested that these symptoms are secondary phenomena and are caused by withdrawal from alcohol and the consequences of severe alcohol-related problems. Alternatively some researchers have proposed that these symptoms are a feature of alcohol problems whatever their severity and are indicative of an underlying disorder. It is therefore hypothesised that;

8. There is a link between the occurrence of psychological symptoms and severity of alcohol-related problems and physical dependence.

PREVALENCE OF FORMAL PSYCHIATRIC DISORDERS

In the previous year, 4% of GCA clients and 12% (chi-squared, NS) of ATU patients reported phobic anxiety states of clinical intensity occurring during periods of abstinence. Both samples contained the same proportion of depressed patients i.e. 10%. However in the ATU sample there was some overlap between subjects who were depressed and phobic (6%). This meant that the absolute numbers of subjects with these difficulties were very similar as 14% of GCA clients and 16% of ATU patients reported a psychological disorder in the past year (Table 11). This can be contrasted with the high numbers of subjects who reported psychological symptoms which reached "caseness" on the GHQ; 70% of of GCA attenders and 86% of ATU patients.

TABLE 11 Rates of psychiatric disorder

	GCA	ATU
Affective Disorder	10%	4%
Phobic Disorder	4%	6%
Phobic and Affective Disorder	-	6%
Total	14%	16%

Few subjects fulfilled the criteria for personality disorder. This occurred in 4 (8%) GCA clients and one male ATU patient (2%). These rates were much lower than expected but in some measure reflect the stringency of the criteria employed. Simply allocating patients who had committed criminal offences to this category would have produced inflated rates as 44% of GCA clients, and 32% of ATU patients had been involved with the police in the previous two years (Table Three). These results support the hypothesis that there were no significant differences in the incidence of psychiatric disorder between the two agencies.

LINKS BETWEEN PSYCHIATRIC DISORDER AND OTHER MEASURES

Because the number of subjects experiencing phobic or depressive disorders were small, they were pooled to form a single category of psychiatric disorder. Using ANOVA there were no significant differences between the phobic and/or clinically depressed group and subjects without these disorders when examining dependence on alcohol, social disruption, social stability or social adjustment. Subjects who had experienced a clinical disorder in the previous year

had higher GHQ scores $F(1,98)=4.5$, $p<0.05$. These results were found regardless of whether subjects attended the ATU or GCA. It therefore appears that psychiatric disorder is largely independent of severity of alcohol-related difficulties.

PERSONALITY DISORDER, PSYCHOLOGICAL SYMPTOMS AND ALCOHOL-RELATED PROBLEMS

As so few subjects received a diagnosis of personality disorder (n=5) data were pooled for statistical analysis.

TABLE 12 A comparison between subjects with and without personality disorder

	No Personality Disorder n=95	Personality Disorder n=5	t test (Sig)
	Mean (SD)	Mean (SD)	
SADQ Total Score	24.0 (13.8)	40.2 (11.3)	2.57 p<0.01
GHQ Total Score	11.2 (8.0)	21.2 (6.3)	2.71 p<0.01
Social Adjustment	3.3 (0.2)	4.6 (0.5)	3.82 p<0.001
Social Stability	2.9 (1.1)	0.6 (0.8)	3.32* p<0.01
Social Disruption	3.6 (3.6)	13 (5.5)	3.21* p<0.01
Problem Total	2.0 (1.4)	3.8 (1.7)	2.57 p<0.01
No. of Sessions	4.2 (3.6)	2.6 (1.5)	1.0 NS
Time in Treatment	6.7 (7.5)	2.6 (1.6)	3.89 p<0.001
Age	42.0 (10.3)	34.4 (10.6)	1.6 NS

* These variables were tested using the Mann-Whitney and the figures are for z scores.

Using Student's t, as a group they reported higher GHQ scores ($p<0.01$) were more heavily dependent on alcohol ($p<0.01$) and were more socially unstable ($p<0.01$), had experienced more social disruption ($p<0.01$) and were more poorly socially adjusted ($p<0.001$). They had more alcohol-related problems ($p<0.01$) and spent less time in treatment ($p<0.001$). They also tended to be younger with an mean age of 34.4 years compared to those without a personality disorder who were aged 42 years. This difference did not reach statistical significance (Table 12). Four out of five were male. Therefore in contrast to phobic anxiety and affective disorder, personality disorder was associated with very severe alcohol problems.

Despite the high numbers of psychological symptoms of anxiety and depression reported both at the interview and over the previous year, it was not possible to assess this group during a period of abstinence as only one subject stopped drinking long enough to allow an assessment to be carried out. This man received a diagnosis of depression, which occurred during a period of enforced abstinence in prison.

THE RELATIONSHIP OF GHQ SCORES TO DEPENDENCE AND ALCOHOL-RELATED PROBLEMS

In the previous chapter no significant differences were noted between overall GHQ scores for attenders at different agencies. These data were therefore pooled to allow analysis of the relationship between psychological symptoms as measured on the GHQ and other measures of alcohol-related problems to examine the hypothesis that these symptoms were linked to severity.

The mean GHQ score for the whole group (n=100) was 11.75 (SD= 8.2), and 78% of subjects obtained a score of 5 or more which represents the cut-off point for "caseness". The Pearson product moment correlation coefficient between the total GHQ score and total SADQ was 0.4 ($p<0.001$) indicating that levels of psychological distress were associated, albeit weakly with increased dependence on alcohol. A further examination was made of the relationship between the GHQ sub-scales and sub-scales of the SADQ. The SADQ has 6 sub-scales which measure physical withdrawal (Phys), affective withdrawal (Aff), craving and relief drinking (Need), reinstatement after abstinence (Postab) and quantity of alcohol consumed (Alc). The majority of GHQ sub-scales were significantly correlated with each of the SADQ sub-scales as well as total SADQ (Table 13). The correlations between affective withdrawal and all GHQ sub-scales were highly significant.

There was a significant negative correlation between GHQ sub-scales and total GHQ and number of days the subject had been abstinent, indicating that elevated GHQ scores were associated with recent drinking. Indicators of harm from drinking which included social adjustment and alcohol-related problems were consistently, although weakly correlated with all subtests of the GHQ as well as total GHQ.

A regression analysis was performed to explore the relationship between GHQ scores and demographic variables, which included age, sex, social class and the type of agency attended. Subjects were divided into two social class groups of comparable size. Social classes A, B and C1 were combined and contained 55% of the sample and

TABLE 13 Pearson correlations of GHQ sub-scale with SADQ sub-scales and alcohol-related problems

GHQ Sub-scales	SADQ (Phys)	SADQ (Aff)	SADQ (Need)	SADQ (Alc)	SADQ (Post-ab)	SADQ Total	Abst. Days	Problem Total	Social Adjustment
Somatic Symptoms	0.25 **	0.33 ***	0.25 **	0.28 **	0.34 ***	0.37 ***	-0.27 **	0.13	0.27 **
Anxiety and Insomnia	0.29 ***	0.50 ***	0.33 ***	0.24 **	0.35 ***	0.45 ***	-0.22 *	0.26 **	0.34 ***
Social Dysfunction	0.15	0.34 ***	0.25 **	0.24 **	0.10	0.28 **	-0.19 *	0.19 *	0.23 **
Severe Depression	0.18 *	0.45 ***	0.15	0.18 *	0.13	0.28 **	-0.21 *	0.20 *	0.22 **
GHQ Total	0.25 **	0.49 ***	0.28 **	0.27 **	0.25 **	0.40 ***	-0.27 **	0.23 **	0.31 ***

*** $p<0.001$
** $p<0.01$
* $p<0.05$

C2, D and E were combined and contained 45% of the sample. Only social class predicted GHQ scores, $F(1,97)=6.52$, $p<0.01$, accounting for 6.3% of the variance.

A further analysis was carried to examine the effects of total SADQ score, number of alcohol problems, social adjustment, number of days of abstinence before interview and clinical diagnosis. Total SADQ score accounted for the greatest amount of variance (16.5%) followed by number of days of abstinence (5.7%) and then social adjustment (4%) (Table 14).

TABLE 14 Regression analysis of physical dependence, number of abstinent days and social adjustment (SAS)

Variables	F	DF	F(sig)	Rsq.	RsqCh.
Total SADQ	19.2	1,97	.001	.1656	.1656
No. days Abstinent	13.8	2,96	.001	.2234	.0578
SAS Global	11.3	3,95	.001	.2639	.0405

TABLE 15 Regression analysis of affective withdrawal symptoms (Aff), number of abstinent days and social adjustment (SAS)

Variables	F	DF	F(sig)	Rsq.	RsqCh.
SADQ (Aff)	31.9	1,97	.001	.2478	.2478
No. days Abstinent	13.8	2,96	.001	.3047	.0569
SAS Global	11.3	3,95	.001	.3567	.0521

A regression analysis was performed which included all of the sub-scales of the SADQ as well as indices of alcohol related problems. Affective withdrawal accounted for 24.7% of the variance, followed by number of abstinent days (5.6%), and social adjustment (5.2%). None of the other SADQ sub-scales predicted total GHQ scores.

CHAPTER TWELVE WOMEN AND ALCOHOL PROBLEMS

In the previous chapter, one fifth of clients attending a voluntary agency presented for treatment with an alcohol problem which has been complicated by affective disorder, phobic anxiety or personality disorder. Similar levels of formal psychiatric disorder were apparent in patients attending an ATU. These types of disorders have been reported as more likely to occur in women rather than men. Apart from psychiatric disorder, women are said to develop more serious consequences from their drinking than their male counterparts. Female alcoholics attending psychiatric facilities are said to be particularly impaired, although women attending community based agencies have seldom been studied. The following hypotheses will therefore be examined;

9. Are there significant differences between men and women with alcohol problems, in terms of severity of dependence on alcohol and alcohol-related problems?

10. Is their evidence that women suffer greater degrees of maladjustment and psychological disturbance, including high levels of denial?

11. Are there major differences between women attending a community based voluntary agency and those attending an Alcohol Treatment Unit located in a psychiatric hospital, in particular is the hospital group more severely impaired?

The focus of this section is on sex differences. As the previous chapter reported a series of comparisons between Glasgow Council on Alcohol and an Alcohol Treatment Unit, only where there are significant between agency differences will these be mentioned in the text. Unless stated otherwise the significance levels quoted are for the F-test in ANOVA for continuous scales, and chi-squared for categorical variables.

SOCIODEMOGRAPHIC AND CLINICAL CHARACTERISTICS

There were no significant differences between the sexes in age, social class, employment status, or marital situation (Table 16).

TABLE 16 Socio-demographic feature of men and women

	Men (n=69)	Women (n=31)
Married	40%	52%
Single	25%	32%
Separated	12%	3%
Divorced	16%	7%
Widowed	7%	6%
Mean Age	42	40
SD	10	11.3
Employed	41%	51%
Unemployed	53%	26%
Housewife/ Retired	6%	23%

Men were significantly more dependent on alcohol as measured on the SADQ, with a mean score of 27.1 compared with a mean score of 19.7 for women ($p<0.01$) (Table 17). Some differences in subtest scores were apparent as men drank larger quantities of alcohol ($p<0.001$), described more drinking to relieve withdrawal symptoms ($p<0.01$) and reported the rapid reinstatement of withdrawal symptoms after resuming drinking ($p<0.05$). Attenders at the ATU were more likely to have affective withdrawal symptoms ($p<0.05$) and relief drinking occurred more frequently amongst this group ($p<0.05$). There were no interaction effects.

TABLE 17 A comparison of sex and agency differences on SADQ and subscales

	df	Sex F ratio	Agency F ratio
Physical Withdrawal	1,96	2.86 NS	2.19 NS
Affective Symptoms	1,96	1.91 NS	3.88 p<0.05
Relief Drinking	1,96	7.49 p<0.01	4.43 p<0.05
Quantity Drunk	1,96	3.05 p<0.001	1.05 NS
Reinstate-ment	1,96	3.94 p<0.05	0.05 NS
Total SADQ	1,96	6.45 p<0.01	3.11 NS

Both men and women acknowledged a wide range of alcohol-related problems, with larger percentages of men in every problem category. In particular men were more likely to have legal difficulties ($p<0.05$) and money worries ($p<0.01$) (Table 18). In view of the greater susceptibility of women to physical damage it was surprising that only 19% of the sample had been told their liver was damaged, compared to 27% of men. Women were also prepared to acknowledge difficulties not usually associated with female drinking, for example 21% reported being asked to leave a public place because they were intoxicated. Men rather than women scored more highly on the "common" problems subscale ($p<0.001$) (Table 19).

TABLE 18 Sex differences in Problems with Alcohol Scale

	Males	Females	chi-squared
Ulcers/ Stomach Trouble	18%	13%	NS
Liver Trouble	27%	19%	NS
Accident	54%	36%	NS
Missed Work	68%	52%	NS
Trouble at Work	53%	35%	NS
Arguments at Home	83%	77%	NS
Violent Arguments	21%	12%	NS
Threatened/Actual Rupture	36%	24%	NS
Money Worries	61%	29%	$p<0.01$
Police Trouble	45%	23%	$p<0.05$
Asked to leave a public place	37%	21%	NS

Half of the women (56%) and 35% of men were socially stable. Only one woman (3%) was seriously disadvantaged with no job, spouse or family home, while 10% of men fell into the "skid row" category. In terms of overall score men were more socially unstable ($p<0.01$) and had experienced more recent social disruption ($p<0.05$) than women, irrespective of the agency attended (Tables 19 and 20).

On the Social Adjustment Scale there were no significant differences between the sexes on overall rating of social adjustment, the subscales measuring work performance, social and leisure activities and interaction with extended family (Table 20). Men were significantly more impaired in their roles as husbands ($p<0.05$) and as parents ($p<0.01$).

TABLE 19 A comparison of sex and agency differences

	df	Sex F ratio	Agency F ratio
GHQ Total	1,95	0.04 NS	2.50 NS
Social Stability	1,96	5.11 p<0.01	0.97 NS
Social Disruption	1,96	3.81 p<0.05	0.92 NS
Problem Total	1,96	11.33 p<0.001	0.57 NS
Time in Treatment	1,96	9.14 p<0.01	0.66 NS

TABLE 20 A comparison of sex and agency differences on the Social Adjustment Scale

	df	Sex F ratio	Agency F ratio
Work	1,66	2.0 NS	3.8 p<0.05
Social	1,96	2.3 NS	2.7 NS
Family	1,92	1.6 NS	5.1 p<0.05
Marital	1,49	4.8 p<0.05	1.0 NS
Parental	1,55	7.1 p<0.01	2.3 NS
Global	1,96	3.2 NS	0.8 NS

This result requires some explanation as it seems opposite to what one would sensibly expect. It probably reflects the difficulty in making meaningful comparisons between the roles of men and women in the areas of parenthood and being a spouse. Attenders at the ATU were

more likely to have impairment in work performance ($p<0.05$), and relationships with extended family ($p<0.05$), irrespective of sex.

Denial or minimisation of problem drinking has been considered to be a feature of women drinkers. This obviously poses a problem when comparisons are made between men and women. Any differences found may be due to women consistently under-reporting the adverse consequences of their drinking. Results for "denial" were fully reported in Chapter 10, but of relevance to this section, only a very small proportion of men (12%) and women (10%) claimed to be having no difficulties in their use of alcohol. A quarter of men (25%) and 19% of women placed themselves at the maximum point on the scale, indicating that their difficulties with alcohol "could not be worse". The mean score for men was 7.0 and 6.8 for women, and contrary to prediction there were no statistically significant differences between the sexes in acknowledging alcohol as causing them difficulty.

There appeared to be some evidence that females may be more sensitive to the effects of their drinking. Despite a consistent pattern of less severe alcohol problems for women, the sexes did not differ in their willingness to acknowledge alcohol as a problem. The raters also assessed women as having a less severe alcohol problem on the visual analogue scale ($t=2.73$, $p<0.01$).

Failure to involve patients in treatment is often attributed to denial, although in this sample women remained in treatment for significantly longer periods. They attended for an average of ten weeks compared to five weeks for men ($p<0.01$) (Table 19). Attendance

beyond a six month period was a relatively infrequent event for both sexes. Ninety-four per cent of men and 84% of women had left treatment before this point. No significant between agency effects were noted. Because of these factors it seems unlikely that the findings reported in this study are due to inaccurate answers from female subjects.

SEX DIFFERENCES IN CLINICAL DISORDER AND PSYCHOLOGICAL SYMPTOMS

As there were no major differences between the samples attending different agencies in terms of psychiatric disorder, data were pooled to examine sex differences. Ten percent of both men and women displayed symptoms of depressive disorder. Four percent of men and 16% of women had experienced a phobic disorder (chi-squared, NS). There was some overlap between those who were depressed and phobic. One man and two women, all three attending the ATU, had both disorders. This meant that the absolute numbers of subjects with these difficulties was similar in both samples. In the previous year 13% of men and 19% of women reported a psychological disorder of clinical intensity (Table 21).

TABLE 21 Percentages and numbers of men and women with clinical disorder

	Males n=69	Females n=31
Phobic	2.8% (2)	9.6% (3)
Depressed	8.6% (6)	3.2% (1)
Phobic and Depressed	1.4% (1)	6.4% (2)
Total	13% (9)	19% (6)

High levels of psychological distress as measured on all subtests of the GHQ were apparent for the majority of subjects, irrespective of sex or agency. Using cut-off points suggested by Goldberg and Hillier (1979) for caseness, 77% of men and 80% of women obtained a score of 5 or more at the time of initial interview. A two-way ANOVA was carried out to examine the effects of sex and agency attended. Overall there were no significant differences between males and females (Table 19). The male mean score was 11.6 (SD=8.5) and the mean female score was 12.0 (SD=7.6).

There were no statistically significant differences between the number of men (36%) and women (45%) who were prescribed drugs in the 12 months before the interview. The most commonly used drugs were anxiolytics, consumed by 30% of men and 29% of women. More women (26%) than men (7%) were prescribed hypnotics ($p<0.05$), and 6% of men, and 19% of women received analgesics (NS). There were no significant differences between men (6%) and women (13%) in the use of antidepressants. There appeared to be a tendency for women to be prescribed two or more different kinds of drugs, 26% compared to 10% of men, but this difference was not statistically significant.

A higher percentage of women had overdosed in the past, 29% compared to 15% of men. These differences were also apparent within the previous twelve months as 6% of men and 16% of women had overdosed. None of these differences were statistically significant.

COMPARISONS BETWEEN WOMEN ATTENDING DIFFERENT AGENCIES

Women attending the ATU had elevated levels of phobic disorder compared to all other groups, 25% (n=4) compared to 7% (n=1) of GCA females, 6% (n=2) of ATU males and 3% (n=1) of GCA males.

TABLE 22 Percentages and numbers of women with psychiatric disorder attending GCA and the ATU.

	Males		Females	
	GCA (n=35)	ATU (n=34)	GCA (n=15)	ATU (n=16)
Phobic Disorder	3%(1)	3%(1)	7%(1)	12.5%(2)
Affective Disorder	11%(4)	6%(2)	7%(1)	-
Phobic and Depressed	-	3%(1)	-	12.5%(2)
Total	14%(5)	12%(4)	14%(2)	25%(4)

Using Fisher's exact test, none of these differences were significant. Amongst the group of ATU female phobics, 12.5% (n=2) attracted a further diagnosis of affective disorder causing an overlap between the two categories. No attender at GCA had an overlap between these two categories (Table 22).

Using ANOVA there were no significant differences between women attending the ATU and GCA on SADQ, "common" problems with alcohol scale, social stability, social disruption and all aspects of social adjustment. Psychological symptoms as assessed by the GHQ were higher in the ATU sample with a mean score of 14.33, compared to 9.73 in the GCA group, but these differences failed to reach statistical significance.

Overdoses (ever) were also a feature of this group, 44% compared to 13% of GCA women (chi-squared, NS). This female ATU group contained numbers of women with psychological symptoms, psychiatric disorder and a history of overdoses features which are consistent with the stereotype of the alcoholic woman.

DISCRIMINANT ANALYSIS

In the two previous chapters, univariate analyses of the data had indicated that there were few differences between attenders at different agencies on a wide range of variables. A multivariate approach, using discriminant analysis with agency attended as the classification variable was carried out. The independent variables used in the analysis were dependence on alcohol, alcohol problems, social adjustment, clinical diagnosis and GHQ scores. Using this technique 55% of subjects were correctly classified according to agency, which is no better than chance.

From the results in this chapter, sex appeared to be a more powerful classification variable than agency attended. Using the same range of variables a further discriminant analysis was carried out. There were significant differences between the discriminant scores (Wilks' lambda statistic=0.85, $p<0.05$). However when the classification of cases into groups was examined, only 62% of cases were correctly classified which is only slightly better than chance.

CHAPTER THIRTEEN DISCUSSION

CLIENT CHARACTERISTICS AND HELP-SEEKING PATTERNS

The assumption that clients using a community-based treatment agency in the form of a Council on Alcohol have less serious alcohol problems uncomplicated by physical and social difficulties was not confirmed. On the contrary Council clients displayed a wide range of difficulties, many were severely impaired and one third had an established pattern of physical dependence on alcohol. Most clients attended the Council for a brief period of time and this confirmed the findings of the first study reported in this thesis, namely that a quarter of clients failed to return after their first contact and that by six months the overwhelming majority were no longer attending the agency. Paradoxically, the target client group that Councils were set up to deal with were those who stayed the least time in counselling. Those with more severe problems stayed for a relatively longer time in treatment.

Considerable support for Ogborne et al.'s (1985) analysis of help-seeking behaviour as unstructured and chaotic was provided by the present study. Problem drinkers were observed to use many different agencies, with high degrees of crossover over a brief time scale. Attenders at both GCA and the ATU had help-seeking patterns similar to those described for other populations which were discontinuous and unco-ordinated and featured multiple service contacts and on occasion simultaneous use of different services (Delahaye and Hore, 1974; Ogborne et al., 1985).

This mismatch between clients and treatment resources has probably occurred for a number of reasons. It is perhaps not surprising, in that given relatively free access to health care it may be optimistic expect that those in crisis are in a position to assess their problems and present themselves at the most appropriate agency. The situation is compounded as the majority of services allow direct access, and some including Councils on Alcohol actively promote self-referral. There has also been a growth in all types of service provision with no overall planning or co-ordination (Baggot, 1990). Finally the pattern of service use also reflects to some extent the nature of the disorder itself. Alcohol problems often result in acute and distressing crises, when patients and their families seek help urgently and feel unable to wait for appropriate referral. Together these factors have produced the present chaotic situation.

The question that must be asked is, does it matter? It has already been noted that it can be difficult to attract drinkers into treatment and that the majority of drinkers never receive formal help for their difficulties (Edwards et al., 1973). At least a variety of accessible agencies increases the chances of the drinker attending at least one agency even if it is not entirely appropriate. The author has some sympathy with this view, although given the current political and financial climate it is no longer tenable. Added to this, the amount of research available on effective treatment methods and the spiralling cost of health care make it unlikely that this situation will continue for much longer.

A GRADED INTENSITY APPROACH TO TREATMENT

At the clinical level there has been a fundamental change in the way treatment is viewed. The Institute of Medicine (1990), in an analysis of the evolution of treatment has pointed out that treatment for most problems tends to originate when attention is focused on the most severe cases. As time passes and knowledge of the condition increases, it becomes clear that less severe cases exist and that other methods than those originally employed can be used to deal with them. The history of treatment for alcohol problems has followed this progression.

Over the last few years a consensus view has emerged providing general principles for treatment planning (Ogborne and Gavin, 1990). A graded intensity approach has been proposed whereby the intensity of the treatment response is relevant to the magnitude of the presenting problem (Marlatt, 1988). Wherever possible simpler, less intrusive approaches are preferred on an out-patient or day-patient basis. Where these fail, or when the presenting problem is severe or complicated by physical or psychiatric illness more prolonged treatment intervention with occasional use of in-patient services may be required.

In practical terms what does this mean for Councils on Alcohol? It has become clear from the previous research that Councils are not providing services to the early problem drinker but are providing a specialist response to those who have moderate to severe alcohol problems. Treatment provided appeared to be of two degrees of intensity. Many clients, particularly those with less severe problems

remained in counselling for very brief periods of time. Those with more severe problems remained rather longer in counselling. The typical treatment package provided by GCA for this second group is perhaps nearest in spirit to what has been described as "brief" therapy. This consists of about six sessions of out-patient counselling and has been considered to be mid-level in terms of intensity of response (Institute of Medicine, 1990). Some degree of training and expertise is essential for this approach which has much in common with the counselling style favoured by Councils which depends upon a developing relationship between counsellor and client over a period of time.

Perhaps what is less satisfactory is the treatment response to clients with minimal or moderate dependence on alcohol, low levels of alcohol-related problems and relatively intact social support systems. Treatment procedures for this group are in some ways harder to specify as most research work has been carried out with more damaged individuals. More recently workers with a behavioural orientation have designed programmes for use with this type of patient. Because many people give up addictive habits without lengthy professional contact some early intervention procedures involve enhancing the client's own ability to change using brief advice sessions and self-help manuals (Marlatt, 1988). Innovative approaches have developed by researchers working in General hospital settings which were aimed at patients who were socially stable, low dependence drinkers experiencing a medical condition caused or aggravated by a their heavy drinking (Chick, Lloyd and Crombie, 1985). Treatment consisted of a brief, ten minute screening interview carried out by a nurse followed by detailed advice to cut down consumption to recommended "safe " levels, all taking place

within a single session. At a follow-up interview twelve months later, those receiving the advice session had reduced their consumption compared to a no treatment control.

In a primary care project described by Heather (1986) heavy drinkers were advised by their family doctor to reduce their consumption using material from the DRAMS scheme. DRAMS, which stands for Drinking Reasonably and Moderately with Self-Control was designed to be a simple, structured interactive approach suitable for administration by primary care workers. At the first interview the contribution of alcohol to the patients difficulties was discussed, a blood sample was taken and the patient given a self-monitoring card. At the second consultation two weeks later the results of the blood test and the contents of the drinking diary were reviewed and the patient given a self-help manual advising him to cut down his drinking. Further appointments were then made if necessary. These two highly prescriptive approaches are brief and directive and in some ways may be more appropriate to the pattern of service use that has been observed to occur amongst GCA attenders who have relatively less severe problems.

Apart from clients with mild to moderate alcohol problems, there were also attenders at GCA with evidence of severe dependence, physical disease, accompanying psychiatric disorder and poor social support. This group required a more intensive approach in the form of medically supervised detoxification as well as a range of specialised services typically found in an ATU. No formal mechanism for referring clients to other agencies existed although this does occur

occasionally through personal contacts. Transfer to other agencies is also inhibited by the prevailing ethos that volunteers should be able to deal with the majority of problems that come their way.

THE WORK OF AN ALCOHOL TREATMENT UNIT

The starting point for this thesis was to evaluate the work of a Council on Alcohol. This cannot be done in isolation without reference to the other major treatment services in the field which are ATU's. By defining and describing the work of one treatment organisation this also sheds light on the work of other agencies. In the first instance there appeared to be little difference between clients at both agencies. Both services had attenders with a wide range of problems although the ATU had patients who were more likely to be physically damaged, to have more psychological symptoms and to have received previous advice about their drinking. Crossover to other agencies was noted, but there was evidence that ATU attenders were more likely to re-attend the ATU.

These results create the impression that GCA and ATU are dealing with very similar populations. However consideration has to be given to the effect of the sampling procedures used, which have had an impact on the group of subjects obtained from the ATU. First of all subjects with obvious brain impairment were excluded from the study because of the difficulty in obtaining accurate information from them. Many ATU's including the one in this study provide a service to patients who sustain neuropsychological damage as a result of their drinking. Considerable resources and expertise are directed towards the assessment and rehabilitation of this group. They are important in terms of health economics, as at present they form a substantial

proportion of the patients who will continue to require long-term, psychiatric care (Smith, 1991).

They have been considered to respond poorly to a variety of alcohol treatments (Miller, 1986b). Organic damage caused by alcohol results in a reduction in the capacities for self-regulation and forward planning, abilities that are central for effective participation in treatment programmes (Heather, 1986). Because of this they are more appropriately placed within an intensive treatment milieu although outcome has not been generally favourable (Shaw et al., 1990). By excluding subjects with organic damage, the composition of the sample has not been significantly affected as they form less than 5% of attenders at an ATU (Smith, 1991).

The second and more important factor that must be taken into consideration was the stratification of the ATU sample by sex. Women made up one third of attenders at GCA, while in the ATU they formed only one fifth of the patient group. A review of the relevant research made it likely that females would present with rather different alcohol problems to their male counterparts. Therefore, in order to provide a valid comparison group, male and female subjects were recruited from the ATU until they were represented in the same ratio as GCA. Subsequent analysis of the data has indicated that there were significant differences between men and women, as women presented with much less severe problems. The effect of this sampling procedures has been to minimise the differences between attenders at both agencies. A representative sample of attenders at the ATU would contain a larger proportion of men, the group which is most heavily dependent on alcohol and is more severely impaired.

The services provided by ATU's reflect the level of disability experienced by patients, some of whom were severely impaired. Many patients lacked the social supports to allow them to benefit from less intensive treatment options and required more intensive help (Chick et al., 1988). Apart from the group requiring intensive input and psychiatric management, other attenders at the ATU could legitimately be seen at a Council on Alcohol as they had moderate degrees of impairment coupled with relatively intact social support systems. Evidence from the research literature suggests that fairly minimal intervention would be an effective option (Orford and Edwards, 1977).

MATCHING CLIENTS TO TREATMENT

In an exploration of the means by which clients could be matched to appropriate treatment, Ogborne et al. (1985) have described a number of mechanisms to promote co-operation, at both the organisational and clinical levels. The model they propose has two components, which are aimed at co-ordinating the treatment of individual clients. The first component is a comprehensive assessment of individual clients, followed by an appropriate referral to assist with the most pressing problems. The second component involves the services of a "case manager" who links up with the client at the time of initial assessment and guides the client through the treatment system, easing access to community services and helping with crises. This assumes levels of common funding and co-operation between agencies which does not exist in the U.K. and which has also been problematic in Canada where this solution was proposed (Ogborne and Rush, 1983).

Since this present study was carried out, the way local Health Boards are constituted and provide services have undergone major changes. A competitive, contracting model of service delivery has been proposed. This restructuring has implications for the way alcohol services are delivered. Health Boards and General Practitioners are now in a position to to purchase client services from voluntary agencies or any other body for their patients. The stress is on cost and value for money which presumably would to some extent avoid some of the duplication of service use that currently occurs.

COST OF TREATMENT

When discussing evaluation methods in Chapter 5 no reference was made to the relative costs of particular treatments, although this has become a highly topical and important dimension. Voluntary counsellors by definition give their services without payment therefore it seems obvious that they are extremely cost effective compared to care provided by salaried Health service employees. However it is important to realise that volunteers cannot operate without a basic infrastructure. A careful screening and selection procedure is carried out on the hundreds of people who apply each year to the SCA for counsellor training. Volunteers also require office premises, administrative back-up and close support and supervision of their counselling work if they are to provide effective services (SCA, 1981).

These functions are carried out by two different groups. Managerial and administrative tasks are carried out by paid staff who nevertheless in keeping with the prevailing ethic of voluntary work

do substantial amounts of unpaid overtime during unsocial hours. Training and the support and supervision of volunteers has typically been carried out by health and social service professionals usually for token payments or honoraria which do not cover the full value of these activities. With the changed relationships envisaged between voluntary organisations and statutory bodies such as the Health Boards and Social Work departments many of these hidden costs will become apparent. The partnership between voluntary agencies and professional workers will undoubtedly be compromised if a competitive, tendering system is adopted for the provision of services. It has already become more difficult to recruit Area Tutors and Council Tutors to supervise and support volunteers and much more reliance has to be placed on other volunteers for this task (Brown, 1991).

Given the rising number of problems and and the uneven distribution of resources in this area the need for co-ordination has never been stronger. Whether empirical data of this type can be used as a basis for the planning and development of services has yet to be tested. Information provided by some of the very simple measures used in this study allows an agency to describe the characteristics of its client group, evaluate whether there is an appropriate match between client needs and available resources and monitor compliance with treatment. The final, and most difficult stage would involve making the appropriate changes to service delivery.

ALCOHOL PROBLEMS AND DENIAL

Visual analogue scales provided a simple device to quantify views about alcohol problems not only from the interviewer's perspective

but also from the patient's point of view. Using this scale, most heavy drinkers, regardless of the agency they were attending, acknowledged that their alcohol use was causing them problems. A small group was identified where there was a major discrepancy between the interviewer and the subject. This group fitted the stereotype of the denying alcoholic, as subjects themselves were willing to report a whole range of alcohol-related difficulties, but not to acknowledge that these were related to their consumption of alcohol. Subjects did not appear to distort or minimise these difficulties but simply refused to formally acknowledge that they were experiencing an alcohol problem.

Despite an initial failure to appreciate their predicament this group remained in treatment for the same amount of time as the non-deniers. The failure to find a link between "denial" at the first interview and compliance with treatment raises an important issue. Many practitioners feel that unless the patient fully accepts the view that their difficulties are alcohol-related treatment cannot proceed. This does not appear to be necessary, certainly as far as attending for treatment is concerned. It may be that an offer of further help should be made regardless of how the patient presents himself at interview.

This is in contrast to the findings of Goldsmith and Green (1988) who studied denial in young offenders referred by the courts. They considered that over half the group examined exhibited outright denial although, as found in this study, subsequent attendance for treatment was not linked to initial denial. The differences between the two studies are probably due not only to the measuring techniques

used, but also to the differing approaches to treatment in America and the U.K. In America, treatment techniques are often heavily confrontational directed towards the patient fully endorsing and adopting a specific view of alcohol problems which has a strong disease orientation (Miller, 1983; Miller et al., 1988). Miller (1988) has suggested that these techniques are in some measure responsible for the high levels of denial encountered as patients are considered to adopt this strategy as a protective device. The levels of confrontation acceptable to British patients are considerably lower and many treatment approaches deliberately adopt a low key reflective style for just this particular reason. Therefore it seems likely that cultural differences in styles of counselling may explain some of the differing findings.

When the "denial" group were removed from the main sample there were still statistically significant differences between subject's and interviewer's assessment of severity although these differences were much less pronounced. In general there was a tendency to present things in a not too unfavourable light rather than obviously "faking good".

Some of the discrepancies between the interviewers and subjects were not always in the ways expected. Almost a quarter of the group felt that their difficulties with alcohol were more severe than the rater did. This has not been described as a feature of problem drinkers, although it has been noted to occur in drug abusing populations and has been considered to be due to subjects presenting themselves to authority figures as "addicted" or "sick" or even "faking bad" (Davies and Baker, 1987). No such interpretation can be drawn from this study but the authors impression was rather that these views

reflected the degree of distress felt by subjects who often attended treatment at times of great personal crisis and reflected naive notions about the possible extent and severity of alcohol problems.

The previous points highlight some of the complexities of the task in hand. From the subject's perspective a number of processes have been described which have been contributing to the discrepancies occurring between subject and interviewer. It is also important to remember that the interviewer or indeed any experienced therapists clinically based model of alcohol problems is derived from seeing perhaps many hundreds of patients. This can be contrasted with the frame of reference provided by patients who are drawing on their own highly personal experiences. It is perhaps optimistic to expect there could be a close match between two observers from such disparate view points.

An appreciation of the universal nature of this phenomenon may make it more understandable and acceptable to therapists. Extreme denial is not confined to alcohol problems but appears to be a common response in dealing with serious conditions. Hackett and Cassem (1974) have observed this phenomena in almost one fifth of general medical patients who have experienced myocardial infarction. They also noted that a similar proportion of patients with serious malignancies exhibited outright denial of their condition.

Although not clinically used in this study there may be benefits to using the visual analogue scales within a counselling session to explore some of the differences between patients and therapists. Finally despite the striking nature of denial encountered in a small

minority of patients in this study, initial levels of denial were not related to subsequent compliance with treatment.

ALCOHOL PROBLEMS AND PSYCHIATRIC DISORDER

Approximately one fifth of clients attending a community based counselling agency had an alcohol problem complicated by phobic disorder, depression or personality disorder. Similar rates of clinical disorder occurred in an alcoholic, psychiatric sample indicating that these disorders were a feature of at least 20% of drinkers regardless of the agency they were attending. It appears that the occurrence of psychiatric disorder in conjunction with an alcohol problem is not simply an artefact of studying psychiatric samples.

These lower rates of clinical disorder are similar to a number of other findings which have been reported when strict assessment procedures were adhered to (Keeler et al., 1979; O' Sullivan et al., 1983). The considerably higher rates found in other studies probably reflect more liberal assessment procedures which rely exclusively on self-report data, and carried out subjects have been intoxicated or withdrawing from alcohol (Schuckit and Monteiro, 1988; Weiss et al., 1992).

Murray and Bernadt (1986) reported that in a comparative study of alcoholic and non-alcoholic psychiatric patients, 15.8% of alcoholics received a further diagnosis of depression, anxiety or phobic neurosis. These authors also noted that 15.4% of non-alcoholic

psychiatric patients in their study also received further diagnoses of these types. This suggests that these disorders may not be more common amongst alcoholics than amongst psychiatric patients with other primary diagnoses. This must cast some doubt on the view that they are of significance in the development of the majority of alcohol problems.

PSYCHOLOGICAL SYMPTOMS AND ALCOHOL DEPENDENCE

Psychological symptoms (as opposed to clinical disorder) were pervasive amongst the groups studied, with most subjects reaching criteria for "caseness". These symptoms were a feature of those who were most severely dependent on alcohol and in particular those who were experiencing regular affective withdrawal symptoms the morning after heavy drinking. Heavy recent drinking and withdrawal from alcohol can produce transient psychological symptoms. In this context GHQ symptoms can be interpreted as measuring the acute levels of distress experienced by patients attending these agencies. There was also additional evidence that these symptoms were likely to decrease with abstinence, indicating that they may not represent an independent clinical disorder. Because of this premature treatment for a supposed clinical disorder before withdrawal symptoms have subsided, would not be warranted.

A possible explanation for the association found between psychological symptoms and lower social class, is that higher socio-economic status may have a protective effect. This phenomenon has been noted in the development of alcohol-related problems by other workers (Drummond, 1990).

DIAGNOSIS AND TREATMENT OF DUAL-DIAGNOSIS PATIENTS

Recently, there has been a great deal of attention focused on what are now described as "dual-diagnosis" patients in terms of assessment and treatment (Weiss, Mirin and Griffin, 1992). A number of guidelines can be derived from this thesis and other research findings. When people seek treatment they are often in acute turmoil but the most likely outcome is that with abstinence from alcohol, coupled with explanation and reassurance these symptoms will decrease rapidly within days (Schuckit and Monteiro, 1988).

Within this group between 15%-20% of patients will be left with symptoms of anxiety or depression of clinical intensity. Approaches to these patients have followed a number of courses. Proponents of the "disease model" of alcoholism have totally rejected psychiatric concepts and methods of treatment, preferring to concentrate exclusively on the presenting alcohol problem as the major method of treatment (Institute of Medicine, 1990). This has been an extreme reaction to the view that alcohol problems are a symptom of an underlying psychiatric condition which requires psychotherapy or pharmacological treatment for the resolution of the difficulty. Both of these approaches have been brought into disrepute, the first because lack of effectiveness and the second, because of the complications that have been produced by addiction to prescribed drugs.

Despite these misgivings, common sense suggests that a substantial minority of alcoholics are likely to benefit from appropriate treatment directed towards the accompanying clinical disorder.

Despite this, examination of research findings indicates that the treatment of depression in alcohol abusers has not produced encouraging results. Having an additional diagnosis of depression was associated with a poorer outcome for men, but an improved outcome for women (Rounsaville et al., 1987). Patients with high "psychiatric severity" had a poor treatment outcome using a variety of treatment types (McLellan et al., 1983). O'Sullivan et al. (1988), in a careful examination of this issue found no differences in outcome between primary alcoholics and alcoholics with affective disorder. In an effort to explain these findings these authors have concluded that once a patient with an affective disorder becomes alcoholic, the addictive process becomes the more clinically dominant illness. They are firmly of the opinion that treatment should be first of all directed towards the alcohol problem. After a period of abstinence, if symptoms of clinical intensity persist they should then be treated by psychological or pharmacological methods.

The interest in phobic anxiety states has come not only from researchers and clinicians in the alcohol field (Mullaney and Trippet, 1979, Stockwell and Bolderston, 1987) but also from other workers (Wilson, 1988). This area of study has been of particular interest to psychologists because of its theoretical links with learning theory (Hodgson et al., 1979; Young et al., 1990). Many of the points made about the assessment and treatment of depression also apply to phobic anxiety states. It is important to observe the condition during a period of abstinence and only if the condition does not improve should a behavioural approach be used. The consequences of failing to address the alcohol problem are that transient withdrawal symptoms are inappropriately and ineffectively treated. Stockwell et al. (1984) have also presented evidence that

physically dependent drinkers experience a worsening of their fears after a period of heavy drinking.

The author is not aware of any specific studies examining the outcome of alcoholics with co-existing phobic disorder but some general observations can be made. A behavioural approach depends for its success on the use of exposure as the main therapeutic strategy. From a theoretical point of view the regular use of a CNS suppressant such as alcohol would seriously reduce the effectiveness of this procedure (Bibb and Chambless, 1986). There is evidence that the use of alcohol acts to retard the process of desensitisation amongst clinically anxious patients (Cameron et al., 1987, Thyer et al., 1986), although this has not as yet been replicated amongst alcoholic patients.

ANTISOCIAL PERSONALITY DISORDER

Only a small number of subjects were considered to meet criteria for antisocial personality disorder and this undoubtedly reflects the stringency of the criteria employed (Weiss et al, 1992). This group were younger, heavily dependent on alcohol and had numerous alcohol related problems and did not remain in treatment for long. They reported very high levels of psychological symptoms presumably due to severe physical dependence in combination with impulsive, aggressive and risk-taking behaviour. As noted previously it was not possible to assess the occurrence of psychiatric syndromes as only one subject had any significant period of abstinence in the previous twelve months. This man experienced an episode of depression while in prison. A number of other researchers have found that the co-occurrence of alcoholism and personality disorder result in

presenting problems of some severity (Hesselbrock et al., 1985; Schuckit, 1973).

The prognosis for this group is generally considered to be poor (Hesselbrock et al., 1985; Schuckit, 1985). It has been suggested that treatment programmes which are highly structured may be more helpful than those which are less rigorous, although data on this is lacking (Miller and Hester, 1986a). Glasgow Council has been involved in developing and providing services for alcoholic prisoners some of whom meet the criteria for personality disorder. In Barlinnie Prison, where the project is situated 45% of prisoners are considered to have alcohol and drug problems. This has involved the provision of pre-release counselling, linking newly released prisoners with counselling agencies and advice to family members (Small, 1991). This approach is currently being evaluated by psychologists at the University of Strathclyde.

WOMEN AND ALCOHOL

In a direct comparison, problem drinking appeared to be a more serious disorder for men rather than women. Men drank larger quantities of alcohol, were more severely dependent on alcohol and had experienced many more alcohol-related difficulties. When examining more fine-grained aspects of social functioning both sexes showed disruption in work performance, social and leisure activities and relationships with their extended families. This meant that despite rather lower levels of most alcohol-related difficulties these more subtle aspects of social functioning were impaired in women to the same extent as men.

Surprisingly men rather than women showed more impairment in their roles as spouses and parents, although there is a sense in which this comparison is not valid as the respective roles of men and women in these spheres is qualitatively different. However men did describe a great deal of friction, low levels of involvement and poor communication with their families leading to a disturbance in these relationships.

A number of points should be kept in mind when direct comparisons are made between men and women. Some of the differences mentioned reflect the finding that women in general display less deviant and aggressive behaviour than men. Even with the development of an alcohol problem there is no reason to suppose that women will act outside the bounds of what are socially prescribed norms of behaviour (Roman, 1988). This to some extent may explains their much lower rates of police involvement, homelessness and social deterioration.

In common with other studies the use of prescribed psychotropic drugs was more prevalent amongst women than men. An exact comparisons with other studies was not possible, as these have tended to concentrate on the use of benzodiazepines where women appear to be the majority users (Busto et al., 1983; Ciraulo, Sands and Shader, 1988). A quarter of the women in this study were prescribed two or more different kinds of drugs. Smart (1979) has interpreted this as reflecting the practices of over-medicating female patients whatever their initial diagnosis. From a treatment perspective the level of drug use must raise concerns about the increased risk of accidental and deliberate overdose as well as the development of dependence on

prescribed drugs. Women in this study had elevated rates of overdoses compared to men, a finding which has been reported by other researchers (Schuckit and Morrissey, 1979; Ross, Glaser and Stiasny, 1988).

There were no differences between males and females in the self-report of psychological symptoms by questionnaire. These findings differ from earlier reports (Beckman 1975) but are in agreement with more recent studies. Ross et al. (1988) using an expanded version of the GHQ with a Canadian sample of alcohol and drug abusers found essentially similar results. Swift et al. (1990) found no sex differences in minor psychopathology using the GHQ with opioid users seeking treatment. It is possible that the use of empirical research methods have produced this type of result as much of the writing on women and alcohol problems has been anecdotal and based on clinical impression rather than the use of more rigorous methods.

The use of stringent assessment procedures resulted in 13% of men and 19% of women identified as having phobic and affective disorders, and 6% of men and 3% of women exhibiting personality disorders. Previous researchers have also reported higher rates of ASP and lower rates of phobic disorders in their male subjects in comparison to female subjects (Hesselbrock et al., 1985; Rounsaville et al., 1987). Equal proportions of men and women in this study had affective disorder. Previous reports have usually found that women have higher rates of affective disorder, but two recent studies (Ross et al., 1988; Robins et al., 1988) found no sex differences.

One quarter of women attending an Alcohol Treatment Unit had affective and phobic disorders forming a small subgroup fulfilling

the stereotype of the anxious and depressed female alcoholic. Simply concentrating on this group in the past may have produced distorted results as it contains the largest proportion of subjects with psychiatric diagnoses. However this is considerably less than has been suggested by other studies and was not typical of the majority of women in either sample.

Because these findings differ from some previous reports, the question of their validity must be raised, as denial or minimisation of problem drinking has been considered to be a feature of women drinkers. To counter this, the interview schedule used included a combination of self-report measures as well as semi-structured interview schedules using all available information. Using a visual analogue scale, women were just as willing as men to acknowledge that their problems were alcohol related. Outright denial was a rare phenomenon for both men and women and no sex differences were found. Poor compliance and low motivation have frequently been considered to be associated with female drinkers, however the women in this sample remained almost twice as long in treatment as the men. Because of these factors it seems unlikely that the findings reported in this study are due to inaccurate answers from female subjects.

There has been much speculation about what constitutes an optimal treatment response for women (Thom, 1986) and whether the provision of entirely separate and unique facilities should be available. Drawing on the results of this research, Councils on Alcohol appear to be an appropriate treatment setting for the majority of women with alcohol problems. Their levels of physical dependence are low and they are therefore not in need of medically supervised

detoxification. They tend to be socially stable with characteristics which would indicate a relatively good prognosis (Straus and Bacon, 1951). This may in part explain why they are present in such low numbers in Alcohol Treatment Units. Part of the function of such units is to detoxify those who are heavily dependent on alcohol and this appears to be more of a male rather than a female difficulty, hence their larger numbers in this type of setting. The provision of psychiatric support for the small group of women whose alcohol problems are complicated by psychiatric disorder would presumably still require a specialist response.

Earlier studies on women and alcohol have not been supported by recent work using more rigorous techniques. However as the number of women in this study was small a replication of the main findings with a larger sample is indicated. There are probably historical and theoretical reasons for the popularity of these view about female alcoholics (Allan and Cooke, 1985). In the context of psychological disorder, Saunders (1980) has argued that in earlier decades when per capita consumption of alcohol was relatively modest especially for women, serious disturbance may have been necessary to cause women to drink. He has suggested that as female drinking become more widely the norm, it is probable that the female alcoholic of today and the future will be different from her counterpart of more abstemious times and therefore more like male drinkers.

There appear to be social and cultural reasons for the popularity of the view that women drinkers are sicker and more abnormal than their male counterparts despite a lack of empirical support. Sociological studies of deviance and psychiatric illness suggest that deviant behaviour that is inconsistent with sex-role expectations,

particularly if it is defined as more appropriate for the opposite sex, is seen as more problematic and more in need of a special explanation (Rosenfield, 1982). Women's alcohol misuse falls into this category of deviant, deviance.

The concentration on a small range of issues centring around themes highlighting the damaged and deviant female has to some extent diverted attention away from much more interesting topics. Given their proposed biological and psychological vulnerability an unanswered question is why so few women drink heavily or develop alcohol related problems? As the provision of effective prevention strategies has become important, it is a matter of concern to identify the protective factors which allow women to be at consistently low risk for problem drinking (Allan, 1991). Ferrence (1980) has speculated that the strong social sanctions that continue to operate against heavy alcohol use in women have had a beneficial effect. She has also suggested that the social circumstances of women may be important. Women have less disposable income, are still employed in closely supervised jobs and encounter less heavy drinking social occasions than men, factors which contribute to lower consumption. She is optimistic that even with an improvement in the status in women this does not inevitably mean a convergence in terms of drinking problems between the sexes. She has noted that the feminist movement has always accorded a high priority to health and it is possible that even more stringent informal sanctions against heavy drinking may occur.

FUTURE DIRECTIONS

The previous research has provided some quantitative and qualitative information about the clients attending a Council on Alcohol. The main question which remains unanswered is, are voluntary counsellors effective in helping clients to resolve their problems with alcohol? The information obtained makes it clear that the clients are a heterogeneous group with a wide spectrum of alcohol problems making it unlikely that a single treatment approach would be helpful to all. In the previous discussion a distinction was made between clients with alcohol disorders of varying levels of severity, and it may be possible to capitalise on these differences to design treatment outcome studies. A useful evaluative strategy for low dependence, socially stable problem drinkers would be a controlled trial examining a self-help manual compared to a standard counselling regime.

Attenders with evidence of more extensive problems have tended to be more compliant with traditional counselling approaches. The familiar format of brief advice versus a standard treatment package which in this case would be an individual counselling approach would be an appropriate research design. The efficacy of brief advice has never been evaluated outside highly prestigious hospital units and it would be of great interest to see if voluntary workers can produce changes of the same magnitude as professional staff.

APPENDIX-INTERVIEW SCHEDULE

THE GENERAL HEALTH QUESTIONNAIRE
GHQ 28

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently

A1 - been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2 - been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3 - been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4 - felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5 - been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6 - been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7 - been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual

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B1 - lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2 - had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual

Have you recently?

B3 - felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4 - been getting edgy and bad tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5 - been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6 - found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7 - been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

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C1 - been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2 - been taking longer over things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3 - felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4 - been satisfied with the way you've carried out your task?	More satisfied	Same as usual	Less satisfied than usual	Much less satisfied
C5 - felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6 - felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7 - been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual

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Have you recently

D1 - been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual

D2 - felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3 - felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4 - thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5 - found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6 - found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7 - found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely not

PREVIOUS TREATMENT

Please record the following for each treatment agency - date of first contact, date of last contact and number of visits.

1. Has your family doctor given you help or advice about your drinking (ie specific counselling, Abstem)?

2. Do you have a social worker?

If yes - has your social worker given help or advice about your drinking - record time and frequency as above.

3. Have you attended AA for help or advice on drinking?

4. Have you seen a psychiatrist for help with your drinking (ie not a specialist unit) - were you an in-patient, out-patient or day-patient?

5. Have you received help from the ATU at Gartnavel Royal Hospital - were you an in-patient, out-patient, day-patient?

6. Have you received help from other ATUs or specialist NHS alcoholism services, were you an in-patient, day-patient or out-patient?

7. Has GCA given you help or advice about your drinking?

8. Have you attended any other Councils for help (eg Clydebank, Dumbarton, Monklands)?

Fill in Drinking Chart for last 12 months

Month	Anchor Point	Drinking: Dependent, Heavy, No Probs, Abstinent

SADQ

FIRST OF ALL WE WOULD LIKE YOU TO RECALL A RECENT MONTH WHEN YOU WERE DRINKING HEAVILY IN A WAY WHICH, FOR YOU, WAS FAIRLY TYPICAL OF A HEAVY DRINKING PERIOD.

PLEASE FILL IN THE MONTH AND THE YEAR:

MONTH ..... YEAR .....

WE WOULD LIKE TO KNOW MORE ABOUT YOUR DRINKING DURING THIS TIME AND DURING OTHER PERIODS WHEN YOUR DRINKING WAS SIMILAR. WE WANT TO KNOW HOW OFTEN YOU EXPERIENCED CERTAIN FEELINGS. PLEASE REPLY TO SUCH STATEMENTS BY PUTTING A CIRCLE ROUND ALMOST NEVER OR SOMETIMES OR OFTEN OR NEARLY ALWAYS AFTER EACH QUESTION.

FIRST WE WANT TO KNOW ABOUT THE PHYSICAL SYMPTOMS THAT YOU HAVE EXPERIENCED FIRST THING IN THE MORNING DURING THESE TYPICAL PERIODS OF HEAVY DRINKING.

PLEASE ANSWER EVERY QUESTION

1. During a heavy drinking period, I wake up feeling sweaty:

   ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

2. During a heavy drinking period, my hands shake first thing in the morning:

   ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

3. During a heavy drinking period, my whole body shakes violently first thing in the morning if I don't have a drink:

   ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

4. During a heavy drinking period, I wake up absolutely drenched in sweat:

   ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

THE FOLLOWING STATEMENTS REFER TO MOODS AND STATES OF MIND YOU MAY HAVE EXPERIENCED FIRST THING IN THE MORNING DURING THESE PERIODS OF HEAVY DRINKING

5. When I'm drinking heavily, I dread waking up in the morning:

   ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

6. During a heavy drinking period, I am frightened of meeting people first thing in the morning:

   ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

7. During a heavy drinking period I feel at the edge of despair when I awake:

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

PLEASE ANSWER EVERY QUESTION

8. During a heavy drinking period I feel very frightened when I wake up:

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

THE FOLLOWING STATEMENTS ALSO REFER TO THE RECENT PERIOD WHEN YOUR DRINKING WAS HEAVY, AND TO PERIODS LIKE IT:

9. During a heavy drinking period, I like to have a morning drink:

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

10. During a heavy drinking period, I always gulp my first few morning drinks as quickly as possible.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

11. During a heavy drinking period, I drink in the morning to get rid of the shakes:

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

12. During a heavy drinking period, I have a very strong craving for a drink when I awake:

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

AGAIN THE FOLLOWING STATEMENTS REFER TO THE <u>RECENT PERIOD OF HEAVY DRINKING</u> AND THE PERIODS LIKE IT

13. During a heavy drinking period, I drink more than a quarter of a bottle of spirits per day (4 doubles of wine or 4 pints of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

14. During a heavy drinking period, I drink more than half a bottle of spirits per day (or 2 bottles of wine or 8 pints of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

15. During a heavy drinking period, I drink more than one bottle of spirits per day (or 4 bottles of wine or 15 pints of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

16. During a heavy drinking period, I drink more than 2 bottles of spirits per day (or 8 bottles of wine or 30 pints of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

IMAGINE THE FOLLOWING SITUATION

1. You have been COMPLETELY off drink for a few weeks.
2. You then drink VERY HEAVILY for TWO DAYS.

HOW WOULD YOU FEEL THE MORNING AFTER THOSE TWO DAYS OF HEAVY DRINKING:

17. I would start to sweat:

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

18. My hands would shake:

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

19. My body would shake:

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

20. I would be craving for a drink:

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

PROBLEMS WITH ALCOHOL SCALE

In the past 2 years have you suffered from any of the following conditions - Stomach or Duodenal ulcer?	No (or definitely not alcohol-related)	0
	Yes (alcohol-related)	1
Not applicable if YES to ulcer Have you been off work because of stomach trouble due to drinking?	N/A	8
	No	0
	Yes, once	1
	Yes, more than once	2
Ever had any liver trouble?	No (or definitely not alcohol-related)	0
	Yes (definitely alcohol-related)	1
Have you been in an accident at work or on the roads in the past 2 years - was alcohol partly to blame (at home for housewives)?	No	0
	Yes	1
In the past 2 years have you missed work for reasons connected with drinking, or were unable to do housework, eg bad hangover?	No	0
	Yes	1
Have you had any trouble at work (a warning, etc) due to drinking or hangovers?	No	0
	Yes	1
	N/A	8
Have you had arguments at home (in family, or where you live) about drinking?	No	0
	Yes	1
	N/A lives alone	8
In these arguments - have blows ever been exchanged (exclude walloping children) Was alcohol involved?	No	0
	Yes	1
	N/A lives alone	8
Have arguments over last 2 years caused your spouse to threaten, or to actually leave?	No	0
	Threatened Rupture ...	1
	Actual Rupture	2
	N/A	8
Have you had any trouble with the police connected with your drinking (in the past 2 years)?	No	0
	Yes	1
Have you ever been asked to leave a place (party, bar, etc) because you'd had too much to drink?	No	0
	Yes	1
	N/A never out of the house	8
	Total Score	____

CLINICAL RATING FOR AGORAPHOBIA

Rate symptoms after 7 days of abstinence.

Score situations which subject would definitely avoid

1. Travelling alone by bus or coach — range 0-1 = 0, 2-4 = 1, 5+ = 2
2. Walking alone in busy street
3. Going into crowded shops
4. Going alone far from home
5. Wide open spaces (eg parks, open country)
6. Leaving the house
7. Being alone at home

Intensity

Elicit subjectives and physiological symptoms.

no symptoms of clinical intensity or tendency to avoid = 0
avoid for a few minutes then return = 1
immediate escape = 2

Frequency

Intensity of 1 less than once per week or Intensity 2 less than once per month = 0

Intensity of 1 more than once per week/Intensity of 2 more than once per month, but less than once per week = 1

Intensity of 2 more than once per week = 2

(Adjust for avoidance causing low frequency of attacks)

$$\text{OVERALL SCORE} = R + I + F = \frac{\text{Total}}{3}$$

CLINICAL RATING FOR SOCIAL PHOBIA

Score situations which subject would definitely avoid

1. Eating with other people (cafes, restaurant, canteen)
2. Being watched or stared at
3. Talking to people in authority (boss etc)

4. Speaking up in a group

5. Being criticised or disagreeing with others

6. Going to parties or social gatherings — range 0-2 = 0, 3-5 = 1, 6-8 = 2

7. Talking to someone you do not know well

8. Signing your name in front of others

Intensity

Elicit subjectives and physiological symptoms

no symptoms of clinical intensity or tendency to avoid = 0
avoid for a few minutes then return = 1
immediate escape = 2

Frequency

Intensity of less than once per week/Intensity of 2 less than once per month = 0

Intensity of 1 more than once per week/Intensity of 2 more than once per month but less than once per week = 1

Intensity of 2 more than once per week = 2

OVERALL SCORE

$$R + I + F = \frac{\text{Total}}{3}$$

0 = 0.5
1 = 0.6 - 1.5 (mild social phobia)
2 = 1.6 + (severe social phobia)

DRUG USAGE

Over the last year has your doctor prescribed any drugs for you?

For Sleep - Hypnotics, sedatives (Mogadon, Heminevrin, Normison, Temazepam, Euhypnos)	YES - 1 NO - 0
For anxiety or panic - Anxiolytics, Ativan (Lorazepam), Serenid- D, Librium, Valium	YES - 1 NO - 0
For depression - Anti-depressants - Mianserin, Triptizol, Lentizol, Anafranil, Bolvidon, Sinequan, Phenelzine	YES - 1 NO - 0
For pain - analgesics - DF118, Fortral, Temgesic, Codeine, Distalgesic	YES - 1 NO - 0
Vitamins (Orovite, BC500)	YES - 1 NO - 0
Antabuse (Abstem)	YES - 1 NO - 0

Duration - How long have you been taking these drugs?

0 = 0 - 4 weeks	Hypnotics/Sedatives
1 = 1 - 3 months	
2 = 3 - 6 months	Anxiolytics
3 = 6 - 12 months	
4 = 1 - 2 years	Anti-depressants
5 = 2 - 5 years	
6 = 5 - 8 years	Analgesics
7 = 8 years +	

In the past - have you ever overdosed with pills and alcohol in an accident?

never.....0
ever.....1
last 12 months 2

Have you ever overdosed with pills and alcohol in a suicide attempt?

never.....0
ever.....1
last 12 months 2

Have you ever been hospitalised because of this?

never.....0
ever.....1
last 12 months.....2

SOCIAL ADJUSTMENT SCALE

Introduction

"I am interested in finding out how you have been doing in the last 2 months. I'd like to ask you some questions about your work, your leisure time and your family life. There are no right or wrong answers to these questions. We want to know the answer that best describes how you have been getting on. If any question does not make sense to you, let me know. Please try to answer all the questions for the last 2 months - that would be from (date) to today. Do you have any questions before we begin?

"The first set of questions has to do with your work"

MALE - "Have you been working continuously since (date)?"

FEMALE - "Do you work full or part-time outside your home?"

worker = 1
housewife = 2
N/A = 8

For worker and housewife

Time lost Have you missed any time from work in the last 2 months. How many days did you miss?

0 - 2 days = 1
3 - 5 days = 2
6 - 10 days = 3
11 - 20 days = 4
21 + days = 5

Impaired Performance

Have you been doing your job well during during the last 2 months.

no impairment = 1
adequate with some impairment = 2
moderate impairment = 3
does poorly = 4
does very poorly = 5

Friction

Have you tended to argue with people you have come into contact with while doing your work (eg neighbours, repairmen for the housewife)

no problems = 1
slight difficulty = 2
moderate difficulty = 3
moderately severe = 4
many severe difficulties = 5

SOCIAL LEISURE

Diminished Contacts

How many close friends do you have. By close friends I mean people you have regularly seen or telephoned during the last 2 months.

9 or more = 1
5 - 8 = 2
2 - 4 = 3
one = 4
no close friends = 5

Reticence

Omit if no close friends. Have you been able to talk openly about your feelings with friends.

reasonably open with at least on person = 1
mildly reticent = 2
moderately reticent = 3
usually unable to discuss feelings = 4
usually unable to discuss feelings anytime = 5

Diminished Social Interactions

How many times have you done something socially with friends in the last 2 months.

16 or more = 1
8 - 15 = 2
4 - 7 = 3
2 - 3 = 4
0 - 1 = 5

Impaired Leisure Activities

Do you have any hobbies or special interests

well-developed interests, on a weekly basis = 1
definite, but less frequent activity = 2
sporadic interest = 3
superficial (eg TV) = 4
no interest = 5

DO NOT ASK IF NEITHER FRIENDS NOR CONTACT

Friction

How have you been getting along with friends during the last 2 months?

Have people gotten on your nerves or made you angry?

smooth relationship = 1
unprovocative but overt difficulty with sensitive situations = 2
rather uneasy tense relationship or one major incident = 3
moderate friction or friction with many people = 4
many furious clashes or is deliberately avoided by all others = 5

Hypersensitivity

Have any of your friends offended you or hurt your feelings in the last 2 months?

behaviour reasonable = 1
behaviour affected but returns to normal within hours = 2
behaviour affected but recovers in days = 3
behaviour altered requiring a week or more to recover = 4
behaviour altered and has not recovered in a month = 5

Diminished Dating

How often have you spent time with a boyfriend/girlfriend in the last 2 months? (Single, divorced, separated, widowed)

more than twice weekly (16 times) = 1
once or twice weekly (8 to 15 times) = 2
once every two weeks (4 to 7 times) = 3
once per month (1 to 3 times) = 4
not at all = 5

Extended Family

The next questions are about your outside family, your relatives, not your husband or children at home. How have you been getting along with your relatives?

Lets start with your parents

Friction

harmonious family relations = 1
fairly harmonious family relations = 2
indifferent or a few disagreements or one major argument = 3
moderate friction involving more than one person = 4
very discordant family relations = 5

Reticent

During the last 2 months have you been able to talk about your feelings and problems openly with any of these relatives?

reasonably open with at least one person = 1
mildly reticent = 2
moderately reticent or occasionally unable to discuss = 3
usually unable to discuss feelings = 4
unable to discuss feelings at any time = 5

Withdrawn

In the last 2 months, have you made an effort to keep in touch with family members or have you waited for them to contact you?

initiates some contact regularly = 1
initiates some contacts = 2
relies on family to initiate contacts = 3
avoids family contacts = 4
no contact with family at all = 5

Dependency

Do you depend on your family for help or advice? for baby sitting? for financial help? when you go visiting or go out is it usually with family or friends?

quite independent = 1
a few dependent relationships = 2
mostly dependent but has other resources = 3
almost totally dependent = 4
completely dependent = 5

Rebellious

Did you do things just to make your family angry or annoyed or just to go against their wishes?

feels no urge to defy family = 1
a little inhibited by need to defy family = 2
some decisions and values determined solely by a need to defy = 3
many important decisions and values determined solely to defy = 4
goes out of way to defy family continuously = 5

Marital

These questions have to do with marriage or a partnership between 2 people. Are you married? Do you live with a member or the opposite sex?

Legally married or remarried and living with spouse at any time during the period = 1
Living in a permanent relationship (at least 2 months) but not legally married (include even if still legally married to a past spouse) = 2
Separated, living alone but still has regular contact with spouse = 3

Friction

How have you and your husband/wife been getting along in the last 2 months?

smooth, warm relationship = 1
a few tensions and disagreements = 2
moderate friction or coolness = 3
marked friction = 4
constant friction, marriage may be breaking = 5

Reticence

Have you been able to talk about your feelings and problems with your husband/wife these last 2 months?

confides freely = 1
keeps back only a little = 2
moderate disability in communication = 3
marked disability = 4
completely unable to express themselves = 5

Domineering Behaviour

Who has been making most of the decisions at home in the last 2 months?

What decisions have you been making? Do you take your spouse's wishes into consideration? Even when he's not there?

Non-domineering = 1
mildly domineering = 2
moderately domineering = 3
little consideration given to spouse's wishes = 4
tyrannical = 5

Submissiveness

If you and your husband/wife have a disagreement on something who usually gets their way? Who usually goes along? Have you been pressured or bullied by your spouse during the last 2 months? Could you give me an example?

can be firm when necessary = 1
firm enough except on unimportant issues = 2
cannot assert self against spouse's firm decisions = 3
cannot assert self against spouse's minor opposition = 4
cannot assert opinion even if invited to do so = 5

Dependency

During the last 2 months have you had to depend on your husband/wife to help you?

reasonably independent = 1
dependent in some ways = 2
moderately dependent = 3
markedly dependent = 4
depends on spouse in least things, cannot care for self = 5

Diminished Sexual Intercourse

Have you and your husband/wife been using any form of birth control of rhythm method?

About how frequently have you had sexual relations in the past 2 months?

16 or more times = 1
8 - 15 times = 2
4 - 7 times = 3
1 - 3 times = 4
none = 5

Sexual Problems

Have you been having any problems during sexual relations - pain, difficulties in reaching a climax?

none = 1
minor frequent problems = 2
sometimes problems but can be normal = 3
significant difficulties = 4
difficulties always experienced = 5

Parent

Lack of Involvement

What kind of things have you been doing with the children during the last 2 months?

active involvement in children's lives = 1
good interest = 2
moderate interest = 3
little interest = 4
disinterested, totally uninvolved = 5

Impaired communication

Have you been able to talk with your children during the last 2 months?

communicates easily = 1
most times can communicate = 2
fair communication = 3
rarely able to talk = 4
never able to talk = 5

Friction

During the past 2 months how much friction has there been between you and the children?

smooth relationships = 1
a little friction or tension = 2
moderate friction = 3
marked friction = 4
constant state of friction or children are intimidated and avoid parent totally = 5

Economic Inadequacy

This last question has to do with your finances. In the last 2 months have you had enough money for your basic needs?

income adequate for needs (not necessarily adequate for wants) = 1
income and reserves adequate with minor problems = 2
income inadequate leading to a major problems and/or small loans = 3
income inadequate, needed supplements from outside resources, subject is having major problems = 4
severe financial problems, totally dependent with no income or reserves, on welfare = 5

Globals - Social Adjustment Ratings

These should be done immediately after the interview. Take into account all information available, and take into account suspected. Refer to manual and do not use average of the interview items.

Work	Good - no maladjustment - 1 Mild maladjustment - 2 Moderate maladjustment - 3 Marked maladjustment - 4 Severe maladjustment - 5
Social Leisure	Good - no maladjustment - 1 Mild maladjustment - 2 Moderate maladjustment - 3 Marked maladjustment - 4 Severe maladjustment - 5
Extended Family	Good - no maladjustment - 1 Mild maladjustment - 2 Moderate maladjustment - 3 Marked maladjustment - 4 Severe maladjustment - 5
Marital	Good - no maladjustment - 1 Mild maladjustment - 2 Moderate maladjustment - 3 Marked maladjustment - 4 Severe maladjustment - 5
Parental	Good - no maladjustment - 1 Mild maladjustment - 2 Moderate maladjustment - 3 Marked maladjustment - 4 Severe maladjustment - 5
Overall Adjustment	Good - no maladjustment - 1 Mild maladjustment - 2 Moderate maladjustment - 3 Marked maladjustment - 4 Severe maladjustment - 5

Straus Bacon Scale

Yes - 1 No - 0

1. Has subject held a steady job for 3 years (in past)?
2. Has he lived in town of present residence for 2 years?
3. Currently living in own, family or friends home?
4. Currently living with wife/common-law wife?

SOCIAL DISRUPTION (For married woman entirely dependent on spouse answer questions on behalf of husband)

Employment How many of past 12 months have you worked?

10 - 12 months/retired	= 0
7 - 9 months	= 1
4 - 6 months	= 2
1 - 3 months	= 3
0	= 4

Income How do you get your main income?

pension/steady employment	= 0
periodic employment/casual work	= 1
sickness, invalidity, unemployment benefit	= 2
supplementary benefit	= 3
begging, hand-outs	= 4

Accommodation

House (rented/owned)	= 0
Private lodgings/bed-sit	= 1
Bed & Breakfast, Dry Hostel	= 2
Private Hotels, Great Eastern Council Hostel	= 3
Talbot, Night Shelter, NFA	= 4

Moving How many times have you moved over last year?

no moves	= 0
1 move	= 1
2 moves	= 2
3 moves	= 3
4 moves	= 4

Legal How many encounters with the law, eg warnings from a police officer, an arrest or summons over last 12 months?

none	= 0
1 - 2	= 1
3 - 4	= 2
5 - 6	= 3
7+	= 4

Prison How much time in custody over last 12 months?

none	= 0
1 - 4 weeks	= 1
1 - 2 months	= 2
3 - 4 months	= 3
4+ months	= 4

TOTAL SCORE

Antisocial Personality

(Ask if evidence of prior instability: poor social adjustment, police troubles)

There are 4 criteria

1. Since age 15, poor occupational performance over several years as shown by at least one of the following. (Note: school may substitute for this criterion in individuals who, by virtue of their age or circumstances, have not had an opportunity to demonstrate their occupational adjustment).

Since you started working have you changed jobs a lot (yes if 3 or more jobs in 5 years, not accounted for by either the nature of the job, or economic or seasonal fluctuations?).....

Have you had periods when you were not working (yes, if a total of 6 months or more during 10 years when expected to work and not due to physical illness)? .....

Did you miss a lot of time when you were working (yes, if absenteeism involved an average of 3 days or more per month when either late or absent)? .....

Total

2. Onset in childhood as indicated by a history of 3 or more of the following (at least one beginning before age 15):

When you were younger .....

did you play truant from school a lot (more that once per year for at least 2 years not including senior year of high school)?

were you ever expelled from school?

did people expect you to make better grades than you did (yes, if academic achievements below level expected on the basis of rater's judgement of likely IQ level)?

were you always breaking the rules at school or home?

were you arrested or sent to juvenile court because of something you had done?

did you run away from home overnight (at least twice while living in a parental or parental surrogate home)?.pa

did you lie a lot?

did you drink a lot before most of the other (boys, girls) of your age?

did you steal things?

did you break windows, destroy property (vandalism)?

did you start having sex long before most of the other (boys, girls) of your age (yes, if unusually early or aggressive sexual behaviour)?

Total

3. At least 2 of the following since age 15:

Since age 15 have you

been arrested (yes, if 3 or more serious arrests)?

been divorced or separated (yes, if 2 or more divorces and/or separations whether legally married or not)?

gotten into fights (physically)?

often gotten drunk every week?

often not paid debts or taken care of other expected financial responsibilities (eg child support)?

ever had a period of time when you had no permanent residence or wandered from place to place with no pre-arranged plans (other than vacations)?

Total

4. There is some evidence of a markedly impaired capacity to sustain lasting, close, warm, and responsible relationships with family, friends or sexual partner. (Thus individuals who demonstrate the capacity for this kind of relationship are not given this diagnosis).

Is there anyone that you feel very close to?

Anyone else?

How long have you felt this way?

Do you help them out when they have problems?
Do you keep the same friends for a long time?

Total

Subject has met criteria for A S Personality YES NO

Depressive Disorder

Rate symptoms after 7 days of abstinence within last 12 months if not currently abstinent. Use Drinking Chart to pin point abstinent periods.

Criteria - The following 3 criteria are required for a definite diagnosis of depressive disorder.

1. Have you had a period that lasted at least one week (ie following a week of abstinence from alcohol) when you were bothered by feeling depressed, sad, hopeless, down in the dumps, that you didn't care any more, or didn't enjoy anything? What about feeling irritable or easily annoyed?

2. During this time (ie when depressed) did you seek help from anyone, like a doctor, or minister or even a friend, or did anyone suggest that you seek help? Did you take medication? Did you act differently with people, your family, at work?

If these 2 criteria are fulfilled proceed to questions for Major Depressive Disorder.

If not fulfilled, fill in the following:

Patient denies depression 0
Patient has fleeting feelings of depression not causing great problems 1

Has patient had at least 4 (if past episodes) or 5 (if current episodes) associated with the most severe period or depressed or irritable mood or pervasive loss of interest or pleasure (inquire for all symptoms).

During the most severe period were you bothered by:-

poor appetite or weight loss, or increased appetite or weight gain?
trouble sleeping or sleeping too much?
loss of energy, easily fatigued, or feeling tired?
loss of interest or pleasure in your usual activities or sex (may or may not be pervasive)?
feeling guilty or down on yourself?
trouble concentrating, thinking, or making decisions?
thinking about death or suicide? (Did you attempt suicide?)
being unable to sit still and have to keep moving or the opposite - feeling slowed down and have trouble moving?

No of definite symptoms =

Subject meets criteria for MAJ DEP YES
NO

If subject fulfils criteria for Major Depression assess for Endogenous Depression - if not proceed to Minor.

From groups A and B a total of at least 4 symptoms for probable, 6

for definite, including at least on symptom from Group A.

A

1. Distinct quality to depressed mood, ie depressed mood is perceived as distinctly different from the kind of feeling he would have or has had following the death of a loved one.

2. Lack of reactivity to environmental changes (once depressed doesn't feel better, even temporarily, when something good happens).

3. Mood is regularly worse in the morning.

4. Pervasive loss of interest or pleasure.

B

1. Feelings of self-reproach or excessive or inappropriate guilt.

2. Early morning awakening or middle insomnia.

3. Psychomotor retardation or agitation (more than mere subjective feeling of being slowed down or restless).

4. Poor appetite.

5. Weight loss (2lbs a week over several weeks or 20lbs in a year when not dieting).

6. Loss of interest or pleasure (may or may not be pervasive) in usual activities or decreased sexual drive).

Subject meets criteria for ENDOG DEP YES
NO

Minor Depressive Disorder

Has subject experienced any of the following during the most severe period of depressed mood. Two needed for a diagnosis.

Note: please count also items endorsed for MAJ DEPRESSIVE DISORDER.

crying?
thinking about things with a pessimistic outlook?
brooding about unpleasant things that happened?
feeling inadequate?
feeling resentful, irritable, angry?
needing reassurance or help from somebody (demandingness, or clinging dependency)?
feeling sorry for yourself (self-pity)?
physical complaints that didn't seem to be caused by any particular physical illness?

Subject meets criteria for Minor Depressive Disorder YES
NO

SELF ASSESSMENT

Thinking about event over the last year - how much of problem has alcohol been to you?

No problem with alcohol

Problems with alcohol could not be worse

---

0 10

Raters Assessment: use line to estimate severity of problem

No problem with alcohol

Problems with alcohol could not be worse

---

0 10

British Journal of Addiction (1987) 82, 1143–1147

Seeking Help for Drinking Problems from a Community-based Voluntary Agency. Patterns of compliance amongst men and women

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Summary

A consecutive series of Problem drinkers (n=112) attending a community-based voluntary agency were followed up over a 6-month period, in order to measure their compliance with treatment. This was assessed by recording time in treatment, number of sessions attended and method of leaving the agency. Particular attention was focussed on source of referral, and women's use of services in a facility which provided female counsellors for women in a non-stigmatized setting.

In common with many other treatment agencies attrition rates were high. This was especially true for self-referrals. However, those coming through the usual referral channels attended more frequently. Clients attending from the Courts, hostels and from employers attained the highest rates of compliance. Women were poorly represented amongst these coercive type referrals, perhaps explaining their lower rates of attendance.

Introduction

Patients with alcohol problems are notorously difficult to engage in treatment. Their help-seeking has been characterized as highly ambivalent and often explained in terms of poor motivation.[1] Depending on the characteristics of the populations studied between 28% and 80% of patients drop out within a month of beginning treatment.[2]

Attrition rates are of interest, partly because there is evidence that drop-outs or sporadic attenders have relatively low rates of remission.[3] Studies of patient compliance in its own right provide information of the quality of service offered, and at the very least its acceptability to the target patient group.

Patient variables have been extensively studied, including severity of the drinking problem, but only crude sociodemographic variables have been reliably associated with premature drop-out.[4,5]

Factors intrinsic to the helping agencies themselves may be influential. Many facilities are based in stigmatized settings like psychiatric hospitals which many patients find embarassing and unacceptable.[6] Long waiting-lists for non-urgent appointments,[7] and no consistent therapist,[2] characterize some treatment settings and have a demonstrable effect on compliance rates.

Shaw[8] *et al.* (1978) have suggested that low morale and poor therapeutic commitment displayed by some professional workers have communicated themselves to patients with subsequent poor uptake of services. The dominant psychiatric model operating with static models of motivation has been particularly criticized as not conducive or helpful to patients with alcohol problems.[9]

Because of the expansion of the voluntary sector in the form of Councils on Alcohol it is now possible to examine compliance rates while altering many of the factors considered to be inimical to sustained help-seeking.

Councils aim to provide an easily accessible, and

rapid response to the problem drinker in relatively anonymous office premises not associated with Health or Social Services. Intervention is carried out by voluntary counsellors who receive a brief training in individual counselling skills using an eclectic non-psychodynamic model.[10] Facilities are limited in that they cannot provide a detoxification service for the heavily dependent drinker, or direct access to medical or psychiatric advice. This provides a degree of homogeneity in the treatment offered.

Source of referral has been an area neglected by those examining compliance rates. Voluntary agencies advertise their services and attract a substantial proportion of self referrals who approach the agency directly without using a referral agent like a General Practitioner. This allows the examination of this type of client compared to those who come by orthodox means, or who are referred by more coercive sources like the Courts or through Employers.

Councils have been successful in attracting women with drinking problems, who may be underrepresented in more traditional facilities. There has been a great deal of speculation about what constitutes an appropriate response to women with drink problems who are considered to be a particularly vulnerable group, although factual data is lacking.[11] Councils provide some of the features which have been suggested as particularly appropriate for this group. This includes providing women clients with female counsellors, to reduce stigma, a flexible appointment system for day or evening and reliance on individual counselling, as women may function less well in groups.[12]

The aims of this present study are therefore, firstly to look at compliance in a community-based facility which uses volunteers as treatment personnel, secondly examine the influence of source of referral and thirdly to look at womens' use of services which are specifically designed to attract and hold them in treatment.

Method

This study was carried out at Glasgow Council on Alcohol (GCA) which was chosen as typical of urban Councils in Scotland. There are now 26 such Councils in Scotland. GCA deals with 600 referrals per year[13] in office premises in the City Centre. Typically clients or referral agents contact the Centre by telephone and are given appointments within 1–5 days.

Subjects

Data was collected on 121 consecutive attenders at GCA during January to March 1986.

Measures—client factors

During the first interview, the counsellor collected details of age, sex, marital status and employment. A full drinking history was taken, covering quantities of alcohol consumed over the last 7 days, significant life problems associated with consumption and signs of physical dependence on alcohol. Self-referrals were those who had contacted the Council because of worries about their drinking, or at the request of their family. Other referral categories were those from family doctors, local hospitals, employers and hostels.

No departure from routine GCA practice was involved as Sutherland *et al.*[14] have demonstrated that intensive research interviews at this point can seriously distort compliance rates. They boosted attendance from a routine 56% to 95% for a second interview during a research project.

Counsellor Variables

Forty-one counsellors were involved in the study, the majority of whom were female (63%). As far as possible female clients were allocated to the same sex counsellor.

Measures of Compliance

A number of measures of outcome were employed. The most widely used method adopted by Baekland[2] involved the following categories:

(1) Immediate drop-outs—clients who attended for their initial appointment and then subsequently fail to return. Counsellors are specifically trained in techniques to inhibit drop-out at this crucial point.

(2) Rapid drop-out—those who attended more than once, but dropped out within a month of initial attendance.

(3) Slow drop-outs—those who dropped out within 2–5 months.

(4) Clinic attenders—those who attended on a long-term basis for 6 months or more. This is based on the notion that sustained attendance over this time period is associated with a more favourable outcome.,[15,16] although not the minimum aim of treatment.

Finally, the method of leaving treatment was noted. Many clients disappear abruptly, and this group were deemed to have left in an 'unplanned manner.' All clients who fail to attend were followed up by telephone or letter, only after these avenues were exhausted was a client finally discharged.

Table 1. *Sociodemographic Indicators*

	GCA (1986)	Edwards (1967)[17]	ATU (1981)[18]
Married	52%	48%	53%
Single	21%	16%	22%
Separated	11%	24%	10%
Divorced	13%	9%	8%
Widowed	2.7%	3%	7%
Employed	61%	67%	41%
Unemployed	31%	32%	49%
Retired/housewife	10.7%	1%	10%
Age (years)	40	43.1	42
Sex ratio	2:1	7:1	4:1

Results

Nine clients (7%) were excluded from the following anlysis, as their main purpose in attending GCA was to seek help on behalf of a relative. All of the 112 clients eventually included in the study were assessed by the counsellor involved as having a drink problem requiring intervention.

Client Characteristics

Most clients were married (52%) with one quarter describing themselves as divorced or separated. A further 21% were single. The majority were employed (61%). The average age was 40 years, with a range from 18 to 65 years. These figures were remarkably similar to those described by Edwards *et al.*[17] in 1967 during a survey of Councils, including GCA. They are also similar to those produced by a Scottish Alcoholism Treatment Unit.[18] The major difference appeared in the sex ratio, as the percentage of women clients attending Councils in 1986 was three times higher than in 1967.

Compliance

Twenty-seven per cent of the sample attended for one interview and than failed to return. This compared favourably with results published by Rees[19] and Rees *et al.*[7] describing 35% and 44% respectively as the initial drop-out from an ATU. However, as time goes on drop-out continued rapidly with a further 37% of clients dropping out over the first 4 weeks. By 6 months a further 29% had left. Long-term attenders in this sample are infrequent with 7% continuing beyond this point.

Glasgow Council on Alcohol's figures are remarkably similar to those described by Silberfield & Glaser.[20] By 3 months 83% of their sample were lost, and by one year, only 5% were still attending. The corresponding figures for this sample are 83% at 3 months, and 7% attending beyond 6 months.

Leaving Treatment

Seventy-two per cent of the sample left the Council abruptly and failed to respond to follow up attempts. Twenty-one per cent left after a mutually agreed period of attendance, while the remaining 7% continued to attend.

Sex Differences

There were some differences between men and women in compliance with treatment although none of the differences reached statistical significance. Over a third of women attended the Council on one occasion (35%) compared to 21% of males. Men attended for an average of 4.7 sessions over an average time of 6 weeks, while women attended for 3.3 sessions over an average time of $4\frac{1}{2}$ weeks. No woman was a 'clinic attender' whereas 11% of men attended for 6 months or more ($\chi^2=4.25$, $p<.09$ NS).

These results indicating almost equal compliance between the sexes do not appear to be attributable to allocating women to female counsellors, who saw 78% of female clients. Using a two-way analysis of variance the sex of the counsellor had no effect on compliance for male or female clients, for time in treatment ($F=1.72$, $p<.3$ NS) or number of sessions ($F=1.168$, $p<.3$ NS).

Source of Referral

Source of referral appears to be important for subsequent attendance. Forty-nine per cent of clients were self-referrals coming directly to GCA. The rest come from a variety of sources with General Practitioners, Hospitals and hostels providing the bulk of what will be described as 'agency referrals'.

Agency referrals are likely to attend more frequently ($t=2.32$ $p<.02$) and for a longer period of time ($t=2.64$ $p<.009$). Fourteen per cent attended

Table 2. *Drop-out Categories*

	Immediate (one interview)	Rapid up to 1 month	Slow drop-out 2–6 months	Clinic attended 6 months and over
Combined (GCA)	27%	37%	29%	7%
Male (GCA)	22%	42%	24%	11%
Female (GCA)	35%	27%	38%	–
Rees[19] (1985)	35%	18%	24%	23%
Rees *et al.*[7] (1984)	44%	6%	35%	15%

Table 3. *Source of Referral*

Referral	Males	Females
Self-referral	45% (n=34)	57% (n=21)
GP	13% (n=10)	5% (n= 2)
Hospital	7% (n= 5)	14% (n= 5)
Courts	4% (n= 3)	0% (n= 0)
Employer	8% (n= 6)	5% (n= 2)
Other*	10% (n= 7)	19% (n= 7)
Hostels	13% (n=10)	0% (n= 0)

* Marriage Guidance, Minister of Religion, other voluntary agencies, etc.

beyond a 6 months cut-off point, while only 1.8% of self-referrals beyond this time.

No differences in marital status (x^2=7.3 d.f.=4 p<.12 NS) employment (x^2=0.46 d.f.=2 p<.79 NS) or age (t=0.07 p<.94 NS), were found between the two groups. However, closer examination of the source of referral indicated that referrals from coercive sources like the Courts, Employers or Hostels where non-compliance with treatment may have rapid and unpleasant consequences are associated with the highest rates of attendance. As a group, coercive referrals compared to self-referrals attend with a high degree of regularity in terms on individual sessions (t=2.77 p<.007) and time (t=2.99 p<.004). The average self referral attended for 3.4 sessions over 3.7 weeks, while the average coercive referral visited the agency for 6.1 sessions over 9.1 weeks. Eighty per cent of non-coercive referrals left treatment abruptly in an unplanned fashion, but this is less likely to be the case with coercive referrals, where 52% left in this way.

Women were poorly represented amongst coercive referrals, as only two women referred by employers fell into this category. Using a two-way analysis of variance to examine the effects of sex differences and referral, coercive referrals attended more frequently (F=4.52 d.f.=1 p<.02) and for significantly longer (F=5.08 d.f.=1 p<.02) irrespective of sex. This may help to explain the lower rates of attendance for women, who in the main are self-referrals or from non-coercive sources.

Discussion

Community based voluntary agencies in common with most other treatment agencies studied have significant numbers of clients whose attendance is very brief. This is especially true for those who are self-referred. Clients in this category appear to be particularly tentative in their help seeking. Realistically, the first session may be the only interview, and it would be unwise to treat this as the prelude to sustained contact. One response would be to concentrate therapeutic effort in the first session, along the lines suggested by Orford & Edwards.[21] This would involve thorough assessment, coupled with clear recommendations on treatment goals at the earliest stage of counselling.

Those who reach treatment through the more usual routes have better rates of compliance. The culmination of this effect can be seen in the high rates of attendance attained by coercive referrals. Far from being insensitive to the pressures exerted by referral agents, clients appear to be highly responsive, at least as far as attending for counselling is concerned. The results from this study would endorse the extension of employee alcohol policies[22] and court referrals for those convicted of drinking and driving offences.[23] Community-based agencies may be particularly appropriate for this type of client.

Explanations of womens' failure to make use of services have tended to suggest they are somehow 'sicker' and more in need of special types of help.[24] Data from this sample on referral sources would tend to suggest that a more mundane explanation may be offered. Women for a variety of social and cultural reasons are less likely to commit offences while intoxicated, be subject to disciplinary proce-

dures at work or become homeless. Because of this they are less likely to be referred from the coercive sources which in varying degrees provided the powerful pressures for men to remain in counselling.

Acknowledgements

The author would like to thank Mr J. Cuthbert (Manager) and Counsellors, Glasgow Council on Alcohol, Dr J. G. Greene for comments on the manuscript and Miss Carole Dempster for typing the manuscript.

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British Journal of Addiction (1989) 84, 73–80

Characteristics and Help-seeking Patterns of Attenders at a Community-based Voluntary Agency and an Alcohol and Drug Treatment Unit

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Summary

The assumption that clients using community-based facilities in the form of Councils on Alcohol have less serious alcohol problems uncomplicated by the physical, social and psychological difficulties found in those attending Alcohol Treatment Units was not confirmed. One of the most striking findings were the similarities, rather than the differences between the two samples. Both groups had attenders who were heavily dependent on alcohol and were experiencing a wide range of problems. Attenders at both agencies, women as well as men, had help seeking patterns similar to those described for other populations which were discontinuous and uncoordinated and featured multiple contacts and simultaneous use of different services. The need for co-ordination was discussed in the light of the improved outcome which can be expected given appropriate matching of clients to treatment. Some suggestions as to how this might be achieved were discussed.

Introduction

Councils on Alcohol specifically targeted at the early problem drinker now make a major contribution to the network of alcohol services. In Scotland alone 6,000 clients per annum were seen by voluntary counsellors in these agencies.[1] Local Councils on Alcohol aim to provide an easily accessible, non-medical response to problem drinkers.[2] The co-ordinating body the Scottish Council on Alcohol (SCA) selects and trains volunteers in individual counselling skills using an eclectic non-psychodynamic approach for this purpose.[3] However, apart from a survey of clients attending three Councils on Alcohol,[4] and a study of compliance, which found that clients attending a voluntary agency, had like their counterparts attending Health service facilities high drop-out rates from treatment,[5] there appears to be little published work on this topic.

This contrasts with patients attending Alcohol and Drug Treatment Units who have been extensively studied. These patients have been characterized as having a wide variety of problems associated with heavy drinking, including physical, social and psychological difficulties.[6,7] A comparison between these two groups would help to highlight the characteristics of those attending voluntary agencies and their specific treatment needs.

The whole process of monitoring and evaluating services has become increasingly important, as economic forces and the growing consumer movement have demanded greater accountability from agencies providing care.[8] Apart from these considerations, past research has indicated that the appropriate matching of clients to treatment can enhance outcome. In particular patients with more extensive difficulties, such as severe dependence on alcohol, physical or social problems may derive more benefit from an intensive treatment approach.[9]

This notion is implicit in the way services tend to be organized, with the assumption that clients seeking help from voluntary agencies will have less severe problems. However, the process by which this is achieved is far from clear. Thom[10] in a theoretical discussion of the use patients make of services has suggested a 'stages' approach to help-seeking. These stages would involve attending one agency at a time, and if this is unsuccessful the patient then discontinues contact and attends another agency which may fulfil his needs. Thom expressed the reservation that this process is unlikely to be a rational progression for most people, but nevertheless provides a useful research device.

Other workers in Canada have noted that problem drinkers interact with many types of agencies and that the management of these individuals is often discontinuous and unco-ordinated.[11,12] In a British context Hore[13] examined the use of services of 624 alcoholics, and found that the majority of patients (83%) had attended at least one other agency, other than the one they were currently attending and that many had multiple service contacts.

High degrees of crossover were noted between all agencies, with some clients attending agencies concurrently. This kind of service use has implications for service planning, if scarce resources are to be used to maximum effect.

Councils on Alcohol appear to be successful in attracting women to their services, as previous research has indicated that one-third of their clients were female, compared to an Alcohol and Drugs Treatment Unit where women formed one-fifth of patients.[5] There has been much speculation about what constitutes an appropriate response to women with drink problems, and it has been suggested that women may be particularly susceptible to barriers and difficulties in entering into treatment.[14] Previous work by Thom[15] with a psychiatric sample has indicated that both men and women have ambivalent attitudes about engaging in treatment. A detailed examination of help-seeking behaviour would indicate whether there are differences in the number and variety of treatment agencies used by men and women.

Using a sample of clients attending a Council on Alcohol, and as a comparison group a sample of patients attending an Alcohol and Drug Treatment Unit, the following points will be examined.

(1) Is there a match between treatment resources and clients? Do Councils intervene at an early stage in the problem drinkers career, before he or she is heavily dependent on alcohol or has suffered other forms of alcohol-related harm?

(2) Is help-seeking an essentially rational process, with clients attending a voluntary agency before using other treatment resources? Is this done over a relatively sustained period, involving a single agency at a time?

(3) Are women particularly vulnerable to barriers in seeking treatment, resulting in relatively few treatment contacts compared to men?

Method

This study was carried out at Glasgow Council on Alcohol (GCA) which was chosen as representative of urban Councils in Scotland. A group of 40 voluntary counsellors supported by paid administrative staff deals with approximately 600 referrals per year[16] in office premises in the city centre. Typically clients or referrals agents contact the Council by telephone and are given an appointment within 5 days. Clients are drawn from all areas of the city. Facilities are limited in that there are no detoxification services or direct access to medical or psychiatric advice. This provides a degree of homogeneity in the service offered which in the majority of cases involves individual counselling sessions.

For purposes of comparison a series of patients attending an Alcohol and Drug Treatment Unit (ATU) situated within Gartnavel Royal Hospital, a psychiatric hospital in the west of the city were obtained. The hospital serves a socially mixed community, including large areas of both local authority and owner-occupied housing. The area is fairly representative of the City of Glasgow as a whole. The Unit provides inpatient detoxification beds, as well as a range of day and outpatient treatment options, both on an individual and group basis. Staffing is on a multi-disciplinary basis and 500 patients per year are seen in the Unit. Examination of ward records and discussion with staff revealed that entry into the Unit's treatment programme was through two main routes. The majority of patients (60%) were given clinic appointments, usually within 3 weeks of referral. The rest attended the Unit at very short notice or without any prior arrangement.

Subjects

Data were collected on a random sample of 50 clients attending GCA counsellors for an initial appointment. Fifty-two clients were asked to take

part in the study, and two refused. Missed appointments with counsellors were a common occurrence, therefore one day per week was allocated for data collection and all new clients attending the agency on that day were interviewed after they had completed their first counselling session. Different days of the week as well as evening counselling appointmens were sampled to avoid possible selection bias. Clients were new referrals in the sense that they were beginning a new episode of treatment, although in common with other agencies a proportion were past attenders.

A comparison group of 50 patients beginning a new contact for an alcohol problem was obtained from an Alcohol and Drug Treatment Unit (ATU) through two methods. A consecutive series of attenders for prearranged clinic appointments were interviewed after they had seen clinic staff. This group made up 58% of the sample, and no patient refused to participate in the study. Patients who attended the Unit as crisis referrals were sometimes not available for immediate interview because of their physical or mental condition. Interviews with this group took place as soon as possible, usually within 2 or 3 days after admission. One day per week was set aside for data collection and new patients available were interviewed by the researchers. Again different days of the week were sampled to avoid bias. All patients asked agreed to participate in the study. A very small proportion of patients discharged themselves from the unit prematurely and were therefore unavailable for interview. Scrutiny of information obtained by the admitting doctor and case notes indicated that these patients did not differ substantially from those seen for interview.

Previous research had already indicated that there were differences in the proportions of men and women attending the two different agencies. Women made up one-third of attenders at GCA, but only formed one-fifth of attenders at the hospital services.[5] Male and female patients were recruited from the hospital Unit until they were represented in the same ratio as the Council sample. Data collection at both agencies took place between May 1985 and April 1986.

The Interview Schedule

In all cases data were collected by direct interview. This was administered by two research workers (the author and a specially trained graduate psychologist) and lasted approximately $1\frac{1}{4}$ h. The interview schedule was pre-tested on a sample of inpatients in the Alcohol and Drug Treatment Unit.

(1) *Socio-demographic Indices.* Details of age, sex, social class,[17] employment and marital status were collected.

(2) *The Severity of Alcohol Dependence Questionnaire (SADQ).* This was used to measure physical dependence on alcohol. A score of 30 and below indicates mild to moderate dependence, while a cut-off point of 31 and above indicates severe dependence.[18] Councils would aim to intervene before this point is reached as they are unable to provide detoxification facilities.[2]

(3) *General Health Questionnaire (GHQ).* The version of this screening instrument used consists of 28 items with four sub-scales measuring somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. A threshold score of five and above was used by Goldberg and Hillier[19] to indicate 'a case'. Particular attention was paid to the sub-scales measuring anxiety and depression as it has been suggested these are rare phenomena outside a psychiatric sample.[3] There are formidable methodological problems in measuring these disorders in problem drinkers, not the least of which is the overlap of withdrawal symptoms with the phenomena being measured. Because of these difficulties no attempt will be made to examine the aetiology of these disorders, but simply to quantify the level of psychological distress experienced by clients attending GCA.

(4) *Straus–Bacon Scale.* Councils hope to intervene before social adjustment indices are grossly affected. These were measured using the Straus–Bacon Scale.[20] This is a 4-point scale which measures social and occupational integration. A maximum score of four indicates a high level of social stability. These type of measures have been demonstrated to be accurate predictors in treatment outcome.[21]

(5) *Problems with Alcohol Scale.* This 12-point scale covers some of the major indices of alcohol-related harm which includes the physical, social and marital consequences of heavy drinking and is of proven inter-rater reliability.[22]

(6) *Alcohol Services.* A checklist containing names of alcohol services in the city and surrounding area was used as a prompt to obtain details of treatment contacts at any time in the past, and in more detail

over the last 6 months.

The following data were sought:

(1) Details of specific advice or help from General Practitioners to alter drinking. Only details of first advice session were noted as in practice it was difficult for clients to recall ongoing advice which was often given in the context of other problems.

(2) Details of contact with Social Work Department, and details of specific advice on drinking problems.

(3) Dates and details of contact with general psychiatric services for help with a drink problem. Attendance at specialist hospital alcohol services, Alcohol and Drug Units and use of residential hostels.

(4) Dates and details of contact with Alcoholics Anonymous.

(5) Dates and details of contact with local Councils on Alcohol.

(6) Details of present contact with GCA including number of individual sessions and length of time in treatment during a 6-month period (see Allan[5] for details of method). Attendance at the ATU was also monitored.

Results

(A) *Characteristics of the Two Groups*

The average age of those who attended GCA was 41 years, with a range from 21 to 65 years. Half of the sample were employed (54%), a further 36% were unemployed, were retired or described themselves as housewives (10%). The social class distribution reflected that found in the general population, as the majority of clients (58%) came from social class III. Most clients were married (44%) with 18% either divorced or separated (Table 1). These figures are similar to the socio-demographic characteristics described for a consecutive series of attenders at GCA.[5]

Using chi-square, there were no significant differences in these indices for attenders at an ATU, although a larger proportion of ATU patients were unemployed. A previous study in this ATU[23] which reported on the characteristics of a consecutive series of referrals to the agency had essentially similar results.

Source of Referrals. Clients came to GCA from a variety of sources. The majority were non-agency referrals (56%) which are made up of self-referrals (28%) or those who have attended at the suggestion of their family or friends (28%) the rest came from GPs (10%) and from employers, hostels, hospitals, social workers and other voluntary agencies, etc. (34%). The pattern of referral to an ATU was different in that the majority of referrals came from General Practitioners, although 16% were self-referrals.

Table 1. *Socio-demographic Features of Attenders at Glasgow Council on Alcohol (GCA) and an Alcohol and Drug Treatment Unit (ATU)*

	GCA $n=50$	ATU $n=50$
Married	44%	44%
Single	26%	28%
Separated	8%	10%
Divorced	10%	16%
Widowed	12%	2%
Mean age	40.8	42
SD	11.7	9.0
Employed	54%	36%
Unemployed	36%	54%
Retired/Housewife	10%	10%
% Female patients	30%	32%

SADQ. In this sample 30% of clients scored above 30 on the SADQ indicating severe dependence on alcohol. The average score was 22.4 (SD=13.2). The Alcohol and Drug Treatment used in this study had a higher average score of 27.1 (SD=14.7), but a similar proportion of those scoring above 30, i.e. 30%. Some differences in subtest scores were apparent with higher rates of affective disturbance ($p<0.04$) and relief drinking ($p<0.04$) in the ATU sample. Therefore, contrary to expectations about a third of GCA clients have an established pattern of physical dependence on alcohol (Table 2).

Table 2. *Comparison of SADQ Scores Between Council Clients and ATU Patients*

	GCA	ATU	*t*-test
Mean	22.4	27.1	$p<0.09$ (NS)
Physical withdrawal	4.1	5.1	NS
Affective symptoms	3.8	5.3	$p<0.04$
Relief drinking	4.4	6.0	$p<0.04$
Quantity	5.6	6.2	NS
Reinstatement	4.4	4.5	NS
% Score over 30	30%	32%	NS

GHQ. Seventy per cent of clients obtained a score of five or more at the time of initial interview,

Table 3. *Comparison of Alcohol-related Problems Amongst Council Clients and ATU Patients*

GCA	ATU	GCA	χ^3
Ulcers/Stomach trouble	8%	30%	$p<0.02$
Liver problems	20%	30%	NS
Accident	48%	48%	NS
Missed work	57%	69%	NS
Trouble at work	60%	54%	NS
Arguments at home	74%	86%	NS
Violent arguments	20%	16%	NS
Threatened/Actual rupture	34%	31%	NS
Money worries	52%	50%	NS
Police trouble	44%	32%	NS
Asked to leave a public place	31%	33%	NS
Average number of problems	3.7	4.5	NS

indicating high levels of psychological distress in this sample. A third of the sample (30%) obtained a score of four or more for the depression sub-scale, and 38% scored above five for anxiety, cut-off points suggested by Aylard *et al.*[24] The hospital sample had a larger proportion of distressed patients (86%) as well as larger groups of depressed (34%) and anxious (54%) patients, but none of these differences reached statistical significance.

Problems with Alcohol Scale. Twenty per cent of clients had been told their liver had been damaged through drinking, and 48% had been involved in an accident when they had been drinking. Many had missed work (57%) and had experienced difficulties while at work (60%). Marital difficulties were particularly frequent, 74% mentioned arguments at home about drinking, and as an indication of severity 34% had experienced threatened or actual of separation. Legal difficulties were common, as 44% described either warnings or arrests by the Police (Table 3).

It seems therefore that clients experienced a wide variety of physical, social and marital difficulties as a result of their drinking. Patients attending an ATU had a similar pattern of difficulty, although a higher proportion had physical difficulties in the form of liver and stomach problems.

Assessment of Social Stability. A third of clients (36%) were socially stable. However, 10% of the sample were seriously disadvantaged with no job, no stable residence, no wife or family home, characteristics associated with a poor prognosis.[20] The rest fell into intermediate categories. There were marginal differences with ATU patients, as the hospital group had slightly more stable patients.

(B) *Seeking Help for Drinking Problems*

Previous Treatment. Contrary to expectations the majority of Council clients (72%) have received specific advice or treatment directed towards their drinking. This ranged from no previous treatment contact (28%), to those who have been in contact with three or more agencies (30%) (Table 4). One very active client managed to become involved with 10 separate agencies. However, after excluding those who have received no previous treatment, clients have been in contact with an average of 2.5 agencies.

Table 4. *Number of Agency Contacts*

No. of Agency contacts	GCA attenders	ATU attenders
0	28%	12%
1	32%	28%
2	10%	26%
3	12%	20%
4	6%	4%
5	8%	8%
6	2%	2%
10	2%	0%
Mean	1.8	1.9

Range of Treatment. A wide variety of agencies were involved in advising about drinking. Nearly half the sample (44%) reported specific advice or treatment from their GP aimed at modifying their drinking. Council clients had extensively used hospital based psychiatric services, both as inpatients and outpatients (44%). They had also attended Alcoholics Anonymous (38%), and 18% were past attenders at Glasgow Council on Alcohol. There was therefore a large degree of crossover between different types of

services. The hypothesis that clients are more likely not to have been involved with other helping agencies was not supported.

Treatment in the Last 6 Months. Not only do clients have many past contacts, some of these have occurred over an extended time scale in some cases more than 10 years ago. More recently, over the last 6 months similar patterns of crossover were noted. This ranged from no treatment contact (38%) to a very active client who had attended five separate agencies. Eighteen per cent of clients had attended three or more agencies.

Treatment in the Last 4 Weeks. Despite embarking on a new contact with GCA some clients were simultaneously involved with other agencies. For example, within the 4 weeks before attending GCA 14% of clients attended an AA meeting and 18% attended a hospital-based unit.

Compliance with Treatment. To see if clients repeated this pattern of tentative contact in their current involvement with GCA compliance was monitored by noting number of individual sessions and recording time in treatment. The results confirm a previous study[5] that a quarter of clients failed to return for a subsequent appointment, and by 6 months 96% of clients were no longer attending the agency.

A similar pattern was observed amongst attenders at an ATU. A smaller proportion of patients had received no treatment or had only one treatment contact; 40% as compared to 60% of Council clients. There was crossover to other agencies, but less extensively than that observed in Council clients. Excluding those with one or less treatment contacts, the rest had an average of three contacts. This was higher for council clients, who had a rate of 3.8 contacts. There was a marked tendency for patients to be past attenders at the ATU ($p<0.002$) suggesting some measure of containment. Direct comparisons in the case of compliance with treatment are probably not meaningful. Councils rely heavily on individual counselling which is more easy to quantify than day-patient or inpatient intervention. However, in crude terms by 6 months 12% of patients were still in contact with the Unit.

(C) *Characteristics of Those with Varying Degrees of Help-seeking Behaviour*

There were significant differences using Student's t between those who had received modest amounts of treatment (i.e. one or no previous contact) and those who had between two and 10 previous contacts. These frequent users or 'help-seekers' were more heavily dependent on alcohol ($p<0.05$), had more alcohol-related problems, more severe psychological symptoms ($p<0.03$) and were less socially stable ($p<0.005$). This more severe group were likely to receive more individual sessions ($p<0.04$) and remain in treatment for longer ($p<0.06$), while those with less severe problems, the main target group for Councils remained in counselling for relatively brief periods of time, for an average of 3.5 sessions over a 7-week period (Table 5).

A similar pattern was found in the ATU sample, with multiple help-seekers likely to have more serious difficulties, although this only reached statistical significance in the number of alcohol-related problems ($p<0.003$).

(D) *The Use Women Make of Services*

Particular attention was paid to women's use of services, and it was found that there were no differences in the number and variety used by them. Like their male counterparts in both GCA and the

Table 5. *Characteristics of Help-seekers Attending GCA*

	0–1 Previous contacts	2–10 Previous contacts	t test
% of clients	60%	40%	
GHQ total score	8.8	14	$p<0.03$
SADQ total score	20.05	27.6	$p<0.05$
Problem score total	3.5	4.2	NS
Social stability	3.05	1.93	$p<0.005$
Individual sessions	3.47	6.75	$p<0.04$
Weeks in treatment	5.17	11.25	$p<0.06$

ATU they had an average of just under two previous contacts. Despite the barriers proposed for them women appear just as persistent as men in seeking out and receiving treatment.

Conclusions

The assumption that clients using a community-based treatment agency in the form of a Council on Alcohol have less serious alcohol problems uncomplicated by the physical and social difficulties commonly found amongst those who attend psychiatric facilities was not confirmed. On the contrary one of the most striking findings were the similarities rather than the differences between the two groups. This mismatch between clients and treatment resources is perhaps not surprising, in that given relatively free access to health care it is perhaps optimistic to expect that those in crisis are in a position to assess their problems and present themselves at the most appropriate agency.

Considerable support for Ogborne *et al.*[11] analysis of help-seeking behaviour was provided by the present study. Problem drinkers were observed to use many different agencies, with high degrees of crossover over a brief time scale. Attenders at both agencies had help-seeking patterns similar to those described for other populations which were discontinuous and unco-ordinated and featured multiple service contacts and on occasion simultaneous use of different services.

In an exploration of this problem Ogborne & Rush[12] have described a number of mechanisms to promote co-operation, at both the organizational and clinical levels. The model they propose has two components, which are aimed at co-ordinating the treatment of individual clients. The first component is a comprehensive assessment of individual clients, followed by an appropriate referral to assist with the most pressing problems. The second component involves the services of a 'case manager' who links up with the client at the time of initial assessment and guides the client through the treatment system, easing access to community services and helping with crises.

Given the rising number of problems and the uneven distribution of resources in this area the need for co-ordination has never been stronger. Whether empirical data of this type can be used as a basis for the planning and development of services has yet to be tested. Information provided by some of the very simple measures used in this study allows an agency to describe the characteristics of its client group, evaluate whether there is an appropriate match between client needs and available resources and monitor compliance with treatment. The final, and most difficult stage would involve making the appropriate changes to service delivery.

Acknowledgements

The author would like to thank Mr J. Cuthbert (Manager), and counsellors, GCA for access to clients and Dr P. Kershaw, Dr J. G. Greene, Dr A. Crawford, Mr B. Piggot and Professor N. Brookes for comments on the manuscript, and A. Miller and P. McColm for assistance with data collection and preparation.

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Health Bulletin 48/5 September 1990

Glasgow Council on Alcohol: Trends and Developments in a Community Based Voluntary Organisation (1968–1989).

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Abstract

Since 1968, Glasgow Council on Alcohol has steadily increased the scope and variety of its efforts to help problem drinkers and their families. Apart from a large increase in client numbers over the last 20 years, there has been a number of interesting developments in identifying 'at risk' groups and directing them into the helping process. Prevention of alcohol problems has also become a major issue for this agency.

Introduction

Councils on Alcohol make a distinctive contribution to the network of alcohol services. In Scotland alone 6,000 clients per annum were seen by voluntary counsellors in these agencies[1]. Glasgow Council on Alcohol (GCA), the largest of these counselling organisations, offered help to 807 clients last year, the highest total since records were kept in 1968.

Councils aim to provide an easily accessible and rapid response to the problem drinker in relatively anonymous office premises located within the client's own community. The co-ordinating body, the Scottish Council on Alcohol (SCA), selects and trains volunteers in individual counselling skills using an eclectic non-psychodynamic approach for this purpose[2].

Councils on Alcohol have now been operating for over 20 years and this seems an opportune time to examine some of the original aims and purposes upon which they were founded and to trace developments since then. Specifically they were hoping to cater for 'that large and hitherto neglected section of the population of problem drinkers who do not seek contact with professional services, but who do not fit in with the atmosphere and ideology of Alcoholics Anonymous'. Problem drinkers without 'such

intractable problems as single homelessness or liver damage' were the target group for this service[3]. The aim therefore was two-fold; to attract the early problem drinker and to extend help to those who were not involved with other services.

Despite an impressive record of expansion which includes the development of 26 local Councils on Alcohol throughout Scotland, there is a dearth of information about the nature of the client group served by these agencies. Only one of the Councils, GCA, has systematically enquired into the nature of its service. This is partly due to the close links it has with the University of Glasgow as well as its position as the largest of the urban Councils. Because of its size there are limitations on the ability to generalise the results to for example a small rural Council with a small number of clients and counsellors. However it is likely that the main findings are of relevance to these other organisations.

How have Councils Developed?

A review of clients attending GCA by O'Donnell[4] during its first nine years from 1968–1977 indicated that Councils were attracting a predominantly middle aged group of male heavy drinkers. He described an identi-kit picture of the typical client as male, aged 42, married and in regular employment. He noted an increasing proportion of women (23 per cent, in 1977) in the client population, and noted that 20 per cent were in their teens and twenties. Referrals came from a variety of sources, the largest group being self-referrals (64 per cent).

At the present time the most noteworthy finding is an increase in numbers, from 127 clients in 1968, to over 800 clients in 1989, (representing a 635 per cent increase).

A study in 1986 of 112 clients carried out by Allan[5] showed that despite the huge increase in numbers very little has changed in the decade since O'Donnell[4] reported his findings. The majority of clients were male, most were employed (61 per cent) and they sought treatment in their early forties. The numbers of females had increased slightly to form 29 per cent of all clients.

Do Community-Based Services Enhance Compliance with Treatment?

Allan's series of 112 clients were followed up in order to measure their compliance with treatment. This was assessed by recording time in treatment, number of sessions attended and method of leaving the agency. Compliance is of interest as patients with alcohol problems are notoriously difficult to engage in treatment. Depending on the characteristics of the populations studied between 28 per cent and 80 per cent of patients drop out within a month of beginning treatment. In common with most other treatment agencies attrition rates were high. Twenty-seven per cent attended for one interview and then failed to return. Long term attenders in this sample were infrequent with only seven per cent continuing beyond a six month point.

Source of referral appeared to be an important factor in subsequent attendance for treatment. Forty-nine per cent of clients were self-referrals coming directly to GCA. The rest came from General Practitioners, Hospitals and hostels etc. and provided the bulk of what were described as 'agency referrals'.

Agency referrals attended more frequently and for a longer time period than self-referrals. Detailed examination revealed that referrals from coercive sources like the Courts, employers and hostels attained the very highest rates of attendance. Far from being insensitive to the pressures exerted by referral agents, clients appeared to be highly responsive, at least as far as attending for counselling is concerned. Self referrals had the lowest rates of attendance, remaining in counselling for 3.4 sessions over 3.7 weeks, while the average coercive referral visited the agency for 6.1 sessions over 9.1 weeks.

The results from this study would strongly endorse the developments which have been occurring in GCA. There have been a number of projects which have deliberately linked potential clients with the Council. This involves alcohol policies negotiated with employers, whereby employees are given the opportunity of receiving help with drinking problems which affect their work performance. At the other end of the social spectrum GCA has developed a hostels project to provide outreach workers for the eight Glasgow District Council hostels for single, homeless men and women. Clients are either counselled in the hostels or are encouraged to attend GCA. Many problem drinkers are convicted of minor alcohol related offences and in conjunction with the District Court some offenders, after assessment receive a deferred sentence on condition that they seek help through GCA. Community based agencies may be particularly appropriate for this type of client where voluntary effort by fellow citizens removes some of the coercive element involved in the operation of such schemes.

Do Councils Serve a Distinctive Groups of Early Problem Drinkers?

There were limits to the conclusions that could be drawn from the previous study, as it was essentially a monitoring exercise involving relatively simple measures of client characteristics. GCA therefore decided to fund a detailed, in-depth evaluation of the clients using its services and compare them to patients attending a unit located in a local psychiatric hospital.

An intensive study of 50 clients attending GCA, and of 50 patients attending the Alcohol Treatment Unit (ATU) in Gartnavel Royal Hospital, was therefore carried out[6].The similarities between the groups were more striking than the differences. Both groups had attenders who were heavily dependent on alcohol and were experiencing a wide range of problems. The ATU group had more physical problems and reported more psychological symptoms as a consequence of their drinking. Contrary to expectations the majority of Council clients (72 per cent) had received specific advice or treatment directed towards their drinking. This ranged from no previous contact (28 per cent), to those who have been in contact with three per cent or more agencies (30 per cent). One very active client managed to become involved with 10 separate agencies.

In view of the limits of funding and the improved outcome which can be expected given appropriate matching of clients to treatment, the need for some co-ordination between treatment organisations has never been stronger. In an exploration of this problem Ogbourne and Rush[7] have described a number of mechanisms to promote co-operation, at both the organisational and clinical level. Perhaps in these times of joint planning and finance between Health Boards and Social Work Agencies a more rational and co-ordinated response to the problem drinker can be devised.

Women and Alcohol

Councils have been very successful in attracting women with drinking problems to their services. Previous research has indicated that one third of their clients were female compared to an Alcohol and Drugs Treatment Unit where women form only a fifth of patients[5]. There has been a great deal of speculation about what constitutes an optimum treatment response to women with drink problems as they are considered to be a particularly vulnerable group[8]. Councils provide some of the features which have been suggested as particularly appropriate for this group. This includes providing women clients with female counsellors, a flexible appointment system and reliance on individual counselling as women may function less well in groups.

Prevention of Alcohol Problems

While increases in the numbers coming to treatment are to be welcomed and encouraged, it is clearly of pressing importance to look at ways to minimise the number of people experiencing such problems. Prevention strategies that have been adopted by the Council have taken a number of forms.

Because of the disabling nature of the alcohol problems experienced by many of these clients, the Council has established a 'dry' social club. This provides alternative social facilities for those who have successfully resolved their drink problem, and is valuable in preventing relapse.

This year the Barlinnie Project in conjunction with the Prison authorities and the Social Work Department will provide pre-release alcohol and drug counselling for prisoners and the families to which they will return. Prisoners will also be actively linked with existing alcohol services.

The Council has developed an Alcohol and Drug Abuse Prevention Team (ADAPT) with the aim of fostering local prevention strategies and will be located in the Maryhill area of Glasgow. Glasgow's first embryonic temperance organisation started in Maryhill in 1829 and had similar aims to the present project which is to encourage moderation and avoid excessive alcohol consumption[9]. Preventive education directed towards children and young people is a priority as a great deal of research has indicated that children form their attitudes about alcohol at a very early age[10]. The team also has a campaigning remit which will encompass the pricing, availability and advertising of alcohol. The well established links between high per capita consumption and the large increases in drink related problems mean that any credible prevention strategy must address these issues[11].

The Future

The notion that if services had a community base large numbers of early problem drinkers would seek treatment has not been realised. However the trend of overtly linking a wide variety of clients to treatment has been a particular fruitful approach. The further targeting of vulnerable groups for example the habitual drunken offender or those convicted of drunk-driving offences may be appropriate developments for the future.

The development of formal links between NHS, Social Work and the voluntary agencies would allow more ease of movement between treatment facilities allowing a more appropriate matching of client to treatment. Finally, successive governments may have done less than they might to reduce individual indulgence in alcohol; more might well be done in this field.

Acknowledgements

The author would like to thank Mr J Cuthbert Manager, and Counsellors, Glasgow Council on Alcohol for access to clients and Dr P Kershaw for access to his patients, also Dr J G Greene and Professor N Brooks for comments on the manuscript, and Christine Mathieson for typing the manuscript.

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British Journal of Addiction (1991) 86, 419–427

RESEARCH REPORT

Psychological symptoms, psychiatric disorder and alcohol dependence amongst men and women attending a community-based voluntary agency and an Alcohol Treatment Unit

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Abstract

One-fifth of clients attending a community-based voluntary agency presented for treatment with an alcohol problem complicated by affective disorder, phobic anxiety or personality disorder. A matched sample of patients recruited from an Alcohol Treatment Unit, and assessed using the same stringent clinical criteria, had similar levels of formal psychiatric disorder, except for a small group of women. One quarter of women in this group were phobic with some overlap of affective disorder. Rates of psychological symptoms as opposed to psychiatric disorder were high in both samples and appeared to be associated with severity of dependence on alcohol. No sex differences were apparent in the rates of psychological symptoms. The practical as well as theoretical implications of these findings were discussed.

Introduction

Surveys of patients attending Alcohol Treatment Units (ATUs) reveal that the presenting alcohol problem may be complicated by affective disorder (O'Sullivan *et al.*, 1983) phobic-anxiety state (Mullaney & Trippet, 1979) or personality disorder (Vaillant, 1983). The common occurrence of these formal psychiatric disorders in conjunction with an alcohol problem has led to suggestions that they may be of aetiological significance. The development of heavy drinking in women has been particularly associated with this view (Beckman, 1975). However, a growing body of evidence now suggests that these difficulties may, in many cases, be secondary to alcohol abuse. It has become clear that the chronic ingestion of alcohol, which is a nervous system depressant, can lead to profound changes in affect which can mimic a depressive episode (Mayfield & Coleman, 1968). Similarly Stockwell & Bolderston (1987) have reviewed a number of studies suggesting that heavy alcohol use is often associated with an increase in anxiety leading to tension induction, rather than the expected tension reduction.

Interpretation of these and many other findings has been difficult for a number of reasons, not the least of which is the almost exclusive focus on highly selected groups of alcoholics receiving treatment in units located in psychiatric hospitals. Woodruff *et al.* (1973) compared patients who were treated at a psychiatric clinic with alcoholic relatives who had not sought treatment. There was great similarity between the two groups in terms of severity of drinking problem; the major difference occurred in the presence of depression in the group who sought treatment. These authors have speculated that those

who are alcoholic and depressed are more likely to present themselves to doctors for treatment, and therefore be available for study. Because of the expansion of community-based voluntary agencies in the form of local Councils on Alcohol a different population is now available for study. These agencies aim to provide an easily accessible, non-medical response to problem drinkers. In Scotland alone 6000 clients were seen in 26 Local Councils during the year this study was carried out (Scottish Council on Alcohol, 1986). At the very least the examination of another alcoholic group would indicate whether depression, phobic-anxiety and personality disorder occur with any frequency outside a psychiatric sample.

Schuckit & Monteiro (1988) have suggested that the severity of an alcohol problem may be a crucial factor in the development of psychological disorder. A combination of the effects of heavy alcohol consumption and the life problems associated with this may lead to an affective disturbance. On the other hand, some workers have felt that psychological disorders are an important correlate of alcohol problems whatever their severity and have built causal hypotheses around this (Weissman, 1977). If drinking to cope with depression or anxiety is important in the development of an alcohol problem these types of symptoms should be found amongst those whose problems are less severe.

Previous research has demonstrated an overlap in severity of symptoms between patients attending an ATU and the clients of Councils on Alcohol (Allan, 1989). The Council group contained a number of clients who had significantly less physical damage and there was also a trend for this group to have less psychological symptoms than those attending a hospital unit. By including a Council and an ATU sample, subjects with a wide range of difficulties can be examined.

Drinking in response to stress has been widely cited as the mechanism by which women develop drinking problems. The suggestion of a stress-related disorder underpinning the more overt drink problem has led to the belief that women with drink problems are more psychologically impaired than their male counterparts (Beckman, 1975). Councils have been very successful in attracting women into treatment. One third of their clients were female, compared to an Alcohol and Drug Treatment Unit where women formed one-fifth of patients (Allan, 1987). Because of their small numbers in this type of setting it has been suggested that these women are unrepresentative of female problem drinkers (Ferrence, 1982). Inclusion of women from a voluntary agency would provide a non-clinical sample for study.

Apart from the restricted range of populations studied, many of the assessment procedures used have been described as over-inclusive and inappropriate leading to wide differences in reported results (Keeler, Taylor & Miller, 1979). Keeler *et al.* (1979), using four different measures of depression on the same sample, found the percentage of patients considered depressed varied from 8.6%, employing a clinical diagnosis, to 69%, using a self-rating scale. They concluded that heavy recent drinking can produce signs and symptoms of depression that can invalidate self-administered tests used for diagnostic purposes as these simply take into account the presence of symptoms. They favour a structured clinical interview to arrive at a diagnosis, as this allows the evaluation of qualitative features such as the severity of symptoms, their history and the circumstances surrounding their occurrence. These types of measures will be used in the following research.

Using a sample of clients attending a Council on Alcohol, and a matched group of patients attending an ATU, the following points will be examined.

1. Are Council clients relatively free of the complications of formal psychiatric disorder in particular affective disorder, phobic anxiety or personality disorder which occur in patients attending an Alcohol Treatment Unit?

2. Can the results from this research which examines a rarely studied population attending a voluntary agency be used to add to current theories about the relationship between psychological symptoms, psychiatric disorder and alcohol dependence?

Method

Subjects

This study was carried out at Glasgow Council on Alcohol (GCA) which was chosen as typical of urban Councils in Scotland (Brown, 1981). A group of 40 voluntary counsellors supported by a small number of administrative staff dealt with approximately 600 referrals during the year the study was carried out (Glasgow Council on Alcohol, 1986). Data were collected to obtain a random sample of 50 clients attending GCA counsellors for an initial appointment. Subjects who were intoxicated or showing evidence of organic impairment were not included. Fifty-two clients were asked to take part

in the study, and two refused. One day per week was allocated for data collection and all new clients attending the agency on that day were interviewed after they had completed their first counselling session. Different days of the week as well as evening counselling appointments were sampled to avoid possible selection bias. Clients were new referrals in the sense that they were beginning a new episode of treatment, although in common with other agencies a proportion were past attenders (18%).

Approximately half of the clients (49%) were self-referrals and came directly to the Council. The remainder came from a variety of sources including G.P.s, hospitals and other voluntary agencies [see Allan (1989) for further details].

Half of the GCA sample were employed (54%), a further 36% were unemployed, were retired or described themselves as housewives (10%). The social class distribution reflected that found in the general population, as the majority of clients (58%) came from social class III. Most clients were married (44%), with 18% either divorced or separated. These sociodemographic characteristics are the same as those found when a consecutive series of GCA attenders were intervewed (Allan, 1987).

A matched group of 50 patients beginning a new treatment contact were obtained from an Alcohol Treatment Unit (ATU) situated within Gartnavel Royal Hospital, a psychiatric hospital in the west of the city. The Unit provides, as part of its services, six in-patient detoxification beds, as well as a range of day and out-patient treatment options. Five-hundred patients per year are seen in the Unit. No patient refused to take part in the study. The sample was stratified to include out-patient attenders as well as in-patients [see Allan (1989) for details]. The majority of referrals were from G.P.s, although approximately 20% of patients were self-referrals.

Previous research had already indicated that there were no differences in the age of GCA clients and ATU patients—40.8 and 42 years, respectively (Allan, 1989). There were, however, differences in the proportions of men and women attending the two agencies. Women made up one-third of attenders at GCA, but only formed one-fifth of attenders at the hospital services. Male and female patients were recruited from the hospital Unit until they were represented in the same ratio as the Council sample.

Previous research has indicated that there were no major differences in sociodemographic indices between the two samples although a larger proportion of ATU attenders were unemployed (54%).

The interview schedule

In all cases data were collected by direct interview. This was administered by two research workers (the author and a specially trained graduate psychologist) and lasted appoximately $1\frac{1}{4}$ hours. The interview schedule was pre-tested on a sample of in-patients in the ATU, and included questions in the following areas.

Measures of dependence and alcohol-related problems

The Severity of Alcohol Dependence Questionnaire (SADQ) was used to measure physical dependence on alcohol (Stockwell, Murphy & Hodgson, 1983). The SADQ covers the main features of the alcohol-dependence syndrome as described by Edwards & Gross (1976) and contains items relating to consumption of alcohol, the physical and affective correlates of withdrawal and the reinstatement of the syndrome after a period of abstinence.

Social stability was measured using the Straus–Bacon Scale (Straus & Bacon, 1951). A maximum score of 4 indicates a high level of social stability. These types of measures have been demonstrated to be accurate predictors in treatment outcome (Costello, 1980).

A measure of social disruption was used which covers occupational, residential, financial and legal stability over the previous 12 months. It is an abbreviated version of a scale used by Smart (1979) for examining the characteristics of male and female alcoholics entering treatment. The maximum score is 24, and poor stability is associated with a high score. It is concerned with recent social disruption, while the Straus–Bacon Scale is concerned with more long-term breakdown of social stability.

A modified version of the Social Adjustment Scale (SAS), which is a semi-structured interview, was used to elicit subtle disturbances in the subjects social functioning. It contains items covering five major aspects of functioning: work as an employee, social and leisure activities, relationships with extended family and roles as spouse and parent. Questions in each area fall into the following categories: the subjects performance on expected tasks, the amount of friction he has with people, and finer aspects of his interpersonal relationships. The items concerning subjective feelings were omitted as

it was felt that these would be adequately covered by the GHQ which was used to measure psychological symptoms.

The scoring for individual items and global ratings ranged from 1 to 5. Ratings were made on the basis of subjects responses, as well as taking into account all available information, rather than relying purely on the patients self-report. In all cases higher scores reflect poorer adjustment. An overall rating of social adjustment was obtained for each subject taking into account all areas of functioning. The period rated was the previous 2 months. The SAS has been extensively used with psychiatric patients (Bothwell & Weissman, 1977) as well as alcoholics (Pottenger *et al.*, 1978) and is of proven reliability and validity (Paykel *et al.*, 1971; Weissman *et al.*, 1971).

Assessment of psychiatric disorder

Many patients attend treatment facilities in a very distressed condition. However, it would be over-inclusive to view such people as clinically depressed. The presence of depressive disorder, as distinct from depressive symptoms [which was measured on one of the sub-tests of the General Health Questionnaire (GHQ)], was assessed using the SADS (Endicott & Spitzer, 1978). This was used in conjunction with the Research Diagnostic Criteria (RDC) which contains a consistent set of criteria for allocating subjects to diagnostic groups (Spitzer *et al.*, 1978). The RDC explicitly requires that diagnoses can only be made if there is no known organic aetiology (including the ingestion of alcohol or drugs) for the symptoms. Because many patients seek treatment after recent periods of heavy drinking the clinical picture is often unclear. Schuckit (1983) has described the commonest of these symptoms as transient, disappearing within 7 days of abstinence in many patients. To avoid spuriously elevated scores, patients were assessed if they had been abstinent from alcohol for 7 days. If they had not had an alcohol-free period preceding the interview they were asked to recall alcohol-free periods during the previous 12 months. All subjects were assisted by the interviewers to complete a drinking history chart which graphed fluctuations in alcohol consumption during this time. This method of eliciting information has been more fully described by Stockwell *et al.* (1984) and was used in this instance. No attempt was made to sort out the chronology of alcoholism and depression as the aim was simply to quantify the levels of disorder present. Assessments were also carried out for the occurrence of antisocial personality disorder using RDC criteria. This category requires that subjects exhibit the disorder before the age of 15 years and is characterized by antisocial activities in many areas of life. A failure to maintain close, warm and responsible relationships is also a feature of the disorder.

Clinical rating scales for agoraphobia and social phobia have been developed by Smail *et al.* (1984) for use in assessing phobic states in alcohol-dependent in-patients. The measures used have clear subjective, behavioural and physiological components and avoid simply focusing on unpleasant mood states, generalized panic, fears of meeting people the morning after a heavy drinking session, withdrawal from many social activities, etc., which are common features in patients who are experiencing the consequences of prolonged heavy drinking. As described previously for depression, only symptoms occurring during periods of abstinence were included.

While drawing up their drinking history chart, subjects were asked to indicate their last drinking day. The number of abstinent days before the interview were then recorded.

Assessment of psychological symptoms

Psychological symptoms were measured using the GHQ. The shortened version used consisted of 28 items with four sub-scales measuring somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. A threshold socre of 5 and above was used by Goldberg & Hillier (1979) to indicate 'a case'. There are formidable difficulties in the interpretation of the occurrence of these types of symptoms in alcohol-dependent drinkers because of the likely overlap with withdawal symptoms. Despite these difficulties the GHQ can be interpreted as measuring the levels of psychological distress experienced by patients attending these treatment agencies.

Results

Prevalence of depressive and phobic disorders in attenders at both agencies

In the previous year 4% of GCA clients and 12% (χ^2, NS) of ATU patients reported phobic anxiety states of clinical intensity occurring during periods of abstinence.

Both samples contained the same proportion of

depressed patients, i.e. 10%. However, in the ATU sample there was some overlap between those who were depressed and phobic. This meant that the absolute members of those with these difficulties were very similar as 14% of GCA clients and 16% of ATU patients reported a psychological disorder in the past year (Table 1).

Table 1. *Rates of clinical disorder*

	GCA	ATU
Affective disorder	10%	10%
Phobic disorder	4%	12%
Phobic and/or affective disorder	14%	16%

Using ANOVA there were no significant differences between the phobic and/or clinically depressed groups and those without these disorders when examining dependence on alcohol, social disruption, social stability or social adjustment. Those who had experienced a clinical disorder in the previous year had higher GHQ scores ($F=4.5$, $p<0.03$). These results were found regardless of whether subjects attended the ATU or GCA.

Sex differences

Women attending the ATU had elevated levels of phobic disorder compared to all other groups, 25% ($N=4$) compared to 7% ($N=1$) of GCA females, 6% ($N=2$) of ATU males and 3% ($N=1$) of GCA males. Using chi-squared, none of these differences were significant. Amongst the group of ATU female phobics, 12.5% ($N=2$) attracted a further diagnosis of affective disorder causing an overlap between the two categories. No attender at GCA had an overlap between these two categories.

As there appeared to be no major differences between the samples in terms of psychiatric disorder, they were pooled to examine sex differences. Ten per cent of both men and women displayed symptoms of depressive disorder. Four per cent of men and 16% of women experienced a phobic disorder (χ^2, NS). There was some overlap between those who were depressed and phobic. One man and two women, all three attending the ATU, had both disorders. This meant that the absolute numbers of subjects with these difficulties was similar in both samples. In the previous year, 13% of men and 19% of women reported a psychological disorder of clinical intensity.

Prevalence of personality disorder

This occurred in 8% of GCA clients. Only one male ATU patient received a diagnosis of personality disorder therefore data were pooled for statistical analysis using Student's t-test. As a group they reported higher GHQ scores ($p<0.008$), were more heavily dependent on alcohol ($p<0.01$) and were more socially unstable ($p<0.0001$), had experienced more social disruption ($p<0.05$) and were less well socially adjusted ($p<0.0001$). They also tended to be younger with an mean age of 32.7 years compared to those without a personality disorder who were aged 41.5 years. This difference did not reach statistical significance (Table 2). Four out of five were male.

Despite the high numbers of psychological symptoms of anxiety and depression reported both at the interview and over the previous year, it was not possible to assess this group during a period of abstinence as only one subject stopped drinking long enough to allow an assessment to be carried out. This man received a diagnosis of depression, which occurred during a period of enforced abstinence in prison.

The relationship of GHQ scores to dependence and problems

The mean GHQ score for the whole group ($N=100$) was 11.75 (SD=8.2), and 78% of subjects obtained a score of 5 or more which represents the cut-off point for 'caseness'. The Pearson product moment correlation coefficient between the total GHQ score and total SADQ was 0.4 ($p<0.0001$), indicating that levels of psychological distress were associated with increased dependence on alcohol.

A further examination was made of the relationship between the GHQ sub-scales and sub-scales of the SADQ. The SADQ has six sub-scales which measure physical withdrawal (Phys), affective withdrawal (Aff), craving and relief drinking (Need), reinstatement after abstinence (Postab) and quantity of alcohol consumed (Alc). The correlations are shown in Table 3. The majority of GHQ sub-scales were significantly correlated with each of the SADQ sub-scales as well as total SADQ. The correlations between affective withdrawal and all GHQ sub-scales were highly significant.

Table 2. *A comparison between subjects with and without personality disorder*

	No personality disorder $n=95$ Mean (SD)	Personality disorder $n=5$ Mean (SD)	t-test (significance)
SADQ total score	24.0 (13.8)	40.2 (11.3)	$p<0.01$
GHQ total score	11.2 (8.0)	21.2 (6.3)	$p<0.008$
Social adjustment	3.3 (0.2)	4.6 (0.5)	$p<0.0001$
Social stability	2.9 (1.1)	0.6 (0.8)	$p<0.0001$
Social disruption	4.4 (9.5)	13 (5.5)	$p<0.05$
Age	41.5 (11.5)	32.7 (11.5)	NS

Table 3. *Pearson correlations of GHQ sub-scale with SADQ sub-scales and alcohol-related problems*

GHQ sub-scales	SADQ (Phys)	SADQ (Aff)	SADQ (Need)	SADQ (Alc)	SADQ (Post-ab)	SADQ total	Abst. days	Social disruption	Social stability	Social adjustment
Somatic symptoms	0.25 **	0.33 ***	0.25 **	0.28 **	0.34 ***	0.37 ***	−0.27 **	0.15	−0.19 *	0.27 **
Anxiety and insomnia	0.29 ***	0.50 ***	0.33 ***	0.24 **	0.35 ***	0.45 ***	−0.22 *	0.24 **	−0.29 **	0.34 ***
Social dysfunction	0.15	0.34 ***	0.25 **	0.24 **	0.10	0.28 **	−0.19 *	0.18 *	−0.17 *	0.23 **
Severe depression	0.18 *	0.45 ***	0.15	0.18 *	0.13	0.28 **	−0.21 *	0.06	−0.17 *	0.22 **
GHQ total	0.25 **	0.49 ***	0.28 **	0.27 **	0.25 **	0.40 ***	−0.27 **	0.17 *	−0.23 **	0.31 ***

*$p<0.05$, **$p<0.01$, ***$p<0.001$.

There was a significant negative correlation between GHQ sub-scales and total GHQ and number of days the subject had been abstinent, indicating that elevated GHQ scores were associated with recent drinking. Indices of alcohol-related problems including social adjustment, social stability and social disruption, were consistently although weakly correlated with all subtests of the GHQ as well as total GHQ.

A regression analysis was performed to explore the relationship between GHQ scores and demographic variables, which included age, sex, social class and the type of agency attended. Subjects were divided into two social class groups of comparable size. Social classes A, B and C1 were combined and contained 55% of the sample and C2, D and E were combined and contained 45% of the sample. Only social class predicted GHQ scores accounting for 6.5% ($p<0.01$) of the variance.

A further analysis was carried out to examine the effects of total SADQ score, social stability, social disruption and social adjustment a number of days of abstinence before interview. Total SADQ score accounted for the greatest amount of variance (16.5%, $p<0.0001$) followed by number of days of abstinence (5.7%, $p<0.009$) and then social adjustment (4%, $p<0.04$).

A regression analysis was performed which included all of the sub-scales of the SADQ as well as indices of alcohol-related problems. Affective withdrawal accounted for 24.7% ($p<0.0001$) of the variance, followed by number of abstinent days

(5.6%, $p<0.006$) and social adjustment (5.2%, $p<0.007$). None of the other SADQ sub-scales predicted total GHQ scores.

Sex differences and GHQ scores

As noted previously sex did not predict GHQ score. A two-way ANOVA was carried out to examine the effects of sex and agency attended. Overall there were no significant differences between males and females. The male mean score was 11.6 (SD=8.5) and the mean female score was 12.0 (SD=7.6). Females attending the ATU had the highest mean score at 14.3 and females attending the GCA had the lowest mean score at 9.7, but neither of these differences were statistically significant.

Discussion

Approximately one-fifth of clients attending a community-based counselling agency had an alcohol problem complicated by phobic disorder, depression or personality disorder. Similar rates of clinical disorder occurred in an alcoholic, psychiatric sample indicating that these disorders were a feature of at least 20% of drinkers regardless of the agency they were attending.

These lower rates of clinical disorder are similar to a number of other findings which have been reported when strict assessment procedures were adhered to (Keeler *et al.*, 1979; O'Sullivan *et al.*, 1983). Murray & Bernadt (1986) reported that 15.8% of alcoholics received a further diagnosis of depression, anxiety or phobic neurosis. These authors also noted that 15.4% of non-alcoholic psychiatric patients in their study also received further diagnoses of these types. This suggests that these disorders are not more common amongst alcoholics than amongst psychiatric patients with other primary diagnoses. This must cast some doubt on the view that they are of significance in the development of the majority of alcohol problems. Despite this, a substantial minority of alcoholics would probably benefit from appropriate treatment directed towards the accompanying clinical disorder.

One-quarter of women attending an ATU had affective and phobic disorders, forming a small subgroup fulfilling the stereotype of the anxious and depressed female alcoholic. However, this is considerably less than has been suggested by other studies and was not typical of the majority of women in either sample.

Only a small number of subjects were considered to meet strict criteria for antisocial personality disorder. This group experienced very high levels of stress, presumably due to severe physical dependence in combination with impulsive, aggressive and risk-taking behaviour.

In contrast, psychological symptoms (as opposed to clinical disorder) were pervasive amongst the groups studied, with most subjects reaching criteria for 'caseness'. They were a feature of those who were most severely dependent on alcohol and in particular those who were experiencing regular affective withdrawal symptoms the morning after heavy drinking. There was also additional evidence that these symptoms were likely to decrease with abstinence, indicating that they may not represent an independent clinical disorder. Presumably appropriate detoxification procedures and sustained abstinence from alcohol would result in a significant decrease in the severity of these symptoms. Premature treatment for a supposed clinical disorder before withdrawal symptoms have subsided, would not be warranted.

A possible explanation for the association of these types of symptoms with lower social class is that higher socio-economic status may have a protective effect. This phenomenon has been noted in the development of alcohol-related problems by other workers (Drummond, 1990).

There were no differences between males and females in the self-report of psychological symptoms by questionnaire. These findings differ from previous reports (Beckman, 1975) but are in agreement with more recent studies. Ross, Glaser & Stiansy (1988), using an expanded version of the GHQ with a Canadian sample of alcohol and drug abusers, found essentially similar results. Swift *et al.* (1990) found no sex differences in minor psychopathology using the GHQ with opioid users seeking treatment.

It is possible that the use of empirical research methods have produced these types of result. Much of the writing on women and alcohol problems has been anecdotal and based on clinical impression rather than the use of more rigorous methods. Typically data have been presented for women alone with the untested assumption that men did not have similar rates of symptoms. This type of 'special' explanation for women, although without empirical support, has had an effect on clinical practice. Psychotropic drug treatment is often directed towards relieving the stresses thought to underpin the heavy drinking (Allan & Cooke, 1986). Schuckit & Morrissey (1979) have found that

prescribing at this point exacerbates rather than ameliorates addictive behaviour.

Acknowledgements

The author would like to thank Dr P. Kershaw for advice and access to his patients, J. Cuthbert and GCA counsellors, Dr J. G. Greene, Prof. N. Brooks for comments on the manuscript, P. McColm and A. Miller for assistance with data collection and preparation and Christine Mathieson for typing the manuscript.

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0022-3018/91/1791-0620$03.00/0
THE JOURNAL OF NERVOUS AND MENTAL DISEASE

Vol. 179, No. 10
Printed in U.S.A.

Acknowledging Alcohol Problems

The Use of a Visual Analogue Scale to Measure Denial

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Despite the frequent mention of denial in the alcohol treatment literature, there appears to be no consensus about its measurement. At its most basic, an operational definition of the term should contain the notion of the drinker refusing to acknowledge or at least minimizing the role of alcohol in his or her difficulties. Visual analogue scales provide a technique for measuring subjective experiences of this type. Subjects from a community-based voluntary agency and an alcohol treatment unit were asked to indicate the magnitude of their problems with alcohol on this scale. Both groups acknowledged high levels of problems with alcohol. Despite this, there was evidence of systematic bias in that half of the sample underestimated the severity of their drinking in comparison to an interviewer's rating using the same scale. A small group was identified that seemed to fit the stereotype of the alcoholic "denier" mentioned so frequently in the treatment literature. There was no relationship between "denial" and subsequent compliance with treatment.

—*J Nerv Ment Dis* 179:620–625, 1991

The unpopularity of the alcoholic patient is often attributed to the frustrating business of dealing with an individual who, despite evidence to the contrary, refuses to acknowledge his or her difficulties with alcohol. This process is enshrined in the notion of denial, which has been considered one of the major obstacles to the recovery of the alcoholic patient (Goldsmith and Green, 1988).

The term itself is an early psychoanalytic concept used by Freud among others, to describe one of the psychic defense mechanisms (Hinshelwood, 1989). Weisman (1984) has suggested that the process involves ignoring or distorting consequences that are unacceptable to the individual. The popular stereotype of the alcoholic who has ruined his health, lost his job, estranged his family, and still claims to be having no difficulties with his alcohol consumption exemplifies the extremes of this behavior.

Goldsmith and Green (1988) have reported the development of a Denial Rating Scale which they have used to assess a group of young male offenders. Ratings were carried out by an interviewer estimating levels of denial in the patient by using written transcripts of interviews. They found that it was pervasive among this group of offenders, who had been "coerced" into treatment as an alternative to a custodial sentence.

In contrast, some workers (Miller, 1983; Miller et al., 1988) have suggested that denial is not a characteristic of alcoholics, but is a product of the confrontational way that therapists interact with patients. Miller has described this as particularly marked in approaches that persuade the client to recognize that he is an "alcoholic" in an effort to "motivate" him toward accepting treatment.

At the other end of the spectrum from mandatory treatment, voluntary agencies like Councils on Alcohol encourage clients to self-refer with the aim of targeting a highly motivated group of clients. It is possible that denial is not a particular issue in this type of setting, in which voluntary counselors are encouraged to adopt a reflective, nonconfrontational counseling style (Brown, 1980). A comparison between attenders at a more traditional treatment facility like an alcohol treatment unit and attenders at a voluntary agency may help clarify the role of agency factors.

Many anecdotal reports of psychiatric populations have suggested that denial is a feature of women with alcohol problems, leading to a reluctance to recognize alcohol as a problem (Sheehan and Watson, 1980). Allan (1990a) found that Councils on Alcohol have been particularly successful in attracting women to its services. While not specifically examining denial, no differences were found between the sexes in their willingness to acknowledge alcohol problems. A more detailed analysis would indicate whether women are more likely to adopt a denial strategy.

Despite the frequent mention of denial in the treat-

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The author would like to thank Mr. J. Cuthbert and counselors on the Glasgow Council on Alcohol for access to clients, and Dr. P. Kershaw for access to his patients, Dr. J. G. Greene and Professor N. Brooks for comments on the manuscript, P. McColm and A. Miller for assistance with data collection and preparation, and Christine Mathieson for typing the manuscript.

ment literature, there appears to be no consensus about its measurement. At its most basic, an operational definition of the term should contain the notion of the drinker refusing to acknowledge or at least minimizing the role of alcohol in his or her difficulties. By implication, this requires that there should be evidence of rather more severe difficulties than are being acknowledged, producing a conflict between the perception of the patient and an interviewer about the severity or even presence of a disorder.

Visual analogue scales (VAS) provide a technique for measuring subjective experiences of this type (McCormack et al., 1988). Most VAS studies have been used for self-assessment; however, several studies have also used them for observer ratings and have reported significant levels of interrater reliability when used in this way (Malpas et al., 1974). This methodology will be used in this study. It differs from previous studies since the measures employed will allow both the interviewer and subject an opportunity to make an assessment of the contribution of alcohol to the subjects current difficulties using the same scale.

The complexities of denial have been used to explain therapeutic failures with alcoholics. Many practitioners feel that unless the patient fully accepts the view that his difficulties are alcohol-related, treatment cannot proceed since compliance will be poor. A quantitative measure of denial obtained using the VAS would allow this hypothesis to be examined.

Apart from outright "denial," the tendency of some subjects to "fake good" or present themselves in a socially favorable light has been recognized for many years (Eysenck and Eysenck, 1966). Davies and Baker (1987) have noted that distortions are more likely to occur when the data are sensitive and have personal significance. This phenomenon has also been noted in a general population study of alcohol consumption in which the heaviest consumers had increased "lie scale" scores (Cooke and Allan, 1983). If faking good does occur, differences between interviewers and subjects should be ones of degree, rather than extreme discrepancies.

The following issues will be examined using a sample of clients attending a Glasgow Council on Alcohol (GCA) and a group of patients attending an alcohol treatment unit:

1. Are subjects willing to acknowledge their use of alcohol as a problem and does this have any relationship to an interviewer's assessment or other measures of alcohol-related problems?
2. Does this type of agency attended or sex of the subject have an effect on self- or interviewer rating?
3. Can a group be identified that fits the stereotype of the "denying alcoholic" and does this have implications for subsequent compliance with treatment?

The data were collected in a study that examined the characteristics of attenders at a community-based voluntary agency and an alcohol treatment unit (ATU) located in a psychiatric hospital. Results pertaining to patient characteristics and help-seeking patterns have been reported in a study by Allan (1989), which also contains a detailed account of the design. An examination of sex differences (Allan, 1990a) and the analysis of the relationship between problem drinking and psychopathology have been reported elsewhere (Allan, 1990b).

Method

Data were collected to obtain a random sample of 50 clients attending GCA counselors for an initial appointment. Fifty-two clients were asked to take part in the study and two refused. Missed appointments with counselors were a common occurrence; therefore, 1 day per week was allocated for data collection and all new clients attending the agency on that day were interviewed after they had completed their first counseling session. Clients were new referrals in the sense that they were beginning a new episode of treatment, although, in common with other agencies, a proportion (18%) were past attenders.

A matched group of 50 patients beginning a new treatment contact was obtained from an ATU. Previous research had already indicated that there were no differences in the age distribution of GCA clients and ATU patients (Allan, 1987). There were, however, differences in the proportions of men and women attending the two agencies. Women made up one third of attenders at GCA, but only formed one fifth of attenders at the hospital services. Male and female patients were recruited from the hospital unit until they were represented in the same ratio as the Council sample. There were two routes of entry to the ATU. The sample was stratified to include not only the routine clinic attender, but also those who attended on an emergency basis (see Allan, 1989, for details). Data collection at both agencies took place between May 1985 and April 1986. Subjects with clinically obvious memory impairment were not included in either sample.

The average age of those who attended GCA was 41 years. Half of the sample were employed, and the social class distribution reflected the general population, since the majority of the clients came from social class III. Attenders at an ATU had essentially similar sociodemographic features, although a larger proportion of ATU patients were unemployed (54%, compared with 36% at GCA). In general, there was an overlap in severity of symptoms between attenders at an ATU and clients attending a Council on Alcohol.

The ATU group contained subjects with more physical damage and there was also a trend for this group to have more psychological symptoms (Allan, 1989).

The pattern of referral to the GCA and the ATU was different. The majority of referrals to the GCA attended through informal means as self-referrals (58%) and referrals from general practitioners (10%) or other agencies (34%). The majority of referrals to the ATU were from general practitioners (68%), followed by self-referrals (16%) and other agencies (16%).

The Interview

Two different techniques were used to obtain information. First, a semistructured interview was used to assess the range of difficulties with alcohol, indices of social adjustment, and compliance with treatment. Second, self-administered questionnaires were used in the assessment of severity of dependence on alcohol and measures of denial. The interview was administered by two research workers (the author and a specially trained graduate psychologist) and lasted approximately an hour and fifteen minutes. The interview schedule was pretested on a sample of inpatients in the alcohol and drug treatment unit.

Assessment of Alcohol-Related Problems

The Problems with Alcohol Scale was used to assess alcohol-related consequences for the subject's family, work, and general health. The scale has been used in a number of other studies and is of proven interrater reliability (Chick et al., 1985). The Severity of Alcohol Dependence Questionnaire was used to measure physical dependence on alcohol (Stockwell et al., 1983) and covers the main features of the alcohol dependence syndrome as described by Edwards and Gross (1976).

Measures of Social Adjustment and Stability

Social stability was measured using the Straus-Bacon Scale (Straus and Bacon, 1951), which measures social and occupational integration. These types of measures have been demonstrated to be accurate predictors in treatment outcome (Costello, 1980). Recent social disruption covering occupational, residential, financial, and legal stability over the previous 12 months was measured (Smart, 1979). A modified version of the Social Adjustment Scale, a semistructured interview, was used to elicit subtle disturbances in the subjects' social functioning. The Social Adjustment Scale has been used extensively with psychiatric patients (Bothwell and Weissman, 1977), as well as with alcoholics (Pottenger et al., 1978), and is of proven reliability and validity (Paykel et al., 1971; Weissman et al., 1971).

Compliance with Treatment

The length of time in treatment during a 6-month period was recorded. This was based on the notion that sustained attendance over this time period is associated with a more favorable outcome (Kissin et al., 1968).

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The Visual Analogue Scale was used to measure the subjective experience of an alcohol problem. The scale consisted of a horizontal, 10-cm line anchored at both ends with words descriptive of the maximal and minimal extremes of the dimension being measured. The anchor terms used in this case were "no problems with alcohol" and "problems with alcohol could not be worse." Subjects were asked to indicate their feelings by marking the line at the appropriate point between the two extreme statements. The interviewers also rated the severity of the subjects' problems with alcohol, taking into account all the information available to them.

Results

Ratings on the Visual Analogue Scale

Subjects from both agencies acknowledged a fairly high degree of difficulty with alcohol. The modal score was 10, and almost a quarter of the group (23%) placed themselves at the extreme end of the scale (Table 1). The average score was 6.9 (SD = 2.6). All subjects were assessed as having some degree of difficulty with alcohol by the interviewers. The modal score was 8, which was applied to 52% of the sample. The mean score was 8.04 (SD = 1.1).

Twenty-two percent of subjects and interviewers arrived at exactly the same rating. Twenty-four percent of the subjects rated their problems as more severe than the rater did. The rest rated themselves lower than the rater did (46%). Many subjects acknowledged quite severe difficulties with alcohol, but, overall, the raters assessed these problems as more severe ($t = 4.16$, $p < .0001$).

The Effect of Agency Attended

Using t-tests, there were no significant differences between subjects attending different agencies on self-rating of alcohol problems. There were also no differences between the interviewers' ratings for attenders at both agencies. Attenders at the ATU and GCA were willing to acknowledge difficulties with alcohol, but for both groups, the raters assessed their problems as more severe (Table 2).

Features of the "Denial Group"

There was a small group of 11 subjects (11%) in

TABLE 1
Self- and Interviewer Rating on Visual Analogue Scale

VAS Scale	Self-Rating Frequency (N = 100)	Interviewer-Rating Frequency (N = 100)
0	6	0
4	6	0
5	19	2
6	4	3
7	17	14
8	19	52
9	6	24
10	23	5

TABLE 2
Comparisons of VAS Scores of GCA Clients and ATU Patients

Agency	Self-Rating	Interviewer Rating	*t*-Value
GCA	6.8 ± 2.9	7.9 ± 1.4	2.64*
ATU	7.1 ± 2.2	8.1 ± .7	3.55**

*$p < .01$; **$p < .001$.

which there was a large discrepancy between the subjects' and interviewers' assessments. This was computed by subtracting the subjects' VAS score from the raters' VAS score (Table 3). For the purposes of this study, those subjects whose scores fell one standard deviation below the mean of these differences were considered to be "denying" their alcohol problem. This group rated their problems with alcohol between 4 and 9 points below the point selected by the rater. Contained within the denial group were a very small proportion of subjects (6%) who claimed to be having no difficulties at all with alcohol.

There was no evidence of sex differences since 12% of men and 10% of women were in the denial category. The majority (16%) of deniers attended the GCA, while 6% attended the ATU (χ^2, NS). Despite rating themselves as having little in the way of problems on the visual analogue scale, there were no significant differences between the denial group and the rest of the sample on severity of dependence on alcohol, alcohol-related difficulties, and indices of social stability. This meant that subjects were quite willing to report a whole range of problems, many of them obviously alcohol-related, without acknowledging that alcohol was causing them difficulty.

The denial group had a mean score of 1.9 (SD = 2.2) on the VAS, while the interviewer assessed them at 8.1 (SD = .8). The difference between these scores was highly significant ($t = -9.90$, $p < .0001$). The rest of the sample had a mean score of 7.6 (SD = 1.8) on the VAS, while the interviewers assessed them slightly higher, at 8.0 (SD = 1.1). The difference in scores was statistically significant ($t = -2.27$, $p < .02$).

Compliance with Treatment

There were no differences in compliance with treatment between deniers who attended for an average of 6 weeks compared with the rest, who attended for 6½ weeks. Long-term compliance with treatment was poor for both groups, since only 9% of deniers ($N = 1$) and 8% of the rest ($N = 7$) were still attending at 6 months. Therefore, a failure to acknowledge alcohol as a significant difficulty in the first session did not affect subsequent attendance.

Discussion

Most heavy drinkers, regardless of the agency they were attending, acknowledged that their alcohol use was causing them problems. This is in contrast to the findings of Goldsmith and Green (1988), who studied clients referred by the courts; over half the group examined failed to acknowledge alcohol as a problem.

There were discrepancies between the interviewers' and subjects' assessment of degree of severity, but not always in the ways expected. Almost as many subjects overestimated or arrived at exactly the same rating as those who underestimated their difficulties. These differences appeared to be due to a number of factors. A small group was identified in which there was a major discrepancy between the interviewer and the subject. This group fitted the stereotype of the denying alcoholic, as subjects were willing to report a whole range of alcohol-related difficulties, but not to acknowledge that these were related to consumption of alcohol. This type of blanket denial is not confined to alcohol problems, but appears to be a common response in dealing with serious conditions. Hackett and Cassem (1974) have observed extreme denial by almost one fifth of general medical patients who have experienced myocardial infarction. They also noted that a similar proportion of those with serious malignancies exhibited outright denial of their condition.

Despite a initial failure to appreciate their predicament, this group remained in treatment for the same amount of time as the nondeniers. The failure to find a link between denial at the first interview and compliance with treatment raises an important issue. Many practitioners feel that unless the patient fully accepts the view that their difficulties are alcohol-related, treatment cannot proceed. This does not appear to be necessary, certainly as far as attending for treatment is concerned. It may be that an offer of further help should be made regardless of how the patient presents himself at interview.

Denial or minimization of problem drinking has long been considered to be a feature of women drinkers. In this study, men were as likely as women to be rep-

TABLE 3
Differences between Interviewers' and Subjects' Scores on the Visual Analogue Scale

Differences	Frequency	Cumulative Percentage
−5	1	1
−3	2	3
−2	11	14
−1	10	24
0	22	46
1	20	66
2	9	75
3	14	89
4	4	93
5	1	94
7	2	96
8	2	98
9	2	100
	100	

resented in the denial category. Because these findings differ from some previous reports, the question of their reliability and validity must be raised. Any differences found may be due to women consistently underreporting the adverse consequences of their drinking. Women were just as willing as men to acknowledge that their problems were alcohol related on a visual analogue scale. Failure to involve patients in treatment is often attributed to the patients' denial: however, the women in this study remained in treatment almost twice as long as the men (Allan, 1990b). Because of these factors, it seems unlikely that the findings reported in this study are due to inaccurate answers from female subjects.

Despite many subjects being willing to acknowledge difficulties, the interviewers assessed their difficulties as more severe. In general, there was a tendency to present things in a not too unfavorable light, rather than obviously faking good. The finding that some subjects overestimated their difficulties with alcohol has not been described as a feature of problem drinkers. It has, however, been noted to occur in drug-abusing populations and has been considered to be due to the subjects presenting themselves as "addicted" or "sick" (Davies and Baker, 1987). No such interpretation can be drawn from this study, but perhaps the interpretation highlights some of the complexities of the task in hand.

The interviewer or, indeed, any experienced therapist's clinically based model of alcohol problems is derived from seeing perhaps many hundreds of patients. This can be contrasted with the frame of reference provided by patients who are drawing on their own highly personal experiences. It is perhaps optimistic to expect that there could be a close match between two observers from such disparate view points.

Conclusions

Visual analogue scales provided a simple device to quantify views about alcohol problems not only from the clinician's perspective, but also from the patient's point of view. A number of factors, apart from denial, were involved in producing discrepancies. The tendency to present oneself in a reasonably good light appeared to be important. An appreciation of the universality of this phenomenon may make it more understandable and acceptable to therapists. Some patients were operating with models of alcohol problems that were at variance with those which are clinically derived. Sensitive counseling and education may be a useful way to approach this area. Although not clinically used in this study, there may be benefits to using the visual analogue scales within a counseling session to explore some of the differences between patients and therapists. Finally, despite the striking nature of denial encountered in a small minority of patients in this study, initial levels of denial were not related to subsequent compliance with treatment.

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