Correlation of the attrition rate of black female alcoholics in treatment

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ATLANTA UNIVERSITY
ABSTRACT
SOCIAL WORK

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CORRELATION OF THE ATTRITION RATE OF BLACK FEMALE ALCOHOLICS IN TREATMENT

Advisor: Professor Mamie R. Darlington

This study examined the correlation between the attrition rate of black female alcoholics in treatment and several personality and psychophysiological variables. Subjects of this study were enrolled in a 28-day treatment program in a local county treatment center with any DMS III diagnosis of alcoholism. Data were collected through a secondary analysis of the records of black female alcoholic patients who entered treatment between December 1982 and December 1985.

Of the three hypotheses examined, only one was significant. Results of this study indicated that those women who terminated treatment prematurely were different from those who completed treatment in terms of age and onset of drinking behavior. A Fisher's Exact Test revealed a significant relationship between the two groups regarding use of other drugs. Those women who failed to complete treatment were more likely to be multiple drug users. The remaining variables were found not to be significant.

Concentration: Clinical
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CORRELATION OF THE ATTRITION RATE OF BLACK FEMALE ALCOHOLICS IN TREATMENT

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
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ATLANTA, GEORGIA  30314
MAY 1986
ATLANTA UNIVERSITY SCHOOL OF SOCIAL WORK
ATLANTA, GEORGIA 30314

DATE: May 1986

THE UNDERSIGNED HAS EXAMINED A THESIS ENTITLED:

"Correlation of the Attrition Rate of Black Female Alcoholics in Treatment"

PRESENTED BY Suzette Moss-Wells, A CANDIDATE FOR THE DEGREE OF MASTER OF SOCIAL WORK, AND HEREBY CERTIFIES THAT IN THEIR OPINION IT IS WORTHY OF ACCEPTANCE.

[Signatures and dates]
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Dedication

This paper is dedicated to my mother, "Ms. Gloria" and my sister Sharon whose shoulders and ears were always available. A special dedication to Ralph whose love and encouragement carried me through my journey.

Acknowledgements

This author would like to express appreciation for the help, encouragement and confidence of Ms. Iris Smith, Dr. Arthur Falek, Dr. Claire Coles, Dr. J. Lancaster, Dr. K. Platzman and Ms. Verna White.
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Alcohol is an acceptable social drug in our society. However, the alcoholic woman is considered worthless and unfit. She is expected to have the ability to endure any and everything and if she fails to maintain that superperson image, she pays dearly for it. Society finds the alcoholic woman unforgivable. Compared to the male alcoholic, the woman risks everything when she develops this illness. She is more likely to lose her children and her husband. Husbands of alcoholic wives find it difficult to continue the relationship. They may see their children poorly cared for and money being spent on liquor that should go for paying bills. Further, the stigma of being married to an alcoholic may cause problems for his career. He also considers it to be her problem and is less likely to become associated with Al-Anon (Curlee, 1967).

There are different types of alcoholic women, and for each woman the problem is somewhat different. The single woman, for example, may sometimes have trouble finding social acceptance that is necessary for the recovery from alcoholism. The woman who is pursuing a career may experience problems competing with men. They may find a special pressure to prove that they can "drink like a man"; or it may be, according to Curlee (1967), that role confusion was involved in their decision to seek a career, and that this is
merely reflected in their acceptance of male drinking patterns and the consequent acceptance of the risk of alcoholism.

It is evident that the needs of women alcoholics are different from those of men. Treatment facilities should be designed to meet the needs of both men and women. If a woman is strongly influenced by societal beliefs about alcoholism in women, she is probably less likely to complete it.

Further, if there are children involved, many women may have a difficult time arranging for child care during treatment. It is important that we take into consideration the families of the alcoholic woman. Family therapy may make a significant difference if the problem drinking can be traced back to some stressful situation within the family itself.

Dawkins (1983) found in his study of 201 women (38 blacks and 163 whites) that blacks were significantly younger when starting regular and heavy drinking and when becoming involved in treatment. He also found that blacks were more frequently consumers of gin and bootleg liquor, more likely to drink in the mornings and on holidays than whites. Dawkins (1983) felt that his findings indicated that while women alcoholics tend to be alike with respect to some alcohol-related experiences, racial and subcultural influences may operate to create some important differences between black and white problem drinkers.

With this information in mind, it is important that these differences be taken into consideration in the treatment process. Black alcoholic women should have their specific needs addressed as
should white alcoholic women. Treatment and prevention efforts should be targeted to the specific needs of various racial subgroups (Dawkins, 1983).

This study will analyze the attrition rate of black women in treatment. Studying this issue would be a significant step toward the development of appropriate treatment programs for minority women. My principle interests are in the relationship between social support, drinking history, physiological and psychological dependence and source of referral to the termination of treatment.

The attrition rate of black women in treatment will be studied by conducting a secondary analysis of the records of the South Dekalb Alcoholism Treatment Center. One hundred records will be reviewed and divided into two groups: those women who completed treatment and those who terminated during the treatment process. A survey will be developed to obtain information concerning demographics, social support, drinking history, physiological and psychological dependence and source of referral.
CHAPTER II
LITERATURE REVIEW

Many reports on attrition indicate that more than five percent of patients admitted for treatment become successful graduates (Sheffet, 1973). Welte (1981) found that clients who terminated or withdrew against advice had much higher drinking rates at follow-up than those who completed treatment. Therefore, it is important that once an individual comes in for treatment, it must be completed in order for it to be effective. Smart (1978) found that patients remaining in treatment were more likely to have a variety of medical interventions than those who dropped out early (e.g., medication, medical assessment and treatment in a medical facility). This indicates the importance of the type of treatment used. There is inadequate literature that separates the attrition rate of female from male alcoholics and even more inadequate is the separation of black and white female alcoholics when studying the rate of attrition.

In attempting to reduce the rate of attrition of women in treatment, it is important to design a treatment approach to accommodate those individuals who are potential dropouts. Bander (1983) found that attendance to treatment facilities was significantly predicted by a combination of sociodemographic and drinking history variables. Also, even though this program was specifically designed to serve a relatively unstable population, social stability and higher functioning
at intake (employment, married, etc.) remain the best predictors of subsequent abstinence and employment. Therefore, it is important to take into account the social stability of an individual when he/she is entering treatment.

The stereotypes that are associated with the woman alcoholic still persist and create problems for her. She bears a greater stigma than her male counterpart. She is regarded as an especially degraded creature, and is likely to share that opinion of herself. She is likely, therefore, to suffer even more self-loathing and self-contempt than a man does. This may be one factor that makes it more difficult for women alcoholic to recover than men (Curlee, 1967).

Once the alcoholic woman decides to seek treatment, there is another problem. There are few treatment facilities and approaches that are modeled to meet the needs of women, most facilities are designed for the problems of men. It is not known whether this is the result of the assumption that what will work for men will work for women or that society is still unwilling to accept the problem of alcoholism among women (Curlee, 1967).

In a comparison of alcoholic women with non-alcoholic women, Hoar found that women in the alcoholic group were significantly more field dependent than non-alcoholic women, which seems to indicate that this group of alcoholic women might be more dependent and passive in their overall psychological functioning compared to non-alcoholic women like them (1983). If this is true, then treatment or counseling should be designed to increase the client's ability to feel comfortable
in the choice-making process (Hoar, 1983).

Hoar also found that the alcoholic group may be influenced by significant others (husbands, parents...etc.) and are more likely to go along with the wants and needs of others than their non-alcoholic counterparts. This may indicate some type of internal conflict that the alcoholic group may be experiencing. It is important that this also be taken into consideration during the counseling or treatment process (1983).

It has been established that alcoholic women have poor self-concepts and low self-esteem (Beckman, 1975). Generally, women come into treatment due to interpersonal crisis. It appears that some fairly clearly defined stress or difficulty is frequently associated with the onset of heavy and controlled drinking (Curlee, 1969).

Leigh (1984) conducted a study of 172 patients (40 women) who had completed their intake procedures and had been assigned to treatment. The independent variables in the study consisted of personality items in which patients completed a shortened version of the Personality Research Form yielding nine subscores on achievement, affiliation autonomy, endurance, harm avoidance, impulsivity, nurturance, social recognition and desirability; The Basic Personality Inventory yielding 12 subscores; Levenson's Interval-External Locus of Control Scale, Oltman's Rod and Frame test eight applications yielding one measure of field dependence, the Wide Range Achievement Test; the Digit Symbol tests from the Wechsler Adult Intelligence Scale; and Benton's Visual Retention Test. Sociodemographic variables studied were age, sex,
occupation, income, residence, marital status, present legal status and number of prior alcohol related convictions. A composite social stability score based on residence, family contact, occupation and legal status was constructed for each subject. Symptom levels and treatment history variables included the frequency of alcohol consumption in the past two months, the amount of beer, distilled spirits and wine consumed on an average day, the frequency and type of drugs used, and the age at the first use and misuse of drugs. Patients completed the Michigan Alcoholism Screening Test (MAST) which orders respondents along a continuum of severity of alcohol-related problems. Information on the number, length and type of previous treatment involvements was also solicited.

Treatment system variables consisted of: (1) the time from initial inquiry to first appointment; (2) the time from first appointment to assessment; (3) the time from the assessment to the first treatment appointment; (4) whether a primary care appointment between assessment and treatment was given and kept; (5) the primary care worker; (6) the assessment worker; and (7) the therapist (Leigh, 1984).

Dependent variables studied were: (1) the number of treatment appointments kept; and (2) whether treatment was considered by therapist to be satisfactorily completed.

Results of the above study showed that of the 172 subjects, 15.1 percent kept zero outpatient appointments, 27.9 kept one to two appointments, 18 percent kept three to five appointments, 12 percent kept six to seven, and 25.6 percent kept eight plus. Thus, 72 percent
of all the appointments scheduled were kept.

A series of regression analyses, performed separately on each group on independent variables listed above, revealed which variables discriminated between patients who failed to show up for treatment at all and those who kept one appointment. Failure to attend was more likely associated with: (1) more than 14 days of delay from assessment to first appointment; (2) patients age under 31; (3) inpatient treatment attendance in the past year; (4) a history of two or more alcohol relation convictions; (5) the absence of dependents at home; (6) a MAST score of under 20; and (7) use of at least one illicit drug (Leigh, 1984).

**Early dropouts vs. completers.** From regression analysis, only two variables were found to discriminate patients who dropped out of treatment after one to two sessions from those seen as having satisfactorily completed treatment: a social stability score of less than seven (p < .05) and the absence of dependents at home (p < .01). There was also evidence suggesting that rates for dropout early in treatment differed according to which therapist was seen, but number of patients seen by some therapists were too small to be drawn. In this study, most of the personality and demographic variables did not contribute significantly to the prediction of premature termination of treatment. An exception to this was for age and social stability variables, which have appeared consistently in reports of patients attrition from alcoholism treatment programs (Baekeland and Lundwall, 1975; Leigh, 1984).
Apart from these demographic variables and other variables that reflect the severity of drinking problems (prior inpatient treatment, prior alcohol related convictions and the use of at least one illicit drug), there was also evidence that treatment system variables (time delay and characteristics of individual staff members) affect patient dropout.

Treatment variables may also account for the small number of no-shows for the first treatment session. Patients reaching this point in the system have already negotiated several hurdles (the initial inquiry, scheduling the first appointment, the initial interview with a primary care worker, and the delay between primary care and assessment), which thereby excludes patients not seriously intending to receive treatment. Of patients seeking assistance early in 1980, only 54 percent of those given primary care appointments and only about two-thirds of those scheduled for assessment showed up. It is likely, therefore, that the subjects of this study were a self-selected group of quite highly motivated individuals. The results of this study also indicate that time factors significantly affect attendance rates for both primary care and assessment.

Unfortunately, the Leigh study did not separate the population by race and a large percentage of these individuals were male. It would be interesting to further study the relationship between termination and the characteristics of treatment staff. Although demographic variables did not contribute to the prediction of premature dropout, social stability and age were significant. This is an indication of the types
of treatment strategies that should be taken into account when designing a treatment program.

Welte (1981) conducted a study of 1,340 clients who received inpatient treatment for alcoholism at 17 New York State-sponsored alcoholism rehabilitation units. The study sample consisted of 82 percent male and 17.1 percent female. White clients comprised 72.8 percent of the sample; 22 percent were black and the remaining 5.2 percent were a scattering of other minority groups.

There were 14 pretreatment variables being considered in this analysis: social stability (1) number of job changes in the last three years; (2) number of address changes in the last three years; (3) residence type (house, apartment, hotel, etc.); (4) employment status; (5) marital status; and (6) family composition (Welte, 1981).

Socioeconomic status: a scale composed of occupation and education.

Financial status: the financial status was constituted to reflect the tendency for a client to be a benefit or a burden to society in the financial sense.

Drug abuse: this scale is a weighted count of all of the illegal drugs used by the client in the 30 days before entering treatment.

Social adjustment: one of these questions ask the respondents to rate how well (very well, satisfactorily, or poorly) they get along with the most important person in their lives.

Treatment history: client's lifetime frequency of alcoholics anonymous attendance, inpatient and outpatient treatment for alcoholism
and use of detoxification services. This reflects the extent of the client's past experience with alcoholism treatment (Welte, 1981).

Physiological and psychological dependence: psychological dependence was determined by noting the presence of 19 behavioral signs and symptoms. Physiological dependence was determined by 11 physiological signs and symptoms. The above variables were measured by using guidelines suggested by the National Council on Alcoholism (Welte, 1981).

The remaining pretreatment variables employed in the above analysis are: sex, race, age, employment status in the 30 days before entering treatment, lifetime number of arrests, and average daily alcohol consumption in the 30 days before entering treatment (Welte, 1981).

There were four treatment related variables that were of primary interest in this study. They were: reason for leaving treatment, the medical orientation scale, the rehabilitative (non-medical) professional scale, and the peer group orientation scale (Welte, 1981).

The results of the above cited study showed that those clients who were terminated or withdrew against advice have much higher drinking rates at follow-up than those who completed treatment, even after these rates were statistically corrected for some differential pretreatment characteristics, such as length of stay in treatment. The fact that clients left treatment early is not by itself sufficient to explain all or even most of the differences. The same is true when quantity of alcohol consumed is used as the dependent variable (Welte, 1981).

Several pretreatment variables had significant power to predict the way in which treatment will be terminated. Those clients who were
in the top half of financial status before treatment had a greater rate of successfully completing treatment than those in the lower half. Type of termination of treatment was also correlated with the time since last employment and social stability, each in the expected direction. Older clients completed treatment more often than younger clients. No characteristics related to the seriousness of the client's drinking problem had a significant ability to predict completion of treatment. Also, the nature of the treatment itself was not a significant predictor. In the stepwise analyses, the best discriminators between those who completed treatment and those who were terminated were age and financial status. Young clients most often fell afoul of the unit's rules for client behavior (Welte, 1981).

The above study acknowledges that every effort should be made to arrange for clients to complete treatment. This indicates the importance of the completion of treatment by clients if the treatment is to be successful. Again, this study population was predominately white male. There was no division of subjects by race or sex.

Mendelson (1982) conducted a study of middle class alcoholic men and women and analyzed their medical problems, social, psychological demographic characteristics. Data is reported on 3,411 first admissions for alcoholism treatment to nine proprietary hospitals located in six states in the United States. This study represents the largest and most systematic survey of middle class patients treated in inpatient hospital facilities for alcoholism.
Data were based on a standardize questionnaire instrument used by all nine hospitals. Questionnaires were completed upon admission by the physicians and nursing staff, once patients were able to cooperate with the interviewer. Data forms were processed at a central computer facility and stored on computer tape. Tapes were forwarded to and analyzed at the Alcohol and Drug Abuse Research Center, Harvard Medical School-McLean Hospital. Patient confidentiality was insured, since patients were identified only by hospital code number, no names and addresses or other unique identifiers were known to the data analysts (Mendelson, 1982).

Men comprised 77 percent of the sample and women accounted for 23 percent. The distribution of men and women was approximately equivalent within the nine hospitals (Mendelson, 1982).

The patients were between 15 and 85 years of age. No significant differences were found between the male and female patients. The majority of the first admissions were between 35 and 59 years of age. The average age of the entire sample was 47. These age distributions were representative of all hospitals with two exceptions: (1) although young patients (15 to 24 years of age) represented 2.7 percent of the total patient population, 19 percent of patients admitted to a Salt Lake City hospital were in this age range; and (2) patients 65 and older accounted for 12.9 percent of the total sample, but 17 percent of the patients admitted to a Las Vegas hospital were 65 and older. There were no other significant differences in the age distribution of patients admitted to the eight hospitals (Mendelson, 1982).
About half of the sample had some high school level training and 34.2 percent had graduated from high school. Over a quarter of the sample had college experience and 14.0 percent had college and advanced degrees. Most (52.1 percent) were employed at the time of admission and only nine percent unemployed (Mendelson, 1982).

Sources of patient referral are described in Table 1. Only 8.7 percent of these patients came to the Raleigh Hills Hospitals after referral by a physician. Over 55 percent of these reported entering the hospital after discussions with former patients or after seeing a television advertisement that described the Raleigh Hills Hospital's program for alcoholism treatment. Court referrals accounted for less than one percent of this patient sample (Mendelson, 1982).

Table 1
Source of Patient Referral.

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Television</td>
<td>36.7</td>
</tr>
<tr>
<td>Other</td>
<td>29.2</td>
</tr>
<tr>
<td>Former patient</td>
<td>19.0</td>
</tr>
<tr>
<td>Physician</td>
<td>8.7</td>
</tr>
<tr>
<td>Family</td>
<td>5.7</td>
</tr>
<tr>
<td>Court or attorney</td>
<td>0.7</td>
</tr>
</tbody>
</table>
In addition to evaluation upon admission, a detailed drinking history and family history of alcohol-related problems were obtained from each patient. Over 80 percent of the sample had drunk heavily within 24 hours prior to admission, and over 50 percent reported that they had been heavily intoxicated every day during the week before admission. Over 86 percent of the patients had previously sought treatment for alcohol related problems and most (84 percent) had some contact with Alcoholics Anonymous (Mendelson, 1982).

Over 22 percent of this sample began drinking alcohol before age 15. However, the majority began drinking in their late teens and early twenties. Excessive drinking developed relatively early in life. Fifteen percent described their alcohol use as excessive before age 20, and 32.2 percent began drinking to excess between the ages of 20 and 29. Twenty-three percent of the sample developed excessive drinking patterns between the ages of 30 and 39. Thereafter, excessive alcohol use developed at a slower rate and only 7.2 percent of this sample reported the onset of excessive drinking after age 55 (Mendelson, 1982).

Although the population of the above cited study was done predominately on middle class white males, an important finding in this study was the high percentage of referral sources by television advertisements and other former alcohol patients. This finding would be important in determining some characteristics of other different populations. Television advertisement may be a source of outreach for other populations; not exclusively in terms of private hospitals
but also the public alcohol treatment centers as an effort to produce a more efficient type of outreach to encourage blacks and minorities to seek the help that they need. Also of importance in this study is that an overwhelming majority of the patients (80 percent) had drunk heavily within 24 hours prior to admission and over half had been intoxicated everyday during a week before admission. Both this and the fact that excessive drinking developed relatively early in life are also important facts to be taken into consideration when designing a treatment plan (Mendelson, 1982).

Hahn (1982) conducted a study of persons admitted to an alcoholism treatment unit of a county hospital. The program began with one to three days of detoxification, with the remaining time being dedicated to rehabilitation. During this process, patients were required to attend five group therapy sessions daily. These sessions are devoted to educating the client about the nature of alcoholism as a disease, the social, psychological, and physical consequences of alcoholism and the AA approach to recovery. The goal of the rehabilitation phase is to get patients to take the first five steps in the AA program and become active AA members upon discharge.

Since a large number of cases had missing data, a check was made to determine the representativeness of the remaining sample. Employing the variables of sex, age, race, social class, and the number of times previously admitted to the unit chi-square, test revealed three significant ($p < .05$) differences between these groups. The group with missing data had a significant larger proportion of females, tended
to be of lower social class and were more likely to have been admitted several times previously (Hahn, 1982).

The patient population was predominantly white (81.2 percent), male (80.4 percent) and presently employed (51 percent). Most patients had been married at one time (87.8 percent), although only a minority (46.7 percent) were still married. The average age of patients was 45 years, with an average educational level of 10.6 years. The majority of patients were working (43.2 percent) or lower class (28.4 percent) with an average income of $8,285. Most persons were not former members of AA (73.2 percent), and were sober (38.7 percent) or mildly intoxicated (40.2 percent) upon admission. With respect to their drinking history, patients began drinking at an average age of 19 years and had drunk on the average of nine years after loss of control. A majority of persons had not been previously treated for alcoholism (64.2 percent), but had experienced at least one arrest for public intoxication (69 percent). Those referred to the rehabilitation unit were often directed by their AA sponsor (32.3 percent), or a social service agency (25.4 percent). Many alcoholics were accompanied on admission by a family member (28.4 percent) or their AA sponsor (29.3 percent) (Hahn, 1982).

Factors distinguishing between patients who complete treatment and those who prematurely dropped out of treatment in the alcoholism rehabilitation unit are: total household income, having an AA sponsor during treatment; number of serious months in AA; father having an alcohol problem; number of months spent in jail; divorced marital
status; number of years of drinking after loss of control; listing the emergency contact as a non-nuclear family relative-neighbor-friend; employer referring the patient to the program; being employed; being male; age at which drinking began; and being single (Hahn, 1982).

The following factors were found to be predictive of dropping out of treatment: sociodemographic variables being male; environmental resources variables—having a mother or father with an alcohol problem; having spent several months in AA; having several alcohol related arrests; and having spent several months in jail. The variables associated with completing treatment were: sociodemographic variables—having a high level of total household income; drinking related variables—having drunk several years after loss of control; having begun drinking at a later age, having cirrhosis; environmental resources variable—being single or divorce, being employed; having an AA sponsor during treatment; having a non-nuclear family relative or a neighbor or friend as an emergency contact; and being treated by an employer (Hahn, 1982).

After reviewing previous studies on related literature, the following hypotheses were advanced: (1) the higher the level of total household income, the less likely a person is to complete treatment; (2) a male client is more likely to continue treatment than a female client; (3) the longer the period of drinking after loss of control, the less likely the person is to complete treatment; (4) the younger a person was when drinking began, the less likely the person is to complete treatment; and (5) the less serious a person's alcohol-related
medical problem, the less likely the person is to complete treatment. However, mixed support was found for the hypothesis advanced in this research. Environmental support factors are clearly associated with program completion. But strong nuclear family ties are associated with premature termination of treatment. The investigators of this study felt that this suggests to policymakers and agency personnel that patients' characteristics can not be their total concern. For patients who lack environmental resources, agencies must consider ways to stimulate these factors within treatment settings in order to help insure patient program completion. An example given is that staff may aid in providing concerned AA sponsors or soliciting employer cooperation with treatment (Hahn, 1982).

Also of importance, is that a percentage of the group was dropped due to missing data. There was a significantly larger proportion of females in this group, and they tended to be of lower social class and were more likely to have been admitted several times previously. The investigators acknowledged that these findings suggest that these persons constituted a distinct type of dropout who merit further study. Both suggestions are valid and it is believed that this group is a special population of persons that merit specific needs that should be addressed in addition to the regular or usual population of alcohol treatment patients.

Bander (1983) designed a program that was a multifaceted outpatient treatment unit of the Hartford Connecticut Department of Social Services, which is designed to serve inner city women alcoholics. It
provided a combination of individual and group counseling on both a scheduled and drop-in basis. Daytime and evening hours were available. Outreach was accomplished through frequent home and hospital visits. Cultural and recreational activities were included to serve a socialization function as well as to provide structure to women's days. Program participants were encouraged to drop in at the facility as often as they desired, thus creating a casual community-like atmosphere. In conjunction with other inner city agencies, the program offered vocational training, employment counseling, and access to medical care and legal advice. Also, bus passes were offered as an incentive to program attendance. Staff included an administrator, two social work supervisors, and three full-time counselors.

The subjects of the above study were 167 women residents of an urban area who entered the program between October 1977 and March 1979. They ranged in age from 19 to 70 years with a mean age of 40. Fifty-six percent of the patients were black, 31 percent white, 7 percent American Indian, and 6 percent Hispanic. Social services agencies referred 46 percent of the sample; alcoholism related agencies referred 25 percent; referrals from family or friends comprised 19 percent; and the remaining 10 percent were referred by information hot-lines, hospitals and probation officers. At referral the majority of the subjects were unmarried (86 percent), unemployed (89 percent), and receiving government financial aid. Fifty-five percent had been employed sometime during the year prior to intake (Bander, 1983).

Patients' alcoholism histories indicated that the average age at the onset of heavy drinking was 25 years. Twenty-nine percent began
heavy drinking before age 20; 42 percent began between 20 and 30; 15 percent began between 30 and 40; and 14 percent began after 40. Seventy-nine percent of the sample admitted to drinking during the month prior to intake. Approximately 10 percent claimed abstinence for at least six but felt that alcoholism remained a significant problem. The mean reported alcohol consumption on a typical drinking day was 7.39 ounces of ethnol, according to Armer et al quantity frequency index. A five-ounce per-day criterion was used by Anmos (1976) as an indicator of alcoholism as defined by consumption alone; thus, by this criterion, the subjects of this study can clearly be considered alcoholics. At the time of intake, 77 percent of the women who had been drinking during the previous month (58 percent of the total sample) acknowledged one or more serious symptoms of alcohol addiction (i.e., blackouts, delirium tremors, morning drinking and drinking alone) (Bander, 1983).

Attendance, abstinence and employment data were examined through correlation and multiple regression analysis. Hierarchical blocks were used in ten regression analyses to assess the independent contributions of sociodemographic and drinking characteristics to the variance of the three dependent measures. Sociodemographic characteristics were entered first since, as a class of variables, they were assumed to proceed drinking habits causally. A stepwise discriminant analysis with a classification procedure was then performed on attendance data to determine the percentage of cases accurately categorized by differential intake characteristics. Finally, the interrelationships
of the three dependent variables were explored.

Sixty-six percent of the patients continued treatment beyond the first session and 44 percent maintained contact for at least six months. When categorized into four attendance patterns, 19 percent of the sample were nonattenders, 28 percent were slow dropouts, 30 percent were erratic attenders and 23 percent were regular attenders as displayed in Table 2. Attendance was significantly correlated with source of income, occupational level and age at which the patient began drinking heavily or frequently. More regular attendance was associated with receipt of government financial assistance, higher occupational levels, and older age at onset of heavy drinking.

Assessment of patient status three months prior to the end of the data collection revealed that 19 percent (32) of the patients were judged by their counselors to have been abstinent six months or more. In regard to individual predictors of abstinence, a significant association was found with marital status—service of income and length of abstinence at intake; that is, longer periods with no drinking after commencing treatment were related to being married, being self-supporting and having a longer period of abstinence at intake. Increased periods of abstinence tended to be correlated with living with others rather than living alone.

Twenty-six percent (431) of the patients were employed during their involvement with the program. (Those clients with missing data on abstinence or employment were presumed to be drinking or unemployed or both. Thus, all data on abstinence are conservatively biased.)
Table 2
Correlations of Sociodemographic and Drinking Characteristics with Attendance and Employment Status

<table>
<thead>
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<th>Independence Variables</th>
<th>Attendance</th>
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<td>(143)</td>
<td>(81)</td>
<td>(130)</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td>.14</td>
<td>.18</td>
<td>.14</td>
</tr>
<tr>
<td></td>
<td>(154)</td>
<td>(86)</td>
<td>(140)</td>
</tr>
<tr>
<td>Source of Income</td>
<td>.22+</td>
<td>.29+</td>
<td>.30+</td>
</tr>
<tr>
<td></td>
<td>(143)</td>
<td>(78)</td>
<td>(130)</td>
</tr>
<tr>
<td>Occupational Level</td>
<td>.19*</td>
<td>.15</td>
<td>.23+</td>
</tr>
<tr>
<td></td>
<td>(139)</td>
<td>(83)</td>
<td>(129)</td>
</tr>
<tr>
<td>Quantity-Frequency</td>
<td>.14</td>
<td>.12</td>
<td>.14</td>
</tr>
<tr>
<td></td>
<td>(101)</td>
<td>(55)</td>
<td>(94)</td>
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<tr>
<td>Behavioral Symptoms</td>
<td>.03</td>
<td>.07</td>
<td>.33+</td>
</tr>
<tr>
<td></td>
<td>(116)</td>
<td>(63)</td>
<td>(106)</td>
</tr>
<tr>
<td>Age Patient Began Drinking</td>
<td>.25+</td>
<td>.11</td>
<td>.11</td>
</tr>
<tr>
<td></td>
<td>(149)</td>
<td>(84)</td>
<td>(136)</td>
</tr>
<tr>
<td>Period of Abstinence at Intake</td>
<td>.03</td>
<td>.52+</td>
<td>.10</td>
</tr>
<tr>
<td></td>
<td>(153)</td>
<td>(86)</td>
<td>(139)</td>
</tr>
</tbody>
</table>

* All variables are coded so that lower levels of status or functioning and higher values represent higher levels. Numbers in parentheses indicated number of cases for each correlation. +P < .05    +P < .01
This program was successful in maintaining attendance in a population typically at high risk for treatment dropout (i.e., 40 percent of the sample withdrawal from treatment) (Bander, 1983).

The investigators of the above cited study felt that their results indicated that attendance was significantly predicted by a combination of sociodemographic and treatment history variables. Also, this study suggests that unemployment and social isolation, which generally have been related to decreased attendance, were in this case associated with more regular attendance. This apparent contradiction might be explained by the program having been developed specifically for the probable dropout (Bander, 1983).

This study revealed some important facts in that it brings about a question of whether there is truly a difference between men and women alcoholics; since the treatment program was specifically designed to target those individuals who were potential dropouts. Further, the subjects were predominately black, low income individuals, which may indicate an even more unique population of individuals with specific needs to be addressed. However, data given on abstinence and employment appeared to be biased. It was indicated that those clients with missing data on abstinence or employment were presumed to be drinking or unemployed. Therefore, it is not known what percentage was actually abstinent or unemployed. However, the above cited study was appropriate in the specific treatment designed and the results.
indicated that this may be a possible guideline for future design
treatment populations similar to this one.
CHAPTER III
STATEMENT OF THEORY

In discussing the previously cited literature it is evident that there is a great deal of contradiction displayed in the results of these studies. One reason for this problem may be that the investigators of these studies attempted to generalize their population when in fact there are very concrete differences in alcohol treatment populations. Also of importance is the social stability of an individual when entering treatment. It is felt by the investigator that differences in individuals should always be considered in designing treatment processes for those individuals. It is also felt that social support in regard to stability, such as employment status, job changes, residence, marital status and family composition, plays a role in the prediction of the attrition rate of black female alcoholics in treatment. And along with that issue, social adjustment, such as how well an individual is getting along with the most important person in his/her life is also of importance.

The importance of addressing the issue of social stability is that the types of variables described above are problems that most individuals would try to solve first and only after such problems have been satisfactorily resolved would the problem of alcoholism be addressed (i.e., loss of job, insufficient housing, etc.). Further, if a woman is having marital or family difficulties, these are problems that she is likely to attempt to solve first before deciding to go into
treatment. Also, since women generally go into treatment due to interpersonal crises (Curlee, 1969), it is possible that these difficulties led them into heavy drinking patterns. Therefore, if these problems can be addressed during the course of the treatment process, this may make it easier for the individual to continue treatment.

Another variable that is of importance is the individual's drinking history. It is felt that items as family history of alcohol-related problems should be considered along with age of onset of drinking alcohol. It would also be of interest to know the frequency of contact with Alcoholics Anonymous or other alcohol treatment facilities and the age of onset of excessive drinking.

Also of importance are the physiological and psychological effects of alcohol dependence. This is in regard to behavioral and psychological signs and symptoms that an individual may be experiencing. The presence of these signs or symptoms should be taken into account during the planning of treatment strategies as they will more than likely interfere with the treatment process. Presence of these signs and symptoms may also indicate the need for medical attention (possibly drug therapy) along with non-medical treatment strategies. The emphasis here lies in the combination of medication and therapy so that the patient will feel comfortable during the treatment process. It is very important that the type of treatment techniques used in treating alcoholics are appropriate. If the treatment techniques are inappropriate, the result could be the termination of treatment.
Finally, the relationship of the source of referral and the termination of treatment are of interest in this study. It is important that appropriate and successful outreach strategies are used in getting the black woman in treatment. It has been established that in many cases, significant others (i.e., wife, husband) may have difficulty adjusting to the alcoholic's role change such as an individual no longer being dependent upon another's income or refusing to see the alcoholic in any normal or recovering role (Hahn, 1982; Jackson, 1954). Therefore, significant others can play a major role in the decision to terminate treatment. It is important that the individual within the treatment process have the emotional support of others who have a vested interest in seeing the individual recover. Successful completion of treatment is facilitated when significant others (such as those who will not accept the recovery of an alcoholic) are not present as is the case with single and divorced individuals and those individuals whose emergency contact lie outside the nuclear family (Hahn, 1982).

Because of the stigma generally attached to being an alcoholic woman, the black woman alcoholic may experience difficulties coming to the decision of seeking treatment. Again, outreach strategies should be implemented to inform these individuals of services that may be of some help to them.

Understanding the possibility of racial and subcultural differences in women would be a positive contribution to the planning of alcohol treatment programs for black women. Studying the above mentioned
variables may provide the necessary steps for further studying this issue.

From reviewing related material on the topic of attrition, the following hypotheses were generated: (1) the less social support a black female alcoholic has, the more likely she is to terminate treatment prematurely; (2) the greater the physiological and psychological dependence, the more likely the black alcoholic woman will terminate treatment prematurely; and (3) the younger the black female is when drinking began, the less likely the probability that she will complete treatment.
CHAPTER IV
METHODOLOGY

Program

The program used for the purpose of this study was the Dekalb Addiction Clinic designed to serve all Dekalb County residents with any alcohol related problems. This was a 28-day treatment program which provides group counseling to their patient.

Subjects

The subjects of this study were 20 residents of the Dekalb County area who entered treatment between the years December 1982 to December 1985. Subjects were chosen by reviewing records of all black women of the above stated facility and determined by filling out an instrument designed to obtain the information for the purpose of this study.

Procedure

Data were collected through a secondary analysis conducted of the records of patients who entered treatment within the above stated time span. These records were divided into two groups: (1) those individuals who terminated treatment early; and (2) those individuals who completed treatment. Data from the following items were derived from reviewing patient records: (1) drinking history; (2) social support; (3) physiological and psychological dependence; and (4) referral source.
Drinking history was based on information such as age at onset of drinking, age at onset of heavy drinking, and previous treatment for alcoholism. The drinking history indicated past experiences with alcohol treatment centers and also the age of onset of drinking and heavy drinking. Although several studies found that the younger an alcoholic is at onset of drinking, the less likely he/she is to complete the treatment process (Hahn, 1982; Bander, 1983). Dawkins (1983) found in his comparison of black and white female alcoholics that blacks tended to start drinking at an earlier age than did whites. This finding may indicate the need to address the problems of black female alcoholics in specific ways.

Physiological and psychological dependence was measured by using a series of questions derived from the MAST. This variable was of interest because the severity of the alcoholism problem may be a prediction of premature termination, especially in black women. With the stigma attached to being an alcoholic woman, it may be difficult for a black woman with a severe drinking problem to feel comfortable enough to complete treatment.

Social stability was based on information such as: (1) number of job changes within the past three years; (2) number of address changes in the past three years; (3) resident type (house, apartment, hotel, etc.); (4) employment status; (5) marital status; and (6) family composition. The variable has been of interest to several researchers, however, the results have been mixed (Hahn, 1982; Bander, 1983; Welte, 1981). It is of interest in this study to show that the social
stability of black women alcoholics can be a method of predicting premature termination.

Source of referral was derived from individual record account of what individual social agency made the referral to the treatment center. Also of importance was the type of referral, such as television, social agency, former patient, employer, physician, or family member.

In the appendix is a copy of the questionnaire that was used to collect the data necessary for this study.
Subjects of this study were black women in an alcohol treatment facility with a primary diagnosis of: DSM III; 303.91 (alcohol addiction), 303.92J (alcohol dependence, episodic) or 303.93J (alcohol dependence).

The subjects (n = 20) were divided into two groups: (1) those individuals who completed treatment; and (2) those who terminated treatment prematurely. The mean age of those who completed treatment was 40.7. The mean age for those who terminated prematurely was 29.1. The mean age at onset of drinking for completers was 21.3 and for those who terminated prematurely was 15.6.

Eighteen percent of the terminators were married (n = 11) and 33.3 percent of the completers were married (n = 9). A Fisher's Exact Test found no significant relationship between the two groups.

Eighty percent (n = 10) of the terminators received a monthly income of less than $600. Seventy-seven percent of the completers received an income of less than $600 per month. The Fisher's Exact Test found no significant relationship between the two groups.

All of the terminators had at least one parent with an alcohol problem (n = 9), compared to 57 percent of the completers. There was also no relationship between the two groups regarding legal problems. Forty percent of the individuals who terminated treatment (n = 10) reported legal problems due to alcohol use, compared to
44 percent of the completers (n = 9).

Although a Fisher's Exact Test revealed no significant relationship between the two groups regarding D.T.s and hallucinations, a larger percentage of the completers (55 percent, n = 9) revealed these symptoms than terminators (20 percent, n = 10) revealed symptoms. Twenty-five percent of the terminators (n = 8) complained of experiencing trouble at work due to their drinking, compared to 55 percent of the completers (n = 9). A Fisher's Exact Test indicated no significant relationship between the two groups.

Seventy-one percent of those who terminated treatment prematurely (n = 7), compared to 75 percent of those who completed treatment (n = 4), complained of neglected obligations due to drinking. Fisher's Exact Test revealed no significant relationship between the two groups.

Sixty-six percent of the completers (n = 9) experienced blackouts compared to 50 percent of the terminators (n = 10). However, a Fisher's Exact Test indicated no significant relationship between the two groups.

A Fisher's Exact Test also indicated no significant relationship between terminators and completers regarding fights due to drinking. However, 30 percent of the terminators (n = 10) experienced fights due to drinking, compared to 66 percent of the completers (n = 8). Also, 45 percent of the terminators (n = 11) are listed as self-supporting, compared to only 18 percent of the completers (n = 9). A Fisher's Exact Test, however, revealed no significant relationship between the two groups.
On the referral source variable, 27 percent of the terminators (n = 11) referred themselves into treatment, compared to only 11 percent of the completers (n = 9). Fisher's Exact Test revealed no significant relationship between the two groups. The small number of subjects used in this study made it difficult to compute the Fisher's Exact Test on separate variables for referral source (i.e., police, social agency, employer). Therefore, an analysis was done using self and any referral other than self.

There was also no relationship between the two groups regarding psychiatric hospitalization due to drinking. The data showed that 40 percent of the terminators (n = 10) had been hospitalized on a psychiatric ward, compared to 44 percent of the completers (n = 9). Fisher's Exact Test also indicated no significant relationship between terminators (n = 10) and completers (n = 8) regarding alcohol related arrests. Thirty percent of the terminators (n = 10) had previous alcohol related arrests, compared to 38 percent of those who completed treatment (n = 8).

Fisher's Exact Test also showed no significant relationship between the two groups regarding getting help for their drinking problems on their own. Thirty-three percent of the terminators (n = 9) went for help on their own, compared to only 28 percent of the completers (n = 7). There was also no significant relationship between the two groups regarding alcohol-related hospitalization, according to the Fisher's Exact Test. Forty-four percent of the completers (n = 9) had been hospitalized, compared to 40 percent of the completers
(n = 10). There was no significant relationship between the two groups regarding previous treatment for alcoholism. Forty percent of the terminator (n = 10) had been in treatment previously, compared to 55 percent of the completers (n = 9).

A Fisher's Exact Test showed no significant relationship between the two groups regarding DUIs. Twenty-nine percent of the terminators (n = 7) had DUIs, compared to 38 percent of the completers (n = 8). Data also indicated that 64 percent of the terminators (n = 11) reported other drug use along with alcohol, compared to 11 percent of those women who completed treatment (n = 9). The Fisher's Exact Test indicated a significant relationship between the two groups (P = 0.23).
CHAPTER VI
FINDINGS AND IMPLICATIONS FOR SOCIAL WORK PRACTICE

Results of this study indicated that those women who were more likely to terminate treatment prematurely were different from those women who completed treatment in terms of age and onset of drinking behavior. The completers tended to be older and began drinking at an earlier age than those who terminated prematurely.

Most of the variables that were examined for this study were found to be significant. The author feels, however, that the reason for this was that the population used for the study was too small. Had a larger population been used, there is a strong possibility that a significant difference between the two groups may have been found. For example, it appeared that the higher percentage of those women who completed treatment showed some physiological and/or psychological consequences from alcohol use (see Table 3). This may have indicated that those who were more likely to complete treatment were or have been experiencing some discomfort from the abuse of alcohol. Since it had already been established that those who were more likely to complete treatment were older, perhaps those individuals had been drinking longer and therefore displayed those symptoms. Also, a higher percentage of the completed treatment group reported previous treatment. This finding may have indicated the possibility that when completers were in treatment at an earlier age (possibly before experiencing physiological discomfort), they may also have been prone to premature termination.
Table 3

Demographic and Social Support Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Termination</th>
<th>Completed</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trouble at Work</td>
<td>25% (n = 8)</td>
<td>55% (n = 9)</td>
<td>.181</td>
</tr>
<tr>
<td>Neglected Obligations</td>
<td>71% (n = 7)</td>
<td>75% (n = 4)</td>
<td>.509</td>
</tr>
<tr>
<td>Self-supporting</td>
<td>45% (n = 11)</td>
<td>18% (n = 9)</td>
<td>.214</td>
</tr>
<tr>
<td>Self-referred</td>
<td>27% (n = 11)</td>
<td>11% (n = 9)</td>
<td>.306</td>
</tr>
<tr>
<td>Help on Their Own</td>
<td>33% (n = 9)</td>
<td>28% (n = 7)</td>
<td>.403</td>
</tr>
<tr>
<td>Married</td>
<td>18% (n = 11)</td>
<td>33% (n = 9)</td>
<td>.298</td>
</tr>
</tbody>
</table>

There was a significant difference between the two groups regarding the use of other drugs along with alcohol abuse. Those women who terminated treatment prematurely were more likely to use other drugs (i.e., marijuana, stimulants, etc.). This may be an indication that black women who are multiple drug users may need special consideration regarding their use of other drugs while in treatment with a primary diagnosis of alcoholism. The fact that they may also be addicted to other drugs may make it difficult for them to
successfully complete the treatment program if the focus of treatment is only on one drug addiction. It is important that the treatment program focus on all aspects of addiction, including all drugs used during the addiction process.

The results of this study indicated that a higher percent of those women who completed treatment reported that they had been hospitalized on a psychiatric ward due to alcohol abuse. Again, this may be an indication that the completers may be experiencing more chronic alcohol-related problems, and were therefore more likely to complete treatment.

Also of importance in this study was that all of the women who terminated treatment prematurely had at least one family member who had an alcohol problem, compared to only 57 percent of those who completed the treatment. This finding may indicate that drinking behavior may be greatly influenced by family attitudes regarding alcohol use as well as the social context of drinking behavior (see Table 4).

Although the Fisher's Exact Test indicated no significant differences between the two groups on such variables as alcohol-related arrests, other legal problems, fights, DUIs, or hospitalization due to complication from alcohol abuse, it is interesting to note that higher percentages of these variables were found in the completed treatment group (with the exception of hospitalization due to alcohol abuse - see Table 5).
Table 4
Physiological and Psychological Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>% Terminated</th>
<th>% Completed</th>
<th>Fisher's Exact P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucinations: DTs</td>
<td>20% (n = 10)</td>
<td>55% (n = 9)</td>
<td>.112</td>
</tr>
<tr>
<td>Previous Treatment</td>
<td>40% (n = 10)</td>
<td>55% (n = 9)</td>
<td>.286</td>
</tr>
<tr>
<td>Blackouts</td>
<td>50% (n = 10)</td>
<td>66% (n = 9)</td>
<td>.280</td>
</tr>
<tr>
<td>Family History</td>
<td>100% (n = 7)</td>
<td>57% (n = 7)</td>
<td>.062</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>40% (n = 9)</td>
<td>44% (n = 9)</td>
<td>.350</td>
</tr>
<tr>
<td>Other Drug Use</td>
<td>64% (n = 11)</td>
<td>11% (n = 9)</td>
<td>.023</td>
</tr>
</tbody>
</table>

Table 5
Legal Problems

<table>
<thead>
<tr>
<th>Variable</th>
<th>% Terminated</th>
<th>% Completed</th>
<th>Fisher's Exact P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Related Arrests</td>
<td>30% (n = 10)</td>
<td>38% (n = 8)</td>
<td>.87</td>
</tr>
<tr>
<td>Other Legal Problems</td>
<td>40% (n = 10)</td>
<td>44% (n = 9)</td>
<td>.350</td>
</tr>
<tr>
<td>Fights</td>
<td>30% (n = 10)</td>
<td>66% (n = 8)</td>
<td>.153</td>
</tr>
<tr>
<td>DUIs</td>
<td>29% (n = 7)</td>
<td>38% (n = 8)</td>
<td>.391</td>
</tr>
<tr>
<td>Hospitalized</td>
<td>44% (n = 9)</td>
<td>40% (n = 10)</td>
<td>.350</td>
</tr>
</tbody>
</table>
Many of the items asked regarding the social stability variables were incomplete in many of the charts reviewed. Little or no information was collected regarding resident type or number of address changes within the past three years. Also, the item inquiring about the longest held position was generally not clear in the chart. This author felt that the above items would help social work practitioners develop a better treatment plan for these women which would be of great benefit to them.

The charts that were reviewed for the purpose of this study also had very little or no information on who should be contacted in case of emergency. This information should be considered not only as contact in case of an emergency, but also in helping to determine who the client may use as support systems (i.e., AA sponsors, family member or friends). The support systems are among the tools that the clients will utilize in their struggle to keep their sobriety.

The implications here are that black female alcoholic women have specific needs that should be addressed if they are to successfully enter and complete treatment. Although the variables studied (social support, physiological and psychological dependence, source of referral and drinking history) did not confirm a correlation between premature treatment termination and completion of treatment in black female alcoholics, it was felt that further research in this area, using a larger predominately black population, may yield some concrete differences.
The need for treatment programs designed to help those individuals within a specific target population is of importance. If the target population is of a minority background or on the contrary, it is necessary to design the treatment strategies that will promote low attrition rates as well as developing outreach strategies to inform the target population of the services offered and the benefits of those services.

This study attempted to examine sources of referral as a variable for two main reasons: (1) to determine whether the alcoholic is receiving the family support that is much needed in the recovery process; and (2) determining the specific type of outreach strategies needed to inform black women in the surrounding community that there is help for them. There appears to be a lack of communication to black alcoholic women as to the services provided by alcohol treatment centers. On the other hand, these women may simply need to be assured that they can be helped and to feel comfortable in getting the help needed without the feeling of low self-esteem that often accompanies alcoholism in women.
APPENDIX
PREDICTION OF ATTRITION
STUDY

ID# ________

1. Age: ________

2. Income (monthly):
   a) $0 - 300  b) $301 - 600
   b) $601 - 900  d) $901 - over

3. Marital status:
   a) Single  b) Married  c) Divorced
   d) Widowed  e) Other  ____________

4. Ethnic group:
   a) Black  b) White  c) Other  ____________

5. Employment Status (patient support by):
   a) Self  b) Spouse  c) Public assistance
   d) Parents  e) Other  ____________

6. Resident type:
   a) House (1. Rent, 2. Own)  b) Apartment  c) Boarding facility
   d) Parents  e) Other  ____________

7. Longest held position:
   a) 6 months - 1 year  b) 1 year - 3 years
   c) Over 3 years  d) Never employed

8. Number of address changes within past 3 years:
   a) 0 - 2  b) 2 - 4  c) 4 - 6  d) More than 6
Drinking History

1. Age at onset of drinking: __________

2. Age at onset of heavy drinking: __________

3. Previous treatment for alcoholism: _______
   a) Yes          b) No

4. Any legal problems due to drinking:
   a) Cases Pending          b) Previous arrests or convictions
   c) Other ________________  d) None

5. Family history of alcoholism:
   a) Mother          b) Father  c) Sibling
   d) Grandparents  e) Other __________

6. Other drug use:
   a) Marijuana          b) Stimulants  c) Opiates
   d) No other drug use  3) Other __________

Referral Source

1. Patient's source of referral:
   a) Police department (probation Officer)  b) Employer
   c) Social agency                      d) Spouse
   e) Physician                        f) Self
   g) Other ____________________

2. Person listed as patient's emergency contact:
   a) Spouse          b) Parents or sibling
   c) AA sponsor      d) Friend
   e) Other __________
Physiological and Psychological Dependence

1. DMS III diagnosis: ____________________________

2. Does patient have blackouts?
   a) Yes  b) No

3. Does patient ever feel guilty or "bad" about his/her drinking?
   a) Yes  b) No

4. Has patient ever been involved in fights when drinking?
   a) Yes  b) No

5. Has patient ever been in trouble at work due to drinking?
   a) Yes  b) No

6. Has patient ever neglected obligations (i.e., family or work more than two days in a row due to drinking)?
   a) Yes  b) No

7. Has patient ever been diagnosed as having liver trouble or cirrhosis?
   a) Yes  b) No

8. Has patient ever experienced delirium tremens, severe shaking, heard voices, or seen things that were not there after drinking?
   a) Yes  b) No

9. Has patient ever gone for help on his/her own about his/her drinking?
   a) Yes  b) No

10. Has patient ever been in the hospital because of his/her drinking?
    a) Yes  b) No

11. Has patient ever been in a psychiatric hospital or psychiatric ward where drinking was part of the problem
    a) Yes  b) No
12. Has patient ever been arrested, even for a few hours, because of drinking behavior?
   a) Yes           b) No

13. Has patient ever been arrested for drunk driving or driving after drinking?
   a) Yes           b) No

Termination

1. Patient terminated after ________ days of treatment.

2. Patient left following intake.
   a) Yes           b) No

3. Patient completed 28 days treatment program.
   a) Yes           b) No
REFERENCES


