PROBATION AND PAROLE OFFICERS' PERCEPTIONS OF ALCOHOLISM AND ALCOHOLICS

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OF ALCOHOLISM AND ALCOHOLICS

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CHAPTER I

INTRODUCTION

Background Information

In studying human social behavior, the core of the analysis resides in studying social interaction as a dynamic process within a social system. This assertion implies that there are at least two parties to the interaction, and that the social constructions of reality of both parties, as well as external constraints imposed by the system, need to be examined. The social meanings brought to the interaction include expectations beyond the boundaries of the formal, institutionalized role definitions which influence the way the individuals involved evaluate and act toward one another. Consequently, the outcome of the interaction may be expected, unanticipated, or result in a self-fulfilling prophecy.

In the realm of social deviance, the focus of research frequently has been on the party to the interaction who is considered the deviant (by society's dominant values). His or her characteristics, background and behavior have been investigated in order to find out why he or she did not behave as expected or perform "successfully" (Freidson, 1970b: 46-47). With the emergence of the societal reaction (labeling) approach to deviance, it has been suggested that the encounter between the imputed deviant and social control agent is an interactive one, thus requiring examination of the "audience," including the social control agent, in addition to the deviant.

In broadening the investigation of social deviance areas to include the total interaction system, a number of additional factors must be considered. For instance, expectations of the social control agents, which may be based on invalid stereotypes, along with their personal and cultural determinants (Bloom, 1963) should be examined. The relative power of the interaction participants, the degree to which each party has been socialized into his or her role, and the organizational constraints on the agent's behavior cannot be ignored. In addition, the _consequences_ of these and other elements of the social control agent's situation for the interaction between him or her and the "deviant" must be given attention. In short, as Lemert (1972:24) noted: "Measures are needed not only of the amount and kinds of damage done by deviants to our society, but also of the costs of various modes and means of defining and dealing with them."

In the field of alcoholism, most people are aware of the enormous economic, social, and personal costs attributable to alcoholics. Long before the societal reaction approach to deviance became popular, and before alcoholism was "officially" designated a disease by the legal and medical institutions (Schneider, 1978), researchers in several human services professions were concerned that their profession's means of dealing with alcoholism was costly. They were convinced and demonstrated empirically that the prevalent negative definitions and attitudes created institutional settings which did not permit alcoholics to use therapy constructively (Sterne and Pittman, 1965). They also called for and carried out educational efforts with health care agents to change the situation. Such findings have been well documented for nurses, physicians (including psychiatrists), general hospital staff members,

psychologists, social workers, alcoholism counselors, industrial supervisors, school guidance counselors and others in human services.

For practitioners in the criminal justice system, however, there is a notable lack of information regarding their knowledge, attitudes, and behavior toward alcoholism and alcoholics. Mackey (1969) included police officers in comparison with other helping professionals in his attitude survey. Dorsch et al. (1969; 1973) incorporated court-counseling services and probation officers into their larger category of "social-counseling agencies" and had specifically law enforcement agencies like police departments and sheriff's offices in the first part of their four-year study; however, in addition to not singling out criminal justice personnel for separate analysis, they studied only awareness and utilization of alcoholism treatment programs rather than attitudes. Soden (1975) discussed the need for probation/parole officers to be informed about alcoholism and suggested ways for them to use other helpful agencies. Robinson (1976) had a sample of only 23 probation officers in his study about alcoholism in London, reflecting not only a small sample, but also cultural differences. Finally, Margolis et al. (1964) described how probation officers were used as "therapeutic agents" in a therapy program for chronic alcoholic offenders. In short, the data are almost nonexistent--none on knowledge, two studies each on attitudes/behavior with limited samples, and only two specifically on probation or parole officers.

Introduction to criminology texts refer to the strong relationship between alcohol consumption and the commission of felony crimes as well as the preponderance of arrests for public intoxication and other alcohol-related offenses. Similarly, it has been frequently estimated or

documented that up to half the incarcerated felons in the United States have drinking problems, and further that the great majority of those felons will return to the community with their alcohol problems untreated. Pittman (1974:225) went on to point out that criminal recidivism rates tend to decrease with age, _except_ for those individuals who are also alcoholics. It seems apparent that the problem of alcoholic criminals is costly. Equally clear from this information is that criminal justice professionals have daily contact with people with alcohol-related problems. Surprisingly, however, a thorough review of the literature did not reveal any study of criminal justice personnel's views toward alcoholism or alcoholics.

Purpose of Study

It was suggested strongly in the foregoing section that alcohol consumption and alcoholism are important elements in the commission of criminal offenses. It also was noted that there is a paucity of information on the way workers in the criminal justice system perceive these important alcohol-related problems. It has been documented repeatedly that workers in other fields tend to hold basically negative attitudes toward alcoholism and alcoholics, and that these attitudes influence their interaction with alcoholic clients, often resulting in unfortunate therapeutic consequences. Thus, it is important that more information be gathered about views of criminal justice practitioners on the subject.

Therefore, it was the purpose of the present study to examine members of one segment of the criminal justice system, probation and parole officers, regarding their views on alcohol problems. More specifically, the intention was to explore systematically: 1) their

knowledge about alcohol and alcoholism; 2) the dimensions and components of their attitudes toward alcoholism and alcoholics, as well as possible sources of those attitudes; and 3) their behavioral experience and predispositions toward alcoholics.

Significance of Study

Substantive

The 1978 Oklahoma Alcohol Services Act (Oklahoma Senate Bill 280, 1978:Section 2111) specifically called for alcoholism treatment services for alcoholic criminal offenders, and probation/parole officers are especially important persons on the interface between offenders and the treatment system. In the first place, they have longer term and more continuous contact with offenders than do police officers. Secondly, alcoholism treatment programs have been established in state correctional institutions, and it is important to develop some expectations for attitudes offenders will face when they return to their local communities as parolees (Shaw, 1979). Thirdly, since most offenders are placed on probation and remain in the community, the probation/parole officers may be the _only_ official bridge between them and treatment for their alcoholism problems. Thus, results of this study have immediate practical implications for the corrections system in Oklahoma, and perhaps it can serve as a baseline for such studies in other states.

Another area of substantive contribution lies in education. The Kerr Foundation Task Force on Alcohol Abuse (1979:45) cited views of Oklahoma professionals which reflected those of human services practitioners all over the United States regarding the inadequacy of traditional alcohol education:

> Those interviewed almost unanimously expressed a desire for additional education concerning the nature of alcohol abuse, techniques for detection and intervention, and the existence of treatment resources in the state.

Results of this study can serve to establish a baseline for starting some of that education and providing the basis for measurement of its impact.

Yet a third substantive contribution of significance lies in the fact that what little is reported about offenders in the criminal justice system with alcohol-related problems virtually excludes information on female offenders. Since evidence indicates that both alcoholism and crime rates are increasing rapidly for women, this research explored whether probation/parole officers perceive and work with men and women alcohol clients differently. Such data can provide at least a beginning in filling an important void in the research on alcohol, crime, and its follow-up.

Theoretical

The labeling theory of deviance has been criticized frequently for its lack of empirical support. According to Becker (1964), Erikson (1964), Schur (1971), Suchar (1978), and others, a major focus of study for labeling theorists is the "audience," those doing the labeling. The study reported here examined precisely that, the views of the audience. The theory also has been challenged for emphasizing _formal_ labels stamped on persons by people-processing organizations as the labeling audience. The present study concentrated on perceptions of those social control agents dealing with "deviants" at a more primary level of interaction, showing the theory's debt to the symbolic interaction perspective.

A related criticism of labeling theory deals with the empirical demonstration that formal labeling does not automatically lead to

secondary deviance. Although Suchar (1978) dismissed secondary deviation as an unessential part of a labeling approach, the researcher agrees with Clinard and Meier (1979), who argued that secondary deviance needs to be explored at levels other than that of the formal social control agency. They found that informal labeling in primary interaction was more strongly related to narcotic addict relapse than were formal labels. Since research on other professions has indicated that stereotyping and labeling in interaction with the therapist in a primary relationship does have important outcomes for alcoholics, the present study addresses itself to this critical theoretical issue by exploring attitudes of social control agents who interact at a more personal level with offenders.

Methodological

The study reported here utilized some widely accepted scales in the survey instrument, for which another occupational group has been provided for comparative purposes. The most popular scale (the Marcus Alcoholism Questionnaire) was factor analyzed to see if its factor structure still holds several years after its inception, at least with one study group.

Prior survey studies have measured attitudes toward the condition of alcoholism or toward the alcoholic person, but not toward both simultaneously. Since both were included in the questionnaire used here, statistical measures of association ascertained just what relationships existed between the two types of attitudes, at least for one study sample. An examination of such a relationship (or lack of it) has important implications for future alcoholism attitude studies.

CHAPTER II

REVIEW OF THE LITERATURE

The theoretical framework for the study at hand must look at aspects of what needs to be a primary relationship within the imperatives of bureaucratic organization. Furthermore, it must take cognizance of the fact that one member of the relationship is a paid member of the formal organization and generally defined as a conforming member of society. The other participant is essentially an outsider to the organization. Moreover, in a sense, he or she is a "double deviant," not only because of breaking the law, but also because she or he has a socially stigmatized condition called alcoholism. It is the latter form of deviance which is the primary focus here.

Alcoholism and Criminal Offenders

The first task is to place alcoholism in the proper perspective for the framework of this research. There are many complicated definitions of alcoholism, but most incorporate the facets stated simply by Jones et al. (1979:184):

> 'Alcoholism is the point at which a person's drinking interferes with some aspect of his or her life.' . . . The way to judge if someone suffers from alcoholism is not to measure how much he or she drinks but to observe what effect drinking has on their life.

This is the concept of alcoholism which will direct this study.

It is generally agreed that alcoholism is costly in dollars, health, family disorganization, and crime. It was estimated that alcoholism

cost the United States nearly $43 billion in 1975 in lost production, health costs, motor vehicle accidents, violent crime, and social agency costs (Berry et al., 1977). When the contribution of alcohol to other diseases and to accidents is considered, it becomes one of the leading causes of death (Fort, 1973), and in fact has been labeled the "number one hidden health problem in the United States" (Jones et al., 1979:183). Jacob et al. (1978) listed 98 references to studies describing the impact of alcoholism on the family in their article surveying the topic.

With regard to crime, very little has been presented relating to female offenders, except to note that Pelka-Slugocki and Slugocki (1977) found among women prisoners in Poland that 17% were alcoholics and an additional 32% alcohol abusers. In Oklahoma in 1979, females accounted for 13.8% of all juvenile and 8.9% of all adult alcohol-related arrests (OSBI, 1980:50,54). For male offenders, however, alcohol-related arrests are the most frequent type of crime, accounted for mostly by public drunk arrests (Barlow, 1978). In Oklahoma, there were 75,461 alcohol-related arrests in 1979 (driving under the influence, liquor laws, and drunkenness), constituting 50.4% of all arrests for both sexes reported for the year (OSBI, 1980:4). While there is no way to prove a causal link between any drug and crime, alcohol is the drug most strongly linked as a situational factor in many crimes, especially assaultive ones like homicide, aggravated assault, rape, and family violence (Barlow, 1978; Pittman, 1974). For example, Wolfgang (1958) found alcohol present in 64% of the 588 murders he studied in Philadelphia. Johnson et al. (1978) found that the rapist had been drinking in 63.1% of the reported rapes in Winnipeg in the ten-year period preceding 1975, and that the presence of alcohol increased the

likelihood of force being used in the rape. Amir (1977) found the same association in Philadelphia rapes. Wolfgang (1958) suggested that if anything, this relationship between violent crime and alcohol consumption probably is underestimated, since it is usually based on police reports rather than blood or urine tests. Wolfgang (1958:135) went on to point out:

> Unless the police specifically mention in a case file the presence of alcohol, the absence of alcohol is assumed. Therefore, if there is recorded bias in any direction, it is in favor of the absence of alcohol.

For example, Pittman cited just such a study where the results at least equaled those of Wolfgang. In his discussion of intoxication and assaultive crime, Pittman (1974:224-225) noted a study where 882 persons had urine analysis for alcohol concentration immediately after being picked up for a felony. Sixty-four per cent were enough under the influence of alcohol that their inhibitions were reduced. Pittman (1974:225) described this finding as being "of major significance to American criminologists."

Although a great deal of crime is alcohol-related, it is evident that not all criminals are alcoholics. Nevertheless, Pittman (1974) noted that the major variable associated with dropping out of a criminal career is age, except when the individual has an alcoholism problem. Radzinowicz and Wolfgang (1971) and Fox (1976) reported that crimes associated with alcoholism in these older criminals, especially check forgery and petty theft, are among the crimes with the highest recidivism rates. In a similar vein, Sutherland and Cressey (1978) reported a study on a sample of 10,000 incarcerated felons, 43% of whom reported drinking at the time of their offense; half of those admitted being at least "heavy" drinkers. In the most comprehensive longitudinal study yet of

convicted felons, Guze and Cantwell (1965) diagnosed 43% of their original sample as alcoholic. In a three-year follow-up, when some of the original "questionable alcoholics" became diagnosed as alcoholic, they found statistically significant differences between alcoholics and non-alcoholics on three of four measures of recidivism, with the alcoholics having higher recidivism rates on all four measures. In an eight-year follow-up of 176 of the original sample of 223, 67% reported drinking problems, although 38 alcoholics had been "in remission" for at least two years. The "remitted" group had significantly fewer arrests than those who were still drinking (Goodwin et al., 1971). In a 12% random sample of the 13,300 persons under state probation-parole supervision in 1978 in Oklahoma, 16.1% reported moderate or severe drinking problems to their probation/parole officers (Collins, 1979). This is low compared to national estimates, but since abstinence from alcoholic beverages is part of the parole contract in Oklahoma, such problems are extremely likely to be under-reported.

Confusion about Alcoholism

It is clear that alcohol use and abuse, as well as alcoholism, are expensive, including being very much tied in with crime and, therefore, the correctional system. No evidence was found in the literature to dispute this complex association. However, this is where agreement ends. Just defining alcoholism is a complicated matter; it seems to have gone the route from sin to crime to disease or illness (Schneider, 1978), and some experts are now urging that it be called a "condition" (Tarter and Sugerman, 1976). Since the mid-1960's, the *major* professional emphasis, legally and medically, has been to label it as a disease or illness, thus

shifting responsibility for its occurrence, and allowing the alcoholic to be "treated" as a sick person rather than punished (Dinitz et al., 1969).

> However, while the label of illness does seem to function to discourage punitive reactions, it does not discourage condemnatory reactions. The 'illness' is condemned rather than the person, but it is condemned nonetheless. The person is treated with sympathy rather than punishment, but he is expected to rid himself of the condemned attribute or behavior. Thus, while (ideally) the person may not be judged, his 'disease' certainly is judged and his 'disease' is part of him (Freidson, 1970a:253).

In other words, whether the alcoholic is seen as criminal, sinful, or sick, he or she may still wear a stigmatized label and be defined and treated as deviant. The studies to be cited will indicate that many persons, even medical and other human services professionals, still view the alcoholic as a skid row derelict, weak-willed, responsible for his/her condition, unmotivated for treatment and having a poor prognosis for recovery.

Closely related to differences in the conceptualization of alcoholism is disagreement concerning its etiology. Some proponents argue for biochemical or genetic links, others for psychological causes (including alcoholic personality, psychodynamic underpinnings, and learning theories), and still others propose a relationship between alcohol problems and the sociocultural setting in which the problem is located (Tarter and Sugerman, 1976; Robinson, 1976). Then come the conflicts over treatment modalities (disulfiram, psychotherapy, group therapy, Alcoholics Anonymous, behavior modification, etc.) and treatment goals, e.g., abstinence, controlled drinking, increased social functioning (Fox, 1967; Pattison, 1966).

The conflicts among professional "experts" have led to inconsistencies in the views of various populations. Both psychiatrists and

psychologists, for instance, were found not to accept the disease concept of alcoholism, but both groups also tended to view the hospital as the appropriate place to treat the alcoholic (Knox, 1969; 1971). On the other hand, Bailey (1970), found that 97% of the social workers in her study defined alcoholism as a disease, but 83% felt a combination of their (nonmedical) counseling and Alcoholics Anonymous (essentially treatment by lay people) was the treatment of choice. Reinehr (1969) discovered that alcoholism therapists and alcoholic patients displayed virtually no agreement on the characteristics of alcoholics. These inconsistencies are more than just interesting; they have critical implications for the treatment of alcoholics. As Robinson (1976:57), who found similar inconsistencies with both lay people and professionals, noted:

> It is clear that a large number of well-developed 'scientific' theories of alcoholism are available. However, if we are interested in why people do what they do in relation to both alcohol and drinkers we need to have access to the helping 'professional' and 'everyday' theories of alcoholism in terms of which people actually operate in particular situations.

Primary Interaction and Treatment of Alcoholics

Before the actual images held by treatment and social control agents are pursued further, the importance of interaction between the agent and patient/client should be noted. Symbolic interaction theory always has emphasized the importance of primary relations in supporting and sustaining a person's self-image (Shibutani, 1961). Either illness (Mechanic, 1978) or deviance (Goffman, 1963; Lemert, 1972) mean an assault on the self-image. Alcoholism may qualify as either or both in certain circum-

stances.[1] In fact, Freidson (1970b:255) pointed out that as physicians become moral entrepreneurs, they may create secondary deviance in the form of sick roles every bit as much as social control agents create it for those labeled deviant in the sense of being undesirable. Bloom (1963) and Goffman (1961) were among the earliest sociologists to recognize the general implications of health agent/patient interaction for restoring self-esteem to medical and mental health patients.

As a consequence, a great deal has been written in this area for all types of illness and deviance. Much attention has been paid to the "therapeutic" relationship between alcoholics and those who treat them and the importance of the interaction that takes place in that relationship for the recovery of the alcoholic. Physicians have been told that a disapproving, condescending, or punitive attitude will have a harmful effect on the alcoholic patient, who needs someone to understand him or her and be willing to help (Bell, 1963). Queen (1971) warned nurses that their attitudes toward the alcoholic patient and his/her family are so vital that they can provide the turning point in motivation for recovery; and Moody (1971) studied nurses' attitudes for the very reason that the treatment of alcoholism depends to a major degree on the rapport established between therapist and patient. Likewise, Bailey (1970) prefaced her research on social workers with the statement that the therapeutic relationship is interactive. Dealing specifically with alcoholism counselors, Blischarski (1972:5) remarked that the patient's prognosis is directly related to her/his identification and involvement

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[1]Indeed this ambiguity of status for the alcoholic may leave him or her in a double bind, because the "dual ideologies" lead to a combination of rejection and rehabilitative actions being directed to his/her social reinstatement (see Lemert, 1972:76; Dinitz et al., 1969:19).

with the treatment milieu, concluding that ". . . the therapist-patient relationship may influence the effectiveness of all forms of treatment needed to help the alcoholic patient." Finally, in the classic study in this area, encompassing a wide variety of human services professionals, Sterne and Pittman (1965:54) observed:

> . . . the responsibility for discontinuance in treatment need not invariably be the alcoholic's. The therapeutic situation is an interactive one, and research has shown that therapists play a large part in determining the nature of the therapeutic relationship.

Contribution of Labeling Theory

Sterne and Pittman's comment directs attention to the contribution that societal reaction or labeling theory can make to an understanding of alcoholism treatment. Conventional deviance theory focused on the deviant and his or her personal characteristics. Health and social control agents traditionally have done this; they frequently look for the motive of the deviant actor, and through "retrospective interpretation" (Schur, 1971:54), they come to see the act as the outcome of the actor's traits or "essential self" (Hawkins and Tiedeman, 1975:96). Professionals treating alcoholics are no exception. Physicians often do not like to work with alcoholics because they feel the patient rarely follows their recommendations (Cantor, 1977) or because they think the recovery rate is too low (Hayman, 1956); that is, they impute causes of treatment problems to the alcoholic. With social workers, Bailey (1970: 673-674) found that even after thirty hours of alcoholism training, 51% still saw alcoholism as self-inflicted, and 47% felt that if an alcoholic fails to stay in treatment, the responsibility lies with the alcoholic, while only 18% attributed any responsibility to the professional.

Sterne and Pittman (1965) again provided the direct vital link to labeling theory in discussing their findings that 3/4 of the helping professionals they surveyed saw motivation as crucial for initiating treatment and for recovery from alcoholism. Three-fourths (76%) of those emphasizing motivation relied on "post-factum" (similar to Schur's retrospective interpretation), rather than "predictive" imputations of motivation. After pointing out that post-factum imputation carries the danger of reifying the motivation concept, Sterne and Pittman (1965: 46-47) asserted that motivation becomes:

> . . . a global, intuitive explanation of behavior, locating its source as entirely within the individual, and advancing us not one step further in our understanding of specific antecedents to behavior. This use of the motivation concept is closer to judgment than to explanation; it is a summary way of stating that the alcoholic succeeds or fails in conforming to the expectations of the treatment agent, without attempting to understand why this is so. . . . Those who impute motivation post-factum from behavior overlook the possibility of . . . modifying traditional modes in which treatment services are given in order to attract and successfully treat alcoholics who, for want of more imaginative handling, are currently labeled 'unmotivated.'

The journal noted the Sterne and Pittman article was received for publication in 1963, so it is unlikely that they had seen Becker's 1964 comments on contributions of a labeling approach (1964:3):

> . . . if we assume . . . that deviance is somehow a quality of the person committing the deviant act, we are likely to suppose without looking any further into the matter that the person who commits the deviant act is somehow compelled to do so. On the other hand, if we view deviance as something that arises in interaction with others, we realize that changes in interaction may produce significant changes in behavior.

These almost amazingly parallel statements suggest that indeed the social audience interacting with the individual, rather than the individual actor alone, must be considered a critical variable in the study of deviance (Erikson, 1964:11). Clinard and Meier (1979) accused the

labeling approach of focusing only on the audience composed of the official agents of control; however, Hawkins and Tiedeman (1975:49), as well as Schur (1971:12-13), while recognizing that labeling theory has emphasized this level of social control, asserted that other audiences include society at large and those people with whom a person has informal and intimate contacts. Both called for more investigation of how these three levels of audiences interact in their response to deviation. Alcoholism treatment agents certainly are representatives of official control agencies; as noted above, however, to be successful in therapy with alcoholics, they must maintain some intimate interaction with the alcoholic which is reinforcing to his/her self-concept; at the same time the studies show they frequently react to this intimate interaction on the basis of stereotypes, which are generated mostly from society at large. Thus, an opportunity is provided here to examine the interaction between the three levels of audiences.[2]

Stereotyping is the critical variable to be explored. Schur (1971: 41) viewed stereotyping as the "central component" of the social processes in operation with the audience, for in part they lead to selective perception and thus the potential for reactions based on inaccurate judgments. These stereotypes may become reified, leading people "to see others through labels, rather than as unique individuals (especially when the label refers to something they do not completely understand--e.g., mental illness or alcoholism)" (Hawkins and Tiedeman, 1975:62). Most

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[2]To focus on the audience is not to imply that the "deviant" is an innocent bystander, but he or she has been probed in depth already. It _is_ to suggest, as Simmons (1969:25) pointed out, that society is an active _partner_ in the interaction producing the deviance, and its part _also_ must be explored in any effort to understand.

societal reaction theorists agree with Simmons (1969:35) that the consequence of the labeling process is almost automatic rejection of the person so labeled. At this point, the usual extension of the labeling argument, that becoming an outsider and the shift from primary to secondary deviance is inevitable, will not be argued. Berger (1975) found the issue of deviant identity to be one of the key areas of inconsistency among labeling theorists. Suffice it to say that one consequence certainly may be a self-fulfilling prophecy, especially for a condition like alcoholism where denial mechanisms on the part of the alcoholic and his/her significant others play an important role.

Labeling Theory Applied to Human Services Professionals and Alcoholics

Returning to the alcoholism literature for empirical verification of the labeling process, Suchar's (1978:230) summary of the approach is helpful:

> Labeling analysts are concerned with the *construction of moral meanings* and the interpretations of social control agents that designate acceptable or unacceptable behavior. It studies deviance as an *evaluative reality*. The focii [sic] of the labeling perspective are the social and social-psychological dynamics that influence definitions of the social worth of individuals. [Emphasis in original.]

Thus, in addition to identifying the attitudes held by human services professionals toward alcoholics, a major concern was to search for variables related to those attitudes.

In addition to Sterne and Pittman (1965), other alcohol researchers have supported the labeling approach. For example, Reinehr (1969:445), after comparing the descriptions of alcoholism counselors with those of their alcoholic patients, concluded that the therapists reacted to

patients "as members of a group whose characteristics are undesirable," [Emphasis added] although the patients saw themselves quite differently. Ewing (1971) reported that if it were announced ahead of time that a patient to be presented at clinical rounds was an alcoholic, both medical students and physicians displayed a different attitude than if the alcolism were not mentioned until the meeting started. Mendelson and Hyde (1971) recognized the influence of the societal audience when they commented that a value system affects the criteria physicians use for judging what is successful remission in chronic disease, referring to more pride being felt with dialysis patients than with alcoholic patients who did well. In her study of alcoholic halfway house staff members, Martin (1979:219) found their expectations for client behavior to be based on their personal expectations, independent of the clients' capabilities and limitations, leading her to conclude that organizations should have "clear-cut treatment philosophies or orientations" to guide the behavior of staff and clients. On the other hand, even when treatment organizations have definitely stated philosophies and goals, individual members of those organizations do not necessarily share them (e.g., Bailey, 1970). In short, scientists themselves do not agree on the definition of alcoholism or its etiology, nor do they agree on treatment methods or goals. Therefore, it is not surprising that treatment agents react to alcoholics, at least in part, on the basis of stereotypical thinking, as suggested in the studies just cited.

In general, three conclusions can be reached from surveying studies from a variety of human services professions: 1) attitudes toward both alcoholism and alcoholics tended to be more negative than positive; 2) attitudes within the same sample frequently were inconsistent; and 3)

attitudes varied considerably between studies, even holding constant time of study and profession being studied.

Characterization of Alcoholism and Alcoholics

On the matter of defining alcoholism, Robinson (1976) found general practitioners were more likely than social workers or probation officers to view it as a mental illness, but more likely to disagree that it is a physical disease. His respondents did not even agree on labels; general practitioners talked about alcoholics, and social workers talked about problem drinkers, while probation officers were split in their labels. In Bailey's (1970) sample of social workers, 85% before and 97% after training said alcoholism is a disease, but 59% of Chalfant and Kurtz' (1971) sample of social workers did not see the alcoholic as legitimately sick.

Among psychiatrists and psychologists, Knox (1969; 1971) found that both groups defined alcoholism as a behavior problem, with the disease concept coming in last in a list of five possible definitions. Ferneau and Gertler (1971), on the other hand, discovered that psychiatric residents saw alcoholism as a character defect instead of as an illness. This is not too different from Hayman's conclusion years earlier (1956:492) that "Alcoholism appears to be the delinquent child of psychiatry." He found then (before the popularity of the disease concept) that psychiatrists were not even very interested in alcoholism.

Ferneau and Morton (1968) found nurses to be inconsistent, accepting alcoholism as an illness, but also scoring high on viewing it as a character defect. Without indicating specific attitudes, Chodorkoff (1967; 1969) discovered student nurses to have significantly "more

favorable attitudes" toward alcoholism and alcoholics than medical students, although medical students were significantly more knowledgeable about alcoholism. Gurel (1976), with a population of undergraduate and graduate student nurses enrolled in special alcoholism courses, found them highly in favor of an illness concept. With a variety of human services students and professionals after training, Williams et al. (1974) and Waring (1978) found strong endorsement of the disease concept. Finally, White (1975), with a sample of health professionals in eighteen small hospitals in Oklahoma and Kansas, found 87% agreeing with the disease idea.

However, as Freidson's (1970a:253) comment above indicates, just because many persons shift their concept from moral defect to disease, it does not follow that the stigma is necessarily reduced. In fact, more specifically with regard to characteristics of alcoholics themselves, the negative stereotypes still prevailed. Wolf et al. (1965) found that although physicians could abstractly define alcoholism as a disease that can occur in any population segment, interviews indicated that at the more emotional level they perceived alcoholics as skid row derelicts. Fisher et al. (1976), on the other hand, with a sample of family medical practice residents, established that after alcoholism training, the only adjectives their sample members checked differently for alcoholics and "normal persons" were on the sick-healthy continuum.

Reinehr's (1969) sample of a variety of alcoholism counselors (physicians, psychologists, social workers, and volunteers) checked virtually all negative or critical adjectives to describe alcoholics, none at a 70% agreement level with the adjectives checked by the

alcoholic patients. Sowa and Cutter (1974) sampled 80% of the staff at a large alcoholism treatment center (from clerical and maintenance staff to psychologists and physicians) with the same adjective checklist used by Reinehr; they found all levels of staff to be generally negative in their views regarding characteristics of alcoholics. Similarly, Mackey (1969) discovered that mental health professionals, school guidance counselors, social workers, and police officers checked generally positive adjectives to describe "normal" people, but their mean ratings showed relatively undesirable characteristics associated with both men and women alcoholics.

Etiology of Alcoholism

In probing professionals' views on the etiology of alcoholism, Robinson (1976) found all three professional groups explaining alcoholism in terms of social learning and coping with difficult life situations, with the least support for biochemical/genetic theories. There is strong agreement among several other groups that emotional difficulties lead to alcoholism; this finding was supported for nurses (Ferneau and Morton, 1968); physicians (Ferneau and Gertler, 1971); psychiatrists and psychologists across a period of several years (Knox, 1969; 1971; 1976); and undergraduate human services majors (Waring, 1978). Ninety-seven percent of Bailey's (1970) social workers also agreed with the idea of emotional etiology, but at the same time 93% said alcoholism results from a combination of emotional factors and physiological predisposition. Ferneau and Morton (1968) and Ferneau and Gertler (1971) found that both nurses and physicians believed alcoholics can control their drinking, as did 60% of White's sample (1975); but

Greer (1975), studying special education teachers, and Waring (1978) discovered that their respondents believed alcoholics have loss of control over drinking.

Treatment Modalities and Goals

Regarding appropriate treatment for alcoholics, in 1956, Hayman learned that psychiatrists preferred supportive or insight therapy in combination with sedatives; however, 99% had positive attitudes toward Alcoholics Anonymous (AA), and 77% had referred patients to AA. Bailey (1970) found that 83% of her social work sample thought a combination of professional help and AA was most beneficial. The rest of those who included questions about treatment found AA to be the treatment of choice, among psychiatrists and psychologists (Knox, 1969; 1971), nurses (Rosenbaum, 1977), and members of all types of helping professions (Dorsch and Talley, 1973). As for goals of treatment, only three studies reviewed surveyed attitudes about them. All saw permanent abstinence as a necessary goal, but preferably in conjunction with decreasing problems in other areas of living (Bailey, 1970; Knox, 1971; 1976; Rosenbaum, 1977).

Prognosis for Recovery

The defeatist pessimism regarding prognosis for recovery of alcoholics that Hayman (1956) and Sterne and Pittman (1965) found so prevalent does seem to be changing somewhat with time. Knox's psychologists, who tended to be pessimistic in 1969, continued to be so in 1976; Greer (1975) reported that special education teachers felt more pessimistic about the recovery of alcoholics than of "other disabled persons;" and

Dorsch and Talley (1973) noted that "some" respondents felt alcoholics are "hopeless." The remainder of the researchers discovered, however, that 60% to 87% of their professionals felt alcoholics can recover with treatment (Bailey, 1970; Williams et al., 1974; White, 1975), while others' respondents had scores on the Marcus Alcoholism Questionnaire suggesting more optimism for recovery than in the past (Ferneau and Morton, 1968; Ferneau and Gertler, 1971; Gurel, 1976; Waring, 1978).

Personal Factors Underlying Professional Attitudes

It is clear that human services professionals have a number of stereotyped attitudes toward alcoholism and alcoholics; their very inconsistency (e.g., labeling alcoholism a disease but also a character defect, accepting a disease concept but suggesting an organization of lay people provides the most beneficial treatment or vice versa) indicate the stereotypical nature of their orientations. Where do the typifications derive from? Some obviously are a result of general cultural views, reflecting changing ideologies (Linsky, 1970), but are there more specific factors related to certain attitude clusters? The literature does not seem to be particularly helpful in answering this question, partly because not many related variables are examined, and partly because when they are, the results are mixed.

Demographic Variables

The standard demographic variables were rarely mentioned in the literature. Although a considerable amount of work has been done in sociology relating _subcultural_ influences of race, ethnicity, and

religion to differences in general attitudes about drinking (Robinson, 1976), none of these variables were even mentioned in the studies of professionals. Most of the studies reviewed did not refer to sex of respondents, although it too, has been found significant in studies of alcohol attitudes in the general population (Kilty, 1978; Robinson, 1976). Lemos and Moran (1978), in a study of Veterans Administration hospital staff members, did comment that sex was not related to attitudes; Mackey (1969) found some sex differences statistically significant in stereotypes of alcoholics, but concluded that occupational differences accounted for more differences. Similar lack of results was found for age, although Robinson (1976) and others noted it was related to alcohol attitudes. Lemos and Moran (1978) did not find age related to alcohol attitudes among physicians. Distefano et al. (1975) were the only researchers to note educational level, finding it positively correlated with both attitude and knowledge about alcoholism; however, formal education was not related to change in either attitude or knowledge as a result of training.

Occupational Variables

The only social structural variables studied to any extent were type of occupation and professional level, but with conflicting results. Regarding professional level, among staff members of alcoholism and psychiatric in- and outpatient facilities, professionals were more disease-oriented, less pessimistic and less moralistic than nonprofessional staff members, but experience working with alcoholics was more strongly related to attitude clusters than was professional level (Mogar et al., 1969). Ferneau and Morton (1968) found RN's to have more

positive attitudes than nurse assistants, but others have discovered reverse order in attitudes. For instance, Chodorkoff (1969) reported nursing students to have significantly more favorable attitudes than medical students, while Sowa and Cutter (1974), with three status levels of staff members in a treatment center, found the highest status to be the most negative and lowest status to be the least negative in attitudes toward alcoholics. Still others have found professional level not to make a difference; Moody (1971) with three levels of nurses, and Mendelson et al. (1964), with levels of physicians, found no differences between the statuses on the Custodial Attitude Inventory toward alcoholics, and Sterne and Pittman (1965) concluded that professional level had a relatively low impact on conceptions of motivation for alcoholism treatment.

Type of occupation also showed mixed results. Sterne and Pittman (1965) discovered that physicians and social workers placed slightly less emphasis on motivation for treatment than did members of other occupations. Concerning moralistic views toward alcoholics, they found statistically significant differences between occupations with religious specialists the most moralistic, followed by administrators, nurses, physicians, and finally, social workers were the least moralistic. Dorsch et al. (1969; 1973) reported physicians reluctant to deal with alcoholics and also most negative in attitudes toward them; clergy, lawyers, hospital emergency room staff, social counseling agency staff and law enforcement personnel would not accept total responsibility for treating alcoholism, but neither did they reject it as not meriting any concern at all by their profession. When the same people were sampled for attitudes, physicians were most negative, with clergy, lawyers,

and social counseling agency staff being increasingly more positive. Reinehr (1969) and Lemos and Moran (1978) surveyed a number of health occupations with contrasting results; Reinehr's sample members were uniformly negative, while Lemos and Moran's were uniformly positive. Differences between general practitioners, social workers and probation officers reported by Robinson (1976) have been noted previously. Mackey (1969) compared a wide variety of occupations--mental health professionals, school guidance counselors, public welfare workers, and police officers--in an Eastern community suburb. Each of the three other occupational groups was compared with the mental health professionals on adjective checklists describing normal and alcoholic man and normal and alcoholic woman. The police officers were the occupation most negatively different from the mental health professionals on all four adjective checklists.

Other Personal Variables

The other variables reported to be related to attitude in any systematic manner were authoritarianism, knowledge, and experience. Authoritarianism was popular primarily in the earlier studies surveyed. In 1964, Mendelson et al. reported a statistically significant positive correlation between authoritarianism and custodialism in attitudes toward alcoholism for all levels of physicians. They also found authoritarianism to be related significantly to professional level of physician and to religion, neither of which was related to alcoholism attitude. Chodorkoff (1967) discovered authoritarianism was not related to alcoholism attitudes among medical students, but was significantly related (inversely) for nursing students (Chodorkoff, 1969). This finding led

to a reversal of his 1967 suggestions that education should be directed to the specific attitude rather than to general personality characteristics since they varied independently. However, the latter data persuaded Chodorkoff (1969:663) that nursing and medical students are different types of people, so one must know his or her educational audience and realize the earlier proposal might not work to overcome limitations imposed by certain personality characteristics. Studying student nurses, Moody (1971) found results similar to those of Mendelson et al. (1964); there was a statistically significant positive correlation between custodialism and F score for every classification level. However, when he controlled for economic status, the relationship was much stronger for students from the middle class than from upper and lower socioeconomic groups. This led him also to conclude that education and recruitment for alcoholism counseling should take into account different types of people. Gray et al. (1969) found that physicians low in authoritarianism were not only more willing to treat alcoholics, but also significantly more likely to actually treat them (53% versus only 15% of those with high authoritarianism scores treated alcoholics). They suggested that physicians with authoritarian personalities cannot fulfill the interpersonal expectations of alcoholics. This variable has been given extended attention here because of the popular idea that criminal justice personnel tend to be more authoritarian than the general public (e.g., see Parker, 1980:14). If this is true, then one would expect them to hold more negative attitudes than others.

With regard to knowledge about alcohol and/or alcoholism, Chodorkoff (1967) found a strong positive correlation between knowledge and attitude for medical students, but virtually no correlation between

the two for nursing students (Chodorkoff, 1969). Moreover, Chodorkoff (1967; 1969), Bailey (1970), and Lemos and Moran (1978) did not find significant positive changes in attitudes after training courses in alcoholism. On the other hand, Gurel (1976), Distefano et al. (1975), Williams et al. (1974), and Waring (1978) did, at least for most attitudinal dimensions tested. Given the mixed findings, it appears to this researcher that a number of variables such as length and content of course, as well as level and type of initial attitudes, needs to be examined more systematically before definitive conclusions can be drawn about increasing knowledge and its effect on attitudes.

Experience working with alcoholics seems to have mixed results for attitudes. Sowa and Cutter (1974) found that although the highest status workers had the most direct therapeutic experience, they had the most negative attitudes. Lemos and Moran (1978) discovered that working on a special alcoholism unit in a V.A. hospital had different effects on the attitudes of several occupational groups, but there was no apparent relationship between professional level as Sowa and Cutter (1974) found. Mogar et al. (1969:454), comparing several combinations of professional level and experience working with alcoholics, concluded that "one of the most powerful determinants of differing attitude clusters . . . is experience working with alcoholics," with more experience resulting in more positive attitudes. Berger-Gross and Lisman (1979) offered a clue to these conflicting results by suggesting that type of experience may be important by showing different types of attitudes with most variables held constant except for working in a ten-week inpatient alcoholism treatment facility versus working in a 24-hour sobering-up station. Their research is only a three-page "brief report"

on an exploratory study, but certainly presents a variable worthy of interest in the current study.

Four studies mentioned personal and family drinking experience and personal attitudes toward drinking in different ways. Mendelson et al. (1964) found little relationship between family or personal drinking patterns and custodial attitudes among physicians. Robinson (1976), on the other hand, found personal and family drinking patterns related to a variety of attitudes regarding alcoholism. The other two studies looked at drinking attitudes (Bailey, 1970) and personal drinking behavior (Waring, 1978) as dependent variables. Bailey (1970) found that social drinking attitudes became slightly more conservative after alcoholism training. Waring (1978) discovered a decrease in drinking after training. The researcher's personal conversations with members of the treatment and law enforcement communities and members of the general population suggest, in spite of lack of prior data, that these personal experiences with drinking are understudied and are important to consider as background variables.

Organizational Constraints

One other level of the audience discussed in labeling theory must be taken into consideration as influencing the interaction between treatment or social control agent and alcoholic. That is, such interaction most often takes place within a formal, organized framework which imposes its own set of imperatives on interaction. Thompson (1961:3) synthesized the emphases of several organizational theorists in his definition of a formal organization: "a highly rationalized and impersonal integration of a large number of specialists cooperating to achieve some announced

objective." All aspects of organizations cannot be discussed here, but some are especially pertinent to understanding the case at hand.

Specialization

One attribute of formal organization noted in the definition above is specialization leading to an increased division of labor (Weber, 1958), which has numerous implications. For one thing, after we have trained a nation of specialists, we are now asking members of human services professions to become generalists again, by adding other areas of concern to their jobs, e.g., alcoholism.

Secondly, and perhaps more importantly, the specialist is expected to limit his/her participation in work relationships only to the area of his or her specialty; i.e., for a large organization to function efficiently, it should have a secondary group structure and ignore the peculiarities of individual cases (Parsons, 1956). This results in "formalistic impersonality" (Weber, 1964:340), where actors should respond to one another only in terms of rigidly prescribed roles. It has been demonstrated time and again, however, that members of the organization do not accept this definition of their situation and engage in primary relationships for reinforcement of their self-conception (e.g., Gouldner, 1954, in industry; Sykes and Messinger, 1960, in prisons; Goffman, 1961, in mental hospitals). Clients of organizations are also affected by this impersonality; Merton (1957) observed that a major structural source of conflict between officials and clients is pressure for formal, impersonal treatment when the client desires individual, personalized attention. The necessity for this primary relationship type of interaction for alcoholics in treat-

ment has been previously documented in this review, but organizational demands add one more barrier to its occurrence.

Organizational Efficiency

Organizations place other pressures upon their personnel to operate efficiently, which almost automatically lead to "processing stereotypes" (Hawkins and Tiedeman, 1975:183). For example, they frequently have to process a large number of cases, deal with ambiguity and uncertainty in categorizing those cases on standardized forms, while simultaneously promoting a smooth flow of persons through the system. They also are held up to both internal and external accountability: the individual staff member may have to be accountable for his/her time, number of cases handled, etc. (Hawkins and Tiedeman, 1975:191). Operating with processing stereotypes helps her or him do these tasks more quickly, but they also preclude much time spent in primary interaction with clients. These same numbers, proving that the organization is doing its job in the community, etc., constitute pressures for external accountability, to funding sources, mass media, public opinion and others who may be calling for punitive reactions in opposition to individual organizational members' rehabilitative orientations or vice versa (Schur, 1971:85).

Differential Power

Labeling theorists frequently refer to power as an integral part of their conception of deviance, with one group having the power to label the other one (Clinard and Meier, 1979). Organizational theorists refer to hierarchy (Weber, 1958) which implies legitimate power with the

clients, who as temporary members of the organization have the least power to define their situation in a manner desirable to themselves. This has been amply illustrated in other settings (e.g., Stanton and Schwartz, 1954, in mental hospitals; Barnhill-Berger and Taylor, 1966, with tuberculosis patients). Martin (1979) pointed to the fact of therapists having legitimate control over alcoholic residents in therapeutic settings, thus defining the situation regarding appropriate behavior for patients. The power situation is amplified by the fact that the staff member is "on-stage" only, while the client is left more vulnerable because the social control agent has legal access to his/her "back-stage" region of private information (Goffman, 1959:106-140), leaving little room for the client to have functional autonomy. The client's less powerful position becomes even more complicated by the fact that the formal social control agent has been well socialized into his/her role (Coe and Wessen, 1965:1028). Accordingly, she or he has specified expectations for the client's behavior based on past experience, while the client may be much more imperfectly socialized into his or her role. Mogar et al. (1969) and Reinehr (1969) both confirmed that therapists and alcoholic patients have incompatible views of what an alcoholic is, thus making it easy for Sterne and Pittman's (1965) "post-factum" imputation of motivation to occur, resulting in further deviant labels for the alcoholic patient.

Multiple Goals

Finally, but not exhaustively, Thompson's (1961) definition of organization included working to achieve some announced objective, or stated goal, in a rational, efficient manner. In the complex bureau-

cracies of contemporary society, there may be a multiplicity of goals within the same organization, leading to ambiguity for all concerned. As noted earlier, the position of the alcoholic already is ambiguous with treatment agents and agencies having conflicting goals for her/his treatment, e.g., custodial, humanistic, recovery, or other forms of rehabilitation. If the alcoholic also is a criminal, the goals become even more complex, for now they include punitive or community protection objectives in addition to the treatment objectives.

It is apparent that all these organizational imperatives for efficiency can interfere with organizational effectiveness, or the actual accomplishment of stated goals. Add to this audience the actual therapeutic personnel who are closer to the alcoholic patient/client, as well as significant others of the patient/client, all of whom are affected by the values, norms and ideologies of the largest audience, society. The treatment agents also are influenced by the organizational imperatives. The outcome can be dysfunctional for the alcoholic if all three levels of audience converge to hinder her/his recovery.

Attitudes and Behavior

So far, this review of literature has suggested that human services professionals hold a variety of stereotyped attitudes toward alcoholism and alcoholics which are statistically related to a variety of other variables. This must be carried one step further, into action. Suchar (1978:175) noted: "Deviant labeling thus involves _interpretation_, _definition_, and the _action_ based upon these." [Emphasis in original.] The researchers reviewed here tended to agree with that labeling theory assumption. Sterne and Pittman (1965:54) concluded that "therapists

play a large part in determining the nature of the therapeutic relationship." Similarly, Mackey (1969:670) pointed out that the "disabling stereotypes" he found led to labeling all alcoholics, with the consequence of "rejection of the alcoholic as a person." Mendelson and Hyde (1971: 68) contended, "it has long been known that the attitude a physician holds about alcohol-related illness may determine how he approaches and treats alcoholic patients." After ascertaining that therapists and patients had no overlap in their descriptions of alcoholics, Reinehr (1969:445) noted that therapists may react to patients "as members of a group whose characteristics are quite undesirable," although patients see themselves very differently. "The effect such a divergence in perceptions can have on communication in the group . . . is likely to be substantial." Every study surveyed came to similar conclusions; the ones cited here are sufficient to illustrate that they support almost all the tenets of the labeling approach as outlined above.

The problem encountered is whether it is valid to impute such behavioral implications from studies made on attitudes. Deutscher (1969; 1970) claimed that in sociology's "obsession with reliability," it has ignored validity, which "poses a serious problem when we use instruments [questionnaires] designed to provide estimates of hypothetical behavior" (Deutscher, 1969:40). LaPiere (1969:41) was even more extreme in agreeing that because of persistence in using verbal responses as indicators of social conduct, "the very foundations of our discipline as it is now constituted might well be in jeopardy." Erlich (1969) disagreed on both methodological and conceptual grounds, while Ajzen et al. (1970), Lastrucci (1970), and Tarter (1970) proposed solutions

to Deutscher's and LaPiere's dilemma.

It is the contention here that if the suggestions of those mentioned above and others is heeded, and if attitudes, as discussed in this study, are taken to be a combination of behavioral predispositions, based on some set of feelings, which in turn are based on cognitive knowledge (correct or stereotypical), then results of questionnaire studies may not be so perilous as LaPiere (1969) feared. In any event, there are numerous studies to support the labeling approach discussed in this chapter. Some findings relevant here include Litman's (1962:557) empirical demonstration that:

> There is a direct relationship between a person's conception of self and his response to a program of physical rehabilitation. . . . Patients who are able to evaluate the reactions of others toward the disability favorably . . . will actively engage in their care.

Likewise, for patients with myocardial infarction, Straus (1960) found a relationship between sociocultural responses to the patient and the social conditions in the hospital on the one hand and the patient's physical recovery on the other. Wallston et al. (1976), concerned over the same problems as Deutscher and LaPiere, wondered if nurses describing on a questionnaire their perception of a typical alcoholic would respond in the same way to an actual alcoholic. To test the attitude versus reaction relationship, they randomly divided nurses into experimental and control groups, with both groups hearing a five-minute tape describing Mr. Fox, a bleeding ulcer patient. . . . As part of the description, the experimental group heard that Mr. Fox was an alcoholic, but the control group did not. Then, both groups were provided with adjective checklists to describe Mr. Fox; the nurses in the experimental group described him more negatively (in a statistically

significant relationship) on almost every scale than did nurses in the control group. The authors concluded that there indeed was a relationship between stereotypes and behavior; once the patient was labeled, they reacted to him as a label rather than as an individual. They warned that the resulting interaction easily could end in a self-fulfilling prophecy, with the patient adopting a hostile, counter-therapeutic posture. In a similar study with physicians, Fisher et al. (1976) showed that by actually changing the affective (feeling) part of the attitude cluster as well as the cognitive part, the physicians' behavior toward alcoholics changed.

In short, as the review of literature indicates, the position of the person "in the middle," the treatment or social control agent, can be critical. For this reason, views, determinants of those views, and organizational constraints on the behavior of those who interact "officially" with the alcoholic are important data to obtain.

Probation/Parole Officers and Alcoholic Offenders

Where do probation and parole officers fit into all of this?[3] In the first place, with current official legal and medical definitions of

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[3]Probation "is the status of a convicted offender during a period of suspension of sentence, in which the criminal is given liberty conditioned on good behavior, and in which the state, by personal supervision, attempts to help the offender maintain good behavior" (Sutherland and Cressey, 1978:498). Parole "is the act of releasing or the status of being released from a penal institution in which a criminal has served a part of a maximum sentence, on condition of maintaining good behavior and remaining in the custody and under the guidance of the institution or some other agency approved by the state until a final discharge is granted" (Sutherland and Cressey, 1978:635).

alcoholism as a physical and/or emotional illness or disease (Schneider, 1978), it takes its proper place in what has popularly been called the "community mental health system."[4] Despite the stated goals of the Community Mental Health Act, the personnel working in the area were primarily those trained specifically in mental health, thus creating a personnel shortage. Partially to alleviate this personnel shortage, Berger (1970a) proposed adding an intermediate screen focusing on both prevention and treatment, which would be threatening to neither the professional screen nor the social screen (potential clients, patients, or whatever, and their significant others). One segment of this intermediate screen would be persons already performing jobs heretofore seen as only peripheral to mental health. As early as 1961, the Joint Commission on Mental Illness and Health (1961:257) concluded:

> A host of persons, untrained or partially trained in mental health principles and practices--clergymen, family physicians, teachers, _probation officers_, public health nurses, sheriffs, judges, public welfare workers, scoutmasters, county farm agents, and others--are already trying to help and to treat the mentally ill in the absence of professional resources . . . [Emphasis added.]

Bard and Berkowitz (1967) identified police officers as already being members of this intermediate screen in domestic situations and showed how with minimal extra training, they could act effectively as case finders and referral agents. Sutherland and Cressey (1978) noted

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[4]The community mental health system, which has grown rapidly since the 1963 Community Mental Health Centers Act, has the official goal of bringing psychiatry and other forms of counseling into the community. According to Roman and Trice (1974:2-3): "This act provided the basis for broadly widening the definition of (1) those people termed emotionally disturbed, (2) those qualified to treat the emotionally disturbed, (3) the therapeutic techniques that might be used, and (4) where treatment can be attempted."

that guidance and assistance to the offender are relatively new ideal components of the probation/parole officer's role, with the emphasis on community-based corrections. However, they continued that under present conditions, especially for parolees, the reaction still is more punitive than rehabilitative because of the constant reminder of their "conditional liberation" (Sutherland and Cressey, 1978:642). There is no reason, though, that probation/parole officers cannot function as effective members of the intermediate screen.

In the second place, in the absence of primary prevention, secondary prevention comprises strategies of locating cases of alcoholism "early enough to reduce the incidence of 'full-blown' disorder" (Roman and Trice, 1974:95). This strategy involves early identification and intervention attempts, "usually . . . treatment to curb the disorder's progression" (Roman and Trice, 1974:98). In a successful experiment treating court-referred alcoholics, using probation officers as "therapeutic assistants," Margolis et al. (1964) noted that courts are frequently among the first agencies to have official contact with alcoholics. They argued that early referral to treatment of alcoholic offenders on probation could assist in keeping many from the progressive decline characteristic of alcoholism.[5] Since about 50% of all convicted offenders are placed on probation (Barlow, 1978:451), and since the use of

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[5]Incidentally, Margolis et al. (1964) described the treatment of alcoholics in their sample as involving <u>attempts to motivate</u> for treatment, along with several other differences from traditional therapeutic techniques, which allowed their therapists not to fall into the trap of "post-factum" imputation of motivation characteristic of treatment agents in Sterne and Pittman's (1965) sample. It also showed that the "audience" as well as the "deviant" can change, with more productive results.

probation is likely to increase (Gibbs, 1975:67), this places probation officers in an advantageous position for secondary prevention in alcoholism.

Tertiary prevention, or actual therapy or rehabilitation with persons whose alcoholism has progressed further than discussed above, is not impossible either. Many felons released on parole are in this more advanced stage of alcoholism. Gallant and associates (1968) reported on a pilot study with just such a group of criminal alcoholics on parole. Working closely with parole officers, they found that those randomly assigned to compulsory treatment for their alcoholism had even better treatment results in a one-year follow-up than those whose participation was voluntary. In fact, at the end of a year, most of those in compulsory treatment were abstinent and working (compared with none in the voluntary group), while over half those in the voluntary group were back in prison. It should be mentioned that the authors attributed their success primarily to three factors, two of which usually are inimical to parole practices: 1) no abstinence requirement during parole, to give the parolee greater freedom to discuss his drinking behavior with the therapist, and 2) revocation of parole for missing a single therapy session, giving them a great deal to lose (personal communication with a number of local parole officers, indicates an offense this "minor" usually is not considered grounds enough for revocation). The third factor, according to the authors, suggests the criminal alcoholic on parole may be an even more suitable subject to treatment than the chronic drunk offender, since he "has had a long drying-out period in prison prior to treatment and his personality does not reflect the total lack of existential concern that is shown

by many chronic municipal court alcoholic offenders" (Gallant et al., 1968:82). (Again, personal communication with both ex-convicts and correctional officers suggests that prison inmates are not necessarily in a drying-out period, because reportedly alcohol is available if an inmate wants it "bad enough.") Thus, evidence indicates probation and parole officers can and do work effectively with alcoholics, both in early and later stages of their alcoholism.

Thirdly, data presented earlier in this review clearly show that not only is alcohol use and abuse strongly related to the commission of crime, but also that a large percentage of offenders are alcoholics. Evidence also was presented to establish that alcoholic offenders have higher recidivism rates than do other offenders. Therefore, probation/ parole officers undoubtedly are in daily contact with such persons and thus in a position to be instrumental as interveners in their alcohol problems. If they can be effective as interveners, then the probability is great that the higher recidivism rates will decrease.

CHAPTER III

RESEARCH QUESTIONS

Babbie (1979) described the basic purposes of sociological research as exploration, description, and explanation, with the ultimate goal being explanation through the practice of testing theoretically well-grounded hypotheses. However, in the present case, Robinson's (1976) research was the only study located dealing specifically with attitudes of probation officers (no parole officers) toward alcoholism and/or alcoholics.[1] Robinson's (1976:57) sample of probation officers was small (N = 23, only 19 on some questions); no information was given about how the sample was selected except to note that it comprised half the probation officers in the research area, so there is no way to know how representative of the area probation officers the sample was. His research was conducted in a South London borough, so international cultural differences might have influenced his respondents in ways which could bias generalization to American probation officers.

In addition, the data reviewed from several other human services professions are so inconsistent that it would be difficult to develop hypotheses even about members of one of them. Therefore, the investi-

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[1]National computer searches were made through both Operation SEEK of the Oklahoma Department of Education and the National Criminal Justice Reference Service, and an extensive personal search of alcoholism and other drug journals and abstracts was conducted by the researcher, with no further references located.

gator did not make precise hypotheses in this research; instead, the study is more exploratory and descriptive in nature. However, based primarily on the information from other professions and on the labeling perspective described in Chapter II, several research questions were developed to give direction to the research. In addition, several background variables were examined to provide a baseline for future research.

Knowledge about Alcohol and Alcoholism

Before any human services professional can deal helpfully with alcoholics, he or she must have some accurate knowledge about the drug alcohol and about alcoholism. Furthermore, it would be ideal if people recognized the limits of their knowledge and felt the need and desire for further information.

Regarding knowledge about alcohol and alcoholism in this research, it was anticipated that the level of knowledge of most probation/parole officers would not be great. First, the studies reviewed showed that those individuals in professions where one would expect alcohol knowledge to be high (health professions) were not particularly knowledgeable (e.g., Chodorkoff, 1967; 1969; Gurel, 1976; Distefano et al., 1975), so why should those in an occupation not so "illness-related" be expected to know a great deal about it? Second, one reference of a sort is available on knowledge among probation/parole officers. No published reports were located, but a letter from the Coordinator of Alcohol and Drug Programs for North Carolina's Southeastern Mental Health Center described their "Criminal Justice Alcoholism Project." Most parole officers involved in the project "had had a fairly long association" with it. The director described them as "generally most cooperative, although not as

knowledgeable about alcoholism as we would wish" (Webb, 1979:1).

Of course, knowledge level should be related to how much and what type training the officers have had regarding the subject. This is difficult to estimate, but based on twelve years of experience with many probation/parole officers who are college-educated, it is expected that few of them had much in-depth training as part of their college preparation. However, in addition to college education, they could have received other forms of both formal and personal educational experience regarding alcohol and alcoholism which would affect their knowledge level.

The review of literature demonstrated that alcohol indeed is a problem for a large proportion of probationers and parolees, both nationally and in Oklahoma. In addition, the Oklahoma official job description for Probation and Parole Officer I (see Appendix A) includes the advising of clients on their personal problems, and alcohol-related problems should fit into that category. For these reasons and because members of other human services professions frequently feel frustrated over how to deal with alcoholics, the researcher anticipated that most probation/parole officers would feel they need and/or want more training on the topic. There is another possibility, however. It may be that some probation/parole officers do not want to expand their specialized role to handle client problems other than those directly related to their official criminal status, regardless of job description. In that instance, they might not be desirous of further information, because then they would be expected to engage in additional activities with clients. A third possibility emerges from the sociological concept of definition of the situation. There is evidence from other fields of study, especially racial prejudice, that suggests many people believe they have accurate

knowledge about a topic and thus do not feel a need for further information, even if their "knowledge" is inaccurate.

Thus, the first research question sought to determine the level of knowledge probation/parole officers had about alcohol and alcoholism. Also, the effect of amount and kinds of education on knowledge level were investigated, along with the perceived need and/or desire for further alcoholism training.

Attitudes toward Alcoholism and Alcoholics

With reference to the attitudes of probation/parole officers, it was expected that they would be generally negative toward both alcoholism and alcoholics, for the simple reason that that is the most consistent finding in the studies of other human services professionals.

Defining Alcoholism

The campaign to accept alcoholism as a disease or illness has been going on for several years now (Schneider, 1978); the controversy about moving away from the disease concept is only a year or so old in the professional alcohol-related journals; and studies of both the general public and helping professionals indicated growing acceptance of the disease/illness concept. Therefore, it was expected that probation/parole officers also would tend to accept that alcoholism is a disease or illness. On the other hand, from years of personal experience discussing alcoholism with criminal justice majors in the university classroom, it was expected that a large proportion of the officers also would see alcoholism as a character defect or a matter of will power and would hold the alcoholic responsible for his/her condition, often simul-

taneously with accepting the disease concept.

Sowa and Cutter (1974), finding similarly inconsistent attitudes, suggested that there still is a prevalent dual, overlapping medical/moral attitude. Put another way, it is easy to agree with Ewing (1971) that even medical school faculty members say intellectually that alcoholism is a disease while emotionally denying it. It is the view of the investigator that public education and propaganda campaigns _have_ been effective at the intellectual level, but the stigma referred to by Freidson early in Chapter II still carries over to the disease. Adler (1975:61) observed that "until World War II, prostitution was lumped together with gambling and _alcoholism_ as a package of social evils and placed beyond the pale." [Emphasis added.] Most probation/parole officers today were around during World War II or are the children of parents who shared the values of that era.

Etiology

The probation/parole officers were asked several questions regarding the etiology of alcoholism. Their perceptions of this aspect are important because it is such a crucial factor in determining how people react to alcoholics, especially regarding the issue of responsibility for the condition. If people perceive the alcoholic as not responsible for his/her condition, indicated by things like the belief that alcoholics suffer loss of control over their drinking and that alcohol is an addictive drug, then they are most likely to see treatment as the appro-

priate follow-up response rather than punishment.[2]

The results of studies on other helping professionals are contradictory; for example, professional social workers are trained in the psychoanalytic framework, yet 93% said alcoholism was a result of both emotional and physical factors (Bailey, 1970). There was widespread agreement that alcoholism is caused by emotional difficulties, but results of previous studies were mixed regarding whether loss of control over drinking is involved. Given the inconsistency of views on etiology from other professions, it was difficult to predict how probation/parole officers would see these issues. If they are truly in tune with the disease concept, they should accept the "medicalized" beliefs about etiology, thus removing responsibility for the condition from the alcoholic client. On the other hand, if they are steeped in criminal justice ideology, it is likely that they could generalize the imputation of responsibility for behavior to a client's alcoholism.

Prognosis

It was expected that, in general, the probation/parole officers would be pessimistic regarding the prognosis for recovery of alcoholics. The variable of experience working with alcoholics should be influential on this attitude. Although previous studies showed mixed results, it will be remembered that Berger-Gross and Lisman (1979) suggested that type of experience might be a mitigating factor. Expanding on their research, it is likely that state probation/parole officers have had

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[2]For a more complete discussion of the issue regarding perceived responsibility and treatment versus punishment, see Freidson (1965), Berger (1975), Schur (1979).

more negative experiences working with alcoholics than positive ones. It seems probable that those in most community criminal justice jobs have the majority of their experience with alcoholics while the alcoholic is intoxicated or where alcohol use has been involved in a crime or parole violation. Similarly, those officers working with chronic drunk offenders as probationers on felony offenses they may have committed undoubtedly have had more experience with the stereotyped "skid row drunk" than have other people. Therefore, it would be surprising if their prognosis were optimistic.

The researcher does not mean to suggest that being negative about prognosis for recovery is inevitable and irreversible for probation/parole officers. Recall that Margolis et al. (1964) and Gallant et al. (1968) found probation/parole officers to work successfully with alcoholic offenders, but their officers had been the recipients of intensive specialized training.

Alcoholism versus Alcoholic

It would seem logical to assume that as attitudes toward alcoholism become more illness-oriented, alcoholics would come to be seen as sick people, as deserving of treatment as any other sick people. It should follow from this assumption that negative attitudes toward alcoholics, expressed as stereotypes, also would change. However, for a variety of reasons, the researcher did not expect this to happen with the subjects of this study.

After reviewing several definitions of deviance, Edward Sagarin (1975:9) concluded:

I would speak not of human behavior as deviant, but of human

> behavior or human beings as deviant, for this usage permits one to understand that deviance is a matter of being or doing, and perhaps both, but that under some circumstances it may be one without the other. [Emphasis in original]

It will be recalled from Chapter II that Freidson (1970a) pointed out that even if redefinition of a condition occurs to become more positive, stigma for the person with the condition is not necessarily removed.

Based on the prior discussion of labeling, stereotyping, and their implications for therapeutic interaction, it seemed critical to the researcher to see how much correspondence there is between views toward the condition called alcoholism and the person called alcoholic. Almost all studies reviewed examined attitudes of human services professionals toward one but not the other, with increasingly "positive" (illness-oriented) views toward alcoholism, but consistently negative stereotypes toward alcoholics. The former finding is understandable, given what Ferneau and Morton (1968:175) called the "'positive attitude' propaganda which has been aimed at both the public and at professional groups." What is surprising is that given the consistency of the latter finding, more research has not been done on the relationship between views toward the condition versus views toward the person.

The investigator has had innumerable discussions regarding alcoholism in classes she has taught. After concluding, with students in agreement, that alcoholism is an illness not confined to the three per cent of the alcoholics who fit the skid row stereotype (Bucky, 1978:1), the researcher brought in a recovering alcoholic as a guest speaker. Without exception, over a period of several years, some students approached the researcher with the statement, "But he (she) doesn't look like one!" Even students in a semester-long class on the subject, who not only were exposed to guest speakers, but also

visited treatment centers, AA meetings, etc., had the same reaction at the end of the semester. Intellectually, many were able to change their views toward alcoholism, but their deeply internalized stereotypes were much more impervious to change. The only study located that discussed this issue was a relatively informal interview study by Wolf et al. (1965), which found essentially similar results with physicians after traditional alcoholism education.

In short, because of 1) personal teaching experience; 2) contradictory results in studies examining alcoholism and alcoholics separately; and 3) theoretical grounding in the labeling approach, the researcher hoped to provide a beginning in filling this void in information by systematically comparing attitudes toward the condition of alcoholism and the person perceived as alcoholic. She expected to find relatively negative attitudes toward alcoholics and very little relationship between these attitudes and those toward alcoholism.

Male versus Female Alcoholics

Several works in recent years have established that not only is the number of women alcoholics increasing rapidly, but also that they have, to some extent, a different set of characteristics and counseling needs than do men alcoholics (see, for example, Langone and Langone, 1980). In addition, women alcoholics, because of traditional sex roles, have tended to face greater stigma for their disease than have their male counterparts. Of the several studies reviewed which examined professionals' stereotypes of alcoholic people, only Mackey (1969) separated men and women in his questionnaire. Not only did he discover that his respondents differed in the way they viewed men and women alcoholics, but

he also found police officers to have the most negative views toward female alcoholics of four occupations studied.

On the basis of this information, it was felt that probation/parole officers should be asked some questions separately about male and female alcoholics. They were questioned about men and women alcoholic clients separately, and they also were asked to contrast men and women alcoholics with "normal" men and women in general. Partly because of the differences in the general population, and especially given the responses of the police officers in Mackey's (1969) study, it was anticipated that the probation/parole officers would perceive female alcoholics differently (and in some cases, more negatively) than they perceived male alcoholics.

In sum, the second research question examined the attitudes of probation/parole officers toward alcoholism; how they defined alcoholism, what they perceived as its etiology and the locus of responsibility for it, and their views on prognosis for recovery were investigated. Also, attitudes toward alcoholics as persons as opposed to alcoholism as a condition were explored and the two sets of attitudes compared to one another. Finally, views toward male alcoholics were compared with views toward female alcoholics.

Treatment Modalities and Goals

It will be remembered that in discussing treatment alternatives, most helping professionals chose Alcoholics Anonymous. Robinson (1976: 136), in his London study, found different results for probation officers. They were not asked about treatment of choice, but were asked about where they had referred alcoholic clients. Of those probation

officers who had made referrals, 61% had made them to halfway houses, 56% had referred to psychiatric hospitals, and 35% to AA. Interestingly, in analyzing another set of data on referrals, Robinson (1976:153) noted that probation officers tended to resent psychiatrists for not giving them feedback on referrals to the psychiatric hospitals. It is uncertain whether these contradictory data represent cultural or occupational differences, so as with the question of etiology, examination had to be exploratory. As of November, 1978, there were 75 identified alcoholism service programs in Oklahoma, exclusive of the hundreds of Alcoholics Anonymous groups (Kerr Foundation, 1979), so there are numerous places for referral, statewide. Questions relating to knowledge of, as well as attitudes toward and referral to, these services were asked.

With reference to treatment goals, again it was difficult to anticipate the responses of probation/parole officers. Although the three studies reviewed which asked questions about treatment goals found respondents proposing abstinence as a primary goal, they were published prior to or concurrently with the controversial and highly publicized "Rand Report" (Armor et al., 1976), which suggested that alcoholics could return to controlled social drinking. The professional alcoholism journals were replete with studies on both sides of this issue in the ensuing years, culminating in studies both in Oklahoma (Paredes et al., 1979) and by the original authors (NIAAA, 1980) which rejected the results of the popularized 1976 report. However, their latest findings (NIAAA, 1980:1), which "suggest that 'abstinence is the most appropriate goal in the treatment of alcoholism,'" have not received nearly the amount of popular media publicity as did the original report. Thus, it was unclear what the probation/parole officers in the present study

would describe as the most important treatment goals, but knowledge of this information is important, because it undoubtedly influences recommendations they make to alcoholic clients.

In short, the third research question sought to determine probation/parole officer knowledge of alcoholism treatment programs, along with attitudes toward and referrals to the programs. Goals of treatment for alcoholism and their relative importance to officers were examined.

Possible Sources of Attitudes

In exploring possible sources of attitudes, several variables were examined.

Demographic Variables

Although the literature lacks information on the standard demographic variables, they were included in the survey instrument. With little previous information (and what there was being contradictory), it was difficult to anticipate what the differences between officers on the basis of such variables might be.

Occupational Variables

The social structural variables of professional level and occupation were the ones noted in the literature. Occupation was not relevant to internal differences for this study sample. The respondents were all in essentially the same occupation, although results were compared with findings from occupations in other studies.

Professional level was not as pronounced as in some professions, but years in service was considered, as well as prior experience in

other types of occupation.

Other Personal Variables

Personal variables probed in the literature were knowledge, authoritarianism, and experience. Work experience already has been discussed above, with regard to optimism or pessimism about prognosis. It was felt that type of experience might be more important than length of experience in being related to attitudes for reasons noted in the aforementioned discussion.

Knowledge about alcohol and alcoholism also was discussed earlier as a focus variable. As a background variable related to attitudes, the literature provided contradictory results. However, as noted in the literature review, it is felt that the knowledge issue is broader than just the amount of it as measured by a pencil-and-paper test. Knowledge gained from personal acquaintance with treatment modes and with both practicing and recovering alcoholics, amount of exposure to specifically alcohol-related educational efforts, perception of one's amount of knowledge--intuitively all these seem to be intimately related to "knowledge," and information regarding them was ascertained in the survey.

Authoritarianism has not been examined in the alcohol attitude studies for several years. However, in the field of criminal justice, there are frequent discussions of authoritarianism in relation to corrections and law enforcement personnel, so it seemed it should be considered as a background variable. Although some of the earlier researchers who studied authoritarianism questioned the relationship between a general personality characteristic and specific attitude, the

evidence does seem ample enough to suggest that the higher the degree of authoritarianism, the more negative the attitudes toward alcoholism and alcoholics. Traditional authoritarianism scales were not used, but a number of items were included in the survey instrument to evaluate probation/parole officers' general attitude toward their clients, some of which were more authoritarian than others. While acknowledging the methodological risks involved in not using already-standardized scales, it was felt that some of the items in those scales were outdated for 1980, and that questions pertaining directly to probation/parole work might be more relevant. These were examined within the broader framework of attitudes toward clients, with authoritarianism as one possible type of attitude.

Personal and family experience with drinking and personal attitudes toward drinking, while explored only slightly in the literature, seem relevant. It seems logical to assume that someone who has negative attitudes toward even social drinking might have more negative attitudes toward alcoholism and alcoholics. With regard to personal experience with alcoholism, prior studies or questionnaires reviewed asked only if relatives or the respondent were alcoholic, ignoring whether treatment had been involved. Teaching experience and personal communication with many people suggest that those who have either personal or family experience with recovery from alcoholism may have more positive attitudes, while persons with untreated drinking problems of their own or within their families may have more negative attitudes (unless they have been exposed to some family-oriented program such as Al-Anon). Robinson (1976) did find that respondents with personal or family drinking problems differed in attitudes from those whose knowledge came from the

general culture, but he did not distinguish between those whose experience with alcoholism was recovery-oriented and those who had untreated drinking problems.

Thus, the fourth research question examined a variety of background variables to determine their relationship to attitudes, including standard demographic variables. Occupational variables comprised job level, years in service and other occupational experience. Other personal variables were examined; these included the knowledge variables of the first research question and attitudes toward clients, along with experience with drinking and alcoholics as well as attitudes toward social drinking.

Organizational Constraints

The issue of organizational imperatives must be considered as yet another level of "audience" influencing attitudes of probation/parole officers, which in turn may influence interaction with clients. In a study of the nature of the one at hand, some of the organizational constraints can only be recognized and discussed, while others are indirectly measurable.

Specialization

The specialization implicit in modern organizations has important implications for the probation/parole officer in regard to the alcoholic. It was noted in Chapter II that just as we have become socialized as a culture to accept specialization, we are now asking some of those specialists to become generalists. This has been justified in the health care system as it was realized that specialized medical personnel

were being trained to treat "disease entities," not the "total patient." Thus, increasingly, their training is beginning to emphasize continuity of care to counteract the fragmentation of services which was becoming prevalent and leaving the patient "out" (e.g., see Mechanic, 1978). Using this logic, it seems reasonable to train the probation/parole officer, as the major bridge between the individual offender and the formal social control structure, to provide the continuity needed, engaging as she/he does in the most primary relationship with the offender of anyone in the system. At the current time, however, at least at the university where the researcher teaches, the requirements for the bachelor's degree in criminal justice are very specialized, and there is no reason to doubt it is much different in many other such programs.

Therefore, it was expected that probation/parole officers probably would tend not to agree that their role should be expanded. Not only has their training probably emphasized otherwise, but also the literature supports such an expectation. In Robinson's study (1976), 73% of the probation officers felt special training was required to help alcoholics, while only 39% felt they personally had anything to offer alcoholics; furthermore, only 17% agreed that they would like to have special responsibility for alcoholics in their organization (caution: N = 23). It also will be recalled that Dorsch et al. (1969:917), in studying members of several human services professions, discovered that most of them felt alcoholism was only peripheral to their tasks. They concluded that while there was "a modicum of awareness" in all the professions, "it also seems clear that the professionals and agencies surveyed are not doing everything that those who are planning alcoholism

services might hope for."

The current job description for probation/parole officers in Oklahoma (Appendix A) described both supervision for compliance with probation/parole conditions and counseling about personal problems as "examples of work performed," which could be interpreted as becoming more generalized. Sutherland and Cressey (1978:506-513 and 643-645) pointed out, however, that not only can these two functions be contradictory, but also that probation/parole officers usually see their major job as one or the other, implying different philosophical orientations as well as emphasis on specialization again. These various issues concerning specialization (and coincidentally work philosophy) were explored in relation to attitudes.

Organizational Efficiency

Other organizational pressures for efficiency which contribute to "processing stereotypes" were discussed in Chapter II. These same pressures are there for probation/parole officers, only some of which can be measured. There are needs to develop "objective" client classification which can be reduced to standardized forms filled out by probation/parole officers, with the goals of decreasing client misbehavior, maximizing efficiency, and minimizing client contact with probation/parole supervision (Collins, 1978).[3] Larger than ideal case

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[3]This last goal is to "serve the rehabilitative needs of clients." This apparently is part of current community corrections philosophy, but directly contradicts the premise that primary interaction is important. The logic of the goal is apparent, as both Gibbs (1975) and Sutherland and Cressey (1978) indicated offenders are likely to define close supervision as punitive surveillance. But Sutherland and Cressey (1978:646) were quick to point out that differential association theory suggests

loads (which can be measured) not only are realities in most probation/ parole agencies, but also are inconsistent with the supervision and guidance principles recently introduced as probation goals (Sutherland and Cressey, 1978:507). It was expected that size of case load would be related inversely to desire to expand the officer's role. Employees of government agencies usually are held accountable for their time, have myriads of paper work for each client in a large case load, etc. If Hawkins and Tiedeman (1975) were correct, this also should be related to their tendency to stereotype, in an effort to be more efficient.

It also must be remembered that the officers studied work for agencies which themselves are accountable to funding sources, which in turn are accountable to their constituents and mass media opinions. These factors have an influence on the officially stated orientation of the agencies, which must be adhered to at least in part by employees (e.g., punitive versus rehabilitative, custodial versus humanistic). Officers were asked for their perceptions of organizational philosophy; these perceptions were tested for their relationship to attitudes.

Differential Power

As in any social control or treatment agency, probation/parole officers have legitimate power over the probationers/parolees. As such, they have access to back-stage, private information about clients, without having to reciprocate with such information about themselves.

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if intimate associations are formed between the offender and law-abiding persons, he or she is more likely to become and remain a law-abiding person. In any event, this goal certainly lends further support to the prediction that probation/parole officers would not agree that their role should be expanded.

Along with this, the officer has been well socialized into her or his role, thus having clear-cut expectations for the role relationship with the client, while the imperfectly socialized client's expectations may be much more ambiguous. This makes it easier for conflicting definitions of the situation by both participants, e.g., the observation above that even if the officer defines close interaction as guidance, the offender may define it as punitive surveillance. There also are the official rules to be adhered to by the offender, e.g., the rule for all parolees and most probationers to abstain from alcoholic beverages for the duration of their sentence, making it uncomfortable for both to discuss a drinking problem if it does exist (see Gallant et al., 1968). All these elements of differential power, albeit legitimate and legal, must inevitably erect some barriers to effective communication between officer and client. In a study of this nature, it was not possible to measure such factors as degree of socialization into the role; however, questions were asked which could indicate to some extent the officer's perception of differential power and his/her right to exercise such power.

Multiple Goals

The multiplicity of organizational goals was mentioned in the discussion of organizational pressures in Chapter II. When the client is in the clear-cut role of felony offender and in the ambiguous role of alcoholic, this can lead to confusion in setting appropriate goals, thus having consequences for organizational effectiveness. By questioning the probation/parole officer about the priority of his or her everyday operating goals, as well as her or his perceptions of the

organization's goals, it was hoped that some relationship could be discerned between these priorities and attitudes toward alcoholism, alcoholics, and time spent to work with them.

In sum, the fifth research question sought to determine the impact certain organizational constraints had on probation/parole officer attitudes. Issues involved in specialization were investigated, especially attitudes toward working with alcoholics and whether officers perceived supervision or counseling as the most important specialized work task. Pressures for organizational efficiency were examined as measured by size of case load and emphasis placed on paper work. Officers' perceptions of their power relative to clients and their right to exercise that power were explored, along with their perceptions of their organization's multiple goals.

Attitudes and Behavior

Finally, are attitudes expressed in action? As discussed earlier, this is a controversial question with contradictory evidence. The writers answering no to the question have tended to cite research primarily from the relationship between prejudice and discrimination (e.g., Deutscher, 1969), with some apparent justification. But these studies deal essentially with inter*group* interaction, where social distance is easier to maintain even if expressed attitudes and behaviors are discrepant. The evidence which poses affirmative answers appears to be in areas of more inter*personal* interaction, where nonverbal behavioral cues, subtle nuances and the like are easier to detect and have important consequences for the interaction and for the participants' views of each other and themselves. This seems to be at the base

of symbolic interaction theory (see Meltzer et al., 1975:34), out of which the labeling approach to deviance primarily emerged. Thus, on the basis of this theoretical interpretation and the empirical evidence provided earlier on treatment agent-patient interaction, it was expected that there should be some relationship between attitude and behavior for the interaction between probation/parole officers and alcoholic clients. Such a relationship is difficult to ascertain from paper-and-pencil questionnaires; obviously nonverbal behavior cannot be measured. Nonetheless, questions can be asked about past behaviors and behavioral predispositions. Thus, there were items regarding previous "diagnostic" and referral behavior with clients, attempts to relate attitudes to officers' own desired future behavior (i.e., whether they wanted or felt they needed more alcohol training), etc.

It seems apparent that this is the weakest area of research questions presented here, even for a study that is frankly exploratory and descriptive. The investigator agrees that it is indeed quite difficult to infer behavior from even the most rigorous survey instrument. But probing the issue even superficially, as must be done here, seems defensible, because it should provide some broad guidelines for future studies in this basically unexplored area.

The sixth and final research question explored whether attitudes (labels) do have consequences for behavior (reaction). While this cannot be determined completely from a survey, it can provide guidelines for future research.

Conclusion

Research questions to be investigated in the present research have been stated neither precisely nor concisely. There has been little attempt to specify variables as explicitly independent or dependent, nor have the direction of expected relationships between variables always been clearly delineated. This is deliberate. The most important reason is the exploratory nature of this study. While physicians, psychologists, nurses, social workers, and others reviewed in Chapter II and in this chapter, along with probation/parole officers, are all human services professionals, they are very different types of human services professionals. Although the other professionals reviewed at least have in common some kind of loosely-defined "medical-therapeutic" orientation, enough differences were found among them to make it difficult to generalize even between their occupations. With probation/parole officers being professionally socialized into either a "correctional-punitive" or "correctional-therapeutic" orientation, further generalization seems grandiose, if not downright dangerous.

Furthermore, the vast majority of studies reviewed investigated only a limited set of attitudes within a limited theoretical and explanational framework, most frequently relating attitudes to only one or two independent variables. The effort outlined here is far more comprehensive. It attempted to test empirically a broader framework of especially labeling theory, analyzing the impact of more than one audience level on attitudes or stereotypes, along with some of their implications for actual behavior. Moreover, the substantive area in question, probation/parole officers and views on alcoholism, has not been studied even in the more narrow sense mentioned above. Therefore,

it is the opinion of the investigator that to offer more specific hypotheses at this time would have been inappropriate.

CHAPTER IV

RESEARCH METHODOLOGY

Sample

The sample for this investigation was taken from the population of all probation/parole officers employed by the Division of Community Services, Probation and Parole, of the Oklahoma Department of Corrections. These officers are responsible for supervising approximately 13,000 primarily felony probation and parole clients throughout the state of Oklahoma (Shaw, 1979).

Questionnaires were distributed to all probation/parole officers and their district supervisory personnel in all seven probation/parole districts in Oklahoma in late March, 1980. Prior approval was obtained from administrative personnel at the state level of the department.

From a total population of 206, the researcher had a sample of 186 usable questionnaires, yielding a 90.3% response rate. Six additional questionnaires were returned which were unusable. The final sample consisted of four of the seven district supervisors, eight of the eleven assistant supervisors, 172 of the 188 probation/parole officers, and two who did not state their job title. Two districts had a 100% response rate, although one unusable questionnaire was returned from each of these districts.

Sample Profile

Since less than ten per cent of the total population of probation/ parole officers in the state of Oklahoma at the time of data collection were not included, it seems safe to assume that the descriptive profile provided by the sample is representative of the population.

There are seven probation/parole districts in Oklahoma, three of which are in the two largest cities in the state (Districts A, B and C).[1] Districts D, E, F and G serve primarily rural communities. The three urban districts were significantly more likely to be comprised of female officers ($X^2 = 19.304$, $p = .0037$) than were the other four districts (see Table I). Districts A, B and C ranged from 47% to 56% female, with one of them having the only female district supervisor; the four rural districts ranged from 10% to 37% female.

The chi square was also significant for age distribution by district ($X^2 = 31.608$, $p = .0016$). The three urban districts (A, B and C) had fewer than 13% of their officers forty years old or older, while one rural district (District F) that was 90% male had 58% of its officers forty or older, and only 16% under thirty years old. District G, another rural district, had the greatest number of officers in the middle age group, with half its officers from 30 to 39 years of age. Two urban districts (A and B) had half or more of their officers under 30.

The X^2 for education by district (49.784) had a probability of

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[1]The seven districts usually are referred to by number. For purposes of this study, they were reordered randomly and given letter designations to avoid identification as much as possible. These designations will be used throughout the study.

TABLE I

CHI SQUARE FOR DISTRICT BY SEX, AGE AND EDUCATION, IN PER CENT

	A	B	C	D	E	F	G	x^2	df	Probability
Sex										
Male	45.5	53.1	43.9	63.2	65.0	89.5	81.8			
Female	54.5	46.9	56.1	36.8	35.0	10.5	18.2			
(N)	(33)	(32)	(41)	(19)	(20)	(19)	(22)	19.304	6	.0037
Age										
Under 30	54.5	50.0	46.2	47.4	45.0	15.8	27.3			
30 - 39	33.0	27.5	41.0	31.6	10.0	26.3	50.0			
40 Plus	12.1	12.5	12.8	21.1	45.0	57.9	22.7			
(N)	(33)	(32)	(39)	(19)	(20)	(19)	(22)	31.608	12	.0016
Education										
HS-Some College	6.1	0.0	7.3	10.5	15.0	42.1	13.6			
College Degree	51.5	34.4	19.5	10.5	40.0	36.8	45.5			
Some Graduate	21.2	28.1	34.1	57.9	20.0	15.8	31.8			
Graduate Degree	21.2	37.5	39.0	21.1	25.0	5.3	9.1			
(N)	(33)	(32)	(41)	(19)	(20)	(19)	(22)	49.784	18	.0001

.0001. A bachelor's degree was not required to become a probation/parole officer in Oklahoma until 1975 (see Appendix A). District F, which already has been described as unique in terms of sex and age, stood out here too. While only 11% of the total sample did not have degrees, 42% of the officers in that district did not; likewise, only 21% of its officers had any education beyond the bachelor's level, compared with 55% of the total sample. One urban district (District B) had no officers without a degree; as might be expected, the graduate degrees were concentrated in Districts A, B and C (75% of all graduate degrees were in those three urban districts). Interestingly, one of the rural districts (District D), 37% female and 47% under thirty years old, had considerably more officers with education beyond the baccalaureate than any other district (79%).

In short, the seven probation/parole districts in the state were quite heterogeneous at the time of data collection in sex, age, and education; the three urban districts (A, B and C) were not too dissimilar from one another, but the four rural districts were quite different among themselves. It should be noted, though, that due to the way boundaries are drawn to delineate districts, officers who were in some rural districts were more likely than those in other rural districts to live and/or work in communities very close to urban centers and/or major universities.

In examining the total sample, it can be seen from Table II that the sample was almost 60% male. The mean age of sample members was 34.2 years, but the median was 30, reflecting a relatively young group. Over 65% of the females were under thirty, compared to 28% of the males

TABLE II

DEMOGRAPHIC PROFILE OF PROBATION/PAROLE OFFICER SAMPLE

Characteristic	Categories	N	Per Cent
District[a]	A	33	17.7
	B	32	17.2
	C	41	22.0
	D	19	10.2
	E	20	10.8
	F	19	10.2
	G	22	11.8
		186[b]	99.9
Sex	Male	110	59.1
	Female	76	40.9
		186	100.0
Age	Under 30	79	42.9
	30 - 39	63	34.2
	40 and Over	42	22.8
		184	99.9
Racial Origin	Native American	4	2.2
	Black	19	10.3
	White	158	85.9
	Other	3	1.6
		184	100.0
Size Community Raised In	Under 5,000	61	32.8
	5,001 - 25,000	31	16.7
	25,001 - 50,000	20	10.8
	Over 50,000	74	39.8
		186	100.1
Size Community Live In Now	Under 5,000	19	10.3
	5,001 - 25,000	30	16.2
	25,001 - 50,000	22	11.9
	Over 50,000	114	61.6
		185	100.0
Marital Status	Never Married	34	18.3
	Married	127	68.3
	No Longer Married	25	13.4
		186	100.0

TABLE II (Continued)

Characteristic	Categories	N	Per Cent
Religious Affiliation	Roman Catholic	18	9.7
	Jewish	3	1.6
	Protestant (Allows Drinking Alcoholic Beverages)	68	36.6
	Protestant (Frowns on Drinking Alcoholic Beverages)	60	32.3
	Other	9	4.8
	None	28	15.1
		186	100.1
Highest Educational Level Completed	High School - Some College	21	11.3
	College Degree	63	33.9
	Some Graduate Work	55	29.6
	Graduate Degree	47	25.3
		186	100.1
Job Title	Probation/Parole Officer	172	93.5
	Supervisory Personnel	12	6.5
		184	100.0
Length of Time in Job	Less than One Year	33	17.7
	1 - 5 Years	106	57.0
	6 - 10 Years	33	17.7
	Over 10 Years	14	7.6
		186	100.0
Length of Time Working For Agency	Less than One Year	23	12.4
	1 - 5 Years	103	55.4
	6 - 10 Years	42	22.6
	Over 10 Years	18	9.7
		186	100.1
Length of Time Working in Corrections Field	Less than One Year	18	9.7
	1 - 5 Years	105	56.5
	6 - 10 Years	43	23.1
	Over 10 Years	20	10.7
		186	100.0
Other Criminal Justice Jobs Held in Past	Adult Institutional	31	22.1
	Other Adult Corrections	20	14.3
	Juvenile Corrections	21	15.0
	Law Enforcement	32	22.9
	Other	17	12.1
	None	53	37.9
		174	124.3[c]

TABLE II (Continued)

Characteristic	Categories	N	Per Cent
Other Types of Jobs Held in Past	Counseling	27	19.7
	People-oriented	77	56.2
	Nonpeople-oriented	51	37.2
	None	21	15.3
		186	128.4[d]

[a]Districts usually are referred to by number. For this study, they were reordered randomly and given letter designations to avoid identification as much as possible.

[b]Number of respondents varies slightly on some characteristics since information from some respondents was incomplete.

[c]Percentages based on 140 respondents who answered question. Percentages total more than 100% because some respondents had more than one job.

[d]Percentages based on 137 respondents who answered question. Percentages total more than 100% because some respondents had more than one job.

(see Table III); only 12% of the females were over forty, while 30% of the males were ($X^2 = 26.247$, $p < .0001$). Forty-five per cent of the females were married, compared to 84% of the males; and 37% of the females, but only 6% of the males had never been married ($X^2 = 37.027$, $p < .0001$). Interestingly, males and females were almost equally likely to have post-baccalaureate college work. Twenty-five per cent of each sex had graduate degrees, while an additional 31% of the men and 28% of the women had some graduate work ($X^2 = 6.874$, $p = .0760$). These relationships for sex, age, marital status and education probably reflect the sex composition of many other human services occupations requiring college education today. As Table III also indicates, this relationship is further supported by the fact that whether it is length of time in job ($X^2 = 12.209$, $p = .0067$), length of time working for the agency ($X^2 = 15.144$, $p = .0017$), or length of time working in the corrections field ($X^2 = 17.212$, $p = .0006$), males were significantly likely to be working much longer than female officers.

Returning to Table II, racially, 86% were white, 10% black, and 3% Native American. The blacks were more likely to be female and under thirty than were whites, but equally likely to have graduate degrees. As with women, this probably reflects relatively recent opening up of this occupation to minorities, but also as with women, equal educational preparation with whites and males. It is interesting that blacks were represented among probation/parole officers proportionately to their representation within the total Oklahoma population, but Native Americans were grossly underrepresented.

Sutherland and Cressey (1978:507) noted that in 1976, nationally, 61% of the probation officers were male and 89% white. Thus, the 1980

TABLE III

CHI SQUARE FOR SEX BY AGE, MARITAL STATUS, EDUCATION, AND TIME IN JOB, AGENCY AND CORRECTIONS, IN PER CENT

	Males	Females	X^2	df	Probability
Age					
Under 30	27.5	65.3			
30 - 39	42.2	22.7			
40 Plus	30.3	12.0			
(N)	(109)	(75)	26.247	2	.0000
Marital Status					
Never Married	5.5	36.8			
Married	84.5	44.7			
No Longer Married	10.0	18.4			
(N)	(110)	(76)	37.027	2	.0000
Education					
HS-Some College	15.5	5.3			
College Degree	28.2	42.1			
Some Graduate	30.9	27.6			
Graduate Degree	25.5	25.0			
(N)	(110)	(76)	6.874	3	.0760
Time in Job					
Less than One Year	12.7	25.0			
1 - 5 Years	53.6	61.8			
6 - 10 Years	22.7	10.5			
Over 10 Years	10.9	2.6			
(N)	(110)	(76)	12.209	3	.0067
Time in Agency					
Less than One Year	8.2	18.4			
1 - 5 Years	49.1	64.5			
6 - 10 Years	29.1	13.2			
Over 10 Years	13.6	3.9			
(N)	(110)	(76)	15.144	3	.0017
Time in Corrections					
Less than One Year	6.4	14.5			
1 - 5 Years	48.2	68.4			
6 - 10 Years	31.8	10.5			
Over 10 Years	13.6	6.6			
(N)	(110)	(76)	17.212	3	.0006

Oklahoma percentages of 59% and 86% respectively for male and white probation/parole officers is comparable to the national figures.

Table II indicates that the sample members were more likely to live in urban communities at the time of the study than they were to be reared in them. Over 2/3 were married at the time of the survey. A similar proportion (68.9%) were likely to consider themselves Protestant, but fewer than half of those identified themselves as Protestants whose church frowns on drinking (32.3% of the total sample). As a group, the probation/parole officers were more educated than might be expected; while 68% had been with the agency five years or less, 89% had at least a bachelor's degree and degrees have been a job requirement only since 1975. The job tenure was in keeping with the relatively young age of the group, but the two characteristics suggest a high rate of turnover among probation/parole officers in the state (less than ten per cent had been with the agency for more than ten years).

Almost half the probation/parole officers (41%) indicated they had worked in some other type of criminal justice job prior to becoming a probation/parole officer. Fifteen per cent indicated they had never worked in any type of job except in the criminal justice system. Of those who had worked in other types of jobs, they were considerably more likely to have worked in a people-oriented job than a nonpeople-oriented one (see Appendices B and C for descriptions of how jobs were categorized).

Slightly under half the probation/parole officers had had at least part of their college education at two of the three largest universities in Oklahoma. Due to officers frequently attending several schools, it was impossible to know exactly how many of them were educated in Okla-

homa, but the 186 officers gave 206 references to Oklahoma state-supported universities and colleges and 44 references to private schools in Oklahoma. There were 47 officers who mentioned attending out-of-state colleges and universities. Also, since many officers had more than one degree, frequently with different majors for each degree, it was difficult to relate major fields of study to particular schools or degrees, but 68 had a specifically criminal justice major at some point in their educational career, and 97 had a major related to criminal justice, while 82 listed unrelated majors (see Appendix D for the way majors were categorized).[2]

The probation/parole officers considered an ideal size case load 48 (mean; median was 50). Sutherland and Cressey (1978:507) stated that nationally an ideal case load of only probationers is considered to be 50, although "most full-time probation officers have several times that number of probationers under supervision" (Sutherland and Cressey, 1978:507). They did not list an ideal size case load for parolees, but Sutherland and Cressey (1978:643) noted that "case loads sometimes run as high as two or three hundred per officer," citing an average of 90 in California and 60 in Pennsylvania. Oklahoma probation/parole officers in the current sample had a mean <u>total</u> case load of 74 (median = 76); that breaks down into an average of 64 probationers (median 65, range 23 - 108) and a mean of ten parolees (median 9, range 0 - 35). Therefore, while the actual case loads were larger than what either Oklahoma officers or "national experts" considered ideal, they did not compare

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[2]As with college(s) attended, the number of majors totaled more than 186, because many respondents listed multiple colleges and majors.

with case loads in some states. As would be expected, there were more men (mean 62, median 63) than women (mean 12, median 11) in the average Oklahoma probation/parole officer case load.

Data Collection Procedure

Printed surveys entitled "1980 Alcohol Attitude Survey" (see description below in section on Data Collection Instrument) were mailed to each probation/parole officer, assistant supervisor, and supervisor in late March, 1980, at their individual office addresses. They were accompanied by cover letters from the researcher and the Assistant Deputy Director for Probation and Parole for the Department of Corrections. Officers were asked to complete the questionnaires and bring them to their regular monthly meeting in April at the district supervisor's office.

Each month just prior to the monthly district meetings for all probation/parole officers, the district supervisors meet together at the state office of the Department of Corrections in Oklahoma City. The researcher was invited to that meeting in April, 1980, by the Assistant Deputy Director for Probation and Parole to explain the survey further and to answer any questions from the supervisors. The researcher then attended the district meetings for six of the seven probation/parole districts, scheduled from April 9 to April 16. At each meeting, she described to the probation/parole officers what would happen to the questionnaires after they were turned in, agreed to present research results at a future district meeting if requested, and answered questions regarding the research purpose, questionnaire, and anonymity.

The researcher had an alphabetized list of probation/parole officers

at each district meeting. After all questions from officers had been answered, she circulated among the officers and collected each survey individually. The officer's name was checked off on the researcher's list so that it would be known who still had surveys to turn in, but no identifying marks were made on individual questionnaires. Twelve questionnaires were mailed to the researcher's office by officers who did not have them completed at the district meetings.

Limitations

Although it was felt personal contact with probation/parole officers was important to impress upon them the guarantee of anonymity, this was not possible in one of the seven districts. At the time of the supervisor's meeting in Oklahoma City, the supervisor of that district was ill and sent a substitute to the meeting. Whether that or something else led to miscommunication is unknown; however, when the researcher arrived at that district meeting as scheduled, it was discovered that the probation/parole officers had left their questionnaires with an assistant supervisor and had gone to an inservice education project elsewhere. It was feared at first that transferring questionnaires through an assistant supervisor might result in less honest answers than if questionnaires had been given directly to the researcher. Analysis of the data through the statistical tests to be described below indicated, however, that responses in this district were not significantly different from those in other districts. The response rate from that district was slightly lower than the overall response rate (86.5%), but one other district visited by the researcher had a similarly low response rate (85.2%).

A second difficulty emerged from the general method of data collection. Promises of anonymity of responses were made in writing by both the researcher and the Assistant Deputy Director for Probation and Parole. Nevertheless, an undesirable political situation that was not known previously by the researcher was existing between the Probation and Parole Division and the state Department of Corrections at the time of data collection. It was learned during visits to the district meetings that a sizable proportion of probation/parole officers feared they could and would be identified by listing colleges and universities they had attended.[3] As a result, it was acknowledged to the researcher that several officers in each district had given deliberately dishonest answers to the questions relating to the respondent's personal drinking behavior. Not only did later analysis confirm that the drinking behavior of respondents appeared to be much less in quantity and frequency than studies of the general population have indicated (e.g., Cahalan, 1968), but also stories related to the researcher by probation/parole officers she personally knew in most districts suggested that the statistical results showed an under-estimation of drinking behavior by sample members. Consequently, these questions were eliminated as background variables in subsequent analyses.

It was proposed by an officer in one district that had the re-

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[3]Field notes written by the researcher after each district meeting visit noted it was the older probation/parole officers who tended to ask questions about anonymity most often. A probation/parole staff member from the state office confirmed that the longer probation/parole officers work for the department, "the more paranoid they become" because of prior experience with administrative changes. Interestingly, this is supported somewhat by Parker (1980) in a recent study of police officers; of officers studied in three different police departments in Oklahoma, he found those in the department with the oldest officers tended to be the least trusting of people in general.

searcher visited the district meetings first to describe and explain the study, then distributed the surveys with stamped return envelopes, some responses might have been more honest. However, it was felt by the researcher that the personal drinking behavior questions were the only ones seriously affected by the procedure followed. Also, prior experience suggests that even if stamped return envelopes are provided, mail-back questionnaires generally result in a much lower response rate than the one obtained in the present study.

Advantages

While there were drawbacks in the data collection procedure and indeed overt hostility on the part of a few probation/parole officers during district meetings, there also were certain advantages involved. For one, as noted above, a much higher response rate was obtained than is typical for mail-return questionnaires.

Secondly, although some statements at meetings reflected hostility toward the questionnaire itself and its assumed purpose, as well as fear of anonymity, at most district meetings there also was enthusiasm expressed by several officers for the survey. They not only expressed frustration about dealing with alcoholic offenders, but also voiced a hope that this survey would lead to more training in the area. In five of the seven districts, several officers, especially young ones, indicated a strong desire to receive feedback on the survey results. In addition, a large number of officers wrote extensively on the open-ended questions, further reflecting their interest.

A third factor could have been either an advantage or a limitation, but it is felt by the researcher that it operated more as an advantage

than as a disadvantage. This was the element of personal contact, manifested in two ways. One was the fact that the researcher met with the district supervisors almost as soon as the questionnaires were mailed out. Several questions about the survey and fears regarding it were answered in that meeting, prior to most officers actually responding to it. It is hoped that these answers were passed on to officers when supervisors returned to their districts. The second element of personal contact had to do with the fact that in six of the seven districts there were former students of the researcher, most of whom she had had good rapport with while they were in her classes. Hopefully, at least some of them assured fellow officers of the legitimacy of the research and of the researcher's integrity regarding their anonymity.

Data Collection Instrument

The instrument used to collect data was a self-administered paper-and-pencil questionnaire, entitled "1980 Alcohol Attitude Survey" (see Appendix E for the survey in its entirety). A cover letter on the researcher's professional affiliation letterhead preceded the survey itself, explaining the purpose of the study and guaranteeing anonymity. Also accompanying the survey was a letter from the Assistant Deputy Director for Probation and Parole for the Oklahoma Department of Corrections acknowledging the survey, assuring anonymity and encouraging cooperation in completing the questionnaire (see Appendix F).

The format used in the questionnaire was primarily close-ended questions. A survey with mostly close-ended questions was chosen because of several advantages adhering to it: 1) the large number of variables being measured made it a faster way to collect data and ul-

timately to analyze it; 2) it allowed for standardized responses and helped to insure that questions were answered within a frame of reference relevant to the research goals (Babbie, 1979); 3) with respondents scattered all over the state, it was easier to administer and allowed for a larger sample than other methods or formats would have; 4) in an area full of ambiguities such as alcoholism, the close-ended questions perhaps made the meanings of some questions clearer by providing alternatives; 5) especially for questions regarding attitudes and perceptions, close-ended questions required the respondents to make their own judgments about their feelings rather than relying on coders' judgments.

These strengths of surveys with close-ended questions do not ignore their shortcomings: 1) they may force opinions on an issue where respondents actually have no opinion or little knowledge; 2) it is possible to fit "round pegs into square holes" (Babbie, 1979:346) by forcing respondents to use a limited set of categories, thus not adequately representing their opinions and resulting in bias; 3) respondents may interpret questions differently than the researcher intended; 4) close-ended question surveys cannot deal adequately with the total social context within which the respondents are operating; 5) surveys cannot measure social action directly.

Several strategies were utilized to overcome some of the weaknesses just listed: 1) on strictly knowledge questions, a "don't know" category was included so that respondents were not forced to guess at an answer; 2) precisely because of the ambiguities in the alcoholism area noted above under advantages, some questions were deliberately left open-ended so that the extent of the respondents' knowledge could be ascertained, e.g., listing alcoholism treatment organizations;

3) to alleviate the disadvantage regarding the respondents' social context, some open-ended questions allowed them to define the situation themselves, e.g., regarding symptoms of alcoholism, whereas other questions allowed respondents to add categories relevant to their situation, e.g., work activities and treatment goals; 4) both past and hypothetical behaviors were asked about, to compensate in part for the inability to measure action directly; 5) no formal interviews were carried out, but the researcher engaged in informal conversations with some probation/parole officers representing every level of the hierarchy and with a staff member from the state office (a former probation/parole officer herself) who was at each district meeting the researcher attended, in an effort to gain additional information which would aid in interpretation of data.

The survey instrument was pretested with 125 primarily criminal justice students at a large university for clarity of instructions and questions. The pretest also allowed the researcher to estimate the average time necessary for respondents to fill out the questionnaire. Necessary revisions in the instrument were made following the pretest.

Survey Items

Background Variables

Since so little research has been done in the area examined by this study, a variety of variables were included in the questionnaire. Social demographic variables which are standard in most surveys were taken into account: sex, age, racial origin, size of community of upbringing and current residence, marital status, religious affiliation, education, job title, length of time in current job, present agency and corrections

field, and other work experiences.

A number of other variables were included to pursue the research questions outlined in Chapter III. Some of these items dealt with the respondents' personal and family experiences with drinking; they were asked to categorize the general drinking behavior of their parents, spouse, and themselves; unique to this study were separate categories for "alcoholic drinker" and "recovered alcoholic," since prior studies reviewed used only one category--"alcoholic." In addition, they were asked to estimate how many, if any, practicing and recovering alcoholics there were among their siblings, children, other relatives, close friends, and work associates (all separated by sex). In all cases where a recovered alcoholic was mentioned, treatment method was requested. Four items relating to attitudes toward social drinking were borrowed from Bailey (1970) in the hope of constructing an index to use as another background variable, although Bailey analyzed each item separately.[4]

The questionnaire contained other sets of items relating to respondents' professional experience with alcoholism. Previous studies have tended to ask general questions about whether respondents had prior training in alcoholism; in this research, respondents were asked to list specific examples of prior training in eight individual areas, plus a catch-all "other" category. They also were asked in separate questions whether they needed and wanted more training regarding alcoholism, and why. Three close-ended questions were included with reference to personal feelings about working with alcoholic clients, with the goal of

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[4]Since items described in this section were scrambled in the questionnaire, they are listed by topic in Appendix G.

constructing an index.

As discussed in Chapter II, interaction between probation/parole officers and clients usually occurs within a formal, organized framework, which influences interaction. These organizational imperatives were measured indirectly. To this end, officers were asked to rank a list of ten work activities in two different ways: first, in the order of time actually spent at each activity, and secondly, in the order in which they felt were ideal time priorities. They also were asked what they felt would be an ideal size case load, along with how many clients they had at the time of the research. In addition, close-ended questions were included to measure their perceptions of their agency's goals, both with regard to the agency's general philosophy toward probation/parole clients and with respect to the agency's stand on drinking behavior of clients. The multiplicity of organizational goals was contrasted with officers' personal goals toward working with clients in general and toward working with alcoholic clients in particular. The aim of these items also was to measure officers' views on their power relative to that of clients. Organizational items were designed specifically for use in this research.

Focus Variables

The primary purpose of this study was to examine probation/parole officers' views about alcoholism and alcoholics. The background variables described above were investigated to see whether and how much they were related to the views which were the focus of the research. Using ideas from a variety of previous studies, the researcher developed her own primarily open-ended items to explore knowledge of and attitude toward alcoholism treatment goals and modalities. Other researcher-designed

items were included to tap personal definitions of symptoms of drinking-related problems and how officers put these definitions into practice with specific male and female clients.

Marcus Alcoholism Questionnaire. Attitudes toward the condition of alcoholism were measured using "The Alcoholism Questionnaire" developed as the outcome of a factor analytic study which isolated nine factors "considered to represent the major dimensions of popular opinion about alcoholism" (Marcus, 1963:1). The instrument consists of forty statements to which the individual responds by checking a scale position ranging from one to seven, with one representing complete disagreement. Scoring yields nine individual or mean factor scores (MFS) for groups. The instrument includes complete instructions for administration, scoring, presentation, and interpretation of data, and mean factor scores for five samples which can be used as norm groups for comparison purposes. Marcus (1963:9) recommended that since scientific expert opinion is not in agreement as to the "facts," the items should be regarded as "opinion," and the best method of interpretation is to compare one's obtained MFS's with the general population or professional norm groups. This has been the general practice in the many studies using the questionnaire (e.g., Ferneau and Morton, 1968; Ferneau and Gertler, 1971; Waring, 1978; Lemos and Moran, 1978). Table IV defines the nine factors and indicates whether a high or low score was considered as "positive" in attitude by Marcus' (1963) professional staff. "Positive" is based on the concept that alcoholism is a treatable disease or illness, which also is the position taken by the 1978 Oklahoma Alcohol Services Act (Oklahoma Senate Bill 280, 1978:Section 2101). For this reason, and because the Marcus questionnaire is the most widely

TABLE IV

MARCUS FACTOR DEFINITIONS

Factor	Interpretation	Experts' Position
1. Emotional difficulties	A high score indicates the belief that emotional difficulties or psychological problems are an important contributing factor in the development of alcoholism.	High
2. Loss of control	A high score indicates the belief that the alcoholic is unable to control his/her drinking behavior.	High
3. Prognosis for recovery	A high score indicates the belief that most alcoholics do not, and cannot be helped to, recover from alcoholism.	Low
4. The alcoholic as a steady drinker	A high score indicates the belief that periodic excessive drinkers can be alcoholics. A low score indicates the belief that a person must be a continual excessive drinker in order to be classified as an alcoholic.	High
5. Alcoholism and character defect	A high score indicates the belief that the alcoholic is a weak-willed person.	Low
6. Social status of the alcoholic	A high score indicates the belief that alcoholics come from the lower socioeconomic strata of society.	Low
7. Alcoholism as an illness	A high score indicates the belief that alcoholism is not an illness.	Low
8. Harmless voluntary indulgence	A high score indicates the belief that the alcoholic is a harmless heavy drinker whose drinking is motivated only by his/her fondness for alcohol.	Low
9. Addiction liability	A high score indicates the belief that alcohol is a highly addicting substance.	High

used questionnaire (with the most complete set of instructions) in the review of literature for comparison purposes, it was used in its entirety.[5]

Semantic Differential. Attitudes toward the alcoholic as a person were measured using the semantic differential bi-polar adjective scales. This technique was chosen because variations of it were the most frequently used such scales in the literature reviewed (e.g., Marcus, 1960; Mackey, 1969; White, 1975; Fisher et al., 1976; Wallston et al., 1976). Developed by Osgood as a generalized measurement technique to tap the principles of evaluation, potency, and activity, it provides standardization of categories and a balance between positive and negative answers; it also allows for fast responses. The adjectives chosen may be adapted to fit the requirements of each individual research problem (Osgood et al., 1957). The method "has been shown to provide a sensitive and valid measure of the affective meaning underlying concepts held by homogeneous groups of individuals" (Wallston et al., 1976:661).

The studies referred to above used a range of seven to 18 adjective pairs. They were scrutinized carefully and compared for overlap between scales and for scales which showed the greatest distinction between relevant concepts. Based on that research, 18 bi-polar scales were chosen: evaluation (good-bad, valuable-worthless, intelligent-ignorant, wise-foolish); potency (strong-weak, bold-timid); and activity (active-passive, excitable-calm). Marcus (1960) used four other scales

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[5]For comparison purposes, the factors in the original Marcus questionnaire were used in this study. However, it should be noted that in a factor analysis of the 36 items with the current sample, a different grouping of factors appeared. These will be discussed in Chapter V.

relevant to alcoholic stereotypes, while Wallston et al. (1976:661) added five scales to constitute "a social stimulus value factor" and four "independent scales," and Mackey (1969) used several extra dimensions which he did not identify. Several of those seemed pertinent to the present research: healthy-sick, understandable-confusing, reliable-unreliable, familiar-strange, safe-dangerous, relaxed-tense, hopeful-hopeless, motivated-aimless, predictable-unpredictable, self reliant-dependent. They were used by the researcher as "alcoholic stereotype" scales. Of the 18 scales, all but five were used by at least two of the other researchers.

The order and direction of the scales were randomly determined. While most studies asked respondents to rate several concepts, in this research, they were asked to rate four groups--"normal" woman, alcoholic woman, "normal" man, and alcoholic man--on each adjective pair according to a seven-point scale.[6] Fisher et al. (1976:1691) suggested that if stereotyping is not present, the ratings of "normal" and alcoholic persons should differ only on the healthy-sick continuum.

Student Alcohol Questionnaire. Finally, knowledge about alcohol and alcoholism had to be determined, both as background and focus variable. Several knowledge scales have been constructed which pertain to objectives of particular training courses (e.g., Gurel, 1976; Fisher et al., 1976). The most up-to-date general knowledge inventory was the "Student

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[6]In the pretest, one-third of the students received each of the following labels, distributed randomly--"normal," "typical," and "average." Analysis of means showed very little difference between the three labels, but students in a class on alcohol abuse discussed it and concluded they felt most comfortable with "normal," so it was used in the final survey.

Alcohol Questionnaire" devised by Engs (1975), and it was used in this study. The knowledge questions of this questionnaire comprise 36 true-false items; it was tested on a national sample of colleges and universities. Mean scores for comparison were provided for all students who took the questionnaire and were separated by race and sex. Reliability was determined for the knowledge scale using the Kuder-Richardson ($r = .79$) and Spearman-Brown ($r = .82$) techniques (Engs, 1975). Validity was determined by consultation with individuals working in alcohol education and research, as well as with students, and the questionnaire went through several revisions (Engs, 1977).

Analysis of Data

After going through all the questionnaires for patterns of responses, the researcher developed a code book for the open-ended questions. She and a research assistant each coded approximately half the questionnaires and then checked each other's coding. Disagreement over coding responses was minimal and was solved by discussion between researcher and assistant. The data were transferred to IBM cards directly from the questionnaires for computer-assisted statistical analysis using SPSS (Nie et al., 1975).

Descriptive statistics were used to examine the total sample. To examine differences between subgroups in the sample, the primary statistical test utilized was analysis of variance (AOV). Technically only the knowledge scale yields the interval-level data required for AOV; the Likert-type responses to the Marcus Alcoholism Questionnaire and responses to the semantic differential technically are ordinal-level scales. However, researchers in the literature reviewed assumed them

to be interval-level, using means, t-tests, AOV, regression analyses, etc., so the researcher followed that convention. Not only do the parametric statistics permit more mathematical manipulation and thus more information about one's data, but their use also allows for more comparison with previous research. Chi square also was used with some nominal scale items.

Pearson product moment correlation was used to measure strength of relationships among knowledge, attitudes toward alcoholism, and views toward alcoholic persons. Finally, factor analysis was performed on the Marcus Alcoholism Questionnaire to determine any patterns which might emerge in those data.

CHAPTER V

FINDINGS AND DISCUSSION

It was pointed out in Chapter III that this study is primarily exploratory and descriptive, since so little prior information exists in the area of interest. Therefore, several relatively general research questions were asked, to give some direction to the research. The purpose of this chapter is to describe findings from the current set of data relevant to each of those research questions. Possible meanings of and reasons for the results obtained also will be discussed, along with consequences which could follow from certain kinds of knowledge or attitudes.

Knowledge about Alcohol and Alcoholism

In Chapter III it was suggested that some accurate knowledge about alcohol and alcoholism is necessary if needs of alcoholics are to be met with understanding by human services professionals. Thus, the purpose of the first research question was to determine the level of that knowledge among the probation/parole officers, along with how much and what kinds of alcoholism education the officers had had and how this training related to their knowledge level. Based on prior studies of other human services professionals, it was anticipated that their knowledge level would not be high and that they would not have a great amount of training. Because of these expectations, it was anticipated that the officers would need and want further alcoholism training and that they would

perceive their fellow officers as undereducated on the topic.

Knowledge Scale

Engs' (1975) "Student Alcohol Questionnaire" was the general knowledge scale used in this research. This scale is comprised of 36 questions with alternatives of true, false, or don't know for each question. Engs (1975:1), with a sample of 1,128 undergraduate students from thirteen colleges nationwide, found the mean number of correct responses to be 20.06. The probation/parole officers in this sample scored a mean of 22.26 correct (see Table V), making them slightly more knowledgeable than Engs' sample members. That results in an average of 61.8% for the probation/parole officers, contrasted with 55.7% for Engs' students.

TABLE V

MEAN NUMBER CORRECT, WRONG AND DON'T KNOW ON KNOWLEDGE SCALE OF 36 ITEMS

	$\overline{X}$	S.D.	Range
Correct	22.26	5.00	5 - 32
Wrong	5.56	3.14	1 - 17
Don't Know	9.24	5.57	1 - 30

Comparison with the other studies is difficult from two standpoints: first, most studies reviewed discussed differences in scores before and

after training without giving actual scores (e.g., Waring, 1978; Fisher et al., 1976); second, most who did give actual scores described their knowledge scales as designated for the particular training program they were evaluating (e.g., Williams et al., 1974; Distefano et al., 1975). Two researchers stated they used standardized scales, but their content is unknown. One was Chodorkoff (1967; 1969) with medical and nursing students; on his "Alcohol Information" instrument, both groups averaged 56% correct before training, somewhat below the probation/parole officers in this study. After training and experience, though different for the two groups, Chodorkoff's medical students rose to 83%, while his nursing students rose to 77% correct. Gurel's (1976) nursing students averaged 65% and 69% on two knowledge scales before training, somewhat higher than the probation/parole officers. After one quarter of training, their average score increased to 67% and 82%, after three quarters to 74% and 90% on the respective tests. Thus, in general, the probation/parole officers appeared to be midway between health professionals without training, given the caution about comparing possibly different types of knowledge scales. The relationship of probation/parole officer scores to training will be discussed below in the section on Sum of Training.

The researcher carried the scoring a step further than Engs (1975) did (at least in her available published results). As Table V demonstrates, the probation/parole officers were more likely to acknowledge they did not know the answer ($\overline{X}$ = 9.24) than to guess incorrectly or to assume they knew an answer when they did not ($\overline{X}$ wrong = 5.56).

This latter finding is bolstered by the fact that the less an officer knew, the more likely he or she was to admit his/her lack of know-

ledge. Correct responses were divided into four categories, based on falling within one or two-plus standard deviations from the mean. As can be seen from Table VI, analysis of variance to test a relationship between number correct, on the one hand, and number wrong and don't know on the other, revealed a very statistically significant relationship between these variables. Those who scored 2+ standard deviations above the mean number correct had a mean of 3.87 don't knows, while those with scores 2+ standard deviations below the mean had an average of 19.18 don't knows ($F = 113.314$, $p < .0001$). In fact, all 22 respondents with the very low correct scores acknowledged they did not know the answers to some items, while only 23 of the 37 officers with the highest correct scores admitted as much. Coincidentally, those the furthest below the mean number correct had the fewest wrong answers, while those in between the extremes on knowledge had the most wrong answers, and even those who scored the most right had more wrong than "don't know" ($F = 3.911$, $p = .0098$). Further confirmation that probation/parole officers recognized to some extent the limits of their knowledge was that those with the least knowledge were significantly more likely to agree that they personally did not have much to offer alcoholics in the course of their job than were other respondents ($F = 3.372$, $p = .0197$).[1]

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[1]It should be noted that although the relationship between knowledge and having something to offer alcoholics was statistically significant, even those with the highest mean score on that item were likely to disagree with the statement that "I feel I personally do not have much to offer alcoholics in the course of my job" (see Table VI). Indeed, less than one-third (32.5%) of the total sample even agreed with that statement at all, although 77.4% of the total sample agreed that special training is required to help alcoholics. There was no difference by knowledge level on that item ($F = 0.711$, $p = .5467$).

TABLE VI

MEANS, F-SCORES AND PROBABILITY FACTORS FOR NUMBER CORRECT ON KNOWLEDGE SCALE AS IT RELATES TO OTHER KNOWLEDGE SCORES AND ATTITUDES TOWARD WORKING WITH ALCOHOLICS

Variable	Means					F-Score	Probability
	2 SD Below[a]	1 SD Below	1 SD Above	2 SD Above	Total		
Number Wrong	3.85	6.26	5.85	4.86	5.56	3.911	.0098
Number Don't Know	19.18	10.62	6.47	3.87	9.25	113.314	.0000
Helping Alcoholics Has Low Priority	1.82	1.98	1.78	1.84	1.86	0.587	.6241
Don't Have Much to Offer Alcoholics	2.55	2.28	1.99	2.06	2.16	3.372	.0197
Would Like Special Responsibility for Alcoholics	2.05	2.14	1.88	2.05	2.02	0.701	.5527
Helping Alcoholics Requires Special Training	3.00	3.03	3.21	3.00	3.09	0.711	.5467
(N)[b]	(22)	(58)	(68)	(37)	(185)		

[a]Refers to number correct being "minus two or more standard deviations from the mean."

[b]Total number in each category before AOV; varies slightly since information from some respondents was incomplete.

The knowledge items were separated into several broad categories in order to see if probation/parole officers were more knowledgeable in some areas than in others. No clear-cut patterns emerged. Ten questions dealt with alcohol itself; they ranged from 15% to 91% correct on those items, with a median of about 72%. Only 9% did not answer correctly that alcohol is a drug, but 25% did not answer correctly that it is not a stimulant. Thirty-two per cent, 57%, 68%, and 69% answered correctly the four questions about the amount of alcohol contained in various alcoholic beverages. Ten questions dealt with various effects of drinking on people. The range was from 9% to 78% correct, with a median of 56% correct. They were basically not knowledgeable on what beverages or food mixed with alcohol affect people at different speeds, how long it takes for alcohol to leave one's body, etc. They showed the least knowledge on eight questions that had to do with what the researcher labeled legal or social facts about drinking; correct responses ranged from 21% to 60%, with a median of about 47% on this set. Only 60% answered correctly a question dealing with the legal definition of intoxication, and only 29% correctly answered a question about the percentage of alcohol-related highway fatalities. Only about half responded correctly to three questions dealing with cultural patterns associated with drinking. They seemed to be most knowledgeable on three questions regarding reasons for drinking (96%, 97%, 99% correct on many Americans drinking for social acceptance, to escape, and for "social lubricant" reasons, respectively). The remaining four questions dealt with drinking history, ranging from 55% to 96% correct.

Of particular concern to the investigator is the fact that persons who work with alcoholics need to have accurate knowledge regarding the

drug, alcohol, itself, its physical effect on people, and legal-social facts about its use in our country. Otherwise, it will be very easy for them either to under- or overestimate alcohol-related problems, not only in general, but also in the way they perceive clients (see Jones et al., 1979, for corroboration on this view). Goodwin (1976:vii) added:

> . . . the book begins at the beginning, with yeast, and discusses alcoholic beverages, what happens to alcohol in the human body and why it affects people differently. The idea is that unless you know something about alcohol you will not be in a position to understand much about alcoholism. . . .

Alcoholism Education and Training

Probation/parole officers in the survey were asked to describe briefly the types of training and other educational experience they had had regarding alcoholism. Those results are shown in Table VII.[2] Of 133 responding to discussed briefly in college course, 80.5% said they had, mostly in sociology courses (30.1%). As expected, from the discussion on specialization in Chapter III, less than a tenth (9.8%) mentioned discussing alcoholism in criminal justice courses. (Appendix H describes the types of responses placed in each category.) Officers also were asked if they had been in a college course with alcoholism as the major topic. Again, as anticipated, of the 103 who responded, only 22.3% acknowledged they had had such a course.

There were other questions dealing with noncollege-related alcoholism training. One dealt with special training programs and/or workshops.

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[2]Large, but varying, numbers of officers did not respond to certain subsections of this item. Since it was impossible to know whether their lack of response was because of no training in that particular category or because of just choosing not to answer the question, "no response" was eliminated from the analysis. Only those who specifically wrote in "no," "none," "yes," etc., or a description were counted.

TABLE VII

TYPES OF ALCOHOLISM EDUCATION AND TRAINING
REPORTED BY PROBATION/PAROLE OFFICERS

Type	Categories	N	Per Cent
Brief Discussion, College Course	Sociology Courses	40	30.1
	Psychology Courses	30	22.6
	Criminal Justice Courses	13	9.8
	Other Courses	24	18.0
	Yes, Vague or Unspecified	37	27.8
	None	26	19.5
	(N Responding = 133)[a]		127.8[b]
Major Topic, College Course	Alcoholism Course	15	14.6
	General Drug Course	3	2.9
	Yes, Vague or Unspecified	7	6.8
	None	80	77.7
	(N Responding = 103)		102.0
Special Training or Workshops	Katharyn Cornell School	24	17.8
	OAAAA Annual Conference	7	5.2
	Other Workshops or Schools	39	28.8
	Yes, Vague or Unspecified	23	17.0
	None	64	47.4
	(N Responding = 135)		116.2
Inservice Education	PPO Basic Training	14	11.0
	PPO Ongoing Education	44	34.6
	Other Occupations	25	19.7
	Yes, Vague or Unspecified	22	17.3
	None	40	31.5
	(N Responding = 127)		114.1
Open AA Meetings	Personal Reasons	7	6.0
	Work Reasons	7	6.0
	Education Reasons	5	4.3
	Yes, Vague or Unspecified	29	24.8
	None	71	60.7
	(N Responding = 117)		101.8
Visit Inpatient Treatment Program	Residential Facility	30	25.2
	State Hospital	18	15.1
	General Hospital	8	6.7
	Yes, Vague or Unspecified	23	19.3
	None	56	47.1
	(N Responding = 119)		113.4

TABLE VII (Continued)

Type	Categories	N	Per Cent
Visit Outpatient Treatment Program	Facility Specified	21	18.9
	Incorrect Identification	9	8.1
	Yes, Vague or Unspecified	20	18.0
	None	66	59.5
	(N Responding = 111)		104.5
Other Experience Mentioned	Personal Family Experience	9	15.3
	Previous Work Experience	16	27.1
	Personal Study	6	10.2
	None	33	55.9
	(N Responding = 59)		108.5

[a] All percentages based on number responding to that question.

[b] Percentages total over 100% because some respondents listed more than one category.

Over half (52.6%) of the 135 who answered this question stated they had had special training of some sort. The most frequently mentioned program was the Katharyn Cornell School of Alcohol and Other Drug Studies (Basic--three days, and/or Advanced--four days) held each summer in Tulsa, Oklahome, which 17.8% stated they had attended. Another 5.2% had attended the Oklahoma Association on Alcohol Abuse and Alcoholism (OAAAA) annual conference, held for four days every April in Norman, Oklahoma. The remainder listed a wide variety of seminars, workshops, and institutes, as described in Appendix H. Another formal type of training is _inservice education_, to which 127 responded; 31.5% of those said they had never had inservice training. However, 11.0% stated they had had such training in probation/parole officer basic training, while 34.6% cited ongoing education through the Department of Corrections. Thus, on this question, at least, it would seem there was a great deal of "underanswering," because all probation/parole officers undoubtedly have had such training in basic training and during their tenure as an officer. Several interpretations of this result are possible: 1) it could be that such training was more salient to some officers than to others, thus reflecting more or less accurately how many actually gained usable knowledge from it; 2) some officers could have wanted to inflate their training background to make themselves look very knowledgeable; 3) some officers could have been just "lazy" in responding to open-ended questions while others were more serious and thoughtful in contemplating their experience. Subjectively, reflecting back to the questionnaires, it seems to the researcher that all three processes probably were operating for different officers, but of course, it is impossible to know for certain what occurred and how many probation/parole officers fell into

each category. It did seem that the majority of officers made a serious attempt to answer most open-ended questions. Another 19.7% reported in-service training in other occupations (e.g., police, military, health-related jobs).

As discussed in Chapter III, not all "education" comes from formal training; it is the experience of the researcher that much learning can take place in what sociologists label "participant observation." Fewer probation/parole officers listed this type of educational experience, but several did. Of the 117 who responded to the question about attending open AA meetings, 60.7% related they had never been to one. Personal reasons and work-related attendance each were reported by 6.0%, while another 4.3% noted attending for educational reasons. Some officers also had visited alcoholism treatment programs. Of 119 responding to a question about inpatient programs, almost half (47.1%) had never been to one. Almong those who had, they were most likely to have visited a residential facility (25.2%), followed by visits to state hospitals (15.1%) and general hospital programs (6.7%). Even fewer had visited outpatient programs; 59.5% of the 111 who answered said none. An interesting example of misinformation occurred with this question; nine people listed programs they had visited as outpatient which actually are inpatient programs according to the Kerr Foundation (1979) report and various state directories. An open-ended "other" category revealed that nine respondents listed personal family experience with alcoholism, while another sixteen had had work experience on alcoholism in previous jobs.

Sum of Training

A weighted index was constructed to measure the total amount of alcoholism training reported. Since full-length college courses and special training programs or workshops are likely to give more in-depth coverage of the topic, they each were weighted two, while all other forms of alcoholism training were weighted one, then totaled to provide a measure of "sum of training." Twenty-five officers had a score of zero, while eight had a score of more than ten. The mean score on the sum of training index was 3.34. The sum of training scores were then broken into categories of 0, 1-2, 3-4, and 5 or more, for use as a background variable. The data presented in Table VIII show that sum of training was significantly related to mean number correct, wrong and don't know. The more training one had, the more he or she answered correctly on the knowledge scale ($F = 4.345$, $p = .0055$), and the fewer he or she did not know ($F = 5.047$, $p = .0023$). In the AOV for mean number wrong by sum of training ($F = 2.620$, $p = .0523$), those with no training had the most wrong, but those with a score of 5 or more on training had the second most wrong. There is no readily apparent explanation for this, unless those with the most training felt a little overconfident. Just as with knowledge score in general, recognition of the limits of one's training was fairly apparent, in that the higher one's training score, the more likely she or he was to feel she/he had something to offer alcoholics ($F = 4.161$, $p = .0070$). Interestingly, those with a score of 0 felt a little more likely they had something to offer than did those with a score of 1-2.

In the review of literature, it was reported that both Chodorkoff (1967; 1969) and Gurel (1976) found significant changes in knowledge

TABLE VIII

MEANS, F-SCORES AND PROBABILITY FACTORS FOR SUM OF TRAINING SCORE AS IT RELATES TO KNOWLEDGE SCORES AND ATTITUDES TOWARD WORKING WITH ALCOHOLICS

Variable	Means					F-Score	Probability
	0	1 - 2	3 - 4	5+	Total		
Number Correct	19.88	21.58	22.53	23.96	22.26	4.345	.0055
Number Wrong	6.83	4.95	5.23	6.04	5.56	2.620	.0523
Number Don't Know	10.86	10.90	8.86	6.88	9.25	5.047	.0023
Helping Alcoholics Has Low Priority	2.24	1.92	1.68	1.80	1.86	2.541	.0579
Don't Have Much to Offer Alcoholics	2.21	2.42	2.08	1.90	2.16	4.161	.0070
Would Like Special Responsibility for Alcoholics	1.96	1.98	2.00	2.08	2.01	0.116	.9507
Helping Alcoholics Requires Special Training	3.12	3.12	3.09	3.02	3.09	0.138	.9370
(N)[b]	(25)	(59)	(53)	(49)	(186)		

[a]Total number in each category before AOV; varies slightly since information from some respondents was incomplete.

among their subjects after training. A parallel could be drawn between those studies and the present one; that is, although there are no before-after test scores, the relationship between sum of training and knowledge did show that training made a significant difference in one's knowledge level among the probation/parole officers. While not as dramatic as changes in the other studies cited, among probation/parole officers who reported no alcoholism education, the average knowledge score was 55.2%; for those with a score of 5+ on sum of training, the average knowledge score was 66.6% (see Table VIII). Based on the previous studies, the researcher anticipated that those with the most training would know the answers to more than 2/3 of the items. However, the before-after scores reported from the other studies were based on knowledge scales geared specifically to the training being measured and were administered immediately after completion of training, rather than months and/or years later.

Needing and Wanting More Training

In Chapter III it was suggested that probation/parole officers probably would need and/or want more training regarding alcoholism. In response to whether they needed more training, 70.3% said yes, while 72.7% stated they wanted more training. Table IX breaks down the reasons why they did. The most frequent reason given for needing more training (38.5%) was that many clients have alcohol-related problems; the reason cited most often for wanting more training (34.6%) was to deal with clients more effectively and/or more helpfully. (Appendix I lists examples of statements coded into the various categories since these were open-ended questions.) The major answer for needing more

TABLE IX

PROBATION/PAROLE OFFICERS WHO NEEDED AND WANTED MORE ALCOHOLISM TRAINING: WHY AND ASPECTS

Variable	Need		Want	
	N	Per Cent	N	Per Cent
Why				
Many Clients Have Alcohol-Related Problems	50	38.5	20	15.0
Many Alcohol-Related Offenses	9	6.9	5	3.8
Deal with Clients More Effectively and/or Helpfully	20	15.4	46	34.6
Increase Knowledge and/or Understanding of Alcoholism	28	21.5	33	24.8
Learn Specific Aspects of the Problem	16	12.3	17	12.8
General Seriousness of Alcoholism/Alcoholic Clients	6	4.6	3	2.3
Coordinate Efforts with Other Agencies	2	1.5	1	0.8
Yes, Vague or Unspecified	12	9.3	23	17.3
(N Responding to Question)[a]	(130)	110.0[b]	(133)	111.4[b]
Aspects of Alcoholism to Learn More About				
Detection of Alcoholism	9	6.9	5	3.8
Ways to Motivate Alcoholic to Seek Treatment	11	8.5	5	3.8
Causes of Alcoholism/Characteristics of Alcoholics	18	13.8	10	7.5
Community Resources for Use and Referral	11	8.5	15	11.3
Understand Alcoholism Treatment Methods	17	13.1	16	12.0
Assist Family of Alcoholic	10	7.7	9	6.8
General Counseling Techniques or Help Alcoholic	27	20.8	20	15.0
"All Aspects" or Other	17	13.1	15	11.3
Yes, But No Response on Aspects	51	39.2	66	49.6
(N Responding to Question)	(130)	131.6	(133)	121.1

[a]All percentages based on number responding to that question.

[b]Percentages total over 100% because some respondents listed two reasons or aspects.

training suggests a realistic appraisal of problems among their clients. The primary reason for wanting more training has important implications for the discussion of organizational imperatives (particularly specialization and multiple goals) to be discussed in another section.

The second most cited reason both for needing (21.5%) and wanting (24.8%) more training was to increase one's own general knowledge and/or understanding of alcoholism. This is yet another indication of the implications discussed earlier that many probation/parole officers do recognize their limitations in the area of alcoholism, and further, that they desire to correct those limitations.[3]

The major discouraging factor with this item was that so few (1.5% for need, 0.8% for want) mentioned coordinating efforts with other agencies. As Roman and Trice (1974) noted, that is one of the major goals of the broader community mental health movement. But then again, perhaps this question was interpreted by probation/parole officers at a more personal level. On a related item later in the questionnaire, consulting with other agencies was ranked as the fifth most frequent job activity actually engaged in, but ranked third in perception of ideal work time allotment, just behind supervising and counseling clients.

Officers who answered yes to these two questions (need and want more training) were asked to describe what aspects of alcoholism they

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[3]It should be pointed out that space was allowed to code up to two reasons each for needing/wanting (or not) more training, so it is entirely possible that the same person could need/want more training both for job reasons and better general understanding. In fact, some officers listed several reasons; the first two given were the ones coded. The same coding procedure applied to aspects of alcoholism they wanted to learn more about.

desired to know more about. As Table IX indicates, many officers who said they needed/wanted more training did not respond to this question (39.2% on need, 49.6% on want). Among those who did fill it in, "general counseling techniques or helping the alcoholic" drew the most responses (20.8% for need, 15.0% for want). It appears to the researcher that very appropriate roles for the probation/parole officer in coordinating the overall effort to get treatment for alcoholic offenders would lie precisely in those aspects least frequently mentioned: detection of alcoholism (6.9% for need, 3.8% for want) and ways to motivate the alcoholic to seek treatment (8.5% for need, 3.8% for want).

Nevertheless, replies to these two questions indicate that on the whole, probation/parole officers in Oklahoma seemed to be concerned about the problem of alcoholism as it related to their job, and also that most of them took the questionnaire itself seriously. Not only did over 70% indicate a felt need and desire for more training, but also most of them took time to write out thoughtful answers to an open-ended question.

Of course, there were officers who stated they did not need (29.7%) or want (27.3%) more training regarding alcoholism (see Table X). As anticipated in Chapter III, the most frequent reasons cited for not needing more training were "adequate or sufficient knowledge about the subject" (38.2%), followed by "our job is referral, not counseling--referral sources are available" (32.7%). Major reasons for not wanting more training were equally divided among the two just cited, along with simply "don't want training." (Each of the three were responded to by 20.0% of those not wanting training.)

TABLE X

PROBATION/PAROLE OFFICERS WHO DID NOT NEED OR WANT MORE ALCOHOLISM TRAINING: WHY

Reason	Need		Want	
	N	Per Cent	N	Per Cent
Have Adequate or Sufficient Knowledge	21	38.2	10	20.0
Our Job is Referral, Not Counseling	18	32.7	10	20.0
Lack of Time, Other Priorities	7	12.7	7	14.0
Fatalistic Attitude toward Treatment/ Training	7	12.7	4	8.0
Don't Want Training	1	1.8	10	20.0
No, Vague or Unspecified	7	12.7	11	22.0
(N Responding to Question)[a]	(55)	110.8[b]	(50)	104.0[b]

[a]All percentages based on number responding to that question.

[b]Percentages total over 100% because some respondents listed two reasons.

Unlike the relationship between sum of training and knowledge level, as shown in Tables XI, XII, and XIII, AOV or chi square analysis revealed no statistically significant relationships between needing or wanting more training and sum of training or any of the knowledge variables (correct, wrong, don't know). On the other hand, just as with knowledge and sum of training, both were related to the officer's feeling that he or she did not have much to offer alcoholics (need: $F = 3.668$, $p = .0570$; want: $F = 9.595$, $p = .0023$). Both those who needed and those who wanted more training were significantly more likely to feel they did have something to offer alcoholics.

TABLE XI

MEANS, F-SCORES AND PROBABILITY FACTORS FOR NEED MORE ALCOHOLISM TRAINING AS IT RELATES TO KNOWLEDGE SCORES AND ATTITUDES TOWARD WORKING WITH ALCOHOLICS

Variable	Means			F-Score	Probability
	Yes	No	Total		
Number Correct	22.00	22.91	22.27	1.251	.2648
Number Wrong	5.36	6.02	5.56	1.652	.2003
Number Don't Know	9.51	8.55	9.25	0.953	.3305
Helping Alcoholics Has Low Priority	1.80	2.00	1.86	2.009	.1580
Don't Have Much to Offer Alcoholics	2.08	2.33	2.15	3.668	.0570
Would Like Special Respons-ibility for Alcoholics	2.12	1.76	2.01	4.752	.0306
Helping Alcoholics Requires Special Training	3.22	2.76	3.09	11.806	.0007
(N)[a]	(130)	(55)	(185)		

[a]Total number in each category before AOV; varies slightly since information from some respondents was incomplete.

TABLE XII

MEANS, F-SCORES AND PROBABILITY FACTORS FOR WANT MORE ALCOHOLISM TRAINING AS IT RELATES TO KNOWLEDGE SCORES AND ATTITUDES TOWARD WORKING WITH ALCOHOLICS

Variable	Means			F-Score	Probability
	Yes	No	Total		
Number Correct	22.13	22.69	22.28	0.451	.5027
Number Wrong	5.28	6.22	5.54	3.406	.0666
Number Don't Know	9.52	8.50	9.27	1.004	.3179
Helping Alcoholics Has Low Priority	1.74	2.14	1.85	8.110	.0049
Don't Have Much to Offer Alcoholics	2.03	2.44	2.14	9.595	.0023
Would Like Special Responsibility for Alcoholics	2.08	1.82	2.01	2.356	.1265
Helping Alcoholics Requires Special Training	3.15	2.90	3.08	3.136	.0783
(N)[a]	(133)	(50)	(185)		

[a]Total number in each category before AOV; varies slightly since information from some respondents was incomplete.

TABLE XIII

CHI SQUARE FOR SUM OF TRAINING BY NEED AND WANT MORE ALCOHOLISM TRAINING, IN PER CENT

	0	1-2	3-4	5+	X^2	df	Probability
Need More Training							
Yes	76.0	70.7	69.8	67.3			
No	24.0	29.3	30.2	32.7			
(N)	(25)	(58)	(53)	(49)	0.604	3	.8956
Want More Training							
Yes	75.0	65.5	73.1	79.6			
No	25.0	34.5	26.9	20.4			
(N)	(24)	(58)	(52)	(49)	2.747	3	.4324

There was another item relevant to how much one felt she/he had to offer alcoholic clients that was related much differently to knowledge items. It was noted that all knowledge issues discussed--score on knowledge scale, sum of training, and need/want more training--were significantly related to the item on how much one had to offer, as shown by statistical tests. However, another item read, "To effectively help alcoholics requires special training." It would be logical to assume from the foregoing that officers with more knowledge, more training, and more desire for further training also would agree with this statement. Such was not the case: AOV resulted in little relationship between number correct ($F = 0.711$, $p = .5467$, Table VI) or sum of training ($F = 0.138$, $p = .9370$, Table VIII), and the item about special training. Those who wanted more training were a little more likely to agree ($F = 3.136$, $p = .0783$, Table XII), while the only statistically significant re-

lationship was with the need for more training ($F = 11.806$, $p = .0007$, Table XI). On a four-point scale (4 = definitely agree), the mean for the total sample on that item was 3.09, demonstrating that most did feel training was necessary; for those who said they needed more training, the average was 3.22, and 2.76 for those who felt they did not need more training (see Table XI).

Other Variables Related to Knowledge Items

Since this was an exploratory study, a large number of background variables was investigated to determine their relationship to the knowledge variables. With some background variables, there seemed to be no more statistically significant relationships than might be expected by chance; on the other hand, there were a few background variables which had more statistically significant relationships to knowledge and/or attitude focus variables than would be expected by chance. (A complete list of background variables which were examined appears in Appendix J.)

Investigation of standard demographic factors revealed sex to be the one most consistently related to the focus variables. In Chapter IV, it was disclosed that sex was significantly related to district, age, and marital status, as well as to time in current job, agency, and corrections field. Since none of these other variables were consistent in being related to focus variables, it can be assumed that sex is the more important background variable. Sex was related significantly to every knowledge variable discussed above except sum of training ($X^2 = 2.460$, $p = .4826$, Table XIV). Males were a little more likely to have no training (15.5% compared with 10.5% for females), but they were about equally likely to have more training at the other extreme (27.3% of the

males, 25.0% of the females scored 5+). This is similar to educational background of the sexes reported in Chapter IV. As data in Table XIV indicate, women also were much more likely to say they needed more training (X^2 = 8.842, p = .0029) and to want more training (X^2 = 9.728, p = .0018). Well over 80% of the women responded "yes" to both questions, while fewer than 65% of the men answered "yes" to either question.

TABLE XIV

CHI SQUARE FOR SEX BY SUM OF TRAINING AND NEED/WANT MORE ALCOHOLISM TRAINING, IN PER CENT

	Males	Females	X^2	df	Probability
Sum of Training					
0	15.5	10.5			
1-2	32.7	30.3			
3-4	24.5	34.2			
5+	27.3	25.0			
(N)	(110)	(76)	2.460	3	.4826
Need More Training					
Yes	61.5	82.9			
No	38.5	17.1			
(N)	(109)	(76)	8.842	1	.0029
Want More Training					
Yes	63.6	85.5			
No	36.4	14.5			
(N)	(107)	(76)	9.728	1	.0018

Engs (1975:1) reported knowledge scores by sex: males had a mean of 19.22 correct ($\bar{X}$ = 23.38 in the present sample), while females in her study had a mean of 20.88 correct (compared with 20.66 for female pro-

bation/parole officers). As Table XV shows, the difference in number correct between males and females in this study was statistically significant at the .0002 level, as measured by an F score. Not only were men likely to have more correct, they also were likely to have more wrong ($F = 10.223$, $p = .0016$), while women were more likely to acknowledge they did not know the answer ($F = 20.288$, $p < .0001$).

TABLE XV

MEANS, F-SCORES AND PROBABILITY FACTORS FOR
SEX AS IT RELATES TO KNOWLEDGE SCORES

Variable	Means			F-Score	Probability
	Males	Females	Total		
Number Correct	23.38	20.66	22.26	14.166	.0002
Number Wrong	6.17	4.69	5.56	10.223	.0016
Number Don't Know	7.63	11.39	9.25	20.288	.0000
(N)[a]	(110)	(76)	(186)		

[a]Total number in each category before AOV; varies slightly since information from some respondents was incomplete.

What David and Brannon (1976), writing on the masculine sex role, and Chafetz (1978), comparing both masculine and feminine sex roles, suggested about sex-role socialization may help explain some of the sex differences on knowledge issues. It was noted that women and men in the present sample were almost equally likely to have advanced formal educa-

tion and a higher amount of alcoholism training, and that men were slightly more likely to have little formal education and no training in alcoholism. It would be easy to assume from this that women should have higher knowledge scores, and yet this was not the case.

David and Brannon (1976), along with Chafetz (1978), suggested that men are more likely to be socialized into having to appear "right," while it is easier for women to acknowledge uncertainty, from their socialization. If one guesses at answers to true-false questions, he or she has a 50% chance of guessing correctly. This process may have been operating with responses to the knowledge scale. Women were significantly more likely to admit they did not know the answer to a question. On the other hand, although men had significantly more right, they also had significantly more items wrong. This finding would be consistent with the "guessing" hypothesis suggested above, especially since repeated testing has demonstrated that men and women are not different in the type of ability required to be knowledgeable about alcoholism (Deaux, 1976:5). This explanation also would be consistent with the fact that women were significantly more likely to admit they could use even further training in the subject matter at hand.

Deaux went on to cite studies showing that men are more likely than women to predict they will do well on tests. She noted (1976:39-40):

> Are men generally overestimating their ability and/or are women underestimating theirs? The evidence, while sparse, suggests that both patterns are true. . . . In a wide variety of situations, men think they will do better than women. Yet in the majority of these same situations, men and women do equally well.

This, too, would be consistent with the hypothesis that men probation/ parole officers were more reluctant to admit they did not know, prefer-

ring instead to take a chance on being correct.

A sociological question of importance is who a person uses as his or her major reference group. The size of community a person was reared in showed two statistically significant differences regarding knowledge issues. Those reared in the smallest communities (under 5,000) had the most correct on the knowledge scale ($F = 3.205$, $p = .0245$); they also were the least likely to feel they needed further training in alcoholism, with only 57.4% expressing such a need, compared to 78.4% of those reared in communities with populations over 50,000 ($X^2 = 7.771$, $p = .0510$). These relationships are somewhat puzzling, since as noted in Chapter IV, sample members were not likely to live in small communities at the time of the research.

In fact, the _type_ district one worked in appeared to be a more important reference group than where he/she lived. Only one knowledge item showed a significant difference when all seven districts were considered separately. Those in District F were by far the least interested in further training, only 52.6% saying they wanted it, in contrast to District A, where 90.6% expressed such a desire ($X^2 = 13.797$, $p = .0320$).

When districts were separated into only two categories, urban versus rural, more differences emerged (see Table XVI). Unexpectedly, among those in rural districts, the mean number correct was 23.22, compared to an average of 21.55 in the urban districts ($F = 5.146$, $p = .0245$). Urban officers had an average of 10.29 don't knows, while rural officers averaged 7.78 don't knows ($F = 8.461$, $p = .0041$), although there was no statistically significant difference between the groups on the number wrong. However, officers in rural districts had slightly more wrong, on the average.

TABLE XVI

MEANS, F-SCORES AND PROBABILITY FACTORS FOR TYPE DISTRICT AS IT RELATES TO KNOWLEDGE SCORES

Variable	Means			F-Score	Probability
	Urban	Rural	Total		
Number Correct	21.55	23.22	22.26	5.146	.0245
Number Wrong	5.18	6.06	5.56	3.561	.0608
Number Don't Know	10.29	7.78	9.25	8.461	.0041
(N)[a]	(106)	(80)	(186)		

[a]Total number in each category before AOV; varies slightly since information from some respondents was incomplete.

Furthermore, as Table XVII shows, officers in rural districts were significantly less likely to indicate a need for more training, with only 61.3% stating such a need, compared to 77.1% of the urban officers ($F = 4.755$, $p = .0292$). Although the relationship was not statistically significant, rural officers also were less likely to want more training.

The researcher had anticipated urban officers to be more knowledgeable, given their access to many facilities. Also, in terms of reference group interaction, urban officers should be likely to interact with more fellow officers, since almost all officers in their district work out of the same office. Rural districts, on the other hand, have their officers scattered throughout a large geographical area, and there may not be much interaction between many officers in those districts except at monthly meetings. Thus, trying to explain the opposite results was perplexing.

It was noted in Chapter IV that several individual officers in rural districts did live in or near academic communities and/or urban areas where they, too, would have access to some of the same facilities. A probation/parole officer with the department for some time also pointed out that urban districts have a higher rate of turnover in officers than do rural districts. Thus, those in rural districts may have had more exposure to training such as inservice education.

TABLE XVII

CHI SQUARE FOR TYPE DISTRICT BY NEED/WANT MORE ALCOHOLISM TRAINING, IN PER CENT

	Urban	Rural	X^2	df	Probability
Need More Training					
Yes	77.1	61.3			
No	22.9	38.8			
(N)	(105)	(80)	4.755	1	.0292
Want More Training					
Yes	77.9	65.8			
No	22.1	34.2			
(N)	(104)	(79)	2.710	1	.0997

In addition to demographic variables and items regarding probation/parole officers' feelings about working with alcoholic clients, tests of significance also were run on knowledge issues' relationships with a variety of other attitudinal variables, such as those dealing with general attitudes toward clients, perceptions of organizational goals, and social drinking attitudes. Statistically significant relationships between most

attitudes and knowledge issues were so sporadic that they probably occurred by chance. Social drinking attitudes, however, were a different matter. As mentioned in Chapter IV, the researcher planned to construct a social drinking index; however, while the Pearson correlation between each social drinking attitude and the total score was high (.6175 to .7644), there was so little intracorrelation between the items themselves, it was decided to examine them individually, as Bailey (1970) did. Data relating to social drinking attitudes and number correct on the knowledge scale are displayed in Table XVIII.

TABLE XVIII

MEANS, F-SCORES AND PROBABILITY FACTORS FOR NUMBER CORRECT ON KNOWLEDGE SCALE AS IT RELATES TO SOCIAL DRINKING ATTITUDES

Variable	Means			F-Score	Probability
	Agree	Dis-agree	Total		
Moderate Drinking Good to Promote Sociability	24.11	21.82	22.26	6.321	.0128
(N)	(38)	(146)	(184)		
Moderate Drinking Good to Relax from Tension	23.56	21.45	22.26	8.055	.0051
(N)	(73)	(112)	(185)		
Getting Drunk Sometimes OK if Not Driving	22.67	21.65	22.26	1.847	.1758
(N)	(111)	(75)	(186)		
Voluntary Abstinence Better than Any Alcohol	22.41	22.02	22.26	0.263	.6090
(N)	(119)	(66)	(185)		

Those officers who were positive toward social drinking tended to be more knowledgeable than were those who perceived social drinking negatively. Those who agreed that moderate drinking is good to promote sociability ($F = 6.321$, $p = .0128$) and those who agreed that moderate use of alcohol is beneficial for relaxing from tension ($F = 8.055$, $p = .0051$) had significantly higher correct scores on the knowledge scale than did those who disagreed. While not statistically significant, the trend was in the same direction for those who agreed that getting drunk occasionally is all right if one is not driving. Scores were almost the same on the item about abstinence being better than any alcohol.

One final issue related to knowledge is how much alcoholism training probation/parole officers estimate <u>other</u> probation/parole officers have. Table XIX reveals that, as a group, they were not very confident about the training of their colleagues. Only 25.7% felt officers received "enough to get the job done." However, responses on this item were not related to any of the other knowledge issues.

TABLE XIX

PROBATION/PAROLE OFFICER ESTIMATES OF HOW MUCH ALCOHOLISM TRAINING MOST OFFICERS HAVE

Categories	N	Per Cent
None	6	3.3
Very Little	69	37.7
Some, But Not Enough for Job	61	33.3
Enough to Get Job Done	47	25.7
Too Much, Other Job Concerns More Important	0	0.0
	183	100.0

Summary

Knowledge about alcohol and alcoholism was measured using Engs' (1975) "Student Alcohol Questionnaire." Probation/parole officers in the present study were slightly more knowledgeable about alcohol and alcoholism than college students tested on the same knowledge scale. Their most frequent sources of alcoholism training were brief discussions in college courses, special workshops and inservice education. The total amount of alcoholism training was related significantly to knowledge scores, so there is some payoff in training people about the subject. The great majority of officers stated they both needed and wanted further training in alcoholism, but these desires were not related to knowledge or sum of training. Officers also tended to be somewhat pessimistic regarding how much training in alcoholism their colleagues had.

Scores on all the knowledge issues were significantly related to whether probation/parole officers felt they had something to offer alcoholics. In general, the more one had correct on the knowledge scale and the more alcoholism training one had, the more he/she felt he or she had to offer alcoholics; also, those who needed and wanted further training felt they had more to offer. However, only the felt need for further training was related to whether officers thought helping alcoholics requires special training, with those needing more training feeling special training is necessary. Sex and type of district were the only demographic variables systematically related to knowledge issues, with males and officers in rural districts scoring higher on number correct on the knowledge scale; females and urban officers were more likely to state they needed and wanted more training in alcoholism. Officers who saw some aspects of social drinking in a positive light were more knowledgeable than those

who held negative social drinking views. No other area of attitudinal variables was consistently related to knowledge issues.

Attitudes toward Alcoholism and Alcoholics

It was anticipated that probation/parole officers would be generally negative in their attitudes toward alcoholism and toward alcoholics. Regarding perceptions of alcoholism, the Marcus Alcoholism Questionnaire was used to determine views toward defining the condition of alcoholism, the etiology and locus of responsibility for its occurrence, and prognosis for recovery from alcoholism. Other studies have shown mixed and sometimes contradictory results on this issue.

Other research basically has not considered the relationship of attitudes toward the condition (alcoholism) and the person (alcoholic). This study did make that comparison using semantic differential scales, with the expectation that views of alcoholics would be more negative than those toward alcoholism. Numerous studies have found professionals to be negative toward alcoholics; in addition, some labeling theorists propose that even if attitudes change toward the condition, the stigma may remain for the person with that condition. Furthermore, traditional wisdom maintains that female alcoholics face even more stigma than do male alcoholics. Since virtually no studies were found regarding whether this assertion is accurate, the probation/parole officers were asked for their attitudes toward men and women alcoholics separately, compared with their views of "normal" men and women.

The major instrument used to measure attitudes toward the condition of alcoholism was the Marcus Alcoholism Questionnaire (Marcus, 1963). Mean factor scores were obtained using the method described in Chapter

IV, where the description of the factors as seen by the "experts" (alcoholism treatment professionals) are in Table II. Three other Marcus items and one original item also were used in exploring areas of attitudes toward alcoholism. It should be kept in mind when examining the mean scores below that means for the Marcus factors are based on four items each, while the other four means are based on single items.

Table XX presents the mean factor scores for the probation/parole officers in the present study, compared with Marcus' (1963:6) general population sample and staff "expert" sample, as well as with some more recent samples of nurses (Ferneau and Morton, 1968:175), nursing students (Gurel, 1976:128), and undergraduate human services majors (Waring, 1978:852). These latter studies all involved mean factor scores before and after training; since sum of training was a background variable in the current study, the before-after scores both are presented to compare with probation/parole officers' sum of training, as described in the previous section. This does not present a wide variety of occupations for comparison, but the only other study located was one on psychiatric residents with a sample of five (Ferneau and Gertler, 1971). In examining Table XX and results within subgroups of probation/parole officers, it would be wise to remember Marcus' caution (1963:9): ". . . one should ignore mean factor score differences that are less than 0.50 and pay particular attention to those which are greater than 1.00."

The results reported in Table XX will be discussed below based on separate categories of attitudes determined by the direction taken in the research questions asked in Chapter III. "Positive" in the discussion below may be taken to mean the attitudes expressed by the alcoholism "experts" in Marcus' staff sample.

TABLE XX

MARCUS MEAN FACTOR SCORES COMPARED WITH
MEAN FACTOR SCORES OF OTHER SAMPLES

Factor	Probation/ Parole Officers	Marcus Samples[a]		Ferneau and Morton[b]		Gurel[c]				Waring[d]	
		General Population	Staff Experts	Registered Nurses	Nursing Assistants	Graduate Students		Under-graduates		Under-graduates	
						Before	After	Before	After	Before	After
Emotional Problems	4.73	5.16*	5.20*	5.2*	4.9*					4.9*	5.6
Loss of Control	4.26	5.03	5.35**	4.9	4.8					3.7	7.2[e]
Prognosis	2.84	2.99*	2.11	2.2	2.6*	2.09	1.66**	1.81**	1.73**	2.4*	1.5**
Steady Drinker	5.07	3.18**	5.23*	4.4	3.9**					4.2	5.6
Character Defect	3.25	3.51*	3.18*	3.3*	4.0	1.97**	1.69**	1.85**	1.68**	3.0*	2.3
Social Status	2.70	2.88*	2.68*	2.6*	2.6*					2.3*	1.7**
Illness	2.92	3.07*	2.68*	2.4	3.5	2.38	1.87**	2.32	2.05	2.7*	2.2
Harmless Indulgence	2.43	3.22	2.54*	2.6*	3.1	1.77	1.47	1.86	1.85	2.0*	1.1**
Addiction Liability	4.93	4.60*	4.35	4.9*	4.7*	4.66*	5.12*	4.53*	4.70*	4.3	5.0*

* Mean factor difference = 0.50 or less from probation/parole officers
** Mean factor difference = 1.00 or more from probation/parole officers

[a]Source: Alan M. Marcus, Alcoholism Questionnaire. Mimeo. Toronto, Canada: Alcohol and Drug Addiction Research Foundation, 1963, p. 6.

[b]Source: Ernest W. Ferneau, Jr., and Elvera L. Morton, "Nursing personnel and alcoholism." Nursing Research 17 (1968), p. 175.

[c]Source: Mehmet Gurel, "An alcoholism training program: its effect on trainees and faculty." Nursing Research 25 (1976), p. 128. Her respondents were tested only on five factors.

[d]Source: Mary L. Waring, "The effects of alcoholism training on the knowledge, attitudes, and drinking behavior of college students in the human services." International Journal of the Addictions 13 (1978), p. 852.

[e]This is an impossible mean for a seven-point scale, but it is the score reported by Waring (1978:852).

Defining Alcoholism

In Chapter III, it was anticipated by the researcher that probation/parole officers would tend to have what Sowa and Cutter (1974) called an overlapping "medical/moral" attitude toward alcoholism. That is, it was thought they would view alcoholism as a disease/illness, but simultaneously have a moral carry-over in still viewing it as a character defect or as a matter of will power. Results showed partial confirmation for this expectation. The probation/parole officers had a mean factor score (MFS) of 2.92 regarding alcoholism as an illness; that is in the positive direction, but still barely more than one point away from the neutral response of four. Their MFS for seeing alcoholism as a character defect, while also in the positive direction (3.25), was even closer to the neutral position. Thus, while both perceptions of alcoholism clearly were in the positive direction, the moral view was slightly stronger than the illness definition. Given that almost all officers had had some training in alcoholism, and given that virtually all training courses on the subject define alcoholism as an illness or disease, the researcher expected the illness conception to be stronger than it was.

When compared to the Marcus norm groups, the probation/parole officer MFS differences for both illness and character defect were less than 0.50 from both the general population and the expert examples, but also lying between the views of the two groups. They were closer in MFS to Ferneau and Morton's (1968) registered nurses (RN) than nursing assistants, but Ferneau and Morton (1968:176) suggested that their RN's were members of both the general population and a professional subgroup. It seems that the probation/parole officers also had both the lay person and professional influences, when compared with the older

studies. However, when examined relative to samples in more recent studies, while very similar to Waring's (1978) pretraining undergraduates, the officers were not comparable to her students after training. They also were less likely to see alcoholism as an illness than Gurel's (1976) nursing students, both before and after training. If one heeds Marcus' (1963) advice to pay special attention to differences greater than 1.00, then the officers were much more likely to view alcoholism as a character defect than were Gurel's (1976) nursing students. Her students had greater than a one-point difference even before training, with the gap growing wider after training. This was the most profound consistent difference found between the probation/parole officers and any other group for which comparisons were available. In short, the probation/parole officers in the present study still were in some apparent conflict over how to view the condition of alcoholism, viewing it more as an illness than not, but with distinctive moral overtones, seeing it more as character defect than as illness.

Three other Marcus factors also seem to define a person's view of the nature of alcoholism: alcoholic as steady drinker, social status of the alcoholic, and alcoholism as harmless voluntary indulgence. The probation/parole officers were considerably closer to the professionals than to the lay person samples with their steady drinker MFS (5.07).[4] This means they were more likely than not to believe that periodic excessive drinkers can be alcoholics, rather than feeling that only con-

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[4]When "lay person sample" is used, it refers to Marcus' (1963) general population sample in the singular; in the plural, the researcher also is referring to Ferneau and Morton's (1968) nursing assistant sample and to Waring's (1978) undergraduate human service majors _before_ training.

tinual drinkers are alcoholics. Their MFS of 2.70 on social status suggests they were more likely than not to believe an alcoholic can come from any socioeconomic level. On this factor, they essentially were in agreement with both lay and professional samples, except for Waring's (1978) human services undergraduates whose MFS was 1.7 after training, signifying even greater acceptance that alcoholics can come from any stratum of society. With regard to harmless voluntary indulgence, the probation/parole officers were closer to the professionals in believing that alcoholics are not just harmless heavy drinkers (MFS = 2.43). Although this was the probation/parole officers' MFS furthest away from the neutral position, Gurel's (1976) nurses and Waring's (1978) students after training still were considerably further away than were the officers. While on the subject, it should be noted that as with character defect and illness, while the probation/parole officer MFS's for steady drinker and social status indeed were in the positive direction, they still were barely more than a point away from the neutral position. However, as Table XXI points out, the standard deviation for illness (S.D. = 1.12) and character defect (S.D. = 1.22) are considerably higher than most other standard deviations, indicating that many officers had negative views on the basic definitional issue. One standard deviation for each factor points to the negative direction. The standard deviation for steady drinker (S.D. = .96), social status (S.D. = .92), and harmless voluntary indulgence (S.D. = .87) are somewhat smaller; one standard deviation still is in the positive direction for all three factors. Obviously there was more disagreement on the basic medical/moral overlap than on the other definitional factors.

TABLE XXI

MARCUS MEAN FACTOR SCORES AND STANDARD DEVIATIONS

Factor	$\overline{X}$	S.D.
Emotional Difficulties	4.73	0.99
Loss of Control	4.26	1.14
Prognosis	2.84	1.02
Steady Drinker	5.07	0.96
Character Defect	3.25	1.22
Social Status	2.70	0.92
Illness	2.92	1.12
Harmless Indulgence	2.43	0.87
Addiction Liability	4.93	0.96

Before leaving the subject of defining alcoholism, one other point should be made. In probing individual items which make up the Marcus factors related to defining alcoholism, two items stood out as having means much more in the negative direction relative to other items. One, in the character defect factor, has to do with alcoholics usually lacking in will power; it had a mean of 4.09 among the officers, contrasted to the MFS of 3.25. The other, part of the illness factor, states, "The alcoholic has only himself or herself to blame for his or her problems." While the illness MFS was 2.92, the mean for that one item was 4.03. Along with their relevance for the general moral attitude discussed above, and anticipated in Chapter III, these two items have important implications for the issue of responsibility, to be discussed below.

Etiology

". . . there is no single cause of alcoholism" (Schuckit and Haglund, 1977:24). So ended a chapter on etiological theories of alcoholism written by a physician and a social worker, after discussing sociocultural, psychological, and biological theories. Regardless of discipline represented, that is the way discussions on causes of alcoholism almost always end; even the Department of Health, Education, and Welfare formally stated that alcoholism probably results from the interaction between physiological, psychological, and sociological factors (Robinson, 1976:49). Despite all the disagreement on etiology, or agreement about the complexity of it, sociologist Robinson (1976:48) felt it more important:

> . . . to look at the kind of causal theories with which other people, both professional and lay, tend to operate. For causal theories are not merely things which 'scientists' or 'theorists' construct. Causal theories are part . . . of everyday knowledge in terms of which each of us makes our way around the social world as we see it. Any attempt to understand the way in which people behave in relation . . . to people with some 'alcohol problem' will be enhanced, therefore, by a consideration of the causal theories with which those individuals appear to be operating.

Among the helping or human services professionals, there obviously is disagreement over many aspects of alcoholism, but etiology is an area where even "scientific experts" frequently disagree. Robinson's general "definition of the situation" approach becomes especially critical here then. It has been pointed out that at some intellectual level, most people today partially accept a disease/illness concept of alcoholism. However, as with most medical and social problems, people tend to react to alcoholism especially on the basis of what they believe causes it. This is particularly true regarding the issue of responsibility for the

condition, because while people are stigmatized for having certain conditions, they still are seen as deserving of treatment rather than punishment if they are defined as not responsible for their condition (Parsons, 1950, Chapter X; Sagarin, 1975).

Only a glimpse of this complex issue can be gained from the data of the present study, but it provides at least a beginning in enhancing the understanding that Robinson (1976) referred to in the quote above. The higher one's score on the Marcus emotional difficulties factor, the greater the belief such difficulties help cause alcoholism. The MFS on that factor for probation/parole officers was 4.73, just barely in the positive direction. As the data in Table XX show, they were closer to the respondents of other studies on this than on any other factor except social status of the alcoholic. They differed from every sample by less than 0.50 point except for Waring's (1978) students after training. Since the MFS score was so close to the neutral position, they must have believed other causative factors also were operating.

The only way to measure other beliefs about causality itself was a single item on the Marcus scale, "A person can inherit a weakness for alcohol." This suggests a belief in physical or biological etiology. The mean for this item among probation/parole officers was 3.55, again very close to the neutral view. Interestingly, all the measures of central tendency were further apart than on any other Marcus item: the median was 3.67, but the mode was 1.0 and standard deviation 1.93, a further sign of widespread disagreement among the officers themselves. This reflects the general lack of consensus among other professionals regarding physical causality of alcoholism (see Robinson, 1976).

Although there was no clear-cut stand taken on the actual etiology

of alcoholism, the issue of responsibility for the condition can be probed in still other ways. Individual items regarding will power and who is "to blame" for alcoholism were discussed in the previous section. The issue of whether the alcoholic can control his or her drinking behavior is related to both the disease concept and the responsibility aspect. The MFS for probation/parole officers on the loss of control factor was 4.26, hardly in the positive direction (see Table XX). In fact, it was closer to the neutral point than any other MFS for the present sample. They also differed more from Marcus' two norm groups on this than on any other factor; both his groups were much more positive. They also were more than 0.50 point away from MFS's of other comparable groups.

Another factor that touches on both definition of condition and responsibility is belief in addiction liability to alcohol. The MFS for probation/parole officers was 4.93, just less than a point in the positive direction from the neutral view. This MFS was in essential agreement with those of all the comparison groups available. This finding was surprising to the researcher for all the samples represented in Table XX since even the most elementary material in any alcoholism training points out strongly the addictive potential of the drug alcohol (e.g., see Jones et al., 1979).

Given that the other samples reported in Table XX tended to have similar MFS's, the researcher speculates that from one to all of three factors may have been operating with various sample members (in other samples as well as in the present one): 1) Many, if not most, Americans would readily agree with a statement that drugs are addictive (in itself a false statement when applied to all drugs), but they often still fail

to place alcohol in the drug category, supported in this belief by the media. Most media use the same references as even the new text by Jones et al. (1979) does--its title is Drugs and Alcohol. 2) Alcohol probably is the major drug of choice of Americans in general; if one allows himself or herself to believe it is not addictive, then it makes it easier to drink alcohol in even large quantities. 3) The questions representing the "addiction liability" factor may be confusing. The first speculation can be corroborated by examining any newspaper, magazine, or bookshelf. The second idea can be tested to a limited extent in this sample by examining responses to the addiction factor in relation to semantic differential attitudes. The researcher already has some support for the third hypothesis; for two of the questions in this factor, several students in the pretest wrote comments about their lack of clarity.[5]

In short, if only MFS's were examined, it would be difficult to determine just where the probation/parole officers stood with regard to etiology of and responsibility for alcoholism, since the means are all so middle-of-the-road. Once more the standard deviations in Table XXI may help clarify whether there is intrasample disagreement or whether officers were unsure of themselves and marked neutral responses. Regarding etiology, the widespread disagreement on the inheritance item already was noted above. The standard deviation for emotional difficulties was .99, so with a midway MFS, responses ran almost the entire range. On the responsibility issues discussed above, results were similar on the addiction liability factors (S.D. = .96). On the other hand, the loss of

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[5]These questions were not reworded in the final survey, because then true replication of the Marcus Alcoholism Questionnaire would not have been possible.

control factor, with the most neutral mean, had the second largest standard deviation (S.D. = 1.14) of all nine factors, thus showing more disagreement. Since results are contradictory on both the etiology and responsibility issues, this question must be examined in more detail when looking at possible sources of attitudes.

Three other attitude items seem to be particularly relevant to the responsibility issue. As noted above, the probation/parole officers had no clear-cut consensus regarding whether alcoholics are responsible for their condition, so it becomes difficult to estimate whether they would propose the treatment or the punitive approach, as questioned in Chapter III. The data indicated that they seemed to be equally confused on what to do. One Marcus item read, "The most sensible way to deal with alcoholics is to compel them to go somewhere for treatment."[6] A first impression of that statement may be that it is of a punitive nature, but it also could imply that the alcoholic is not responsible and needs outside intervention. As a group, the probation/parole officers were essentially neutral on the item, with a mean of 4.08, perhaps reflecting the possible dual interpretation of the statement. The dual interpretation (or disagreement) is supported by a standard deviation of 1.85 on this item.

A statement even more clearly related to responsibility was "Even if

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[6]For years, traditional wisdom was that an alcoholic could not be helped until he or she wanted help. However, the utility of intervention is a current controversial matter among treatment professionals, but more and more are becoming convinced that forced treatment does work under some conditions (e.g., Brinson, 1980; O'Connor, 1980). As with some other controversies discussed earlier, this one may not have reached too far outside the treatment community yet. However, it should also be remembered that Gallant et al. (1968) found compulsory treatment effective with offenders several years ago, with the use of specially trained parole officers.

an alcoholic has a sincere desire to stop drinking, he or she cannot possibly do so without help from others." Agreement with this statement should indicate acceptance of the illness concept of alcoholism, removing responsibility from the alcoholic for his/her condition. Just as with the prior item, however, the mean was essentially at the neutral point (3.86), only very slightly in the area of disagreement. A standard deviation of 1.87 suggests considerable intrasample disagreement on this item. The fact that a substantial number did disagree reflects belief in line with the focus of two other individual items previously discussed, namely that will power (i.e., individual responsibility) is involved in alcoholism.

One more attempt to probe the responsibility issue lay in a researcher-constructed item, "Breaking probation or parole rules about drinking should be sufficient cause for revocation." Although not dealing explicitly with alcoholism, agreement with this statement would seem to place responsibility on the client. On a four-point scale, the neutral position would be 2.5. Following their pattern, the mean for the probation/parole officers was 2.34, barely in the disagreement direction again.

It seems safe to assume that, as a group, probation/parole officers in Oklahoma were uncertain about the etiology of alcoholism. With this apparent uncertainty, it is not surprising that they were equally unsure where to assign responsibility for the behavior of the alcoholic. These results also are consistent with the earlier finding that while they leaned in the direction of seeing alcoholism as an illness, they were slightly more likely to perceive it as a character defect and a matter of will power.

Prognosis

In Chapter III, it was expected that based on type of experience, probation/parole officers would likely be pessimistic regarding the prognosis for recovery from alcoholism. Evidence from the two previously discussed areas of attitudes lends further support to such a contention. Therefore, it was surprising that their MFS on prognosis was in the positive direction (2.84). This placed them between Marcus' (1963) lay person sample and his professional sample, but closer to the lay sample. The officers were less positive on prognosis than Ferneau and Morton's (1968) more professional RN's and less professional nursing assistants. This latter pattern was even more pronounced with the other two samples; both Gurel's (1976) and Waring's (1978) students were extremely optimistic regarding the possibility for recovery after they went through training (see Table XX).

Before ending discussion of the Marcus Alcoholism Questionnaire, it should be noted that except for those groups tested after specialized training, the probation/parole officers in the present sample just were not too different from groups of varying professional backgrounds tested over a seventeen-year time span, using the factors emerging from Marcus' (1963) original factor analysis. However, since the questionnaire was seventeen years old, and since a great deal has changed in the alcoholism field since that time, it was decided to run a factor analysis on the 36 Marcus items representing the nine factors to see if the original factors were still relevant in 1980. The factor structure which emerged was quite different from the original one. There were twelve factors instead of nine, with almost no overlap with the original factors except for some congruence on the character defect and emotional difficulty

factors. No attempt is being made to evaluate the new set of factors here. The purpose of using the Marcus Alcoholism Questionnaire in the first place was to compare the probation/parole officers with other studied groups, which could be done only with Marcus' nine factors.

The new factor analysis is mentioned because it is felt that additional research should be done with the questionnaire to determine if the probation/parole officers were just a unique group or if the structure of beliefs about alcoholism is changing. Only in this way can social science avoid reifying a research instrument merely because it at one time had acceptable validity and reliability, and has been replicated many times.

It is not the intent of the researcher to denigrate the replication process, because that certainly is one of the major methods of strengthening the foundations of generalization within sociology; on the other hand, knowledge about alcoholism has changed drastically in seventeen years. Marcus (1963:5) himself urged:

> Since the items used in this type of questionnaire are truly opinion (and not information) statements, there are no absolutely 'right' or 'wrong' answers. . . . . For this reason, the factor scores for any group become meaningful only in comparison with some other group or possibly with respect to an arbitrary criterion of 'what we would like people to believe.' . . . . Whatever the comparison in which you are interested, though, it will always be a relative one (unless we eventually do find the 'true' answer to all the questionnaire items).

For example, many times in the original questionnaire <u>are</u> now considered to be basically information instead of opinion. Virtually everything written by professionals agrees on most of the social status items, addiction liability, the harm done by and to alcoholics, and that periodic drinkers can become alcoholics; furthermore, they are documented by a wealth of empirical data (for just a few examples, see Fort, 1973;

Pittman, 1974; Tarter and Sugerman, 1976; Berry et al., 1977; Jones et al., 1979; NIAAA, 1980).

Alcoholism versus Alcoholic

It will be remembered that in both Chapters II and III, it was suggested that even if attitudes toward a condition or behavior change, it does not necessarily follow that views toward the person with the condition will change. Grounded in labeling theory, it was proposed that views toward the alcoholic person would tend to be negative, and that these views would not be highly related to attitudes toward the condition of alcoholism. It was demonstrated above that views of the probation/parole officers toward various facets of alcoholism were very slightly in a positive direction.

Using the semantic differential with the eighteen polar adjective scales described in Chapter IV, it was found that indeed the sample members were considerably more negative toward alcoholic persons than toward normal persons on all eighteen scales. On a seven-point scale, with seven being most positive and four as the neutral point, all 36 means for normal man and normal woman were above the neutral point. Twenty-three (63.9%) were more than a point above neutral (means greater than 5.00). In rating alcoholic women and men, two means were just barely at the neutral point; the remainder were below the neutral point, with 22 (61.1%) being over a point below neutral (means below 3.00). Further, the highest mean for an alcoholic person (4.04) was lower than the lowest mean for a normal person (4.22). In short, as a group, the probation/parole officers were much more negative toward alcoholic persons than they were toward the condition of alcoholism.

The researcher's anticipation of generally negative attitudes toward alcoholics as <u>persons</u> has been supported. As noted above, it was further expected that these stereotypes would not be related systematically to attitudes about the <u>condition</u> of alcoholism, based on personal teaching experience, labeling approach concepts, and previous studies. In Chapter IV, it was noted that based on past studies, the Marcus Alcoholism Questionnaire and the semantic differentials would be treated as interval-level data for purposes of this study. With that in mind, Pearson correlation coefficients were computed between the semantic differential scales and the Marcus factor scores before they had been averaged into mean factor scores. Both the normal and the alcoholic semantic differential scales were tested with the correlation, with the normals being used as a control group. If the alcoholic indeed is seen as different, then the Marcus attitude factors should correlate differently with them than with the normals (if there is any correlation with the normals at all). A one-tailed Student's t test was computed for each correlation to estimate its likelihood of occurring by chance. Any correlation with a Student's t probability of .05 or less was considered statistically significant.

For purposes of the correlation analysis, the semantic differential scales were broken down into five categories, the first three from Osgood's principles described in Chapter IV: evaluation, activity, and potency. Because of Fisher et al.'s (1976) assertion that if no stereotyping was occurring, then the only significantly different scale should be the healthy-sick continuum, it was left as an individual scale. The remaining nine scales were combined into one category labeled "alcoholic stereotype."

From these five categories, there were 180 correlations with the Marcus factors; the ones statistically significant at the .05 level or less are shown in Table XXII. Of the correlations for normals, 15.6% were statistically significant, compared with 45.6% of the correlations for alcoholics. In examining the table, it can be seen that contrary to the expectations expressed in Chapter III, there were some patterns which emerged, at least at the statistically significant level. First, there were many fewer statistically significant correlations for either normal woman or normal man; when there were, they almost always were in the opposite direction from those for alcoholics on the same factors.

In considering the correlations from the standpoint of the Marcus factors, five features stand out as particularly important. 1) On the emotional difficulties factor, there were statistically significant correlations on every category of semantic differentials for both women and men alcoholics except for the evaluation component. The more officers accepted emotional difficulties as a causal factor in alcohclism, the more negatively they rated alcoholics on the semantic differentials. The strongest relationship for both male and female alcoholics was on the healthy-sick continuum, which should be expected. 2) On the character defect factor, the more alcoholism was seen as a character defect, the more negative the ratings on four categories for males and two for females (at a statistically significant level). Also importantly the character defect factor was not correlated in a statistically significant manner with the healthy-sick continuum for either sex. 3) The higher the score on the steady drinker factor, the more negative the ratings on three categories for women and four for men. This suggested that the more officers accepted that periodic excessive drinkers can be

TABLE XXII

PEARSON CORRELATION COEFFICIENTS BETWEEN MARCUS FACTOR SCORES AND SEMANTIC DIFFERENTIAL COMPONENTS FOR NORMAL WOMAN, NORMAL MAN, ALCOHOLIC WOMAN AND ALCOHOLIC MAN WITH A STATISTICAL PROBABILITY OF .05 OR LESS

Marcus Factor Scores	Normal Woman					Normal Man				
	Evaluation	Activity	Potency	Alcoholic Stereotype	Healthy-Sick	Evaluation	Activity	Potency	Alcoholic Stereotype	Healthy-Sick
Emotional				.1254[a]					.1295	.1224
Difficulties				.047[b]					.042	.051
Loss of						.1329				
Control						.038				
Prognosis		-.1237	-.1210	-.1398						
for Recovery		.049	.053	.031						
Steady	.1573			.1208						
Drinker	.017			.053						
Character		-.1313				.1283	.1534		.1346	
Defect		.040				.043	.020		.036	
Social						.1246				
Status						.048				
Illness										
Harmless Indulgence										
Addiction Liability										

TABLE XXII (Continued)

Marcus Factor Scores	Alcoholic Woman					Alcoholic Man				
	Evaluation	Activity	Potency	Alcoholic Stereotype	Healthy-Sick	Evaluation	Activity	Potency	Alcoholic Stereotype	Healthy-Sick
Emotional Difficulties		-.1871 .006	-.1817 .007	-.2133 .002	-.2325 .001		-.1968 .004	-.1661 .013	-.1624 .015	-.2107 .002
Loss of Control				-.1196 .055		-.1533 .020				
Prognosis for Recovery		.2548 .000			.1624 .015	.1606 .016	.1478 .024			
Steady Drinker		-.1655 .013		-.1279 .044	-.2138 .002		-.1276 .044	-.1360 .034	-.1534 .020	-.2344 .001
Character Defect	-.3577 .000			-.2211 .001		-.3661 .000	-.1466 .025	-.1449 .026	-.1940 .005	
Social Status	-.1556 .018					-.1867 .006		-.1242 .048		
Illness		.2164 .002	.1608 .016				.1687 .012	.1870 .006		.1437 .027
Harmless Indulgence		.2000 .004			.1852 .007		.1598 .016			.1646 .014
Addiction Liability						-.1396 .031				-.1197 .055

[a]Pearson correlation coefficient.

[b]Statistical probability for one-tailed Student's t test.

alcoholics, the more negative their semantic differential ratings for alcoholic persons. Again the correlation which was most statistically significant was on the healthy-sick continuum for both sexes. 4) On the illness factor there were only five statistically significant correlations, with the male alcoholic having that factor correlated with the healthy-sick continuum in a statistically significant way, but not the female. 5) On eight of the nine Marcus factors, if the correlation with the evaluation component was statistically significant, the one for the healthy-sick continuum was not, and vice versa. The ninth factor, addiction liability, displayed a total of only two statistically significant correlations--for evaluation and healthy-sick on alcoholic man. Combined with the correlations on the character defect factor, this suggests that there may be an important distinction between probation/parole officers who view alcoholism in a primarily moral sense and those who view it from an illness/disease viewpoint. It was noted in the discussion of defining alcoholism that there was a medical/moral overlap in the way officers perceived the condition. This finding provides further confirmation for that overlap.

A very strong word of caution must be made regarding the results just discussed on Pearson correlations. All the relationships noted were statistically significant at the .05 level or less, but the actual strength of the relationships was quite small. If the correlation coefficients were squared, the explained variance would be minute. The largest explained variance would be 13.4%. Thus, the substantive significance of these findings are questionable without further research.

Nevertheless, what slight relationships did emerge certainly seem worth pursuing further. In the absence of such studies in the past, the

researcher had predicted no relationship, based partly on the studies of attitudes toward each other separately. Although generally probation/parole officers were more negative toward alcoholics than toward alcoholism, several seemingly logical patterns emerged which suggest that at least certain attitudes toward alcoholism are related to certain attitudes toward alcoholics. That, in fact, may be the clue to the results. The findings suggest that neither attitudes toward the condition (alcoholism) nor attitudes toward the person (alcoholic) are global. Instead both may have to be broken down into several component parts in order for there to be meaningful understanding of this complex set of views.

Normal versus Alcoholic Persons

In the preceding section it was noted that in responding to the semantic differential scales, on the average, probation/parole officers ranked normal persons above the neutral point on a seven-point scale on every adjective scale. In contrast, only two means for alcoholic persons were barely above the mid-point with the remainder below the neutral position. Thus, it appears that the primary stereotyping was between persons perceived as normal versus those perceived as alcoholics rather than between men and women. Given previously cited evidence that stereotyping tends to lead to labeling, with consequences for behavior toward labeled persons, this relation needs to be explored further. Therefore, Table XXIII presents officers' mean scores on every semantic differential scale for all four types of persons, along with mean differences between views toward normal people, alcoholic people, and normal versus alcoholic people of both sexes.

TABLE XXIII

MEAN RATINGS AND MEAN DIFFERENCES ON SEMANTIC DIFFERENTIAL SCALES FOR NORMAL WOMAN, NORMAL MAN, ALCOHOLIC WOMAN AND ALCOHOLIC MAN

	Mean Ratings[a]				Mean Differences			
Scale	Normal Woman	Normal Man	Alcoholic Woman	Alcoholic Man	Normal Woman-Normal Man	Alcoholic Woman-Alcoholic Man	Normal Woman-Alcoholic Woman	Normal Man-Alcoholic Man
Foolish-Wise	5.25	5.14	2.70	2.78	.11	- .08	2.55	2.36
Confusing-Understandable	5.15	5.04	2.77	2.83	.11	- .06	2.38	2.21
Excitable-Calm	4.47	4.91	2.77	2.87	- .44	- .10	1.70	2.04
Weak-Strong	4.93	5.20	2.65	2.88	- .27	- .23	2.28	2.32
Dependent-Self Reliant	4.56	5.18	2.33	2.70	- .62	- .37	2.23	2.48
Passive-Active	4.78	5.28	2.90	3.12	- .50	- .22	1.88	2.16
Bad-Good	5.13	5.03	3.55	3.51	.10	.04	1.58	1.52
Strange-Familiar	4.87	4.96	3.39	3.37	- .09	.02	1.48	1.59
Dangerous-Safe	5.14	5.10	2.83	2.69	.04	.14	2.31	2.41
Aimless-Motivated	5.25	5.40	2.64	2.82	- .15	- .18	2.61	2.58
Worthless-Valuable	5.67	5.46	3.78	3.64	.21	.14	1.89	1.82
Unreliable-Reliable	5.34	5.34	2.45	2.52	.00	- .07	2.89	2.82
Unpredictable-Predictable	4.22	4.97	2.74	2.83	- .75	- .09	1.48	2.14
Tense-Relaxed	4.62	4.73	2.94	3.03	- .11	- .09	1.68	1.70
Ignorant-Intelligent	5.34	5.12	4.01	3.88	.22	.13	1.33	1.24
Timid-Bold	4.45	4.92	4.04	3.98	- .47	.06	.41	.94
Hopeless-Hopeful	5.35	5.31	3.37	3.36	.04	.01	1.98	1.95
Sick-Healthy	5.30	5.45	2.64	2.68	- .15	- .04	2.66	2.77

[a]Responses were measured on a scale of 1 to 7. The higher the mean score, the more closely the responses resembled the second word of the pair, 4.00 being a neutral response.

The data make it clear that the major differences were between normal and alcoholic people instead of between the sexes, with essentially stigmatic responses to alcoholics. Put another way, only two mean differences between normal women and men were over a half point, for predictability (mean difference = .75) and self reliance (mean difference = .62). Only one average difference between alcoholic men and women was even greater than .25, for self reliance (mean difference = .37). On the other hand, only one difference between normal and alcoholic people was below one point, on the timid-bold scale (mean difference: men = .94, women = .41).

The greatest average difference perceived between normal and alcoholic people was in reliability (mean difference: men = 2.82; women = 2.89), with health showing the second greatest mean difference (mean difference: men = 2.77, women = 2.66), and degree of motivation third (mean difference: men = 2.58, women = 2.61). The three greatest differences were the same for both sexes. As Table XXIII shows, alcoholic women also were seen as very different from normal women on wisdom (mean difference = 2.55) and understandability (mean difference = 2.38). Alcoholic men were perceived as markedly different from normal men on the degree of self-reliance (mean difference = 2.48) and safety (mean difference = 2.41). The difference in healthy-sick ratings would be expected if one is operating out of the context that alcoholism is an illness or disease. As described in Chapter II, that is the concept used in this study; also, see Fisher et al. (1976). Although there is a tiny kernel of truth to many stereotypes, the other characteristics clearly <u>are</u> stereotypes.

By far the smallest difference between normal and alcoholic people was on the bold-timid scale, where all groups except normal man had a

mean very close to the neutral point. The second smallest difference dealt with intelligence (mean difference: men = 1.24, women = 1.33), where alcoholics were rated very close to the neutral point again.[7]

In comparison with other studies which examined alcoholics only (not alcoholism), Mackey (1969) and Fisher et al. (1976) each had eleven adjective scales which overlapped with those in the present survey. Table XXIV displays comparisons on means for the overlapping scales between the present study and two of Mackey's (1969:667, 669) occupations, along with those from Fisher et al.'s (1976:1690) research. Mackey studied school guidance counselors, welfare workers, mental health professionals and police officers. Table XXIV shows the means for the mental health workers as his norm group and for the police from a suburb of a large eastern city. The police officers in that study were the only occupational group from the criminal justice system found for comparison here.

The mental health professionals tended to rank normal people higher than the probation/parole officers did, with 81.8% of their means more than one point above neutral. On the same eleven adjectives, the probation/parole officers had 54.5% of their means over 5.00. Similarly, the mental health workers had 54.5% of their means more than one point below neutral for alcoholics, compared with 72.7% for the probation/parole officers on the same sets of adjectives. Among Mackey's police officers, the highest averages for normal people were higher than among the probation/parole officers, but his range of means was greater;

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[7]After data were collected, it was pointed out to the researcher by a disinterested observer that the "ignorant-intelligent" scale was not a particularly good one. "Ignorant" has other value connotations which have nothing to do with degree of intelligence. The researcher agrees; but she unthinkingly had chosen that scale from other studies. In similar studies in the future, the researcher will change that scale.

TABLE XXIV

MEAN RATINGS ON ELEVEN SEMANTIC DIFFERENTIAL SCALES COMPARED WITH MEAN RATINGS ON SEMANTIC DIFFERENTIAL SCALES FROM OTHER SAMPLES ON NORMAL WOMAN, NORMAL MAN, ALCOHOLIC WOMAN AND ALCOHOLIC MAN (OR AVERAGE PERSONS AND ALCOHOLICS)[a]

					Mackey[b]								Fisher et al.[c]			
	Probation/Parole Officers				Police Officers				Mental Health Professionals				Resident Physicians			
	Normal Woman	Normal Man	Alcoholic Woman	Alcoholic Man	Normal Woman	Normal Man	Alcoholic Woman	Alcoholic Man	Normal Woman	Normal Man	Alcoholic Woman	Alcoholic Man	Average Persons		Alcoholics	
Scale													Pre	Post	Pre	Post
Foolish-Wise	5.25	5.14	2.70	2.78	5.65	5.48	2.36	2.54	5.15	4.96	2.92	2.94	4.11	4.24	2.83	3.64
Excitable-Calm	4.47	4.91	2.77	2.87	4.42	4.07	2.64	3.55	5.02	4.81	2.79	2.88	3.57	3.64	3.11	3.33
Weak-Strong	4.93	5.20	2.65	2.88	4.78	5.00	3.28	3.39	5.08	5.21	2.54	2.54	4.09	4.24	2.20	2.85
Passive-Active	4.78	5.28	2.90	3.12	5.75	5.54	3.75	3.72	4.77	5.04	2.88	2.52	3.83	4.21	2.57	2.79
Strange-Familiar	4.87	4.96	3.39	3.37	4.87	4.57	3.10	3.33	5.19	5.08	3.83	4.06	4.71	4.85	4.34	4.33
Dangerous-Safe	5.14	5.10	2.83	2.69	5.81	5.42	3.22	3.32	5.60	5.63	3.73	3.69	5.69	5.45	3.62	4.12
Aimless-Motivated	5.25	5.40	2.64	2.82	5.65	5.26	3.41	2.87	5.92	5.81	3.04	3.23	4.51	4.79	2.66	3.24
Unpredictable-Predictable	4.22	4.97	2.74	2.83	4.54	4.75	2.55	2.72	5.40	5.25	3.38	3.54	5.06	4.85	4.43	4.30
Tense-Relaxed	4.62	4.73	2.94	3.03	4.72	4.23	2.86	3.39	5.15	4.73	2.54	2.42	3.49	3.61	2.40	2.55
Hopeless-Hopeful	5.35	5.31	3.37	3.36	6.04	5.68	3.71	3.70	5.71	5.58	3.15	3.04	5.09	5.21	3.34	3.70
Sick-Healthy	5.30	5.45	2.64	2.68	5.97	5.75	2.78	2.49	5.56	5.67	2.35	2.46	5.20	5.12	2.29	2.24

[a]Responses were measured on a scale of 1 to 7. The higher the mean score, the more closely the responses resembled the second word of the pair, 4.00 being a neutral response.

[b]Source: Richard A. Mackey, "Views of caregiving and mental-health groups about alcoholics." Quarterly Journal of Studies on Alcohol 30 (1969), pp. 667 and 669.

[c]Source: Joseph V. Fisher, Joseph C. Fisher, and Robert L. Mason, "Physicians and alcoholics: modifying behavior and attitudes of family-practice residents." Journal of Studies on Alcohol 37 (1976), p. 1690. (Ratings pre- and posttraining).

however, all comparable normal people characteristics still were above the neutral point. On the other hand, while all Mackey's police officer means for alcoholic people were below neutral, the lowest ones were not as low as those in the probation/parole officer sample. The range for characteristics assigned to alcoholics was narrower among police officers. Police officers were closer than mental health professionals to the probation/parole officers in describing normal people, in the sense that both groups had 54.5% of their comparable means over 5.00. But in rating alcoholics, the police officers could be described as even more positive than the mental health workers, with only 40.9% of their means below 3.00, contrasted with 72.7% for the probation/parole officers. Mackey (1969) described the police officers as most different from the mental health workers of any group in his study. Nevertheless, as the group most similar to the probation/parole officers in occupation, it should be noted that the police officers generally were more positive toward the alcoholic than were the probation/parole officers, even in a study reported eleven years earlier.

Fisher et al. (1976) included the same eleven adjective pairs as Mackey (1969); their results also are in Table XXIV. They studied resident physicians before and after training, with considerably different results; part of the difference may be due to the fact that they used "average" instead of "normal," while they also compared only "average person" versus "alcoholic," without the sex separation of Mackey and the current study.[8] With each label, for both pre- and posttraining,

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[8] However, in the researcher's pretest for the present survey, results for "average" versus "normal" people were similar.

their range of means was considerably wider than either Mackey's or the present study. Furthermore, at both times they had a number of "average" person means below the neutral point, with fewer a point or more above. For alcoholics, although the total post-training ratings between average and alcoholic persons were still statistically significant, Fisher et al. (1976:1689) concluded that "only one adjective pair (sick-healthy) contributed significantly to the over-all difference. . . ." They continued (1976:1691) that this was evidence that after training, "the residents were uninfluenced by moral concerns," leading the resident physicians also to alter their behavior toward alcoholics significantly.

In short, what Fisher et al. (1976) were proposing was that with a decrease in stereotyping came a decrease in labeling, followed by more positive treatment of alcoholics and their condition. Reflecting back to Table XXIII, it can be seen that probation/parole officers in the present research certainly were engaging in stereotyping of alcoholic women and men. This stereotyping was described in Chapter II as the critical variable to explore from the labeling theory standpoint, because of its influence on behavior.

Male versus Female Alcoholics

One of the major surprises to emerge from this study for the researcher was the mean ratings given to men and women alcoholics by the probation/parole officers. Common wisdom has it that female alcoholics face much greater stigma than do male alcoholics. In the only study located which measured perceptions of alcoholics by sex, Mackey (1969) found several differences in the way men and women were viewed. In

the present study, as Table XXIII aptly illustrated, the probation/parole officers perceived the major differences to be between the normal people and alcoholic people instead of between women and men. In analyzing mean differences between groups, overall there were even greater perceived differences between normal women and men than between alcoholic women and men.

The mean differences between alcoholic men and women as seen by probation/parole officers were so small it is even difficult to discuss them by categories. The greatest difference (.37) was that they saw male alcoholics as slightly less dependent than female alcoholics. They saw female alcoholics as a little weaker (mean difference = .23) and a little more passive (mean difference = .22). All three of these characteristics tend to be associated with general sex-role stereotyping; in fact, they saw greater differences between normal men and women on all three. No other characteristic had a mean difference of two-tenths point or more between alcoholics separated by sex.

The characteristics describing alcoholics are rank ordered in Table XXV, with the most positive mean being number one. This table shows even more clearly how little sex-difference stereotyping there was. The first six characteristics were the same for both sexes. Only three characteristics were ranked more than two positions apart: safe-dangerous, strong-weak, and self reliant-dependent. As noted above, these are more general sex-role stereotypical differences. It is interesting to note that the alcoholics were perceived as somewhat more valuable than they were hopeful.

TABLE XXV

RANK ORDER OF ADJECTIVE SCALES ASSIGNED TO ALCOHOLIC WOMEN AND MEN BASED ON SEMANTIC DIFFERENTIAL MEAN SCORES (1 = MOST POSITIVE)

	Alcoholic Women		Alcoholic Men
1.	Timid-Bold	1.	Timid-Bold
2.	Ignorant-Intelligent	2.	Ignorant-Intelligent
3.	Worthless-Valuable	3.	Worthless-Valuable
4.	Bad-Good	4.	Bad-Good
5.	Strange-Familiar	5.	Strange-Familiar
6.	Hopeless-Hopeful	6.	Hopeless-Hopeful
7.	Tense-Relaxed	7.	Passive-Active
8.	Passive-Active	8.	Tense-Relaxed
9.	Dangerous-Safe	9.	Weak-Strong
10.	Confusing-Understandable	10.	Excitable-Calm
	Excitable-Calm	11.	Confusing-Understandable
12.	Unpredictable-Predictable		Unpredictable-Predictable
13.	Foolish-Wise	13.	Aimless-Motivated
14.	Weak-Strong	14.	Foolish-Wise
15.	Aimless-Motivated	15.	Dependent-Self Reliant
	Sick-Healthy	16.	Dangerous-Safe
17.	Unreliable-Reliable	17.	Sick-Healthy
18.	Dependent-Self Reliant	18.	Unreliable-Reliable

In examining the correlations between categories of characteristics and attitude factors, there were more statistically significant correlations on the evaluation component for men alcoholics (5) than for women alcoholics (2). Men also had more statistically significant correlations on the potency component (5) than women (2). Of 45 possible correlations for each sex, 53.3% were statistically significant for male alcoholics, while 37.8% were statistically significant for female alcoholics. Given the similarities on the individual characteristics, the differences in the correlations by categories are somewhat surprising.

In general, it appears that probation/parole officers do not place a greater stigma on female alcoholics than on male alcoholics. However, probation/parole officers should be (or become) aware of different needs of men and women alcoholics in actually interacting with them (e.g., see Langone and Langone, 1980).

Summary

Attitudes toward alcoholism were measured using the factors from the Marcus Alcoholism Questionnaire and some individual survey items. Probation/parole officers scored slightly in the positive direction in defining alcoholism as an illness; they also scored in the positive direction, but less so, in not seeing it as a character defect. This reflects a still overlapping "medical/moral" attitude toward alcoholism. They were more likely than not to believe that periodic excessive drinkers can become alcoholics, that alcoholics can come from any social stratum, and that alcoholism is not just a harmless voluntary indulgence. The officers' beliefs held no consistent relationship with those of professional or lay samples from previous studies.

In examining views on the etiology of alcoholism, it was found that they were only slightly likely to believe that emotional difficulties contribute to the onset of alcoholism and tended to disagree that alcoholism can be inherited. The officers displayed little consensus on whether an alcoholic has lost control over his or her drinking; they were barely in the positive direction in believing that alcohol is addictive; they were also at the middle of the road in whether they believed alcoholism is a matter of will power and whether the alcoholic has only herself or himself to blame. Mid-range means on other items

reflected that they were uncertain about where responsibility for treatment of alcoholism rested.

Given their lack of consensus about the definition of alcoholism and its etiology, it was interesting to find the officers tended to be optimistic about the prognosis for recovery. However, they were not as optimistic as the other professional samples with which they were compared.

Probation/parole officers' views toward alcoholism were compared with their views toward alcoholics, as measured by eighteen semantic differential adjective scales. They were found to hold more negative views toward the person than toward the condition. The officers had, on the average, more negative views toward alcoholics than did mental health workers, police officers, and physicians studied by other researchers.

Pearson correlation coefficients were computed to test the strength of the relationships between scores on Marcus factors and semantic differential items. There were considerably more statistically significant correlations with Marcus factors and alcoholics than for normal people. The emotional difficulties, character defect, and steady drinker factors resulted in the strongest correlations. Especially important was the fact that when a Marcus factor was correlated with the evaluation principle on the semantic differentials, it was not correlated with the healthy-sick continuum, and vice versa. Substantive significance of these correlations is questionable because the correlation coefficients were very low, but the patterns point to potentially fruitful further research.

Contrary to researcher expectations, there were much greater mean

differences on semantic differential scales between normal and alcoholic people than between males and females of either status. Alcoholic men and women were characterized in almost identical ways on semantic differential characteristics, but men alcoholics showed more statistically significant correlations between their perceived characteristics and Marcus factors than did women alcoholics. Despite traditional wisdom, women alcoholics were not perceived in a more stigmatic manner than men alcoholics, but it is important to remember that their treatment needs are different.

Treatment Modalities and Goals

In addition to hundreds of AA groups, there were 75 identified alcoholism treatment programs in Oklahoma in 1978 (Kerr Foundation, 1979). The purpose of this question was to ascertain how knowledgeable probation/parole officers were regarding those programs. It also sought to determine what they perceived as goals of alcoholism treatment, compared to what treatment professionals think.

Treatment Programs

In an open-ended question, probation/parole officers were asked to identify hospitals, agencies, or organizations where they could refer clients with drinking problems. For each organization listed, they were asked if they could contact it, along with how many men and women clients they had referred to it. Finally, they were asked to rank the organizations they listed in order of their treatment effectiveness. Only 2.2% of the officers stated they knew no such organizations.

Prior studies of other professions (e.g., Knox, 1969; 1971; Dorsch

and Talley, 1973) found the major treatment of choice to be Alcoholics Anonymous (AA) or a combination of professional help and AA (e.g., Bailey, 1970). On the other hand, in the only study available on probation officers, Robinson (1976) found that those he studied in London did not cite AA first, so there were no predictions made on this question.

Three problems emerged which made it impossible to use data from the question on ranking treatment modalities. First, many officers must have misunderstood the question, because they would perhaps rank three organizations "1," another organization "2," then two more "0," etc. The second problem arose from an error in judgment on the part of the researcher, even for officers who understood the question. After the data were collected, it was realized that in effect, they had been asked to rank apples and oranges instead of grades of apples. In other words, the treatment programs listed had many different purposes; thus it is irrelevant to compare the effectiveness of a four-week inpatient treatment program, a residential facility, and AA, because they all may be equally effective at different stages in treatment. A third problem lay in the fact that most treatment programs are regional and thus more likely to be known in some parts of the state than others. For example, it would be an unfair comparison to examine rankings of a treatment program in an urban area with those of a program in rural southwestern Oklahoma. Therefore, that question was omitted from the analysis. The closest way organizations can be ranked from the remaining data is by their frequency of being mentioned, keeping in mind regional differences.

From Table XXVI, it is clear that AA is the most widely known treatment program, with 75.3% of the probation/parole officers listing it.

This is hardly surprising since there are several hundred AA groups statewide (Kerr Foundation, 1979). Of more significance is the fact that it was the first organization listed by 39.2% of the officers. This finding seems to lend support to choices of members of other professions in this country more than to the choices of London probation officers.

TABLE XXVI

ALCOHOLISM TREATMENT PROGRAMS IN OKLAHOMA KNOWN BY PROBATION/PAROLE OFFICERS

Type Program	Number Mentioning Mentioning It	Per Cent of Sample
Alcoholics Anonymous	140	75.3
State Mental Hospitals	99	53.2
Small Residential Facilities	76	40.9
Women's 12.4%		
Men's 28.5%		
Veterans Administration Hospitals	64	34.4
State Sponsored Outpatient	63	33.9
Private, Other Outpatient	50	26.9
Valley Hope	46	24.7
General Hospital Units	32	17.2
Indian Treatment Programs	28	15.1
Educational, Diagnostic	13	7.0
Missions, Shelters	12	6.5

Second most frequently mentioned were the three state mental hospitals. They were listed by 53.2% of the officers, although they are fairly inaccessible to residents in the northwest and southeast parts of the state. The state hospitals provide mostly inpatient treatment

at no cost to patients. Along with their satellites in various cities scattered throughout the state, they also provide some outpatient care on a no-cost basis.

Small residential facilities were ranked third in frequency of mention (40.9%). The state's three largest cities have such facilities for women; they were listed by 12.4% of the officers. The remainder are essentially for male alcoholics, and scattered over the state; they were mentioned by 28.5% of the officers. It is interesting to note that almost half the listings in this male residential category were to one fifteen-bed facility in a very small Oklahoma town. The researcher was puzzled until a probation/parole officer informed her that this particular facility was very active in community education as well as treatment. According to the officer, staff members there have provided many hours of inservice education for officers in the district.[9]

Northeastern Oklahoma has two Veterans Administration hospitals, and central Oklahoma has one, all with alcoholism treatment units. They were ranked fourth, listed by 34.4% of the officers. Fifth were state mental health centers and alcoholism treatment centers (all outpatient), mentioned by 33.9%. Private and other outpatient treatment programs were listed by 26.9%. These centers are scattered throughout the state.

One private inpatient treatment facility was mentioned by 24.7% of the officers, ranked seventh. Located slightly north of central Oklahoma, it was listed by officers in every probation/parole district.

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[9]On the questionnaire item about educational experience, one officer in that same district mentioned he or she was Chairman of the Board of a treatment center. If it should be the facility described here, it certainly indicates just how much can be done if probation/parole officers become personally involved.

Although the question was eliminated from formal analysis, it should be mentioned this facility was ranked best by most officers who listed it. Although expensive, this four-week inpatient treatment program, which is AA-oriented, is viewed as the most effective professional alcoholism treatment available in Oklahoma by most members of the alcoholism treatment community. This is being discussed more extensively because it seems to indicate that at least a fourth of the probation/parole officers in Oklahoma are knowledgeable about high-quality treatment. Few mentioned referring clients there, probably because of the expense, but if such quality programs were more available at less cost, they might be utilized.

Eighth in frequency of mention (17.2%) were two Oklahoma City general hospitals which have inpatient alcoholism treatment units. Also expensive and AA-oriented, they are highly regarded by most treatment professionals in the area.

Of special interest were a variety of Indian programs throughout the state mentioned by 15.1% of the officers. Every one of them which provides residential services has only male beds (Kerr Foundation, 1979). There is a considerable alcoholism problem for Indians in Oklahoma, even with so few Indian probation/parole officers. It is encouraging that treatment facilities at least are obviously available for male Indians and that the probation/parole officers are aware of them. There are no treatment facilities in the state oriented to the black population, however.

Seven per cent of the officers cited alcoholism education or diagnostic programs, while 6.5% mentioned missions and shelters in the Oklahoma City area. Various church-related, out-of-state, punitive

and other programs were listed by 53 officers. Overall, almost all treatment programs in the state were listed by at least one officer, so the probation/parole officers did have some knowledge of what is available. However, after consulting three state-wide treatment directories and two treatment professionals who are quite aware of programs throughout the state, fourteen programs listed were never located by the researcher.

Treatment Goals

In spite of some recent controversy noted in Chapter III, the majority of treatment professionals still tend to see abstinence as the primary goal of alcoholism treatment. Abstinence is more likely to be maintained if there is improvement in one's living problems (e.g., see Bailey, 1970; Rosenbaum, 1977). The probation/parole officers in the present study appeared closer to the professionals on this issue than on any other except the importance of AA as a treatment modality. As Table XXVII indicates, abstinence was agreed to by 87.2%, increased self-respect by 89.4%, and decreased living problems by 86.1%. Those goals least subscribed to by treatment professionals were least mentioned by probation/parole officers: 46.1% agreed with controlled drinking, and 35.6% agreed with more time between drinking bouts. However, it is important that almost half and over a third of the officers saw basically unsound goals as viable ones.

When asked to rank treatment goals in order of importance, abstinence was by far most likely to be listed as most important. Just as with checking agreement, self-respect was second most likely to be ranked first, with decreased living problems third. The order changed,

however, when mean rank was considered. Abstinence still had the highest mean rank (1.71), but decreased living problems was second ($\bar{X}$ = 2.46), and increased self-respect third ($\bar{X}$ = 3.04).

TABLE XXVII

ALCOHOLISM TREATMENT GOALS: OFFICERS' AGREEMENT WITH AND RANK AS MOST IMPORTANT, AND MEAN RANK OF GOAL

Treatment Goal	Agree With Goal N	Agree With Goal Per Cent	Rank First N	Mean Rank
Abstinence	157	87.2	99	1.71
Decreased Living Problems	155	86.1	24	2.46
Controlled Drinking	83	46.1	5	4.13
Improved Physical Health	142	78.9	3	3.90
More Time Between Bouts	64	35.6	0	5.45
Family Report Fewer Problems	133	73.9	2	4.18
Increased Self-Respect	160	89.4	27	3.04
(N = 180)				

The position of increased self-respect in treatment goals is particularly interesting. Based on the literature review, it was not even placed on the list of goals in the pretest. Since three pretest subjects wrote it in, it was included in the final survey and was highly ranked by the probation/parole officers. It seems obvious that increased self-respect would be critical in achieving the other major goals of treatment. While discussed frequently as a major part of recovery in the AA program (Alcoholics Anonymous, 1976), it was not referred to in the literature on treatment professionals. An important question for further

research, although unrelated specifically to this study, seems to be whether treatment professionals implicitly assume self-respect to be concomitant with the other improvements, or whether they really judge improvement on the basis of outward signs.

Summary

Three-fourths of the officers in the present study listed AA as a known alcoholism treatment program in an open-ended question, consistent with literature on treatment professionals. In descending order of frequency, they also were familiar with state mental hospitals, small residential facilities, Veterans Administration hospitals, state and private outpatient clinics, the major private inpatient treatment facility in Oklahoma, treatment units in two general hospitals, and programs aimed at Indians. Almost every one of the treatment programs available in the state were familiar to at least a few officers.

The probation/parole officers were essentially in agreement with treatment professionals by viewing abstinence and decreased problems in living as the most important goals in treating alcoholism. However, unlike treatment professionals in the literature reviewed, the officers regarded increased self-respect as almost equally important. Although it had a relatively low mean rank, controlled drinking was checked as a viable goal by almost half the officers.

Possible Sources of Attitudes

Earlier in this chapter it was noted that a large number of background variables were explored to see if they were related to knowledge and attitudes. So many were used because this research is probing a

topic about which little is known. With regard to knowledge issues as focus variables, it was found that sex, type of district (urban or rural), and attitudes toward social drinking displayed the most consistent relationships. This section examines that same large set of variables, plus the knowledge variables, as possible background factors with relation to attitudes toward primarily alcoholism and alcoholics. The complete list of background variables examined appears in Appendix J; just as with knowledge as a focus variable, most background variables yielded few more statistically significant relationships than might be expected by chance.

Because probation/parole officers as a whole were not far from the mid-point on most attitudinal factors toward alcoholism, it needs to be found whether this basically neutral position was descriptive of all probation/parole officers or whether background factors created differences among them. When all background variables were considered, the officers tended to have slightly more differences among themselves on definitional issues than on etiology/responsibility issues. It was noted above that they also were more inconsistent in relation to other study samples on definitional factors, and more in agreement with other samples on etiology/responsibility issues. The greatest difference between sample subgroups regarded prognosis for recovery.

The negative view of the probation/parole officers toward alcoholics showed even less difference among sample subgroups, considerably less than between the officers and other study samples. When examining all eighteen semantic differentials against all background variables, of almost two thousand possible relationships, only 7% of the AOV's were statistically significant at the .05 level or less. Exactly half the

statistically significant relationships involved attitudes toward normal people, and half were toward alcoholics. When the semantic differentials were broken down into the five categories discussed above, less than 9% of over four hundred possible relationships were statistically significant on AOV. There were just slightly more for alcoholics (N = 21), than for normal people (N = 17). This number of statistically significant relationships could be expected by chance. The greatest number of statistically significant relationships within the sample were on the activity principle, followed closely by the health-sick continuum and alcoholic stereotypes. Again, because of the massive number of relationships explored, the attitudes toward persons will be looked at by categories instead of examining all eighteen semantic differentials. This is further justified by the fact that the proportion of statistically significant relationships was similar for both ways of exploring attitudes toward alcoholics. The question now becomes which background variables were related in any consistent manner to categories of attitudes toward both alcoholism and alcoholics?

Demographic Variables

Demographic variables were not consistently or systematically explored in previous research, so there was little basis for predicting how they would be related to attitudes in this research. It is somewhat surprising that sex and the type district one worked in were not related to alcoholism attitudes as frequently as they were to knowledge. Indeed, there was _no_ demographic variable with more than three statistically significant relationships to alcoholism attitudes; district, age, and sex each had three. However, when area of attitude is inspected,

some patterns do emerge, so they will be examined instead of demographic variables individually. Just as when all background variables were considered, there were more differences on definitional factors than on etiology/responsibility issues. Steady drinker, social status, and voluntary harmless indulgence were the factors described as tangential to conceptualizing alcoholism; they revealed virtually no difference by demographic variables. The only real differences were with regard to the major issue of characterizing alcoholism as illness or character defect.

Table XXVIII presents the AOV's for sex as it related to all the alcoholism attitude variables. Although it was just noted that sex was not as consistently related to attitudes as it was to knowledge, it was an important background variable on some of the alcoholism factors which showed the most intrasample differences. For instance, females were much less likely to see alcoholism as a character defect than were males ($F = 10.155$, $p = .0017$) and even more likely to see it as an illness ($F = 13.349$, $p = .0003$). As with knowledge, it is not difficult to trace this difference back to sex-role socialization. Consistent with most sociologists writing on the topic, according to Forisha (1978:147, 149):

> Within the framework of sex-role stereotypes man is regarded as the achiever. . . . Within this same framework woman is regarded as the nurturer. . . .
>
> Stereotypes of masculinity and femininity mold and shape the lives of all of us today. . . . Men grow up and live out their lives knowing . . . they must choose to be strong or pay the price of inner guilt and/or the disapproval of members of our society. Women also know that in some way they must nurture others. . . .

Implications of these sex-role stereotypes include for men that along with self-judgment, there is likely to be negative valuation of others who are not perceived as assuming their "appropriate" sex-role expecta-

TABLE XXVIII

MEANS, F-SCORES AND PROBABILITY FACTORS FOR SEX AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means			F-Score	Probability
	Males	Females	Total		
Emotional Difficulties (7 = Positive)	4.68	4.80	4.73	0.614	.4345
Loss of Control (7 = Positive)	4.18	4.36	4.26	1.053	.3062
Prognosis for Recovery (1 = Positive)	3.08	2.49	2.83	16.124	.0001
Steady Drinker (7 = Positive)	4.98	5.22	5.07	2.911	.0897
Character Defect (1 = Positive)	3.48	2.92	3.25	10.155	.0017
Social Status (1 = Positive)	2.78	2.58	2.70	2.089	.1501
Illness (1 = Positive)	3.17	2.57	2.92	13.349	.0003
Harmless Indulgence (1 = Positive)	2.52	2.31	2.43	2.787	.0968
Addiction Liability (7 = Positive)	4.90	4.97	4.93	0.273	.6022
Can Inherit Alcoholism	3.39	3.78	3.55	1.840	.1767
Compel Alcoholic to Get Treatment	3.96	4.24	4.08	0.983	.3227
Alcoholic Needs Help to Stop Drinking	3.81	3.93	3.86	0.204	.6518
(N)	(110)	(76)	(186)		

tions, i.e., as possessing a character defect. Within this same framework, women are not only allowed, but expected, to be nurturant, thus given more permission to see someone not living up to role expectations as sick (in a sense similar to the stereotype of the nurse as the caregiver to patients) (Parsons, 1950).[10]

Table XXIX displays the AOV's for district as it relates to all the alcoholism attitude variables. As it shows, district was significantly related to viewing alcoholism as an illness ($F = 3.487$, $p = .0028$). Officers in District F were the ones least likely to see it as an illness ($\overline{X} = 3.53$). On the other hand, although the AOV was not statistically significant, they ranked in the middle among districts in regarding alcoholism as a character defect. District D officers were the most likely to view alcoholism as an illness ($\overline{X} = 2.37$); however, they too were in the middle among districts in viewing it as a character defect. District A had the other mean closest to seeing alcoholism as an illness ($\overline{X} = 2.45$); their members also were least likely to view it as a character defect. In general, officers in rural districts ($\overline{X} = 3.50$) were significantly more likely than officers in urban districts ($\overline{X} = 3.07$) to view alcoholism as a character defect ($F = 5.916$, $p = .0160$).[11]

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[10]This interpretation can be supported further with attitudes toward alcoholics, where it was found that with alcoholics of both sexes, women were significantly more likely than men to view them as sick.

[11]In light of its importance as a variable in knowledge issues, it should be pointed out that this was the only statistically significant relationship on alcoholism attitudes by urban versus rural districts. Thus, type of district is not displayed in table format for the alcoholism attitude variables. This practice will be followed throughout the remainder of this chapter; i.e., when there are only one or two statistically significant relationships that could easily have occurred by chance, no table will be presented.

TABLE XXIX

MEANS, F-SCORES AND PROBABILITY FACTORS FOR DISTRICT AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means								F-Score	Probability
	A	B	C	D	E	F	G	Total		
Emotional Difficulties (7 = Positive)	4.90	4.77	4.53	4.93	4.95	4.49	4.64	4.73	0.981	.4396
Loss of Control (7 = Positive)	4.07	4.09	4.29	4.46	4.11	4.45	4.50	4.26	0.680	.6662
Prognosis for Recovery (1 = Positive)	2.61	2.72	2.91	2.21	2.80	3.24	3.42	2.83	3.539	.0025
Steady Drinker (7 = Positive)	5.12	5.00	5.16	4.88	5.16	5.16	4.95	5.07	0.339	.9162
Character Defect (1 = Positive)	2.94	3.18	3.08	3.41	3.76	3.39	3.43	3.25	1.286	.2659
Social Status (1 = Positive)	2.72	2.81	2.56	2.80	2.50	2.83	2.74	2.70	0.498	.8094
Illness (1 = Positive)	2.45	2.96	2.92	2.37	3.19	3.53	3.30	2.92	3.487	.0028
Harmless Indulgence (1 = Positive)	2.36	2.41	2.51	2.49	2.25	2.42	2.57	2.43	0.333	.9189
Addiction Liability (7 = Positive)	4.98	5.02	4.83	5.14	4.60	5.04	4.90	4.93	0.726	.6292
Can Inherit Alcoholism	3.81	3.28	3.90	3.47	2.85	3.84	3.32	3.56	0.995	.4303
Compel Alcoholic to Get Treatment	4.18	4.72	3.90	5.00	3.05	3.89	3.64	4.08	2.917	.0097
Alcoholic Needs Help to Stop Drinking	3.76	4.12	3.63	4.67	4.00	3.42	3.64	3.86	1.023	.4117
(N)	(33)	(32)	(41)	(19)	(20)	(19)	(22)	(186)		

Table XXX shows the AOV's for age as it relates to all the alcoholism attitude variables. It indicates that age also was significantly related to perceiving alcoholism as a character defect ($F = 5.795$, $p = .0036$). Although not statistically significant as that is defined in this study, age also showed a strong relationship ($F = 2.777$, $p = .0649$) to seeing alcoholism as an illness. Officers under the age of thirty were least likely to view alcoholism as a character defect and most likely to view it as an illness.

Historically in the United States, one's religious group has been viewed as a strong reference group for her or his beliefs and attitudes. Thus the researcher expected religion to be an important background variable in relation to probation/parole officers' beliefs and attitudes, especially with the distinction between the two types of Protestant denominations (those who allow versus those who frown on drinking alcoholic beverages). However, religion turned out as one of the least important background variables. Although it could have occurred by chance, there _was_ a statistically significant relationship between religion and character defect ($F = 2.964$, $p = .0337$) with results in the anticipated direction. Those Protestants who saw their denomination as frowning on drinking were most likely to view alcoholism as a character defect ($\bar{X} = 3.62$); but it should be pointed out that their mean was below the neutral point of four. This compares with a mean of 3.29 for Protestants who viewed their denomination as allowing drinking. Also as anticipated, Catholics and those who checked "none" for religion were least likely to perceive alcoholism as a character defect (Catholic: $\bar{X} = 2.92$; none: $\bar{X} = 2.96$).[12] In trying to discern why religion was

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[12]Jews and those who checked "other" on the religion item were

TABLE XXX

MEANS, F-SCORES AND PROBABILITY FACTORS FOR AGE AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means				F-Score	Probability
	Under 30	30 - 39	40 Plus	Total		
Emotional Difficulties (7 = Positive)	4.77	4.68	4.70	4.72	0.165	.8477
Loss of Control (7 = Positive)	4.13	4.29	4.43	4.26	0.965	.3828
Prognosis for Recovery (1 = Positive)	2.55	3.04	3.07	2.84	5.567	.0045
Steady Drinker (7 = Positive)	4.96	5.12	5.25	5.08	1.321	.2693
Character Defect (1 = Positive)	2.93	3.36	3.67	3.24	5.795	.0036
Social Status (1 = Positive)	2.61	2.87	2.62	2.70	1.530	.2193
Illness (1 = Positive)	2.71	3.13	3.04	2.93	2.777	.0649
Harmless Indulgence (1 = Positive)	2.34	2.56	2.42	2.44	1.122	.3280
Addiction Liability (7 = Positive)	4.80	4.95	5.12	4.93	1.595	.2058
Can Inherit Alcoholism	3.57	3.53	3.55	3.55	0.007	.9935
Compel Alcoholic to Get Treatment	4.45	4.10	3.38	4.08	4.745	.0098
Alcoholic Needs Help to Stop Drinking	3.94	3.76	3.86	3.86	0.148	.8628
(N)	(79)	(63)	(42)	(184)		

unrelated to beliefs and attitudes, the researcher consulted a comprehensive review of studies which had tried to relate religion to racial prejudice (Berger, 1970b). It was concluded in that review that religion as an independent variable was so complex that it almost defied reasonable understanding in relation to prejudice. Many factors other than religious affiliation had been examined, e.g., individual church attendance, church organization, perception of religious authority as legitimate; but no one had yet described a meaningful relationship between religion and prejudice. It seems logical that this same complexity would apply to other areas of attitudes besides prejudice. In short, religious affiliation alone may not be an adequate predictor of much of anything. It also adds confusion to the question of who probation/parole officers may turn to as important reference groups for their views, since no other group explored seems to be consistent as a reference group either. For example, although size of community where one was raised was related to some knowledge issues, it was not related to attitudinal variables. District, type district, and size of community where one lived at the time of data collection did not reveal consistent relationships.

Demographic variables resulted in no statistically significant relationships on etiology factors. On responsibility issues, only two exhibited any consistent intrasample differences: loss of control and whether alcoholics should be compelled to get treatment. Only the latter one was related to any demographic variables. Officers in District D ($\overline{X}$ = 5.00) and those in District B ($\overline{X}$ = 4.72) were most likely to agree

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omitted from AOV computations because there were too few of them to result in meaningful comparisons (N = 3 and 9 respectively).

that treatment should be compulsory (refer to Table XXIX). Officers in District E were most likely to disagree on this item ($\bar{X}$ = 3.05). AOV on this item by district yielded F = 2.917, p = .0097. Age also was related to this item (F = 4.745, p = .0098, Table XXX). Officers under thirty, while basically neutral on the issue, were most likely to agree that alcoholics should be compelled to go for treatment ($\bar{X}$ = 4.45); as seen above, they also were the age group most likely to see alcoholism as an illness and not as a character defect.

It was noted above that prognosis for recovery was the alcoholism factor that showed the most difference for subgroups within the sample. Consistent with previously reported results, females were significantly more likely than males to be optimistic regarding the ability of alcoholics to recover (F = 16.124, p = .0001, Table XXVIII). Also in keeping with other findings, officers under the age of thirty were the most optimistic regarding prognosis (F = 5.567, p = .0045, Table XXX). Similarly, those in District D were the most optimistic, while those in Districts F and G were the least optimistic (F = 3.539, p = .0025, Table XXIX). It should be kept in mind that even for those groups which were least optimistic, their means on prognosis still were at least slightly in the positive direction. In fact, no subgroup in the entire sample of probation/parole officers had an MFS in the negative direction on the prognosis issue.

Based on the consistent lack of relationships concerning knowledge and alcoholism attitudes with background variables, fewer AOV's were computed on attitudes toward alcoholics than on the other two focus variables. (See Appendix J for the list of background variables probed here.) Referring back to Table XXII on page 140, it can be seen that

when the scores for five categories of semantic differential attitudes toward normal persons and alcoholic persons were correlated with Marcus factor attitudes toward alcoholism, 55 (30.6%) of the 180 correlations were statistically significant. Forty-one, or 74.5% of the statistically significant relationships regarded alcoholic persons. When AOV's were computed on the same five categories with 22 background variables, 38 (8.6%) of the 440 F-scores were statistically significant at the .05 level or below. This time, however, only 21, or 55.3%, of the statistically significant relationships had to do with alcoholic persons.

In other words, almost half the statistically significant relationships regarded normal persons, and most of these involved demographic variables. One of the more surprising findings of the entire study dealt with age and person attitudes. Age had no bearing at all on knowledge scores and was related to only a few of the most important alcoholism attitudes. It also was significantly related to one category of attitudes toward alcoholic persons (activity for alcoholic woman). As Table XXXI indicates, the surprising element lies in the fact that age was significantly related to all but one of the categories of normal person, that one being normal woman on the healthy-sick continuum. Without exception on all nine categories, the middle age group (31 - 39) had the lowest mean score, almost midway between mean scores for officers under thirty and forty or older. The oldest age group had slightly higher means than the youngest on seven of the nine categories. If the relationship had been a simple clear-cut one with means increasing by age, it would be easy to say sex-role stereotyping de-

TABLE XXXI

MEANS, F-SCORES AND PROBABILITY FACTORS FOR AGE AS IT RELATES TO SEMANTIC DIFFERENTIAL COMPONENTS ON NORMAL WOMAN, NORMAL MAN, ALCOHOLIC WOMAN AND ALCOHOLIC MAN

Variable	Means				F-Score	Probability
	Under 30	30 - 39	40 Plus	Total		
Normal Woman						
Evaluation (Maximum Score = 28)	21.93	20.27	21.90	21.37	3.833	.0235
Activity (Maximum Score = 14)	9.39	8.60	9.93	9.25	4.405	.0136
Potency (Maximum Score = 14)	9.57	8.88	9.71	9.37	3.420	.0349
Alcoholic Stereotype (Maximum Score = 63)	45.71	41.70	46.02	44.43	5.129	.0068
Sick-Healthy (Healthy = 7)	5.43	5.07	5.40	5.30	1.464	.2342
Normal Man						
Evaluation (Maximum Score = 28)	21.14	19.47	21.81	20.74	5.556	.0046
Activity (Maximum Score = 14)	10.14	9.65	11.05	10.19	6.201	.0025
Potency (Maximum Score = 14)	10.50	9.42	10.33	10.10	5.889	.0033
Alcoholic Stereotype (Maximum Score = 63)	46.12	43.30	49.52	45.97	7.339	.0009
Sick-Healthy (Healthy = 7)	5.64	5.02	5.76	5.46	5.903	.0033

TABLE XXXI (Continued)

Variable	Means				F-Score	Probability
	Under 30	30 - 39	40 Plus	Total		
Alcoholic Woman						
Evaluation (Maximum Score = 28)	14.24	14.05	13.60	14.02	0.367	.6937
Activity (Maximum Score = 14)	5.63	6.15	5.14	5.69	3.144	.0456
Potency (Maximum Score = 14)	6.63	6.60	6.93	6.69	0.617	.5408
Alcoholic Stereotype (Maximum Score = 63)	25.61	26.45	23.90	25.49	1.677	.1899
Sick-Healthy (Healthy = 7)	2.51	2.83	2.54	2.63	1.469	.2331
Alcoholic Man						
Evaluation (Maximum Score = 28)	14.03	13.80	13.43	13.81	0.271	.7627
Activity (Maximum Score = 14)	5.99	6.27	5.67	6.01	0.993	.3726
Potency (Maximum Score = 14)	6.89	6.68	6.95	6.84	0.319	.7275
Alcoholic Stereotype (Maximum Score = 63)	25.93	27.02	25.43	26.18	0.612	.5432
Sick-Healthy (Healthy = 7)	2.61	2.80	2.57	2.66	0.574	.5644
(N)	(76)	(60)	(42)	(178)		

creases with age; anyway, the two extreme age groups had almost similar means. Neither can it be explained by sex composition of age categories, because the under-30 group was comprised of 62.0% women, while 27.0% of the middle age group and 21.4% of the 40-plus age group were women. Besides, sex as a background variable only yielded one statistically significant relationship on those categories. Age was significantly related to district, but absolutely no statistically significant relationships emerged by district with regard to attitudes toward persons. In short, the relationship between age and attitudes toward normal persons is unexplained, and the pattern is stranger since it did not extend to attitudes toward alcoholics.

It was noted earlier that the activity component yielded the largest number of statistically significant AOV relationships. Most of these were in the alcoholic woman classification, where all demographic variables except district showed a significant relationship. Table XXXII shows that males had higher mean scores than females on this dimension ($F = 6.344$, $p = .0127$); again the middle age group had the highest mean score ($F = 3.144$, $p = .0456$, Table XXXI). Even religion was related to the activity principle on alcoholic woman, with Catholics having the lowest mean and those with no religious affiliation the highest ($F = 2.707$, $p = .0470$).[13] Unexpectedly, education also was related to this dimension ($F = 2.970$, $p = .0333$); as seen in Table XXXIII, those with graduate degrees had the highest mean, while officers

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[13]It was noted earlier that religion yielded only one other statistically significant relationship. But neither one seemed isolated as a fairly certain chance relationship. Instead, both were on attitude dimensions where many subgroups within the sample had significantly different views.

TABLE XXXII

MEANS, F-SCORES AND PROBABILITY FACTORS FOR SEX AS IT RELATES TO SEMANTIC DIFFERENTIAL COMPONENTS ON NORMAL WOMAN, NORMAL MAN, ALCOHOLIC WOMAN AND ALCOHOLIC MAN

Variable	Means			F-Scores	Probability
	Males	Females	Total		
Normal Woman					
Evaluation (Maximum Score = 28)	21.18	21.61	21.36	0.557	.4563
Activity (Maximum Score = 14)	8.98	9.63	9.25	3.420	.0661
Potency (Maximum Score = 14)	9.14	9.71	9.38	4.295	.0397
Alcoholic Stereotype (Maximum Score = 63)	43.64	45.52	44.42	2.253	.1351
Sick-Healthy (Healthy = 7)	5.25	5.37	5.30	0.398	.5287
Normal Man					
Evaluation (Maximum Score = 28)	20.74	20.69	20.72	0.007	.9342
Activity (Maximum Score = 14)	10.28	10.07	10.19	0.466	.4957
Potency (Maximum Score = 14)	10.05	10.15	10.09	0.144	.7365
Alcoholic Stereotype (Maximum Score = 63)	46.19	45.60	45.94	0.217	.6418
Sick-Healthy (Healthy = 7)	5.38	5.55	5.45	0.739	.3912

TABLE XXXII (Continued)

Variable	Means: Males	Means: Females	Means: Total	F-Score	Probability
Alcoholic Woman					
Evaluation (Maximum Score = 28)	13.97	14.09	14.02	0.043	.8357
Activity (Maximum Score = 14)	5.99	5.23	5.67	6.344	.0127
Potency (Maximum Score = 14)	6.85	6.47	6.69	2.555	.1117
Alcoholic Stereotype (Maximum Score = 63)	25.96	24.73	25.45	1.369	.2435
Sick-Healthy (Healthy = 7)	2.84	2.36	2.64	7.767	.0059
Alcoholic Man					
Evaluation (Maximum Score = 28)	13.82	13.80	13.81	0.001	.9762
Activity (Maximum Score = 14)	6.13	5.80	5.99	1.087	.2986
Potency (Maximum Score = 14)	6.90	6.75	6.84	0.316	.5745
Alcoholic Stereotype (Maximum Score = 63)	26.87	25.11	26.13	2.400	.1231
Sick-Healthy (Healthy = 7)	2.85	2.41	2.67	5.655	.0185
(N)	(105)	(75)	(180)		

TABLE XXXIII

MEANS, F-SCORES AND PROBABILITY FACTORS FOR EDUCATION AS IT RELATES TO SEMANTIC DIFFERENTIAL COMPONENTS ON NORMAL WOMAN, NORMAL MAN, ALCOHOLIC WOMAN AND ALCOHOLIC MAN

Variable	Means					F-Score	Probability
	HS-Some College	College Degree	Some Graduate	Graduate Degree	Total		
Normal Woman							
Evaluation (Maximum Score = 28)	23.33	21.29	21.38	20.51	21.36	2.681	.0484
Activity (Maximum Score = 14)	10.14	8.79	9.48	9.20	9.25	2.053	.1082
Potency (Maximum Score = 14)	10.52	9.16	9.35	9.18	9.38	3.400	.0190
Alcoholic Stereotype (Maximum Score = 63)	44.86	44.24	44.75	42.69	44.42	1.908	.1300
Sick-Healthy (Healthy = 7)	5.81	5.27	5.13	5.29	5.30	1.341	.2628
Normal Man							
Evaluation (Maximum Score = 28)	22.19	20.89	20.13	20.49	20.72	1.518	.2114
Activity (Maximum Score = 14)	11.19	9.79	10.17	10.29	10.19	2.614	.0528
Potency (Maximum Score = 14)	10.48	10.23	9.88	9.96	10.09	0.640	.5901
Alcoholic Stereotype (Maximum Score = 63)	50.05	45.00	45.54	45.80	45.94	2.031	.1112
Sick-Healthy (Healthy = 7)	5.86	5.50	5.25	5.42	5.45	1.185	.3171

TABLE XXXIII (Continued)

Variable	HS-Some College	College Degree	Some Graduate	Graduate Degree	Total	F-Score	Probability
Alcoholic Woman							
Evaluation (Maximum Score = 28)	12.67	14.32	14.04	14.22	14.02	1.022	.3842
Activity (Maximum Score = 14)	4.81	5.76	5.40	6.27	5.67	2.970	.0333
Potency (Maximum Score = 14)	7.05	6.65	6.62	6.67	6.69	0.411	.7450
Alcoholic Stereotype (Maximum Score = 63)	22.10	26.16	24.79	26.80	25.45	2.640	.0510
Sick-Healthy (Healthy = 7)	2.90	2.50	2.54	2.82	2.64	1.162	.3260
Alcoholic Man							
Evaluation (Maximum Score = 28)	12.81	14.00	14.04	13.76	13.81	0.494	.6872
Activity (Maximum Score = 14)	5.76	6.06	5.81	6.22	5.99	0.412	.7445
Potency (Maximum Score = 14)	6.95	6.89	6.67	6.91	6.84	0.199	.8972
Alcoholic Stereotype (Maximum Score = 63)	24.90	26.81	25.06	27.02	26.13	0.909	.4377
Sick-Healthy (Healthy = 7)	2.76	2.61	2.50	2.89	2.67	0.897	.4439
(N)	(21)	(62)	(52)	(45)	(180)		

with less than a bachelor's degree had the lowest.

Education, like religion, showed surprising results throughout the study. In studies of many areas of attitudes, amount of formal education makes a difference; the same was expected in this study. However, education bore no relationship to knowledge and almost none to alcoholism attitudes; furthermore, there was no direct relationship, with attitudes or knowledge steadily increasing or decreasing with amount of formal education. That same lack of linear patterning showed in this area of attitudes, where education did reveal a few (5 out of a possible 20) statistically significant relationships. As with age, most related to normal people (3); as can be seen from Table XXXIII though, there was no distinct pattern with one educational level consistently having highest or lowest means. In fact, since age was significantly related to education, education was explored when trying to explain the age pattern discussed above. But because of this lack of uniformity in means by educational level, it was discounted as related to the age findings. The point being made is that formal educational level just was not a relevant variable for the sample studied in this research. One qualification must be made though; as pointed out much earlier in this chapter, "education" as related to alcohol and alcoholism is much broader than amount of formal education. For just one example, officers with some graduate work were the most likely to have a sum of training score of 5+ (38.2% had 5+), while officers with bachelor's degrees (20.6% of them had none) and graduate degrees (14.9%) were the groups most likely to have no alcoholism training ($X^2 = 16.913$, $p = .0501$).

For the first time district made no difference in attitudes,

while the only differences for sex were related to the healthy-sick continuum. Table XXXII indicates that consistent with their definitions of alcoholism, females were significantly more likely than males to view both alcoholic woman ($F = 7.767$, $p = .0059$) and alcoholic man ($F = 5.655$, $p = .0185$) as sick.

Occupational Variables

In Chapter III, it was proposed that job level, years of service, and prior experience in other occupations be examined since all respondents were in the same occupation. Recalling that the supervisory category was extremely small (N = 12) in relation to probation/parole officers, job level made no difference on knowledge issues. Length of time in service made only a negligible difference on knowledge issues.

As with demographic variables, it made more sense to examine attitudes by attitude category than by background variable, since again the total number of statistically significant relationships was small. Table XXXIV presents the AOV's for length of time in current job, Table XXXV the AOV's for length of time with the agency, and Table XXXVI the AOV's for length of time working in the corrections field, as each relates to all the alcoholism attitude variables. Occupational variables made almost no difference with regard to defining alcoholism as char-defect versus illness. On the related issue of social status of alcoholics, three of the four statistically significant relationships were accounted for by occupational variables. Length of time in job ($F = 3.089$, $p = .0285$), length of time with agency ($F = 2.901$, $p = .0364$), and length of time working in the corrections field ($F = 3.237$, $p = .0235$) were all related to perceived social status of the alcoholic.

TABLE XXXIV

MEANS, F-SCORES AND PROBABILITY FACTORS FOR LENGTH OF TIME IN JOB AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means					F-Score	Probability
	Under 1 Year	1 - 5 Years	6 - 10 Years	Over 10 Years	Total		
Emotional Difficulties (7 = Positive)	4.91	4.73	4.67	4.48	4.73	0.700	.5529
Loss of Control (7 = Positive)	4.35	4.12	4.58	4.30	4.26	1.518	.2114
Prognosis for Recovery (1 = Positive)	2.67	2.77	3.02	3.32	2.83	1.885	.1337
Steady Drinker (7 = Positive)	5.00	5.08	5.12	5.09	5.07	0.094	.9633
Character Defect (1 = Positive)	2.87	3.23	3.73	3.18	3.25	2.846	.0390
Social Status (1 = Positive)	2.58	2.73	2.97	2.12	2.70	3.089	.0285
Illness (1 = Positive)	2.69	2.93	3.02	3.23	2.92	0.900	.4425
Harmless Indulgence (1 = Positive)	2.48	2.39	2.48	2.52	2.43	0.172	.9151
Addiction Liability (7 = Positive)	5.08	4.86	4.83	5.30	4.93	1.313	.2716
Can Inherit Alcoholism	3.61	3.54	3.44	3.71	3.55	0.079	.9713
Compel Alcoholic to Get Treatment	4.61	4.16	3.67	3.14	4.08	2.796	.0416
Alcoholic Needs Help to Stop Drinking	4.30	3.72	4.06	3.36	3.86	1.267	.2872
(N)	(33)	(106)	(33)	(14)	(186)		

TABLE XXXV

MEANS, F-SCORES AND PROBABILITY FACTORS FOR LENGTH OF TIME WORKING FOR AGENCY AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means					F-Score	Probability
	Under 1 Year	1 - 5 Years	6 - 10 Years	Over 10 Years	Total		
Emotional Difficulties (7 = Positive)	5.08	4.67	4.70	4.71	4.73	1.084	.3573
Loss of Control (7 = Positive)	4.16	4.08	4.54	4.69	4.26	2.621	.0522
Prognosis for Recovery (1 = Positive)	2.50	2.77	3.08	3.08	2.83	2.160	.0943
Steady Drinker (7 = Positive)	5.01	5.06	5.10	5.17	5.07	0.106	.9563
Character Defect (1 = Positive)	3.00	3.15	3.57	3.42	3.25	1.649	.1796
Social Status (1 = Positive)	2.67	2.67	2.98	2.25	2.70	2.901	.0364
Illness (1 = Positive)	2.80	2.89	3.04	3.00	2.92	0.298	.8266
Harmless Indulgence (1 = Positive)	2.59	2.36	2.52	2.44	2.43	0.643	.5883
Addiction Liability (7 = Positive)	5.20	4.84	4.84	5.31	4.93	1.997	.1160
Can Inherit Alcoholism	3.48	3.46	3.73	3.72	3.55	0.256	.8569
Compel Alcoholic to Get Treatment	4.57	4.15	3.79	3.72	4.08	1.159	.3270
Alcoholic Needs Help to Stop Drinking	4.74	3.58	4.14	3.67	3.86	2.926	.0352
(N)	(23)	(103)	(42)	(18)	(186)		

TABLE XXXVI

MEANS, F-SCORES AND PROBABILITY FACTORS FOR LENGTH OF TIME IN CORRECTIONS FIELD AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means					F-Score	Probability
	Under 1 Year	1 - 5 Years	6 - 10 Years	Over 10 Years	Total		
Emotional Difficulties (7 = Positive)	5.35	4.66	4.66	4.71	4.73	2.685	.0481
Loss of Control (7 = Positive)	4.10	4.12	4.42	4.78	4.26	2.363	.0728
Prognosis for Recovery (1 = Positive)	2.53	2.74	3.07	3.11	2.83	2.147	.0959
Steady Drinker (7 = Positive)	5.08	5.04	5.03	5.31	5.07	0.472	.7019
Character Defect (1 = Positive)	3.08	3.13	3.55	3.41	3.25	1.466	.2252
Social Status (1 = Positive)	2.56	2.68	3.00	2.28	2.70	3.237	.0235
Illness (1 = Positive)	2.74	2.89	3.13	2.88	2.92	0.732	.5341
Harmless Indulgence (1 = Positive)	2.57	2.36	2.58	2.36	2.43	0.800	.4954
Addiction Liability (7 = Positive)	5.17	4.83	4.87	5.32	4.93	1.939	.1249
Can Inherit Alcoholism	3.50	3.43	3.71	3.85	3.55	0.399	.7536
Compel Alcoholic to Get Treatment	4.44	4.19	3.70	3.95	4.08	1.010	.3896
Alcoholic Needs Help to Stop Drinking	5.06	3.53	4.21	3.75	3.86	4.259	.0062
(N)	(18)	(105)	(43)	(20)	(186)		

In all three cases, officers with over ten years in service were most likely to view the alcoholic as coming from any socioeconomic status. Interestingly, those with 6 - 10 years on all three variables were least likely to see alcoholism as not related to the alcoholic's social status. It is unclear why those with less than one year or from 1 - 5 years had the mid-range MFS's. Of course, all three of these background variables undoubtedly are highly interrelated among themselves, so perhaps the significant relationships occurred by chance since social status only yielded four statistically significant relationships altogether. On the other hand, there were a number of other variables where only one of the time-related variables resulted in statistically significant relationships, so the interrelationship surely is not the total answer.

There was almost no occupational variable influence on etiology issues, but there was some relationship to responsibility variables. Regarding loss of control, job level yielded its only statistically significant relationship in the entire study ($F = 5.158$, $p = .0243$); supervisory personnel ($\overline{X} = 4.98$) were more likely than field probation/parole officers ($\overline{X} = 4.21$) to believe alcoholics lose control over drinking. Length of time with agency ($F = 2.621$, $p = .0522$) also was related to the loss of control variable; officers with six or more years with the agency were more likely to believe that alcoholics are unable to control their drinking behavior. On the question of whether the alcoholic needs help to stop drinking, length of time with the agency ($F = 2.926$, $p = .0352$) and length of time in the corrections field ($F = 4.259$, $p = .0062$) were the only background variables studied which were significantly related to the issue. However, results were contradictory on the other responsibility issue related to occupational

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variables. Alcoholism professionals believe that it is precisely because of the loss of control over drinking that the alcoholic needs help to stop even if he or she has a desire to stop (e.g., see Bucky, 1978). Contrary to the loss of control findings, however, officers with less than one year with the agency or in corrections were most likely to agree that the alcoholic needs help to stop. In fact those with more than ten years, who were most likely to agree with the loss of control factor, had means in the direction of disagreement on the item about needing help to stop. This contradiction has been given some extra attention because it supports a point made earlier in this chapter that attitude toward alcoholism is not a global-type attitude. Rather it must be looked at as a set of complex separate (and sometimes contradictory) entities.

No occupational variable was related in any statistically significant manner to prognosis for recovery, although it was the alcoholism attitude which revealed the most intrasample differences. Statistically significant relationships between occupational variables and attitudes toward normal versus alcoholic persons were so few and so scattered that they probably occurred by chance.

Several times in this chapter the question of who probation/parole officers tend to use for reference groups has arisen. Results so far have shown such little uniformity that no one group for which data were gathered could be pointed to as a consistent reference group. This is the last background variable to be discussed which would be relevant to that question, and it may be the one to provide the primary answer. Occupational variables resulted in few statistically significant differences on any knowledge or attitudinal issue. Therefore, it may be that the occupational group itself provides the major reference group

for generating views. Mackey (1969) studied only one area of focus variables explored in the present study, attitudes toward alcoholic persons compared with attitudes toward normal people. He included four occupations with at least minimal overlap in their functions in that they all were primarily human services professions. Yet he found occupation to be the most important factor related to attitudes throughout his study. Sex was the second most important variable having an impact on attitudes in his study. In the present study, sex has been the most frequent background variable showing statistically significant relationships across the entire range of focus variables. However, as documented several times above, sex differences in views are more likely to be a product of sex-role socialization than a reference group orientation. Also as in the present study, Mackey (1969:668) studied a variety of other variables, specifically mentioning "age, years in line of work and formal education . . . ." But as here, he found so few significant differences he attributed them to possible chance factors. In Chapter II several other studies that found differences between occupations in attitudes toward alcoholism or alcoholics were referenced (e.g., Dorsch et al., 1969; 1973; Robinson, 1976). Unlike Mackey (1969), however, they did not mention studying other background variables to see if occupation was the major factor. In short, although occupation obviously cannot be controlled as a variable in the research reported here, from all indications it indeed may be the major reference group for probation/ parole officer views. Of course, this conclusion could be ascertained only by using the same survey instrument with other occupational groups in the future.

Other Personal Variables

In Chapter III it was proposed that knowledge, attitude toward clients, and experience other than occupation might be related to attitudes. These are investigated below.

Knowledge. Knowledge was considered earlier as a primary focus variable in this research. Here it is examined as a background variable potentially related to attitudes toward alcoholism and/or alcoholics. As proposed in Chapter III, knowledge will be examined as an issue broader than a score on a paper-and-pencil test. Just as when it was viewed as a focus variable, knowledge will be investigated here as number correct on the knowledge scale, sum of training, and expression of need and/or want for further alcoholism training.

Score on the Engs (1975) knowledge scale was probed in two ways. First, AOV's were computed between it and focus variables after scores were broken down into categories as described earlier (see page 94). Relative to all the areas of alcoholism attitudes--definition, etiology/ responsibility, and prognosis--knowledge score displayed only one statistically significant relationship which could have occurred by chance. Similar results were obtained when comparing knowledge score with attitudes toward alcoholics. As noted in Chapter IV, Marcus factors, semantic differentials, and knowledge score were assumed to be interval scales. In order to make use of exact scores instead of means and categories, Pearson correlation coefficients were computed to test strength of relationships. A statistically significant correlation existed between number correct on knowledge scale and only one of the nine Marcus factor scores, which is fewer than the number of sta-

tistically significant correlations (3) between "don't know" and Marcus factor scores; further, the substantive significance of the statistically significant correlations was negligible. Even less relationship was indicated between knowledge score and attitudes toward persons, where only two out of twenty correlations were statistically significant. Thus two separate statistical tests revealed no systematic relationship between objective knowledge and attitudes toward alcoholism or alcoholics.

Sum of training score was no more relevant than objective knowledge. The only statistically significant relationship was between sum of training and prognosis ($F = 3.089$, $p = .0285$); prognosis consistently has been the alcoholism attitude factor which showed the most difference within the sample. However, the relationship was not as might be expected: officers with a sum of training score of 3 - 4 were most optimistic ($\overline{X} = 2.51$), followed by those with the most training ($\overline{X} = 2.85$). Those with no training were least optimistic ($\overline{X} = 3.17$), but still had a mean in the positive direction; those with a score of 1 - 2 had a mean of 2.97 regarding prognosis. Sum of training was related to attitude toward normal woman and alcoholic man on the healthy-sick continuum, which does not indicate any pattern. As pointed out earlier in the chapter, knowledge and sum of training were related to one another, but neither had any apparent relationship to attitudes toward condition of alcoholism or alcoholic person.

While this study found very few relationships between knowledge and/or training and attitudes toward alcoholism and alcoholics, it should not be surprising based on past studies. Research into a variety of issues has revealed no necessary relationship between cognitive and affective elements (see Fisher et al., 1976, as this issue relates to alcoholism).

Furthermore, this study, as has prior research (e.g., Wolf et al., 1965; Sowa and Cutter, 1974), supported Freidson's (1970a) contention that even if a medical (thus supposedly objective) model is accepted, the moral (thus stigmatic) model does not automatically disappear. Finally, as demonstrated in Chapter II, other studies have shown no uniform relationship between knowledge and attitude, even after training on some occasions. It was suggested in that chapter that several factors (e.g., length and content of course, level and type of initial attitudes) should be taken into account when analyzing the effect of training on attitudes. While some studies did show positive changes in attitudes after training (e.g., Gurel, 1976; Waring, 1978), others did not (e.g., Chodorkoff, 1967; 1969; Bailey, 1970), and those were surveys taken immediately after training. The sum of training score in this research probably is a more realistic measure of the everyday working knowledge with which people act (see prior quotes from Robinson, 1976). To repeat, then, results from the present research regarding the relationship between knowledge/training and attitudes should not be surprising.

One more knowledge issue has to be examined; one way to measure perception of one's amount of knowledge (as proposed in Chapter III) is to see if she/he feels the need for or wants further knowledge. The variables of needing and wanting more alcoholism training were not significantly related to either amount of knowledge or sum of training. However, they *were* related to feelings probation/parole officers had about working with alcoholics, and they were the two background variables with the largest number of statistically significant relationships regarding attitudes.

Table XXXVII displays the AOV's for needing more alcoholism training and Table XXXVIII the AOV's for wanting more alcoholism training as each relates to all the alcoholism attitude variables. On the issue of defining alcoholism, both need ($F = 10.439$, $p = .0015$) and want ($F = 8.560$, $p = .0039$) were significantly related to perceiving alcoholism as an illness. Those officers who needed or wanted more alcoholism training were both more likely to see it as an illness than were those who answered no to those questions.[14] Interestingly, however, unlike the relationship with some other background variables, their MFS's on viewing alcoholism as a character defect were almost the same. But at least officers who needed and/or wanted more training were a step ahead toward incorporating the medical model into their way of thinking (again, refer to Robinson's, 1976, definition of the situation framework). The implications of this incorporation of the illness idea (even alongside the character defect view) were evident in other statistically significant relationships. For instance, regarding the etiology of alcoholism, officers who said they needed ($F = 11.832$, $p = .0007$) or wanted ($F = 7.796$, $p = .0058$) more training were more likely than those who did not to view emotional difficulties as an important contributing factor in developing alcoholism. Those who needed more training also were less likely to disagree with the idea that alcoholism can be inherited ($F = 5.357$, $p = .0218$). Regarding responsibility, officers who needed ($F = 5.266$, $p = .0229$) or wanted

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[14]Undoubtedly there is a great deal of overlap between those who responded yes to the questions regarding needing and wanting more training; but means, F scores, and chi squares revealed there was not total overlap, so they still should be analyzed as two separate variables.

TABLE XXXVII

MEANS, F-SCORES AND PROBABILITY FACTORS FOR NEED MORE ALCOHOLISM TRAINING AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means			F-Score	Probability
	Yes	No	Total		
Emotional Difficulties (7 = Positive)	4.89	4.36	4.73	11.832	.0007
Loss of Control (7 = Positive)	4.38	3.96	4.26	5.266	.0229
Prognosis for Recovery (1 = Positive)	2.70	3.16	2.84	8.193	.0047
Steady Drinker (7 = Positive)	5.14	4.95	5.08	1.482	.2250
Character Defect (1 = Positive)	3.27	3.22	3.25	0.047	.8290
Social Status (1 = Positive)	2.71	2.69	2.70	0.024	.8761
Illness (1 = Positive)	2.76	3.33	2.93	10.439	.0015
Harmless Indulgence (1 = Positive)	2.36	2.62	2.44	3.533	.0618
Addiction Liability (7 = Positive)	4.91	4.96	4.93	0.104	.7474
Can Inherit Alcoholism	3.77	3.05	3.55	5.357	.0218
Compel Alcoholic to Get Treatment	4.14	3.96	4.09	0.344	.5582
Alcoholic Needs Help to Stop Drinking	3.85	3.87	3.85	0.006	.9395
(N)	(130)	(55)	(185)		

TABLE XXXVIII

MEANS, F-SCORES AND PROBABILITY FACTORS FOR WANT MORE ALCOHOLISM TRAINING AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means			F-Score	Probability
	Yes	No	Total		
Emotional Difficulties (7 = Positive)	4.84	4.40	4.72	7.796	.0058
Loss of Control (7 = Positive)	4.34	3.98	4.24	3.797	.0529
Prognosis for Recovery (1 = Positive)	2.66	3.25	2.82	13.318	.0003
Steady Drinker (7 = Positive)	5.16	4.86	5.08	3.528	.0619
Character Defect (1 = Positive)	3.23	3.29	3.24	0.100	.7525
Social Status (1 = Positive)	2.65	2.86	2.71	1.935	.1659
Illness (1 = Positive)	2.77	3.30	2.91	8.560	.0039
Harmless Indulgence (1 = Positive)	2.34	2.69	2.43	6.077	.0146
Addiction Liability (7 = Positive)	4.91	4.95	4.92	0.063	.8025
Can Inherit Alcoholism	3.69	3.26	3.57	1.791	.1825
Compel Alcoholic to Get Treatment	4.07	4.08	4.07	0.002	.9639
Alcoholic Needs Help to Stop Drinking	3.81	3.88	3.83	0.044	.8350
(N)	(133)	(50)	(183)		

(F = 3.797, p = .0529) more training again leaned toward the medical model by agreeing that alcoholics lose control over their drinking behavior. The pattern continued with regard to prognosis about recovery; those who needed (F = 8.193, p = .0047) or wanted (F = 13.318, p = .0003) more training tended to be considerably more optimistic. It should be pointed out that officers who said they did not need or want more training still had mean scores in the positive direction on every factor mentioned except loss of control, but those who answered yes to these questions were considerably more positive.

There was the same uniformity when shifting to attitudes toward alcoholics. Table XXXIX presents the AOV's for needing more alcoholism training and Table XL the AOV's for wanting more alcoholism training as each relates to the semantic differential components reflecting attitudes toward normal and alcoholic people. Except for the unexplainable relationships for age, needing/wanting more training exhibited more statistically significant relationships here too. More importantly, the training variables were related to attitudes toward alcoholic persons, whereas the age relationships dealt with normal persons. The activity component for alcoholic woman was significantly related to both need (F = 8.670, p = .0037) and want for more training (F = 6.654, p = .0107), and the same principle for alcoholic man was related to wanting more alcoholism training (F = 5.503, p = .0201). In all three cases, officers who answered "no" had higher mean scores on the activity element. A fascinating and startling reversal in attitude occurred with respect to alcoholic stereotypes. This category was significantly related to need (F = 6.900, p = .0094) and want for more training (F = 7.453, p = .0070) regarding alcoholic woman; it also was related

TABLE XXXIX

MEANS, F-SCORES AND PROBABILITY FACTORS FOR NEED MORE ALCOHOLISM TRAINING AS IT RELATES TO SEMANTIC DIFFERENTIAL COMPONENTS FOR NORMAL WOMAN, NORMAL MAN, ALCOHOLIC WOMAN AND ALCOHOLIC MAN

Variable	Means			F-Score	Probability
	Yes	No	Total		
Normal Woman					
Evaluation (Maximum Score = 28)	21.62	20.81	21.38	1.664	.1987
Activity (Maximum Score = 14)	9.43	8.85	9.26	2.325	.1291
Potency (Maximum Score = 14)	9.45	9.17	9.37	0.902	.3436
Alcoholic Stereotype (Maximum Score = 63)	45.24	42.66	44.47	3.637	.0581
Sick-Healthy (Healthy = 7)	5.29	5.32	5.30	0.016	.9008
Normal Man					
Evaluation (Maximum Score = 28)	21.06	20.00	20.75	2.868	.0921
Activity (Maximum Score = 14)	10.33	9.89	10.20	1.748	.1879
Potency (Maximum Score = 14)	10.27	9.68	10.10	3.488	.0635
Alcoholic Stereotype (Maximum Score = 63)	46.73	44.25	45.99	3.345	.0691
Sick-Healthy (Healthy = 7)	5.58	5.17	5.46	3.925	.0491

TABLE XXXIX (Continued)

Variable	Means			F-Score	Probability
	Yes	No	Total		
Alcoholic Woman					
Evaluation (Maximum Score = 28)	13.94	14.23	14.02	0.207	.6498
Activity (Maximum Score = 14)	5.40	6.36	5.68	8.670	.0037
Potency (Maximum Score = 14)	6.63	6.85	6.69	0.730	.3941
Alcoholic Stereotype (Maximum Score = 63)	24.58	27.53	25.45	6.900	.0094
Sick-Healthy (Healthy = 7)	2.57	2.77	2.63	1.092	.2975
Alcoholic Man					
Evaluation (Maximum Score = 28)	13.72	14.02	13.81	0.186	.6670
Activity (Maximum Score = 14)	5.80	6.45	5.99	3.567	.0606
Potency (Maximum Score = 14)	6.71	7.13	6.83	1.968	.1625
Alcoholic Stereotype (Maximum Score = 63)	25.39	27.91	26.13	4.205	.0418
Sick-Healthy (Healthy = 7)	2.63	2.72	2.66	0.167	.6832
(N)	(126)	(53)	(179)		

TABLE XL

MEANS, F-SCORES AND PROBABILITY FACTORS FOR WANT MORE ALCOHOLISM TRAINING AS IT RELATES TO SEMANTIC DIFFERENTIAL COMPONENTS FOR NORMAL WOMAN, NORMAL MAN, ALCOHOLIC WOMAN AND ALCOHOLIC MAN

Variable	Means			F-Score	Probability
	Yes	No	Total		
Normal Woman					
Evaluation (Maximum Score = 28)	21.60	20.90	21.41	1.202	.2744
Activity (Maximum Score = 14)	9.43	8.96	9.31	1.504	.2218
Potency (Maximum Score = 14)	9.45	9.29	9.41	0.271	.6035
Alcoholic Stereotype (Maximum Score = 63)	45.02	43.29	44.55	1.520	.2193
Sick-Healthy (Healthy = 7)	5.27	5.40	5.31	0.309	.5788
Normal Man					
Evaluation (Maximum Score = 28)	20.89	20.27	20.72	0.904	.3430
Activity (Maximum Score = 14)	10.28	9.96	10.19	0.863	.3543
Potency (Maximum Score = 14)	10.22	9.71	10.08	2.473	.1176
Alcoholic Stereotype (Maximum Score = 63)	46.40	44.81	45.97	1.259	.2633
Sick-Healthy (Healthy = 7)	5.54	5.23	5.46	2.115	.1477

TABLE XL (Continued)

Variable	Means			F-Score	Probability
	Yes	No	Total		
Alcoholic Woman					
Evaluation (Maximum Score = 28)	13.91	14.50	14.07	0.831	.3632
Activity (Maximum Score = 14)	5.42	6.29	5.66	6.654	.0107
Potency (Maximum Score = 14)	6.66	6.79	6.69	0.241	.6238
Alcoholic Stereotype (Maximum Score = 63)	24.64	27.81	25.50	7.453	.0070
Sick-Healthy (Healthy = 7)	2.53	2.96	2.65	4.821	.0294
Alcoholic Man					
Evaluation (Maximum Score = 28)	13.79	14.17	13.89	0.287	.5928
Activity (Maximum Score = 14)	5.80	6.62	6.02	5.503	.0201
Potency (Maximum Score = 14)	6.72	7.12	6.83	1.663	.1989
Alcoholic Stereotype (Maximum Score = 63)	25.56	28.12	26.25	4.154	.0431
Sick-Healthy (Healthy = 7)	2.60	2.88	2.67	1.819	.1791
(N)	(129)	(48)	(177)		

to needing ($F = 4.205$, $p = .0418$) and wanting more training ($F = 4.154$, $p = .0431$) for alcoholic man. The curious thing is that in all cases, those who needed or wanted more training had significantly more negative stereotypes, especially regarding being dangerous and unreliable for both sexes, and being aimless and tense for women. This result is totally inconsistent with all the other attitudes that differ on these background variables. Add to this the fact that for alcoholics on the healthy-sick continuum, only one relationship was statistically significant, for alcoholic woman by training want ($F = 4.821$, $p = .0294$), with means in the expected direction. The only suggestion the researcher has to offer at this point is to return to the proposal stated earlier that attitudes toward alcoholism and alcoholics may have to be broken into several component parts to have meaningful understanding. This would involve in part relating attitude clusters toward the condition to attitude clusters toward the person within subgroups (such as those needing and/or wanting more training) as was done in an earlier section for the total sample.

Officer attitudes toward clients. In Chapter III the researcher discussed exploring authoritarianism as a background variable related to attitudes for two reasons: first, that it had been studied in previous research on human services professionals' attitudes toward alcoholism; second, that it was a variable often associated with criminal justice personnel in the literature. In reality, a standardized authoritarianism scale was not used; instead the researcher constructed several items to measure probation/parole officers' general attitudes toward their clients. Authoritarianism then was seen as one component of a wider spectrum of attitudes. An attempt was made to construct an index from

these items to have a general attitude toward clients index. However, there was almost no intracorrelation among the items and relatively low correlations between individual items and the total score (r = .3147 to .5290). Therefore, four items, two of which could be interpreted as authoritarian and the other two as gentler attitudes toward clients, were used as background variables (see Appendix G).

Before examining the relationship of attitudes toward clients to attitudes toward alcoholism and alcoholics, their distribution among sample members should be mentioned in order to understand the general orientation of the probation/parole officers. Informal conversations with probation/parole officers in several districts revealed that among themselves they tend to label one another as having predominantly "cop" or "social worker" viewpoints in working with clients. Table XLI shows the distribution of these attitudes within the sample.

The attitudes the researcher referred to as authoritarian could be seen as also a measure of what the officers called "cop" attitudes; these same items were the ones used to measure officers' perception of their power relative to clients discussed in the section below on organizational constraints. It can be seen from Table XLI that probation/parole officers were likely to disagree that the best way to work with clients is to make sure they remember who is boss, with a mean of 1.97 on a four-point scale. There was less disagreement with the opinion that clients need to be constantly mindful that violations can lead to revocation, with a mean of 2.42, basically at the neutral point. Put another way, 24.8% generally agreed with the first statement, while 42.7% agreed with the second. The Pearson correlation coefficient between these two items was only .1581, so they actually may not be tapping the same attitudinal

dimension. However, as the only items available in this survey to measure authoritarianism or a "cop" attitude, they suggest that the majority of officers did not lean in the direction of being authoritarian or having to maintain a clear-cut "power" relationship with clients. But it should be kept in mind that almost half the officers did feel clients must be constantly mindful of revocation possibilities.

TABLE XLI

ATTITUDES OF PROBATION/PAROLE OFFICERS
TOWARD WORKING WITH CLIENTS

Item	Definitely Disagree		Tend to Disagree		Tend to Agree		Definitely Agree		Total	Mean
	N	%	N	%	N	%	N	%		
Surveillance										
Make Sure Clients Remember Who is Boss	54	29.2	85	45.9	43	23.2	3	1.6	185	1.97
Keep Clients Constantly Mindful Violations Lead to Revocation	20	10.8	86	46.5	61	33.0	18	9.7	185	2.42
Guidance										
Assist Clients in Solving Major Problems in Living	10	5.5	18	9.8	91	49.7	64	35.0	183	3.14
Treat Clients More as "Patients" Than as Offenders	57	30.6	78	41.9	46	24.7	5	2.7	186	2.00

Considering the two more nonauthoritarian items, the vast majority of officers agreed that the best way to work with clients is to assist them in solving major problems in living. Not only were there more

"definitely agree" responses to this item than to any of the other three, it also had the mean furthest away from the neutral view ($\bar{X}$ = 3.14). The other item, representing a more extreme "social work" viewpoint, dealt with treating clients more as "patients" than as offenders. Officers basically disagreed with that view, with more responses in the "definitely disagree" category than any of the other items ($\bar{X}$ = 2.00). As could be expected, the correlation coefficient between these two items was only .0491; 84.7% agreed with the first item, while only 27.4% agreed with the second item.

Looked at another way, 84.7% agreed with the item about assisting clients to solve problems in living, which could be a reflection of the counseling function of the probation/parole officer job description (see Appendix A). The item about constantly reminding clients that violations can lead to revocation drew 42.7% agreement, a rough reflection of the supervision function in the job description. The correlation between these two items was only .0139, so they could be seen as essentially independent of one another. (They also generally correspond to Sutherland and Cressey's, 1978, distinction between "guidance" and "surveillance" orientations.)

The researcher will not go so far as to tack on the labels of "cop" or "social worker." However, in general, except for the item partially reflecting a medical model, the probation/parole officers could be described as seeing themselves more as members of a human services profession than of a policing profession. This set of items made little difference in attitudes toward alcoholism; the four items accounted for only four statistically significant relationships out of a possible 48 in this area. Two relationships are worth mentioning:

although the two items the researcher regarded as nonauthoritarian or guidance-oriented did not show much relationship to one another, both were significantly related to the Marcus prognosis factor, which already has been seen to be the alcoholism attitude reflecting the most intrasample differences. Officers who agreed that they should help clients solve major living problems ($F = 6.621$, $p = .0109$) and officers who agreed that clients should be treated more as "patients" ($F = 10.423$, $p = .0015$) were significantly more optimistic about recovery possibility than were those who disagreed with those items. Those who agreed with these two items had means of 2.75 and 2.45 respectively regarding prognosis, compared with respective means of 3.29 and 2.98 on the prognosis issue for those who disagreed with the guidance-oriented items.[15]

Experience with Drinking. In Chapter III experience with drinking was described as including both personal experience with alcoholics and attitudes toward social drinking. It was anticipated that those officers who had current experience with recovering alcoholics would have more positive attitudes, while those who had current experience with practicing alcoholics would have more negative attitudes. It also was expected that negative attitudes toward social drinking would be related to negative attitudes toward alcoholism and alcoholics.

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[15]One other statistically significant relationship dealt with the fact that those who felt clients should be constantly mindful of revoocation possibilities were less likely ($\bar{X} = 4.89$) than those who disagreed with the item ($\bar{X} = 5.20$) to believe that periodic excessive drinkers can be alcoholics ($F = 4.801$, $p = .0297$). Also, officers who felt that clients must remember who is boss ($\bar{X} = 4.80$) were more likely than those who disagreed with that item ($\bar{X} = 3.83$) to think that alcoholics should be compelled to get treatment ($F = 10.132$, $p = .0017$).

The probation/parole officers were asked to characterize the drinking patterns of their parents, spouses, and themselves. They also were asked to estimate how many practicing and recovering alcoholics were among their male and female siblings, children and other relatives, close friends and work associates. Based on median scores, they tended to characterize their fathers, spouses, ex-spouses, and themselves as infrequent drinkers, and their mothers as nondrinkers. It is easy to understand why no officers characterized themselves as alcoholic drinkers, but three (1.6%) acknowledged being recovering alcoholics.

The item about parent/spouse drinking practices was combined with the items about estimating other people to be alcoholics to examine the issue in broader terms. Officers who estimated they knew alcoholics were most likely to check that they knew one or two, especially for recovering alcoholics. Fifty-six (30.1%) of the officers said they knew no practicing alcoholics or problem drinkers. Among the other 130 officers, there were 259 references to male alcoholics and 133 references made to female alcoholics.[16] Keeping in mind that no officers acknowledged being an alcoholic drinker (which would be expected), 47.8% of the officers estimated they knew one or more practicing alcoholics among male work associates, and 28.3% among female work associates. Regarding recovering alcoholics, 127 (68.3%) estimated they knew none. Among the other 59 officers, there were 76 references

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[16]Those are underestimates of the actual number of alcoholics officers stated they knew. Because the category system on the questionnaire stated 1-2, 3-4, 5-9, and 10+, there was no way to count the exact number of alcoholics estimated. So "reference" means checking any category other than "none." The same procedure was followed for recovering alcoholics.

to male and 39 references to female recovering alcoholics. Two-thirds (66.1%) of the references to each group (practicing and recovering) were to males.

Officers who said they knew recovering alcoholics were asked the recovery methods used. Most frequent mention (38) was made of AA; 19 stated the alcoholic quit on his or her own; 16 mentioned inpatient treatment, seven outpatient treatment, and four religion. Some used a combination of recovery methods; but as with organizations where probation/parole officers would refer clients, AA was by far the most frequently mentioned.

An admittedly crude ordinal-level index was constructed to provide a rough estimate of the total number of practicing and recovering alcoholics officers estimated they knew. These indexes were based on category numbers rather than actual number of alcoholics known. Contrary to expectations of the researcher, each index revealed only one significant relationship to attitudes toward alcoholism, none to attitudes toward alcoholics. Neither were they related to knowledge.

It is difficult to dispute statistically insignificant findings on many items, especially where they are coded directly from a circled number. Nevertheless, the researcher does question the results of tests with these two variables on the basis of subjective evidence: teaching experience, working as a volunteer among treatment professionals, and many personal conversations convinces her there _is_ a difference in attitudes, based on whether one knows practicing or recovering alcoholics. Several factors could have contributed to problems with validity on these two variables: 1) A major issue could have been the method of constructing the indexes. Rather than making them the rough "estimate"

ordinal index as described above, perhaps they should have been simple nominal categories of knowing anyone in the practicing (or recovering) alcoholic category or not; or maybe a measure should have been devised based on whether an officer knew people in one or both categories or neither of them. Perhaps separate measures or a weighted measure should have been constructed based on assumed social distance of the person by relationship to him or her. 2) Honesty could have been another difficulty. It was pointed out in Chapter IV that personal drinking items already were eliminated from analysis because of acknowledged dishonesty. It also is clear from the reporting of findings that as a group the probation/parole officers did not hold alcoholics in very high esteem. So it would not be illogical to assume that some felt the same stigma and did not want to acknowledge alcoholism among especially their family members.[17] 3) There is the possibility of definitional difficulties. It was noted above that although no officers acknowledged being alcoholic, a large number of probation/parole officers said they knew alcoholics among their work associates. One potential definitional problem could be that some officers included clients or work associates other than probation/parole officers (perhaps the term "colleague" would have been a better choice). Another definitional problem could stem from people's definition of alcoholic, for it is obvious from earlier results that at least the abstract level officers did not agree on defining the condition. Of course, the dis-

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[17]More than likely some probation/parole officers know alcoholics (particularly recovering ones) but do not know they are alcoholics. However, that would not be part of the honesty problem, because the officer would not have the label to react to.

crepancy between officers' accounts of others' behavior versus their own also could fit into the honesty issue; very few people admit they are practicing alcoholics (or even heavy drinkers, which only one officer admitted to being), even to themselves. It is probable that all three factors were operating, although in unknown degrees. In any event, the researcher will remain suspect of the results using knowledge of practicing and recovering alcoholics as background variables. The difficulty of definitions would remain problematic; however, there is no doubt a better index could have been constructed. Also, if questionnaires were responded to in a less threatening situation than the one described in Chapter IV, the honesty issue might be less of a problem.

The final personal variables to be considered were attitudes toward social drinking. The researcher had no expectations that they would be related to knowledge, but they were. She did expect those with negative attitudes toward social drinking to have more negative attitudes toward alcoholism and alcoholics.

Distribution of social drinking attitudes among the probation/parole officers are shown in Table XLII. The mean for three of the four items was less than 0.50 point from the neutral view of 2.5, and the fourth was just barely half a point away from neutral. Three means were slightly in the direction of being negative toward social drinking, and only one was toward the positive direction. On the one item which reflected a slightly positive attitude ($\overline{X} = 2.68$) toward social drinking, 59.6% agreed that getting drunk occasionally is all right if one is not driving. Fewer (39.4%) agreed that moderate drinking is good to relax from tension ($\overline{X} = 2.29$), and even fewer (20.6%) that

moderate drinking is good to promote sociability ($\overline{X}$ = 1.96). On the question of abstinence being better for individuals than drinking any alcohol, 64.4% agreed ($\overline{X}$ = 2.82). The means reflect a more middle-of-the-road view toward drinking than do the percentages agreeing with the statements. The only group available for comparison were Bailey's (1970) social workers. They showed much more liberal views toward social drinking than did the probation/parole officers in this study ten years later. They were similar to the officers on the getting drunk occasionally item (61% agreed after an alcoholism training program), but much different on the other items. After training, 55% agreed to drinking for sociability, 51% to drinking to relax, and only 38% to abstinence being better than any alcohol.

TABLE XLII

ATTITUDES OF PROBATION/PAROLE OFFICERS TOWARD SOCIAL DRINKING

Item	Definitely Disagree		Tend to Disagree		Tend to Agree		Definitely Agree		Total	Mean
	N	%	N	%	N	%	N	%		
Getting Drunk Sometimes OK if Not Driving	14	7.5	61	32.8	81	43.5	30	16.1	186	2.68
Moderate Drinking Good to Promote Sociability	53	28.8	93	50.5	31	16.8	7	3.8	184	1.96
Moderate Drinking Good to Relax from Tension	27	14.6	85	45.9	65	35.1	8	4.3	185	2.29
Voluntary Abstinence Better than Any Alcohol	14	7.6	52	28.1	73	39.5	46	24.9	185	2.82

As background variables, the social drinking items exhibited a scattering of statistically significant relationships regarding attitudes toward alcoholism. Table XLIII shows the AOV's for the "getting drunk" item, Table XLIV the AOV's for the "sociability" item, Table XLV the AOV's for the "relax from tension" item, and Table XLVI the AOV's for the "abstinence" item, as each relates to all the alcoholism attitude variables. Some of those seem to have some important consistencies. Both the sociability item ($F = 4.263$, $p = .0404$) and the "getting drunk" item ($F = 6.216$, $p = .0135$) were significantly related to the view toward alcoholism as an illness. In both cases those officers who were negative toward social drinking (disagreed with the statement) were the most likely to define alcoholism as an illness. On items regarding responsibility, those who agreed that abstinence is better were more likely to believe that alcoholics cannot control their drinking ($F = 9.910$, $p = .0019$) and that alcohol is an addictive substance ($F = 10.458$, $p = .0014$). Officers who were against getting drunk occasionally also were more likely to agree with the addictive quality of alcohol ($F = 4.531$, $p = .0346$).

Only the "getting drunk" and "abstinence" items were included as background variables in examining attitudes toward alcoholics, but neither yielded any statistically significant difference. Thus social drinking attitudes did generate some patterned differences on two of the three focus issues, but in an interestingly paradoxical manner. On the objective knowledge scale, those who agreed with the two "moderate drinking as good" items had significantly higher scores, while those who were "anti-getting drunk" and "pro-abstinence" had significantly more wrong. The paradox is that those who favored the latter

TABLE XLIII

MEANS, F-SCORES AND PROBABILITY FACTORS FOR ATTITUDE THAT GETTING DRUNK SOMETIMES IS OK IF ONE IS NOT DRIVING AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means			F-Score	Probability
	Agree	Disagree	Total		
Emotional Difficulties (7 = Positive)	4.69	4.80	4.73	0.554	.4578
Loss of Control (7 = Positive)	4.30	4.20	4.26	0.332	.5652
Prognosis for Recovery (1 = Positive)	2.78	2.91	2.83	0.745	.3893
Steady Drinker (7 = Positive)	5.04	5.12	5.07	0.250	.6175
Character Defect (1 = Positive)	3.13	3.43	3.25	2.676	.1036
Social Status (1 = Positive)	2.70	2.70	2.70	0.000	.9880
Illness (1 = Positive)	3.09	2.68	2.92	6.216	.0135
Harmless Indulgence (1 = Positive)	2.44	2.42	2.43	0.027	.8699
Addiction Liability (7 = Positive)	4.80	5.11	4.93	4.531	.0346
Can Inherit Alcoholism	3.51	3.60	3.55	0.098	.7544
Compel Alcoholic to Get Treatment	4.23	3.84	4.08	2.059	.1530
Alcoholic Needs Help to Stop Drinking	3.79	3.96	3.86	0.350	.5549
(N)	(111)	(75)	(186)		

TABLE XLIV

MEANS, F-SCORES AND PROBABILITY FACTORS FOR ATTITUDE THAT MODERATE DRINKING IS GOOD TO PROMOTE SOCIABILITY AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means			F-Score	Probability
	Agree	Disagree	Total		
Emotional Difficulties (7 = Positive)	4.60	4.75	4.72	0.729	.3944
Loss of Control (7 = Positive)	4.28	4.25	4.26	0.012	.9126
Prognosis for Recovery (1 = Positive)	3.09	2.76	2.83	3.123	.0789
Steady Drinker (7 = Positive)	4.89	5.12	5.08	1.840	.1766
Character Defect (1 = Positive)	3.53	3.16	3.24	2.678	.1035
Social Status (1 = Positive)	3.07	2.60	2.70	8.306	.0044
Illness (1 = Positive)	3.26	2.84	2.92	4.263	.0404
Harmless Indulgence (1 = Positive)	2.62	2.38	2.43	2.338	.1280
Addiction Liability (7 = Positive)	4.70	4.98	4.93	2.574	.1103
Can Inherit Alcoholism	3.66	3.52	3.55	0.157	.6925
Compel Alcoholic to Get Treatment	4.38	3.98	4.06	1.377	.2422
Alcoholic Needs Help to Stop Drinking	3.92	3.86	3.87	0.033	.8567
(N)	(38)	(146)	(184)		

TABLE XLV

MEANS, F-SCORES AND PROBABILITY FACTORS FOR ATTITUDE THAT MODERATE DRINKING IS GOOD TO RELAX FROM TENSION AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means			F-Score	Probability
	Agree	Disagree	Total		
Emotional Difficulties (7 = Positive)	4.80	4.68	4.73	0.597	.4408
Loss of Control (7 = Positive)	4.17	4.31	4.26	0.664	.4162
Prognosis for Recovery (1 = Positive)	2.84	2.83	2.83	0.009	.9251
Steady Drinker (7 = Positive)	4.93	5.17	5.08	2.889	.0909
Character Defect (1 = Positive)	3.26	3.24	3.25	0.021	.8836
Social Status (1 = Positive)	2.85	2.60	2.70	3.181	.0761
Illness (1 = Positive)	3.07	2.82	2.92	2.285	.1323
Harmless Indulgence (1 = Positive)	2.58	2.34	2.43	3.309	.0705
Addiction Liability (7 = Positive)	4.80	5.01	4.93	2.113	.1477
Can Inherit Alcoholism	3.86	3.35	3.55	3.104	.0798
Compel Alcoholic to Get Treatment	4.00	4.11	4.07	0.147	.7018
Alcoholic Needs Help to Stop Drinking	3.67	3.99	3.86	1.310	.2540
(N)	(73)	(112)	(185)		

TABLE XLVI

MEANS, F-SCORES AND PROBABILITY FACTORS FOR ATTITUDE THAT VOLUNTARY ABSTINENCE IS BETTER THAN ANY ALCOHOL AS IT RELATES TO MARCUS MEAN FACTOR SCORES AND OTHER ALCOHOLISM ATTITUDES

Variable	Means			F-Score	Probability
	Agree	Disagree	Total		
Emotional Difficulties (7 = Positive)	4.77	4.65	4.73	0.683	.4097
Loss of Control (7 = Positive)	4.45	3.91	4.26	9.910	.0019
Prognosis for Recovery (1 = Positive)	2.86	2.78	2.83	0.279	.5980
Steady Drinker (7 = Positive)	5.22	4.81	5.08	7.910	.0055
Character Defect (1 = Positive)	3.34	3.09	3.25	1.771	.1849
Social Status (1 = Positive)	2.70	2.69	2.70	0.007	.9321
Illness (1 = Positive)	2.86	3.02	2.92	0.896	.3452
Harmless Indulgence (1 = Positive)	2.40	2.50	2.43	0.620	.4319
Addiction Liability (7 = Positive)	5.09	4.63	4.93	10.458	.0014
Can Inherit Alcoholism	3.59	3.48	3.55	0.138	.7108
Compel Alcoholic to Get Treatment	4.21	3.80	4.07	2.088	.1502
Alcoholic Needs Help to Stop Drinking	3.99	3.63	3.86	1.556	.2138
(N)	(119)	(66)	(185)		

two attitudes were significantly more likely to agree to attitude factors that most "experts" now consider information or fact rather than opinion. Thus, in one way they were the more "knowledgeable" group. This contradiction is being pointed out because it is one more in a growing list of results in this research to confirm that alcohol knowledge and attitudes are a much more complex matter than many studies of the past seem to indicate.

Summary

Four major conclusions emerged from investigating background variables in relation to attitudes (especially when compared to knowledge relationships). 1) There was virtually no relationship between how much an officer knew about alcohol/alcoholism or how much alcoholism training he or she had had and his/her attitudes toward alcoholism or alcoholics. 2) There also was no relationship between knowledge or sum of training and whether an officer needed or wanted further alcoholism training; yet those who needed and wanted more alcoholism training were significantly more positive in most of their attitudes toward alcoholism and toward alcoholics than those who didn't, except for those needing and wanting more training being likely to hold more stereotyped views of alcoholics on that semantic differential component. In fact, needing and wanting more training were the background variables which yielded the greatest number of statistically significant relationships with attitudes. This suggests that alcoholism education focused on attitudes rather than the traditional approach to

cognitive knowledge might be more successful.[18] 3) Part of the examination of background variables was a search for who probation/parole officers used as a reference group for their attitudes. The only background variable which showed much consistency across all three focus variables (knowledge and attitudes toward alcoholism and alcoholics) was sex. Sex differences, however, are more likely to be a product of sex-role socialization than a reference group orientation. It was concluded, therefore, that members of the occupation itself may provide the major reference group for one's attitudes. This conclusion needs to be tested further with comparative studies of other occupations and more studies of occupational socialization. 4) Several contradictory results lent further support to the conclusion reached in an earlier section of the chapter that attitudes in the area of alcoholism are far more complex than many previous studies have indicated. This, too, has important implications for alcoholism education.

Organizational Constraints

It was noted in Chapter II that labeling theory has been accused of focusing on society's official labeling process to the point of excluding the more informal interaction process. However, other labeling theorists (e.g., Hawkins and Tiedeman, 1975; Schur, 1971; 1979) were pointed to as urging that in interaction with deviants, there is more than one level of audience whose reactions are important in deviance outcomes. It is clear that the focus of this research is a social con-

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[18] This conclusion and its relation to the first one will be discussed in more detail in the next chapter.

trol agent who interacts at an important informal level with alcoholic offenders. Nevertheless, for all the emphasis on the primary interaction between the probation/parole officer and her or his clients, it cannot be forgotten that the probation/parole officers also are members of a formal social control organization. In that role, "they implement the broader and more diffuse societal definitions through organized structures and institutionalized procedures" (Schur, 1971:13). Therefore, the constraints imposed by the formal organization as perceived by the probation/parole officer cannot be ignored, for they too usually influence the officer's attitudes with implications for interaction with clients. A few of those organizational imperatives were indirectly measured in this research. They were tested against attitudes with AOV to see if they were related to the attitudes of probation/parole officers toward the focus variables.

Specialization

In Chapter III it was indicated that some human services professions are attempting to train their members to generalize their functions, in spite of the specialization inherent in modern organization. It also was pointed out that the probation/parole officer is a logical person to engage in some of this role expansion since she or he is a major figure on the interface between the offender and other parts of the formal social control structure, e.g., alcoholism treatment programs. At the same time, it also was expected that probation/parole officers would resist attempts to expand their role, based on previous studies.

One method of exploring this expectation was to ask officers

specifically about working with alcoholic clients. It may be recalled that these variables had some important relationships to knowledge issues. They were not so strongly related to attitudes toward alcoholism or alcoholics, but they did exhibit some informative patterns. As Table XLVII shows, 77.4% agreed that helping alcoholics requires special training (compared with 73% of Robinson's, 1976, probation officers). Among Robinson's probation officers, 39% felt they had something to offer alcoholics in their job, but 67.5% of the officers in this study felt they did. Furthermore, 82.8% disagreed that helping clients with drinking problems was a low professional priority. However, only 27.8% agreed they would like to be a worker with special responsibility for alcoholics in their agency, compared to 17% of Robinson's probation officers. The probation/parole officers in this study indicated more interest in helping alcoholics than did Robinson's (1976) probation officers. However, while they felt they could and should help alcoholics, not many wanted to do it full-time. In fact, examining relationships (or lack of them) just among these variables provides some interesting insights. Probation/parole officers who would like special responsibility for alcoholics ($\overline{X}$ = 3.29) were significantly more likely than those who would not ($\overline{X}$ = 2.99) to feel that helping alcoholics requires special training (F = 4.711, p = .0313). Neither of the other items, "could" and "should" help, were related to the item about special training. Officers who agreed that helping alcoholics held a low priority for them ($\overline{X}$ = 2.47) also were more likely than those who disagreed on that item ($\overline{X}$ = 2.09) to say they did not have much to offer alcoholics (F = 5.807, p = .0169), indicating some recognition of their limitations. But there was no

TABLE XLVII

ATTITUDES OF PROBATION/PAROLE OFFICERS
TOWARD ALCOHOLIC CLIENTS

Item	Definitely Disagree		Tend to Disagree		Tend to Agree		Definitely Agree		Total	Mean
	N	%	N	%	N	%	N	%		
Helping Alcoholics Requires Special Training	9	4.8	33	17.7	77	41.4	67	36.0	186	2.68
Don't Have Much to Offer Alcoholics	40	21.6	85	45.9	51	27.6	9	4.9	185	2.16
Helping Alcoholics Has Low Priority	72	38.7	82	44.1	18	9.7	14	7.5	186	1.86
Would Like Special Responsibility for Alcoholics	71	38.6	62	33.7	29	15.8	22	12.0	184	2.01
Refer Alcoholic Clients for Help Part of Job	1	0.5	5	2.7	27	14.6	152	82.2	185	3.78
Counsel Alcoholic Clients Not Part of Job	111	60.0	62	33.5	10	5.4	2	1.1	185	1.48
Break Drinking Rules Sufficient for Revocation	24	13.0	87	47.3	59	32.1	14	7.6	184	2.34
Drinking Problem Sufficient for Revocation	73	40.3	84	46.4	21	11.6	3	1.7	181	1.75
Ignore Drinking Problem Until More Serious Violation	96	51.6	78	41.9	9	4.8	3	1.6	186	1.56

statistically significant relationship between having something to offer and wanting special responsibility.

Probation/parole officers who had been with the agency for over ten years were significantly more likely than others to feel that they had something to offer alcoholics ($F = 3.666$, $p = .0134$).[19] Also, those who had smaller case loads ($\bar{X} = 2.00$) felt they had more to offer ($F = 5.107$, $p = .0252$) than did those with the larger case loads ($\bar{X} = 2.28$). Regarding implications for interaction with alcoholics, the relationship between this item and district was one for concern, because it fit into a strange pattern.

Officers in three districts were significantly more likely to feel they had something to offer alcoholics than officers in the other four districts ($F = 3.530$, $p = .0025$). One of these, District D ($\bar{X} = 1.89$), also had the most correct on the knowledge scale, and was significantly more likely to regard alcoholism as an illness and be most optimistic about prognosis for recovery. Even with all these positive attitudes, they were the district second most likely to want even more training (84.2%). The second district with members more likely to feel they had something to offer ($\bar{X} = 1.88$) presented a contradiction between knowledge and attitudes. It was District A, with the lowest mean score on the knowledge scale; but in statistically significant relationships,

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[19]Time with the agency was not related to any of the other attitudes about working with alcoholics, but on this issue, the officers who had been there over ten years were much different than others, with a mean of 1.61. This compared to $\bar{X} = 2.09$ for officers there less than a year, $\bar{X} = 2.19$ for those there 1 - 5 years, and $\bar{X} = 2.34$ for those with the agency 6 - 10 years. It is interesting to note that officers with the agency less than a year were second most likely to disagree that they did not have much to offer alcoholics.

its members were second behind District D in viewing alcoholism as an illness and being optimistic about recovery; they also were significantly more likely to want further training (90.6%) than officers in any other district. However, District F, the third district ($\overline{X}$ = 1.89) was the one to give cause for concern regarding implications for interacting with alcoholic clients. They had the third lowest mean score on knowledge; they also were the district significantly <u>least</u> likely to see alcoholism as an illness and second least optimistic regarding prognosis. In spite of their most negative attitudes, but apparently in keeping with feeling they had something to offer, they were the district significantly least likely to want further training (52.6%); it was not statistically significant, but officers in this district also were the least likely to feel they needed more training (52.6%). Reflecting back to Table I on page 67, Districts D, A and F also were very different in their age and sex composition and in their educational levels; one is urban while two are rural, and they are in three different areas of the state. In fact, there was almost nothing similar about these three districts except on characteristics or attitudes where all seven districts were similar. These districts were described in some detail because they illustrate so well the theoretical orientation central to this study.

Three groups of people come to a similar definition of the situation, that they can help alcoholics. But these examples demonstrate that labeling theory cannot end its analysis with identifying a simple definition of the situation, because the patterns of "social and social-psychological dynamics that influence definitions" (Suchar, 1978:230) more than likely would result in very different reactions to deviants

(alcoholics in this case), albeit with a similar definition of the situation.

In general, views about working with alcoholic clients did not result in any pattern of statistically significant relationships regarding attitudes toward alcoholism for most issues, but as with several other background variables, two of them were related to prognosis. Officers who indicated helping alcoholics was not a low priority ($\bar{X}$ = 2.75) were more optimistic regarding prognosis (F = 6.584, p = .0111) than were those who felt it was a low priority ($\bar{X}$ = 3.25). Also, those who felt they had something to offer alcoholics (F = 9.413, p = .0025) were more optimistic about recovery from alcoholism ($\bar{X}$ = 2.68) than those who felt they did not have much to offer ($\bar{X}$ = 3.16). The two items just mentioned plus the item about liking special responsibility for alcoholics also had AOV's computed relative to attitudes toward normal versus alcoholic people. The three items as background variables accounted for sixty AOV's on this set of attitudes, only one of which was statistically significant at the .05 level or lower.

Aside from the special task of working with alcoholics, workers in any agency have a variety of other specialized tasks. The probation/parole officers were asked to rank ten activities according to how much time was actually spent doing them and according to how much time ideally should be spent on them. As with treatment organizations, some officers apparently were confused about the ranking system and would list several tasks "1," etc. In addition, most supervisory personnel did not respond to the item because the activities were based primarily on field worker tasks. Thus results on this item were based on an N of 116. Table XLVIII displays the tasks in rank order, along

with their mean ranks. One activity relevant to a major purpose of this study should be pointed out. Although officers ranked inservice education as ninth in terms of actual time involvement, it was ranked sixth in terms of ideal involvement. This suggests they may be open to more training than they have had in the past.

TABLE XLVIII

RANK ORDER AND MEAN RANK OF ACTUAL AND IDEAL TIME ALLOTMENT TO SPECIALIZED WORK ACTIVITIES OF PROBATION/PAROLE OFFICERS

	Actual Rank		Ideal Rank	
Rank	Activity	Mean Rank	Activity	Mean Rank
1.	Paper Work	1.50	Supervise Clients	1.62
2.	Supervise Clients	2.31	Counsel Clients	1.92
3.	Counsel Clients	3.55	Consult with Other Agencies	4.72
4.	Consult with Fellow Workers	4.54	Consult with Fellow Workers	5.40
5.	Consult with Other Agencies	6.25	Paper Work	5.81
6.	Consult with Supervisor	6.46	Inservice Education	6.04
7.	Court Appearances	6.69	Consult with Supervisor	6.92
8.	Staff Meetings	6.94	Job-Related Conferences	7.53
9.	Inservice Education	8.36	Staff Meetings	7.59
10.	Job-Related Conferences (N = 116)	8.67	Court Appearances	7.75

Especially relevant to the issue at hand are the specialized activities of supervising and counseling clients since they may reflect contradictory philosophical orientations regarding one's job (Sutherland

and Cressey, 1978).[20] As noted in Chapter III, both are included in the Oklahoma job description for probation/parole officers, although supervision is listed first. Supervision is ranked higher than counseling on both actual and ideal job lists, although the mean difference between actual and ideal time involvement is greater for counseling (1.63) than for supervision (0.69). On the list of activity ideal time involvement, it should be noted that although supervision is ranked first, compared to other job tasks, they are essentially rated as of equal concern to probation/parole officers: supervision, $\overline{X} = 1.62$; counseling, $\overline{X} = 1.92$; third highest mean is 4.72, for consulting with other agencies. Because both the professional criminologists (e.g., Sutherland and Cressey, 1978) and the probation/parole officers defined these as reflecting different orientations, those who ranked supervision as most ideal (N = 68) and those who listed counseling as most ideal (N = 42) were each compared with those who listed something else as most important job task.[21] Perhaps preferring supervision versus counseling does reflect differing orientations on other topics, but they certainly were not very important with regard to alcoholism knowledge

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[20]It was pointed out earlier in this chapter that many of the probation/parole officers themselves distinguished between the officers with "cop" versus "social work" orientations to their work, similar to Sutherland and Cressey's (1978) surveillance versus guidance.

[21]Another background variable was constructed which included supervision, counseling, and other as ideal tasks, in an effort to compare the two job tasks against one another. During data analysis though, it was discovered that apparently due to computer programming error, those who responded to the item incorrectly were included in the "other" category, so it had to be eliminated. However, in the separate analyses of each task compared with "other," the same goal essentially was accomplished. Supervision or counseling was listed as most important by 110 of the 116 responding to this question correctly, so the "other" category in each case was basically the opposite task.

and attitudes toward alcoholism, alcoholics, or working with alcoholics. The only significant difference other than an isolated one about alcoholism being a voluntary harmless indulgence is that those who ranked counseling most ideal were significantly more likely to need (X^2 = 5.341, p = .0208) and want (X^2 = 3.863, p = .0493) further alcoholism training. Eighty-three and three-tenths per cent of those who ranked counseling first needed and 85.7% wanted more training, compared with 60.8% needing and 67.1% wanting more training among officers who listed another task as most ideal.

In the preceding section some items measuring general attitudes toward clients were described as being somewhat consonant with the two specialized work tasks discussed here. Those items yielded results which might describe the probation/parole officers as more counseling than supervision-oriented. They, too, did not reflect differences in alcoholism attitudes except that those who agreed with the "counseling-type" attitudes were more optimistic regarding prognosis for recovery.

Efficiency

Every organization has efficiency goals; in fact, sometimes they eventually become more important than effectiveness in achieving stated goals (Merton, 1957). In Chapters II and III it was noted that Hawkins and Tiedeman (1975) pointed out that organizational members often resort to "processing stereotypes" in order to meet efficiency requirements.

It was felt that perhaps size of case load might be a factor involved in the development of processing stereotypes. In Chapter IV it was indicated that the mean ideal size case load expressed by the probation/parole officers was 48, while the mean actual case load was

74. The officers were divided into two groups based on the median for size of case load, which was 76, and their attitudes compared. They were not too different from one another in attitudes toward alcoholism. Given the nature of the background variable, the two factors which did result in statistical significance (loss of control and steady drinker) could have occurred by chance. Perhaps more important is a difference noted earlier, that those with the larger case loads were significantly more likely than those with the smaller case loads to feel they did not have much to offer alcoholics ($F = 5.107$, $p = .0252$). As has been demonstrated, several other background variables also were related to this item, but it is not difficult to understand why officers with larger case loads would feel they had little to offer clients outside the strict confines of job description. However, at the same time they were almost exactly alike in needing and wanting further alcoholism training (for both, $X^2 < 0.001$, $p = 1.000$); over 70% of each group needed and wanted more training, so at least they were interested in it regardless of how many clients they had. Size of case load had absolutely no bearing on attitudes toward alcoholics.

One example of work performed in the official job description for probation/parole officer is "maintains detailed records, and issues periodic reports," in addition to writing special reports on pre-sentence and pre-parole investigations (see Appendix A). Hawkins and Tiedeman (1975) referred to paper work as one example of the push for efficiency which may lead to processing stereotypes. Referring back to Table XLVIII, it can be seen that the probation/parole officers in this study ranked paper work far above any other task in time actually involved; in fact, 78.2% of those responding to the item ranked it first in time

spent, although it was ranked fifth in ideal time involvement. Officers who ranked paper work first in actual time spent were compared with those who ranked something else first, but it was a very unimportant background variable as it related to knowledge issues, alcoholism attitudes, or views about working with alcoholics. (Out of 19 AOV's on these issues, one was statistically significant.)

Size of case load and perception of time spent doing paper work admittedly are crude measures of the emphasis on efficiency which is present in almost any formal work organization. As the only ones available in the present survey, they did not relate to attitudes in any really meaningful way. One factor that might be involved is that if case loads were as large as some of those described by Sutherland and Cressey (1978) and reported in Chapter IV, size of case load might have made more of a difference. Even here it made a difference in whether officers felt they had much to offer alcoholics. Secondly, the range of case load size was not wide enough for the feeling of relative deprivation to operate enough to significantly affect attitudes. Third, paper work probably is accepted as a realistic given in any government job and just does not affect attitudes in many areas; in fact, five work activities were ranked <u>below</u> it even on the ideal list. Fourth, if goal displacement (Merton, 1957) occurred to the point where the officer placed paper work at the top of work goals and became a ritualist, then it might make a real difference (only two officers ranked it first on the ideal list). Fifth, although there is somewhat of a feeling of impersonality to it, "objective" client classification is now done through the use of standardized forms by Oklahoma probation/parole officers (Collins, 1978). It is possible that these forms actually reduced paper

work and produced functional "processing stereotypes."

Differential Power

In Chapter III it was pointed out that probation/parole officers have legitimate power over probation/parole clients, along with several other factors that could lead to differing definitions of the situation between officers and clients and potential conflict. How officers perceive their right and/or need to use their legitimate power over clients certainly could influence their interaction. This can be particularly important with alcoholic clients because of probation/parole rules about drinking. Several items constructed for this research attempted to tap officers' perception of this power relationship in general and specifically as it relates to drinking rules. Reference back to Table XLVII shows the distribution of some of these attitudes among the probation/ parole officers.

As reported earlier, 24.8% of the officers agreed that the best way to work with clients is to make sure they remember who is boss, while 42.7% thought the best way was to keep them mindful of revocation potential. Neither of these attitudes was related meaningfully to alcoholism attitudes. However, they *were* related to some items relevant to the current discussion. The item about remembering who is boss was significantly related to the Marcus item about compelling alcoholics to get treatment; those who agreed with the boss item had a mean of 4.80 compared to a mean of 3.83 for those who disagreed, indicating that those who agreed also were much more likely to feel that alcoholics should be compelled to go to treatment ($F = 10.132$, $p = .0017$). Those who agreed to keeping clients aware of revocation possibility also were

more likely to agree that breaking rules about drinking should lead to revocation ($F = 4.624$, $p = .0329$).

The item just mentioned about breaking drinking rules being sufficient cause for revocation was agreed to by 39.7% of the officers. It was the only other item on attitudes toward clients which was tested as a background variable. It resulted in no statistically significant relationships relative to knowledge, alcoholism attitudes, or feelings about working with alcoholics. However, response to the item shows some inconsistencies with some of the others displayed in Table XLVII. Only 13.3% agreed that a client with an actual drinking problem should face revocation, while 96.8% of the officers agreed that part of their job was to refer alcoholic clients to an organization for help with their alcoholism. But almost 40% would send that person to prison for just drinking, which certainly is not going to treat the alcoholism in most cases. In addition, 93.5% felt <u>counseling</u> alcoholic clients about their drinking problem was part of their job, and only 17.2% felt that <u>helping</u> clients with drinking problems was a low job priority. In short, all the other items relating to alcoholic clients had such consistency to their response distribution, that the response to the item about revocation for drinking was mystifying, even if it was related to the more general attitude of keeping clients mindful that violations could result in revocation.

It has been reported throughout this chapter that on the whole, the probation/parole officers in this sample were nonauthoritarian, counseling-oriented, etc. However, the present discussion reveals that a considerable number still have some overlapping attitudes which suggest they are very aware of their differential power and would be pre-

pared to use it. Just as with the overlapping medical/moral view toward alcoholism which represents a current change process, so too may general probation/parole attitudes be in a state of flux. As noted previously, Sutherland and Cressey (1978) indicated that views in probation/parole work are shifting from a surveillance or punitive orientation to a guidance or counseling one, and both are a part of the probation/parole officer job description. One example of work performed is "supervises the activities of probationers and parolees to insure their compliance with the terms of the probation or parole order" (see Appendix A).[22] Thus, just as with alcoholism professionals, probation/parole officers appear to be members of an occupation in the process of change. During that change period, they undoubtedly will have some contradictory views, probably reflected in some contradictory behavior with clients.

Multiple Goals

Chapter III referred to multiple goals on the part of both probation/parole officers and the organization which can impact on a client in the dual role of offender and alcoholic. Some of the problematic consequences for officers holding those multiple goals have just been

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[22]The conflict apparent even within the same officer's views is supported further by the fact that until a few months prior to this writing, probation/parole officers in Oklahoma went through basic training with institutional correctional officers. Thus, even those who are basically counseling-oriented have been given training in being a supervisory law officer. This is not to suggest that the supervisory function should be removed from their job duties, because by definition both probation and parole are conditional freedom (Sutherland and Cressey, 1978:498, 635). The concern of the researcher is that if the surveillance part of the job continues to be applied to alcoholic offenders by some probation/parole officers, the alcoholics will continue to be punished while their disease goes untreated. Without treatment, their criminal careers are likely to continue (Pittman, 1974).

discussed. The organization they work for also has multiple stated (and unstated) goals. As in all formal work organizations, the agency's pursuit of certain goals is beyond the employee's control. On the other hand, as Robinson (1976) emphasized throughout his book, officers' individual perceptions of those goals also have many implications for their behavior. Therefore, several items questioned their perception of organizational goals, both general and specifically related to drinking and/or alcoholic behavior. An attempt was made to organize the general goals into an index. While individual items had correlations ranging from $r = .4324$ to $r = .7100$ with the total score, there was almost no intracorrelation among items. Thus, items were explored individually.

As indicated in Table XLIX, the probation/parole officers were most likely to perceive their agency's general philosophy toward clients as humanistic (80.5%), followed by rehabilitative (75.2%), with punitive (28.8%) and protective (27.9%) being far behind. Except for the contradictory view held by 40% that breaking rules about drinking should lead to revocation, these perceptions were fairly consonant with their personal views toward clients. AOV's were computed relating perceptions of general organizational philosophy to knowledge and alcoholism attitude issues. Perception of the agency philosophy as punitive was the only one which revealed any patterned statistically significant relationships. Officers who felt the organization was punitive had a lower average number correct ($\overline{X} = 21.09$) on the knowledge scale ($F = 5.177$, $p = .0241$) than did others ($\overline{X} = 22.88$). They also were less likely ($\overline{X} = 2.87$) than other officers ($\overline{X} = 3.16$) to agree that special training is required to help alcoholics ($F = 4.527$, $p = .0347$). It is not surprising, then, that those who perceived the organization as punitive also

were less optimistic ($\bar{X}$ = 3.10) about prognosis for recovery (F = 5.525, p = .0198) than were other officers ($\bar{X}$ = 2.71). These results support the suggestion made above about the overlap of contrasting views during a period of role change.[23]

TABLE XLIX

PERCEPTIONS OF PROBATION/PAROLE OFFICERS OF ORGANIZATIONAL PHILOSOPHIES

Organizational Philosophy	Definitely Disagree		Tend to Disagree		Tend to Agree		Definitely Agree		Total	Mean
	N	%	N	%	N	%	N	%		
Humanistic	11	5.9	25	13.5	116	62.7	33	17.8	185	2.92
Rehabilitative	11	5.9	35	18.9	93	50.3	46	24.9	185	2.94
Punitive	34	18.5	97	52.7	46	25.0	7	3.8	184	2.14
Protective	39	21.0	95	51.1	46	24.7	6	3.2	186	2.10
Unconcerned about Drinking Rule Unless Break More Major Rule	21	11.4	63	34.2	73	39.7	27	14.7	184	2.58
Unconcerned about Drinking Problem Unless Create Legal Problem	21	11.4	74	40.2	69	37.5	20	10.9	184	2.48

When questioned about perceptions of agency views on alcohol-

[23]The other three general organizational philosophies resulted in 51 AOV's on knowledge and alcoholism attitude variables and attitudes toward working with alcoholic clients. Of those 51, only three (on scattered Marcus factors) were statistically significant at the .05 level or below.

related matters, there was more contrast with personal views. It will be remembered that almost 40% of the officers felt breaking rules about drinking was sufficient cause for revocation. In clear contrast, though, 54.4% agreed that the agency "does not get too concerned if clients break probation or parole rules about drinking, if they are not breaking more major rules." Views on that item were not related in a statistically significant way to knowledge, alcoholism attitudes, or attitudes about working with alcoholics. Another clear-cut contrast emerged on a related issue. As a personal view, only 6.4% of the officers agreed that a client's drinking problem should be ignored unless he/she "breaks a major law or commits another serious probation or parole violation." On the other hand, 48.4% felt the "agency is not too concerned about clients' alcohol problems unless they create legal problems." Interestingly, officers who agreed that the agency had this lack of concern about client alcoholism also were more likely to relegate clients' drinking problems to a low priority than other officers ($F = 5.355$, $p = .0218$). They also felt they had less to offer alcoholics than other officers ($F = 10.106$, $p = .0017$). It should be pointed out that those officers were not blatantly disregarding alcoholic clients; that is, they still basically disagreed ($\overline{X} = 2.01$) that helping alcoholics was a low priority, just significantly less so than other officers ($\overline{X} = 1.72$) on AOV. They were basically at the neutral point on not having much to offer alcoholics ($\overline{X} = 2.35$), compared to clear-cut disagreement ($\overline{X} = 1.98$) among officers who felt the agency was concerned about drinking problems. Nevertheless, there was a slight pattern emerging which showed some consistency between the officer's personal view and his/her perception of the agency's view

toward alcoholic clients.

Returning to the sample as a whole, though, it is obvious that the officers expressed considerably more concern about clients' drinking behavior and drinking problems than they perceived the agency to have. These contrasts have important implications for both officer behavior toward alcoholic clients and educational efforts. Personal conversation with several officers at the state level in the Department of Corrections indicated to the researcher that they _are_ concerned about client drinking problems, but this concern apparently has not been fully communicated to the officers in the field. Thus, if officers do not feel they have agency support, they may not get as involved in assisting alcoholic clients as they might otherwise. It must be remembered they are accountable to the agency for the way they spend their time, and workers almost anywhere will engage in work activities they feel the agency is most likely to reward them for. Regarding educational implications, it will be recalled that the officers felt they should spend more time in inservice education than they actually do. It seems advisable that agency officials be aware of this fact as well as the discrepancy between their concern and officers' perception of it when planning alcohol educational efforts.

Summary

This section examined organizational variables and their potential influence on probation/parole officer attitudes. Most officers felt they could and should help alcoholics in the course of their job, although just over a fourth would like that as a special responsibility. Almost 95% of the officers felt supervising or counseling clients was

their most important job task, with supervision seen as slightly more important. However, when questioned about alcoholic clients in particular, they seemed to be more counseling-oriented except that 40% thought breaking probation/parole rules about drinking was sufficient cause for revocation. Most officers also perceived the agency's general philosophy as rehabilitative and humanistic instead of punitive or protective; those who perceived the organization as punitive were less knowledgeable and more negative than other officers. Examining officers' views about specialization, differential power over clients, and agency philosophy suggested one common theme: there may be a general surveillance/guidance overlap (Sutherland and Cressey, 1978) in the attitudes of many officers regarding their job at a time when their role is undergoing a great deal of change.

In spite of this important finding about general orientations toward their job, organizational variables made little difference in probation/parole officers' knowledge or attitudes toward alcoholism in general, but they were related to attitudes (and thus, possible behavioral predispositions) about actually working with alcoholic clients. In addition, there was a considerable discrepancy between officers' views about clients' drinking and alcoholic clients and what they perceived the agency's views on the same subject to be, with the officers feeling they were more concerned than the agency about such problems.

Attitudes and Behavior

It has been made clear in this chapter that probation/parole officers in Oklahoma tended to hold negative stereotypes about alcoholic

people, although a great deal of ambivalence was shown regarding how to view alcoholism as a condition. It was shown in Chapter II that stereotypes affect behavior of other human services professionals toward alcoholic clients. It has been shown here that officers hold some clear-cut views about working with alcoholic clients, although again with some ambivalence present. Some of these views are not consonant with what they perceive their agency's philosophy to be. Based on the organizational orientation and studies of other professions presented in Chapter II, it seems logical that these views (including ambivalence) would be conveyed to alcoholic clients. Nevertheless, regardless of the logic and knowledge that attitudes result in behavioral *predispositions*, to demonstrate that the attitudes *do* lead to particular behavioral outcomes is a difficult and sometimes controversial task. Obviously the only accurate way to measure this relationship would be to actually observe behavior. However, as proposed in Chapter III, to follow the theoretical orientation through to its logical conclusion, that labeling results in behavioral reactions, some questions were asked to provide tentative exploration of this relationship. It was hoped that this exploration might provide some broad guidelines for future research in this area.

To probe the relationship between attitudes and behavior, officers were asked in an open-ended question, "What sorts of things might generally lead you to suspect that a client might have a drinking problem or be an alcoholic?" Space was provided to code up to four symptoms for each respondent, although a few listed more than that. In that case, either the first four symptoms listed were coded, or if some symptoms fell into basically similar categories, the widest variety

possible was coded. (Examples of specific officer comments which were placed in coding categories are in Appendix K.)

Next, officers were asked a series of questions about the most recent male and female alcoholic client they had encountered. They were asked how long ago the encounter occurred, how the officer knew there was a drinking problem, what she/he had recommended the client do, and what the client did. Space was provided to code two symptoms, two recommendations, and two client follow-up behaviors. (Examples of what sorts of comments were placed in the categories are in Appendix L.) It is obvious that there cannot be adequate correspondence between general issues and a specific case. However, there still is some opportunity to see if the probation/parole officers even used what they defined as symptoms in actual behavior and if they utilized the treatment resources they said they were aware of.

Symptoms

Table L indicates symptoms or signs officers stated they would use to suspect a drinking problem or alcoholism in a client. O'Connor (1980) suggested that if people wait until repeated obvious intoxication signs appear to suspect a drinking problem, then an alcoholic may not be discovered until he/she has reached the later stages of the disease. She proposed that to detect alcoholism in its earlier stages so treatment can be gotten earlier, other patterns should be watched for, e.g., repeated domestic, job, legal, or financial problems.

There was no way to discern in what order probation/parole officers would utilize the symptoms they described, but they seemed to have some awareness of advice similar to that given by O'Connor. Not surprisingly,

TABLE L

SYMPTOMS DESCRIBED BY PROBATION/PAROLE OFFICERS TO DETECT ALCOHOLISM OR A DRINKING PROBLEM IN A CLIENT

Variable		N	Per Cent
Legal Problems		111	65.7
Alcohol-Related Arrests	45.6%		
Other Arrests	20.1%		
Job-Related Problems		104	61.5
Behavior and Personality		90	53.3
Client Admission	3.0%		
Intoxication Signs	10.1%		
Drinking Signs	8.9%		
Personality Traits	8.9%		
Reporting Behavior	4.7%		
Irresponsibility	4.1%		
Low Self-Image	1.8%		
Other or Vague	11.8%		
Appearance		87	51.5
Excessive drinking signs	26.0%		
"Appearance," Ill-Defined	21.9%		
Health	3.6%		
Living Patterns		67	39.6
Family Problems	34.9%		
Other or Vague	4.7%		
Reports or Complaints from Others		43	25.4
Financial Problems		21	12.4
(N = 169)[a]			

[a]Percentages based on N of 169 who responded to question; they total over 100% because many officers gave multiple responses.

the probation/parole officers most frequently mentioned legal problems (65.7%); alcohol-related arrests were the largest category (45.6%). But 20.1% mentioned other types of arrests or "general arrest record," etc.; it is uncertain how these could be used as drinking problem symptoms alone. Job-related problems were the second most frequent category (61.5%), followed by "behavior and personality" (53.3%). Only 3.0% mentioned clients admitting a problem, which is typical of most alcoholics until they are ready for treatment, but which also indicates officers were relying largely on other manifestations of alcoholism before clients acknowledged it. Ten per cent commented on intoxication signs, but 8.9% listed just drinking behavior. Unless combined with other symptoms, it seems the latter sign could reflect value judgments. It also should be pointed out that increased self-respect was described earlier as the most frequently mentioned criterion for successful alcoholism treatment (mean rank as third most important indicator); yet only 1.8% of the officers mentioned low self-image as a sign to suspect alcoholism.

Fourth was appearance (51.5%); 26.0% mentioned signs which are clearly related to drinking (mostly excessive drinking). However, 21.9% listed ill-defined physical signs (e.g., poor eyesight, tiredness) or just "appearance" or "looks." Without further information, these latter signs could be interpreted as stereotypes. Living patterns were mentioned by 39.6%, primarily family problems. Reports or complaints from other people, primarily family, were listed by 25.4%. Financial problems were noted least frequently, by 12.4%.

In sum, most officers listed signs or symptoms which would be advised by the alcoholism "experts." However, a substantial minority

also noted signs that could be defined as stereotypical or the results of value judgments unless more information were available.

Alcoholic Clients

Of the 170 probation/parole officers responding to the item, all but two discussed seeing male alcoholic clients, half within the past week. Several even said they had encountered such a client " a few minutes ago" or "today." Of the 166 who responded to the question about females, 41 (24.7%) stated they had never had a female alcoholic client. Among those who had, time length was in strong contrast to the males. Only 18.4% said they had seen a female alcoholic client in the past week, with the majority (61.6%) not having seen one for a a month, compared to 20.3% for male clients (see Table LI.)[24]

In response to the question of how the probation/parole officer knew drinking was a problem, the list bore little resemblance to what officers said they would look for. Alcohol-related arrests or offenses were the most frequently mentioned reasons for "knowing" the client had a drinking problem, much more so for male clients (46.4%) than for female clients (30.4%). That is the end of correspondence with symptoms described. Although only three per cent said they used client admission as a general symptom, here it was the second most frequent reason given for defining a client as alcoholic (except for "other behaviors" which will be discussed presently), slightly more often for females (22.4%) than for males (19.6%). Specific drinking-related behaviors (see Appendix L) were used as a sign more often for males (19.0%) than

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[24]Percentages for the remaining issues are based on those officers who described an encounter with alcoholic clients.

TABLE LI

PROBATION/PAROLE OFFICERS' DESCRIPTIONS OF MOST RECENT MALE AND FEMALE ALCOHOLIC CLIENTS ENCOUNTERED

Variable	Male		Female	
	N	%	N	%
How Long Ago				
One Week or Less	85	50.6	23	18.4
Over One Week to One Month	49	29.2	25	20.0
Over One Month to Six Months	26	15.5	46	36.8
Over Six Months to One Year	5	3.0	19	15.2
Over One Year	3	1.8	12	9.6
Never Had Such a Client[a]	2		41	
(N)[b]	(168)	100.1	(125)	100.0
How Officer Knew Drinking Was a Problem				
Client Admission	33	19.6	28	22.4
Alcohol-Related Offense	78	46.4	38	30.4
Official Report	16	9.5	14	11.2
Reports from Others	20	11.9	14	11.2
Drinking-Related Behavior	32	19.0	16	12.8
Other Specific Behaviors	36	21.4	33	26.4
Vague or Other	13	7.7	11	8.8
		135.5[c]		123.2[c]
Officer Recommendation				
Alcoholics Anonymous	69	41.1	51	40.8
Counseling	58	34.5	46	36.8
Hospital/Inpatient	34	20.2	16	12.8
Legal Action	21	12.5	10	8.0
"Lay Advice"	17	10.1	20	16.0
Nothing	4	2.4	5	4.0
Other	23	13.7	10	8.0
		134.5		126.4
Client Follow-Up on Problem				
Alcoholics Anonymous	40	23.8	22	17.6
Counseling	26	15.5	16	12.8
Inpatient Treatment	29	17.3	2	1.6
Legal Action	11	6.5	6	4.8
Nothing, Other Negative	44	26.2	46	36.8
Other Progress	22	13.1	24	19.2
Too Soon to Know	24	14.3	6	4.8
Unknown, Ambiguous	10	6.0	14	11.2
		122.7		108.8

TABLE LI (Continued)

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[a]Number who reported no client out of total number responding to question (males: N = 170; females: N = 166).

[b]All percentages based on number actually reporting encounters with alcoholic clients.

[c]Percentages total over 100% because some respondents listed two answers to the question.

for females (12.8%). In the general listing of symptoms, only two officers mentioned official records, but in terms of actual client-oriented behavior, they were used much more frequently. "Other specific behaviors" were used to "diagnose" 21.4% of the males and 26.4% of the females. As Appendix L indicates, this category encompasses almost all the rest of the symptoms probation/parole officers listed as signs (living patterns, job, appearance, financial, and behavior other than drinking).

At first glance it would seem the assertions early in this section had been negated, that the probation/parole officers did not act based on what they said. In terms of the way the researcher stated she would measure the attitude-behavior relationship (seeing if officers actually diagnosed clients on the basis of general symptoms they described), that is true. But if other factors are examined, the discrepancy might not be so great. The general question asked about symptoms which would lead the probation/parole officer to suspect a drinking problem, not what symptoms would they act upon. As pointed out while describing the symptoms, the officers listed many "textbook" symptoms, but as it has been repeatedly shown, there is very little relationship between objective knowledge and attitudes, so why should there be a necessary correspondence between objective knowledge and behavior?[25] The signs which officers seemed most likely to act upon were those which could not be ignored; that is, they appeared to notice an alcoholic client

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[25]This admittedly reflects an error in judgment by the researcher in constructing the questionnaire. The symptom item still is a legitimate one, but not appropriate for the purpose for which it was asked. This discrepancy could not have been ascertained on the pretest, because pretest respondents were college students who did not have probation/parole case loads.

"officially" when it was brought to their attention by outside factors (e.g., client admission, reports, arrests). Now this behavior does seem consonant with results discussed in the section just before this. That is, officers personally appeared to be more concerned about client drinking problems than they perceived their agency to be. It was pointed out there that officers are accountable to the agency for their time; thus if a drinking problem is brought to their attention, they cannot ignore it, but if they do not feel agency support they are likely not to seek out alcoholic clients to help even if they suspect there is a problem. This is one more example to support the contention discussed earlier that labeling theory cannot stop with simple definitions of the situation, but must look further for interpretations of behavior reactions.

When the recommendations made by probation/parole officers are examined (see Table LI), AA was recommended most often, just as it was mentioned most often in organizations available for referral in general. It was recommended to male and female clients equally (41.1% for males, 40.8% for females). Counseling was listed second most often, slightly more for females (36.8%) than for males (34.5%). It is difficult to compare these referrals with the general list, because many probation/parole officers did not cite specific programs, but were more vague (e.g., alcohol treatment program, physician, competent treatment, professional help). Hospitalization or other inpatient treatment usually is recommended for alcoholics in the later stages; it is significant that it was recommended more often for males (20.2%) than for females (12.8%). There ends the medical model. Still consistent with other findings regarding the surveillance/guidance overlap, 12.5%

either threatened or carried out legal action against males, 8.0% against females. Examples are revocation, violation report, promises of incarceration. Another category of advice given more frequently to females (16.0%) than to males (10.1%) was labeled "lay advice," corresponding to a certain extent with the medical/moral overlap, especially the responsibility issue (e.g., quit, cut down or control drinking; keeping time occupied, drop barrier he erected between us, don't drive). Again going beyond simple definition of the situation, these seemingly contradictory types of recommendations reflect contradictory views held simultaneously by some officers as well as the fact that officers were not unanimous in their views anyway.

Finally, officers were asked what the client did about his/her problem. Perceived client follow-up certainly did not reflect recommendations. Many fewer went to AA than were recommended to it (23.8% of the males, 17.6% of the females). Even worse results were reported about counseling recommendations. Counseling was recommended to slightly fewer males, but they were slightly more likely to go (15.5%) than females (12.8%). Particularly startling were follow-ups to inpatient treatment recommendations; apparently most males who had it recommended went (17.3%), but only 1.6% of the females were reported as going. (It should be pointed out that a very realistic problem for many women going to inpatient treatment is child care responsibility, especially if they are single parents, Asher, 1980). Legal action actually was taken in about half the cases where it was recommended for both sexes. Females (36.8%) were much more likely than males (26.2%) to be perceived as doing little or nothing about their problem (e.g., quit AA or poor AA attendance, wouldn't admit problem, very little,

continues to drink). On the other hand, although they were not perceived as getting their alcoholism treated, females (19.2%) were more likely than males (13.1%) to be seen as making other kinds of progress (e.g., slowed up on drinking, communicates with husband again, better attitude, doesn't drive, married supportive husband, did fine until he died).

On the issue of the relationship between attitude and behavior, there was not a perfect correspondence reported, but neither was there between knowledge and attitudes. However, if factors underlying the labeling process are examined, then some of the reported behavioral reactions become more meaningful, even in describing only two clients.

Further Behavioral Data, Especially Sex Differences

An unanticipated result of exploring this research question was to see that although male and female alcoholics were stereotyped in a similar negative manner on the semantic differential, on behavioral issues they were perceived quite differently. Probation/parole officers were considerably more likely to use evidence other than alcohol-related offenses to define females as alcoholic. At least in one respect their problem may not have been defined as being as serious as that of males in that they were less likely to have inpatient treatment recommended. Corresponding to this, they also were more likely to be given lay advice than referred to treatment for their alcoholism. In describing client follow-up, females were perceived as much less likely to actually get treatment for their alcoholism, but more likely to be

seen as making other forms of progress that may or may not have helped their drinking problem. In general, they also were much more likely to be seen as doing little or nothing about their problem. In one sense, then, females' alcoholism seemed to be taken much less seriously than males'. In another sense, they were viewed more negatively than males in what they did about it.

Part of the different perceptions probably can be explained by the fact that male alcoholic clients, on the whole, had been seen more recently, so many officers had to go further back in their memory to describe the female alcoholic clients; they may not have remembered the females as accurately. However, some other data on perception of officer and client behavior suggest that the difference is more than a memory problem.

The probation/parole officers were asked a series of questions about their current case load regarding alcohol-related problems. Table LII indicates the officers' perceptions about whether alcohol was related to the offense clients were under supervision for and their perception of what percentage of their clients were problem drinkers or alcoholics. A brief glance at this table indicates that female clients (both probation and parole) were much less likely to be seen as having alcohol-related to their arrests or to be alcoholics than were male clients.[26] Although this refers to current case load, it corresponds to responses on the questions about individual clients, where a fourth of the officers responding indicated they had never had a

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[26]One probation/parole officer had no male parolees, and 85 had no female parolees. They were not included in percentages. Likewise, in Tables LIII and LIV, only those clients perceived to be problem drinkers or alcoholics are included in percentages.

female alcoholic client and where officers reported they had encountered male alcoholic clients more recently than females.

TABLE LII

PROBATION/PAROLE OFFICERS' PERCEPTIONS OF PERCENTAGE OF CLIENTS IN CURRENT CASE LOAD WITH ALCOHOL-RELATED ARRESTS AND ALCOHOL PROBLEMS

	None		Under 25%		25% - 50%		51% - 75%		Over 75%		
	N	%	N	%	N	%	N	%	N	%	Total
Alcohol Related to Offense											
Men Probationers	1	0.6	31	18.3	67	39.6	51	30.2	19	11.2	169
Women Probationers	23	13.7	86	51.2	40	23.8	13	7.7	6	3.6	168
Men Parolees	7	4.2	30	18.1	54	32.5	48	28.9	27	16.3	166
Women Parolees	37	44.0	16	19.0	18	21.4	6	7.1	7	8.3	84
Estimated Problem Drinkers/Alcoholics											
Men Probationers	3	1.8	64	37.6	73	42.9	18	10.6	12	7.1	170
Women Probationers	39	23.4	93	55.7	24	14.4	6	3.6	5	3.0	167
Men Parolees	19	11.4	56	33.7	57	34.3	21	12.7	13	7.8	166
Women Parolees	38	45.8	27	32.5	13	15.7	2	2.4	3	3.6	83

Even more relevant to the present discussion are the data presented in the next two tables. Table LIII regards discussion about client drinking problems. The first part of the table refers to a question about what percentage of alcoholic clients initiated discussion about their problem themselves. The second part refers to a question about the probation/parole officer initiating the discussion about the drinking problem. If results on the two sets of responses can be taken as

mutually exclusive, then it appears that no discussion about the problem was much more likely to occur with female alcoholic clients than with male alcoholic clients.

TABLE LIII

PROBATION/PAROLE OFFICERS' PERCEPTIONS OF WHETHER ALCOHOLIC CLIENTS IN CURRENT CASE LOAD OR OFFICER INITIATED DISCUSSION OF CLIENT'S DRINKING PROBLEM

	None		Under 25%		25% - 50%		51% - 75%		Over 75%		
	N	%	N	%	N	%	N	%	N	%	Total
Alcoholic Client Initiate Discussion											
Men Probationers	17	10.2	108	64.7	26	15.6	9	5.4	7	4.2	167
Women Probationers	32	23.7	79	58.5	13	9.6	7	5.2	4	3.0	135
Men Parolees	22	14.9	88	59.5	27	18.2	7	4.7	4	2.7	148
Women Parolees	15	32.6	25	54.3	5	10.9	0	0.0	1	2.2	46
Officer Initiate Discussion											
Men Probationers	4	2.4	38	22.6	41	24.4	23	13.7	62	36.9	168
Women Probationers	15	11.3	35	26.3	24	18.0	14	10.5	45	33.8	133
Men Parolees	6	4.0	43	28.7	30	20.0	19	12.7	52	34.7	150
Women Parolees	10	22.2	11	24.4	8	17.8	3	6.7	13	28.9	45

Among the males, 10.2% of the officers related that no male probationers and 14.9% that no male parolees had initiated discussion about their drinking problem, compared with 23.7% reporting none of the female probationers and 32.6% reporting no female parolees. From the perspective of the probation/parole officer initiating the discussion, it appears that 2.4% of the officers ignored talking about the problem

with the male probationers and 4.0% with the male parolees with alcohol problems. This compares with 11.3% who talked with no female probationers and 22.2% reporting not initiating discussion with female parolees with alcohol problems. This suggests concurrence with the conclusion above that probation/parole officers may take female alcoholism less seriously than male alcoholism. It also is possible that they were more embarrassed to discuss it with females regardless of who initiated the discussion, implying stigma attached to female alcoholism.

On the item about specific clients, it was indicated that probation/parole officers reported that the female alcoholic client admitted the problem slightly more frequently than the male. That is, the evidence from these items on discussion with current case load clients contradicts the finding from individual clients to some extent. Further contradiction comes from the fact that only 8.2% of the officers reported that over half the female alcoholic probationers and 2.2% that over half the female alcoholic parolees initiated discussion about their problem. However, 9.6% reported that over half the male alcoholic probationers and 7.4% that over half the male alcoholic parolees brought up their drinking problem for discussion. While 44.3% of the officers acknowledged initiating the discussion with over half their female alcoholic probationers, only 35.6% reported bringing it up with over half the female alcoholic parolees. Officers still were more likely to initiate discussion with male alcoholic clients: 50.6% with over half the male alcoholic probationers and 47.4% with over half the male parolees.

In addition to the conclusion that female client alcoholism is discussed less often than male client alcoholism, two other important conclusions may be drawn from these data. 1) For some reason, the problem also was discussed less frequently with alcoholic parolees than alcoholic probationers of either sex, although from Table LII it appears that parolees were seen as more likely to have alcohol-related problems. That table shows similar results for alcohol reportedly being related to the offense for which the client was under supervision. 2) If both categories of discussion in Table LIII are combined (alcoholic client or probation/parole officer initiation), only slightly over half the officers reported _any_ discussion of the problem with over 50% of their alcoholic clients. This result provides support for a contention made earlier in this section that probation/parole officers may _act on_ fewer cases of alcoholism than they _suspect_ within their case loads. The fact that the officers were more likely than the alcoholic client to initiate discussion does not contradict that contention, because it will be recalled that close to 80% of the individual alcoholic clients discussed were brought to the attention of the officer by external means other than client admission (e.g., alcohol-related offense, official or other reports, drinking behavior).

When Table LIV is examined, it is clear that probation/parole officers viewed few alcoholic clients in their current case load as getting help or improving. The first part of the table deals with an item where the officers were asked what percentage of their alcoholic clients were "getting some kind of treatment or help for their problem." As with individual clients described earlier, female alcoholics were more likely to be perceived as getting no help (31.6% of the officers

listed none for female probationers, 29.5% for female parolees). This contrasts with 2.4% who reported none of their male alcoholic probationers and 13.3% none of their male alcoholic parolees to be getting treatment. Similarly, only 6.0% of the officers reported that over half their female probationer alcoholics and 9.1% that over half their female alcoholic parolees were getting help; this compares with 14.4% of the officers reporting over half their male alcoholic probationers and 13.3% over half their male alcoholic parolees getting help. In addition, it will be recalled that in the discussion of individual clients, female alcoholic clients were more likely to be described as being recommended "help" other than actual treatment for their disease.

TABLE LIV

PROBATION/PAROLE OFFICERS' PERCEPTIONS OF PERCENTAGE OF N ALCOHOLIC CLIENTS IN CURRENT CASE LOAD GETTING HELP AND IMPROVING WITH THEIR DRINKING PROBLEM

	None		Under 25%		25% - 50%		51% - 75%		Over 75%		
	N	%	N	%	N	%	N	%	N	%	Total
Alcoholic Client Getting Help											
Men Probationers	4	2.4	95	56.9	44	26.3	13	7.8	11	6.6	167
Women Probationers	42	31.6	64	48.1	19	14.3	2	1.5	6	4.5	133
Men Parolees	20	13.3	82	54.7	28	18.7	11	7.3	9	6.0	150
Women Parolees	13	29.5	21	47.7	6	13.6	3	6.8	1	2.3	44
Alcoholic Client Making Improvement											
Men Probationers	10	6.1	96	58.2	39	23.6	15	9.1	5	3.0	165
Women Probationers	40	30.3	57	43.2	24	18.2	6	4.5	5	3.8	132
Men Parolees	24	16.3	77	52.4	29	19.7	15	10.2	2	1.4	147
Women Parolees	14	30.4	22	47.8	5	10.9	3	6.5	2	4.3	46

In the second half of Table LIV, the same pattern holds for probation/parole officers who estimated that none of their alcoholic clients were "making some improvement with their drinking problem." Over 30% felt that none of their female alcoholic clients were improving (30.3% for probationers and 30.4% for parolees). In contrast, only 6.1% felt that none of their male alcoholic probationers and 16.3% that none of the male alcoholic parolees were making improvement. The sex ratio was lowest of any table in this set about alcoholic clients for officers who estimated that over half their alcoholic clients were making improvement. Eight and three-tenths per cent put female probationers in this category, while 10.8% placed female parolees there; 12.1% of the officers placed male probationers there, while 11.6% put male parolees in that category. Thus, a little over ten per cent of the officers perceived over half their alcoholic clients as making improvement with their drinking problem in every group except female probationer. In looking at the percentages for perceiving over half the clients as doing something, it can be seen that males were slightly more likely to be perceived as getting treatment than as making improvement. On the other hand, the females were a little more likely to be viewed as improving than as getting treatment. Again, referring back to the discussion of individual alcoholic clients, the officers were more likely to perceive females as doing little or nothing about their drinking problem or to define them as making progress in ways other than treating their alcoholism. The male individual alcoholic clients were seen as more likely to go for actual alcoholism treatment.

In short, just as with discussing the drinking problem, female alcoholic clients in general were seen by the probation/parole officers

as much less involved in treatment or other help-getting efforts than were males. They also were viewed as much more likely not to improve, but officers were almost as likely to perceive over 50% of their female alcoholic clients improving as they were their male alcoholic clients. However, it also should be noted that "improvement" was defined somewhat differently for the two sexes.

The other pattern noted about discussing the problem with parolees versus probationers did not reveal quite such consistency with getting treatment. The pattern seemed to be more plainly sex-related than probation/parole-related. The same more sex-related pattern held for improvement. Also, in examining the total picture, the officers seemed to be rather pessimistic about their alcoholic clients as a group getting treatment or making improvement with their alcohol-related problems.

In sum, the data reported here suggest that alcoholism among female clients was discussed between client and probation/parole officer considerably less frequently than among male clients. Furthermore, although it was estimated by the officers that parolees were more likely to have alcohol related to their offenses and be alcoholics, the topic apparently was discussed more often with alcoholic probationers. It also appears that for alcoholic clients in any category, their drinking problem was more than likely not even discussed with their probation/parole officer. The percentages of alcoholic clients getting help for their drinking problems or making improvements with them were even lower, again more so for female alcoholic clients than for male alcoholic clients. However, officers' perception of how many clients were in these latter two categories probably is not too different from the

number of alcoholics in the general population who are receiving treatment and/or improving with their alcoholism. If indeed behavioral implications can be drawn from these data, the more important inference seems to derive from the finding that the officers did not discuss the problem with so many of their alcoholic clients. It has been pointed out throughout this study that probation/parole officers are important persons on the interface between clients and treatment for alcoholism. As noted earlier in the discussion of what topics the officers wanted more training about, in this role probation/parole officers can serve an important function in detecting alcoholism among their clients and motivating them to go for treatment, then referring them to appropriate treatment programs for help. Put very simply, this function cannot be performed without discussion.

One other set of data needs to be examined regarding the sex-related differences which emerged in examining behavioral data in this section. Table LV presents some attitudes held by probation/parole officers with regard to male and female alcoholic clients. As data in that table indicate, the officers as a group tended to disagree just slightly that either male alcoholic clients ($\bar{X}$ = 2.10) or female alcoholic clients ($\bar{X}$ = 2.19) were more difficult to work with than those of the other sex. However, in examining distribution of responses, 36.0% of the officers did agree that female alcoholic clients were the more difficult sex to work with, compared with 28.8% who agreed that the males were.

Once more, the officers were barely in the direction of disagreement on mean responses that male alcoholic clients had "more additional problems in living" ($\bar{X}$ = 2.12) or that females had more such problems

($\overline{X}$ = 2.21). But again, 37.3% agreed that female alcoholic clients had more living problems compared with 22.8% who agreed that males did. This does not seem inconsistent with the finding that female alcoholic clients were given non-treatment recommendations more often or that they were defined as improving in non-treatment ways more often than were male alcoholic clients.

TABLE LV

ATTITUDES OF PROBATION/PAROLE OFFICERS REGARDING MALE AND FEMALE ALCOHOLIC CLIENTS

Item	Definitely Disagree		Tend to Disagree		Tend to Agree		Definitely Agree		Total	Mean
	N	%	N	%	N	%	N	%		
Alcoholic Men Clients Harder to Work With	44	24.3	85	47.0	41	22.7	11	6.1	181	2.10
Alcoholic Women Clients Harder to Work With	41	22.4	76	41.5	57	31.1	9	4.9	183	2.19
Alcoholic Men Clients Have More Additional Problems in Living	26	14.1	116	63.0	35	19.0	7	3.8	184	2.12
Alcoholic Women Clients Have More Additional Problems in Living	37	20.0	79	42.7	62	33.5	7	3.8	185	2.21
Agency Harder on Men Clients for Drinking	39	21.1	83	44.9	55	29.7	8	4.3	185	2.17
Agency Harder on Women Clients for Drinking	76	41.1	105	56.8	2	1.1	2	1.1	185	1.62

Finally, the probation/parole officers were asked for their views on which sex their agency would be harder on for drinking. Even the means reflect the difference here. There was slight disagreement that

the agency would be harder on male clients for drinking ($\overline{X}$ = 2.17), but there was clear-cut disagreement that the agency would be harder on females ($\overline{X}$ = 1.62). In examining the distribution of responses, 34.0% agreed the agency would be harder on male clients for drinking, while only 2.2% agreed it would be harder on female clients. This finding provides further support for the earlier suggestion that female drinking (and drinking problems) seem to be taken less seriously than male drinking (and drinking problems).

On five of the six items in Table LV, the means reflect slight disagreement (with a neutral point of 2.5) that clients of one sex or the other would be viewed or treated differently with regard to drinking and drinking-related problems. This could imply a general feeling that males and females are seen as treated more or less the same. However, in each case, there were substantial differences in the percentage agreeing with the statement, with female alcoholic clients being seen more negatively or taken less seriously than male alcoholic clients.

The sex-related findings described in this section regarding both attitudes and reported behavior toward alcoholic clients appear to be in almost direct contradiction to the results on the semantic differential scales. There it was found that alcoholic people were viewed much more negatively in general than were "normal" people, with very little difference between men and women alcoholics. This led the researcher to reject the expectation based on traditional wisdom that women alcoholics face more stigma than do men alcoholics. However, when faced with specific situations regarding their clients, there was considerable support for that expectation for a substantial minority of the

officers. This apparent contradiction is reminiscent of the empirical test of the "American dilemma" regarding racial prejudice, in which Westie (1964:586) asked "respondents to express agreement or disagreement with a general Christian-democratic valuation and with a matched, specific self-involving statement in the area of Negro-white relations." He concluded (Westie, 1964:585) that in fact there is "the existence of a basic conflict between the general and the specific self-involving valuations . . . ."

There seems to be some parallel between Westie's (1964) findings and the current research results regarding female alcoholics. In responding to the general concept of alcoholic, probation/parole officers tended to react to the two sexes in a similar manner. However, when asked to report on "specific self-involving" behaviors (Westie, 1964:585) regarding alcoholics, the conflict was apparent for female alcoholics. (It should be noted that the current research described actually reported behavior, whereas Westie's regarded hypothetical situations, so the present findings should be even more supportive of that conflict.) As to why the present respondents were selective inasmuch as the conflict was evident for females, but not for males, Westie's (1964) research still seems to provide at least part of the answer. Negative stereotypes of alcoholics may be part of the "normative order" (Westie, 1964:582) in at least this region of the United States, but with the growing emphasis on sex discrimination, the probation/parole officers may not have wanted to appear differentially negative in responding to the general concept. However, when describing the "factual order" or the "patterns of behavior the members actually practice, regardless of what they think they ought to do" (Westie,

1964:582), some of the officers may have been caught off guard and thus been more honest.

It is worthy of note that particularly on the last set of questions, regarding perceptions of working with male and female alcoholics and views of agency attitudes toward them, the percentage of probation/parole officers agreeing with them is roughly equivalent to the proportion of officers agreeing with the more punitive attitudes about revocation for breaking drinking rules. Additional research needs to be done to test the relationship between these two sets of attitudes and the perceptions of the individual alcoholic client behavior with the more general punitive attitudes. It will be recalled that those who perceived the agency as punitive already were found to be less knowledgeable and to hold more negative attitudes toward alcoholism and working with alcoholics in general. The difference found between the "normative" and "factual" orders regarding female alcoholics indeed may be involved in the surveillance/guidance and medical/moral overlappings discussed throughout this chapter. Perhaps the overlap might be related even to the "normative" order in the sense that there may be some relation between these behaviors, views and semantic differential attitudes toward female alcoholics.

In short, except for the glaring discrepancy between attitudes and behavior toward female alcoholics for a significant proportion of the probation/parole officers, there did appear to be some consistency between attitudes and two separate sets of reported behavioral data. Although the researcher still agrees that it is difficult to infer behavior from survey research, she still feels that enough evidence has been presented to suggest the fruitfulness of further research into the

relationship between labeling and behavioral reaction if factors underlying the labeling are taken into account. It seems enough evidence also has been presented to conclude that the question of stigma for the female alcoholic is more ambiguous than previously demonstrated and warrants further research.

Summary

Four prominent conclusions emerged from findings in this section. 1) Female alcoholics tended to be perceived differently by many probation/parole officers in action ("factual order") situations than in evaluating them on a general attitude scale ("normative order"). When examining the attitudes, it was found that male and female alcoholics were perceived as almost equally negative. But for at least a substantial minority of the officers, the stigma still seems to be greater for female alcoholics when reported behavioral data are explored. 2) The first conclusion, plus data from reported behavior in general reflected the now-persistent theme of a medical/moral and surveillance/guidance overlap among the officers. 3) The probation/parole officers reported essentially little discussion of drinking-related problems with alcoholic clients. This lack of discussion detracts from a major function that probation/parole officers can serve as members of the broader community mental health system, namely detecting alcoholic clients and motivating them to seek treatment in programs to which the officers might refer them. In reality, they may be able to detect alcoholics better than they think they can. They knew "textbook" symptoms, although a number did mention stereotypes. They also estimated many more alcoholics in their case loads than they reported

discussing the problem with. So the major problem may be overcoming accountability needs and focusing on motivation of alcoholics to seek treatment. 4) If factors underlying the labeling process are taken into consideration, it seems enough consistency was revealed between attitudes and reported behavior to suggest that labeling does lead to reaction and to warrant further research on the relationship.

Summary of Chapter

Findings will not be reported in accordance with each research question here; a brief review of the questions will be in Chapter VI. Instead, a few major results and patterns that seem to tie the research questions together will be presented.

Major results tended to support most expectations of the researcher regarding the focus variables of this study. On a standardized knowledge scale, the probation/parole officers did not score extremely well ($\overline{X}$ score = 62% correct). Unrelated to how much knowledge or alcoholism training they had had, the officers tended to be slightly positive in their attitudes toward alcoholism, based on attitudes of professional alcoholism experts. As a group, they held extremely negative stereotypes of alcoholics relative to their attitudes toward "normal" people. Their reported behavior was relatively consistent with their expressed attitudes, thus suggesting support for the labeling theory orientation central to the present research.

As might be expected from a study of this nature, the primary conclusion reached from the results was that alcoholism-related attitudes among probation/parole officers are far from global and simple. Rather they are quite complex and must be broken down into several component

parts for any kind of meaningful understanding. This complexity can be seen by an examination of three themes running throughout the findings and discussion that were characterized by apparent contradictions and conflicts: overlapping medical/moral and surveillance/guidance orientations, paradoxes regarding background variables related to knowledge and attitudes, and surface-level confusion regarding the relationships between knowledge, attitudes, and behavior.

Overlapping Orientations

Two sets of conflicting orientations were persistent, sometimes present within the same officer and sometimes reflecting subgroup differences. Both sets of orientations seem to mirror ongoing change processes much broader than the relationship between probation/parole officers and their alcoholic clients. Nevertheless, both still have important implications for this specific interaction set.

Medical/Moral Conflict. Reflecting shifts occurring both in the general public and among human services professionals, the probation/parole officers displayed views representing both a moralistic view and a disease/illness concept of alcoholism and alcoholics. Perhaps the major example of this was the fact that while they tended to regard alcoholism as an illness, they were slightly more likely to perceive it as a character defect. Both means were slightly in the positive direction; the mean for character defect ($\overline{X}$ = 3.25) was closer to the mid-range point of 4.00 than was the mean for illness ($\overline{X}$ = 2.92).

As noted above, the attitudes toward alcoholics as persons were generally negative. However, correlations between these attitudes and

those toward alcoholism displayed some statistically significant patterns exhibiting the medical/moral overlap. For instance, the higher one's score on the character defect factor, the more negative were his/her attitudes toward alcoholics. On eight of the nine Marcus factors measuring attitudes toward alcoholism, if the factor was correlated in a statistically significant manner with the evaluation component of the semantic differential continuums measuring attitudes toward alcoholics, it was not correlated in a statistically significant way with the healthy-sick continuum and vice versa.

Finally, but not exhaustively, while most signs probation/parole officers would use to suspect alcoholism were "textbook" symptoms, a significant minority were stereotypical and clearly indicative of value judgments.

While considering this medical/moral overlap, attention should be returned to Suchar's (1978:230) description of the focus of labeling analysts as "the interpretations of social control agents that designate acceptable or nonacceptable behavior. It studies deviance as an evaluative reality." [Emphasis in original.] Based on results of this study, the probation/parole officers may designate alcoholism as an illness, but condemn the alcoholic anyway because of the moral overtones (see Freidson, 1970a:253). That is, the interpretations of the social control agents in this case seemed to lead to moralistic stereotypes of the people involved, which was described in Chapter II as "the critical variable to be explored." Sowa and Cutter (1974:214) summarized the practical impact of this medical/moral stereotyping process:

The positive and negative adjectives may indicate two over-

> lapping attitudes . . . . First, they may be value judgments with a flavor of moral failure. Second, they may be part of a technical, therapeutic vocabulary . . . . The phrase 'character disorder,' for example, may capture this twin medical-moral usage. The consequences of these disvaluing attitudes for effective therapeutic intervention in alcohol . . . problems, as well as the issue of attitude modification, should these attitudes prove therapeutically counterproductive, deserve further study. [Emphasis added]

Surveillance/Guidance Conflict. Whether called surveillance/guidance, "cop"/"social worker," or policing/human services, this contradictory orientation also was discussed throughout this chapter. Like the medical/moral overlap, it signifies an important change occurring now in the corrections field, especially in probation and parole (Sutherland and Cressey, 1978). Also like the medical/moral overlap, it was represented in contradictory forms consistently. Inspecting general attitudes toward working with clients, the probation/parole officers were described as perceiving themselves as more of a human services profession than a policing one. Yet in ranking the ideal importance of work tasks, the officers ranked supervision of clients slightly higher than counseling them. Further, in examining their perception of their differential power over clients, a sizable proportion of the officers seemed to feel it most important that clients remember where the power was. Confusing the issue still further, the great majority of officers looked at their agency as humanistic and rehabilitative, while less than 30% saw it as punitive; but the only view that yielded significant differences in knowledge and attitudes was between those who regarded it as punitive and those who did not.

Thus, it seems apparent that most of the probation/parole officers themselves were unsure of their major function, although those who were

more in tune with the surveillance orientation did have some distinctive views. On all four of these ways of measuring the surveillance/guidance overlap, there were very few significant differences regarding attitudes toward alcoholism. However, there were some important significant differences relative to attitudes toward working with alcoholics and toward training to do that. For example, officers most in favor of maintaining the power differential between them and clients were significantly more likely to feel that alcoholics should be compelled to go to treatment and to think that breaking drinking rules should be sufficient cause for revocation. Further, in addition to being significantly less knowledgeable, officers who perceived the agency as punitive were significantly more likely than others to feel that helping alcoholics does not require special training. Along with those defined as having "policing" attitudes toward clients in general, they also were significantly less optimistic regarding prognosis for recovery from alcoholism.

There is no denying that supervision and/or surveillance are necessary parts of a probation/parole officer's job. Not only is supervision part of the official job description, but by their very definition probation and parole are conditional freedom for people who have broken the law. The critical issue is that those officers who were the <u>most</u> surveillance-oriented frequently generalized this orientation to alcoholic offenders, in spite of not being knowledgeable about alcoholism and not thinking such knowledge was necessary.

The labeling theory focus described in the conclusion about the medical/moral overlap has the same implications for the surveillance/guidance overlap. If the surveillance attitude is acted out with alco-

holic offender, then they still will be punished while their alcoholism continues to be untreated. It was pointed out in Chapter II that Pittman (1974) noted untreated alcoholism is a critical variable in continuing a criminal career. This is especially true for some crimes with the highest recidivism rates such as petty theft and check forgery (Fox, 1976; Radzinowicz and Wolfgang, 1971).

Background Variables

Background variables that made a difference in knowledge and/or attitudes were primarily of two kinds: characteristics of officers and their attitudes.

Characteristics of Officers. The only variable of the first kind, officer characteristics, that remained constant was sex. Male probation/parole officers scored significantly higher on objective knowledge but also had significantly more wrong, while females were significantly more likely to acknowledge they did not know whether a statement was true or false. On the other hand, females tended to hold significantly more positive attitudes toward important aspects of alcoholism and alcoholics and toward wanting to work with alcoholics, and they were significantly more likely to express a need for and want further alcoholism training. While sex was uniform as a background variable, the differences it made sound contradictory, but this contradiction points to two important factors. First, the differences are understandable in terms of sex-role socialization; secondly, if alcoholism training were not so fragmentary and/or oriented toward objective knowledge only, the sex differences probably could be overcome. That is, education geared to-

ward attitudes would ascertain the male tendency toward greater negativity and then attack it head on.

Since sex differences do not reflect true reference group differences and since no other characteristic of probation/parole officers exhibited uniform differences, it was concluded that the occupation itself provided the major reference group for officers. This conclusion was consonant with that reached by Mackey in 1969. He studied attitudes toward alcoholics among four occupations with at least a minimal human services orientation in common. Even with that similarity he found occupation to be the most important variable in explaining differences in their attitudes. Nevertheless, there also was evidence of subgroup differences among the probation/parole officers on some issues that still seemed based on occupation, but more at the district level. For example, it was noted that there were three districts whose members felt they had something to offer alcoholics significantly more so than officers in the other four districts; but when probed further, each district provided unique constellations of characteristics which suggested that what officers in each district had to offer alcoholics would be very different.

If further research comparing probation/parole officers with members of other professions on a similar survey supported the notion of occupational reference group, then this would have important implications for occupational socialization. This is relevant to the type of education probation/parole officers receive about alcoholism and alcoholics since occupational socialization starts in basic training. It continues on through inservice education where what is taught surely legitimates certain attitudes and behavioral predispositions as being

appropriate for a probation/parole officer. People planning such educational efforts, it seems, also should be aware of who reference group leaders are within districts (who may or may not be supervisors) and determine their attitudes.

Attitudes. Two sets of attitudes seemed to be related to knowledge and/or to views about alcoholism and alcoholics, but they generated contradictory views which seem indicative in part of fragmentation in alcoholism education. Again, if these views were known at the beginning of educational efforts, then the education could be directed toward them.

One set of relevant attitudes concerned social drinking. Those who favored social drinking had significantly more correct on the objective knowledge scale; yet those against social drinking on other items about it were significantly more positive toward alcoholism on factors which are now taken to be matters of information rather than opinion by professional alcoholism experts. The second set of attitudes related to whether officers felt they needed or wanted further alcoholism training. Those who needed and/or wanted more training were significantly more positive than others toward important alcoholism attitude factors. However, they were significantly more negative than others on the stereotype component of attitudes toward alcoholics. The need/want attitude also was significantly related to sex and district. Therefore, even interest in alcoholism was related back to officer characteristics with the most impact; this provides further support for the sex-role socialization and occupational reference group conclusions already drawn.

These sets of attitudes about drinking in general and interest in alcoholism, with their contradictory influence, support the contention that alcohol-related attitudes must be broken into several component parts for understanding. Since neither need nor want for further training was related to knowledge or to amount of prior alcoholism education, it also becomes clear once again that traditional educational efforts may have little impact (or that factors other than knowledge or training influence interest in alcoholism). At the very least, it can be suggested that traditional education has had uneven results as it affects attitudes toward alcoholism and alcoholics.

Knowledge-Attitude-Behavior

The research reported here has shown that the relation between the cognitive, affective, and conative aspects of attitude sets (Rose, 1974:101) bear no necessarily logical relation to one another. It has been clearly demonstrated that objective knowledge about alcoholism was not related to attitudes. There was more support for the relationship between attitudes and behavior, but not as they follow from objective knowledge.

It is not meant to suggest that the probation/parole officers were devoid of knowledge espoused by alcoholism experts. For instance, although a few suggested punitive action, the vast majority of officers were aware of treatment organizations and programs available. They also agreed with the experts regarding treatment goals of abstinence and decreased living problems and even added the critical aspect of increased self-respect; again there was a sizable minority who agreed to goals of questionable validity, i.e., controlled drinking and more

time between drinking bouts. Finally, most of the officers could cite symptoms to suspect alcoholism that agreed with the experts' ideas.

Nonetheless, when reporting past behavior there was only partial adherence to these pieces of professional knowledge. Reported behavior seemed more to follow from attitudes, supporting the labeling theory contention noted above in the discussion of the medical/moral overlap. It will be recalled that few alcoholic clients were reported to be involved in treatment efforts and even fewer to be making improvement with with their drinking problem. Obviously there would have to be information on characteristics and attitudes of the clients themselves to determine their contribution to the lack of follow-up on treatment and improvement for complete understanding. However, past research has pointed out that negative attitudes do result in labeling which leads to negative behavioral reactions on the part of formal agents dealing with alcoholic clients, thus influencing the interaction which occurs. It would not hurt to repeat Sterne and Pittman's (1965:54) observation based on empirical research:

> . . . the responsibility for discontinuance in treatment need not invariably be the alcoholic's. The therapeutic situation is an interactive one, and research has shown that therapists play a large part in determining the nature of the therapeutic relationship.

Finally, it should be mentioned that at the surface level, sometimes behavior did not even seem related to attitudes. However, the researcher followed Suchar's (1978:230) advice that "The focii [sic] of the labeling perspective are the social and social-psychological dynamics that influence decisions of the social worth of individuals." [Emphasis added.] When these underlying factors were examined, the reported behavior no longer seemed so confusing. The behavior became much more under-

standable when probed beyond the simple definition of the situation. One example involves the discrepancy between symptoms listed to suspect alcoholism and the ones actually used to decide a client was alcoholic. When other data were probed, it became understandable that probation/ parole officers might act on a set of signs different from ones they would use to suspect a problem, because of accountability to an agency they perceived as unconcerned about problems of alcoholic clients. It should be pointed out that agency officials do seem concerned about alcoholic clients and their problems, but this concern apparently has not been communicated adequately to officers in the field. However, this situation is not irreversible; if the communication channels were opened wider, it could have an impact on officer behavior toward alcoholic clients. As Becker (1964:3) urged, ". . . if we view deviance as something that arises in interaction with others, we realize that changes in interaction may produce significant changes in behavior."

In short, there is not a one-to-one correspondence between knowledge, attitudes and (reported) behavior. However, "knowledge" encompasses much more than objective facts; it also includes erroneous beliefs, e.g., that alcoholics lack will power (see Robinson, 1976, for a discussion of the importance of these beliefs in defining situations). Furthermore, as shown just above, behavior does not automatically follow from surface-level attitudes. Thus, when Weber's debunking motif is followed and other factors are taken into account, the relationship becomes at least a little more meaningful.

In sum, investigation of the overall picture revealed both ambivalence and ambiguity among probation/parole officers as they perceived alcoholism, alcoholics and their alcoholic clients. The confusion and

complication were particularly evident in overlapping orientations, paradoxical background variables and a frequent seeming lack of relationship between knowledge, attitudes and behavior. The overlapping orientations were found to be part of ongoing changes in the environment of the officers. What might be the primary background variable, occupation, could not be controlled in this study, so it was more difficult to establish as related to focus variables. When factors under the surface were examined, the relationship between knowledge, attitudes and behavior became more meaningful. Some questions obviously remain unanswered, but once it is recognized that alcohol-related views are complex instead of simple and global, sources of these complexities can be understood in part through sociological theory.

CHAPTER VI

SUMMARY AND CONCLUSIONS

Review of Purpose and Framework of Study

The relationship between alcohol abuse and crime, especially between alcoholism and recidivism, has been well documented (Pittman, 1974). However, there is a scarcity of information about how criminal justice personnel view alcoholism and alcoholics. Members of one segment of the criminal justice system, probation/parole officers, are major social control agents on the interface between offenders in the community and the alcoholism treatment system. Therefore, the purpose of this research was to explore views of probation/parole officers regarding alcoholism problems, specifically their knowledge about alcohol and alcoholism, their attitudes toward alcoholism and alcoholics and possible sources of those attitudes, and their behavioral experiences and predispositions with alcoholic clients.

The theoretical framework for the study was the societal reaction or labeling approach to deviance. Instead of the traditional focus on the person designated as deviant, this approach concentrates on the outcome of interaction between the deviant and others, thus requiring examination of the "audience" as well as the deviant (Schur, 1971; 1979). Members of the audience, including social control agents, bring to the interaction their own social-psychological background, including attitudes toward the deviant, as well as formal organizational imperatives (Hawkins and

Tiedeman, 1975; Suchar, 1978). These attitudes, frequently reflected in stereotypes, and the prerequisites of the organization influence the behavior of the social control agent toward the deviant, with potential consequences for the self-image and behavior of the person labeled as deviant.

Specifically with regard to alcoholism and alcoholics, ever since the classic study by Sterne and Pittman (1965), researchers have demonstrated with a variety of human services professionals that the professionals greatly influence the nature of the therapeutic relationship with alcoholics. Thus, since there are so many diverse views regarding alcoholism and alcoholics, the way the professional defines the situation becomes a critical issue (Robinson, 1976). Previous research has indicated that human services professionals tended to hold inconsistent, but basically negative, views toward alcoholism and alcoholics. Other studies have shown that certain forms of alcoholism training can reduce these negative stereotypes, with behavioral changes on the part of helping professionals toward alcoholic clients (Fisher et al., 1976).

Review of Methodology

Printed surveys were mailed to all state-employed probation/parole officers and the district supervisory personnel in Oklahoma in early 1980. The questionnaire was accompanied by cover letters from the researcher and the Assistant Deputy Director for Probation and Parole for the Oklahoma Department of Corrections explaining the study and guaranteeing anonymity. The surveys were collected by the researcher at April district meetings for the officers, resulting in a 90.3% response rate. The sample members tended to be male (60%), young (median age

30), white (86%), and well-educated (89% with at least bachelors' degrees, 25% with graduate degrees). The officers had been educated primarily in Oklahoma and most had majors at least related to criminal justice. They reflected relatively high job turnover; 75% had been in their job and 68% with the agency for five years or less. They had a mean case load size of 74 (64 probationers and 10 parolees, 62 men and 12 women, on the average); they considered an ideal case size load to be 48.

The survey instrument was comprised primarily of close-ended questions. It requested information about a wide variety of background variables and responses to several focus variables dealing primarily with knowledge about alcohol, alcoholism and alcoholism treatment methods and goals, attitudes toward alcoholism, and views of alcoholics compared with views of "normal" people. In addition to descriptive statistics, relationships between background and focus variables were tested for statistical significance using analysis of variance and chi square. Pearson correlation coefficients were used to test strength of relationship for some variables.

Limitations of Study

Every research study has a variety of limitations, but four seemed particularly relevant to this research. First, all survey research must deal with the issue of honesty in responses. Every precaution was taken to assure probation/parole officers of anonymity of their answers. However, perhaps indicative of felt stigma in itself and certainly indicative of fear of identification, a number of officers openly admitted not being honest regarding questions about their personal drinking behavior.

Because of so many alternative definitions of the situation regarding attitudes, the researcher felt that except for drinking behavior questions, the respondents were basically honest in their responses.

Second, there is concern for every survey instrument about validity and reliability. This instrument was no exception. Even on some standardized scales, there were a few items with lack of clarity, but they could not be changed if the scales were to be replicated. Some items constructed for this survey were difficult to assess with the pretest group since they pertained specifically to probation/parole work. As a result, a few items were problematic; for example, a number of officers misinterpreted questions asking them to rank treatment organizations and work activities, and the index used to measure acquaintance with practicing and recovering alcoholics turned out to be faulty. Overall, however, there seemed to be few problems with interpretation of survey items.

Third, also inherent to survey research, is the problem of measuring behavior by questionnaire compared to direct observation of behavior. An attempt was made to reduce this limitation by asking officers to report behavior instead of responding to hypothetical situations. Responses were consistent enough to be easily codable into a few categories, and the researcher spoke to several officers informally. Thus, while recognizing there could not be a direct correspondence between reported and actual behavior, it was felt that a fairly accurate representation of behavior was presented.

Finally, as with any study, caution should be taken in generalizing results beyond probation/parole officers in Oklahoma. Although the response rate suggests the sample was representative of the population it

was drawn from, there are no comparable studies of other groups in the criminal justice system. However, this study should provide a baseline for other such studies.

The limitations described here apply to all types of survey research. However, within these inevitable limitations, the researcher believes the major purposes of this research still were accomplished.

Research Questions and Results

The research reported here was probing basically unexplored territory: previous studies on views of probation/parole officers toward alcohol-related issues virtually do not exist; results of such studies on other human services professions are inconsistent; and the researcher was investigating some relationships not examined in prior studies. Therefore, instead of formulating hypotheses for testing, six broad research questions were asked to direct the study, making it primarily exploratory and descriptive in nature.

The first research question sought to determine the level of knowledge probation/parole officers had about alcohol and alcoholism and its relationship to the amount and type of alcoholism training they had had. It also examined their perceived need and/or desire for further alcoholism training. The officers' average score on the knowledge scale was 62% and was positively related to the amount of alcoholism training they had. Their primary sources of training were brief discussions in college courses, inservice education, and special workshops. Unrelated to knowledge or training, over 70% of the officers stated they needed and wanted more alcoholism training. Officers with the most knowledge, most alcoholism training, and the greatest need and desire for more

training were more likely to feel they had something to offer alcoholics. Males and officers in rural districts scored significantly higher on the knowledge scale, while females and urban officers expressed significantly greater need and want for further training. Officers favorable toward social drinking were more knowledgeable than those with negative social drinking views. No other background variables were significantly related to knowledge issues.

The second research question examined attitudes toward alcoholism: its definition, etiology and responsibility for its occurrence, and prognosis for recovery. Attitudes toward alcoholics were explored and compared with attitudes toward alcoholism and toward "normal" persons. Views toward male and female alcoholics also were compared to one another. In defining alcoholism, probation/parole officers were slightly positive toward an illness concept, a little less positive against a character defect view, reflecting a medical/moral overlap view toward alcoholism not too different from views among other human services professionals. Regarding etiology of alcoholism, they were likely to believe emotional difficulties contributed to it and disagreed that it can be inherited. Their responses were most mid-range on where responsibility for alcoholism lay, on items involving loss of control over drinking, addiction liability of alcohol and will power. On the other hand, they were rather optimistic regarding prognosis for recovery, but less so than professionals in prior studies. In general, they adhered to negative stereotypes of alcoholics as persons; they were much more negative toward alcoholic people than toward the alcoholic condition and "normal" people, and more negative than members of other professions toward alcoholic persons. Pearson correlation coefficients relating attitudes

toward alcoholism with attitudes toward alcoholics revealed some substantively slight but statistically significant correlation patterns; the most important pattern was that any Marcus alcoholism factor significantly correlated with the evaluation component of attitudes toward alcoholics was not correlated with the healthy-sick continuum for alcoholics and vice versa. Although men and women alcoholics have different treatment needs and contrary to traditional wisdom that women alcoholics face greater stigma, alcoholics of both sexes were characterized in almost identical ways on semantic differential scales.

The third research question dealt with probation/parole officers' knowledge of and attitudes toward alcoholism treatment programs and treatment goals. Consistent with research on treatment professionals, they were most familiar with Alcoholics Anonymous (75% listed AA). Almost every treatment program in the state was known to at least a few officers. In agreement with treatment professionals, they cited abstinence and decreased living problems as the most important treatment goals; they also ranked increased self-respect as equally important with the other two goals. On the other hand, although it had a low mean rank, almost half the officers checked controlled drinking as a viable treatment goal, contrary to professional views (NIAAA, 1980).

Because of so little information available in the literature, the fourth research question explored a wide variety of background variables to determine their relevance to attitudes of probation/parole officers toward alcoholism and alcoholics. Officers displayed the greatest consensus in their views toward alcoholics, with a slight amount of intra-sample difference regarding etiology and responsibility for alcoholism. They exhibited more internal differences relative to defining alcoholism

and the most difference among themselves on prognosis for recovery. Although not as important a variable as it was with knowledge, sex still remained the most consistent variable reflecting differences across all three focus variables. Although women scored lower on the knowledge scale, they were significantly more positive than men in perceiving alcoholism as an illness, in not viewing it as a character defect, and in being optimistic regarding prognosis. District was unrelated to attitudes toward alcoholics but did emerge as a factor on some other attitudes, reflecting some important attitude constellations; e.g., officers in one district were significantly less likely to want further training, less likely to view alcoholism as an illness, and second most pessimistic regarding recovery, yet (with two other districts) they were significantly more likely to feel they had something to offer alcoholics. Other demographic and occupational variables revealed few differences in attitudes. Importantly, score on the knowledge scale and sum of training were irrelevant in relation to attitudes toward both alcoholism and alcoholics. The more important variable was felt need and desire for further alcoholism training, with major inconsistent results. Those who needed and/or wanted more training were significantly more likely to see alcoholism as an illness, hold positive views regarding etiology and responsibility, and be more optimistic about recovery; yet they also were significantly more likely to hold negative stereotypes of both alcoholic men and women. Although officers' general attitudes toward clients tended to be more guidance than surveillance-oriented in general, these attitudes made no difference in attitudes toward alcoholism; neither did acquaintance with practicing or recovering alcoholics. Social drinking attitudes were related to alcoholism attitudes but not

attitudes toward alcoholics; those who were negative toward social drinking tended to have the more positive views toward alcoholism.

The fifth research question examined the impact of certain organizational constraints on probation/parole officer attitudes. Regarding specialization, most officers felt they could and should help alcoholics in the course of their jobs, but just over a fourth would like that as a special responsibility; none of these was related to attitudes toward alcoholism or alcoholics. Criminologists and probation/parole officers describe emphasis on supervision versus counseling as reflecting different philosophical orientations, but when compared as specialization emphases, they revealed almost no differences in attitudes. Efficiency pressure, as measured by size of case load, showed that those with larger case loads were significantly less likely to feel they had much to offer alcoholics, although officers tended to say they needed and wanted more alcoholism training regardless of case load size. Items regarding how officers felt they should use their differential power over clients revealed no difference in alcoholism attitudes, but those most surveillance-oriented were significantly more likely to feel that breaking probation/parole rules about drinking was sufficient cause for revocation. Officers' perceptions of their agency's multiple goals were to see them as primarily rehabilitative and humanistic. Although fewer than 30% perceived the organization as basically punitive, they were significantly less knowledgeable, less optimistic regarding prognosis, and less likely to feel special training was needed to help alcoholics. Officers also tended to see themselves as more concerned about client drinking problems than they perceived the agency to be.

The sixth research question explored whether attitudes (labels)

have consequences for behavior (reaction) among probation/parole officers. When asked to list signs which would lead them to suspect a drinking problem, they cited "textbook" symptoms, but in reporting on actual alcoholic clients of both sexes they described different signs they actually acted on, primarily ones which would not allow them to ignore the problem. Consistent with responses to the third research question, they recommended AA and counseling most often, but referred males more often to inpatient treatment and gave females more lay advice. They were generally pessimistic regarding client follow-up on drinking problems, but more so for female clients. Questions about alcoholic clients in general yielded results similar to those about individual clients. Most importantly, they reported discussing the drinking problem with alcoholic female clients and alcoholic parolees much less frequently than with alcoholic male clients and alcoholic probationers. In fact, regardless of who the clients were, only half the officers reported discussing the drinking problem with 50% or more of their alcoholic clients. Fewer officers also reported females as getting treatment or improving than males. They tended to perceive alcoholic female clients as harder to work with and as having more additional living problems than alcoholic male clients; they saw the agency as being harder on the alcoholic male client. In general, there was enough consistency between attitudes and reported behavior to warrant more exploration of this issue. Also significant was the fact that general attitudes toward alcoholics were equally negative for both sexes, but reported behavior revealed more stigma for females for a substantial minority of the officers.

In reviewing results for the six research questions directing the

study, the researcher concluded that alcoholism-related attitudes among probation/parole officers are complex and must be broken into several components for meaningful understanding. This complexity was illustrated by three apparently conflicting themes running throughout the findings which do not seem so contradictory when explored in depth. First was the existence of a medical/moral overlap in viewing alcoholism and a surveillance/guidance overlap in orientation among officers. Both overlapping orientations reflect broader ongoing changes among human services and criminal justice professionals respectively, but both have important implications for treatment of alcoholic offenders. Second was background variables. Sex was the only characteristic of probation/parole officers which made a consistent difference across focus variables, but this difference can be explained by sex-role socialization. This led to the conclusion that the major reference group for attitudes must be other probation/parole officers themselves. Attitudes toward social drinking and toward needing and/or wanting further alcoholism training also yielded a number of statistically significant differences in knowledge and/or attitudes, but in an inconsistent manner, suggesting educational implications. Finally, while many officers obviously were knowledgeable about many aspects of alcoholism, their reported behavior seemed more related to attitudes (which were shown not to be related to objective knowledge). Sometimes the surface attitudes did not seem related to behavior, but when other underlying attitudes were examined, the relationship was less confusing.

Relationship of Findings to Proposed Significance of Study

Substantive

Attitudes toward Alcoholics. Although probation/parole officers represent the formal social control establishment, they are the major members of it with continuous, long-term involvement with offenders in the community on probation or parole. In that role, they may be the most important bridge between alcoholic offenders and treatment programs, and they have the opportunity to establish the primary relationship described in Chapter II as essential for success in working with alcoholics. Because of this crucial role and because no prior research exists on the topic, it was felt important to determine attitudes of probation/parole officers in this area.

A number of attitudes and reported behaviors discussed in more detail in Chapter V are very relevant here. Perhaps most essential are the overlapping orientations which emerged as persistent themes. The medical/moral overlap suggests that many officers are ambivalent about alcoholism, and combined with the generally negative attitude toward alcoholics, it is not particularly surprising that so many reported not discussing the issue with clients they perceived as alcoholics. It also has been proposed that the officers' reluctance to be honest regarding their own (and perhaps their family's) drinking behavior may reflect stigma attached to both condition and person. If these stereotypes are conveyed to alcoholic clients, who already are aware of rules about drinking at all, they are likely to shy away from asking for help as well. In short, it seems that many probation/parole officers'

actions indicate they perceive alcoholics as "bad persons needing to get good rather than sick persons needing to get well."

Another clear-cut theme was the surveillance/guidance conflict. This conflict is understandable in a rapidly changing profession, and it is equally obvious that the surveillance orientation cannot be dropped altogether because of who the clients are. The issue of concern here is that there was a substantial minority of the officers who still appeared to be primarily surveillance-oriented, who would extend this punitive attitude to clients for drinking at all, much less to clients with alcohol-related problems.

One other issue pertinent here is that probation/parole officers expressed much more personal concern about alcoholic clients than they perceived their agency to have. It was suggested previously that this perception might be involved in the finding that officers apparently often deal with clients' drinking problems only when they can no longer be ignored, e.g., official reports, new alcohol-related arrests or client admission, in spite of the fact that they showed knowledge of when to suspect a drinking problem. It was proposed that since officers are accountable to the agency for their work time, they are likely to spend their time in activities they feel will be rewarded by the agency. Officials at the state level of the agency have expressed concern about assisting alcoholic clients to the researcher, so it may be that concerns communicated down the hierarchy need to be expressed more clearly.

In short, Collins (1979) noted that 16% of Oklahoma's probation/ parole clients reported drinking problems to their officers. This figure departs greatly from both national estimates and from estimates of Oklahoma's probation/parole officers. Results from this study indicate

that there surely are some probation/parole officer attitude barriers standing in the way of more alcoholic offenders on probation/parole not receiving attention or treatment for their drinking problems.

Education. The probation/parole officers in this study were no different than other human services professionals in Oklahoma in expressing a need and/or desire for further alcoholism training (Kerr Foundation, 1979). Seventy per cent of the officers stated they needed more training, and 73% said they wanted it, although neither of these variables was related in a statistically significant way to how much knowledge or past training the officer had had. However, all of these items remind the researcher of the folk saying that "learning is what you get after you know it all," because all four items were related to how much an officer already felt he or she had to offer alcoholics. That is, those who scored highest on the knowledge scale, had the most previous alcoholism training, and needed/wanted further training were significantly more likely to feel they could offer alcoholics something. To put these findings in reverse, there was some indication of recognition of one's limitations in helping alcoholics on the part of other officers, but simultaneously little felt need or desire to change that situation. Officers who said they needed/wanted more training most often stated they wanted to learn more about general counseling techniques and helping alcoholics. Many fewer expressed a desire to learn more about detection of alcoholism or ways to motivate alcoholics to seek treatment; reasons for this were not ascertained, but these latter two skills seem to be critical functions for probation/parole officers in their role as a bridge between those who need help and those specifically trained to offer such help. It may be recalled that the officers as a group also

ranked inservice education higher as an ideal work activity than as an actual one, so most probably would not be adverse to further training on the job. Inservice education was ranked second behind brief discussions in college courses as the major source of alcoholism training they already had.

It is important to know that most of the probation/parole officers were willing to have and desirous of further alcoholism training. Perhaps more crucial research results are that neither knowledge level nor sum of past training was significantly related to attitudes toward alcoholism or alcoholics and that reported behavior was related more to the overlapping medical/moral attitudes than to objective knowledge. Furthermore, even among those who needed/wanted further training, the attitudes were inconsistent; they held more positive attitudes toward several factors relating to alcoholism, but they had more negative stereotypes toward alcoholic persons, both male and female.

These findings have major implications for the _type_ of education presented in this area, as the researcher suggested in Chapter II. Numerous studies were cited previously which found that after training programs, objective knowledge increased but attitudes and/or behavior toward alcoholism or alcoholics remained basically unchanged. The researcher proposes consideration of an experiment described by Fisher et al. (1976). They pointed out that alcoholism education programs need to take into account all three of these learning areas: cognitive knowledge or objective understanding of alcoholism, the affective domain or the attitudes, and behavioral skills relevant to dealing with alcoholics. In opposition to most traditional educational efforts, Fisher et al. (1976:1687) proposed that "the probability of attitudinal change

might be enhanced by surveying attitudes prior to training and then designing the curriculum around the focal issues that require modification." After training family-practice residents based precisely on this philosophy, they found positive significant changes in both attitudes and behavior as well as in objective knowledge. Fisher et al. (1976: 1691) concluded:

> By knowing in advance that the residents felt that alcoholics were weaker, more passive and more hopeless than average persons, it was possible to explore these salient feelings in class discussions. Thus, attitude change was made possible by making the residents aware of their beliefs and their implications and by presenting alternative positions.

In addition to dealing directly with attitudes and stereotypes of alcoholics, they also "[sensitized] the residents to the presence and magnitude of the problem" (Fisher et al., 1976:1692), and taught them diagnostic criteria and established specific treatment guidelines for them. "The residents may as a consequence have felt more secure in their ability to manage the disease and hence less reluctant to uncover it" (Fisher et al., 1976:1692), thus explaining significant changes in behavior as well as in attitudes.

The Fisher et al. (1976) experiment has been described in some detail for three reasons: 1) The researcher has had some success with this approach; it has not been measured, but she has had numerous opportunities to see it work with current and former students and feels that it has merit. 2) Research findings on the current study sample support the many past studies which found that traditional cognitive-oriented approaches have not worked to alter attitudes and behavior toward alcoholics significantly. 3) One of the goals described for this research in Chapter I was to establish a baseline for new educational efforts along with a basis for measuring its impact. Fisher et al.

(1976) noted that the major drawback to their research was lack of a control group. Hopefully, this research has established some adequate baseline data in all three areas of concern here: cognitive knowledge, attitudes and reported behavior. Since there are seven probation/parole districts, the control groups missing in the other study are already built in. Thus, it seems feasible that officers in some districts could be given more traditional education, those in others the type education described here, and those in yet others none to control for experiences which would occur over time anyway (Campbell and Stanley, 1963). Then officers could be retested and compared with data obtained from them in the present study, as well as with each other. Such research not only could establish guidelines for future training of probation/parole officers, but also could provide valuable insight into training for members of other criminal justice and other human services professionals.

Finally, as discussed in Chapter V, knowledge of the consistent differences between male and female officers on all focus variables should provide some insight for those planning educational programs. Also, the absence of other consistent differences within the sample led to the conclusion that members of the occupational group itself may be the major reference group for alcohol-related attitudes, including those about working with alcoholic clients. If that is true, knowledge of occupational socialization processes suggests that officers with more positive attitudes would pass them on to new officers as they enter the profession, if they are perceived as leaders or as reference others. Of course, this process can operate in reverse and could be a possible drawback if officers with negative views are seen as reference leaders.

Female Clients. In Chapter I it was noted that both crime and alcoholism rates are rising rapidly among women (all officers reported some females in their current case load, and 75% acknowledged experience with at least one female alcoholic client). However, most research dealing with criminal offenders relates to males, so the current study explored probation/parole officers' perceptions of male and female alcoholic clients separately. Responding to characteristics of alcoholics generally, the officers ranked men and women alcoholics almost equally negatively; even the rank order of specific characteristics describing alcoholics was almost the same for both sexes. On the other hand, when reporting experience with alcoholic clients, they differed a great deal in describing encounters and behaviors with female alcoholic clients versus those with male alcoholic clients. The females seemed to have their alcoholism taken less seriously by many officers, and they appeared to be treated more negatively by many officers. Officers also perceived the agency as being harder on male clients for drinking, although more officers personally felt female alcoholic clients were harder to work with. There are important differences in treatment needs for male and female alcoholics, but the differences are in kind, not in seriousness of the problem or in quality of treatment. Based on officer reports in the survey, they have had less experience working with female alcoholics, so it is understandable that there may be some ambiguities and uncertainties in how to deal with them. Nevertheless, since their numbers are increasing, this appears to be a topic of utmost concern for future educational efforts.

Theoretical

The present study was an attempt to provide some empirical support for the societal reaction or labeling approach to deviance. There has been no attempt to deny that the person labeled as deviant is a voluntary actor who contributes to deviance outcomes. Instead, with the recognition that deviance outcomes are the result of an interactive process, this research focused on the other party to the interaction, a portion of the "audience." Also, rather than emphasizing the formal labels attached by impersonal people-processing organizations, it concentrated on social control agents who interact at a more personal, primary level with deviants. It was impossible to follow the process all the way through to actual responses by alcoholic clients, but the researcher tried to follow it far enough to examine implications of informal labeling for the deviant. Numerous studies were cited which did provide empirical evidence that the behavior of human services professionals based on stereotypes had important consequences for alcoholics with whom they interacted.

As described above, it was found that objective understanding of alcoholism was still tinged with moralistic judgments of alcoholics (see Wolf et al., 1965; Sterne and Pittman, 1965, for descriptions of behavioral results of this medical/moral overlap). Reports of past behavior with alcoholic clients also reflected this dual evaluation of alcoholics. Further, officers with more punitive attitudes toward clients in general were found to extend those punitive attitudes to the way alcoholic clients should be dealt with. Evidence also indicated that when factors underlying officers' surface definition of the situation were probed (Robinson, 1976; Suchar, 1978), the behavior they reported became even more understandable within the labeling framework.

In an earlier study (Berger, 1975), it was found that some critics of the labeling approach view it as basically pessimistic in seeing negative deviance outcomes as almost inevitable and predetermined. To the contrary, the researcher is much more optimistic; i.e., once the components making up and underlying the process are documented, it seems they can be changed. Becker's (1964:3) contention bears repeating: ". . . if we view deviance as something that arises in interaction with others, we realize that changes in interaction may produce significant changes in behavior." Similarly, although labeling theory is widely criticized for not asking why deviants deviate in the first place, Becker's comment is not that far removed from those of differential association theorists who do probe causes for deviant behavior. Specifically, while using differential association to explain deviant behavior, Sutherland and Cressey (1978) proposed the same differential association (i.e., interaction) can be used to rehabilitate criminals. Likewise, Trice and Roman (1970) combined labeling and differential association theory to describe in part why Alcoholics Anonymous works in the recovery process for alcoholics.

Methodological

This study replicated some widely used scales to measure focus variables, which provided yet another occupational group for comparative purposes. With the semantic differential scales, a few pretest subjects and study respondents wrote in comments to the effect that "I can't answer this because not all people in those categories are alike." This type of response agreed with the researcher's humanistic concern that decreased stereotyping would be beneficial for both "normal" and alco-

holic people. However, the vast majority of respondents showed that stereotyping is alive and well; they also provided responses consistent enough with previous studies that the researcher feels a reliable replication has been added to the literature.

The Marcus Alcoholism Questionnaire has been used primarily with health professional or general population samples, so a totally different occupational group was added for comparison with other groups on this instrument, with results not that different from previously studied groups. However, in the seventeen years since Marcus' (1963) original factor analysis, there has been a great deal of change in views in the alcoholism field. Therefore, Marcus' items were factor analyzed using the probation/parole officer responses, yielding twelve factors instead of the original nine. Only two factors exhibited some overlap, those on emotional difficulties and character defect. Since the instrument was used for comparison of probation/parole officer views with those of other groups, no attempt was made to analyze the new set of factors. However, a future methodological contribution certainly can be made by doing additional research with the questionnaire to determine if the sample in this study was simply unique or if the structure of beliefs about alcoholism in fact is changing. If the latter possibility *is* the case, then new instruments need to be devised, especially since the Marcus Questionnaire appears to have been one of the favorites in this area since it was developed.

The present study was somewhat unique in its attempt to compare attitudes toward the condition of alcoholism with attitudes toward the alcoholic person. Because of the absence of prior research on this comparison, two relatively different types of scales had to be used. The

only similarities between the two scales were that they have been widely utilized and both used Likert-type scales. The results here were interesting enough that the researcher would suggest further studies using the same scales on other samples or in the development of scales with more similarities to test the same relationship (especially if the Marcus scale should be found to be out-of-date).

Suggestions for Future Research

The research reported here was admittedly exploratory and descriptive since it was examining old attitudes with a new group and since it was probing some relationships not previously researched. It does provide some baselines for several types of additional research, including:

1. Alcohol-related views of probation/parole officers in other states and among other criminal justice personnel need to be ascertained, not just to find out whether the sample here was unique, but also because of the critical relationship between crime and alcohol abuse.
2. More complete studies of other human services professionals who represent people-processing organizations in primary relationships with clients/patients need to be conducted to provide empirical support (or the lack of it) for the labeling approach.
3. Behavioral observation needs to be combined with survey research to test more completely the labeling approach instead of relying on reported behavior.
4. Since this research provided another example in a growing list of occupations where traditional alcoholism education bears little or no relation to changes in attitudes, the researcher

would like to see an educational experiment like the one described above (Fisher et al., 1976) carried out with the group studied here or some other group, adding the control groups Fisher et al. could not provide.

5. The results of this study indicate that further research needs to be done comparing attitudes toward alcoholism with attitudes toward alcoholics. The medical/moral overlap has been documented previously on attitudes toward one or the other, but findings here suggest it may be even stronger and more complex when comparing views toward the condition with views toward the person. Even with more positive attitudes toward the condition, the person still was stigmatized.

6. It would be useful to examine views and behavior of the other party to the interactive process, the alcoholic probation/parole client, to provide more meaningful understanding of deviance outcomes.

7. Another rarely tested comparison tested in this research, views toward male versus female alcoholics, yielded conflicting results, depending on whether one looked at expressed attitudes or reported behavior. Given the unconfirmed traditional wisdom, the confusing results here, and the continuing rapid increase in the number of female alcoholics, this relationship needs to be studied with a variety of occupational and general population groups. Such information could have important implications for females believing the traditional wisdom in seeking treatment for their alcoholism.

8. The Marcus Alcoholism Questionnaire needs to be administered to

several occupational groups and factor analyzed for reasons discussed above.

9. Although it was concluded that occupation itself provided the major reference group for alcohol-related attitudes in this study, that variable obviously could not be controlled. Except for Mackey (1969), who came to the same conclusion, other studies have produced mixed results. The occupational reference group hypothesis needs to be explored with members of other occupations.

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APPENDICES

APPENDIX A

JOB DESCRIPTION FOR PROBATION AND PAROLE OFFICER I

PROBATION AND PAROLE OFFICER I[a]

DEFINITION:

Under immediate supervision, performs field work involved in the rehabilitation of persons who are on probation as the result of a criminal conviction, and/or in the rehabilitation of persons paroled from correctional institutions; performs related work as required.

EXAMPLES OF WORK PERFORMED:

Supervises the activities of probationers and parolees to insure their compliance with the terms of the probation or parole order; develops employment opportunities for probationers and parolees; advises clients concerning personal and family problems; counsels with concerned members of the family, friends, neighbors, businessmen, etc., regarding their relationship with the client.

Conducts pre-sentence and pre-parole investigations and writes special reports for use by the courts, the Pardon and Parole Board and other interested and authorized persons.

Maintains detailed records, and issues periodic reports.

Performs public relations work in the explanation of the duties and responsibilities of the Probation and Parole Section of the Division of Community Services, of the conduct requirements placed upon probationers and parolees, and of the attitudes the public should develop toward persons under the jurisdiction of the Probation and Parole Section.

Arrests and transports probation or parole violators whenever required.

In the event of a prison riot or disturbance, may be called upon to assist in security operations.

MINIMUM QUALIFICATIONS:

1. A bachelor's degree from an accredited college or university including at least twenty-four (24) semester hours in any combination of psychology, sociology, social work, criminology, education, criminal justice administration, penology, or police science. (Statutory: Senate Bill 23. 1975 Session)

2. Some knowledge of the theory, techniques and trends in the field of rehabilitation; of public and private welfare and employment services available to probationers and parolees; of current social and economic conditions; of report writing and record keeping; all as evidenced by a passing grade on an appropriate examination.

3. Ability to establish and maintain effective working relationships with probationers, and parolees, the relatives and friends of probationers and parolees, the courts, attorneys, welfare and various governmental jurisdictions, employment agencies, various civic and social organizations, departmental employees and the general public; to conduct several projects simultaneously; to organize and present facts and opinions clearly and concisely, both orally and in writing; all as evidenced by an investigation and/or an interview.

4. Applicants must possess a valid Oklahoma Driver's License and have an automobile available for continuous use in the performance of assigned duties at the time of appointment.

5. No person who have [sic] been convicted of a felony or a crime involving moral turpitude may be appointed to this classification unless he/she has been granted a full pardon by the proper agency. (Oklahoma Statutes, 1977 Suplement [sic], Title 70,)(3311)

OKLAHOMA: CODE: 4171 ADOPTED: 7-1-67 REVISED: 7-18-78

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[a]Source: State of Oklahoma Merit System.

APPENDIX B

CATEGORIES FOR OTHER CRIMINAL JUSTICE JOBS HELD BY PROBATION/PAROLE OFFICERS

CATEGORIES FOR OTHER CRIMINAL JUSTICE JOBS

HELD BY PROBATION/PAROLE OFFICERS

Adult Institutional

Case manager, classification officer, community treatment center, correctional counselor, correctional officer, deputy warden, inmate counselor, pre-release center, work release counseling, etc.

Other Adult Corrections

Community treatment officer, Department of Corrections (DOC) clerical, DOC investigations, DOC medical officer, DOC planning and research, misdemeanant program counselor, probation/parole aide or intern, probation/parole volunteer, etc.

Juvenile Corrections

Cottage house parent or supervisor, counselor or director of delinquent boys' home, juvenile detention center, juvenile girls' facility, juvenile probation (include intern or volunteer), etc.

Law Enforcement

County jail, highway patrol officer, military (halfway house, Air Police, Military Police, stockade intake worker), police work (chief, dispatcher, internal affairs, officer), security, sheriff's office, etc.

Other

Court clerk, court coordinator, criminal investigation, victim assistance, etc.

APPENDIX C

CATEGORIES FOR OTHER TYPES OF JOBS HELD BY PROBATION/PAROLE OFFICERS

CATEGORIES FOR OTHER TYPES OF JOBS HELD

BY PROBATION/PAROLE OFFICERS

Counseling

Adult counseling (crisis, human relations, marriage/family), alcohol/drug counselor, juvenile counseling (child guidance, emotionally disturbed adolescents, Youth Services), social work (case worker, welfare), etc.

People-Oriented

Business owner, cashier, church-related, food service, medical (hospital corpsman, medical assistant, nursing assistant, nursing, psychiatric attendant, respiratory therapist), office (administrative, employment discrimination, management, personnel counselor, supervisor), park ranger, sales (insurance, pharmaceutical, real estate, retail), service (barber, beautician, life guard), teacher, etc.

Nonpeople-Oriented

Farmer/rancher, horse trainer, labor (construction, factory, oil field, plumber, roughneck, truck driver, woodworking), medical (hospital office clerk, medical laboratory technician, unit clerk), military (other than criminal justice or medical), office (clerical, concrete dispatcher, legal assistant, record researcher, secretarial, typist), technical (audiovisual services, computer programming, data processing aid, drafting, electronics, surveyor), writer, etc.

APPENDIX D

CATEGORIES FOR COLLEGE MAJORS OF PROBATION/PAROLE OFFICERS

CATEGORIES FOR COLLEGE MAJORS OF

PROBATION/PAROLE OFFICERS

Criminal Justice

Corrections, criminal justice, criminal justice or law enforcement administration, criminology, law enforcement, police science, sociology (corrections, criminal justice, or law enforcement emphasis), etc.

Related to Criminal Justice

Behavioral science, counseling, counseling psychology, guidance and counseling, human relations, human resources, law, psychology, social science, social work, sociology, etc.

Unrelated to Criminal Justice

Arts and sciences, biology, business, chemistry, child development and family relations, Christian education, civil defense, drama, education, English, forestry, geography, home economics, human ecology, industrial arts, journalism, languages, liberal arts, medical, political science, religion, speech, etc.

APPENDIX E

SURVEY INSTRUMENT

1980

ALCOHOL ATTITUDE

SURVEY

CENTRAL STATE UNIVERSITY / 100 N UNIVERSITY DRIVE / EDMOND, OKLAHOMA 73034

Department of Sociology
And Criminal Justice

There is little information concerning attitudes of corrections personnel about alcohol-related problems and alcoholism. This survey is being funded by the Alcohol Division of the Oklahoma State Department of Mental Health to help fill this information gap. Your assistance in remedying this situation is requested by completing the questionnaire in this booklet. In fact, your cooperation is essential if our information for this study is to be complete.

Your answers on this survey will remain completely anonymous. Thus, your name should not appear anywhere on the questionnaire. Your answers will be combined with those of many others and will appear only in statistical form. It is important, therefore, that you answer each question honestly and as thoroughly as possible.

Please bring your completed survey to your next staff meeting. I will be there personally to answer any questions and to pick up the completed questionnaires. In that way, no one else where you work will have access to your own survey except yourself.

Thank you for your participation. Your assistance and time by answering this questionnaire is greatly appreciated.

Elizabeth A. Berger
Elizabeth A. Berger
Assistant Professor
Department of Sociology and Criminal Justice

A SPECIAL NOTE REGARDING QUESTION NUMBERS: Please do not be confused by the numbering of questions throughout the survey. They are numbered in such a way that data can be key punched directly from the questionnaire.

PLEASE CIRCLE THE NUMBER OF THE ANSWER WHICH MOST ACCURATELY DESCRIBES YOUR SITUATION, OR FILL IN BRIEFLY WHERE WRITTEN ANSWERS ARE REQUESTED. MAKE SURE YOUR CIRCLE IS SMALL ENOUGH TO ENCLOSE ONLY ONE NUMBER FOR EACH QUESTION.

Card 01

1-4. Survey No. __ __ __ __ (Leave blank)

5. Type of agency:

1 State probation and parole
2 Municipal probation
3 Other:
SPECIFY: ____________________

6. If state agency, what district:

1 District 1
2 District 2
3 District 3
4 District 4
5 District 5
6 District 6
7 District 7
8 Not a state agency

7. Sex: 1 Male
2 Female

8-9. Age: __ __ years

10. Racial or ethnic origin:

1 American Indian/Native American
2 Black/Afro-American
3 Oriental
4 Spanish/Mexican American
5 White/Caucasian
6 Other:
SPECIFY: ____________________

11. What size community were you brought up in:

1 Farming/small town (under 5,000)
2 Town (5,001 - 25,000)
3 Small city (25,001 - 50,000)
4 City (50,001 - 100,000)
5 Urban (100,001 plus)
6 Communities of different sizes

12. What size community do you live in now:

1 Farming/small town (under 5,000)
2 Town (5,001 - 25,000)
3 Small city (25,001 - 50,000)
4 City (50,001 - 100,000)
5 Urban (100,001 plus)

13. Marital status:

1 Never married
2 Married
3 Separated
4 Divorced
5 Widow/Widower

14-15. What religious affiliation do you consider yourself:

1 Roman Catholic
2 Jewish
3 Christian Protestant (allows drinking alcoholic beverages)
SPECIFY: ____________________
4 Christian Protestant (frowns on drinking alcoholic beverages)
SPECIFY: ____________________
5 Other:
SPECIFY: ____________________
6 None

16. What is the highest educational level you have completed:

1 Some high school
2 High school diploma or equivalent
3 Some college
4 College degree
5 Some graduate work
6 Graduate degree
7 Other:
SPECIFY: ____________________

IF YOU ATTENDED COLLEGE, please give the following information for each college attended: (17-41)

NAME AND LOCATION	DEGREE	MAJOR
____________	______	______
____________	______	______
____________	______	______
____________	______	______
____________	______	______
____________	______	______

42. Your current job title:

____

USING THE SCALE BELOW, CIRCLE THE CORRECT ANSWER FOR ITEMS 43 - 45:

1. Less than one year
2. 1 - 5 years
3. 6 - 10 years
4. 11 - 20 years
5. More than 20 years

43. How long have you been in your current job?

1 2 3 4 5

44. How long have you worked for your present agency?

1 2 3 4 5

45. How long have you worked in the corrections field:

1 2 3 4 5

46-49. List other types of work you have done in the corrections field:

____

____

50-53. List other types of work you have spent considerable time doing:

____

____

54. How often, on the average, do you <u>usually</u> drink beer?

1 Every day
2 Three to six times a week
3 One or two times a week
4 At least once a month, but less than once a week
5 More than once a year, but less than once a month
6 Less than once a year
7 Have never had beer

55. When you drink beer, how much, on the average, do you <u>usually</u> drink at any one time?

1 More than one six pack
2 Five or six cans or glasses
3 Three or four cans or glasses
4 One or two cans or glasses
5 Less than one can or glass
6 Don't drink beer

56. How often, on the average, do you usually drink wine?

1 Every day
2 Three to six times a week
3 One or two times a week
4 At least once a month, but less than once a week
5 More than once a year, but less than once a month
6 Less than once a year
7 Have never had wine

57. When you drink wine, how much, on the average, do you usually drink at any one time?

1 Over six wine glasses
2 Five or six wine glasses
3 Three or four wine glasses
4 One or two wine glasses
5 Less than one wine glass of wine
6 Don't drink wine

58. How often, on the average, do you usually have drinks containing liquor (whiskey, gin, rum, mixed drinks, etc.)?

1 Every day
2 Three to six times a week
3 One or two times a week
4 At least once a month, but less than once a week
5 More than once a year, but less than once a month
6 Less than once a year
7 Have never had liquor or whiskey

59. When you drink liquor, on the average, how many drinks do you usually drink at any one time?

1 Over six drinks
2 Five or six drinks
3 Three or four drinks
4 One or two drinks
5 Less than one drink
6 Don't drink liquor

79-80. Card 01

Card 02

1-4. Survey No. __ __ __ __ (Leave blank)

Describe briefly all of the following types of training or other educational experience you have had regarding alcoholism:

5 -7. Discussed briefly in college course____________________ ______________

8-10. College course with it as major topic____________________________

11-13. Special training programs____________________________________

14-16. Workshops or Institutes____________________________________

17-19. Inservice education____

20-22. Attended open AA meeting(s)__________________________________

23-25. Visited inpatient treatment program(s)__________________________

26-28. Visited outpatient treatment program(s)_________________________

29-31. Other____

32-38. Do you think you need more training regarding alcoholism for your job?

1 No: WHY? ____________________
2 Yes: WHY? ____________________
WHAT ASPECTS? ____________________
____

39-45. Do you want more training regarding alcoholism for your job?

1 No: WHY? ____________________
2 Yes: WHY? ____________________
WHAT ASPECTS? ____________________
____

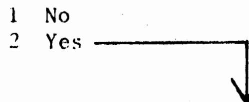
46. How much training in alcoholism do you think most probation/parole officers receive?

1 None
2 Very little
3 Some, but not enough for the job
4 Enough to get the job done
5 Too much, other job concerns are more important

COMMENTS: ____________________
____

47. Do you know the names of any hospitals, agencies, or organizations to which you could refer your clients for drinking problems?

1 No
2 Yes



IF YES: (48-77)

Which organizations do you know about?	Check if you know how to contact it	About how many clients have you referred?		Rank them in order of effectiveness in working with alcoholics (1 = most effective)
		Men	Women	

79-80. Card 02

Card 03

1-4. Survey No. __ __ __ __ (Leave blank)

5-20. Following is a list of criteria different professional people use as indicators of successful treatment of alcoholism; please respond to each column:

	Check all the ones you agree with	Rank the ones checked in order of their importance (1 = most important)
Abstinence, no drinking at all	______	______
Decreased problems in living (job, family, legal, etc.)	______	______
Controlled drinking	______	______
Improved physical health	______	______
More time between drinking bouts	______	______
Fewer problems reported by family	______	______
Increased self respect	______	______
Other______	______	______

WE WOULD LIKE TO TURN TO SOME QUESTIONS ABOUT YOUR OWN CASE LOAD AND CLIENTS.

21-23. How many clients would be an ideal size case load? ______

24-31. How many clients do you have in your current case load?

Probationers		Parolees	
Men____	Women____	Men____	Women____

Of the clients in your case load, what percentage would you estimate had alcohol related in any way to the offense they are under supervision for?

	None	Under 25%	25%-50%	51%-75%	Over 75%
32. Men probationers	1	2	3	4	5
33. Women probationers	1	2	3	4	5
34. Men parolees	1	2	3	4	5
35. Women parolees	1	2	3	4	5

Of the clients in your case load, what percentage would you estimate are problem drinkers or alcoholics?

36. Men probationers	1	2	3	4	5
37. Women probationers	1	2	3	4	5
38. Men parolees	1	2	3	4	5
39. Women parolees	1	2	3	4	5

Of the clients in your case load that you estimate are problem drinkers or alcoholics, what percentage have discussed that problem with you? (Voluntarily initiated discussion themselves?)

	None	Under 25%	25%-50%	51%-75%	Over 75%
40. Men probationers	1	2	3	4	5
41. Women probationers	1	2	3	4	5
42. Men parolees	1	2	3	4	5
43. Women parolees	1	2	3	4	5

Of the clients in your case load that you estimate are problem drinkers or alcoholics, what percentage have you discussed that problem with? (You brought it up for discussion?)

44. Men probationers	1	2	3	4	5
45. Women probationers	1	2	3	4	5
46. Men parolees	1	2	3	4	5
47. Women parolees	1	2	3	4	5

Of the clients in your case load that you estimate are problem drinkers or alcoholics, what percentage are getting some kind of treatment or help for their problem? (At least attending some type of treatment program?)

48. Men probationers	1	2	3	4	5
49. Women probationers	1	2	3	4	5
50. Men parolees	1	2	3	4	5
51. Women parolees	1	2	3	4	5

Of the clients in your case load that you estimate are problem drinkers or alcoholics, what percentage are making some improvement with their drinking problem?

52. Men probationers	1	2	3	4	5
53. Women probationers	1	2	3	4	5
54. Men parolees	1	2	3	4	5
55. Women parolees	1	2	3	4	5

56-62. What sorts of things might generally lead you to suspect that a client might have a drinking problem or be an alcoholic?

____

____

63-70. Think of the most recent male problem drinker or alcoholic you encountered in your case load. How long ago was that? ________ How did you know that drinking was causing a problem for him? ______________________________

____

What did you recommend or do about his problem? ______________________

____

What has he done about his problem? ______________________________

____

71-78. Think of the most recent female problem drinker or alcoholic you encountered in your case load. How long ago was that? _________ How did you know that drinking was causing a problem for her? ____________________

____

What did you recommend or do about her problem? ____________________

____

What has she done about her problem? ____________________

____

Card 04 1-4. Survey No. _ _ _ _ (Leave blank)

5-52. Following is a list of work activities; please make the estimates for each column:

0 = Never	Rank according to how much time you actually do each (1 = most time)	Rank according to how much time ideally should be spent on each
Supervising clients	_______	_______
Counseling clients	_______	_______
Paper work	_______	_______
Staff meetings	_______	_______
Consulting with supervisor	_______	_______
Consulting with fellow workers	_______	_______
Consulting with other agencies	_______	_______
Inservice education	_______	_______
Court appearances	_______	_______
Job-related conferences	_______	_______
Other____________	_______	_______
Other____________	_______	_______

FOLLOWING ARE SOME QUESTIONS ABOUT DRINKING PRACTICES OF OTHER PEOPLE YOU KNOW.

USING THE CATEGORIES BELOW, circle the number for the answer which best describes the drinking practices of the following people currently (or when they were living):

1. Non-drinker
2. Infrequent drinker
3. Moderate drinker
4. Heavy drinker
5. Alcoholic drinker
6. Recovered alcoholic
7. Don't know or does not apply

53. Your father	1	2	3	4	5	6	7
54. Your mother	1	2	3	4	5	6	7
55. Your spouse	1	2	3	4	5	6	7
56. Your ex-spouse	1	2	3	4	5	6	7
57. Yourself	1	2	3	4	5	6	7

58-67. If any of the people just mentioned is a recovered alcoholic, what treatment method(s) did they or you use for recovery? ______________________________

____

For each of the following groups, circle the number of the category which best describes how many you would estimate are problem drinkers or practicing alcoholics:

	None	1-2	3-4	5-9	10+	No such relative
68. Your brothers	1	2	3	4	5	6
69. Your sisters	1	2	3	4	5	6
70. Your male children	1	2	3	4	5	6
71. Your female children	1	2	3	4	5	6
72. Other male relatives	1	2	3	4	5	
73. Other female relatives	1	2	3	4	5	
74. Close male friends	1	2	3	4	5	
75. Close female friends	1	2	3	4	5	
76. Male work associates	1	2	3	4	5	
77. Female work associates	1	2	3	4	5	

79-80. Card 04

Card 05

1-4. Survey No. __ __ __ __ (Leave blank)

For each of the following groups, circle the number of the category which best describes how many you would estimate are recovered or recovering alcoholics:

	None	1-2	3-4	5-9	10+	No such relative
5. Your brothers	1	2	3	4	5	6
6. Your sisters	1	2	3	4	5	6
7. Your male children	1	2	3	4	5	6
8. Your female children	1	2	3	4	5	6
9. Other male relatives	1	2	3	4	5	
10. Other female relatives	1	2	3	4	5	
11. Close male friends	1	2	3	4	5	
12. Close female friends	1	2	3	4	5	
13. Male work associates	1	2	3	4	5	
14. Female work associates	1	2	3	4	5	

For any of the people noted as recovered alcoholics in items 5 - 14, what treatment method(s), that you know of, did they use for recovery? ______________________________

____

Below are a number of statements about various topics, which are primarily concerned with attitudes and opinions, rather than matters of fact. Therefore, there are no right or wrong answers.

Please indicate your opinion on EACH statement, giving the first answer that comes to mind, rather than stopping to think through any statement for very long. Your first impression is most important.

Please use the rating scale below to indicate the response which most nearly represents your feeling. CIRCLE ONLY ONE ANSWER FOR EACH STATEMENT.

1 -- DEFINITELY DISAGREE
2 -- TEND TO DISAGREE
3 -- TEND TO AGREE
4 -- DEFINITELY AGREE

		D			A
15.	Referring alcoholic clients to some agency or organization for help with their drinking problems is part of the job of a probation/parole officer.	1	2	3	4
16.	A client with a drinking problem should have probation or parole revoked and serve the remainder of his/her sentence in jail or prison.	1	2	3	4
17.	I would describe the general philosophy of my agency toward clients as rehabilitative.	1	2	3	4
18.	Alcoholic men clients are harder to work with than are alcoholic women clients.	1	2	3	4
19.	In my opinion, the best way to work with probation and parole clients in general is to assist them in solving their major problems in living.	1	2	3	4
20.	Before alcoholic clients can stop drinking, they need to gain some insight into the reasons for their drinking.	1	2	3	4
21.	In my opinion, the best way to work with probation and parole clients in general is to have as little contact with them as possible.	1	2	3	4
22.	Trying to help a client with his or her drinking problems has a low priority among my professional activities.	1	2	3	4
23.	Men clients are less likely to be alcoholics than are women clients.	1	2	3	4
24.	Alcoholic clients can realize why they drank and solve their other problems only after they stop drinking.	1	2	3	4
25.	In my opinion, the best way to work with probation and parole clients in general is to have frequent contact with them.	1	2	3	4

1 -- DEFINITELY DISAGREE
2 -- TEND TO DISAGREE
3 -- TEND TO AGREE
4 -- DEFINITELY AGREE

		D			A
26.	Getting drunk a few nights a year should not be regarded as of much importance, provided the individual is not driving.	1	2	3	4
27.	Alcoholic women clients are harder to work with than are alcoholic men clients.	1	2	3	4
28.	Alcoholic women clients are likely to have more additional problems in living than are alcoholic men clients.	1	2	3	4
29.	Correctional and helping agencies should have workers who have specialized responsibility for alcoholics.	1	2	3	4
30.	In my opinion, the best way to work with probation and parole clients in general is to keep them constantly mindful that violations can get their probation or parole revoked.	1	2	3	4
31.	I would describe the general philosophy of my agency toward clients as getting cases closed with as little hassle as possible.	1	2	3	4
32.	Drinking in moderation is a positive good, if used to promote sociability.	1	2	3	4
33.	Women clients are less likely to be alcoholics than are men clients.	1	2	3	4
34.	I would like to be a person with special responsibility for alcoholics in my agency.	1	2	3	4
35.	My agency is not too concerned about clients' alcohol problems unless they create legal problems.	1	2	3	4
36.	Counseling alcoholic clients about their alcohol problems is <u>not</u> part of the job of a probation/parole officer.	1	2	3	4
37.	Using a moderate amount of alcohol to relax from tension is beneficial for the individual.	1	2	3	4
38.	I would describe the general philosophy of my agency toward clients as protective.	1	2	3	4
39.	Maybe I can help alcoholic clients solve their other problems after they stop drinking.	1	2	3	4
40.	Individuals who voluntarily abstain from drinking are better off than those who take any alcohol.	1	2	3	4

1 -- DEFINITELY DISAGREE
2 -- TEND TO DISAGREE
3 -- TEND TO AGREE
4 -- DEFINITELY AGREE

		D			A
41.	I would describe the general philosophy of my agency toward clients as humanistic.	1	2	3	4
42.	My agency will be harder on men clients for drinking than it will on women clients for drinking.	1	2	3	4
43.	In my opinion, the best way to work with probation and parole clients in general is to treat them more as "patients" than as offenders.	1	2	3	4
44.	To effectively help alcoholics requires special training.	1	2	3	4
45.	In my opinion, the best way to work with probation and parole clients in general is to make sure they remember who is boss.	1	2	3	4
46.	Alcoholic men clients are likely to have more additional problems in living than are alcoholic women clients.	1	2	3	4
47.	The best thing to do about a client who is having a drinking problem is to ignore it unless he or she breaks a major law or commits another serious probation or parole violation.	1	2	3	4
48.	In my opinion, the best way to work with probation and parole clients is to give them as much freedom as possible as long as they don't get in trouble.	1	2	3	4
49.	I would describe the general philosophy of my agency toward clients as punitive.	1	2	3	4
50.	My agency does not get too concerned if clients break probation or parole rules about drinking, if they are not breaking more major rules.	1	2	3	4
51.	Maybe I can help alcoholic clients solve their other problems if they will cut down on their drinking.	1	2	3	4
52.	A client's drinking problems are nobody's business but his or her own.	1	2	3	4
53.	I feel that I personally do not have much to offer alcoholics in the course of my job.	1	2	3	4
54.	My agency will be harder on women clients for drinking than it will on men clients for drinking.	1	2	3	4
55.	Breaking probation or parole rules about drinking should be sufficient cause for revocation.	1	2	3	4

Following you will find a number of statements about alcoholism. We want to know how much you agree or disagree with each of the statements.

Like everyone else, you will probably feel that you do not know the answer to some of the statements. When this occurs, please make the best guess you can.

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

Please use the rating scale below to indicate the extent to which you agree or disagree with each statement. BE SURE TO CIRCLE YOUR RESPONSE.

1 -- COMPLETELY DISAGREE
2 -- MOSTLY DISAGREE
3 -- DISAGREE MORE THAN AGREE
4 -- NEUTRAL
5 -- AGREE MORE THAN DISAGREE
6 -- MOSTLY AGREE
7 -- COMPLETELY AGREE

		D						A
56.	A person who drinks to the point of drunkenness is almost always an alcoholic.	1	2	3	4	5	6	7
57.	People who become alcoholics are usually lacking in will power.	1	2	3	4	5	6	7
58.	Most alcoholics have no desire to stop drinking.	1	2	3	4	5	6	7
59.	The average alcoholic is usually unemployed.	1	2	3	4	5	6	7
60.	A person can inherit a weakness for alcohol.	1	2	3	4	5	6	7
61.	The alcoholic is helpless to control the amount of alcohol he or she drinks.	1	2	3	4	5	6	7
62.	Alcoholics usually have severe emotional difficulties.	1	2	3	4	5	6	7
63.	Alcoholism is best described as a habit rather than an illness.	1	2	3	4	5	6	7
64.	The alcoholic drinks excessively mainly because he or she enjoys drinking.	1	2	3	4	5	6	7
65.	An alcoholic can get into as much trouble by drinking beer as by drinking liquor.	1	2	3	4	5	6	7
66.	A person who frequently stays intoxicated for several days at a time is unquestionably an alcoholic.	1	2	3	4	5	6	7

1 -- COMPLETELY DISAGREE
2 -- MOSTLY DISAGREE
3 -- DISAGREE MORE THAN AGREE
4 -- NEUTRAL
5 -- AGREE MORE THAN DISAGREE
6 -- MOSTLY AGREE
7 -- COMPLETELY AGREE

		D						A
67.	The alcoholic is seldom helped by any sort of medical or psychological treatment.	1	2	3	4	5	6	7
68.	The alcoholic has only himself or herself to blame for his or her problems.	1	2	3	4	5	6	7
69.	Alcoholics, on the average, have a poorer education than other people.	1	2	3	4	5	6	7
70.	Alcoholics seldom harm anybody but themselves.	1	2	3	4	5	6	7
71.	Hardly any alcoholics could drink less even if they wanted to.	1	2	3	4	5	6	7
72.	The most sensible way to deal with alcoholics is to compel them to go somewhere for treatment.	1	2	3	4	5	6	7
73.	The alcoholic is a morally weak person.	1	2	3	4	5	6	7
74.	An alcoholic's basic troubles were with him or her long before he or she had a problem with alcohol.	1	2	3	4	5	6	7
75.	Once a person becomes an alcoholic he or she can never learn to drink moderately again.	1	2	3	4	5	6	7
76.	The harm done by alcoholics is generally over-estimated.	1	2	3	4	5	6	7
77.	Very few alcoholics come from families in which both parents were abstainers.	1	2	3	4	5	6	7
78.	Even if an alcoholic has a sincere desire to stop drinking, he or she cannot possibly do so without help from others.	1	2	3	4	5	6	7

79-80. Card 05

Card 06

1-4. Survey No. __ __ __ __ (Leave blank)

5.	Nobody who drinks is immune from alcoholism.	1	2	3	4	5	6	7
6.	Even if a heavy drinker is able to stop drinking for several weeks at a time, he or she may still be an alcoholic.	1	2	3	4	5	6	7

1 -- COMPLETELY DISAGREE
2 -- MOSTLY DISAGREE
3 -- DISAGREE MORE THAN AGREE
4 -- NEUTRAL
5 -- AGREE MORE THAN DISAGREE
6 -- MOSTLY AGREE
7 -- COMPLETELY AGREE

	Statement	D						A
7.	Alcoholism is a sign of character weakness.	1	2	3	4	5	6	7
8.	Alcoholism never comes about very suddenly.	1	2	3	4	5	6	7
9.	Unhappy marriages and other unpleasant family situations often lead to alcoholism.	1	2	3	4	5	6	7
10.	Alcoholism is not a disease.	1	2	3	4	5	6	7
11.	Most alcoholics could not be rehabilitated even if more help were available for them.	1	2	3	4	5	6	7
12.	Alcoholics are seldom found in important positions in business.	1	2	3	4	5	6	7
13.	Preferring to drink alone rather than with friends is a sign of alcoholism.	1	2	3	4	5	6	7
14.	Alcoholics are usually in good physical health.	1	2	3	4	5	6	7
15.	The alcoholic is basically a spineless person who has found an easy way out of his or her problems.	1	2	3	4	5	6	7
16.	Some people who drink heavily, but only on weekends, are alcoholics.	1	2	3	4	5	6	7
17.	An alcoholic usually has something in his or her past which is driving him or her to drink.	1	2	3	4	5	6	7
18.	Most alcoholics are completely unconcerned about their problem.	1	2	3	4	5	6	7
19.	With proper treatment, some alcoholics can learn to take the occasional social drink without getting into trouble.	1	2	3	4	5	6	7
20.	Most alcoholics are either drunk or drinking every day.	1	2	3	4	5	6	7
21.	A person usually has very little warning before he or she becomes an alcoholic.	1	2	3	4	5	6	7

NOW WE WOULD LIKE TO ASK YOU SOME INFORMATION ABOUT ALCOHOL ITSELF.

The statements will be either TRUE or FALSE. Circle "T" if the statement is true; circle "F" if it is false. If you do not know the answer, DO NOT GUESS. If you do not know the answer, circle "DK" for DON'T KNOW.

22. T F DK Drinking milk before drinking an alcoholic beverage will slow down the absorption of alcohol into the body.

23. T F DK Wines are made by fermenting grains.

24. T F DK Alcoholic beverages do not provide weight-increasing calories.

25. T F DK In America drinking is usually considered an important socializing custom in business, for relaxation, and for improving interpersonal relationships.

26. T F DK Gulping of alcoholic beverages is a commonly accepted drinking pattern in this country.

27. T F DK Alcohol is usually classified as a stimulant.

28. T F DK Alcohol is not a drug.

29. T F DK A blood alcohol concentration of 0.1% is the legal definition of alcohol intoxication in most states in regard to driving.

30. T F DK Approximately 10% of fatal highway accidents are alcohol-related.

31. T F DK Alcohol was used for centuries as a medicine in childbirth, sedation, and surgery.

32. T F DK Table wines contain from 2 - 12% alcohol by volume.

33. T F DK It is estimated that approximately 85% of the adult Americans who drink misuse or abuse alcoholic beverages.

34. T F DK Many people drink to escape from problems, loneliness, and depression.

35. T F DK Liquor mixed with soda pop will affect you faster than liquor drunk straight.

36. T F DK The most commonly drunk alcoholic beverages in the United States are distilled liquors (whiskey, gin, vodka, etc.).

37. T F DK For a 150 pound person to keep his or her alcohol concentration below the legally intoxicated level means he or she would have to drink less than three beers an hour.

38. T F DK A person cannot become an alcoholic by just drinking beer.

39. T F DK To prevent getting a hangover, one should sip his or her drink slowly, drink and eat at the same time, space drinks over a period of time, and never over drink for his or her limit.

40. T F DK Responsible drinking can result in relaxation, enhanced social interactions, and a feeling of well being.

41. T F DK Distilled liquors (gin, whiskey, vodka, etc.) usually contain about 15 - 20% alcohol by volume.

42. T F DK Moderate consumption of alcoholic beverages is generally not harmful to the body.

43. T F DK It takes about as many hours as the number of beers drunk to completely burn up the alcohol ingested.

44. T F DK An ounce of whiskey contains about 60 calories.

45. T F DK Many people drink for social acceptance, because of peer group pressures, and to gain adult status.

46. T F DK A blood alcohol concentration of .02 usually causes a person to be in a stupor.

47. T F DK Liquors such as gin, scotch, and whiskeys are usually distilled from mashes made from fermenting grains.

48. T F DK Proof on a bottle of liquor represents half the per cent of alcohol contained in the bottle.

49. T F DK The United States lacks a national consensus on what constitutes the responsible use of alcoholic beverages.

50. T F DK There is usually more alcoholism in a society which accepts drunken behavior than in a society which frowns on drunkenness.

51. T F DK Beer usually contains from 2 - 12% alcohol by volume.

52. T F DK Eating while drinking will have no effect on slowing down the absorption of alcohol in the body.

53. T F DK Drinking coffee or taking a cold shower can be an effective way of sobering up.

54. T F DK Wines throughout history have been commonly drunk at religious ceremonies and family gatherings.

55. T F DK Drinking of alcoholic beverages has been common in the U.S. since the Puritans first settled here.

56. T F DK Alcohol has only been used in a very few societies throughout history.

57. T F DK Liquor taken straight will affect you faster than liquor mixed with water.

79-80. Card 06

At the top of each of the following pages you will find a phrase; beneath that phrase are several pairs of adjectives (such as "fair-unfair"). You are asked to indicate how you feel about the phrase at the top of each page in relation to each pair of adjectives.

If you feel that the concept at the top of the page is VERY CLOSELY RELATED to one end of the scale, you should place your "X" as follows:

fair _X_:____:____:____:____:____:____ unfair

OR

fair ____:____:____:____:____:____:_X_ unfair

If you feel that the concept is QUITE CLOSELY RELATED to one or the other end of the scale (but not extremely), you should place your "X" as follows:

fair ____:_X_:____:____:____:____:____ unfair

OR

fair ____:____:____:____:____:_X_:____ unfair

If the concept seems ONLY SLIGHTLY RELATED to one side as opposed to the other side, then your "X" should be as follows:

fair ____:____:_X_:____:____:____:____ unfair

OR

fair ____:____:____:____:_X_:____:____ unfair

The direction toward which you check depends upon which of the two ends of the scale seems most characteristic of the thing you are judging.

If you consider both sides of the scale equally associated with the concept, or if you are undecided, then you should place your "X" in the middle space:

fair ____:____:____:_X_:____:____:____ unfair

IMPORTANT: 1) Be sure you check every scale for every concept.

2) Never put more than one "X" on a single scale.

3) Do not spend more than a few seconds on each scale. Your first impression is what is important.

Card 07
1-4. Survey No.
(Leave blank) _ _ _ _
5-22

NORMAL WOMAN

foolish	____:____:____:____:____:____:____	wise
understandable	____:____:____:____:____:____:____	confusing
calm	____:____:____:____:____:____:____	excitable
weak	____:____:____:____:____:____:____	strong
self-reliant	____:____:____:____:____:____:____	dependent
active	____:____:____:____:____:____:____	passive
good	____:____:____:____:____:____:____	bad
strange	____:____:____:____:____:____:____	familiar
dangerous	____:____:____:____:____:____:____	safe
motivated	____:____:____:____:____:____:____	aimless
worthless	____:____:____:____:____:____:____	valuable
reliable	____:____:____:____:____:____:____	unreliable
predictable	____:____:____:____:____:____:____	unpredictable
tense	____:____:____:____:____:____:____	relaxed
ignorant	____:____:____:____:____:____:____	intelligent
timid	____:____:____:____:____:____:____	bold
hopeless	____:____:____:____:____:____:____	hopeful
healthy	____:____:____:____:____:____:____	sick

PLEASE GO TO NEXT PAGE

23-40

ALCOHOLIC WOMAN

foolish	_____:_____:_____:_____:_____:_____:_____	wise
understandable	_____:_____:_____:_____:_____:_____:_____	confusing
calm	_____:_____:_____:_____:_____:_____:_____	excitable
weak	_____:_____:_____:_____:_____:_____:_____	strong
self-reliant	_____:_____:_____:_____:_____:_____:_____	dependent
active	_____:_____:_____:_____:_____:_____:_____	passive
good	_____:_____:_____:_____:_____:_____:_____	bad
strange	_____:_____:_____:_____:_____:_____:_____	familiar
dangerous	_____:_____:_____:_____:_____:_____:_____	safe
motivated	_____:_____:_____:_____:_____:_____:_____	aimless
worthless	_____:_____:_____:_____:_____:_____:_____	valuable
reliable	_____:_____:_____:_____:_____:_____:_____	unreliable
predictable	_____:_____:_____:_____:_____:_____:_____	unpredictable
tense	_____:_____:_____:_____:_____:_____:_____	relaxed
ignorant	_____:_____:_____:_____:_____:_____:_____	intelligent
timid	_____:_____:_____:_____:_____:_____:_____	bold
hopeless	_____:_____:_____:_____:_____:_____:_____	hopeful
healthy	_____:_____:_____:_____:_____:_____:_____	sick

PLEASE GO TO NEXT PAGE

41-58

NORMAL MAN

foolish	___:___:___:___:___:___:___	wise
understandable	___:___:___:___:___:___:___	confusing
calm	___:___:___:___:___:___:___	excitable
weak	___:___:___:___:___:___:___	strong
self-reliant	___:___:___:___:___:___:___	dependent
active	___:___:___:___:___:___:___	passive
good	___:___:___:___:___:___:___	bad
strange	___:___:___:___:___:___:___	familiar
dangerous	___:___:___:___:___:___:___	safe
motivated	___:___:___:___:___:___:___	aimless
worthless	___:___:___:___:___:___:___	valuable
reliable	___:___:___:___:___:___:___	unreliable
predictable	___:___:___:___:___:___:___	unpredictable
tense	___:___:___:___:___:___:___	relaxed
ignorant	___:___:___:___:___:___:___	intelligent
timid	___:___:___:___:___:___:___	bold
hopeless	___:___:___:___:___:___:___	hopeful
healthy	___:___:___:___:___:___:___	sick

PLEASE GO TO NEXT PAGE

59-76

ALCOHOLIC MAN

foolish	____:____:____:____:____:____:____	wise
understandable	____:____:____:____:____:____:____	confusing
calm	____:____:____:____:____:____:____	excitable
weak	____:____:____:____:____:____:____	strong
self-reliant	____:____:____:____:____:____:____	dependent
active	____:____:____:____:____:____:____	passive
good	____:____:____:____:____:____:____	bad
strange	____:____:____:____:____:____:____	familiar
dangerous	____:____:____:____:____:____:____	safe
motivated	____:____:____:____:____:____:____	aimless
worthless	____:____:____:____:____:____:____	valuable
reliable	____:____:____:____:____:____:____	unreliable
predictable	____:____:____:____:____:____:____	unpredictable
tense	____:____:____:____:____:____:____	relaxed
ignorant	____:____:____:____:____:____:____	intelligent
timid	____:____:____:____:____:____:____	bold
hopeless	____:____:____:____:____:____:____	hopeful
healthy	____:____:____:____:____:____:____	sick

79-80. Card 07

THANK YOU FOR PARTICIPATING IN THIS SURVEY. YOUR ASSISTANCE WILL PROVE VALUABLE IN LEARNING MORE ABOUT THIS IMPORTANT TOPIC. ANY COMMENTS YOU HAVE WILL BE WELCOMED, AND THEY MAY BE PLACED HERE.

APPENDIX F

COVER LETTER FOR SURVEY FROM ASSISTANT

DEPUTY DIRECTOR FOR PROBATION AND

PAROLE FOR OKLAHOMA DEPARTMENT

OF CORRECTIONS

DEPARTMENT OF CORRECTIONS
3400 N. EASTERN - P.O. BOX 11443
OKLAHOMA CITY, OKLAHOMA 73111

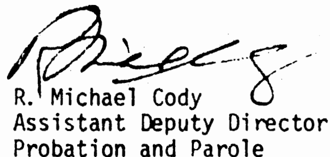
March 21, 1980

Dear Officer:

Please accept this letter as my acknowledgement of the survey which is being conducted to determine attitudes of correctional personnel regarding alcohol related problems and alcoholism. The enclosed letter from Elizabeth A. Berger, Assistant Professor, Department of Sociology and Criminal Justice, is self-explanatory and I would appreciate your full cooperation in completion of the enclosed questionnaire. Your complete and thorough response to questions in this survey will make this endeavor of more benefit to everyone concerned. I assure you that this information is being compiled for the survey only and only Ms. Berger will have access to your personal questionnaire.

Thanking you in advance for your cooperation in this matter, I remain

Sincerely yours,



R. Michael Cody
Assistant Deputy Director
Probation and Parole

RMC:plk

cc: File

APPENDIX G

CATEGORIES FOR RESEARCHER-CONSTRUCTED ITEMS

CATEGORIES FOR RESEARCHER-CONSTRUCTED ITEMS

General Attitudes toward Clients

1. In my opinion, the best way to work with probation and parole clients in general is to assist them in solving their major problems in living. (11-19)[a]

2. In my opinion, the best way to work with probation and parole clients in general is to have as little contact with them as possible. (11-21)

3. In my opinion, the best way to work with probation and parole clients in general is to have frequent contact with them. (11-25)

4. In my opinion, the best way to work with probation and parole clients in general is to keep them constantly mindful that violations can get their probation or parole revoked. (12-30)

5. In my opinion, the best way to work with probation and parole clients in general is to treat them more as "patients" than as offenders. (13-43)

6. In my opinion, the best way to work with probation and parole clients in general is to make sure they remember who is boss. (13-45)

7. In my opinion, the best way to work with probation and parole clients in general is to give them as much freedom as possible as long as they don't get in trouble. (13-48)

Attitudes toward Alcoholic Clients

1. A client with a drinking problem should have probation or parole revoked and serve the remainder of his/her sentence in jail or prison. (11-16)

2. The best thing to do about a client who is having a drinking problem is to ignore it unless he or she breaks a major law or commits another serious probation or parole violation. (13-47)

3. Breaking probation or parole rules about drinking should be sufficient cause for revocation. (13-55)

4. Before alcoholic clients can stop drinking, they need to gain some insight into the reasons for their drinking. (11-20)

5. Alcoholic clients can realize why they drank and solve their other problems only after they stop drinking. (11-24)

6. Maybe I can help alcoholic clients solve their other problems after they stop drinking. (12-39)

7. Maybe I can help alcoholic clients solve their other problems if they will cut down on their drinking. (13-51)

8. A client's drinking problems are nobody's business but his or her own. (13-52)

9. Alcoholic men clients are harder to work with than are alcoholic women clients. (11-18)

10. Alcoholic women clients are harder to work with than are alcoholic men clients. (12-27)

11. Men clients are less likely to be alcoholics than are women clients. (11-23)

12. Women clients are less likely to be alcoholics than are men clients. (12-33)

13. Alcoholic women clients are likely to have more additional problems in living than are alcoholic men clients. (12-28)

14. Alcoholic men clients are likely to have more additional problems in living than are alcoholic women clients. (13-46)

Attitudes toward Working with Alcoholic Clients

1. Referring alcoholic clients to some agency or organization for help with their drinking problems is part of the job of a probation/parole officer. (11-15)

2. Counseling alcoholic clients about their alcohol problems is not part of the job of a probation/parole officer. (12-36)

3. To effectively help alcoholics requires special training. (13-44)

4. Trying to help a client with his or her drinking problems has a low priority among my professional activities. (11-22)

5. Correctional and helping agencies should have workers who have specialized responsibility for alcoholics. (12-29)

6. I would like to be a person with special responsibility for alcoholics in my agency. (12-34)

7. I feel that I personally do not have much to offer alcoholics in the course of my job. (13-53)

Perceived Organizational Philosophies

1. I would describe the general philosophy of my agency toward clients as rehabilitative. (11-17)

2. I would describe the general philosophy of my agency toward clients as getting cases closed with as little hassle as possible. (12-31)

3. I would describe the general philosophy of my agency toward clients as protective. (12-38)

4. I would describe the general philosophy of my agency toward clients as humanistic. (13-41)

5. I would describe the general philosophy of my agency toward clients as punitive. (13-49)

6. My agency is not too concerned about clients' alcohol problems unless they create legal problems. (12-35)

7. My agency will be harder on men clients for drinking than it will on women clients for drinking. (13-42)

8. My agency will be harder on women clients for drinking than it will on men clients for drinking. (13-54)

9. My agency does not get too concerned if clients break probation or parole rules about drinking, if they are not breaking more major rules. (13-50)

Social Drinking Attitudes

1. Getting drunk a few nights a year should not be regarded as of much importance, provided the individual is not driving. (12-26)

2. Drinking in moderation is a positive good, if used to promote sociability. (12-32)

3. Using a moderate amount of alcohol to relax from tension is beneficial for the individual. (12-37)

4. Individuals who voluntarily abstain from drinking are better off than those who take any alcohol. (12-40)

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[a](11-19) refers to page 11, item 19, in the survey in Appendix E.

APPENDIX H

CATEGORIES FOR ALCOHOLISM EDUCATION AND TRAINING

REPORTED BY PROBATION/PAROLE OFFICERS

CATEGORIES FOR ALCOHOLISM EDUCATION AND TRAINING

REPORTED BY PROBATION/PAROLE OFFICERS

Brief Discussion, College Course

Sociology courses
Deviant behavior, introduction to sociology, social problems, social science, sociology major, etc.

Psychology courses
Adolescent psychology, psychopathology, etc.

Criminal justice courses
Alternatives to crime, corrections, criminology, juvenile procedures, law enforcement, etc.

Other courses
Driving, education, health or treatment (behavior modification, counseling techniques, nursing, personal health, rehabilitation counseling, interview skills), human relations, occupational, public safety, social work, etc.

Major Topic, College Course

Alcoholism course
Alcoholism seminar, sociology of alcoholism, etc.

General drug course
Drug abuse class, etc.

Special Training Courses

Other workshops or schools
Alcoholism in the Community, Boys Clubs of America National Conference, college workshops, Domestic Relations Seminar, Drug Abuse Seminar (McAlester, RSAP), DUI schools or workshops, Family Counseling Institute, Inhaling Volatile Substances (White Eagle), MADAC Conference, Mental Health Association Drug and Alcohol Workshop, Norman Alcohol Information Center or Johnston Institute (Norman), NIAAA workshop (Norman), Nebraska School on Alcohol Studies, Northeast Oklahoma Council on Alcoholism and Drug Control, PAC schools, seminar on alcoholism at Taliaferro Mental Health Center, Southwest Institute (Norman), substance abuse program, Women in Treatment, workshop on teenage alcoholics, Worldwide Conference on Alcohol/Drugs (Atlanta), etc.

Inservice Education

Probation/parole officer basic training

Probation/parole training school, training academy, etc.

Probation/parole ongoing education

Alcohol lectures and resources, chemical dependency training in corrections, Department of Corrections training schools, inservice training, lectures related to work, speakers at district meetings, staff development training, staff meetings at Department of Corrections, training from local agencies, etc.

Other occupations

Ambulance technician, breathalyzer operator school, FBI school, military programs, Oklahoma Highway Patrol, peace officer training, police basic training or inservice training, etc.

Open AA Meetings

Personal reasons

For own information, recovering, relative in AA, with a friend, etc.

Work reasons

At institutional level, verify client attendance, with a client, etc.

Education reasons

Conducted at summer workshop, during Cornell program, observation, etc.

Inpatient Treatment Programs

Residential facility

Alpha II, Harbingers, Harbor House, Helen Holiday, Intertribal Alcohol Treatment Program, Miller Manor, NOARC, OAKES, Panhandle Treatment Center, Valley Hope, etc.

State Hospital

Central State Hospital, Eastern State Hospital, Western State Hospital, two out-of-state hospitals listed, etc.

General Hospital

St. Anthony, St. Francis, Veterans Administration, etc.

Outpatient Treatment Programs

CAPCARES, Carl Albert Mental Health Center, Central State Hospital, Detoxification Center, Downtown Alcohol Treatment Center (Oklahoma City), Drug Recovery (Oklahoma City), Mental Health (Shawnee), NAIC, Treatment Alternative to Street Crime (Oklahoma City), etc.

APPENDIX I

CATEGORIES FOR WHY PROBATION/PAROLE OFFICERS DID OR DID NOT WANT MORE ALCOHOLISM TRAINING AND ASPECTS OF ALCOHOLISM WHICH OFFICERS WANTED TO KNOW MORE ABOUT

CATEGORIES FOR WHY PROBATION/PAROLE OFFICERS DID OR DID NOT WANT MORE ALCOHOLISM TRAINING AND ASPECTS OF ALCOHOLISM WHICH OFFICERS WANTED TO KNOW MORE ABOUT

Why Officers Wanted More Training

Many Clients Have Alcohol-Related Problems

A lot of the people I have are in trouble due to alcohol; many of our clients have problems that need to be dealt with; have to face this problem too often with clients; I work with alcoholics daily; major problem with my clients; becoming more serious problem with clients, etc.

Many Alcohol-Related Offenses

Greater emphasis on DWI cases; a lot of crime is alcohol-related; over 50% of clients are drinking at time of violation; most clients have alcohol-related offenses, etc.

Deal with Clients More Effectively and/or Helpfully

To know how to deal with clients; to apply to job-related problems; deal with my clients more effectively; so I can help counsel clients; to better understand how to deal with an alcoholic client; emphasis is toward more involvement with clients; because of the counseling part of my job; to help be a better officer; want to become more tolerant of the alcoholic, etc.

To Increase Knowledge and/or Understanding of Alcoholism

I'm unfamiliar with the topic; more training is always beneficial; to brush up occasionally; because there is a need; don't know enough about it; haven't had comprehensive training course; keep up with latest findings; you can never learn enough about the peculiarities of the disease; more specific knowledge needed; ongoing training prevents burn out; interesting plus a common problem, etc.

Learn Specific Aspects of the Problem

Find out types of programs available; keep current on new techniques and statistics; to understand, counsel and refer; know more about withdrawal; understand behavior and motivation of alcoholic; to make good referrals; understand their reasoning; to recognize symptoms, etc.

General Seriousness of Alcoholism/Alcoholic Clients

Most difficult clients to deal with; alcoholism is a great threat to society; complicated problem; very severe problem, etc.

Coordinate Efforts with Other Agencies

Many clients don't want to deal with other agencies; so our counseling won't interfere with other programs, etc.

Aspects of Alcoholism to Learn More About

<u>Detection of Alcoholism</u>

Signs to recognize; detection; identify alcoholic, etc.

<u>Ways to Motivate Alcoholic to Seek Treatment</u>

Ways to help client to sobriety; counseling client to seek treatment; deal with denial; help alcoholic recognize problem; aid alcoholic to help self to deal with problem; more specific ways to encourage one to seek help, etc.

<u>Causes of Alcoholism/Characteristics of Alcoholics</u>

Cause factor; health; behavior responses; why alcoholics continue drinking; early stages of alcoholism; psychology or personality of alcoholic; addiction; multiple drug use, etc.

<u>Community Resources for Use and Referral</u>

Assistance in getting alcoholic help; places to refer people; comprehensive review of available programs; how set up new programs; reliable referrals, etc.

<u>Understand Alcoholism Treatment Methods</u>

Evaluation of programs; treatment programs with high success rate; latest findings on rehabilitating alcoholics, etc.

<u>Assist Family of Alcoholic</u>

Family counseling; coping with family; help family; family relations, etc.

<u>General Counseling Techniques or Help Alcoholic</u>

Counseling techniques; dealing with the alcoholic; help alcoholic; deal personally with alcoholic; help clients to control their alcoholism; approach techniques, etc.

Why Officers Did Not Want More Training

<u>Have Adequate or Sufficient Knowledge</u>

Have read many articles; have enough training and knowledge; keep myself up to date; experience; sufficient practical training; know enough now; I am competent to handle these problems; adequate training available; enough in college, etc.

<u>Our Job is Referral, Not Counseling</u>

Referral sources better equipped; there are other agencies to refer clients to; enough knowledge to refer client to proper agency; alcohol counseling is done by other agencies, my part is referral; we have specialists; I am in close contact with local programs; alcoholism is a disease, and we aren't doctors; AA does a much better job, etc.

Lack of Time, Other Priorities

Job is more law enforcement-oriented than counseling; alcoholism is only one problem my clients have; not a priority item; not a problem; courts are interested in crime, not treatment; can't be full-time counselors; job isn't counseling-oriented, etc.

Fatalistic Attitude toward Treatment/Training

Show me something that works; training others received hasn't been of benefit; most alcoholics I've worked with don't want help; have not heard anything new at sessions; training is ineffective compared to experience; regardless of knowledge, nothing can be done; training is a waste of time; alcoholics must accept treatment on their own; it is futile, etc.

Don't Want Training

Don't want it; wouldn't be able to use it; not need training; can't use it; know as much about alcoholism as I care to; my job is fine, etc.

APPENDIX J

BACKGROUND VARIABLES EXAMINED WITH ANALYSIS OF VARIANCE OR CHI SQUARE IN RELATION TO FOCUS VARIABLES

BACKGROUND VARIABLES EXAMINED WITH ANALYSIS OF VARIANCE OR CHI SQUARE IN RELATION TO FOCUS VARIABLES

Background Variable	Focus Variables: Knowledge	Attitudes toward Alcoholism	Attitudes toward Alcoholics
District	X	X	X
Urban versus rural districts	X	X	
Sex	X	X	X
Age	X	X	X
Size community raised in	X	X	
Size community live in now	X	X	
Marital status	X	X	
Religious affiliation	X	X	X
Highest educational level completed	X	X	X
Job title	X	X	X
Length of time in job	X	X	
Length of time working for agency	X	X	X
Length of time in corrections field	X	X	
Prior criminal justice jobs	X	X	X
Prior jobs in other fields	X	X	X
Need more alcoholism training[a]	X	X	X
Want more alcoholism training[a]	X	X	X
Perception of how much alcoholism training most officers have	X	X	
Sum of training[a]	X	X	X
Number correct on knowledge scale[a]	X	X	X
Clients remember who is boss	X	X	
Remind clients violations lead to revocation	X	X	
Help clients solve living problems	X	X	
Treat clients as "patients" instead of as offenders	X	X	
Know practicing alcoholics	X	X	X
Know recovering alcoholics	X	X	X
Get drunk sometimes OK if not driving	X	X	X
Moderate drinking good to promote sociability	X	X	
Moderate drinking good to relax from tension	X	X	
Voluntary abstinence better than any alcohol	X	X	X
Helping alcoholics has low priority	X	X	X
Don't have much to offer alcoholics	X	X	X
Would like special responsibility for alcoholics	X	X	X

Background Variable	Focus Variables: Knowledge	Attitudes toward Alcoholism	Attitudes toward Alcoholics
Supervising clients most important	X	X	X
Counseling clients most important	X	X	X
Size of case load	X	X	X
Paper work as most frequent task	X	X	
Break drinking rules should lead to revocation	X	X	
Organization philosophy rehabilitative	X	X	
Organization philosophy punitive	X	X	
Organization philosophy humanistic	X	X	
Organization philosophy protective	X	X	
Agency unconcerned about drinking rules unless more major violations	X	X	
Agency unconcerned about drinking problem unless create legal problem	X	X	

[a]These were focus variables as knowledge issues, but also were used as background variables for other knowledge variables and attitudinal issues.

APPENDIX K

CATEGORIES FOR SYMPTOMS USED BY PROBATION/
PAROLE OFFICERS TO SUSPECT A DRINKING
PROBLEM OR ALCOHOLISM

CATEGORIES FOR SYMPTOMS USED BY PROBATION/ PAROLE OFFICERS TO SUSPECT A DRINKING PROBLEM OR ALCOHOLISM

Legal Problems

Alcohol-related arrests

Past, current, repeated alcohol-related arrests, etc.

Other arrests

Misdemeanors, traffic, assault, violence, resisting arrest, etc.

Job-Related Problems

Unable to hold job, frequent job changes, lost jobs, unstable work record, poor job attendance, missing work, unemployed or underemployed, work habits, etc.

Behavior and Personality

Client admission

Subject admits to drinking problem, statement when case set up, etc.

Intoxication signs

Continually drunk, frequent and compulsive use of alcohol, increasing amounts of alcohol, intoxicated during visits, etc.

Drinking signs

Evidence during home visits, beer cans or liquor bottles or drinks in home, signs of recent drinking, general attitude toward alcohol, known to frequent bars, etc.

Personality traits

Frequent excuses, rationalization for behavior, anxiety, aggressive, forgetfulness, depressed, erratic behavior, moodiness, memory losses, lack of touch with reality, etc.

Reporting behavior

Late reports, failure to report, broken appointments, inconsistent reporting habits, etc.

Irresponsibility

Unreliable, not accept responsibility, unconcerned, client assumes others are responsible for his/her behavior, apathy, lack of motivation, etc.

Low self-image

Low self-esteem, low self-respect, insecure, etc.

Appearance

Excessive drinking signs

Red or yellow or bloodshot eyes, red face, red nose, shakes or tremors, DT's, incoherence, slurred speech, alcohol odor about person, etc.

"Appearance," ill-defined

Poor eyesight, age, physical evidence, tiredness, clothing, "appearance," etc.

Health

Frequent or chronic illness, poor health, physical deterioration, loss of weight, etc.

Living Patterns

Family problems

Marriage or domestic problems, family reports, etc.

Other

Type of friends or associates, frequent moves, unstable living environment, etc.

Reports, Complaints from Others

Family, neighbors, friends, community, official, employer, word of mouth, grapevine, collateral complaints, etc.

Financial Problems

Questionable where money goes, spend money for alcohol, income vs. standard of living, less income without loss of employment, credit or debt problems, etc.

APPENDIX L

CATEGORIES USED BY PROBATION/PAROLE OFFICERS FOR DESCRIBING ALCOHOLIC CLIENT ENCOUNTERS

CATEGORIES USED BY PROBATION/PAROLE OFFICERS FOR DESCRIBING ALCOHOLIC CLIENT ENCOUNTERS

How Officer Knew Drinking was a Problem

Client Admission

Came to me seeking help; advised me he needed help; client statement; she said so; confided in me, etc.

Alcohol-Related Offense

Assault arrest when drunk; DUI arrest; new arrest; nature of offense; criminal record of substance abuse; auto accident with arrests; arson under the influence, etc.

Official Report

From court record; institutional records; reports from other officers; AA required in rules and conditions; got out of OSP (Oklahoma State Penitentiary) on DUI charge; state welfare called about client's children; that's why she was placed on probation; report from other county, etc.

Reports from Others

Family, friends, reputation in community, employer, ex-husband, landlord, grapevine, etc.

Drinking-Related Behavior

Came to office with DT's; continued drinking on probation; often found drinking; stayed drunk; found in bars; empty liquor bottles in home; in hospital for DT's; stated drunk when offense committed; called me every time she got drunk; continual smell of alcohol on breath; hands shaking; now receiving treatment; couldn't stand up; slurred speech; drunk in middle of day, etc.

Other Specific Behaviors

Missed appointments; not report; mood changes; instability on home and job; physical appearance; health; psychological problems; refuse to obey rules; lost job; family problems; beating his wife; bogus checks; drinking problem for years; fight with other women; life style; can't handle problems; wife filed for divorce; two car wrecks; owes many bills; fail to be responsible for self; bored with living; lost husband and child; explosive temper; no motivation; crying; underemployed; blame problems on family, etc.

Officer Recommendation

Alcoholics Anonymous

Go to or continue; go more frequently, etc.

CATEGORIES USED BY PROBATION/PAROLE OFFICERS FOR DESCRIBING ALCOHOLIC CLIENT ENCOUNTERS

How Officer Knew Drinking was a Problem

Client Admission

Came to me seeking help; advised me he needed help; client statement; she said so; confided in me, etc.

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Officer Recommendation

Alcoholics Anonymous

Go to or continue; go more frequently, etc.

Legal Action

Sentence revoked; is in prison; application to revoke, etc.

Nothing, Other Negative

Poor AA attendance; says too busy for treatment; absolutely nothing; very little; claims no transportation and "handling" drinking; absconded supervision; attends AA but drinks on side; "?"; quit AA; discusses problems with me, but refuses to seek other help; wouldn't admit problem; continues to drink, etc.

Other Progress

Slowed up on drinking; abstained from drinking; states he's taking care of his problem; stopped going to bars; got a job; communicates with husband again; has gained self-respect; is successful; better attitude; did fine until he died; drinks less; OK right now; got married to supportive husband; started VoTech to seek stable employment; doesn't drive; successfully completed parole, etc.

Too Soon to Know

Not finalized yet; nothing yet (only two days); too early to tell; haven't checked back with him yet, etc.

Unknown, Ambiguous

Control drinking, but not in treatment; partially improved; claims gone to AA, but see no proof; hard to tell; made attempts to locate suitable program, etc.

VITA[2]

Elizabeth Ann Barnhill Berger

Candidate for the Degree of

Doctor of Philosophy

Thesis: PROBATION AND PAROLE OFFICERS' PERCEPTIONS OF ALCOHOLISM AND ALCOHOLICS

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Biographical:

Personal Data: Born in Tulsa, Oklahoma, August 18, 1940, the daughter of Spencer E. and Viola E. Barnhill.

Education: Graduated from Northwest Classen High School, Oklahoma City, Oklahoma, in 1958; attended Oklahoma City University, 1961-1962; received Bachelor of Arts degree with a double major in Sociology and Psychology from The Lindenwood Colleges, St. Charles, Missouri, in 1963; received Master of Arts degree in Sociology from Washington University, St. Louis, in 1965; post-masters work in Sociology at Washington University, 1965-1967; post-masters work in Sociology at the University of Oklahoma, 1975-1977; completed requirements for the Doctor of Philosophy degree at Oklahoma State University in December, 1980.

Professional Experience: Research Assistant, Social Science Institute, 1960; Research Assistant and Senior Research Assistant, Medical Care Research Center, Jewish Hospital of St. Louis and Washington University, 1963-1966; Consultant, Gerontological Society of St. Louis, 1965; Research Associate and Senior Research Associate, St. Louis County Health Department, 1965-1967; Instructor of Sociology, Evening Division, University of Missouri at St. Louis, 1966-1967; Instructor of Sociology, University of Oklahoma, 1967-1968; Consultant, Oklahoma State Department of Health, 1968-1970; Instructor and Assistant Professor of Sociology, Central State University, Edmond, Oklahoma, 1968-present.

Professional Organizations: Oklahoma Sociological Association, Southwestern Sociological Association, Oklahoma Association on

Alcohol Abuse and Alcoholism.

Other Professional Activities: Listed in Outstanding Young Women of America, 1967; Secretary, American Association of University Professors, Central State University, 1969-1970; appointed to Oklahoma State Committee to Assess Health Education for Youth to Age 21, 1969-1970; member of Nursing Education Committee, Central State University, 1970-present; appointed to Governing Board, Oklahoma Coalition for Clean Air, 1972-1977; listed in Who's Who in American Women, 1977; member of Preschool Education Task Force, Oklahoma City YWCA, 1977-1978; listed in World Who's Who of Women in Education, 1978; appointed to State Planning Body for Alcohol Abuse Prevention, Training and Education, 1980; appointed as Board Member, Harbingers, Oklahoma City, 1980.