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AUTHOR Michaud, Lois I.; And Others
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ABSTRACT

The purpose of this study was to determine the attitudes held by counseling psychologists about alcoholics and alcoholism, and to determine the relationship between these attitudes and the individual's level of experience, knowledge and training in the alcoholism domain. Although counseling psychologists typically deal with developmental issues, career choice, change and adjustment, and situational life problems, it has become increasingly evident that alcohol plays a significant role in the problems of clients they see. In this study counseling psychologists (N=475) responded to a seven-page questionnaire which assessed their attitudes, experience, and factual knowledge about alcoholism. Data were analyzed descriptively and using multiple regression methods. Results indicated: (1) 76% of those sampled indicated that they made a clear distinction between "problem drinking" and "alcoholism"; (2) most viewed alcoholics as generally wanting help, treatable, immature, troublesome in the office, and undependable; (3) most reported feeling comfortable, judgmental, friendly, knowledgeable, and reasonably optimistic when treating an alcoholic client; (4) on the 28-item alcohol/alcoholism information questionnaire, respondents answered an average of 15.92 items correctly; (5) men had more correct answers than women; and (6) no difference in items answered correctly between those who do and those who do not use standardized assessment procedures in identifying and diagnosing alcoholism in their clients. (ABL)

Counseling psychologists' attitudes and knowledge about alcoholism

Lois I. Michaud, Diane S. McDermott, James H. Garner, James W. Lichtenberg
University of Kansas

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Abstract

The purpose of this study was to determine the attitudes held by counseling psychologists about alcoholics and alcoholism, and to determine the relationship between these attitudes and the individual's level of experience, knowledge and training in the alcoholism domain. Although counseling psychologists typically deal with developmental issues, career choice, change and adjustment, and situational life problems, it has become increasingly evident that alcohol plays a significant role in the problems of the clients they see. Current statistics on alcohol-related suicides, domestic violence, incest and child abuse, job loss and disruption, and a myriad of other problems provide ample proof of the insidiousness of this disease, as well as of the need for competent professional counselors. The medical profession has begun to assess the attitudes of its member (Geller, et al., 1989); counseling psychology has begun no such self-examination--despite the fact that our training programs are faced with preparing professionals to address this ever increasing need.

In this study, 1000 randomly selected counseling psychologists were asked to respond to a 7-page questionnaire which assessed their attitudes, experience, and factual knowledge about alcoholism. Data were analyzed descriptively and using multiple regression methods. The results provide evidence for the need for alcohol counseling education for counseling psychologists and provide an impetus for inclusion of this curriculum in professional programs.

Counseling psychologists' attitudes and knowledge about alcoholism

Introduction

The purpose of this study was to investigate the relationship between the attitudes, experience and knowledge about alcoholism among counseling psychologists. For many years, alcohol has been acknowledged to play a significant role in the problems people bring to counseling. In support of this statement, one need only look at current statistics on accidents, injuries, fires, spouse and child abuse, and suicide. In the case of suicide, Kinney and Leaton (1983) state that in up to 65% of all attempts, the individual had been drinking, and that 35% to 40% of all successful attempts are alcohol-related.

Kinney and Leaton also state that in terms of fatal automobile accidents, as many as 40% to 50% of drivers or pedestrians had blood alcohol levels above the legal standard for intoxication. These same authors provide statistics that up to 83% of all fire-related deaths, 50% of home accidents, 70% of all drownings, and 40% of all fatal industrial accidents are alcohol-related.

In terms of alcohol's devastation on the home front, Sorgen (1979) maintains that it is a crucial factor in more than half of the reported cases of child abuse, domestic violence and father-daughter incest. Gorski and Miller (1982) estimate that approximately 20% of private sector hospital beds in the United States are filled with patients who have been treated for alcoholism on at least one occasion.

It is apparent that there is a great, and even urgent, need for competent alcohol counseling among counseling psychologists. Selin and Svanum (1981) express the view that the insidiousness of alcoholism and drug-related problems is

an indicator that mental health professionals should have a basic knowledge and understanding of the evaluation and treatment of alcoholism and drug abuse. According to Geller, et al. (1989), the prevalence of alcoholism and alcohol abuse is high, but diagnosis and treatment are inadequate due to a lack of understanding coupled with negative attitudes on the part of the medical profession.

The medical profession, within the past several years, has begun to examine the attitudes and competencies of its members with respect to the diagnosis and treatment of alcoholism (Geller, et al., 1989; Wechsler & Rohman, 1982). These studies reveal that many doctors and medical students hold negative and moralistic views about alcoholics and do not feel competent to diagnose or treat these individuals. In fact, according to Cooley (1990), "the longer one stays in medical school, the more negative one's attitude is toward alcoholics and the possibility of effective intervention" (p. 1198). Geller, et al. report that it may be the training environment that engenders the negative attitude found among physicians in their study, along with association with faculty who are inadequately informed about alcoholism and exposure mainly to end-state alcoholism.

Kahle and White (1991) looked at attitudes toward alcoholism among psychologists and found that "belief in the disease concept did not preclude accompaniment of attitudes of a moralistic nature" (p. 324) along with stigmatization and attribution of responsibility. These researchers suggested that "the alcoholic's negative self-image and drinking behavior may actually be reinforced by the mental health professional who embraces negative attitudes toward alcoholics" (p. 321).

Despite the obvious need for well qualified professionals to work with the problems of alcoholism, there does not appear to be much response from the academic community, particularly at the graduate level. In a study of 107 American Psychological Association (APA) approved clinical training programs,

Selin and Svanum (1981) found that clinical training and course work related to alcoholism were minimal. Although 66% of the schools surveyed offered courses with some alcoholism or substance abuse content, it was in the context of more general courses on clinical methods or psychopathology. These researchers concluded that the low level of training was clearly disproportionate to the magnitude of the problem.

The Selin and Svanum study was replicated in 1984 by Lubin, Brady, Woodward and Thomas. These researchers surveyed 98 APA approved clinical and counseling psychology programs and found negligible differences between the course offerings of the two areas. Their findings were consistent with those of Selin and Svanum (1981) in that students appeared to receive minimal training in the area of alcoholism and substance abuse. Lubin, et al. (1984) concluded that insufficient treatment for alcohol related problems may be linked to inadequate training provided clinical and counseling psychology students in these areas. They further suggest that "universities are not taking the responsibility for enabling students to look at their own attitudes and value systems regarding working with patients who have alcohol/substance abuse problems..." (p. 153).

Imhof (1991) asserts that countertransference issues may inhibit the counselor from effectively working with an alcoholic. A therapist may find her- or himself "experiencing a formidable and often unwanted array of feelings, reactions and attitudes" toward the client (p. 294). Imhof believes that the most important factor in dealing with countertransference is the effectiveness of the counselor's training and preparation for dealing with the alcoholic client.

Consequences of the paucity of training in alcoholism and substance abuse issues become evident in the reluctance of counselors to identify and refer these problems. According to Cooley (1990), the true measure of effective training in alcohol issues is the number of drinkers successfully referred. A study by

Dalhausen, Dickman, Emener and Lewis (1984) showed that counselors who were untrained in alcoholism and drug abuse recorded only 21 of 343 (= 6%) intakes as alcohol-related, while a trained alcohol counselor reported 84 out of 138 (=61%) subsequent interviews with these same patients as having alcohol-related problems. King and Lorenson (1989) found that "despite evidence that alcohol abuse either causes or exacerbates many problems that necessitate treatment in human service agencies, the alcohol connection is rarely identified as an important factor" (p. 377). Unfortunately, when clients are not identified as alcoholic until they are in the later stages of the disease, their chances for recovery are lessened. King and Lorenson felt that some of the reasons for not referring alcoholic clients in the area, including a belief that to focus on substance abuse would "distract attention from the real problem" or a belief that "treatment is not effective" or would only have a negative effect (p. 377).

Currently an abundance of literature for the lay person exists on alcoholism and other addictions. Scholarly work, however, with the exception of epidemiological studies, exists to a far more limited extent. The fact that alcohol education plays an insignificant role in the professional preparation of counseling psychologists is attested to by the non-existence of published curricula, outcome or evaluation studies of programs, or other studies concerning the preparation of counseling psychologists to work with the alcoholic client. According to Schlesinger (1984), graduate training in psychology ought to recognize the uniqueness of substance misuse and establish a means of monitoring students' competence to treat misusers. This researcher goes on to say that "this may suggest that psychology is out of step with the times and that it has not yet recognized that alcohol and drug misuse differ fundamentally from other behaviors" (p. 136). In all fairness to training programs, Schlesinger points out that those who provide training funds, such as the National Institutes of Mental Health, "have not

specified treatment of substance misuse as a major area for which specialized funding is appropriate" (p. 137).

Myths about alcoholism abound, even if strong data regarding treatment do not. Googins (1984) found that attitudinal myths form a significant barrier to identification and treatment of alcoholism in social service agencies. "Alcoholic clients in most human service agencies stand little chance of being identified, diagnosed and treated for alcoholism in large part because of the negative images, feelings and beliefs...and the subsequent labels attached" (p. 163). There is a "combination of misinformation, negative attitudes, lack of skills and nihilism concerning therapy..." (p. 163). Googins acknowledges, however, that "problem drinking is problem causing" and that when most counselors see a client, the alcoholism is buried within a host of other problems (p. 161). Stainback (1987) asserts that negative attitudes can actually be acquired during the process of education via a transfer to students of the attitudes of the faculty. The result of this process is that "unproductive stereotypes regarding alcoholic patients are perpetuated, few health professionals are stimulated to work with alcoholics, and service delivery suffers tremendously" (p. 23). Stainback also proposes, however, that psychologists can impact medical and counselor education by designing and influencing "the educational components dealing with the development of effective doctor-patient relationships. . .as high levels of interpersonal skills and sensitivity are prerequisites for dealing with the alcoholic patients" (p. 26).

Current enrollment in substance abuse courses reflects the demand for this type of training. Taricone & Janikowski (1990) report that "the diversity of students who are enrolled in substance abuse courses indicates that this type of training has wide appeal to human service professionals from varying disciplines" and the number of non-rehabilitation students enrolled in these courses "suggest that their educational needs are not being met within their

programs" (p. 9). Taricone and Janikowski suggest that attitudes about alcohol misuse must be addressed from a training perspective, including theories about the etiology and treatment of addictions, in order to produce effective, knowledgeable practitioners in the substance abuse field. Miller and Frances (1986) found, in their survey of psychiatrists, that many of the respondents attributed their interest in alcoholism treatment to a training experience and concluded that "training, when it occurs, seems to stimulate continuing interest in alcoholism and substance abuse" (p. 195). Wechsler and Rohman (1982) also found that among the students in their study "students who were most willing to take on alcoholic patients were also far more likely to have been exposed to some kind of alcohol education" (p. 947).

King and Lorenson (1989) identified a number of areas that a training program ought to target in order to counter the stigmatization about substance abuse to which many mental health workers subscribe. They state that "a counselor may feel fearful, insecure, uncertain, and hostile when working with these clients. Such feelings impede effective treatment and must be addressed" (p. 379). Counselor expectations for recovery are important as these expectations impact treatment outcomes. These writers suggest that specialized knowledge and skills necessary to the successful practitioner when working with the alcoholic client include "assessment and diagnosis, limit setting and leverage, client contracting to change drinking behavior, education on alcoholism", as well as knowledge about use of group treatment, family involvement in treatment and use of self-help groups (p. 379). In order to provide the client with alcohol education, the practitioner must be knowledgeable about the subject and confident and competent in presenting this information to the client.

A number of researchers agree that the solutions aimed at enhancing the identification and referral of the alcoholic client are attainable with education.

Googins (1984) suggests promoting an attitudinal change to debunk the myths regarding alcoholism held by mental health workers.

Geller, et al. (1989) report that some medical schools have begun to focus on "skill development in the use of state-of-the-art screening approaches" and to develop "structured patient care experiences with faculty review in small groups to reinforce and model effective diagnostic and treatment approaches" (p. 3119). In addition, the faculty participate in seminars to assist them in modelling appropriate behavior for students, as well as take part in special grand rounds, lectures and fellowship training programs. Imhof (1991) suggests making up for inadequate training in alcoholism treatment by taking advantage of continuing education options, grand rounds, training institutes, workshops and lectures. The end product of a curriculum in alcoholism education, according to King and Lorenson (1989), should be the competence to recognize the symptoms of alcoholism, formulate a diagnosis, develop a treatment program, intervene with clients, recognize and use self-help groups, and willingness to consult and refer.

Schlesinger (1984) summarized the situation quite well in stating "if alcohol misuse constitutes a major health problem and if it overlaps with other psychological problems, then one might argue that graduate psychology training programs should be exposing students to issues of substance misuse to a greater extent than is now the case" (p. 136). Taricone and Janikowski (1990) echo this position by asserting that the disease of alcoholism is a challenge that "must be met by not only rehabilitation practitioners, but educators as well" (p. 4). According to Wechsler and Rohman (1982), "successful identification and treatment of alcohol-related problems are contingent on the caregiver's willingness and ability to recognize and respond to problem drinkers. This response, however, can be encumbered by a lack of appropriate knowledge and skills, moralistic attitudes and prognostic pessimism" (p. 953). They go on to state

that "questions of special population needs and program effectiveness must be addressed in professional education programs so that our future caregivers develop confidence in their professional skills as well as concern for and willingness to treat drinking problems" (p. 954).

In light of the above, the purpose of this study was to investigate the relationship between the attitudes, experience and knowledge about alcoholics and alcoholism as held by counseling psychologists. It was assumed that if counseling psychologists hold negative attitudes or have incorrect information about this disease they will, in general, be less effective as therapeutic agents. The relationship between these variables is important in demonstrating the need for more comprehensive training in the areas of alcohol and drug abuse in counseling psychology training programs.

Method

Subjects

One thousand (N=1000) counseling psychologists were randomly selected from the current membership listing for Division 17 (Counseling Psychology). Member selection from APA's member database was handled by APA's demographics office, which also provided two sets of mailing labels--one for an initial mailing and one for a follow-up reminder. Of the 1000 packets of questionnaires mailed to Division 17 members, 475 (47.5%) usable packets were returned.

Subject demographics. Fifty-nine percent (59%) of the Ss were male, 41% were female; 94.5% were White, 1.5% were Black; 1.5% were Hispanic; 1% were Asian, and 1% were American Indian. Seventy-six percent (76%) of the Ss held Ph.D's; 17% held Ed.D.'s; the remainder indicated holding either a Psy.D., masters degree or specialist degree. The range of years in which these degrees were

awarded was 1952 to 1991 (modal year = 1986; N=37 or 7.8%). The mean age of the subjects was 44.7 (SD=8.52). The mean percentage of time the subjects spent counseling with clients, either individually or in groups, was 67.4% (SD=26.9%). When asked to estimate the incidence (i.e., %) of alcoholism among their clients, the mean was 26% (although there was considerable variability among respondents).

Materials

Each individual selected was sent a packet containing a questionnaire, cover letter, return envelope, and postcard. The questionnaire consisted of four parts. Section A asked for demographic information, as well as a listing of the training experiences of the respondent in the alcohol area. Section B focused on the respondents' professional views and practices concerning the diagnosis and treatment of alcoholism and problem drinking. Section C of the questionnaire was a semantic differential index for determining the respondents' personal attitudes about alcoholism and the alcoholic in general. This section also dealt with the respondent's reported expertise, comfort and confidence in dealing with alcoholic clients. Also included were items which determined the percentage of alcoholic clients in the respondent's case load and the respondent's perceived need and interest in further education about the disease. The last section was a 28-item true/false/don't know test of knowledge about drinking facts and alcoholism information. The items included in the questionnaire were adapted from the work of Geller et al. (1989), Gonzales and Kouba (1979), Kinney and Linsey (1985), Marcus (1980), Morse, Mitchell and Martin (1977), and Warburg et al. (1987). A copy of the survey questionnaire is available from the authors.

Procedure

Each counseling psychologist selected was sent a packet of materials containing a cover letter, 7-page questionnaire, and a self-addressed, stamped

return envelope, and postcard. The respondents were asked to complete the questionnaire and return it and the postcard separately, within 10 days. Each postcard and each name was assigned a number, however there was no identifying number on the questionnaire. At the time the postcard was received, the individual's name was checked off a master list as having returned the questionnaire. After three weeks, those individuals from whom no postcard was received were sent another packet of materials and another request letter stressing the importance of their response.

Results

Descriptive findings

Alcoholism vs. problem drinking. Seventy-six percent of those sampled indicated that they made a clear distinction between "problem drinking" and "alcoholism," and of those making this distinction, 73% indicated that the distinction made a difference in their therapeutic interventions with clients. For those distinguishing between problem drinking and alcoholism, the primary criteria used in making this distinction were clients' ability to control the amount and frequency of their drinking (82%) and the negative effects of drinking (77%). Amount and frequency of drinking were not, in and of themselves, generally identified as criteria for distinguishing between problem drinking and alcoholism, being used as distinguishing criteria, respectively, by 44% and 50% by those making a distinction. Irrespective of any personal distinctions drawn between alcoholism and problem drinking, only 31% of those sampled indicated that they used any formal, standardized instruments in assessing whether or not their clients were alcoholic.

Views regarding the alcoholic person. Using a 10-item 5-point semantic differential scale, subjects indicated their personal views of the alcoholic person. Most respondents reported viewing alcoholics as (a) generally wanting help, (b)

treatable, (c) immature, (d) troublesome in the office, and (d) undependable. Although viewing the alcoholic as treatable, there was considerable variability in terms of their beliefs that the alcoholic was curable. Table 1 summarizes the participants' responses to this portion of the questionnaire and provides a breakdown of those responses by sex.

Insert Table 1 about here

Dealing with the alcoholic person. Again using a 5-point semantic differential scale, subjects indicated their personal views of themselves in dealing with alcoholic clients on 13 different items. Most respondents reported feeling comfortable, judgmental, friendly, knowledgeable, and reasonably optimistic when treating the alcoholic client. Most respondents felt they had "average" to "good ability" to assess alcoholism, and they reported little reluctance to do so. Although reporting that they frequently refer clients to AA, as well as to other chemical dependency resources in their communities, most conducted their own alcoholism assessments and worked with alcoholic clients themselves, rather than referring clients to other treatment sources. Table 2 summarizes the participants' responses to this section of the questionnaire and provides a breakdown of those responses by sex.

Insert Table 2 about here

Knowledge about alcohol and alcoholism

On the 28-item alcohol/alcoholism information questionnaire, respondents (as a whole) correctly answered an average of 15.92 (SD=3.58) of the 28 items, incorrectly responding to an average of 6.42 (SD=2.37) items , and being unsure of the appropriate response to an average of 5.22 items (SD=4.35). Table 3

summarizes the participants' scores on this section and provides a breakdown of those scores by (a) participant sex, (b) whether or not the participants distinguished between alcoholism and problem drinking, and (c) whether or not the participants reported using formal assessment instruments in their detection or diagnosis of alcoholism.

Insert Table 3 about here

Males vs. females. As a group, men had more correct answers than women ($\underline{M}$ = 16.44 for men vs. $\underline{M}$ = 15.14 for women), and fewer "unsure" responses than women ($\underline{M}$ = 4.23 vs. $\underline{M}$ = 6.71); but they also had a greater number of incorrect responses ($\underline{M}$ = 6.96 vs. $\underline{M}$ = 5.59). Due to the ipsative nature of the these measures, the number of items correct was transformed into a proportion correct of those 28 items answered affirmatively (i.e., as either "true" or "false')--thereby eliminating from the analysis those items to which the participants responded "unsure." An analysis of the difference between male and female respondents on these transformed scores found significant difference between the two groups, with the female respondents having a greater proportion of their attempted items as correct, $F(1, 470)=4.75$, $p<.05$. The difference in item uncertainty between the male and female participants was also found to be significant, $F(1,470) =39.53$, $p<.01$. Thus, in terms of "factual" information about alcohol and alcoholism, the males in our sample of counseling psychologists were more certain than the women in their responses. Although this led to them having a higher "correct" score than women on the instrument, it also led to them to be somewhat more in error--as reflected by the number of items to which they responded incorrectly.

Distinguish vs. not distinguish. Analyses of differences in scores between those who do and do not distinguish between alcoholism and problem drinking revealed no difference between the two groups on the proportion of items each

answered correctly, F(1,467)=.644, NS; but a significant difference was found with respect to the number of items on which the respondents were uncertain, F(1,467)=18.56, p<.01. Those who do not distinguish between alcoholism and problem drinking were more unsure of the alcohol knowledge items on the questionnaire (M=6.75) than were those who do make a distinction (M=4.75).

Assess vs not assess. Analyses of differences in scores between those who do and do not use standardized assessment procedures in identifying and diagnosing alcoholism in their clients revealed no difference between the two groups on the proportion of items each answered correctly, F(1,459)=.284, NS; but a significant difference was found with respect to the number of items on which the respondents were uncertain, F(1,459)=30.87, p<.01. Those who do not use formal standardized assessment procedures in their diagnosis of alcoholism were more unsure of the alcohol knowledge items on the questionnaire (M=5.96) than were those who do use standardized assessment instruments (M=3.61).

Correlates of knowledge of alcoholism. Multiple regression procedures were used to investigate the contribution of participants' (a) comfort in dealing with alcoholics, (b) self-reported knowledge in working with alcoholics, and their views of the alcoholic as (c) wanting help and (d) treatable, to the prediction of their knowledge and knowledge uncertainty scores. None of four predictor variables contributed significantly to the prediction of knowledge scores (i.e., proportion of correct responses), F(4,426)=.80, NS; however the regression equation for the participants' uncertainty score was significant, F(4,426)=15.26, p<.01. Contributing significantly to the equation were the participants' self-reported knowledge of working with alcoholic clients (r=.31) and their self-reported level of comfort in dealing with the alcoholic client (r-=.31). Together, the four predictor variables were found to account for 13% of the variance in the knowledge uncertainty scores. Given the direction of scores of the semantic differential items

on the survey questionnaire, the positive correlations between the predictor variables and the uncertain score suggests that self-reported uncomfortableness and ignorance in dealing with the alcoholic client contribute to one's uncertainty on the alcoholism knowledge items. Of course these data also suggest that uncertainty may also lead to feelings of discomfort and ignorance when dealing with the alcoholic client.

Discussion

The results of this study have important implications for counseling psychology training programs as well as for professionals seeking continuing education in the field. It is a positive finding that the majority of counseling psychologists do differentiate between alcoholism and problem drinking and determine treatment based on that distinction. Since the survey did not ask upon what bases these distinctions were made, it is not possibel from these results to determine what guidelines or criteria would have been used. It is of interest to note that the findings of Geller, et.al. (1989) suggest that for medical personnel the rate of differential diagnosis would not be as high.

Also on the positive side is the somewhat more favorable, though also realistic light in which the alcoholic client is seen, and in which the therapist sees him or herself in connection with the client.

One question of interest was whether or not information on alcoholism would be predictive of the distinction made between alcoholism and problem drinking. The only variable that appeared significant was the number of items about what the respondent was uncertain, leaving that question still to be answered.

In reviewing the demographics of the respondents it appears that they are a fairly middle-aged group with a fair amount of experience. The mean estimate of the percentage of alcoholic clients in their caseloads was 26%, indicating

considerable experience with this population. The somewhat positive results may in part be explained by this experience.

If the research of Selin and Svanum (1981) and Lubin, Brady, Woodward and Thomas (1984) still hold, then students emerging from counseling psychology programs have much to learn through field experience about alcoholism. Future research might involve a similar survey to the one in the present study but using doctoral students as the respondents. Not only is the type of training important, but it would be of interest to understand the attitudes and knowledge of these preprofessionals prior to their alcoholism training and practical experience.

Alcoholism continues to be a serious problem in the United States. It would appear that counseling psychologists as a professional group are responsive to the problem, but it is time to call for preprofessional preparation in this important area.

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Table 1

Counseling Psychologists' Views Regarding the Alcoholic Person

View	Group	Rating Distribution(%) 1	2	3	4	5	N	M	SD
Wants help/ Does not want help	Total	13.4	29.5	39.9	13.4	3.9	434	2.65	1.00
	Males	8.9	31.4	39.5	15.5	4.7	258	2.76	.98
	Females	20.2	25.4	41.0	10.4	2.9	173	2.05	1.02
Treatable/ Not treatable	Total	49.1	37.9	9.9	3.1	0.0	454	1.67	.78
	Males	45.4	40.5	10.0	4.1	0.0	269	1.73	.80
	Females	54.4	34.6	9.3	1.6	0.0	182	1.58	.73
Curable/ Not curable	Total	14.3	21.3	23.3	17.6	23.5	442	3.15	1.37
	Males	15.2	22.1	20.9	18.3	23.6	263	3.13	1.39
	Females	12.5	20.5	26.7	17.0	23.3	176	3.18	1.34
Moral/ Immoral	Total	20.5	17.6	58.8	2.1	.9	425	2.45	.87
	Males	16.6	17.0	62.1	2.8	1.6	253	2.56	.86
	Females	26.0	18.9	53.8	1.2	0.0	169	2.30	.87
Troublesome/ Not troublesome	Total	19.5	14.3	39.5	26.7	0.0	435	2.73	1.06
	Males	18.7	16.8	38.5	26.0	0.0	262	2.72	1.05
	Females	20.6	10.6	41.2	27.6	0.0	170	2.76	1.08
Weak-willed/ Strong-willed	Total	7.0	12.8	70.8	9.5	0.0	431	2.83	.69
	Males	6.3	12.5	69.9	11.3	0.0	256	2.86	.69
	Females	8.1	13.4	71.5	7.0	0.0	172	2.77	.69
Mature/ Immature	Total	.5	3.9	47.6	37.5	10.6	435	3.54	.75
	Males	.4	3.5	48.1	39.6	8.5	260	3.52	.72
	Females	.6	4.1	47.1	34.3	14.0	172	3.57	.80

Table 1 (cont.)

View	Group	Rating Distribution(%) 1	2	3	4	5	N	M	SD
Motivated/ Not motivated	Total	2.1	16.0	65.6	14.6	1.6	425	2.98	.68
	Males	1.6	15.6	63.4	16.7	2.7	257	3.04	.70
	Females	3.0	17.0	68.5	11.5	0.0	165	2.88	.63
Easily recognized/ Not easily recog.	Total	40.4	32.7	22.1	4.7	0.0	443	1.91	.90
	Males	35.9	37.4	21.8	5.0	0.0	257	1.96	.88
	Females	46.6	25.8	23.0	4.5	0.0	178	1.85	.93
Dependable/ Undependable	Total	.2	4.1	38.5	44.7	12.4	434	3.65	.76
	Males	.4	4.6	37.1	47.5	10.4	259	3.63	.75
	Females	0.0	3.5	41.3	40.1	15.1	172	3.67	.77

Table 2

Counseling Psychologists' Views of Themselves in Dealing with the Alcoholic Client

View	Group	Rating Distribution(%) 1	2	3	4	5	N	M	SD
Comfortable/ Uncomfortable	Total	33.8	38.6	14.2	12.1	1.3	464	2.08	1.04
	Males	37.0	42.0	10.5	9.4	1.1	276	1.96	.98
	Females	28.6	34.1	19.5	16.2	1.6	185	2.28	1.10
Judging/ Non-judging	Total	25.2	38.7	25.2	11.0	0.0	465	2.22	.95
	Males	23.6	39.9	25.0	11.6	0.0	276	2.25	.94
	Females	27.4	37.6	25.8	9.1	0.0	186	2.17	.94
Pessimistic/ Optimistic	Total	9.5	27.3	39.1	24.1	0.0	465	2.78	.92
	Males	10.9	30.8	34.1	24.3	0.0	276	2.72	.95
	Females	7.5	22.6	47.3	22.6	0.0	186	2.85	.86
Antagonistic/ Friendly	Total	25.1	48.4	23.8	2.8	0.0	463	2.04	.77
	Males	23.6	50.5	22.9	2.9	0.0	275	2.05	.76
	Females	27.6	44.9	25.4	2.2	0.0	185	2.02	.79
Knowledgeable/ Ignorant	Total	22.3	42.2	21.8	12.2	1.5	467	2.28	.99
	Males	26.1	44.6	17.4	9.8	2.2	276	2.17	1.00
	Females	17.0	37.8	28.7	16.0	.5	188	2.45	.97

Table 3

Counseling Psychologists' Knowledge about Alcohol and Alcoholism

Group	N	Knowledge Scores							
		# Correct		#Wrong		#Unsure		%Correct[1]	
		M	SD	M	SD	M	SD	M	SD
Total	475	15.92	3.58	6.42	2.37	5.22	4.35	.70	.10
Males	281	16.44	3.42	6.96	2.30	4.23	4.03	.69	.10
Females	191	15.14	3.70	5.59	2.20	6.71	4.43	.72	.11
Distinguish	358	16.35	3.40	6.55	2.33	4.75	4.12	.71	.10
Not Disting.	111	14.71	3.61	6.05	2.38	6.75	4.74	.70	.10
Assess	144	17.02	3.21	6.94	2.46	3.61	3.82	.70	.10
Not Assess	317	15.52	3.42	6.22	2.26	5.96	4.37	.71	.09

[1] %Correct = $N_{correct}/N_{attempted}$