

THE USE OF THE MANSON EVALUATION
AS AN INDICATOR OF POTENTIAL
HEROIN DEPENDENCE

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Eugene Gubernachuk
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ABSTRACT

Four groups of subjects (male and female) including heroin addicts, alcoholics, criminals, and normals were given the Manson Evaluation, a questionnaire developed to differentiate alcoholics from nonalcoholics. A faking scale was developed to eliminate possible faking by subjects. It was hypothesized that alcoholics and heroin addicts would score similarly and that these two groups would score significantly higher than the criminal and normal groups. Separate one-way analyses of variance were conducted to determine differences among group means on the total test score as well as for trait scores. Differences between individual groups and between mean scores of the seven personality traits within groups were determined by means of individual t-tests. These statistical tests demonstrated that among the male subjects the mean scores of the heroin addicts and alcoholics did not differ but these two groups did score higher than the criminal and normal subjects. The mean scores of the two latter groups also did not differ from each other. On the seven personality traits for males, similar results were obtained. Among the female groups, however, although the mean scores of the heroin addicts and alcoholics did not differ, the criminal group scored much higher than predicted. This result was also reflected in the seven personality traits

measured. It was concluded that the results of this study supported the theory that heroin addicts and alcoholics exhibit similar personality characteristics, and also lended support to the psychological predisposition approach.

The results of this study alone are not sufficient to warrant the use of the Manson Evaluation as a predictive tool for heroin addicts.

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CHAPTER I

INTRODUCTION

HISTORY OF HEROIN DEPENDENCE

In 1898, at the Bayer Company in Germany, a new drug was developed by Professor Heinrich Dreser (Maurer & Vogel, 1967). The drug, prepared by heating morphine with acetic anhydride, was named diacetylmorphine (St. Charles, 1952). Diacetylmorphine was given the trade name of heroin, from the German "heroisch," meaning large and powerful (Lingeman, 1969), thereby disguising to the public any connection it had with morphine (Weekly, 1921). The Bayer Company, when marketing heroin, proclaimed that this drug had no addicting properties (Lingeman, 1969). As a consequence, many doctors who had been using opiates to induce sleep and relieve pain, now tended to prescribe heroin as a substitute (Silverman, 1948).

Heroin was used freely, both alone and in innumerable popular pharmaceutical preparations, not only in Europe but in the Americas (Maurer & Vogel, 1967). As an indication of the gravity of the situation Modell (1967), in reference to the United States, asserts "At the turn of the century it was estimated (however crudely) that there were one million narcotic addicts in this country (p. 348)." A few individuals at the time, among

them Strube at Berlin's University Medical Clinic, Jarrige at the University of Paris, and Pettey in the United States, spoke out against heroin and its hidden addictive properties (Silverman, 1948). Regretfully, no one in those early years from 1899 to 1905 listened to these and other men who rebuked the utility of heroin. Fortunately, as Silverman (1948) pointed out, negative reports concerning heroin began to appear. Montagnini in Italy, Sollier from England and other investigators from Germany and Russia denounced the use of heroin and exposed its addictive properties.

Before commencing with a discussion of the various theories concerned with heroin addiction, the present status of the term "addiction" warrants clarification. The World Health Organization Expert Committee on Addiction Producing Drugs (1952), as a guide to its own deliberations and those of others, attempted to formulate a definition of addiction that would be applicable to drugs under international control. The revised definition of drug addiction proposed by this committee in 1957 was:

A state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose; (3) a psychic (psychological) and generally a physical dependence of the effects of the drug; (4) detrimental effects on the individual and on society (Eddy, Halback, Isbell and Seevers, 1965, p. 722).

This Committee differentiated addiction from habituation, defining the latter as:

A condition resulting from the repeated consumption of a drug. Its characteristics include: (1) a desire (but not a compulsion) to continue taking the drug for the sense of improved well-being which it engenders; (2) little or no tendency to increase the dose; (3) some degree of psychic dependence on the effects of the drug, but absence of physical dependence and hence of an abstinence syndrome; (4) detrimental effects, if any, primarily, on the individual (Eddy et al., 1965, p. 722).

Though these definitions gained some acceptance, confusion in the use of the terms "addiction" and "habituation" continued. Both terms were frequently used interchangeably and often inappropriately. In order to clarify this situation the World Health Organization Expert Committee on Addiction Producing Drugs (1964) recommended substitution of the term "drug dependence" to include both drug addiction and drug habituation. Drug dependence was defined as:

A state of psychic or physical dependence, or both, on a drug, arising in a person following administration of that drug on a sporadic or continuous basis. The characteristics must always be made clear by designating the particular type of drug dependence in each specific case; for example, drug dependence of morphine type, of barbiturate type, of amphetamine type, etc. (Eddy et al., 1965, p. 722).

Physical dependence refers to:

An adaptive state that manifests itself by intense physical disturbances when the administration of the drug is suspended or when its action is affected by the administration of a specific antagonist (Eddy et al., 1965, p. 723).

Psychic dependence is a state in which the individual desires or craves the use of a drug which does not necessarily entail physical dependence upon withdrawal of that drug (Eddy et al., 1965).

One would hardly be convinced today that heroin is a wonder drug saving humanity from the wrath of morphine dependence. Rather, the extensive abuse of heroin is regarded as a definite social, psychological and judiciary problem. It is an enigma which some investigators in the field of drug dependence see as gaining momentum (Ausubel, 1956; Brill, 1970; Lowrie, 1967; St. Charles, 1952; Zimmering, 1951). Why does such a problem exist? Why will an individual, knowing that heroin can produce dependence, voluntarily persist in injecting the substance into his veins until he becomes physically dependent? These are the types of questions being asked.

Many investigators in the field of heroin dependence have hypothesized as to its cause. Basically, there are two schools of thought concerned with this area. The first is oriented towards the notion that one's psychological maladjustment is a major contributing factor towards an individual's addiction. The second states that anyone is capable of being addicted and stresses the importance of withdrawal as a major cause. In the following section these two orientations will be critically discussed.

HEROIN DEPENDENCE AND CAUSATION

Terry and Pellens (1928), early investigators in the field of heroin dependence, were of the opinion that the vast majority of the addicts in the United States were unstable individuals. They were of the opinion that neurotics and psychopaths escaped the realities and burdens of life by the use of narcotics and thus narcotics became a means of escape for these types of individuals. Adams (1937) also believed in the existence of a psychopathic basis in the large majority of addicts.

Charles Schultz (1930), in an extensive study using 318 heroin addicts, classified them into seven categories, which included emotional instability, criminalism, paranoid, nomadism, sexual psychopath, inadequate personality, unclassified. Schultz defined each of these personality characteristics and hypothesized that these might have been variables which predisposed the individual to become dependent upon heroin. Gerard and Kornetsky (1955), in comparing a rather small sample of 30 addicts and 23 controls, found, with the use of testing methods such as the Rorschach and interviews, that addicts tend to deviate toward the psychotic end of the scale while the addicts' controls deviated more toward the neurotic end.

In these writings and those of other investigators

in the field of narcotic dependence (Ausubel, 1956; Brill, 1963; Holmes, 1964; Isbell, 1962; Lehmann, 1963; Vogel & Vogel, 1969) it is apparent that among them there exists a common general hypothesis. They are of the opinion that certain disorders in the personality of the individual preceded the dependence on heroin and that these disorders (which differ with the theorist) acted as a predisposing factor for dependence.

The terms used most frequently by the above cited authors for describing personality disorders of the heroin addict population were neurotic and psychotic (Adams, 1937, p. 53; Holmes, 1964, p. 8; Isbell, 1962, p. 130; Terry & Pellens, 1928, p. 620). Unfortunately, the investigators failed to define their terms more specifically. There are different types of neurosis and psychosis (Cameron & Carmichael, 1963; Taylor, 1954), so if one states that addicts are neurotic or psychotic he must be specific by referring to a particular type of neurosis or psychosis. However, because of the discrepancies usually found in such definitions (Hinsie & Shantzky, 1940), even that will not contribute to uniformity.

Investigators have been critical of the pre-disposition approach, although some have often not given alternative explanations. Joel and Frankel (in Lindesmith, 1968), believed that if one looks hard enough or long enough one could find psychopathic tendencies in almost

everyone. They were of the opinion that in many instances when psychopathology could not be proven the addiction itself was used as an excuse for a maladjusted personality and that this was illogical circular reasoning. O'Donnell (1969) who also criticised the predisposition approach by attacking the methodology of many of these investigators and the inferences that they derive from their research stated:

Numerous students of addiction have classified addicts by the presence or absence of psychopathology and by different psychiatric and psychological nosologies, have correctly pointed out that most addicts studied exhibit some psychopathology, and have illogically inferred that it must be the personality problem which led to the addiction . . . Note that the inference is illogical though not necessarily wrong. It is illogical because no conceivable observation about addicts could be taken as evidence that it was a cause of their addiction, since the data would permit among others, the alternative explanation that the observed fact was an effect of the addiction. Logically, one would have to show, by studying persons prior to addiction, that those who then exhibited personality problems were more likely to develop addiction later (p. 63).

Clausen (1957) extended a valid criticism of the psychological predisposition approach in explaining that it is quite difficult, when interviewing an addict, not to attribute to him the personality traits one's entire training indicate must be there. That, of course, is a criticism which can be applied to many aspects of the social sciences. The limitation is due to the scientist's "tunnel vision" for his own particular biases.

In the study of heroin dependence, another school

of thought, primarily instigated by Alfred R. Lindesmith, is diametrically opposed to the notion that the psychological orientation of the individual has predisposed him towards his dependence. Lindesmith (1968, pp. 157-158), disturbed by the fact that many different terms have been used to describe the pathology of the addict population selected two reports (Terry & Pellens, 1928; Ausubel, 1956). From these he listed 28 different terms used by these two authors to label the personality traits of addicts and by their sheer number indicated this as a criticism of the approach. Lindesmith (1968), in expressing his own theoretical bias, is of the opinion that the addict's withdrawal symptoms¹ are the major causative factor in his dependence. Lindesmith believes that once an individual, who is using narcotics, reaches the point where he experiences withdrawal symptoms and he realizes

¹Maurer & Vogel (1967) have defined withdrawal symptoms pertaining to heroin as physical symptoms which appear after the last injection of heroin if a new injection is not given within 4-6 hours (depending upon last dosage). The symptoms can be classified as:

1. Mild - yawning, eyes water, nose runs, sneezing, perspiration.
2. Moderate - loss of appetite, dilated pupils, tremors, gooseflesh.
3. Marked - deep breathing, fever, restlessness, insomnia; rise in blood pressure.
4. Severe - vomiting, diarrhea, weight loss (p. 168). These symptoms are cumulative and their duration is approximately ten days. Their severity is dependent upon the length of time the addict has taken heroin, the dose level, and purity of the drug.

that these symptoms can be alleviated by the drug, he will consequently repeat using the drug to that end.

It is the author's contention that Lindesmith's point of view seems to be reflected in an experiment published by Weeks (1964). A rat was chronically injected with morphine until tolerance developed. The injections were then terminated and a lever was placed in the cage. A syringe was arranged to automatically inject the animal with morphine every time the lever was pressed. Eventually, the rat began to press the lever at regular intervals. It was further discovered that when the morphine dosage was decreased the response rate increased and, when morphine injections were terminated, the typical abstinence syndrome resulted. The results are compatible with the principle of positive reinforcement (Skinner, 1953), in that presentation of a positive reinforcer and/or removal of a negative reinforcer following a response increases the probability that the response will occur. Thus, in Weeks' experiment, morphine could be considered the positive reinforcer with termination the negative reinforcer. The results, therefore, seem to conform to Lindesmith's notion that the rat injected itself with morphine to supposedly escape withdrawal symptoms, once physical dependence was established. The notion is further supported by Charles R. Schuster (1969) and his colleagues who employed operant conditioning techniques as

a method of studying drug dependence in animals. Lindesmith (1968, pp. 183-184) however, definitely denies any similarities between human and animal studies and criticises the fact that many of these investigators speak of their animals as "addicts."

Thus, although Lindesmith is against the use of animal studies for the purpose of extrapolation to the human condition of addiction, his hypothesis concerning withdrawal symptoms seems to be so incomplete as to lend itself amenable to such comparison. Lundin (1965), in a critique of Lindesmith's hypothesis, remarked that once addiction has occurred the withdrawal syndrome notion may well explain why an addict may sustain his habit but it does not explain why he indulged in drugs initially. In fact, Ausubel (1956) gave several valid reasons why the withdrawal syndrome cannot be accepted as a major factor in the causation of heroin dependence. He stated:

1. Although these symptoms are uncomfortable they are no worse than a bad case of gastro-intestinal influenza.
2. The condition is a self-limited one which disappears in about ten days.
3. It is hardly credible that a normal person would be willing to pay the fantastic price of the drug and risk imprisonment, social disgrace, and ostracism, merely to avoid a moderately severe ten day illness.
4. Each year thousands of persons with severe fractures, burns and surgical conditions receive opiates long enough to develop physiological dependence but

are nevertheless able to break this dependence quite easily.

5. The dosage of morphine required to prevent withdrawal symptoms is never more than one or two grains daily. Hence why will drug addicts take up to twenty grains daily just to feel normal (pp. 377-378).

Ex-addicts, such as Burroughs (1967), have in many instances put forward their own interpretations of the causes of their dependency. In the case of Burroughs he attributes all the blame to the drug itself, stating that anyone is susceptible to heroin addiction if given enough of the drug. This notion of Burroughs' that anyone can become dependent on heroin was one common point raised by the heroin addicts interviewed by the author.² However, it seems rather doubtful that an addict can give a valid explanation of his own dependence. It seems more reasonable to assume that if an individual were endowed with such accurate perception of his own mental state and that of others, the probability that he might become a heroin addict would be rather infinitesimal.

Isidor Chein (1964), a prominent investigator in the field of addiction, is of the opinion that there is no single type or syndrome of maladjustment specific to the

²These interviews were conducted informally with individual heroin addicts at the Narcotic Addiction Foundation of Vancouver in May of 1970. The purpose was to gain a better understanding of the heroin addict.

opiate addict and that investigation should not be focused on some unitary characteristic. The notion that addicts as a population exhibit very few unitary characteristic traits seems tenable. One probably cannot report with assurance that a particular characteristic is definitely a predisposing factor for heroin dependence. As described previously, many types of traits have been proposed as predisposing factors to addiction. Simply by their number it is difficult to discern any particular characteristic which might be used as a base-line or criterion for the predisposition approach. However, a cluster of characteristics might be discernible such that one could predict with a degree of reliability those who might become heroin addicts. Maladjustment in an individual's psychological development can be detected with the aid of psychological tests, particularly those concerned with personality assessment.

A popular personality questionnaire widely used today is the Minnesota Multiphasic Personality Inventory developed in 1943 by Starke and McKinley (Cronbach, 1960). The M.M.P.I. has been utilized extensively in the study of alcoholism and narcotic dependence in order to determine the personality variables involved (Brown, 1950; Button, 1956; Hewitt, 1943; Hill, Hoertzen & Glazer, 1960; Hoyt & Sedlacek, 1958; Olson, 1964; Rosen, 1960).

THE MANSON EVALUATION

In 1948, a personality questionnaire titled the Manson Evaluation was developed by Morse P. Manson (Appendix B). The purpose and method of constructing this test is outlined in the Manual (Appendix A). As is obvious, the Manson Evaluation was developed primarily for alcoholics. However, there exists literature to suggest that alcoholism and narcotic dependence may have many similarities and also similar causative factors.

In reference to drug dependence O'Kelly and Muckler (1955) stated that one craves narcotics for precisely the same reason one craves alcohol, namely, because they both appear to the individual as adequate ways of adjustment.

Gabriel and Kratzman (in Tähkä, 1966) postulated a common predisposition to different kinds of addiction which included alcoholism and narcotic dependence and Meyer (1943) concurred with this view. Mapother (1939), who said that alcoholism often leads to drug addiction, stated there are more similarities than differences in the personalities of alcoholics and drug addicts. Meerloo (1952) believed that although alcoholics usually belong to manic-depressive types and narcotic addicts to schizoid personality types, all addictions show common psychological mechanisms, including unconscious needs for oral

dependency and self-destruction. An Expert Committee of the World Health Organization (1955) has reported that evidence makes it appear that there is more resemblance between the response to the withdrawal of alcohol and of opiates than previously realized.

It is also known that opiate addicts will take drugs of the hypno-sedative type, which induces symptoms resembling alcohol intoxication if they cannot obtain opiates (Kallant & Dews, 1969). Furthermore, many opiate addicts are known to substitute alcohol (a quart or more a day) during periods of abstinence from a particular narcotic drug (Isbell, Harris, Frazer & Wikler, 1955). Conversely, many opiate addicts have had previous alcoholic histories, suggesting there may be a cross dependence between these agents (Isbell et al., 1955). Davis and Walsh (1970) have demonstrated the possible existence of a biochemical basis for alcohol addiction comparable to that of morphine dependence. However, Halushka and Hoffman (1970) are in disagreement with their findings. An increasing number of authors tend to treat drug addiction and alcoholism as comparable orientations based on essentially similar psychological determinants (Glover, 1932; Simmel, 1948; Wexberg, 1951).

It consequently seems that alcohol dependence and heroin dependence have many similarities, and therefore the factors which may predispose an individual to

become an alcoholic may also be in evidence with the heroin addict. Therefore, the Manson Evaluation, designed to detect those individuals who may become alcoholics, might also be applicable to detecting potential heroin addicts. Of course, there are other investigators who indicate that alcoholism and narcotic dependence are two separate phenomena and should be studied as such. Pescor (1941) has written: "The morphine addict goes home and his wife beats him, while the alcoholic goes home and beats his wife (p. 1432)." Wikler (1953) is of the opinion that morphine reduces primary drives and the anxiety associated with the anticipation of these drives. This leaves the individual to pursue with greater freedom such secondary drives as social integration. Alcohol, on the other hand, according to Wikler, gratifies both primary and secondary drives by enabling the alcoholic to act out his aggressions.

Manson used alcoholics and normals as his subjects and identified seven personality traits (Appendix A) in which the alcoholics scored significantly higher than the normals. He then implied that an individual exhibiting these traits potentially may become an alcoholic. Thus, one must assume that, with alcoholics, these traits were in evidence prior to dependence. That, of course, is not empirically based reasoning, as indicated by O'Donnell (1969, p. 63) and could be considered a criticism of

Manson's implication. While a valid criticism, a study of the magnitude O'Donnell has proposed, has not yet been attempted and it is inconceivable that it ever will be, because of the time, resources and sample size required. Until this has been done the approach used by Manson and others may be accepted or at least given consideration on pragmatic grounds.

The literature presented by others concerning the Manson Evaluation is relatively scarce. Murphy (1965), in a study using female subjects, concluded that his results seemed to confirm the validity and reliability of the Manson Evaluation. Boucher (1968), in a study conducted in Germany, reported that he believed the test does not identify alcoholism but only minor maladjustment or a higher degree of neurosis.

As previously reported, there is evidence indicating the similarities between alcohol and heroin dependence. Furthermore, the author is of the conviction that the factors which may have predisposed an individual to heroin dependence may also have been in evidence with the alcoholic. Thus, the study reported herein was undertaken.

Problem

If the Manson Evaluation is presented to a sample of heroin addicts and a matched sample of alcoholics there should be no significant difference between their scores

on the test. However, the scores obtained by control groups who are neither alcoholic nor heroin addicts should differ significantly from the alcoholic and heroin addict group. This would imply that the personality factors which characterize an alcoholic, according to the Manson Evaluation, and which may have predisposed the individual toward alcoholism would also be in evidence with the heroin addict.

Hypothesis

1. On the Manson Evaluation the mean score of heroin addicts does not differ from that of alcoholics, whether male or female.

2. On the Manson Evaluation the mean scores of both heroin addicts and alcoholics differ from the mean scores of normal and criminal control groups, whether male or female.

3. On the Manson Evaluation the mean scores of the criminal and normal control groups do not differ, whether male or female.

CHAPTER II

METHOD

SUBJECTS

Caucasian subjects were selected to constitute four groups: heroin addicts, alcoholics, criminals, normals. After selecting the group of heroin addicts the other three groups were matched to it on age, sex, educational level and marital status (Table 1). Heroin addicts (29 males, 11 females) were defined as those individuals who, at the time of the study, were undergoing treatment for the use of heroin at the Narcotics Addiction Foundation in Vancouver, British Columbia, and had no previous history of alcoholism. All information utilized, pertaining to the heroin addicts, was obtained from the Basic Patient Information Form,³ which is administered to every patient upon admittance to the Foundation (Appendix C).

Alcoholics (31 males, 11 females) were selected from various institutions in Winnipeg, Manitoba (Harbor Light Alcoholic Rehabilitation Center, Winnipeg General

³It was personally communicated by Erwin Henderson (May 1970), researcher at the Narcotics Addiction Foundation that a study to verify the validity of the information on the "Basic Patient Information Form" was conducted by cross-checking various sources (police records, etc.). It was found that the information was valid over 80% of the time.

TABLE 1

MATCHING FACTORS FOR EXPERIMENTAL (HEROIN ADDICTS, ALCOHOLICS)
AND CONTROL (CRIMINAL, NORMAL) GROUPS

GROUP	N	AGE (YEARS)		GRADES COMPLETED		MARITAL STATUS					
		MEAN	RANGE	MEAN	RANGE	SINGLE	MARRIED	DIVORCED SEPARATED COMMON-LAW WIDOWED			
<u>MALE</u>											
Heroin Addict	29	40.10	30-58	8.80	6-12	9	12	0	5	1	2
Alcoholic	31	42.68	30-61	8.87	5-12	8	12	2	5	2	2
Criminal	30	41.30	30-60	8.30	5-13	10	13	0	4	2	1
Normal	30	41.00	30-58	8.93	5-12	9	13	1	5	0	2
Total	120										
<u>FEMALE</u>											
Heroin Addict	11	37.36	30-53	8.64	7-10	1	7	0	1	0	2
Alcoholic	11	38.62	31-54	8.52	6-10	1	8	0	1	0	1
Criminal	9	37.42	31-53	8.46	5-10	1	7	0	1	0	0
Normal	10	38.73	30-55	8.82	6-11	1	8	0	0	0	1
Total	41										

Hospital, River House for Female Alcoholics) where, at the time of the study they were undergoing treatment for alcoholism. To eliminate from the alcoholic group those who had a previous history of drug use the two following written questions were asked at the time the Manson Evaluation was administered:

1. Have you ever used drugs?
2. If so, which types of drugs and under what circumstances?

The criminal group (30 males, 9 females) was selected from Penal Institutions in Manitoba and Ontario (Stony Mountain Penitentiary, Headingly Correctional Institution, Kingston Prison for Women). Only those individuals who had indicated no drug or alcohol involvement on their admission form, the Classification Questionnaire (Appendix D), were selected.

The normal group was selected from the general population in Winnipeg, Manitoba. The information concerned with the individual's criminal and addictive involvement was obtained by attaching a slip of paper to the questionnaire upon which was written:

1. Have you ever been in jail?
2. Have you ever used drugs?
3. If so, which drugs and under what circumstances?

Since 15 of the 30 male heroin addicts tested were

unemployed it was necessary to include the same number to be unemployed in the normal sample. Therefore, 15 unemployed individuals were obtained from the Canada Manpower Centre in Winnipeg, Manitoba. All subjects were 30 years of age or over (male mean = 40.6, range = 30-58), Caucasian, and had no previous alcoholic, narcotic, nor criminal history. A number of unemployed individuals arrived every morning at this centre in order that they could be available if an employer telephoned requesting men for "part-time" employment. They sat together in a room awaiting notification of such employment. These individuals were asked to complete the questionnaire. The Manson Evaluation was administered only to those who volunteered. Along with the Manson Evaluation a separate sheet of paper was added to each questionnaire requesting the following information:

1. Have you ever used drugs?
2. If so, which kind?
3. Do you consider yourself to be:
 - (a) an alcoholic
 - (b) a problem drinker
 - (c) having no alcohol problem
4. Have you ever been in jail?

Only those individuals who answered "No" to number one, checked off part "C" of number three and answered "No" to question four were included in the study.

Within the male groups tested, there were sample differences which are described in Table 2. The male heroin addict sample included individuals who had a criminal history prior to addiction and some who had a criminal history after addiction. This sample also included persons who were unemployed as well as employed. The male alcoholic sample was derived from two different sources as was the male criminal sample. Also, in the male normal sample, as previously indicated, there were employed and unemployed persons.

PROCEDURE

Faking Scale

Prior to administration of the Manson Evaluation to the experimental and control groups, a set of criterion items were established which would indicate faking by the subjects writing the test. The method of developing a faking scale described by Anastasi (1968) was employed for this purpose. One hundred University of Manitoba undergraduates (50 male, 50 female), who were enrolled in first and second year psychology courses, responded to the Manson Evaluation under three conditions:

1. The Normal Condition, i.e., the only instructions given were those on the front of the test.
2. The Fake Good Condition, i.e., the students

TABLE 2

PROFILE OF GROUPS WITHIN THE MALE SAMPLES

GROUP	N	AGE (YEARS)		GRADES COMPLETED		MARITAL STATUS					
		MEAN	RANGE	MEAN	RANGE	SINGLE	MARRIED	DIVORCED	SEPARATED	COMMON-LAW WIDOWED	
Heroin addicts with criminal records prior to addiction	10	39.10	30-50	8.70	6-12	3	4	0	2	0	1
Heroin addicts with criminal records after addiction	19	40.63	30-58	8.89	7-12	6	8	0	3	1	1
Heroin addicts working	14	40.93	30-58	9.07	8-12	5	6	0	2	0	1
Heroin addicts unemployed	15	38.27	30-53	8.60	6-12	4	6	0	3	1	1
Alcoholics (General Hospital)	16	47.31	30-61	9.12	7-12	4	5	1	2	1	2
Alcoholics (Salvation Army)	15	37.73	31-55	8.93	5-12	4	7	1	3	1	0
Criminals (Man. Pen.)	21	43.29	30-60	8.24	5-13	4	7	0	2	1	1
Criminals (Headingly Jail)	9	39.00	31-50	8.44	6-11	6	6	0	2	1	0
Normal (Working)	15	41.40	30-57	8.27	5-12	5	8	0	1	0	1
Normal (Unemployed)	15	40.60	30-58	9.60	7-12	4	5	1	4	0	1

were asked to disregard their previous "normal" responses and to write the test again. This time, however, they were told to attempt to create the best impression they could of themselves.

3. The subjects then were asked to disregard their first two tests and to write the test once more. This time they were requested to create a very unfavorable impression of themselves.

All students responded to all three conditions in the same session and in the same sequence. An item was defined as easily fakable if 100% of the subjects gave a response different from the normal as defined by Manson. Thus, under the fake good condition for a question to be defined as fakable, 100% of the subjects had to answer that question in such a way as to create the best impression of themselves. If every question was answered in the most favorable way, an individual would obtain a score of zero. Under the fake bad condition for a question to be defined as fakable 100% of the subjects had to answer that question in such a way as to create the worst impression of themselves. Therefore, if every question was answered in the least favorable way an individual would obtain a score of 72. Thus, as an example, if for a certain question a "yes" was a deviant response, i.e., a question that Manson found alcoholics responded to as yes, then, for that question to be included in the faking scale 100% of

the subjects under the fake good condition would have to answer "no" to that question or under the fake bad condition 100% of the subjects would be required to answer "yes" to that question.

Of the 72 items on the Manson Evaluation, male undergraduates faked 18 items under condition 2 (fake good) and 15 items under condition 3 (fake bad). Three of these items were faked on both the good and bad conditions. Female undergraduates faked 24 items under the fake good condition and 18 items on the fake bad condition with 10 of these items faked under both conditions. Under the fake good condition 11 items were faked by both male and female subjects and under the fake bad condition six items were faked by both male and female subjects.

To check the possibility of a sequence effect the Manson Evaluation was administered to 24 individuals not attending university, who were randomly selected from the community (Table 3). Six females and six males were assigned to each of the conditions of fake good and fake bad. On the basis of these results four items were eliminated from the female fake good condition and two items from the female fake bad condition. The items included in the final faking scale are given in Table 4.

The questionnaires which had been completed by the experimental groups (heroin addicts and alcoholics) and control groups (criminal and normal) were re-evaluated

TABLE 3
 CHARACTERISTICS OF REVALIDATING FAKING SAMPLE

GROUP	N	AGE (YEARS)		GRADES COMPLETED		MARITAL STATUS	
		MEAN	RANGE	MEAN	RANGE	SINGLE	MARRIED
Male good impression	6	29.17	19-40	11.00	9-13	2	4
Male bad impression	6	30.50	19-42	11.50	10-15	3	3
Female good impression	6	25.00	18-40	12.50	10-14	3	3
Female bad impression	6	29.83	18-57	11.00	10-12	4	2

TABLE 4
 ITEMS CONSTITUTING THE FAKING SCALE

CONDITIONS	QUESTIONS FAKED 100% OF THE TIME												
	1	3	6	8	9	11	12	23	30	33			
Male Fake Good	35	44	46	49	50	51	66	68					
	1	2	9	18	23	25	38	39	41	50			
Male Fake Bad	55	59	61	65	67								
	2	3	8	9	11	12	14	18	22	23			
Female Fake Good	27	30	33	39	56	61	67	68	70	71			
	6	9	10	12	14	22	23	30	33	38			
Female Fake Bad	40	41	47	49	50	67							

utilizing this faking scale. If it was determined that an individual answered all or all but one of the fakable questions in a potentially faking manner then this particular test was disregarded. Table 5 illustrates the number of tests eliminated from the original fake scale in each group.

Testing

The Manson Evaluation was administered in accord with the procedure outlined in the Manual (Appendix A). The heroin addicts, alcoholics and criminals were tested in small groups (not exceeding four) in their respective treatment centres or institutions. The normal group was tested individually, either in their own homes or that of the experimenter. The experimenter administered the tests to all subjects with the exception of the male alcoholic patients in the Winnipeg General Hospital, where this was done by the head nurse on the ward. All subjects participated voluntarily.

TABLE 5
NUMBER OF TESTS ELIMINATED BY FAKING SCALE

GROUPS	<u>N</u>
Heroin Addicts (Male)	1
Heroin Addicts (Female)	0
Alcoholics (Male)	6
Alcoholics (Female)	2
Criminals (Male)	4
Criminals (Female)	0
Normals (Male)	1
Normals (Female)	0

CHAPTER III

RESULTS

Because the Manson Evaluation presents different norms for men and women, separate one-way analyses of variance were used for the male and female samples. As shown in Tables 6 and 7, there were significant group effects for both male ($F = 14.31$, $df = 3/104$, $p < .01$) and female ($F = 3.70$, $df = 3/34$, $p < .05$) subjects.

The t -ratios between groups in the male sample (Table 6) and female sample (Table 7) were computed using the within group mean square (Kolstoe, 1969, pp. 240-243). As hypothesized, the mean score of the male heroin addicts ($m = 31.24$) and alcoholics ($m = 33.64$) did not differ ($t = 1.14$; $p = NS$), though they did differ from both the normal ($m = 20.38$; $t = 5.39$, $p < .01$; $t = 6.37$, $p < .01$) and criminal ($m = 22.38$; $t = 4.27$, $p < .01$; $t = 5.29$, $p < .01$) scores. The mean score of the criminal sample ($m = 22.38$) did not differ from the normal ($m = 20.38$) subjects ($t = .97$, $p = NS$).

In the female samples it was also determined that the mean score of the heroin addicts ($m = 36.70$) and alcoholics ($m = 37.56$) did not differ ($t = .20$, $p = NS$). Surprisingly, not as predicted, there was no significant difference between the heroin addict ($m = 36.70$) and

TABLE 6
 MEANS, SUMMARY OF ANALYSIS OF VARIANCE AND t -RATIOS
 BETWEEN THE MALE GROUPS

GROUP	HEROIN ADDICT	ALCOHOLIC	CRIMINAL	NORMAL
MEAN SCORE	31.25	33.64	22.38	20.38
SOURCE OF VARIANCE	<u>df</u>	SUMS OF SQUARES	MEAN SQUARES	<u>F-RATIO</u>
Between Groups	3	2494.46	831.49	14.31**
Within Groups	104	6041.55	58.09	
Total	107	8536.01		
GROUPS	<u>df</u>			<u>t-RATIO</u>
Heroin Addicts x Alcoholics	51			1.14
Heroin Addicts x Criminals	52			4.27**
Heroin Addicts x Normals	55			5.39**
Alcoholics x Criminals	49			5.29**
Alcoholics x Normals	52			6.37**
Criminals x Normals	53			.97

* $p < .05$

** $p < .01$

TABLE 7

MEANS, SUMMARY OF ANALYSIS OF VARIANCE AND t -RATIOS
BETWEEN THE FEMALE GROUPS

GROUP	HEROIN ADDICT	ALCOHOLIC	CRIMINAL	NORMAL
MEAN SCORE	36.70	37.56	31.89	22.30
SOURCE OF VARIANCE	df	SUMS OF SQUARES	MEAN SQUARES	F -RATIO
Between Groups	3	1111.34	370.45	3.70*
Within Groups	34	3401.68	100.05	
Total	37	4501.02		
GROUPS	df			t -RATIO
Heroin Addicts x Alcoholics	17			.2
Heroin Addicts x Criminals	17			1.07
Heroin Addicts x Normals	18			3.22**
Alcoholics x Criminals	16			1.21
Alcoholics x Normals	17			3.32**
Criminals x Normals	17			2.09*

32

* $p < .05$

** $p < .01$

criminal ($m = 31.89$) scores ($t = 1.07$, $p = NS$) nor between alcoholic ($m = 37.56$) and criminal ($m = 31.89$) scores ($t = 1.21$, $p = NS$), while there was a difference between the criminal ($m = 31.89$) and normal ($m = 22.30$) scores ($t = 2.09$, $p < .05$). As predicted the scores of the heroin addict ($m = 36.70$) and alcoholic ($m = 37.56$) both differed significantly from the normal ($m = 22.30$) sample ($t = 3.22$, $p < .01$; $t = 3.32$, $p < .01$).

Examination of the mean scores of the subgroups within each sample, indicated no significant differences between heroin addicts with criminal records before or after addiction, between heroin addicts who were employed or unemployed nor between normals who were employed or unemployed. Though the alcoholic and criminal subjects were selected from several institutions there were no significant differences between their mean scores.

As described in the manual (Appendix A) the Manson Evaluation includes seven scales, each yielding a subscore on a maladaptive personality trait, which are assumed by Manson to characterize alcoholics in general. The F -ratios of the individual one-way analyses of variance and means for each of the subscores for male and female groups separately are given in Table 8. A significant group effect was evident for all the traits in the male samples except for F -Aloneness whereas among female subjects only trait B -Depressive Fluctuations had no significant group effect.

TABLE 8

F-RATIOS OF THE ANALYSES OF VARIANCE AND MEANS OF THE SEVEN MANSON
EVALUATION SUBSCORES FOR MALE AND FEMALE SUBJECTS

TRAITS	MEANS				F-RATIO
	HEROIN ADDICTS	ALCOHOLICS	CRIMINALS	NORMALS	
<u>MALE</u>					
A-Anxiety	7.18	7.96	3.38	3.21	21.87**
B-Depressive Fluctuations	5.28	4.88	2.81	2.68	13.59**
C-Emotional Sensitivity	4.46	4.48	2.85	3.21	6.48**
D-Resentfulness	4.82	5.02	4.50	2.27	8.90**
E-Incompleteness	9.07	8.24	7.46	5.13	10.84**
F-Aloneness	3.32	3.60	2.77	2.21	1.88
G-Interpersonal Relations	4.25	4.12	3.08	2.27	5.10**
<u>FEMALE</u>					
A-Anxiety	8.60	10.22	7.11	4.30	3.89*
B-Depressive Fluctuations	5.10	6.33	5.00	3.50	2.15
C-Emotional Sensitivity	5.30	6.44	4.44	3.50	3.23*
D-Resentfulness	6.10	6.44	5.89	2.10	11.37**
E-Incompleteness	8.60	9.33	8.22	5.20	3.49*
F-Aloneness	5.10	4.44	4.22	2.20	3.14*
G-Interpersonal Relations	6.10	5.44	5.11	3.10	3.24*

** p < .01

* p < .05

The t -ratios between the possible combinations of the four groups (male and female) with respect to the seven personality traits are given in Tables 9 and 10. Among the male groups the mean differences for the seven traits were as expected. There were no differences between the mean scores of heroin addicts and alcoholics nor between the mean scores of criminals and normals. The mean scores of both the experimental (heroin addict and alcoholic) samples differed significantly from those of both control (criminal and normal) samples. However, among the female groups the criminal subjects scored much higher than predicted. There was no significant difference between the mean scores of the heroin addicts, alcoholics and criminals, though these three female groups each differed significantly from the female normals.

The profiles of the mean scores of the seven traits for male and female are illustrated in Figures 1 and 2. The cleavage between the mean scores of the two experimental and two control groups of males is apparent while the means of both control groups are very similar to Manson's norms. Figure 2 illustrates that the female criminal subjects scored consistently higher than expected and their mean scores were more similar to the heroin addict or alcoholic female scores than to the

TABLE 9
 t-RATIOS BETWEEN COMBINATIONS OF THE FOUR GROUPS ON THE
 SEVEN PERSONALITY TRAITS (MALE)

GROUP	TRAIT						
	A	B	C	D	E	F	G
Heroin vs Alcoholic	1.10	.792	.044	.383	.52		.248
Heroin vs Criminal	5.39**	4.92**	3.66**	.617	2.61**		2.29**
Heroin vs Normal	5.80**	5.33**	2.94**	5.08**	6.57**		3.92**
Alcoholic vs Criminal	6.32**	4.02**	3.62**	.975	1.23		1.97*
Alcoholic vs Normal	6.73**	3.58**	2.87**	5.27**	5.05**		3.56**
Criminal vs Normal	.24	.26	.84	4.33**	3.83**		1.58

NO SIGNIFICANT F-RATIO

** p < .01

* p < .05

TABLE 10

t-RATIOS BETWEEN COMBINATIONS OF THE FOUR GROUPS ON THE SEVEN PERSONALITY TRAITS (FEMALE)

GROUP	TRAIT						
	A	B	C	D	E	F	G
Heroin vs Alcoholic	.99		1.32	.43	.64	.69	.69
Heroin vs Criminal	.91		1.00	.26	.33	.92	1.03
Heroin vs Normal	2.70**		2.16*	5.18**	3.04**	3.10**	3.22**
Alcoholic vs Criminal	1.86		2.27*	.66	1.17	.22	.34
Alcoholic vs Normal	3.61**		3.41**	5.47**	3.59**	2.33**	2.45*
Criminal vs Normal	1.71		1.10	4.78**	2.63**	2.10*	2.19*

NO SIGNIFICANT F-RATIO

** p < .01

* p < .05

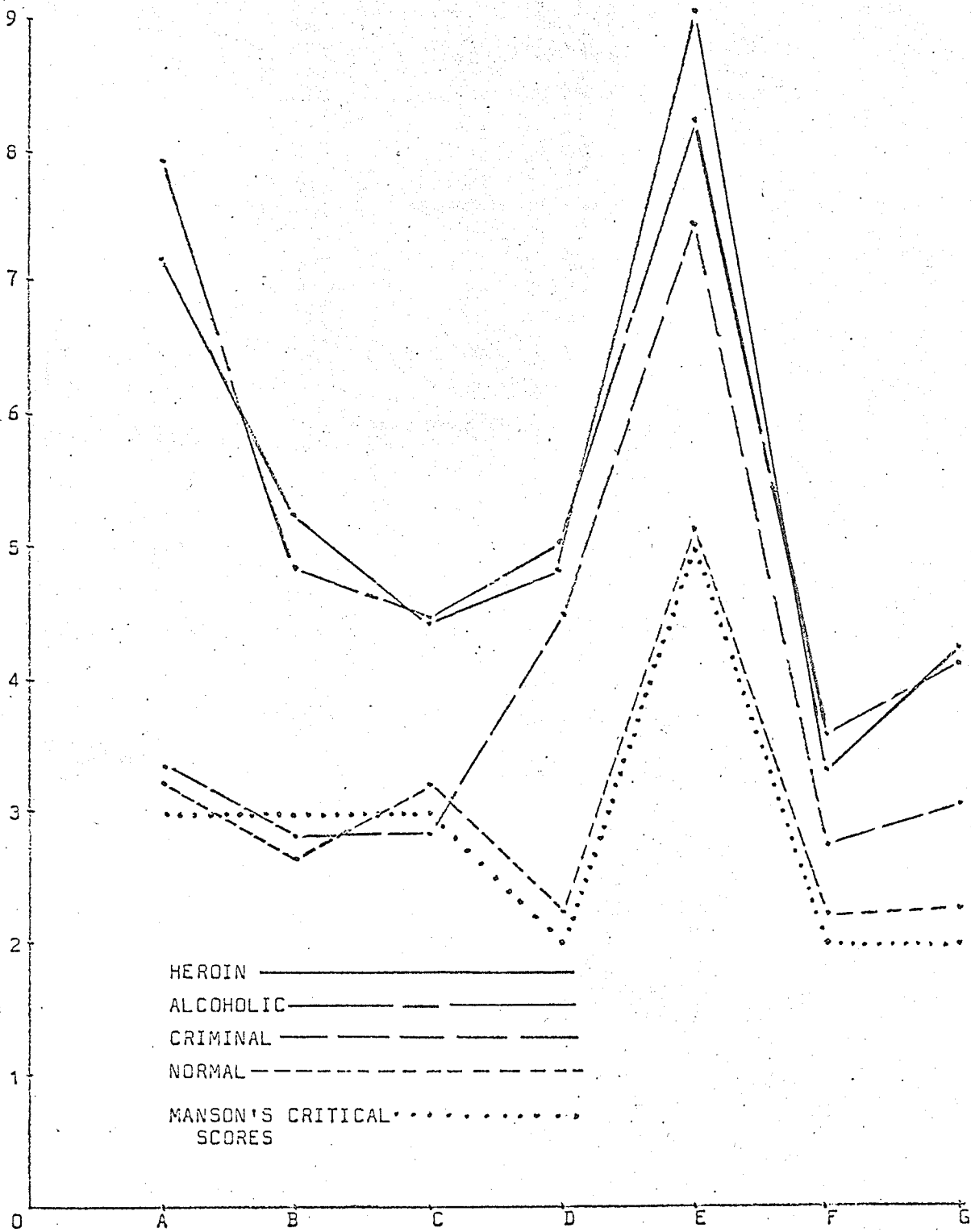


FIGURE 1

MEAN SCORES FOR THE SEVEN TRAITS (MALE)

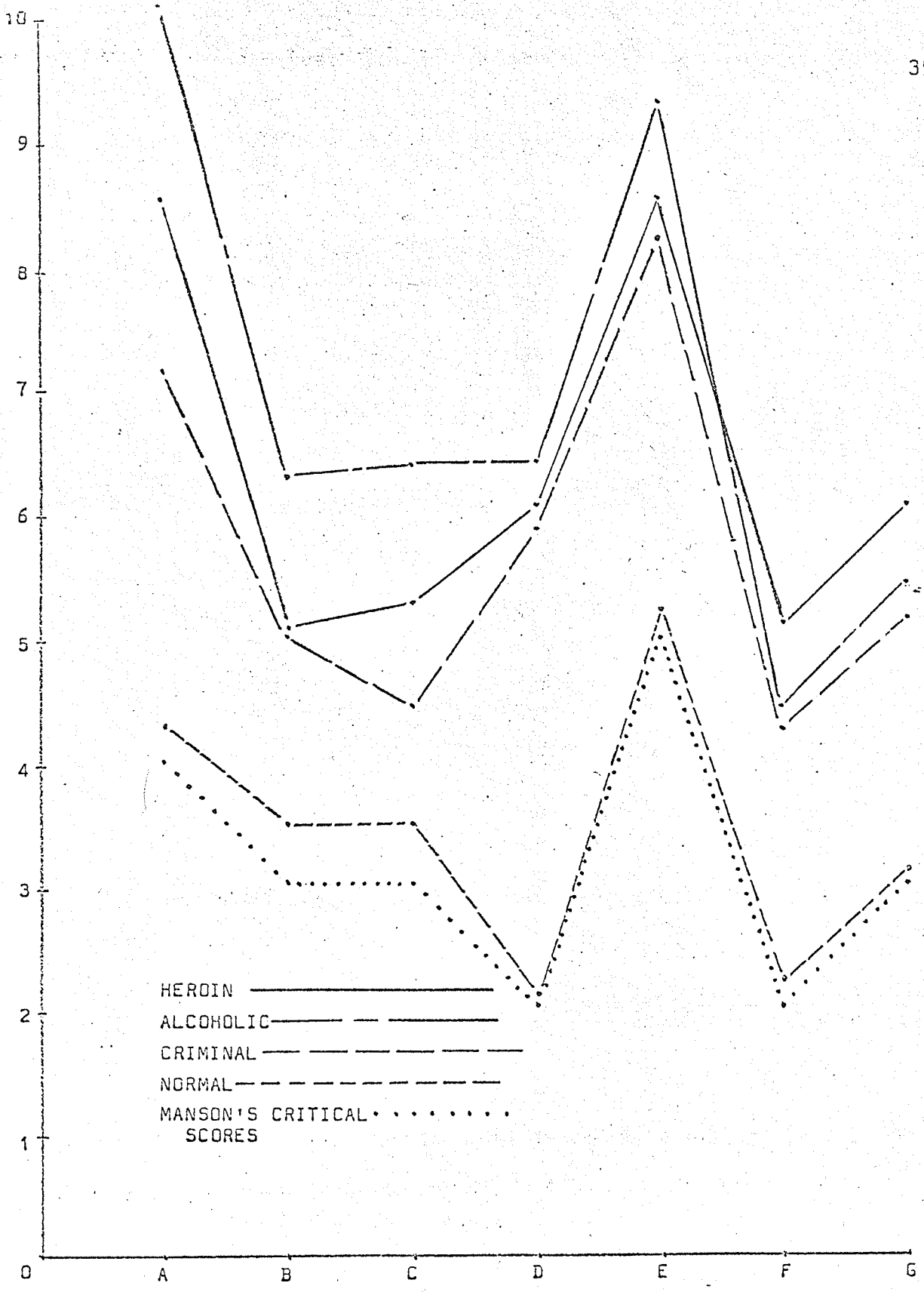


FIGURE 2
MEAN SCORES FOR THE SEVEN TRAITS (FEMALE)

mean scores of the normals or to Manson's critical scores.

CHAPTER IV

DISCUSSION

The results obtained in this study were as expected for the male subjects but not for the female subjects. The male heroin addicts and alcoholic groups did not differ significantly from each other and both were significantly different from the criminal and normal groups. The contention that the personality factors which constitute an alcoholic, according to the Manson Evaluation, and which may have predisposed an individual towards alcoholism may also be in evidence with the heroin addict was supported for the males. If, then, Manson was correct in assuming his test may be used to indicate potential alcoholics, the results obtained support the contention that the Manson Evaluation may be used as a measure of addiction liability in reference to heroin dependence.

Among the female groups the prediction of no significant difference between the scores of the alcoholic sample and the heroin addict sample was supported. However, the female criminal group scored higher than was expected and did not differ from the heroin and alcoholic. A conversation with Miss Des Lauriere, Superintendent of the Women's Correctional Institution in Portage la Prairie Manitoba (Sept. 1970) offers a possible explanation for

these unexpected results, Miss Des Lauriere was of the opinion that women in penitentiaries have a tendency to be more maladjusted than men in penitentiaries. The possible reason being that magistrates and judges do not incarcerate females in penitentiaries unless the charges are serious or the individual is an habitual criminal. Usually women are given suspended sentences, fines or short terms in jail rather than a penitentiary sentence. This may reflect a sentimental bias towards the females and also the lack of facilities in Canada for female prisoners. What facilities exist are very small and inadequate. Thus, a male may receive a penitentiary term for break, enter and theft whereas a female, under similar circumstances, may be given a lesser sentence. Hence, the difference between the male and female criminal samples may reflect a selection bias effected by judicial decisions.

Examination of trait differences indicated that the personality characteristics of both male and female heroin addicts and alcoholics were very similar. Of the seven traits measured none differed significantly between these two groups in both male and female subjects. It will be recalled, however, the F -ratios for F -Aloneness in the male sample and B -Depressive Fluctuations in the female sample were not significant (Table 8). The reason for these two non-significant group effects is unknown.

As with heroin dependence, the literature on alcoholism offers many different theoretical nosologies in respect to underlying causes. Many investigators of alcoholism have adopted the view that one's personality characteristics may have played a large part in predisposing one toward alcoholism (Guze, 1965; Clinebell, 1956; Hoffer, 1964; Knight, 1937; Simmel, 1948; Wallerstein, 1957; Williams, 1964). Catanzaro (1968), critically analyzing this view reported that many of the studies supporting this view have been done with individuals after they are already alcoholics and because of this only inferences could be made as to an individual's personality characteristics prior to alcoholism. He believes though that there are certain characteristics that are quite common in a majority of alcoholics and concluded that various combinations of these characteristics may well have predisposed one towards alcoholism.

Thus, in both heroin dependence and alcoholism many investigators agree that (a) there are personality characteristics which predispose one toward his dependence and (b) those characteristics which predispose one toward alcoholism may also be in evidence in narcotic dependence. The fact that in the present study these groups have scored similarly on the Manson Evaluation indicates similar personality characteristics, thus, suggesting similar causative factors. This result indicates that possibly

narcotic dependence and alcoholism should not be studied as separate, distinct fields of investigation but rather as more unified orientations with similar causative factors. When, for example, one is studying the mother of the addict (Mason, 1958; Zimmering et al., 1951) or the mother of the alcoholic (Lolli, 1956; Gibbons, 1953) possibly it would be advantageous to study such a variable with comparisons between the two addictions rather than separately as if comparison were not possible.

The similarity between the scores of these two groups is not only important in respect to causative factors but also from the viewpoint of treatment. An individual suffering from heroin dependence or alcoholism is usually exposed to a two-fold treatment program: (a) Medical treatment of withdrawal phase and (b) rehabilitation (Catanzaro, 1968; Hayman, 1966; Phillipson, 1970).

The present study was concerned with subjects undergoing some form of rehabilitation. In today's rehabilitative programs for alcoholics different types of treatment institutions are found. Among these are inpatient and outpatient hospital facilities, half way houses, Alcoholics Anonymous, Salvation Army Rehabilitation Centres, and private and public clinics. The types of treatment obtained from these institutions may include medical treatment, chemical therapy (aversive therapy, tranquilizers), psychiatric treatment, group and individual

counselling, family therapy, and religious guidance. For alcoholics, the most recent trend seems to be a cumulative treatment approach in the form of half way houses (Blacker & Kantor, 1968; Richards, 1968) and private and public clinics. Hayman (1966) pointed out that alcoholic treatment is tending to take these forms (a) because of the public health aspects of the problem which then becomes a governmental concern and (b) because these forms of institutions may be easily established at any level of government whether city, county, state, or even local community.

Until recently facilities for the treatment of narcotic addicts in both Canada and the United States were very inadequate, being far out-numbered by those available for alcoholics. However, due to the upsurge of estimated addicts and the decrease in the age of these addicts, a greater number of improved treatment facilities are being made available (Brill, 1970). Once again, as with the facilities for alcoholics, the most recent trend tends to be toward public and private clinics and half-way houses (Connell, 1970). Thus, alcoholics and heroin addicts are treated utilizing similar but separate facilities. The results of this study suggest that the same facilities may possibly be utilized by both groups of addicts, since heroin addicts and alcoholics exhibit similar personality characteristics and consequently their rehabilitative

programs could be more synonymous with each other. It would, therefore, possibly be more beneficial, both economically and psychologically, to treat these individuals within the same facilities rather than separately, with little or no liaison between such facilities.

It is interesting to note that in comparison with the mean scores of the total normal sample in this study (male $m = 20.38$, female $m = 22.30$), Manson's mean scores for his total normal sample were significantly lower (male $m = 14.08$, female $m = 15.28$). This discrepancy may be due in part to the nature of the two samples themselves. Not only were Manson's normal samples much larger (males: $N = 71$; females: $N = 81$) than those in this study (normal male: $N = 29$; normal female: $N = 10$) but on the average his normal subjects were older and more highly educated. Furthermore, Manson's study was carried out in 1948 and this study some 21 years later. The appropriateness of Manson's norms today may, therefore, be questioned. If the average scores of the normal sample in this study are indicative, they would suggest that Manson's critical scores (male ≥ 21 , female ≥ 26) are low. The average scores of the college sample used in developing the faking scale (males = 21.44, females = 24.22) were also higher than Manson's norms (males = 14.08, females = 15.28).

The results of this study are by no means conclusive evidence that the Manson Evaluation measures

predisposition to alcoholism or heroin dependence though they do lend support to such an hypothesis. However, for further research to be meaningful the assumption upon which this hypothesis is based, namely, that such predisposing personality factors actually do exist, requires empirical support particularly of a longitudinal nature. Until empirical evidence of this type is available the Manson Evaluation could not be utilized as a predictive tool. However, the results of this study do indicate that susceptibility to addiction may be measureable if further research is conducted, if not by the Manson Evaluation itself then by a similar test or a battery of tests. Once this point is reached then it is quite feasible to assume that if all school children were tested, complete case histories obtained, etc., then those who were predisposed to addiction could be identified with a reasonable degree of accuracy. If this could be accomplished corrective measures could be instigated immediately rather than once the dependency has started or has quite progressed as is usual in today's situation.

If one were to assume that addiction is definitely the result of predisposing personality factors and if one were certain that such a predisposed personality could be identified either by the Manson Evaluation or similar tests, what steps should be adopted in order to prevent this addiction? A more reasonable question would be: what

steps should be adopted in order to prevent or change this predisposed personality? Until some of these independent variables are determined, actual prevention can only be partially successful. One step toward the development of a preventative program, however, is prediction, and if prediction is possible with a reasonable degree of accuracy, then at least some measures may be taken towards prevention.

This study may be criticised on a number of factors. Even though two control groups were used (criminal control and normal control) one may argue that the Manson Evaluation only measures neurosis in general rather than susceptibility to addiction, i.e., those individuals who have a high degree of neuroses may score high on this test. Thus, it may be stated that heroin addicts and alcoholics are neurotic as are some criminals. This would account for the similar results. If this were so then most neurotics would score high on the Manson Evaluation. To control for this factor a sample of neurotics who were not heroin addicts, alcoholics, or criminals should have been tested.

CHAPTER V

CONCLUSION

In the study of narcotic dependence, two schools of thought predominate. One theory states that an individual must have a maladjusted personality which predisposes him toward dependence, the other that anyone can become an addict and that dependence is associated with withdrawal symptoms. Some theorists, who support the former, suggest that alcoholics also exhibit similar personality maladjustments. To investigate whether similarities between heroin addicts and alcoholics do exist the Manson Evaluation, a test developed to differentiate alcoholic personalities from nonalcoholics, was utilized. Prior to this, a faking scale was developed in order to determine possible faking by the groups involved.

Four groups of subjects (male and female) including heroin addicts, alcoholics, criminals and normals were tested. It was hypothesized that for both males and females the mean scores of the former two groups would not differ significantly and also that the latter two groups would not differ but that the former and the latter would differ between each other. In the male groups this hypothesis was supported not only for the total groups but also in respect to the seven personality traits the test

measures. Among the female subjects, however, the criminal sample scored much higher than predicted which was also reflected in the seven personality traits. It was concluded that the theory proposing psychological similarities between narcotic addicts and alcoholics was supported by the results of this study. Further, the results tended to support the psychological predisposition approach, although it was indicated that the Manson Evaluation could not be used alone as a predictive tool.

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APPENDICES

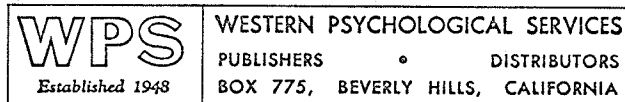
APPENDIX A
THE MANUAL FOR THE MANSON EVALUATION

MANUAL

THE MANSON EVALUATION

By MORSE P. MANSON, Ph.D.

Published By



The Manson Evaluation (ME)

I. Purpose of the Evaluation.—The Evaluation was designed to: (1) identify individuals whose behavior and personality structure indicated they were alcoholics or had serious alcoholic problems; (2) identify nonalcoholic individuals with personality characteristics often found in alcoholics. Perhaps, such individuals would become alcoholics if placed under certain conditions of stress; (3) obtain understanding of the psychodynamics involved in alcoholic or potential alcoholic personalities in order to assist such men and women in their rehabilitation. The identification of alcoholics or potential alcoholics, prior to employment or training, is of great value both to the employer and the employee. The Evaluation may provide new insights to clinicians, personnel administrators, and others working with alcoholic personalities.

II. The Alcoholic Traits.—Clinical studies show that alcoholics have many psychoneurotic and psychopathic traits. The studies leading to the construction of this test indicated seven traits frequently scored high by alcoholics and scored low by nonalcoholics. These were:

1. **A - AN - Anxiety.**—High scores would indicate an excessive number of fears, worries, feelings of insecurity and inadequacy; undue concern over health, easily fatigued.
2. **B - DF - Depressive Fluctuations.**—High scores would indicate easily depressed, sadness, frequent mood swings toward depression; prone to quick disappointments.
3. **C - ES - Emotional Sensitivity.**—High scores would mean extreme emotional sensitivity with inability to make satisfactory social or emotional adjustments; extreme lability with poor defenses; touchiness.
4. **D - RE - Resentfulness.**—High scores would indicate strong and bitter feelings of resentment toward society and individuals; easily irritated; carries chip on shoulder; paranoid ideas.

5. **E - IN - Incompleteness.**—High scores would indicate a series of failures to complete commonly accepted social objectives such as: education, work mastery, steady employment, marital adjustments, community participation, religion, philosophy of life; restlessness, unsteadiness, mobility, and frequent change.
6. **F - AL - Aloneness.**—High scores indicate feelings of being alone in the world, isolated, unique, unwanted, undersocialized; feeling as if there were a barrier between the individual and the world or society.
7. **G - IR - Interpersonal Relations.**—High scores would mean lack of close personal and emotional ties; poor family relations, parental rejection, unhappy childhood; lack of real friends, shallow emotional relationships.

Traits 1, 2, and 3 are frequently noted in psychoneurotics, and might be considered as a triad of psychoneurotic symptoms. Traits 4, 5, 6, and 7 are frequently observed in psychopaths. It thus becomes possible to recognize areas of personality maladjustment or defection and develop programs of therapy with these areas in mind.

III. Construction of the Test.—470 items, believed to be diagnostic in the differentiation of alcoholics from nonalcoholics, were constructed. These were to be answered, if they applied to the subject, with either a "Yes" or "No" response. 126 alcoholics were compared with 157 nonalcoholics. Both groups were relatively comparable in vocabulary ability or intelligence, age, economic and social levels. An item analysis of the 470 questions resulted in the selection of the 72 most diagnostic items to form the present Evaluation. A validating study compared 268 alcoholics with 303 nonalcoholics and satisfactory predictability, reliability and validity were established for the test.

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reliability.—The shorter approximation to the Richardson-Kuder formula was used. This always underestimates slightly the reliability of a test found by the split-half method and the Spearman-Brown correction. The coefficients for the male and female groups were .94 and .94.

V. **Validity.**—The validity of the Evaluation was determined by four methods: (1) selection of highly diagnostic items through an item analysis. Approximately 66 of the 72 items were above the 1% level of confidence, and the remainder were above the 5% level of confidence; (2) correct prediction or diagnoses of 79% of the male group in the validating study (202 alcoholics versus 137 nonalcoholics), and 84% of the female group (66 alcoholics versus 166 nonalcoholics); (3) highly significant critical ratios between mean scores of the alcoholic and nonalcoholic groups (critical ratios of 14.30 for males and 12.37 for females); (4) use of the phi coefficient technique resulted in a coefficient of .71 for the males and .60 for the females when the dichotomous variable of alcoholic-nonalcoholic was compared with the continuous variable of test scores, indicating that alcoholics consistently made higher scores and nonalcoholics consistently made lower scores.

VI. **Administration.**—This test can be administered to individuals or groups. It is self-administering. However, the examiner may read the directions to insure understanding. A simple appeal for full cooperation is desirable. No indication should be made of the purpose or use of the test. It can be completed in 10-20 minutes, but sufficient time should be allowed for completion.

VII. **Scoring.**—The **Scoring Key** exposes the **ALCOHOLIC RESPONSES**. Only exposed marked responses are scored. Each exposed marked response is scored one point. The Total number of exposed marked responses is the total raw score. Blank questions are not scored.

Papers with more than five blanks should be returned and the subject encouraged to answer questions in the direction of his dominant feelings.

The test can be scored in three minutes or less.

A total raw score of 21 or higher for males was found 79 times in 100 in male alcoholics and only 21 times in 100 in nonalcoholics. A total raw score of 26 or higher was found 80 times in 100 in female alcoholics and only 15 times in 100 in nonalcoholics.

Trait scores are obtained by placing a check mark or check marks in the exposed circle or circles, provided there is an exposed marked response for that item. Then by counting the number of check marks under the letters — A-B-C-D-E-F-G—the specific trait scores are determined.

For example, if question No. 1. is exposed and marked, a check mark would be placed in the exposed circle under G. If question No. 7 is exposed and marked, check marks would be placed in the exposed circles under D, E, F. The sum of the check marks is placed in the appropriate box at the bottom of page 3 of the test booklet.

The total test score and trait scores should be placed on the ME Psychograph. From these scores the Profile can be plotted and drawn.

(Note the different norms for males (m) and females (f).)

VIII. **Interpretation of Scores and Profiles.**—The table of norms was derived from 571 cases. Each raw score can be interpreted with three significant points of reference; (1) comparison with mean scores of nonalcoholic groups; (2) comparison with critical scores for the combined group of alcoholics and nonalcoholics; (3) comparison with mean scores of alcoholic groups.

Alongside the critical scores of the combined groups (located in center of psychograph on page 6) are the percentages above and below this score for the nonalcoholics (nonals) and the alcoholic personalities (alpers). For example, the trait A - AN - Anxiety with a score of 5 or higher for males was attained by 81% of the alcoholics, while a score of 5 or lower was attained by 78% of the nonalcoholics.

A glance at the profile reveals how an individual compares with the nonalcoholic and alcoholic groups, the extent of his psychoneurotic (A-B-C) and psychopathic traits (D-E-F-G) and the general pattern of his trait responses. High scores mean more pronounced alcoholic characteristics. Low scores point to nonalcoholic characteristics.

XI. **Norms.**—The validating sample which provided the data for the table of norms was cooperative and sincere in its efforts. The individuals in this group were not seeking treatment or employment.

ME TABLE OF NORMS

No. Scores	MALES		FEMALES	
	Alcoholics	Nonalc.	Alcoholics	Nonalc.
	202 %	137 %	66 %	166 %
60 plus	4	0	5	0
54-59	6	1	3	1
48-53	6	0	15	1
42-47	9	2	16	0
36-41	16	2	19	1
30-35	16	2	12	5
24-29	16	6	16	10
18-23	11	12	8	16
12-17	12	27	3	24
0-11	4	48	3	42

CRITICAL SCORES

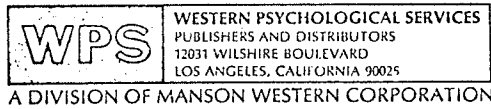
21 and higher....	79	21
26 and higher....	80	15

APPENDIX B
THE MANSON EVALUATION

THE MANSON EVALUATION

By MORSE P. MANSON, Ph.D.

Published by



Name			Sex	Age	Date
Last Name	First Name	Initial			
Occupation:					
Circle one of the following: I am—					
SINGLE — MARRIED — DIVORCED — SEPARATED — WIDOWED					
Circle the last school year you completed:					
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - 11 - 12 - 13 - 14 - 15 - 16 - 17 - 18 - 19 - 20					

DIRECTIONS

Your full cooperation is necessary. Answer each question sincerely. Make every effort to answer as many questions as you can. There are no "right" or "wrong" answers. Many people will answer "yes" to a certain question, while many others will answer "no" to the same question. If your answer to a question is "yes," mark the space under the YES for that question. If your answer is "no," mark the space under the NO for that question. You will have all the time you need to answer all the questions, but work as fast as you can. **YOU MAY NOW TURN THE PAGE AND BEGIN.**

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Printed in U. S. A.

Do Not Write Here

	Yes	No	A	B	C	D	E	F	G
1. I had a happy family life as a child.	1.	⋮	○	○	○	○	○	○	○
2. I become sad quickly.	2.	⋮	○	○	○	○	○	○	○
3. My home life is happy.	3.	⋮	○	○	○	○	○	○	○
4. I am very sensitive and self-analytical.	4.	⋮	○	○	○	○	○	○	○
5. My life is quiet and peaceful.	5.	⋮	○	○	○	○	○	○	○
6. I have a strong and clear faith in life.	6.	⋮	○	○	○	○	○	○	○
7. I often feel I am being held back from doing the things I want to do most.	7.	⋮	○	○	○	○	○	○	○
8. I often have queer sensations in my fingers and toes.	8.	⋮	○	○	○	○	○	○	○
9. I feel myself to be alone in the world.	9.	⋮	○	○	○	○	○	○	○
10. I often feel I am being neglected.	10.	⋮	○	○	○	○	○	○	○
11. I have lived a good life.	11.	⋮	○	○	○	○	○	○	○
12. I often am afraid. I will not be able to sleep.	12.	⋮	○	○	○	○	○	○	○
13. I often have had a strong desire to leave home.	13.	⋮	○	○	○	○	○	○	○
14. I quickly lose my interest or enthusiasm.	14.	⋮	○	○	○	○	○	○	○
15. My friends feel that I am as successful in life as I should be.	15.	⋮	○	○	○	○	○	○	○
16. I sometimes make movements without being aware of them.	16.	⋮	○	○	○	○	○	○	○
17. I often worry about the things I fear.	17.	⋮	○	○	○	○	○	○	○
18. I often feel guilty without knowing why I feel guilty.	18.	⋮	○	○	○	○	○	○	○
19. I like to celebrate when I am happy.	19.	⋮	○	○	○	○	○	○	○
20. It is easy for me to forget unpleasant experiences.	20.	⋮	○	○	○	○	○	○	○
21. I always feel there is something between me and the rest of the world.	21.	⋮	○	○	○	○	○	○	○
22. I often feel tired, have trouble sleeping, and have a poor appetite.	22.	⋮	○	○	○	○	○	○	○
23. I sometimes become sad or depressed for no good reason.	23.	⋮	○	○	○	○	○	○	○
24. My mother worried a great deal over me.	24.	⋮	○	○	○	○	○	○	○
25. I have been unhappy in love.	25.	⋮	○	○	○	○	○	○	○
26. I am very sensitive to what people think about me.	26.	⋮	○	○	○	○	○	○	○
27. I feel lonely even when among people.	27.	⋮	○	○	○	○	○	○	○
28. I cry easily.	28.	⋮	○	○	○	○	○	○	○
29. I often fool myself.	29.	⋮	○	○	○	○	○	○	○
30. I often feel uncomfortable and blue.	30.	⋮	○	○	○	○	○	○	○
31. I often feel all wound up.	31.	⋮	○	○	○	○	○	○	○
32. I often am so deep in thought that I do not notice what is going on around me.	32.	⋮	○	○	○	○	○	○	○
33. I have trouble sleeping.	33.	⋮	○	○	○	○	○	○	○
34. I can make up a good story to get out of a tight spot.	34.	⋮	○	○	○	○	○	○	○
35. I know how to relax and take things easily.	35.	⋮	○	○	○	○	○	○	○
36. I wish people would stop telling me how to live my life.	36.	⋮	○	○	○	○	○	○	○

Do Not Write Here

	Yes	No	A	B	C	D	E	F	G	
37. I frequently feel my muscles quivering.	37.	⋮ ⋮	○	○	○	○	○	○	○	
38. I often am afraid without knowing why I am afraid.	38.	⋮ ⋮	○	○	○	○	○	○	○	
39. My home life is as happy as it should be.	39.	⋮ ⋮	○	○	○	○	○	○	○	
40. I become easily annoyed when I am arguing.	40.	⋮ ⋮	○	○	○	○	○	○	○	
41. I often go out of my way to avoid talking to people I do not like.	41.	⋮ ⋮	○	○	○	○	○	○	○	
42. I take an active interest in politics.	42.	⋮ ⋮	○	○	○	○	○	○	○	
43. I am looking for something but I don't know what it is.	43.	⋮ ⋮	○	○	○	○	○	○	○	
44. I graduated from high school.	44.	⋮ ⋮	○	○	○	○	○	○	○	
45. I have a strong need for someone to love me.	45.	⋮ ⋮	○	○	○	○	○	○	○	
46. Too much was expected from me as a child.	46.	⋮ ⋮	○	○	○	○	○	○	○	
47. People often misunderstand me.	47.	⋮ ⋮	○	○	○	○	○	○	○	
48. I need the help of God.	48.	⋮ ⋮	○	○	○	○	○	○	○	
49. I often go without eating for several days.	49.	⋮ ⋮	○	○	○	○	○	○	○	
50. I am very much interested in my work.	50.	⋮ ⋮	○	○	○	○	○	○	○	
51. I am satisfied with the way I live.	51.	⋮ ⋮	○	○	○	○	○	○	○	
52. I would like to be more independent than I am.	52.	⋮ ⋮	○	○	○	○	○	○	○	
53. My family should be more considerate and understanding.	53.	⋮ ⋮	○	○	○	○	○	○	○	
54. I spend too much time having a good time.	54.	⋮ ⋮	○	○	○	○	○	○	○	
55. People often take advantage of me.	55.	⋮ ⋮	○	○	○	○	○	○	○	
56. I feel shy with members of the same sex.	56.	⋮ ⋮	○	○	○	○	○	○	○	
57. My feelings and emotions change rapidly.	57.	⋮ ⋮	○	○	○	○	○	○	○	
58. I often have feelings of vague restlessness.	58.	⋮ ⋮	○	○	○	○	○	○	○	
59. I tremble when I am excited or afraid.	59.	⋮ ⋮	○	○	○	○	○	○	○	
60. Lately, I have been mixing with many new groups of people.	60.	⋮ ⋮	○	○	○	○	○	○	○	
61. I often feel as if I were not myself.	61.	⋮ ⋮	○	○	○	○	○	○	○	
62. I feel tense and anxious most of the time.	62.	⋮ ⋮	○	○	○	○	○	○	○	
63. I am moderate in all my habits.	63.	⋮ ⋮	○	○	○	○	○	○	○	
64. My friends are more polite to me than are my relatives.	64.	⋮ ⋮	○	○	○	○	○	○	○	
65. I am much more different from most people.	65.	⋮ ⋮	○	○	○	○	○	○	○	
66. I was often unhappy because of sadness.	66.	⋮ ⋮	○	○	○	○	○	○	○	
67. I often feel bored and uneasy.	67.	⋮ ⋮	○	○	○	○	○	○	○	
68. My friends are much happier than I am.	68.	⋮ ⋮	○	○	○	○	○	○	○	
69. I have had a number of strange and unusual experiences.	69.	⋮ ⋮	○	○	○	○	○	○	○	
70. I often pity myself.	70.	⋮ ⋮	○	○	○	○	○	○	○	
71. I swear a good deal.	71.	⋮ ⋮	○	○	○	○	○	○	○	
72. I eat at regular hours.	72.	⋮ ⋮	○	○	○	○	○	○	○	
			TOTAL	A	B	C	D	E	F	G

— END —

APPENDIX C
THE CLASSIFICATION QUESTIONNAIRE

PENITENTIARY
CLASSIFICATION QUESTIONNAIRE

CONFIDENTIAL
DISTRIBUTION
RESTRICTED
AS APPROVED BY
DIVISIONAL DIRECTOR

PENITENTIARY _____

NAME OF INMATE _____
Last: _____ First: _____ Middle: _____

AREA No. _____

DISTRIBUTION:
Copy 1 - Inmate's institutional file
Copy 2 - Judicial Section, D.B.S.
Copy 3 - Penitentiary Headquarters

F.P.S. No. _____

SOURCES OF INFORMATION _____

CRIMINAL HISTORY

Present Conviction

Place of occurrence _____
city or town; _____ province _____

First conviction Yes No N.V.

Offence committed with others Yes No N.V.

Previous Convictions

Juvenile probation Yes No N.V. Adult probation Yes No N.V.

Juvenile institution Times _____ N.V. Gaol or reformatory Times _____ N.V. Penitentiary Times _____

Paroles Times _____ Parole violations Times _____ Escapes Times _____

Age at first conviction Yrs. _____ N.V. Total time spent in adult institutions Mos. _____

ALCOHOL AND DRUGS

Alcohol

Alcoholic Problem drinker No problem

Was alcohol directly associated with offence? Yes No N.V.

Drugs

User Addict Not indicated Duration of addiction or use _____ yrs.

Drugs used	Prin.	Sec.	Prin.	Sec.
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	Other opium compounds	<input type="checkbox"/>
Barbiturates and compounds	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers	<input type="checkbox"/>
Marihuana	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>

Means of supporting drug habit: _____

PSYCHOLOGICAL TEST RESULTS

Beta score _____	Score <input type="checkbox"/>	Valid <input type="checkbox"/>	Invalid <input type="checkbox"/>	No Testing <input type="checkbox"/>						
M.M.P.I. Profile	? <input type="checkbox"/>	L <input type="checkbox"/>	F <input type="checkbox"/>	K <input type="checkbox"/>	Hs <input type="checkbox"/>	D <input type="checkbox"/>	Hy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pd <input type="checkbox"/>	Mf <input type="checkbox"/>	Pa <input type="checkbox"/>	Pt <input type="checkbox"/>	Sc <input type="checkbox"/>	Ma <input type="checkbox"/>				
Other Tests (specify) _____	Score <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL HISTORY

Education

English <input type="checkbox"/>	Mathematics <input type="checkbox"/>	Other (specify) _____
----------------------------------	--------------------------------------	-----------------------

Education test grades _____

Age on leaving school _____ yrs. Grade completed _____

Where obtained _____ Disciplinary record _____

province or country

Yes No N.V.

Occupation

Occupation _____ Industry _____

Employed at time of offence Yes No N.V.

Employment pattern (two years)

Employed _____ mos; Unemployed _____ mos; Incarcerated _____ mos; Financial assistance _____ mos.

Origin

	Father	Mother	Inmate
Ethnic origin _____	_____	_____	_____
Country of birth _____	_____	_____	_____
Year of arrival in Canada _____	_____	_____	_____
Language spoken in the home _____	Languages spoken by inmate _____		

Marital Data

	Single	Married	Common-law	Widowed	Separated	Divorced
Marital status _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of Children _____		Total	N.V.	Partial	N.V.	
		No. of Dependents _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	

Medical Condition

Is the inmate fit for: full duty light duty no duty

Nature of physical or mental disability _____

Is this disability: permanent temporary

FAMILY BACKGROUND

Did the subject grow up with his parents? Yes No

If 'No', at what age did separation occur: From father _____ yrs; From mother _____ yrs.

Nature and number of family substitution: Relative's home _____ Foster home _____ Adoptive home _____ Institution _____ Other _____ Not known

Did his family have any health or welfare assistance? Yes No

Relationships	Firm but kindly	Lax	Overstrict, erratic
Discipline by father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discipline by mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervision by mother	Suitable	Fair	Unsuitable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affection of father	Warm, overprotective	Indifferent or hostile	
	<input type="checkbox"/>	<input type="checkbox"/>	
Affection of mother	<input type="checkbox"/>	<input type="checkbox"/>	

TRAINING RECOMMENDED

ACADEMIC _____

VOCATIONAL _____

SPECIAL THERAPY _____

SECURITY _____

REMARKS

Date _____ Compiling Officer _____ Title _____

APPENDIX D
BASIC PATIENT INFORMATION FORM

BASIC PATIENT INFORMATION

Name: _____ Male () Female ()

Aliases: _____ (7) & (8) Date: _____

Address: _____

(1) - (5) Patient Number _____

On our Medical Plan? Yes () No ()

On another Plan? Yes () No ()

New () Re-Opened () Updating ()

(9) Birth Place _____

(13) - (14) Birthdate _____

(10) Area raised in _____

(11) When arrived in B.C.? _____

(12) Where heroin use began? _____

(16) Single () Married () Divorced () Separated ()

Widowed () Illicit () Common-law () Other ()

(17) Spouse: Addicted? () Not addicted? () N/A ()

(18) Patient: Has Children? () Has no children? ()

N/A ()

(19) Dependents? Yes () No () N/A ()

(39) Employed since 16? Yes () No () N/A ()

(40) Type of work? _____

(41) Length of employment before addiction? _____

(42) Length of employment after addiction? _____

- (43) Continuous employment before addiction? Yes ()
No () N/A ()
- (44) Continuous employment after addiction? Yes ()
No () N/A ()
- (45) Level of education? _____
- (49) Convictions before addiction? None () Juvenile ()
Adult () Both ()
- (50) - (51) Number ()
- (52), (53), (54) Type of conviction before addiction?
None () Theft () Drug () Assault ()
Hustling () Other ()
- (55) Time served before addiction? _____
- (56) Convictions after addiction? None () Some ()
If some, specify what for? _____

- (57) - (58) Number? _____
- (59) Time served after addiction _____
- (60) Alcoholism? N/A () None () Before addiction ()
Alcoholic after addiction () Alcoholism generally ()
- (61) Role of alcoholism? N/A () None () Addiction was
alternative to alcohol () Drugs first used while
using alcohol () Other ()
- (65) Social Worker _____