(mean=16.16 years) completed treatment, whereas clients with lesser duration of drinking (mean=12.50 years) dropped out (p<0.05). Other clinical characteristics such as age of onset of drinking, duration of daily drinking, morning drinking and tolerance did not seem to have a significant bearing on the treatment completion, as these two groups did not differ significantly on these characteristics.

It was further observed that frequency and duration of morning drinking was higher among treatment completers compared to drop-outs though this relationship did not reach a significance level. This also is in the same direction of other findings related to the clinical characteristics. Older individuals with longer duration of alcohol intake seem to be adhering better to treatment and continuing till its completion; this may be due to the fact that because of higher age and longer duration of drinking these clients might be experiencing more severe chronic problems, hence better motivation to give-up drinking and more efforts and desire to complete treatment. Whereas among drop outs, due to their younger age, and lesser duration of drinking they might not have encountered such severe problems. Therefore, they had less motivation to give-up drinks; hence they dropped out of treatment prematurely.

These findings are in line with previous research in
this area. Gillies et al. (1974) found that alcoholics who abstain at 1-year follow-up were older in age. Other studies also have shown that older subjects have a better prognosis (Glatt, 1961; Grimmett et al., 1967; Kissin et al., 1968, 1970, Baekeland, 1971; Edwards et al., 1973). Long duration of heavy drinking was also found to be positively related to good outcome (Grimmet et al., 1967; Baekeland et al., 1971).

Findings in the present study suggest that majority of clients in both treatment completers and drop-outs were initiated to alcohol by friends (80% and 95%, respectively) (Table-11; page 189). Moreover, in most of these cases, the antecedent events for alcohol intake were social pressure (i.e., pressure from friends/relatives) (Table-13; page 191). These findings emphasize the importance of social factors in the acquisition of alcohol problem. Mishra and Kumaraiah (1989) found that 75% of alcoholics acquire this habit through friends. It was also found that acquisition of habit pattern occurs predominantly due to the presence of a model (Caudill and Marlatt, 1975). Hence giving importance to social aspects and incorporating procedures to encounter it in the treatment program would be of relevance in intervention of alcoholism.

History of other substance abuse:

It was seen that majority of clients among treatment
completers (n=23; 76.67%) and all drop-outs (n=20, 100%) had history of nicotine abuse in the form of smoking (Table-15; page 193). This also needs further exploration to plan an intervention program that can deal with other substance abuse such as nicotine. Cases with severe multiple drug dependence were not included in the present study. However, clients with nicotine abuse/dependence had to be included in the sample, as smoking is socially accepted.

Analyses of therapeutic outcome among treatment completers:

In the present study, therapeutic outcome was assessed from the subjective report of clients themselves as well as report from significant others. In majority of cases, outcome could be ascertained by interviewing the family members, except in a few cases where family members could not come for follow-up due to various reasons. In those cases outcome was evaluated based on the subjective report of the clients alone.

Table-2 (page 178) shows classification of outcome among treatment completers. As discussed earlier, 30 clients, who were daily drinkers, completed the treatment program. Of these 30 completers, 40% abstained completely over a duration ranging from 88 to 346 days (N=12). 5 clients had improved to a great extent but had drinks only once (16.67%). Another 4 clients also reported to have improved and abstained but
had drinks 2-4 times (13.33%). However, three clients had drinks frequently after completion of treatment, though the frequency of drinking was reduced compared to their pre-treatment level. 4 clients (13.35%) were found to have relapsed completely either during treatment itself or during follow-up. In two cases no data were available with regard to their post-treatment abstinence status, as these individuals did neither report for follow-up nor responded to letters. However, these two clients were found be abstinent during treatment period.

Overall, of 30 cases, 12 cases totally abstained; 9 cases had improved but had drinks 1-4 times and 7 clients showed failure and started drinking heavily. Classification of this sort was arrived at in order to facilitate further analyses of other variables and to find out the differences among clients based on outcome.

This classification was based on the studies of Fox, 1952; Malla, 1987; and Miller and Dougher, 1989. Data of two clients who lost to post-treatment follow-up could not be further analyzed on other variables as their number was too small for any further statistical interpretation. Hence further analyses were done for these three groups of treatment completers.
Duration of follow-up and outcome characteristics among treatment completers:

Among treatment completers, total duration of follow-up ranged from 57 to 409 days; In order to assess the outcome, two measures were considered, namely, 1) total abstinence, indicating the total number of days abstained after their last drink before starting treatment and, 2. Total number of days abstained after termination of treatment (Table-3; page 179). Majority of clients (n=28; 93.33%) among treatment completers were totally abstinent during the entire period of therapy.

Group-I clients (i.e., total abstainers) (n=12) were totally abstinent for a mean number of 278 days, out of this they had a mean number of 222 days of post-termination abstinence. It was seen that clients who completed treatment and benefited from it, had had no report of drinking during detoxification phase.

In group-II clients (i.e., clients who had improved but had drinks 1-4 times) (n=9) the mean number of total abstinence days were 173, out of which 108 days of abstinence was after termination of therapy. Mention may be made that these individuals had drinks upto 4 times during follow-up. This shows that clients who had had drinks during follow-up period had less number of abstinence days compared to group-I
clients. It can also be observed that clients who had attempted drinking had lesser number of follow-up days compared to group-I clients. (Follow-up periods for group-I and group-II clients ranged from 88 to 346 days and 57-241 days, respectively).

Group-III clients (i.e., clients who had drinks frequently or relapsed) (n=7) though had drinks frequently during therapy and follow-up, showed some degree of improvement; they were also abstained for a mean duration of 94 days of total abstinence and 66 days of abstinence after termination. Though the number of abstinence days is considerably lesser in this group of individuals (who had history of daily drinking prior to treatment) compared to other two outcome groups, they were also benefited to some extent from treatment.

In addition to abstinence, other aspects such as vocational performance, social adjustment, interaction at home and biological functioning were also important factors to be assessed which influence the outcome among alcohol dependent clients. Hence an attempt was made in this direction. For this, information was elicited from significant others. Prior to treatment, majority of these clients were frequently absent from work; they were not attending to household activities; their interaction was
minimal at home; their biological functions were also poor. However, after treatment in all cases, significant others reported a considerable improvement in their vocational functioning, social functioning, inter-personal interaction and biological functioning. These clients were found to be attending to their job more regularly which they were not doing before. Their biological functions such as appetite, sleep and sexual performance improved significantly. After giving up drinks, they were reported to have been spending more time at home with children and family members. They were also reported to have been taking active role in household activities (e.g., purchases, helping the children in their studies, and in recreational activities).

These findings suggest that the clients who had completed treatment were not only abstinent from drinks, but as well improved in various domains of their life situations. These findings are supported by the results of studies in the literature, indicating that alcoholics after treatment, improve in their psychosocial functioning in the areas such as family relationships, job performance and overall functioning in addition to the reduction in drinking behavior (Powell, Penick, Read and Ludwig, 1985). McLellan, Luborsky, O'Brien, Barr and Evans (1986) found that treatment in alcoholics is associated with significant improvement in
important areas such as employment in addition to the target problem of alcohol use.

The above findings satisfy objective-1 of the present study.

History of drinking during treatment:

It was found that among treatment completers very few clients had drinks during treatment (n=2; 6.67%) whereas, among drop-outs, majority of them (n=15; 75%) were reported to have had drinks. Some of them dropped out immediately after starting drinks. These findings suggest that clients who take alcohol during treatment period, either drop out or have a poor prognosis with regard to treatment outcome. Studies have shown that sobriety prior to entering treatment is positively related to better outcome (Ritson, 1968; Goldfried, 1969; Bateman and Peterson, 1971 and Baekeland et al., 1971). Pisany and Motanky (1970) found that drop-outs reported drinking during treatment period.

Booster sessions:

In a few cases (n=9; 30%) booster sessions were given during follow-up (follow-up was scheduled once a month). This consisted of one session of faradic aversin therapy combined with covert sensitization. These booster sessions were felt necessary as some of the clients during follow-up, reported that they occasionally felt like having a drink. Due to
certain negative emotional states such as quarrel at home, or experiencing certain stresses, these clients felt like going for a drink. During such occasions the clients approached therapist. In these clients when booster sessions were given, their craving came down and they did not go for drinks. Booster session were also given in cases where drinking bouts were reported. It was noticed that using booster sessions peridically would help the clients in maintaining abstience.

In the literature, Malezky (1977) in treating homosexuals found that periodic booster sessions were needed to consolidate benefits of treatment. He suggested that it is useful to continue boosters sessions, to ensure continued effects of conditioning.

Reasons for taking alcohol among treatment completers following therapy:

It was attempted to find out the possible reasons for consuming alcohol among treatment completers. Of 30 clients who completed treatment, 16 clients (53.35%) (i.e., clients of groups II and III) had had drinks. From these individuals reasons were elicited for their alcohol consumption which are described below:

Of 16 clients, 9 (56.25%) had consumed drinks due to
negative emotional states resulting from quarrel at home, feeling sad, criticism by family members and feeling apprehensive over not being able to clear debts. 3 clients (18.75%) had drinks due to peer group pressure. One client developed craving for drinks, and started drinking. One client tried 'experimentation' to check the effectiveness of treatment. In two clients (12.50%) reasons were not known.

Various studies have shown that such negative emotional states like depression, anxiety and anger can account for relapses among recovering alcoholics (Rawson and Oppenheim, 1977, 1979; Marlatt and Gordon, 1979). Tamerin (1975) found that these negative emotional states enhance the probability of the desire to drink and drinking among alcoholics. Chaney (1977) also reported that drinking relapses among treatment completers were caused by such reasons as negative emotional states, inability to resist other's pressure to drink and craving.

Reasons for relapse and access to alcohol:

Of 4 clients who had totally relapsed, it was found that access to alcohol in their profession contributed for relapse. Of these, one client was working as a bartender. Another client was working in a set up where he deals with drinks every day and had free access for drinks. Wikler (1965) emphasized the importance of environmental cues in the
relapse behaviour among abstained addicts. According to Ludwig and Wikler (1974) craving occurs during the withdrawal and becomes associated with the stimuli (interoceptive bodily sensations and/or exteroceptive cues) present during withdrawal. If at a later stage, the abstinent individual is exposed to the stimuli previously paired with the experience of withdrawal, then he will experience the conditioned response of craving, which motivates the individual to seek relief through substance use.

Reasons for drop out from treatment:

In many of the alcoholism treatment programs, the proportion of clients dropping out is found to be over 50%. (Baekeland and Lundwall, 1975; Silberfeld and Glaser, 1978). In general, these drop-outs are inarticulate about their reasons for dropping out of treatment (Leigh, Ogborne and Cleland, 1984).

In the present study, drop outs could not be personally contacted through home visits due to practical constraints. It was attempted to contact over phone or through letters. In a few cases information about the drop-outs' clinical status was ascertained from the family members or friends who informed that these clients started drinking again and discontinued treatment. Leigh et al (1984) also reported that drinking while on treatment is one of the reasons for
client's drop out. They found that individuals may drop out due to reasons such as demands of work, forgetting appointments, leaving the city, family conflicts and general pressures of life. Longer treatment duration may be one of the reasons for drop-outs as the individual has to get back to work due to financial problems (Beckman and Bardsley, 1986).

In the present study reasons for clients' drop out were found to be financial problems, poor motivation to give up drinks, ambivalent attitudes towards treatment, family problems, and pressure from work. Mishra and Kumaraiah (1989) found that factors such as lack of time and money, leaving the job, expectancy of drugs, distance from hospital and reaction towards hospitalization contributed towards dropping out among the Indian clients. Leigh et al. (1984) found that there were many factors which affect decisions not to continue treatment and some of these factors were outside the control of those responsible for the treatment (e.g., general life events).

Locus of control and outcome:

It was found that total score on the DRIE scale (Table-23; Page 200) significantly differentiated the treatment completers from drop-outs; treatment completers were significantly more internal compared to drop-outs (p<0.05).
This indicates that the treatment completers perceive that personal events and their consequences depend on their own actions; whereas, drop-outs perceive reinforcements as dependent on external events. This is specifically true with drinking related aspects as the DRIE scores translate generalized expectancies of control to specific expectancies dealing with various drinking related behaviors (Oziel and Obitz, 1975).

On the intrapersonal and interpersonal control factors a trend was seen to score higher among drop-outs, i.e., more external, than the treatment completers though this relationship has not reached a significance level (Table-23; Page 200). Reason for not having reached a significance level may be the small sample size. These findings indicate that the drop-outs have a tendency for apparent inability to resist the temptation to drink and they drink to overcome negative emotional states (i.e. tendency for higher scores on the intrapersonal factor among drop-outs). This can also be corroborated with the finding that the majority of drop-outs (75%) consumed alcohol during treatment period.

Higher scores on the interpersonal control factor among drop-outs also indicate that they have a tendency for inability to resist interpersonal pressures to drink and a tendency for an inability to manage certain emotional states in an interpersonal situation.
These findings are in line with the available literature. Walker et al. (1980) found that clients who left treatment prematurely scored higher (more external) on the general control factor of DRIE scale than those who remained in the treatment. Jones (1985) also found that internal scorers remained in the treatment longer than the external scorers.

Groups of treatment completers did not differ significantly on the DRIE scores (Table-24; Page 201). Though no significant difference was seen among these groups, a trend for higher scores i.e. more external, was noticed among the treatment failure group (i.e., group- III) compared to the total abstainers (group-I) on the total score, intrapersonal and general control factors. The reason for the difference not being significant, once again, may be due to very small numbers among these groups. Literature on this aspect shows that internal score on the I-E scale indicates successful treatment outcome (Pryer and Distefano, 1977; Caputo and McGovern, 1983; Kivlahan et al., 1983; and, Query, 1983).

The above findings satisfy the objective-2 of this study.
Personality characteristics of treatment completers and drop-outs:

Treatment completers and drop-outs differed significantly on various aspects of personal and social adjustment on the California Test of Personality (CTP) (Table-25; Page 203).

Treatment completers scored significantly more than the drop-outs on the "self-reliance sub-scale" (p<0.01). This finding indicates that treatment completers are significantly more emotionally stable, responsible and have more independence compared to drop outs. Scores on the "sense of personal worth" are significantly higher among treatment completers than drop-outs (p<0.05). Treatment completers with high sense of personal worth feel that they are well regarded by others, and they have faith in their future success and ability. On the sense of "personal freedom" also treatment completers scored significantly higher than drop-outs (p<0.01). Individuals with high sense of personal freedom feel that they are permitted to have a reasonable share in the determination of their conduct and in setting general policies that govern their life. Low scores among drop-outs indicate a lack of sense of personal freedom.

On the overall personal adjustment, the treatment completers scored significantly higher than drop-outs.
indicating a better personal adjustment in the former group (p<0.01).

Treatment completers scored significantly higher than drop-outs on the "social standards (p<0.01); higher scores on this sub-scale indicate a better understanding of the right of others and appreciation for the necessity of subordinating their desires to the needs of others. Treatment completers are also found to have significantly better social skills, as indicated by higher scores on the "social skills" sub-scales (p<0.01). These clients, compared to drop-outs are said to be socially skillful and diplomatic in their relations with others and they have a liking for people; they also subordinate their egoistic tendencies in favour of their associates.

Drop-outs showed significantly higher "antisocial tendencies" compared to treatment completers (p<0.01); these drop-outs are said to have given to bullying, frequent quarrelling and disobedience. They seem to get their satisfaction in ways that are damaging and unfair to others. However, treatment completers with their positive scores were found to be relatively free from these tendencies.

Significantly higher score (p<0.01) on the "family relations" sub-scale among treatment completers indicates better family relations than drop-outs; these individuals
show a sense of security and self-respect and feel that they are loved and well-treated at home.

Treatment completers and drop-outs differed significantly (p<0.01) on the total score of the CTP indicating an overall better and positive adjustment compared to drop-outs.

Above all, the findings on the personality scale among treatment completers and drop-outs, indicate that treatment completers are the individuals with positive self-reliance, having good sense of personal worth and personal freedom. These clients were also said to be having desirable social standards with adequate social skills, positive family relations and with less antisocial tendencies. On the other hand, drop-outs were characterized by less self-reliance, poor sense of personal worth and personal freedom. These individuals who dropped-out of treatment also exhibit poor social standards with inadequate social skills and poor family relations. Drop-outs also show more antisocial tendencies. Overall, treatment completers were characterized by better personal adjustment and social adjustment, whereas drop-outs, by poor personal and social adjustment.

These findings on the personality factors and treatment completion, are similar to findings available in the
literature. Drop-outs were found to have higher scores on L, K and Ma scales on MMPI, compared to treatment completers (Hoffman and Jansen, 1973). And also, drop-outs have high Pd scores on MMPI compared to completers (Pekarik et al., 1986). Factors such as independence and extraversion also contribute significantly to dropping out from treatment (O'Leary et al., 1981).

**Personality characteristics of different outcome groups:**

Outcome groups seemed to differ on various personality sub-scales. On the sub-scale "withdrawing tendencies" significant difference was seen between group-I (clients who totally abstained) and group-III clients (clients who had failure) (Table-27; Page 207). Significantly lower scores (p<0.02) among the latter group indicate that these clients who had relapse or drank heavily after treatment are said to be sensitive, lonely and given to self-concern. The total abstainers with higher scores, unlike drop-outs, are reasonably free from these tendencies.

The outcome groups differed significantly on the "antisocial tendencies" sub-scale (Table-28; Page 207). Significant difference was seen between groups I & III and II & III. This indicates that total abstainers are said to be having significantly (p<0.02) lesser antisocial tendencies compared to clients with failure. Similarly higher scores
among group-II (clients who had improved but had had drinks a few times) also indicate that they are reasonably free from these antisocial tendencies, compared to group-III clients. These findings show that treatment failures are characterized by having antisocial tendencies, whereas the total abstainers and clients who had improved with a few drinking lapses have a better adjustment on this sub-scale.

On the "community relations" sub-scale (Table-29; Page 208) total abstainers group scored significantly higher than the clients with treatment failure (p<0.02). These findings demonstrate that individuals in the latter group are characterized by poor interaction with the neighbours, poor interest in community development and not respecting law and regulations pertaining to general welfare, whereas the total abstainers with better community relations are said to have better interaction with their neighbours, and they take pride in community development and respect laws and regulations.

On the overall personal adjustment (Table-30; Page 209) a significant difference (p<0.05) was seen between groups I and II, indicating a better adjustment among treatment completers compared to clients who had a few drinking bouts after treatment. However, no significant difference was seen between total abstainers and treatment failures. But a tendency for lower scores among treatment failures compared
to total abstainers was seen. Reason for this relationship of not being significant, may be the small sample size.

On the total adjustment (personal adjustment plus social adjustment) (Table-31; Page 209) also, groups I and III differed significantly (p<0.05). This shows that clients who had totally abstained had significantly better overall adjustment compared to treatment failures.

Literature on the relationship between personality and treatment outcome indicate that certain personality characteristics have predictive value in the treatment outcome. Successful and relapsed alcoholics tend to differ on their "well-being" and "self-control" (Oatsvall, 1979). Alcoholics with lower hostility scores tend to be abstinent after treatment (Ritson, 1971). Various studies have shown that low Pd sub-score on MMPI (Kurland, 1968; Pokorny et al., 1968; Trice et al., 1969; Rae, 1972), low neuroticism (Edwards, 1966), high extraversion (Edwards, 1966), high H score (Trice et al., 1969), low A score (Kurland, 1968) and low N score (Kurland, 1968; Trice et al., 1969) on 16 P.F. Questionnaire were associated with good prognosis.

Motivation for taking alcohol among treatment completers and drop-outs:

Items on the rating scale to assess motivation for
taking alcohol were classified into: 1) physical; 2) psychological (positive); 3) psychological (negative); 4) social; 5) occupational; and 6) self-control. Scores on the items of these factors were summed up to obtain a total score for each of these areas.

Findings on the rating scale to assess motivation for taking alcohol show a significant difference between treatment completers and drop-outs on the psychological negative aspect (p<0.05) (Table-32; Page 210). This indicates that drop-outs drink significantly more to avoid negative psychological states compared to treatment completers; these drop-outs reported that they drink to overcome feelings of inferiority, sadness, shyness and to forget fearful experiences. On all other aspects, drop-outs scored more than treatment completers, though these differences did not reach significance level. These findings demonstrate that expectancy of the favourable effect of alcohol with regard to its physical, psychological, social and occupational aspects is more among drop-outs than treatment completers.

In the literature, Bales (1945) stressed that individuals drink to avoid feelings of failure. Problem drinkers are found to have high levels of drinking to minimize psychological discomfort (Deardoff, Melges, Hout and Savage, 1975). Farber, Khavari and Douglas (1980) found that
individuals who use alcohol as a reinforcer (escape drinking) scored higher on the alcohol consumption indices compared to the individuals who consume alcohol as a positive reinforcer. Kraft (1971) and Hamburg (1975) suggested that interpersonal situations requiring complex social skills may provoke social anxiety which, in the absence of more adaptive responses, may precipitate drinking among alcoholics.

The above findings of motivation for taking alcohol, specifically, among drop-outs can be explained in the light of available studies. In the present study, individuals who dropped out have poor social skills; they resort to drinking to meet more complex social situations.

Significant prognostic indicators of treatment completers and drop-outs:

In the following section, significant prognosticators that have been found in the present study, differentiating treatment completers from drop-outs are reiterated. These aspects include clinical parameters, locus of control, personality dimensions and motivation for taking alcohol (Table-34; Page 240).
### Significant prognostic indicators

<table>
<thead>
<tr>
<th></th>
<th>Completers</th>
<th>Drop-outs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Clinical Variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Higher</td>
<td>Lower</td>
</tr>
<tr>
<td>Duration of drinking</td>
<td>Longer</td>
<td>Shorter</td>
</tr>
<tr>
<td>Drinking related Problems</td>
<td>Less</td>
<td>More</td>
</tr>
<tr>
<td>Interpersonal Adjustment</td>
<td>Better</td>
<td>Poor</td>
</tr>
<tr>
<td><strong>2. Drinking related locus of control</strong></td>
<td>More internal</td>
<td>More external</td>
</tr>
<tr>
<td><strong>3. Personality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self reliance</td>
<td>Better</td>
<td>Poor</td>
</tr>
<tr>
<td>Sense of personal worth</td>
<td>Better</td>
<td>Poor</td>
</tr>
<tr>
<td>Sense of personal freedom</td>
<td>Better</td>
<td>Poor</td>
</tr>
<tr>
<td>Personal adjustment</td>
<td>Better</td>
<td>Poor</td>
</tr>
<tr>
<td>Social standards</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Social skills</td>
<td>Better</td>
<td>Poor</td>
</tr>
<tr>
<td>Antisocial tendencies</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Family relations</td>
<td>Better</td>
<td>Poor</td>
</tr>
<tr>
<td>Social adjustment</td>
<td>Better</td>
<td>Poor</td>
</tr>
<tr>
<td><strong>4. Motivation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological (negative)</td>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>
1. Clinical variables:

Older clients (mean = 37.33 years) were found to complete treatment more than relatively younger clients (mean=31.90 years) who tend to drop out. Individuals with longer duration of drinking (mean=16.16 years) continue their treatment whereas clients with shorter duration of drinking (mean=12.50 years) tend to drop out of treatment. Less severe drinking related problems are indicative of adhering to treatment; more severe drinking related problems lead to treatment drop out. A better interpersonal adjustment can lead to treatment completion, but individuals with poor adjustment tend to drop out.

2. Locus of control:

More internal scores (mean=10.47) would continue treatment whereas more external scores (mean=12.90) tend to drop out.

3. Personality:

Clients with high self-reliance, high sense of personal freedom tend to continue treatment; moreover, the individuals with high social standards, high social skills, positive family relations and less antisocial tendencies tend to continue treatment. Clients with poor self-reliance, poor sense of personal worth and personal freedom, low social standards, poor social skills, poor family relations and high
antisocial tendencies have tendency to drop out from treatment.

4. Motivation for taking alcohol:

Clients who take alcohol to avoid negative psychological experiences tend to drop out.

Problems encountered during the study:

In conducting the present study, various problems were encountered; these are briefly described:

1. Difficulty of clients in attending therapeutic sessions:

Therapy was programmed on an everyday basis, and clients were advised to come for treatment regularly. Clients who were on an out-patient basis either from the beginning or after discharge were finding it difficult to attend regularly because of conveyance problems and occupational constraints. This might be one of the reasons for high drop-out rate among clients who took treatment as out-patients.

2. Financial constraints:

A few clients, especially who were not attending to work for some time due to severe alcohol related problems did express their difficulty in attending due to financial difficulties.
3. **Occupational hazards:**

A few clients had free access to alcohol in their occupational set-up, e.g., bartender. It was found difficult to control their access to alcohol.

4. **Family co-operation:**

Therapy demanded active involvement of family members; they were asked to adhere to instructions given to them in dealing with client in the natural environment, and to accompany clinical to the clinic periodically. However, in a few cases family members did not show compliance in this regard. They had to be repeatedly reminded about their role in client's health and abstinence.

5. **Inadequate reinforcement patterns from the family members:**

Due to chronic alcoholism, family members often develop an inadequate pattern of reinforcing client's behavior which in turn may maintain the client's drinking. In a few cases, it was observed that family members would argue with the client about his drinking problem, and also would initiate a quarrel especially when the client was intoxicated. This had further exacerbated the problem and led to violence. This was found to be one of the problems in dealing specifically with family members.
6. High expectation of family members:

Family members' expectation from therapy also played a major role. In a few cases, it was found that the expectation was high among family members. Many a time, they expected an 'immediate-cure' of the client's drinking problem. Though they were explained about the nature of problem and type of outcome that can occur, they tend to expect an immediate change in client's drinking behavior after he was brought to the therapeutic set-up. When the individual went back for a drinking bout during therapy, family members reacted negatively towards the client and therapy.

7. Insistence on pharmacotherapy:

Many clients and their family members, who were more oriented towards pharmacotherapy and who were unaware of the importance and availability of psychological intervention, would ask for pharmacological management alone. However, some of these clients could be explained the importance of psychological intervention in dealing with problem drinking.

8. High drop-outs:

As seen in literature, high drop-out rate is one of the major problems in any therapeutic set-up related to alcoholism. Many clients would drop out from treatment before any significant change could occur. Clients did neither turn up for continuing therapy nor responded to letters after dropping-out.
9. Poor follow-up:

Clients were advised to come for follow-up periodically. However, there was a need to remind them by phone calls or through letters to attend the follow-up. This may be because of various reasons. In the sample studies it was observed that, if the client was abstinent, he did not feel the need for regular follow-up. In a few cases, the clients lost to follow-up as they started drinking again. Poor compliance for follow-up was also related to financial constraints, work and family problems.
Thus, in the present study, it was planned to assess the efficacy of a multimodal behavioral treatment program in dealing with alcohol dependence. It was also planned to find out the relationship between variables such as locus of control, personality and motivation for taking alcohol and therapeutic outcome. Findings have satisfied the objectives of the present study. It was also possible to differentiate on some variables, the treatment completers from drop-outs.

In the present study, it was found that the multimodal treatment program was useful in dealing with alcoholic clients. As it was discussed, considerable number of clients were abstinent following treatment. A good number of clients were found to have improved after the treatment program. It was also seen that these clients improved in various life aspects following treatment. Very few clients had total failure. These findings demonstrate the efficacy of the broadspectrum therapeutic program as used in the present study.

Factors like drinking related locus of control, personality and motivation for taking alcohol and some clinical aspects could significantly differentiate the treatment completers from drop-outs. To reiterate, it was found that clients who had more internal DRIE score could complete the treatment and clients with more external locus
of control dropped out. On the personality factor these clients differed significantly on aspects such as self-reliance, sense of personal worth, personal freedom, social skills, family relations and antisocial tendencies. On the motivation for taking alcohol, it was found that drop-outs took alcohol to avoid the negative psychological states.

Clinical characteristics such as age and duration of drinking also significantly differentiated the treatment completers from drop-outs.

On some of the personality aspects a significant difference was found among the outcome groups. On other factors a modest difference was seen. On some of these aspects, the relationship did not reach a significance level. This may be because of small sample size. Among treatment completers, each group consisted of a small number of individuals. Hence, many times the relationship has not reached a significance level though a trend was seen.

Implications:

Results obtained in the present study have the following clinical implications:

1) These results indicate that the broadspectrum behavioral treatment program is effective with alcohol dependant individuals, specifically, in the Indian context.
2) This program was developed keeping in view total abstinence as goal of therapy. Hence in cases where total abstinence is envisaged this program would be of use.

3) In the present study, specific clinical characteristics of drop-outs have been identified. This would help in developing treatment programs that would suit the individuals who have then tendency to drop-out.

4) It was also possible to identify specific personality characteristics of drop-outs which can be used as prognostic indicators with such clinical population. Consequently, it would help in individual therapeutic programming.

5) In the present study, characteristics of those who totally benefitted from treatment and those individuals who would partially benefitted from treatment were identified, which are of help in clinical intervention.