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### ABSTRACT

In an attempt to study the effectiveness of a voluntary or an involuntary participation in a treatment of 31 clergymen who attended the same treatment facility, a structured questionnaire was used to gather data concerning the pre-treatment status, means of entry into program, and subsequent status. There was no indication of a significant difference between that of the voluntary and involuntary treatment.

MOTIVATIONAL FACTORS OF THE ALCOHOLIC PRIEST  
IN SEEKING TREATMENT

Rev. Aloysius Sinsky

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It is claimed that the number three medical problem in the United States is the misuse of alcoholic beverages. United States Department of Health, Education and Welfare says that the use and misuse of alcoholic beverages is a major subject of controversy. Actually it has always been so. There have been various efforts at controlling drinking ranging from the pulpit to the legal courts. This paper is not going to interest itself in the study of the prevention of alcoholism but rather in the motivation of the alcoholic to enter into therapy.

There are several definitions of alcoholism, and there are many descriptions of the alcoholic. Much depends on the interest of the person discussing the subject. Alcoholism can be looked at from the physiological, psychological, psychiatric, endocrinological, socio-cultural and neurological points of view. All these factors are important in the etiology of alcoholism. However, for the purpose of this paper, the definition will be a general one including; first, that there be a loss of control of alcoholic intake; second, that there be a functional or structural damage which may be physiological, psychological, domestic, economic, social or a combination of these; third, that the alcoholic uses alcohol to satisfy abnormal needs. There is a variety of other definitions, but this one is sufficient for this paper.

During the last twenty-five years, as Doctor Jellinek mentions in his disease concept of alcoholism, there appeared a new approach to alcoholism: "Alcoholism is a disease." He, however, also states, "This is not really a new

approach because there are alleged statements by St. John Damascene on the disease nature of inebriety." Numerous other instances point out that alcoholism was suspected to be a disease much before the time our own medical profession had accepted it as such.

This concept of alcoholism as a disease has become a working hypothesis in research and treatment of different varieties of alcoholism and also a central point of certain community activities related to the problem of alcohol.

Interest has grown by leaps and bounds in the prevention and cure of alcoholism especially in the area of industry. Business has suffered an enormous loss of time and money because of this addiction. Surveys have indicated that not only does this financial loss amount to billions of dollars annually but that alcoholism afflicts some of their finest men and men with many years of seniority. For it seems that, by the time the men or employees become aware of their addiction, they have been working for the company a long time and these companies have had a sizeable amount of time and money invested in them. The government, both federal and local, is interested because of the increase of criminality found among those drinking excessively. The high incidents of crime and the high incidents of accidents among those drinking is staggering and need not be repeated here. It came as a surprise to many that even in companies like Eastman Kodak, International Harvester and DuPont, which not only admitted the problem of alcoholism among their employees but had forward-looking and modern effective programs in their organizations, there was about the same percentage of alcoholics in their executive personnel as among their employees. Possibly the reason it was not discovered earlier was that the protection surrounding the executive or junior executive was

greater.

This paper will treat a group who, normally, was least suspected to be afflicted with alcoholism. Despite their better training, intellectual and moral, it was found by practically all the therapists who dealt with priests and alcoholic problems that the percentage of alcoholics among them was generally the same as in other groups.

Alcoholism presents too many problems to be reviewed in one paper. This treatise will confine itself not so much to alcoholism as to the treatment of the alcoholic and more specifically to the motivation of a person to enter into a special holistic treatment for his alcoholism.

Among other terms to be defined in this paper should be "success" and "therapy." Various authors define successful therapy in a myriad different ways ranging from a very minimal change for improvement in drinking to total abstinence. Chafetz (1964) adopts the definition that is used in cancer—that after five years a person who resumes drinking will be considered suffering from a separate disease of alcoholism. In this paper a two-year period of abstinence is considered successful therapy. By successful therapy is not meant a cure of alcoholism but an arresting of the disease. Further definition of different degrees of success will appear in the following survey.

In discussing the amount of coercion or the presence of force in guiding an alcoholic into therapy, one finds that for practical purposes some force, moral or physical, is always present. It is, therefore, not a matter of absence or presence of force but rather the amount, degree or kind of force. In this paper, force will be defined as a choice given by a superior of

entering into therapy for alcoholism or being punished in some serious way such as deprivation of liberty or status.

There are various definitions of success found in the literature. To facilitate an interpretation of the data five categories indicating degree of success were developed—PS, VG, G, R and P.

The category PS or Perfect Sobriety denotes a condition of complete sobriety, i.e., complete abstinence. VG or Very Good denotes a condition in which a man had a few small slips, i.e., with no loss of time or social difficulty. G or Good refers to a condition in which a man had a number of slips about two years apart with very little loss of time but with no loss of position or status. R or Repeater indicates a condition in which a man has had drinking bouts about once a year and required hospitalization. Finally, P or Poor refers to a condition in which a man has had frequent slips, was hospitalized and had an outlook that was poor and doubtful.

Review of Literature

The literature on alcoholism has been widely reviewed but shows little on the motivational aspects of seeking treatment (Blum, 1964). What studies there are stress specific environmental factors such as: marital partner, employer, physician, and clergymen as the precipitating instrument in seeking treatment (Jellinek, 1960; Hoff, 1961). Chafetz (1964) holds that although abstinence enforced by incarceration does not represent a cure for alcoholism yet compulsion can be used constructively. Chafetz (1964) says, "the victim should be given a choice between a jail sentence and confinement in a treatment center (p. 932)." Lemere (1958) found in a study at Shadel Hospital in Seattle that treatment initiated under duress can be successful. He says, "the therapist should not, however, be identified with this pressure but should reserve his talents for helping the patient achieve sobriety."

Forizs (1958) in his motivation of the alcoholic for recovery says that the problem is to manipulate the patient's anxiety to strengthen the motivation not to drink. Delihanty (1956) says that more can be done to motivate the alcoholic to seek treatment earlier by a broad program of education of the public to recognize that the alcoholic is a sick person. Lemere (1958) also states that the commonest reason for seeking treatment was preservation of physical and mental health. He continues stating that a threatened loss of job or spouse was found to correlate with good prognosis. This response indicates that treatment initiated under duress can be successful. Harry Tiebout (1947) in his direct treatment of a symptom talks about a stopping-variety treatment in handling people. This reference is used, as he points out, in many other instances such as incarceration, geographic removal, vacation, residence in a sanatorium. The writer found the paper most closely

related to the subject was by Morris E. Chafetz (1961). He sums up his paper saying, "the element of choice, clearly pointed out to the individual, must be present."

None of the above studies are concerned specifically with the channels by which clergymen enter therapy. Occasionally discursive articles, i.e., Notes on National Clergy Council on Alcoholism, deal with this problem but not in a systematic, objective fashion.



Treatment Facility

Guest House Sanatorium, the treatment facility, in which the Ss of this paper were treated is a large mansion used to house about 16 patients. It is situated on a 40-acre tract of land lying northwest of Detroit, Michigan. The choice of location was guided by the demand for complete rest in a natural environment of woods and lakes but close enough to the city to take advantage of hospitalization, psychiatric and psychological, medical and mental care which might be needed in the therapy. Being near a city, it also affords the patients the ease of attending AA meetings.

This institution was organized for the exclusive use of priest patients who are alcoholics. The principle followed by Mr. Austin Ripley, a layman and alcoholic of twenty-five years sobriety, is to treat the whole man. Time of treatment is a minimum of four months and as long as is necessary for the patient to feel well enough to resume his duties. When the patient first arrives or is sent to this institution, he is given a thorough physical examination in one of the neighboring hospitals similar to that which is given at the Mayo Clinic with special attention to endocrine gland functions, his liver, EKG, and kidneys. Everything is done to find if there is any physical disturbance which might be a reason for his drinking. If some surgery is required, it is performed as soon as possible before any other therapy is initiated. The patient is then welcomed into Guest House as one of sixteen patients in various stages of therapy. He then sees a psychiatrist and a psychologist and is given whatever continuing help is necessary. If the patient, at the time of his arrival, is possessed of a negative attitude towards this therapy, everything is done by the director, staff and patients to help motivate him to change this attitude. This treatment may take from

one week to a month, although there have been cases that took longer. If the patient's attitude changes to a positive one, he is allowed to continue. It is only very rarely that a patient has not changed his attitude. From this point on the patient follows a rather free schedule of attending meetings, eating meals in the dining room in common or in the snack shop, attending lectures, counseling sessions and outside AA meetings. He is given an indoctrination in and the explanation of the twelve steps of Alcoholics Anonymous. A good part of the time is spent in reading, milieu therapy, a free discussion among the patients, and recreation, both indoor and outdoor. His religious supportive moral therapy is left to his own free will.

A patient is free to come and go as he pleases. Should he take a drink, he has to begin his therapy all over again. He is given two chances. The decision to terminate his therapy is left to the staff, to the patient, to the psychologist, and to his superior. Every effort, after the termination of his therapy, is made to consult with his superior as to his future assignment in order that the climate for his re-entry into the normal world will be as favorable as possible. During the entire stay the patient is treated as a sick person, as a priest in good standing. When he leaves he is made to feel welcome to return for a friendly visit or for any therapy in case the need arises. By far the majority of patients have gone away from Guest House with the feeling of having spent some of the happiest months in their lives as evidenced by the return of visiting alumni in great numbers in the years following their therapeutic stay.

### Procedure

This study was conducted with a group of clergymen from whom data was obtained through use of a structured interview. Validity was tested by a check interview given to a peer of each subject. An attempt was made to obtain specific information on the precipitating causes for entering treatment and the channels by which this was done. In addition, general information concerning motivational background was sought.

### Patient Population

The Ss were a group of 32 priests taken from two adjoining dioceses and who went to a specific treatment center for a period of three or four months. These Ss have attended this therapy center in the last fourteen years. The writer contacted each one personally or by telephone. A set of questions was prepared to secure information. These questions were first tested with a pilot group of priests who attended some other treatment center or used other therapy for their own rehabilitation.

### Instrument used

Data was obtained through a structured interview. A questionnaire was constructed to tap (1) the major variables studied—motivational factors underlying referral to Guest House; initial attitudes toward treatment; and degree of success after treatment; (2) variables considered to be important for descriptive purposes—age at time of admission; present age; duration of the drinking history and drinking problem; success of prior attempts to stop drinking; level of tolerance at time of admission; (3) variable that might provide further insights into alcoholism—attitudes of the subject toward alcoholism; changes in eating and smoking behaviors after admission and during treatment; attitude of the subject toward having those in his immediate

environment know about his problem; (4) other variables considered were the attitudes towards continued therapy in AA, psychological therapy and general confidence in their future sobriety. They were questioned about the difficulty with drink and their reaction to those temptations. Of great interest was their considered opinion of the importance of the place of a superior in their rehabilitation. Patients were also questioned about the values of the different therapies which they received in this treatment center.

The final question was one of judgment describing the quality of their sobriety.

The validity of the Ss' responses to the questions tapping the major variables was determined through a check interview with a peer of each subject. These people were either friends, neighbors, or superiors of the Ss in question. It was found that all Ss accurately reported the precipitating causes for entering treatment and the channels by which this was done.

Results

## 1. Present age.

The average age of Ss was 51 years; range, 32 to 67. There were 32 patients questioned, and of these, 31 will be used in this survey. One was disqualified because it was found by the check interview that the subject was not being truthful even though he knew the interrogator was aware of it.

## 2. How old were you when you entered therapy at Guest House?

The average age of the patients entering was 47; their ages ranged from 30 to 64.

The difference between the age at which this survey was taken and the age at which they entered Guest House was then calculated. The average time since Guest House was 5 years and the range was 1 to 14 years. The fact that this paper will be dealing with an average of 5 years of life after therapy should give a good sample for the type and quality of sobriety or success. Almost 30% of the patients have been away from Guest House ten or more years.

## 3. At what age did your social drinking begin?

The average age at which social drinking began was 26 and it ranged from 10 years to 42 years of age.

## 4. How old were you when your drinking became a problem? Either in your own estimation or in the estimation of others?

The average age at which the Ss found that they had a problem was 35 and it ranged from 16 to 52 years of age.

## 5. How many years elapsed from the time of the beginning of your social drinking to the time at which drinking became a problem?

The average age was 10 years and the range from 1 to 28 years.

6. How old were you when you felt that your tolerance was affected?

The average age at which tolerance was affected was 41. The range was 31 to 54 years. It is interesting to note that in 12 cases out of 31, tolerance was not affected at all.

7. How many years had elapsed to the time at which your tolerance was affected?

The average was 14 years; the range from 1 to 30; the median was 20 years.

8. At what age did you find that your drinking interfered with your social life or your work or both?

The average age was 40; the range was 25 to 56; the median and mode were 40.

9. What efforts were made by you or others to stop your drinking?

Only 7 made no attempts to stop drinking. While 6 made pledges and 8 were hospitalized on several occasions, 8 made pledges and were hospitalized. Over one-half were hospitalized. Two tried psychological or psychiatric help.

10. What success did these efforts have?

All reported little, poor, or no success.

11. Over how long a period of time were attempts made to stop drinking?

The average period was 3 years. The range was from 1 to 14 years.

12. What substitution, if any, was used for drinking?

Pills were used in one-third of the cases; librium in 5; food in 1 case. The rest had no substitutes.

13. Has AA been tried?

In over half of the cases AA was tried.

14. For how long a period?

Over an average period of 2 years. The range was anywhere from a few meetings to 3 years.

15. Was there any noticeable change in your smoking habits during this period of drinking?

In 21 cases there was an increase in smoking. In the others there was no noticeable change.

16. Was there any noticeable change in your eating habits during this period?

Twenty-five noticed a decrease in appetite and eating; 6 noticed no change.

17. Was your decision to enter therapy voluntary or forced?

Sixteen of those answering said they went voluntarily and 15 were forced by their legitimate superiors as corroborated in question number 18 which asks if the superior was involved in sending them.

18. Whether you went voluntarily or not, in your own opinion should your superior have sent you?

The answer to this question was unanimously in the affirmative.

19. Would you describe the manner in which this should have been done?

Also unanimously the patients indicated that the manner should have been one of firmness and kindness meaning that a choice should be given; that the manner of sending the patients to therapy should not be punitive but therapeutic; that the superior treat the subject as a sick person not as a moral derelict.

20. With what attitude did you enter therapy?

Seventeen out of the 31 entered therapy at Guest House with a negative attitude. This number points to the fact that even some of those who went voluntarily had a negative attitude, i.e., not too much hope or confidence.

21. If you entered with a negative attitude, how long before your attitude changed?

The average was 2 weeks; the range was 1 to 4 weeks.

22. What therapy of those used did you find most beneficial?

Eighteen of those asked responded that they liked the director's counseling. Second place was given to milieu therapy by 10 Ss; AA, the physician, and psychological counseling were each given respectively by 3, 2 and 5 Ss.

23. What kind of disease do you think alcoholism is?

One patient felt it was a physical disease; 25 patients classed alcoholism as physical and psychological; and 5 patients felt that the addition of morality to the disease concept should be made.

24. Do you think alcoholism is curable?

Twenty-seven answered no and 4 were undecided.

25. Do you think AA therapy is necessary for you?

Twenty-five patients said yes; 3 no and 3 did not know.

26. For how long?

Twenty-five patients felt that this was a permanent need; 3 did not know; 3 thought none was necessary.

27. How often per week?



The average was  $1\frac{1}{2}$  meetings a week; the range was 1 to 4 meetings a week.

28. Is continued psychological treatment necessary to maintain sobriety?

Twenty patients answered yes, 10 no, and 1 was undecided.

29. Do you have confidence in your continued sobriety?

All except 1 were confident.

30. Are you content now?

Thirty yes and 1 partially.

31. Were you able to resume your normal life activities?

Same as previous answer.

32. Have you had any strong temptations to drink?

Seventeen said yes and 14 replied no.

33. What happened?

Eleven had slips without hospitalization; 3 had slips with hospitalizations; 1 of these 3 was hospitalized three different times at Guest House.

34. Should those people in your immediate environment know about your problem?

Twenty-eight felt it would be helpful; 3 did not.

35. How important in therapy or in the obtaining of your sobriety is the role of your superior?

All without exception felt that the superior carried probably one of the more important roles in their attainment of sobriety.

36. Have you had any slips?

Fourteen yes and 17 no.

37. What was the reason for your slips?

All the patients without exception blame their slips on absence from meetings.

Analyzed according to our five categories the data show that 19 of the patients have experienced complete sobriety ever since they left the therapy center. Of these, 12 entered therapy voluntarily and 7 were forced by their superiors. There were 5 patients who were classed as VG; none of them entered therapy voluntarily. Four patients fell in the G group; of these, 2 entered therapy voluntarily and 2 were forced. In the R group there were 2 patients; one entered voluntarily and one was forced. One patient in the P group was forced into therapy.

Results to Second Instrument

Six questions were asked of the peers, friends or superiors regarding the circumstances under which the patient entered therapy, whether or not he was forced by the superior, the success of the therapy, and the present attitude of the patient. They also were questioned on the advisability of the use of force by a superior in getting his subject to enter therapy.

1. Do you feel that this person is an alcoholic?

The answers were all confirmatory.

2. Under what circumstances did this person enter into treatment?

The answers were consistent with the answers given by the patients except in the one case which was removed from the survey as mentioned above.

3. If force was not used, should it have been used?

Without an exception all those questioned felt that force should have been used.

4. Has therapy been successful?

The corroboration tallied perfectly with the replies given by the patients.

5. Is patient content or reasonably happy?

It is surprising how agreement coincided with that of the patients in answering this question.

6. Should superiors force treatment?

Those answering were unanimous in their opinion that superiors should force a subject into treatment, but that this force should take the form of a disagreeable choice: therapy or deprivation of status or punishment.

Discussion

The results, as might be suspected, show that a record of perfect sobriety was much better among those who came to therapy without the intervention of their superiors. However, the fact that 7 out of 15 patients who were forced into therapy remained completely abstinent indicates that authority may be a feasible method for getting alcoholics into therapy. A more realistic view would be of a very marked improvement and change of attitude being a goal to be achieved. It was noted that among those forced there were 5 whose sobriety was classed as Very Good, and 2 as Good. Two others of the Good class were counted among those who volunteered for therapy. Most authors would consider Very Good and Good as successfully treated. If so, our results would then show that both among those forced into therapy and those entering voluntarily the number of "successes" were the same.

It was noted that the time taken to achieve a cooperative attitude had no significant difference among those who entered therapy with a positive or negative attitude. Nor did force have any affect on the time in which the attitude of cooperation was effected. Among those who took the longest period (4 weeks) 2 were forced admissions and one was voluntary. However, each one of these entered with a negative attitude. And it is interesting that among these were found no failures. The results ranged from perfect sobriety to Good. There were 5 patients for whom it took three weeks to cooperate with the program at Guest House. Among these 2 Ss were forced into therapy and 3 were voluntary. Of the 5, two entered with a positive attitude, and 3 came with a negative attitude. All 5 of these Ss have perfect sobriety. All 8 Ss who had 3 or 4 weeks time to change to a cooperative attitude achieved at least a Good sobriety. None have had slips. Of the 8 patients who took three

or more weeks to change their attitudes, 6 entered therapy with a negative attitude, and only 2 had positive motivations. It might be concluded that those who took a longer period of time to affect the change of attitude might have been more serious and sincere. It certainly shows up in the fact that all were successful. It is also interesting to note that in this group are the 2 of the 3 who do not attend AA meetings. These 2 men are older and sick.

It was found that even among those forced into therapy the consensus of opinion was that the superior should have used force. This coincides with what Chafetz (Is Compulsory Treatment of the Alcoholic Effective?) says about the alcoholic interpreting force as interest on the part of the superior. Maier and Fox (Forced Therapy of Probated Alcoholics, 1958) say that it is apparent, however, that a significant number of alcoholics can be helped by forced therapy. Although the ability to remain sober for six months does not indicate a "cure" and that the alcoholic will never drink again, at least the subject is benefited by six months of employment and absence from court and jail. Similarly Dorris and Lindley (Counseling on Alcoholism and Related Disorders) say regardless of his intent and even if he feels that he has been coerced, once he is exposed to treatment, there is a chance that he may decide to become actively involved.

The age at which therapy was initiated made no difference as far as success of the therapy. Another interesting observation is that perfect abstinence could be almost equated with continued regular attendance at AA meetings. There were only 2 exceptions and in both of these cases the Ss were involved in counseling alcoholics.

Of the five types of therapy provided for the patients at the treatment

center, counseling by the director, a layman and sober alcoholic, was chosen by 18 of the patients as the most effective therapy, while only 5 were most helped by counseling by a professional clinical psychologist.

The survey showed that those who attended meetings regularly did not have strong temptations to drink. Of those who did not attend meetings and were successful in their sobriety, it was found that they were very much involved in counseling alcoholics.

Twenty-one out of 31 of the patients showed an increase in their smoking while 25 noticed a decrease in their appetite. No conclusion has been drawn from this except perhaps that in the case of smoking the subject could be considered more easily habituated. In the case of the decrease in eating, consumption of alcohol with its quick energy may have served as a substitute.

Summary and Conclusion

It was found that a group of 31 priests—a complete sample of two adjoining dioceses—entered therapy at Guest House. Fifteen of these were forced by orders of their superiors. Neither age at time of entry nor manner in which therapy was entered had any significant bearing on the success of the therapy, although record of perfect sobriety was better among those Ss entering voluntarily. The attitude of those beginning therapy as a direct result of force by superiors was negative. Such an attitude was found even among a few of those entering voluntarily. This attitude, negative or positive, had no significant effect on the success of the therapy. However, among those who took longer—three or four weeks—to cooperate, there were no unsuccessful patients. Increase in cigarette smoking and decrease in eating habits showed up in a significant number while drinking. Eating habits improved after sobriety was achieved. No notice was made of smoking habits after therapy except that in a few instances patients gave up smoking, but not immediately after therapy.

The survey brings out very strongly the importance of the interest on the part of the superiors in the patient, even to the point of using force therapeutically. It shows that not only motivation and education are needed for patients but also for those concerned with them. Without exception the patients pointed out that interference on the part of the superiors was not only just but an act of charity and love. The good of the individual and the organization both demand it. Too long, as Blum and others concur, has motivation been considered necessary only for the patient. It is even more important at the beginning for the employer or superior.

Structured Interview

1. Present age.
2. How old were you when you entered therapy?
3. At what age did your social drinking begin?
- 4-5. How old were you and after how long a period of time did your drinking become a problem? (In your own estimation)
- 6-7. How old were you and after how long a period of time was your tolerance affected?
8. At what age did you find that your drinking interfered with your social life or your work or both?
9. What efforts were made by you or others to stop your drinking?
10. What success did these efforts have?
11. Over what period of time were these efforts made?
12. What substitutions, if any, were used for drinking?
13. Has AA been tried?
14. If so, for how long? Or, over what period of time?
15. Was there any noticeable change in your smoking habits during this period of drinking?
16. Was there any noticeable change in your eating habits during this period?
17. Was your decision to enter therapy voluntary or forced?
18. Whether you went voluntarily or not, in your own opinion, should your superior have sent you?
19. Would you describe the manner in which this should have been done?
20. With what attitude did you enter therapy?



21. If you entered with a negative attitude, how long before your attitude changed?
22. What therapy of those used did you find most beneficial?
23. What kind of disease do you think is alcoholism?
24. Do you think alcoholism is curable?
25. Do you think AA therapy is necessary for you?
26. For how long?
27. How often (per week)?
28. Is continued psychological therapy necessary to maintain sobriety?
29. Do you have confidence in your continued sobriety?
30. Are you content now?
31. Were you able to resume your normal life activity?
32. Have you had any strong temptations to drink?
33. What happened?
34. Should those people in your immediate environment know about your problem?
35. How important in therapy or in the obtaining of your sobriety is the role of the superior?
36. Have you had any "slips?"
37. What was the reason for your "slips?"

Check Interview

1. Do you feel that this person is an alcoholic?
2. Under what circumstances did this person enter into treatment?
3. If force was not used, should it have been used?
4. Has therapy been successful?
5. Is patient content or reasonably happy?
6. Should superiors force treatment?

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Table 1

Time elapse for attitude of cooperation in negative and positive admission

3 Weeks

1)	N	V	PS
2)	N	F	PS
5)	N	V	PS
11)	P	V	PS
13)	P	F	PS
	<hr/>	<hr/>	<hr/>
	3 N	3 V	5 PS
	2 P	2 F	

4 Weeks

8)	N	F	VG
9)	N	V	PS
14)	N	F	G
	<hr/>	<hr/>	<hr/>
	3 N	1 V	
		2 F	

Table 2  
Motivation

	Forced	Voluntary
PS	7	12
VG	4	1
G	2	2
R	1	1
P	1	

APPROVAL SHEET

The Thesis submitted by Reverend Aloysius Sinsky has been read and approved by the director of the thesis.

Furthermore, the final copies have been examined by the director and the signature which appears below verifies the fact that any necessary changes have been incorporated, and that the thesis is now given final approval.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

6/29/69

Date

William A. Hunt

Signature of Advisor