COUNSELING THE ALCOHOLIC: A CENTURY OF ELUSIVE SUCCESS

by

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PREFACE

Alcoholism: a treatment, a cure, a solution, a mystery to be solved. Various professions may and often do disagree about which is the best strategy to take for confronting the problem of alcoholism. One profession may see it as a somatic illness, another as a psychiatric problem, another may see it as a socially induced and sustained problem of the culture. These disagreements occur to both professionals and lay workers as each attempts to define a particular problem within the scope of its studies. Through cooperation of the various studies a satisfactory answer for the vast social problem may be found.

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CHAPTER I

INTRODUCTION

A Personal Point of View on the Tavern Culture

As a youth, raised in rural Wisconsin, I became acutely aware of the tavern culture. The tavern, is the social club, the meeting place, the dating place, and family entertainment area. During the regular work week the tavern becomes the place to meet your friends, for a few moments of relaxation before going home or where the couples go after supper for socialization purposes. On Friday night, the tavern becomes the family dining spot and social gathering area. On Saturday and Sunday the tavern is where couples met to play cards, dice, or even bowl.

This exposure to such a pervasive influence and my interest in alcoholism fueled my burgeoning discontent over the decades of functioning as a banker. I read and reread articles on alcoholism causation albeit is it a disease or is it due to personality factors. I read of the toll that alcoholism takes in terms of the family, the work place, and of the various treatments to cure this nebulous disorder. The more I became involved in graduate studies the more I began to look at just what is alcoholism. I finally reached a point of saying to myself that this is perhaps one area that I would like to know more about, this is an area that perhaps in the future I will attain additional qualifications and certifications and perhaps an area that I will work in.

Statement of the Problem

I began to examine the literature in my quest for answers to causes and treatments for alcoholism. The more I investigated, the more it became apparent, an exact approach to work with alcoholics alluded me. This paper is therefore addressed to researching state of the art approaches.

The purpose of the research of literature which follows is directed to ascertain the political and social trends evident in treating the use of alcohol as well as the professional and public attitude towards its abusers. The theoretical models used in counseling alcoholics, from 1900 to the present are examined.

The following models are examined in this literature: the physiological or biological, the psychological, and the sociocultural.

The application of the medical, social and psychiatric regimens are explored as they impact upon alcoholism treatment in the setting of the family environment and upon the individual. The effectiveness of each therapeutic design was analyzed to illustrate a continuing evolution of approaches to treatment. Data for this investigation were obtained through historical review of the professional literature of the fields of medicine, sociology, social work, psychology, psychiatry, and counseling. A definition of the problem is the first priority.

Alcoholism by Definition

According to E. M. Jellinek, "Alcoholism is any use of alcoholic beverages that causes any damage to the individual or society or both" (Jellinek, 1960, p. 35). The World Health Organization (WHO) defines alcoholism as any form of drinking which goes beyond the traditional and customary dietary use or ordinary compliance with social drinking customs of the whole community, irrespective of the etiologic factors leading to such behavior, and irrespective also of the extent to which etiologic factors are dependent upon heredity, constitution or acquired physiopathologic and metabolic influences. Howard J. Cleinbeel Jr. (1956) in his book Understanding and Counseling the Alcoholic: Through Religion and Psychology states, "An alcoholic is anyone whose drinking interferes frequently or continuously with any of his important life adjustments and interpersonal relationships" (p. 17).

In August of 1952, Jellinek was present when the Alcoholism Sub-Committee of the Expert Committee on Mental Health of the WHO met for a second time in Geneva, Switzerland and adopted an additional explanation of alcoholism, that being:

> "Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and

mental health, their interpersonal relations, and their smooth social and economic functioning, or who show the prodromal signs of such development" (United Nations, 1952).

The second report of this sub-committee considered it more appropriate to use their earlier formulation to define not alcoholism but excessive drinking. The second committee meeting, in addition to terming alcoholics excessive drinkers, added two additional elements *dependance and disturbance*. In 1964, WHO recommended that the term *dependance* be replaced by *addiction*.

Perhaps one of the clearest definitions which I have found for alcoholism was in the book Alcoholism: Interdisciplinary Approaches to an Enduring Problem, "Alcoholism is intermittent or continual use of alcohol associated with a dependency (psychological or physical) or harm in the sphere or mental, physical, or social activity" (Tarter and Sugarman, 1976, p.69).

Currently, there are some who view alcoholism as a disease yet not long ago alcoholism was considered to be a willful and immoral act and reflected upon the conduct of the individual as a willing participant. There certainly has been continued disagreement on the very basic issue of whether alcoholism is a condition which the individual is able to control or whether people become alcoholics on the basis of personal choice. The differences in the definitions of an alcoholic have to do with the varied criteria used to term someone an alcoholic.

In a medical model, a clinical diagnosis would be possible based on a patient's history, mental status, or other examination findings. A physiologist may look for the causes of alcoholism in the metabolism, a geneticist in the genes, a neurologist in the brain, a psychologist at behavior, or a sociologist in the culture. If, in fact, there is no agreement concerning the nature of alcoholism then the problem of alcoholism is particularly difficult to assess because we do not know where to look for the answer.

The present research focuses on the history of all these schools of thought and their varying degrees of legitimacy over time, although neither side appears to have sufficient ability and evidence to dominate the other.

CHAPTER II

HISTORICAL PERSPECTIVE OF ALCOHOLISM: THEORIES AND TREATMENTS OVER 100 YEARS

Interest in the history of alcohol abuse must begin with an understanding of certain factors, to include the various temperance movements, the most prominent and influential contributors to research, and how they affected the concept or public view of alcohol usage or abuse. A historical perspective is presented by germane periods.

Pre 1900

Benjamin Rush

The intellectual and political founder of the Temperance Movement is often considered to be Dr. Benjamin Rush (1746-1813), an American physician and a signer of the Declaration of Independence. He served as Attorney-General of the United States (1813), and participated in founding the Philadelphia College of Physicians. Benjamin Rush was well-known for his great concern for political and personal honesty and virtue. "Over time, however, Americans came to know him best for his efforts on behalf of temperance" (Lender, 1984, p. 421). Rush had spoken out against the use of

distilled liquors since at least 1772, but his masterpiece on the subject was *An Inquiry Into the Effects of Ardent Spirits on the Human Mind and Body* (1785). The track proposed by Rush was a radical challenge to the traditional dictum that drinking was a positive influence on society. Rush published a number of pamphlets in which he argued that regular drinkers become addicted to alcohol, and described alcohol addiction as a loss of control, a irresistible desire to drink and in general a disease. The cure for this disease, according to Rush, was total abstinence from any spirits. Rush's work precipitated a general medical movement in the United States; throughout the nineteenth century physicians becomes the backbone of most temperance organizations and the authors of highly regarded pamphlets and articles which condemned the consumption of alcohol.

The nineteenth century temperance movement consisted primarily of information gathering and information dispensing about the evils and destructive affects of alcohol. The temperance movement of the nineteenth century reflected the attitude that habitual drinkers were addicts suffering from a condition beyond the control of their will, which was often called, a disease.

1900 to 1950

Prohibition Party

The Prohibition Party, formed in 1869, was a major organization which espoused the view that alcohol production was evil, power for its goals of

inhibiting consumption through regulation was perceived as gained through political representation. In that last regard, the Party encouraged members to stand for election to various state government bodies and encouraged proposal of prohibition laws be passed and enforced. This method was particularly effective in the passing of a sweeping prohibition law, fifty years later. However, "The prohibitionary laws in force in the United States aim merely at the suppression of liquor traffic (i.e., the buying and selling of liquor for beverage purposes) within the boundaries of the particular states which have adopted such laws" (Levine, 1984, p. 109). In general, the nineteenth century temperance movement saw prohibition being achieved as a part of a broad moral reformation of American society, not simply as a result of political pressure.

Anti-Saloon League

The Prohibition Movement of the Twentieth Century differed in organization and ideology of the temperance movement from the previous century. In the twentieth century the temperance movement and liquor control movements are best symbolized by the Anti-Saloon League, a nonpartisan organization that used very modern lobbying and political pressure to accomplish its goals. Like modern day lobbyists it had a large, well paid staff of lawyers who submitted well-written League concepts to be given to various pro-ASL legislatures to push into law. Up until 1913, the League worked

primarily on a local and state level, but in that year it declared itself in favor of a national prohibition amendment to the United States Constitution. The effectiveness of the League is evident in the support that it gained from many protestant churches in collecting money and spreading the word among the church-going public supporting a constitutional prohibition against alcohol. It is striking that much of the support for the movement came from wealthy industrialists and the business elite of the country.

John D. Rockefeller was one of the most famous members of the corporate rich who actively supported the prohibition movement. William Randolph Hurst organized the Hurst Temperance Prize Contest with $25,000 in cash awarded to authors whose works demonstrated antialcoholism.

Perhaps one of the great motivations behind the corporate backing of a temperance or prohibition movement was the supposedly substantial economic benefit from it. With more workers abstaining from alcohol, it was perceived there would be less loss of profits due to accidents and greater production because of greater efficiency. Therefore, workers would have greater amounts of money to spend on the necessities of life since they would not be drinking away their weekly wages. There would, in addition, be less demand for union representation because of greater worker satisfaction. There were further reasons for corporations supporting prohibition. There would be less crime, poverty, and social disorder which would require fewer hospitals, institutions

and police. Such social organizations were, of course, supported in great part by the corporate giants. With the support of big business and big money, the passage of prohibitionary laws was far more politically feasible than all the support churches, social reformers, and Anti-Saloon League could have mustered. It is important to point out that the prohibition movement in this country began as a temperance movement directed toward winning converts by persuasion rather than by law.

Temperance/Prohibition Movement

The Temperance/Prohibition movement which preceded World War I developed over a number of years and may be viewed as disorganized and active chiefly on a local or state level. A large number of states had adopted prohibition laws, but only thirteen states had adopted *bone-dry* laws, which imposed complete abstinence from alcohol. Local option was still the established principle in most of the populous industrial states. In addition, ignoring these actual and potential variations in local theory, there was the proposal (militantly advanced by the Anti-Saloon League) for a single rigid national standard which required absolute and compulsory prohibition for the nation.

World War I

The League could count on its own effective political and religious power based on a steadily increasing resentment in most parts of the country

against saloons, the reluctance of the brewers and distillers to put their trade in order, and (perhaps above all else) the absence of any movement or organization interested in planning a moderate program of reform. With the outbreak of World War I three occurrences increased the impetus for prohibition. The war centralized authority in Washington through the mass mobilization of troops for service in Europe, the necessity of saving food for the war effort, and identification of saloons being of German origin. Thus the war brought new and powerful arguments to the cause of prohibition.

Prohibition Law

Before the war was six weeks old, prohibitionists in Congress attempted to attach a prohibition law to a war bill dealing with German spies. This law failed, but, shortly thereafter, the food control law was passed in Congress and written into this law was a provision forbidding the manufacture of distilled spirits from any form of food stuffs. Debate began on the proposed Eighteenth Amendment to the Constitution and viewed from a modern perspective, surprisingly few hours were spent on the political hot potato. The Amendment was passed by both houses of Congress and on January 18, 1918, the first state, Mississippi, ratified the Eighteenth Amendment. On January 6, 1919, the 36th state, Nebraska, voted for ratification. Three fourths of the states acquiesced and on January 16, 1920, prohibition became law.

During the period of legalized prohibition from 1919 to 1933, amid social and economic shifts, changes occurred in the drinking patterns of the American public. Illegal and illicit stills became the main sources of hard liquor and flourished with a new market on a very ambitious scale. The development of a whole underground system of production and distribution of alcohol was born. Imported liquor, (particularly from Canadian whiskey corporations), flourished beyond their wildest dreams during the 1920's. In the meantime, the illegal use of stills was expanding in both cities and rural districts. Patent medicines came under suspicion and druggists began to be raided.

Failure of the Prohibition Law

The problem of insufficient federal funding for enforcement of the Volstead Act, the primary law for enforcing prohibition, compelled the Department of Justice to abandon plans to add special prosecutors to its staff. Further, the states refused to contribute enforcement personnel forcing the federal authorities in Washington to shoulder the whole burden of enforcement of this new amendment.

By the end of 1925, a great many sets of figures were available to support the purported effects which prohibition was having upon the evil it was originally designed to cure; the evil of intoxication. These figures were produced by such organizations as the World League Against Alcoholism and

the Moderation League, Inc. There was ample opportunity for everyone interested in the results of prohibition to fortify their personal prejudices with well-documented facts and evidence. One such statistic showed the number of prisoners in Connecticut jails charged with drunkenness fell from 7,314 in 1917 to 943 in 1920; arrests for assault and breach of peace were reduced to less than one third (Gordon, 1943). The Salvation Army at this time reported to a congressional investigating committee in existence prior to Prohibition, that cases of poverty in New York City as a result of drunkenness were only a fiftieth of what they used to be, but reported that intemperance among workmen was constantly increasing. A large part of the argument over the effect of prohibition on both prosperity and crime was not subject to proof.

By 1930, it was very clear that the federal government had failed (after ten years of earnest exhortation) to persuade the states to make a realistic effort to enforce prohibition. The central government finally abdicated responsibility for the single-handed enforcement of "bone-dry" prohibition in the United States at the end of 1930, a move that effectively ended the practice. Thus, the difficult responsibility of enforcing prohibition shifted to the states due to the failure of enforcement funding. At the end of 1930, the decisive factors were widespread disregard of the law, indifference in the state legislatures, and unwillingness on the part of the federal government to accept the entire burden of enforcement. By this time, the alternatives for the prohibition amendment

had come down to: (1) willing compliance with the law on the part of a sufficient number of people to produce results; (2) a realistic effort to enforce the law in the face of whatever opposition it encountered; (3) nullification of the law by deliberate failure to enforce it, (4) an effort to modify the law by some change in the Volstead Act, or (5) repeal of the law and restoration of state jurisdiction.

Association Against Prohibition Amendment

The struggle to overturn the 18th Amendment became a political battle of great consequence. The Association Against Prohibition Amendment (AAPA) became the vehicle through which prominent citizens who had previously not engaged in political activity articulated their values and beliefs regarding society, reform, and government. "But the fight for Repeal has been the affair of Wall Street in collusion with the press controlled by Wall Street, a power without equal. Its major organization, the Association Against the Prohibition Amendment, came from the innermost circles of high finance" (Gordon, 1943, p. 79). The AAPA group was organized and lead by some of the wealthiest and most conservative men in America. It was headed by Pierre DuPont of DuPont Chemicals and John J. Raskob of General Motors while its board of Directors included the presidents and chairmen of many major corporations including American Telephone and Telegraph, Southern Pacific Railroad, Goodrich Rubber, Anaconda Copper, United States Steel, General

Electric, Phillips Gas and Oil, Richfield Oil Co., Boeing Aircraft, and Marshall Field Department Stores.

The AAPA believed that liquor taxes would increase the revenue of the government and reduce personal income taxes. By the middle of the 1920's Pierre DuPont had become convinced that if liquor taxes were repealed, he would pay millions less in taxes. A similar, and perhaps even more important reason, why the corporate rich turned against prohibition was evidence that the American public was evincing a new disrespect for the legal system. Of course, the depression of the 1930's did ferment riots and looting by hungry men and women as well as rallies by the unemployed and new political organizations. In 1932 the long time prohibitionist John D. Rockefeller Jr. came out for repeal because he had concluded that prohibition was seriously undermining respect for all law and order. When the 21st Amendment, repealing the 18th, was ratified in December, 1933, the AAPA and the Democratic Party were vigorously attacked by the Republican Party for their platform of repeal. The Democrats countered by suggesting repeal was a method to create jobs, reduce government expenses, and increase revenues, at a time when all of those issues were necessary to stabilize the economy.

Alcoholics Anonymous

The Alcohol Anonymous (A. A.) organization which forged the post-prohibition ways of expressing some of the classic temperance concerns, gained

substance and notoriety in the late 1930s. In 1934, Bill Wilson was hospitalized at the Charles B. Towns Hospital of New York for his alcoholic condition. Dr. William D. Silkworth, a future A. A. co-founder along with Wilson, was Wilson's physician.

At the hospital, Wilson had a personal religious experience where he envisioned himself helping others to overcome alcoholism. After his release from the hospital, he became a participant in various spiritual programs for alcoholics. One of them was the Oxford group, a religious organization which held weekly meetings at the Calvary Church in New York City. At the same time, he began working with alcoholics at the Towns Hospital and the associated mission of the Calvary Church. In 1935, with some of his work and business colleagues he moved to Akron, Ohio to pursue a business venture which eventually failed. Following this failure, most of Wilson's friends returned to New York, but Wilson stayed in Akron and, through a contact he had from the Oxford Group, met Dr. Robert Smith, a local surgeon, who had lost his staff position at Akron City Hospital due to alcoholism. The concept of establishing a fellowship or self help group of alcoholics was formulated at the meetings between Wilson and Smith. When Wilson returned to New York he continued to work through the Oxford Group as well as the Towns Hospital eventually forming a small group of followers who were alcoholic.

By late 1935 Wilson and his wife were holding weekly meetings with alcoholics at their home. In mid 1937, this New York group split from the Oxford Group. The primary reason for breaking with the Oxford Group was a dislike for the Oxford Groups' use of names, since Wilson felt that alcoholics wanted to remain anonymous and, with the publication of a book in 1939, the term Alcoholics Anonymous evolved and applied to the Wilson Group.

The new Alcoholics Anonymous group of New York continued to grow and, in December of 1937, the Alcoholic Foundation was established with the help of Wilson's brother-in-law, Dr. Leonard B. Strong, Jr.. Strong was able to enlist a number of well-known New York business men including the treasurer of the John D. Rockefeller Charities Division.

The National recognition of the Alcoholic Anonymous movement came about as a result of an article in the September 1939, issue of the Liberty Magazine entitled "Alcoholics and God". The magazine's editor, Fulton Ourser, later became a trustee of A. A. From that time on, the development and progress of A. A. grew with generous support from its many members. As part of its growth, it established its own publishing company called the Works Publishing, which produced such books as Alcoholics Anonymous, Living Sober, a membership directory, and the internal magazines The Grapevine and The Bulletin.

In 1958, A.A. helped to develop a full length television production "Days of Wine and Roses" which became a motion picture in 1963, partly with A. A. cooperation. Various other specific groups based upon the A. A. concept were formed as needs were perceived. The first adjunct to A. A. was Alanon, founded in 1949 and incorporated in 1954 as a support group composed of wives, husbands or children of alcoholics. Alateen, a group for teen age alcoholics, was inaugurated in 1957.

The A. A. concept was a reformation of the thinking that drinking and its addiction could be controlled by the individual rather than by elimination of this substance. The doctrine that Bill Wilson and Dr. Robert Smith followed was that people who became alcoholics were afflicted with a disease that would eventually make it impossible for them to control their drinking. This shift from viewing alcohol as universally addictive, to regarding it as a substance which was addictive to only some people, brought the concept again to an individual focus. An interesting similarity exists between the Alcoholics Anonymous doctrine and the pre-1900 temperance movements in that the temperance groups became rescuers with its meetings composed of and attended by reformed drunks who spoke frequently and graphically about their drinking.

Yale Center on Alcohol

Alcoholics Anonymous gained increased support from many wealthy businessmen who had formerly been associated with the Anti-Prohibition movement and a preexisting organization researching alcohol and its effects upon the human body. This organization, which began as a temporary project in 1923, was extended and expanded to become the Yale Center on Alcohol. The center originally founded by Dr. Yandel Hendersen, was assisted by Dr. Howard W. Haggart, author of Devil's, Drugs, and Doctors (1929), who had a popular anti-alcohol radio series from 1925 to 1945. In 1930, the Center began studies that concentrated primarily on alcohol's effect on the body. The research caused much conflict in dispelling myths such as (1) Alcohol is a stimulant or a poison, (2) alcoholism is inherited, (3) alcohol is a direct cause of certain specified diseases, and (4) alcohol damages sperm (Dorris and Lindley, 1968). Undoubtedly it was this research that helped change many of the attitudes toward alcohol. At this time, it became clear to many, that alcoholism must be treated with a multi-faceted approach.

During the period from 1930 to the 1940's, organizations working with alcoholics began to be separated into two groups. Each offered a particular type of treatment for the alcoholic with both achieving some degrees of success and failure. One division consisted of lay groups, the most visible being A. A. The other group was composed of highly trained professionals, including

psychologists, psychiatrists, sociologists, social workers, doctors, and clergymen. Their approach was that only the skilled and educated were properly equipped to deal with alcoholics. Thus, they frequently viewed lay workers as threats to professional ethics and procedures. However, it is important to note that the lay workers were equally committed to their concept of treatment and felt equally threatened by the professional alcoholic treatment programs. These groups had common interests and many common goals. Even though their methods frequently resembled each other, the desire to understand these goals was not always present.

Quarterly Journal of Studies on Alcohol

The two schools or diametrically opposed categories of thought about alcoholism began to develop in separate directions when Dr. E. M. Jellinek, a psychiatric researcher and statistician joined the Yale Center in 1939. Shortly after joining the Center, Jellinek began the well-known and well-respected Quarterly Journal of Studies on Alcohol as a vehicle for communicating the results of research on alcohol and its use. In 1943, Dr. Jellinek began the Summer School of Alcohol Studies, a six weeks course designed to promote interchange and dialogue among researchers on alcoholism. In 1944 the Center opened two out-patient clinics at New Haven and Hartford, with the cooperation of the Connecticut Prison Association. Both of these were successful operations and were invaluable means of gaining first-hand

experience and research regarding the effects of alcoholism on society. Their work and structure provided models for other rehabilitative centers.

World War II

During the period of 1940 to 1945, the major work on combatting alcoholism was undertaken by voluntary organizations such as A. A. Problematically little was accomplished at this time in the form of professional counseling for alcoholism due to the immediacy of World War II and its subsequent influence upon the American public. This is not to imply that alcoholism ceased to be a problem during this era but rather that its immediacy was diminished by the world conflict. It should be noted, however, that the Washington Society, formed in 1841 continued to provide accommodations for homeless alcoholics; the Washington Hospital was opened in 1939, an outpatient alcoholic treatment program was added in 1940, and an aversion therapy program was initiated in 1942.

State Recognition of Alcoholism Problem

Individual states began to assume responsibility for assessing the seriousness of the problem of alcoholism, commencing by taking inventory of their own resources available for the handling of this disorder leading to plans of action. The first state to inaugurate a commission dealing with the problem of alcoholism was Connecticut in 1945, at about the time other states such as

Michigan, Georgia, and Minnesota created official or semi-official bodies with strong lay representation.

During this time period a number of states developed therapy programs. The Hurley Hospital of Flint, Michigan began regular inpatient admission of alcoholics in 1936 and in 1956 set up a group therapy unit as a pilot study to augment the treatment of hospitalized alcoholics. The Georgian Clinic of Atlanta established in 1951 was the first community outpatient clinic for the treatment of alcoholism.

North American Association of Alcoholism Programs

In 1949, North American Association of Alcoholism Programs (N.A.A.A.P.) was created as the first comprehensive federal government program established on the state level partially supported by federal funds. The purpose of this organization was to provide a medium for the exchange of ideas, information and programs on alcoholism among the various types of local governments in North America. This program's goal of sharing information resembled that of the Yale Summer School of Studies on a national plane. "This period has been depicted by many involved in the field as one in which there occurred little development" (Steele, 1989 p. 512). This quotation accurately reflects not only the development of programs for alcoholism but the general social attitudes of this era.

1950 to Present

Employee Assistance Programs

In 1955, it is estimated that there were approximately thirty job based alcohol programs in the country, and by 1972 that number had grown to approximately 300. It was at this time that a new approach to industrial alcoholism problems began to emerge. The flow of industry in 1955 was based upon the Yale Plan, which suggested that a program be established as a formal part of an existing administrative unit, most likely a medical department of a company and that an experienced recovering alcoholic be selected to supervise the program. "The plan stressed the key role of the first line supervisor in identifying clients and referring them to the program, where they in turn would be sent to counseling, often provided by Alcoholics Anonymous groups" (Steele, 1989, p. 513). This concept was a carryover of the Employee Assistance Program (E. A. P.) developed in the 1940's and illustrates uncoordinated efforts where participation was often unregulated and unstructured. As the job-based alcohol programs movement became more organized, there was a formal development of specific groups within the work place. According to Steele (1989) there were four professional groups which had an impact on job based alcohol programs in the fifties, sixties, and part of

the seventies: the American Medical Association, The Yale Research Center for Alcohol Studies, the National Council on Alcoholism, and organized labor.

Alcoholism as a Disease

The contribution of the American Medical Association was to endorse the disease concept of alcoholism in 1956, opening the way for more humane responses to drinking problems, particularly in the work place. The Yale Research Center for Alcohol Studies contributed largely by creating new company programs throughout the country with particular concentration in the East and Midwest. Said plans assumed that all alcohol problems identified in the work place were as treatable as any other disease. The Summer School on Alcohol Studies at Yale became a center for the interchange of new concepts between professionals in the treatment of alcoholics, both in and out of industry. The Summer School became the model for other university based alcohol research summer schools such as the University of Utah Summer School, and the Midwest Institute of Alcoholism at the University of Wisconsin.

National Counsel on Alcoholism

The National Counsel on Alcoholism (N.C.A) was originally founded in 1944 by Marty Mann, a graduate of the Yale Summer School and member of A. A., with full participation of the Yale Center. In 1959, the National Counsel on Alcoholism hired its first director of labor-management services to

develop industrial programs throughout the country. The program called for identifying cases from personnel records and job performance, placing the job based alcohol program within the personnel department, and responding to those problems which were primarily alcohol related in nature.

Organized Labor

Organized labor initially became involved as the labor advisory board of the National Council on Alcoholism through the participation of Walter Reuther of the United Auto Workers (UAW), and John Hood of U.S. Steel. Labor, however, was not particularly anxious to get involved with management when dealing with union members problems. This might have been a reflection of the industrial backing of the temperance and prohibition movements in the formative stages referred to earlier. A more cogent reason the unions chose not to become active in alcoholism programs was that they had their own programs; this avoided possible confrontation with management over the issue of an employee's alcohol problem.

Labor and Union Alcohol Programs

Development of the labor/union alcohol programs began in 1948 when the Congress of Industrial Organizations (CIO), incorporated into the AFL/CIO in 1951, developed a loosely knit national program for alcoholism with Leo Perlis as the director. The program was called the Community Service Activities (CSA) as an affiliate of the AFL/CIO. The CSA staff received

referrals from trained volunteer labor counselors who had developed a network of treatment providers in the community as well as providing education for the unions. These counselors were trained in detection of co-workers with drinking problems, strategies for confrontation and the process of referral to an appropriate agency for assistance.

During the middle 1960's joint sponsorship of job based alcohol programs was widely advocated and eventually adopted by management and labor for implementation at a later time. One of the major problems that kept the union and labor agreement from being finalized was that the unions felt that it was necessary to base the program on obvious problems of alcoholism while management wished to address other problems and the related stresses.

Constructive Confrontation

In the 1940's, efforts to combat alcohol abuse and dependence had increasingly focused on the work place. The early alcoholism programs in industry were often motivated by graduates of the A. A. twelve step program who were educated at the Yale School of Business and Industry which emphasized educating supervisors about alcoholism. The professionals of that time believed in *constructive confrontation* and counseling. By the 1960's the training emphasis had changed dramatically to teaching supervisors to manage employees who were performing at marginal levels and to identify alcoholic employees through their work performance and to refer them for treatment and

counseling. The reason that this system worked was that marginal work performance was often a symptom of a developing alcohol problem and can be identified at an early stage of alcoholism rather than the older method of waiting until more obvious signs of work endangerment identified the alcoholic. The method was called *constructive confrontation strategy*, a progressive discipline which provided the employees with motivation to change their drinking behavior and improve their job performance. This method allowed the employees to make individual corrective choices such as an E.A.P., private programs or any other method the employee might have preferred.

During World War II counseling at the industrial level became important due to ensuing drastic changes in the composition of the work force through the entry of a high number of females, and the increased pressures of production caused by the war. "During World War II hundreds of companies implemented 'emotional first aid stations' but after the war many companies mental health programs were terminated, and few new ones adopted" (Sonnenstuhl W. J., 1988, p. 350).

Broad Brush Strategy

The change in E.A.P. procedures from confrontation of a potential alcoholic is called a "*broad brush strategy* rather than an alcoholic specific one in order to increase both the potential outreach and the number of voluntary

self referrals" (Werner, Smythe and Brook, 1985 p. 176). "In 1972, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommended the *broad brush* approach as the ideal strategy for occupational alcoholism programs" (Werner, et al. p. 176). It was felt that this approach would be less intimidating and carry less stigma than referral to a specific alcohol treatment program. It was also hoped that a greater variety of employee problems would be discovered by this strategy. Organized labor, of course, recommended that alcoholism be the major topic to be addressed and that the *broad brush* approach was counter-productive to the worker's well-being. This difference between organized labor and management created a number of problems in securing the kinds of management/union cooperation necessary for program success.

Philosophical Differences

It is interesting to note that philosophical differences began to appear based upon the division of lay persons and professionals doing the counseling work with the employee, a point which manifests itself in contemporary counseling attitudes. "These differences in opinion about broad brush programs reflect the fact that both positions are based upon untested assumptions, and the issue is likely to remain in the realm of ideological dispute until more substantial evidence can be provided by one side or the other to support their claims" (Werner, et al. 1985, p. 176).

CHAPTER III

TREATMENT APPROACHES

Individual Therapy

Over the past 25 years there has been an increase in the development of family oriented theories regarding the cause and treatment of alcoholism. Much of the effort toward family therapy arose out of the failure to achieve individual therapeutic success. In a somewhat humorous tone, individual therapy may be likened to the Massachusetts Transit Authority (M T A) in the Kingston Trio song where the client becomes "the man who never returned." Clients advance from detoxification center, to rehabilitation center, to halfway house, and finally to alcohol counselor never escaping the alcoholic way of life. Nevertheless, total abstinence without improvement in other areas of life particularly in family and social structure prove to be self defeating. Yet the varieties of therapeutic programs available for individual alcohol treatment are as numerous as perspectives on alcoholism. This chapter discusses and reviews six state of the art treatment approaches.

The many theories of drug dependance are singularly all equally adequate and equally nebulous in various respects. Alcoholism is a multifaceted problem; thus, a treatment approach which is similarly multifaceted appears necessary. The concept of many alcohol treatments

frequently center solely around the goal of abstinence. While this is indeed a desirable goal, numerous other problems such as depression and ill health often go unattended.

The variety of problems that may exist while attaining abstinence also includes poor stress management, difficulty with the individual's environment (such as his family, job, etc.) and possibly poor physical fitness. In other words, it is the whole individual who is unhealthy not an isolated organ or habit pattern and, therefore, it is the whole individual who needs to be treated. It is the mind, the body, and the spirit of the person which are interrelated and inseparable requiring a complete and total change in the alcoholic's life style.

Family Therapy Approach as a Process of Treating Alcoholism

Perspective of Family Therapy

Family therapy is "the most notable current advance in the area of psychotherapy of alcoholism" (O'Farrell & Cowles, 1989, p. 183). Until the second half of this century, there were scattered reports concerning family factors in alcoholism, but the first concerted effort in this direction began in 1954. Prior to this time studies focused primarily on the historical perspective of alcoholism within the family. The historical view of the family in relationship to its alcoholic members, continued to consider the alcoholic in isolation, with treatment thus being individually oriented. The goals of family

therapy however often center around improving the functioning of the entire family system, rather than the more limited goal of reduction or eliminating of drinking in the identified alcoholic.

A survey of 92 treatment agencies in the state of Massachusetts indicated some degree of family orientation for treatment of alcohol. The services which they rendered were usually in the form of individual counseling, despite the wife or children receiving treatment, there was minimum use of family treatment therapy (Regan, Connors, O'Farrell, 1983). A partial reason for the lack of adequate family therapy may lie in the minimal amount of suitable information available to counselors when working with the alcoholic family. The Psychlit database which is provided by the American Psychological Association shows only one article dealing with a therapeutic model for family alcohol treatment in the professional literature published between January 1983 and December 1990. That model by Yeager, R. J., DeGiuseppe, R., Olson, J. T., & Lewis, L. (1988) was contained in the Journal of Rational Emotive Therapy and Cognitive Behavior Therapy.

In 1954, the psychiatric clinic at Johns Hopkins Hospital inaugurated a study which involved concurrent group meetings of male alcoholics and their wives. This study involved nine couples who were placed in separate groups and participated in a group discussion of prevailing family problems of alcohol abuse. The study, although comparatively small, is notable in that the results

showed symptom reduction for both mates involved in the therapy. This concurrent treatment of both members of the marriage subsequently lead to an examination of marital behaviors and interactions as target criteria for therapeutic change.

Methods and Models of Family Therapy in the Treatment of Alcoholism

The pervasiveness of alcohol use and abuse is currently of such proportion as to guarantee that any mental health professional will encounter and work with a significant number of patients or clients who use alcohol in a socially inappropriate manner. It seems clear therefore, that treatment techniques for family therapy and alcoholism must be combined for effective counseling models.

These concepts may emanate from a medical disease model (Pathological) which assumes that people are addicted and unable to control their behavior. The concepts may also emanate from a behavioral adaptive model in which emphasis is placed on detecting and correcting adaptive and reinforcing behavior, or from the personal maladjustment concept which interrelates life problems to alcohol dependance and in which rehabilitation is focused upon altering the interaction with his/her environment (i.e., family, relatives, friends, and others in the social network).

Multivariant Therapy

An additional combination or multivariant look at alcoholism proposes that a number of factors are involved in alcoholism and thus must also be involved in its treatment. The multivariant goal is to match a particular patient with an appropriate treatment program in which he/she will be placed with the appropriate type of personnel, who in turn will adapt treatment to the needs of the patient/client. This multivariable program is often called Family Therapy and is intended to involve the family as soon as possible with the basic purpose of helping the family organize itself so as to include the patient in a new life style as a non-drinker. These premises have resulted in the development of certain models or techniques in family therapy for alcoholic families. Although these therapeutic models may provide insight and on occasion accurate understanding, the therapist must be more open to the realities of each family and to experimentation with therapeutic possibilities. Several approaches follow:

Co-joint Family Therapy

A basic concept of this therapeutic approach is that the family functions as a system. In that context, the family therapist views the individual members of a family as integral parts of an interacting system. Behavior within that system must be analyzed in terms of the influences of that person upon the total interaction of the family with each other. Logically, the therapist must

design methods to improve family functioning and restore family structure to healthy interaction or homeostasis.

Previously, studies involving family therapy techniques have been minimal. An interesting study by Meeks and Kelly (1970) however evaluated family therapy during recovery of alcoholism. The therapy which they studied focused on interaction, communication, role performance, and redefinition of problems in the family. Issues included as part of their study were description and definition of the problems related to communication skills and problem solving as a method of improving family functioning. In the book Clinical Management of Alcoholism, Sheldon Zimberg feels that "Cojoint couples therapy can be extremely important in the ultimate recovery of the alcoholic member in an alcoholic marriage" (Zimberg, 1982, p. 91). Zimberg goes on to say "the conjoint family approach involves the parents as well as the children of nuclear family and may involve important members of the extended family" (Zimberg, 1982, p. 92).

Multiple Group Therapy

Multiple Group Therapy is a particularly popular form of family therapy used extensively in recent years. The first controlled study of multiple group therapy in alcoholism treatment was undertaken by Cadogan with forty alcoholics and their spouses. The results of this study revealed improved

communication and goal setting, conclusive evidence of not only the efficiency but of the quality of multiple family group therapy (Cadogan, 1973).

Multiple group therapy involves group therapy techniques such as interaction of husband and wife, investigation of communications between themselves and others, and the effects of alcoholism on the marital relationship in family situations. Zimberg (1982) recommends that group therapy of couples involve 3-7 married couples who would meet from 1-1/2 to 2 hours weekly or bi-weekly. Interactional relationships are to be discussed and the impact of alcoholism in one spouse explored, in addition to differing ways of dealing with drinking behavior.

The model which Zimberg recommends usually involves strong behavioral modification techniques as part of the family therapy plus the use of behavior methods such as disulfiram and other community reinforcement agencies or groups. An article by Kaufman (1985) state that the cooperation of A. A., Alanon, and Antabuse are possibly parts of an adequate family treatment program. This method of treating a family alcohol problem is often called restructuring as it encompasses a total restructuring of family, values, interrelationships, and life styles.

Holistic Therapy

Family restructuring and the recognition of the role which each member plays in family health is termed the holistic approach, an excellent framework

for working with alcoholic patients and their families. Recommended therapy under a holistic concept is very similar to the restructuring model, in that involvement of the alcoholic's family in the therapeutic process is highly recommended and considered integral to the resolution of the alcoholic problem.

Rosenberg (1981) has postulated four phases which are encountered during the course of family therapy which lead to the development of a solid working relationship among the therapist and the family are: (1) random phase: (the early session and is unstructured,) (2) the recrimination phase: (when the family attempts to include the therapist in blaming the alcoholic,) (3) the policing phase: (a time in which the family members test the boundaries which the therapist has established,) and (4) the therapeutic realization phase: in which a working relationship and alliances are built between the therapist and the patient and the communication among the family members begins to improve dramatically.

Behavioral Adaptive Therapy

This method is the study of alcoholism from the perspective of a behavioral adaptive model where emphasis is placed on finding the causes and reinforcements of drinking behavior. Upon beginning treatment, the alcoholic family characteristically focuses on the drinker as the sick patient while the therapist views the problem drinker as a member of a system. Accordingly,

the initial phase of therapy must involve a comprehensive assessment of how the family functions as a system and what rules of behavior exist within the family unit. This emphasis is a change from previous alcoholism treatment programs that have focused almost entirely on an attenuation of drinking as a sole outcome variable of merit. Within the alcoholic family, it is necessary to recognize that when something happens which threatens to change established family patterns, the family will attempt to restabilize what has been normal for the family, even if it means that the whole family cooperates to provoke a member to resume drinking after he has stopped. "The alcoholic marriage is viewed as a homeostatic mechanism that is established to resist change over long periods of time" (Steinglass, 1976, p. 104).

The results of a rather recent study by O'Farrell and Cutter (1984) suggest that behavioral marital therapy combined or augmented with disulfiram, deserves serious evaluation in the treatment of alcoholism. The O'Farrell and Cutter experience with behavioral couples group interventions suggests that in designing a group, the immediate goal is to change the alcohol related interactional patterns within a marriage, (such as nagging about past drinking,) and altering the general marital pattern to create an atmosphere that is more conducive to sobriety through building positive interrelationships. To accomplish the goals of abstinence from alcohol with a decrease in alcohol related arguments, a program of observing behavior during therapy, with a

antabuse treatment program was begun. This program involved spousal observation and recording when antabuse is taken. The spouse, however is not responsible for administering treatment.

A second goal involved the learning of positive interrelations. The method used for this was a check list for recording positive and caring behavior. Another part was the creation of a list of shared recreational activities and planning for participating in those activities. Perhaps one of the more important segments of the behavioral improvement concept was the teaching of communication skills through counseling sessions which focused on couple's communication, listening, and expressing feelings. The behavioral couples group further utilized behavioral rehearsal and weekly homework assignments to help in the areas mentioned above. As the title implies O'Farrell and Cutter engaged in an ongoing study. Although the results at the time of reporting were inconclusive preliminary findings demonstrated an alcohol abstinence near 86%.

Multiple Couple Group Therapy

Multiple-couples group therapy is also a particularly popular form of family therapy currently being utilized in alcoholism treatment in both inpatient and outpatient settings. As an example, the Alcoholic Treatment Unit at Topeka State Hospital, since 1970, has provided an intensive five-week inpatient treatment program. This program is composed of three phases, with

phases one and two occurring while the patient is in the hospital. This phase includes working with the patient to understand the magnitude of alcoholism and reinforcing the alcoholic's decision to seek help. Phase three of this program involves working with a counselor to establish new behavior programs coexisting with the alcoholics return to his family and the community as an outpatient. This includes modifying the patient's environment so that change within the family can occur. "In early 1972, the hospital staff treatment team underwent comprehensive re-evaluation of its program" (McKamy, L., 1976, p. 199). The re-evaluation acknowledged that Alcoholics Anonymous and associated programs, although effective in their own right, were devoted to individual therapy and not direct intervention into familial units.

A later study done on 227 male patients at the United Hospital of Grand Forks, North Dakota by Catherine Wright and Thomas Scott reinforces the other findings and contentions. Wright and Scott's study revealed that when an alcoholic's wife is active and participates in her husband's inpatient treatment or post-treatment counseling, her husband is more likely to be abstinent (Wright and Scott, 1978).

Summary of Family Treatment Alternatives

Family therapy is not an end within itself. Not all alcoholics can or will participate in family therapy, nor is family therapy indicated in every

instance. Different family situations will allow for or require different types of intervention techniques.

References to family treatment are appearing with increasing frequency in the literature on alcoholism and further explain the reasons for and the values of involving the family in treatment programs. An additional set of questions related to family therapy deal with means and method of treatment since the term *family treatment* may indicate treatment of a whole family, treatment of family members other than the alcoholic, treatment of spouses, or children.

Family therapy has within it programs which are presented an outpatient and inpatient basis. Inpatient programs may involve the spouse who is also an inpatient, the spouse as an outpatient, or the alcoholic as an inpatient and the family including spouse and children on an outpatient basis. Another is with the alcoholic and spouse on an outpatient only basis meeting jointly or separately while working on individual and family problems. Family treatment can thus only be defined as treatment which includes one or more family members in addition to the alcoholic.

Family therapy with alcoholics cannot easily be defined by a specific theoretical position taken by any given treatment program on the nature of relationship between alcoholism and the family. There is, nevertheless, strong indication that family treatment for alcoholism can be successful. Most of the

family treatment that is reported is concurrent with or subsequent to other treatment regimens. However, the success of family treatment for the alcoholic and family does not appear to be contingent on additional treatment. Treatment which begins with the family is apparently successful in producing change both in the alcoholic and in the family. Thus, there is increasing agreement that treatment goals should center around improving the functioning of the entire family system, rather than the more limited goals of reducing or eliminating drinking in the identified alcoholic. This does not mean that a change or focus on the alcoholic should not be adequately addressed, since it can not be assumed that alcohol abuse will cease once structural problems and faulty communication are corrected. The effective therapist must focus on both the primary problem and the family's adaptation to it, since it is clear that once the drinking has been modified further adaptation is required by the family to bring the non-drinking alcoholic back into the system.

Alcoholism is behind marital and family problems in many therapy cases, even if it is not the presenting symptom. While the clients presenting symptom may often provide the motivation for therapy, the family therapist/counselor must be concerned with the wider relationship of the system which supports the symptoms. Family therapists need to know how alcoholism affects family systems, and must acquire basic skills for working with this population.

The individual alcoholic in family therapy frequently faces low self esteem and withdraws from the realities of family interaction to a high dependency on significant others. A marked difficulty in interpersonal relationships further results in rejection and a confirmation of low self esteem.

All the preceding factors contribute to a general state of chronic depression and denial, conditions which must be overcome by the counselor to create motivation for change. "Intervening at the marital/family level with non-alcoholic family members can motivate an initial commitment to change in the alcoholic who is unwilling to seek help" (O'Farrell, 1989, p. 24).

A Pharmacological Approach

If total abstinence is the most important criterion for day-to-day progress in the treatment of alcoholism, then the resumption of drinking must be viewed as a symptom of therapeutic relapse. In recent years, an accumulating body of research has led to the identification of a large group of diseases specifically caused by alcohol addiction. Some of these pathologies arise directly from the toxic effect of ethanol upon body tissues while other pathologies are derived from the malnutrition that at times accompanies alcoholism. If total abstinence is the goal of therapy, then disulfiram (antabuse) serves as a useful chemical barrier to impulsive drinking especially during the first year or two of sobriety.

The use of antabuse in a program designed to terminate drinking habits has many supporters and few detractors within the medical profession. However, the prescription and use of antabuse by professionals in treating alcoholics has greatly changed and improved over the years. A study done by Wallace (1952) compared twenty-six patients treated with disulfiram and conventional therapist with those in another group of equal size who were treated under the usual treatment regimen of the Wallace Sanitarium. The results of this treatment program showed 53% of those who begin the program and 100% of those who continued as disulfiram patients remained abstinent for eighteen months. All in the control group relapsed within six months of treatment.

A more recent study conducted by the Menninger Clinic (Wallerstein, 1957) compared the effectiveness of four different treatment regimes: Antabuse, conditioned reflex therapy/avoidance conditioning, group hypnotherapy, and milieu therapy. The results of this study indicated a much less favorable rate of recovery from avoidance conditioning therapy compared with 53% for antabuse; 36% for hypnotherapy, and 26% with milieu therapy.

As research has progressed, new treatment programs and evaluations have determined which patients would most likely benefit from disulfiram treatment. According to Banys (1988), the persons most likely to benefit from treatment are those who are older, more socially stable with a longer history of

heavy drinking and a history of delirium tremens, good motivation (as manifested by contact with alcoholics anonymous and/or abstinence) and, finally, no history of use of antidepressant medication. It is possible that these may be the same traits which are associated with a better prognosis in chronic alcoholism without the use of disulfiram yet despite the limited evidence favoring disulfiram therapy, it seems to have an assured place in the therapy of chronic alcoholics.

A study by McNichol and Logsdon (1988) reported up to 200,000 alcoholics are taking disulfiram regularly each year. They propose a model in which they assert "addresses many of the shortcomings of the earlier pioneering research on the efficacy of disulfiram as a tool for promoting alcohol abstinence in alcoholic patients" (p. 206). In this model, subjects would be assigned in equal numbers to two groups on the basis of their willingness to take disulfiram. Subjects drawn would be randomly assigned to either a disulfiram condition or a non-disulfiram condition thus creating four experimental groups of equal size. All subjects would receive complete detoxification, in-patient treatment and after release would be referred to local mental health agencies for outpatient follow up. Those taking disulfiram would be scheduled for a comparable number of counselor contacts. After discharge, appropriate follow-up studies would be conducted and the success or failure of the program would be analyzed. A great deal of study has been

done recently regarding the incorporation of disulfiram as an adjunct to a complete treatment program.

The Inpatient/Outpatient - Alcohol Treatment Approach

In-patient alcoholism rehabilitation centers are frequently a specialized unit of either a general hospital or a psychiatric hospital. The types of treatment which may be found in these centers are both short term (2-12 weeks) and long term programs (usually no less than 3 months in duration and extending up to 2 years.) Short-term structure provides a more intensive level of programming and therapy, and are more likely to view themselves as limited to initiating an ongoing recovery process. Long term care may be structured and tries to achieve more treatment goals within the duration of the program itself rather than allowing them to be accomplished over a long period of time following discharge. Thus, long-term programs tend to have a greater emphasis on assisting maladjusted persons to obtain the skills necessary for them to become accepted members of the community. These patients frequently have both major psychiatric illnesses and alcoholism. Shorter periods of rehabilitation are likely to occur in one of three settings:

1. A psychiatric hospital without a specialized alcoholism unit where the patient is traditionally treated for underlying personality disorders which cause alcoholism.

2. An alcoholism rehabilitation unit located either in a psychiatric or acute care hospital.

3. A free standing alcoholism rehabilitation unit that is not part of another facility. This type of facility is frequently interwoven with Alcoholics Anonymous and is primarily for detoxification.

The programs of these types of facilities are frequently similar. Most of them use some form of group therapy as their major treatment mode interacts with a judicious use of individual counseling. Group therapy will vary according to the professionalism of the staff employed by the facility and may simply be self help groups of patients or professionally led psychodynamically oriented groups.

The research on in-patient treatment contains disagreement and controversy regarding its effectiveness, particularly in comparison to outpatient alcoholism treatment. Perhaps one of the greatest deterrents to in-patient service is the cost of in-patient care and the reduced number of insurance companies willing to subsidize long term in-patient alcohol treatment. Since most alcohol treatment programs require sobriety to be attained and since alcohol often distorts cognitive and emotional functions, in-patient treatment may be a consideration. Initially, in these program models most alcoholics will deny that they are alcoholics or that drinking is major cause of their

problems. If this denial continues, an in-patient setting may be a viable option. As stated by Charnus,

> "Often alcoholics may see the consequences of drinking, but on a deeper level deny to themselves that these consequences are related to their alcohol use and therefore that sobriety may improve the quality of their lives. This kind of denial is difficult for therapists to understand because of its almost delusional quality" (Charnus, 1985, p. 70).

The results of inpatient treatment are difficult to evaluate since studies that use an experimental design to distinguish treatment affects from changes associated with treatment are not readily available. An interesting study done by Meyer, Berman, and Rivers examines the relationship among multiple client characteristics, multiple treatments, and multiple outcomes. The study matched treatment and client for optimum results and found "In-patient treatment was related more than outpatient treatment to changes in clients involvement in social activities and membership. Perhaps the forced social interaction of the in-patient milieu teaches a client that he indeed does enjoy more social activities than he thought" (Meyer, Berman and Rivers, 1985 p. 1475).

It is further hypothesized that the discovery of interest, people, organizations and support systems which had not been known prior to hospitalization seem to be associated with positive outcomes. The conclusion

is that in-patient therapy is more appropriate than outpatient care for subjects with low life instability, low problem severity, and a high socioeconomic status.

The relative efficacy of in-patient alcoholic treatment are of dubious merit in light of increasing health care costs and may not be justifiable in comparison with less costly alternatives. The numerous studies of alcoholism treatment have typically compared time in treatment, with short term remission. According to Miller and Hester, however,

> "No reliable conclusions could be drawn from such data because differential outcomes may have been influenced by many confounding and biasing variables not controlled in correlational designs. Given these methodological weaknesses and the inconsistency of findings, uncontrolled studies do not provide reliable support for assertions regarding the relative effectiveness of longer versus shorter or more versus less intensive treatment" (Miller and Hester, 1986, p. 795).

Miller and Hester's review of all comparative research involving in-patient and other treatments concluded that more intensive treatments have not been found to offer greater benefits than those from outpatient therapy for any population. In the area of detoxification "more recent research consistently indicates that in-patient medical detoxification is seldom necessary

and that less costly non-medical alternatives are safe and effective for most alcoholics" (Miller and Hester, 1986 p. 795). In addition, Miller and Hester state that "No study to date has produced convincing evidence that treatment in residential settings is more affective than outpatient treatment. To the contrary, every study has reported either no statistically significant difference between treatment settings or differences favoring less intensive setting" (Miller and Hester, 1986, p.795) Their work does suggest the possibility that hospital treatment may be of greater benefit for those who are more severely deteriorated and less socially stable and in a subsequent 1989 article, they reassert their findings but concede, "we do not advocate the abolition of residential treatment. There may be sub-populations for whom more intensive treatment is justifiable. From a limited matching data available at present it appears that intensive treatment may be better for severely addicted and social unstable individuals" (Miller and Hester, 1989, p. 1246).

CHAPTER IV

CONSIDERATIONS AND RECOMMENDATIONS

Etiology of Alcoholism

This paper has presented an historical overview of alcohol counseling and state of the art approaches. Certainly causes of alcoholism and the complexity of the phenomena observed in alcoholism have increased the search for a satisfying theoretical model or a hypothesis to research. The proliferation of models and theories continues while the elusive answer to a satisfactory explanation of alcoholism is researched. Periodically, new models of alcohol treatment are found, related theories are put forward; momentarily that particular idea may hold the greatest promise for a cure or at least an effective method of combat.

In order to treat or prevent alcoholism, it is essential to identify those factors which contribute to the development of potentially harmful drinking patterns. At least two diverse groups of etiological models which have received the most attention stand out: (1) Physiological or biological models, (medical models), (2) Non-medical or sociocultural models and numerous sub-classifications within each of these concepts.

Medical/Disease Model

The medical model with its focus on alcoholism as a disease utilizes the physiological/biological model of alcoholism. Most versions of the medical model thusly focus on genetic aspects of alcoholism, and the inability of the individual to regulate their alcohol consumption. The Yale Research Center, E. M. Jellinek, and Alcoholics Anonymous have been the primary proponents of these concepts. According to Crawford and Heather, one of the greatest reasons for the success of the disease concept of alcoholism is that "it constitutes a powerful or even essential tool for the promotion of humanitarian attitudes toward alcoholics. This assumption has seldom been questioned and even leading critics of the disease concept appear to endorse it" (Crawford and Heather, 1987, p. 1130).

This article by Crawford and Heather reports on a study to determine the acceptance of the disease concept of alcoholism. The results revealed that the American public accepted alcoholism as a disease and encouraged humanitarian understanding of alcoholism. The disease or medical model of alcoholism is of diagnostic significance in that the disease has symptoms which may be defined, a characteristic clinical course, a prognosis, and a response to therapy.

Sociocultural Model

The medical concept of alcoholism as a disease and the Alcoholics Anonymous assumption that the alcoholic is powerless issues forth a number of very serious counseling problems. Within counseling there are those that believe that the individuals behavior depends on the perception and not on external stimulating conditions. The phenomenal field of perceptions is composed of both conscious and unconscious experiences which compose the concept of self. If the disease model of alcoholism is accepted, the organism would be incapable of change and ones self-regard would be irreversible from previous perceptions. According to Rogers, a client during therapy would

> "perceive himself as a more adequate person, with more worth and possibility of meeting life. He permits more experiential data to enter awareness, and thus, achieve a more realistic appraisal of himself, his relationships, and his environment. He tends to place the basis of standards within himself, recognizing that the goodness or badness of any experience or perceptual object is not something inherent in that object, but is a value placed on it by himself" (Rogers, 1965, p. 138).

As this relates to alcoholism the question is, does the individual have the ability to cease drinking without accepting that alcoholism is a disease.

Developing Comprehensive Programs

Alcoholism as a health and social problem remains covered in a conflicting environment of treatment modalities. There can be little doubt however that alcoholism, substance abuse, and related problems pose unending threats to the health and economic well being of our society. Despite these known factors and the great concern for promoting the health and welfare of the public, the professions involved in providing services to alcoholics and other substance abuses have been minimal.

In 1984 a survey was conducted to determine the current status of alcohol and other substance abuse training that had American Psychiatric Association approved (APA) programs. The study by Lubin, Brady, Woodward, and Thomas (1986) replicating a previous survey done by Selin and Savanum (1981) showed no discernable differences in quantity or quality of offerings between clinical and counseling programs from 1981 to 1984.

Alcoholism remains as a health and social problem with inadequate treatment facilities despite remarkable advances over the past several decades in its acceptance as a treatable problem. "A brief analysis of human service agencies confirms the absence of alcoholism treatment and the presence of significant barriers to developing such treatment. Most agencies, public and private, have neither a developed policy nor sufficient staff knowledge about alcoholism" (Googins, 1984, p. 161). This article further contends that the

problem of alcoholism is being ignored and neglected by institutional and professional services despite the fact that alcohol is the most extensive and costly drug problem in the United States (Googins, 1984). Patterns of consumption remained relatively stable from the 1960' through the 1980's except for a small increase in the percentage of abstainers among men and an increase in a portion of heavy drinkers among both men and women in their 20's. Thusly, alcohol abuse and dependence are serious problems that effect about 10 percent adult Americans (U.S. Department of Health, 1990). This information corresponds to a 1971 Lou Harris survey reporting 10% of its respondents admitting they drink too much.

These statistics bear out the conventional wisdom that between 7-10% of the population of the United States are problem drinkers. Since problem drinking is also problem causing, it is unavoidable that human service staff will encounter a high percentage of clients with a secondary of tertiary alcoholism problem.

According to a 1987 survey by the United States Institute on Abuse a total of 337,928 people were treated for alcohol related problems by community mental health centers, hospitals, correctional facilities, half way houses, other residential facilities, outpatient facilities, and other locations. (United States Bureau of Census, 1990). Thus, there is a gap between the documented need and the available services for alcoholism, which constitutes a

rather curious paradox. Alcoholism paradoxically is apparently primarily relegated to the self help movements or is on the periphery of human service agencies perceived important areas.

According to Googins (1984), the inadequacy of alcoholism counseling is due to a lack of basic and widespread ignorance except by the lay person who is both inadequate and misinformed to provide an effective ministry. In addition, there is a general consensus and belief that there is little hope of treating the alcoholic successfully.

Within the human services agencies the lack of information regarding the alcoholic client means that the client will stand little chance of being identified, diagnosed, and treated for alcoholism. The human service agencies oft times when faced with a multiple diagnoses involving alcoholism will refer the client to a special alcoholism agency or clinic as a way out of treating a problem in which they are engulfed with ignorance. These same agencies are often then lulled or pacified into a false sense of security knowing that A. A. and the alcoholism clinic at a local hospital are available even though previously described statistics indicate that a small percentage of those referred are in fact seen and treated.

It is suggested by Dahlauser, Dickman, Emener, and Lewis (1984) that community based counseling centers are typically designed to treat and be responsive to persons with clearly defined difficulties in the areas of mental

health, spouse abuse, family problems, rape, and many other crisis. Furthermore, it is their contention that most of the goals and objectives of the initial interview are the same as the goals for those of intake counseling, but not for proper diagnosis of the alcoholic client.

Empathy

One of the specialized skills mentioned by Dahlauser et al. is in empathy training, initial interviewing, intake counseling. Rogers (1975) considered empathy to be a process variable that is the sine qua non of the therapeutic relationship. There is further evidence that therapist empathy is related to positive outcome. Because empathy has been considered so effective with alcoholic clients various studies have been done to determine the type of counselor that would best be capable of establishing an empathic relationship with a client. One of the assumptions regarding empathy is that a similarity in background enhances the counselors capability in that area. For example, recovering alcoholics are sometimes encouraged to become counselors since the commonality of a drinking history will enhance the empathic posture of the counselor.

A study done by Kirk, Best, and Irwin (1986), however,does not collaborate "the assumption that the recovering alcoholic is more empathic than a counselor who had not had pathological experience with alcohol" (Kirk, Besk, Irwin, 1986, p. 82). The findings of this study may have far reaching

therapeutic implications revealed in the shortage of competent personnel in the alcoholism counseling field, since this study suggests that counselor empathy may not be simply an outcome of similar experiences.

Fellowship and Belongingness

As an extension of the ongoing debate as to whether alcoholism counselors who are non-alcoholics can be as effective with alcoholic clients as counselors who are themselves recovering from alcoholism additional studies are on record. Research has compared the impact of the recovering alcoholic counselor and the non-alcoholic counselor on an alcoholic client's level of *fellowship* or client perceived *belongingness* with treatment peers, as well as on length of stay in programs and relapse rate in a residential treatment setting. One study showed "a counselor's recovering status does not seem to be any more impactful on the client's perception of belongingness among their peers or on length of stay or relapse rate than their non-alcoholic counselor colleagues" (Machell, 1987, p. 7). These findings are reinforcement to the informational myth that have evolved in our society with the use and abuse of alcohol. Further, these attitudinal myths constitute an even more prominent barrier to the control and curtailment of the problems that prevail toward alcoholics.

Recommendations Regarding Treatment

Agency Requirements

To Googins (1984) there are four essential ingredients to insure that an agency has the basic capacity to treat alcoholics. They are: (1) a written policy which commits the agency to developing an adequate capacity to treat alcoholics; (2) training and education of the employees of human service agencies through in-service staff seminars and video tapes, (3) intake for proper identification of the alcoholic, and (4) community networking to coordinate the continuity of care and insurance that the alcoholic is not lost or falls through the cracks of the system.

The need for specific training in recognizing alcoholic abuse by a counselor is dramatized in a study by Dahlauser, and Dickman, Emener, & Lewis (1984). The study was a comparison of the effectiveness in discovering alcohol abuse among trained and untrained intake counselors. The data illustrates the importance for intake counselors to have a high level alcohol and drug abuse sensitivity and awareness. (Dahlauser, Dickman, Emener, & Lewis, 1984).

The Hazelton Foundation located in Center City, Minnesota offers a chemical dependency counselor training program which graduates 20-25 counselors each year. The Minnesota model, a multi-disciplinary treatment approach, uses A. A. principles as a primary treatment concept. The

counselors training program is a year long non-degreed work study experience that prepares counselors to work in an entry level in alcohol and drug treatment centers that are similar to the Minnesota model. In a study done by Laundergan, Flynn, and Gaboury (1986), 100 former trainees were studied to determine, among other things, the pre and post training characteristics of the chemical dependency counselors graduated from the Hazelton counselor training program. The participants felt that a greater emphasis should be placed on a professional orientation in both the selection and socialization of trainees. Eighty-two percent felt that a bachelors degree would be necessary in the future for chemical dependency counseling and sixty percent felt that a master's degree would be necessary in the future. This study is further indication that the importance of combining present alcohol counseling techniques with advanced education is viewed as a necessity by those who are actively involved in the training of competent counselors.

It is essential to the counselor as a consequence of the various theories and methodologies which have been and are currently being developed that we think of our clients as complex, multifaceted human beings, who must have treatment plans that are as unique as the clients themselves. Thus, the counselor must recognize that there may not be a single goal or treatment method which is likely to be more appropriate than that produced by the individualized counseling method.

Counseling Approach of Lewis, Dana, and Blevins

Perhaps one of the best methods of approaching counseling with the alcoholic is proposed by Lewis, Dana, and Blevins (1988), when they recommend that counselors should:

1. View substance abuse problems on a continuum from non-problematic to problematic use, rather than as an either/or situation.

2. Provide treatment that is individualized, both in goals and in methods,

3. Use methods and approaches that enhance each clients sense of self-efficacy.

4. Provide multi-dimensional treatment that focuses on the social and environmental aspects of long term recovery.

5. Support selection of the least intrusive treatment possible for each client.

6. Remain open to new methods and goals as research findings become available.

7. Be sensitive to the varying needs of diverse client populations.

In view of the above recommendations it is a mandatory obligation of the counselor to remain open to the patterns of dysfunction which may necessitate a multivariant methodology of treatment.

While this paper discusses the most frequently used models for treating alcoholism, it must be pointed out that all methods are available for use in counseling the individual, the group, the family, and the employee. The methods most frequently used by the substance abuse counselor are as diverse as the substance abuse population.

Cooper Counseling Model

The models for counselors to use as suggested in a paper, by Cooper (1983 Survey of Studies on Alcoholism), are:

1. Physiological and biological, in which the medical and disease concept assumes that symptoms and signs of alcoholism can be diagnosed and will respond to a particular therapy. Most versions of the medical model focus on genetic aspects of alcoholism and negate the individuals responsibility in regulating their drinking habits.
2. The psychological model which is broken down into
   (a) psychodynamic formulations which are "based on the premise that alcoholics have unresolved developmental crisis in childhood which lead to the formulation of an immature, orally fixated personality" (Cooper, 1983, p. 974).
   (b) personality trait theory: which perceives alcoholics as having certain individual traits that cause them to be alcoholics.

(c) behavioral learning models: which proposes that alcohol abuse is a learned response as learned from a male adaptive coping to stress. and

(3) Sociocultural models "In contrast to the biological and psychological models, which focus on internal determinants as causal factors for alcoholism, the sociocultural models focus on environment and social effects" (Cooper, 1984, p. 974).

Bean Counseling Models

The models suggested by Cooper have a similarity in content to the three models which Margaret Bean (1984), describes as the

(1) the disease model: followed by most recently trained physicians.

(2) The moral model: which "assumes that alcoholism is a result of voluntarily chosen behavior which results from either immorality or defective will power (Bean, 1984 p. 92)." This is what Cooper called the psychological model.

(3) The symptom model: "behavior can be interpreted, for example, as resulting from unconscious suicidal impulses or primitive oral drives or poor impulse controls, and can be resolved by psychotherapy" (Bean, (1984, p. 90).

Dhooper and Sullivan Model

Dhooper and Sullivan (1986) add to Bean's work by proposing additional causes for alcoholism:

I. Sociological model: covers three assumptions

(a) sociological variables, such as age, sex, gender, ethnicity economic class, religion, and family background as an influence on an individual's drinking behavior;

(b) alcoholism is a result of a career of deviancy established through transactions between an individual and other persons, his family, and institutions;

(c) Self fulfilling prophesies of being a drinker.

II. The family interaction model: views alcoholism as a familial illness and family members are caught up in achieving homeostasis (Dhooper & Sullivan, 1986).

In the treatment process regardless of the models that one may use it is possible that the world of pharmacological vis a vis disulfiram, behavioral modification techniques, cognitive influences, all come into play along with teaching social and vocational skills. In fact, any combination of the methods listed may be appropriate for a specific client. it would not be effective however to use this entire group of interventions as a package for all substance-abusing clients.

Albert Bandura's Self Efficacy

To Albert Bandura medication is not the sine qua non, he proposes that an individual's self efficacy is able to deal with the environment and learn the skills needed to manage challenging situations.

> "Self-Percepts of Efficacy are not simply inert predictors of future behavior. People's beliefs about their capabilities influence how they behave, their thought patterns, and the emotional reactions they experience in taxing situations. Those who regard themselves as highly efficacious set themselves challenges, intensify their efforts when their performances fall short of their goals, persevere despite repeated failures, make causal ascriptions for failure that support a success orientation, approach potentially threatening tasks non-anxiously, and experience little in the way of stress reactions. In mark contrast, those who regard themselves as inefficacious shy away from difficult tasks, slacken their efforts and give up readily in the face of difficulties, dwell on their personal deficiencies, thus, detracting attention from task demands, lower their aspirations, and suffer much anxiety and stress" (Bandura, 1984, p. 138).

In a supportive study regarding the worth of self efficacy and alcohol abuse, clients who had the largest changes in self efficacy during treatment also

had the highest abstinence rates of consumption. (Burling, Reilly, Moltzen & Ziff, 1989)

Considerable research appears ongoing toward the development of the self-efficacy theory which has been adapted to a variety of treatment programs indeed. "It is hypothesized that self efficacy beliefs about the problem behavior, change systematically across treatment, and that such beliefs profoundly affect treatment outcome" (Burling, et al., 1989, p. 354).

In further support of self efficacy, research has also demonstrated that the enhancement of a patient's belief in their own ability to succeed will result in positive outcomes. "Efficacy involves a general ability to deal with one's environment, mobilizing whatever cognitive and behavioral skills are needed to manage challenging situations" (Lewis, Dana, Blevins, 1988 p. 14) Therefore, regardless of the methods used, it would seem that the counselor has the responsibility to encourage the clients sense of control over ones self.

In spite of all the theory and research, the training of counselors and the counseling of alcoholics remain at a seminal state. Much remains to be learned both as to the nature of alcoholism and as to approaches which will afford the alcoholic the opportunity to delete intoxicants and to secure a place in the sun where a life of harmony exists.

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