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ABSTRACT

This paper examines the counseling of alcoholics in an effort to determine its value and significance. It includes a cursory look at the development, etiology and history of treatment methods and the role of personality theory. However, the main emphasis is on the different types of counseling used in each particular counseling setting. The settings include doctors' offices, hospitals, rehabilitation centers, pastoral settings, social agencies, industry and Alcoholics Anonymous. Research indicates that, regardless of the institution or method, the recovery rate for alcoholics is very low. However, in the past 35 years, the recovery rate has risen from approximately 1% to approximately 35%. One of the major future needs is intensive, controlled studies on the various types of treatment now being used to measure their relative efficacy and determine the type of patient for which each method is most suitable. (Author/HMV)

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Counseling in Alcoholism

Counseling in the field of alcoholism is a relatively new phenomenon of the past twenty to twenty-five years. In this paper an examination will be made of counseling in this field to determine its value and significance. Counseling in general will be defined as will be alcoholism. They will then be related. A cursory look at the development, etiology, history of treatment methods, and the role of personality theory in alcoholism will be made to give added perspective to the role counseling has in this specialized area. The main emphasis of this paper will be the different types of counseling used with the focal point being goals and processes. An evaluation of counseling methods and research possibilities will conclude the paper.

According to Tyler (1969) counseling is a process used to facilitate development or patterned change throughout the life of the organism in such areas as work, interpersonal relationships and aloneness. The author discriminates among choice, structure, and change cases. Choice cases involve a search for structure to replace confusion; change cases involve removal of obstacles blocking possible avenues of choice, and/or the creation of new possibilities. There are several techniques used to reach the desired goals in each type of case.

Miller (1961) defines alcoholism as a symptomatic condition of deeper underlying personality distrubances. Lundin (1965) defines it as a compulsive disorder that operates to relieve anxiety. The most widely accepted definition is given by Mann (1958): Alcoholism is a chronic progressive disease that manifests itself as a continuing problem in some area of a person's life due to alcohol ingestion.

Alcoholism is a critical problem in American society. The National Council on Alcoholism (1970) estimates the number of alcoholics in the United States to be approximately six and one half million. Along with heart disease, mental illness and cancer the American Medical Association, according to Block (1962), places alcoholism among the four most serious public health problems facing the nation today. Not only does alcoholism affect the individual alcoholic, but its ramifications for the family and society in general are profound. Counselors in a variety of settings frequently encounter this problem. The school counselor sees children whose lives are deeply influenced by the alcoholic parent. More and more alcoholics can be found in the rehabilitation counselor's caseload. Personnel and employment counselors deal with the effects of alcoholism on vocational performance. Counseling at every level is affected by alcoholism. Therefore, an understanding of the problem and a knowledge of succesful procedures will facilitate counselor effectiveness.

Now that counseling and alcoholism have been defined and related, a brief look at the development, etiology, history of treatments, and the role of personality theory will be made. Jellenik (1952) distinguished three categories of alcoholics; the alcohol addict or compulsive drinkers; the habitual symptomatic excessive drinker; and the occasional symptomatic excessive drinker. He has described the course of alcoholic addiction in four rather distinct phases which cover several years. The prealcoholic symptomatic phase is highlighted by drinking to relieve anxiety and an increase in tolerance to ethyl alcohol. The prodromal phase is highlighted by blackouts and the occasional loss of control over drinking. In the crucial phase there is total loss of control of drinking and rationalization of maladaptive

behavior. In the final or chronic phase there are prolonged benders coupled with physical, social and psychological deterioration. The single cause of alcoholism is not known. Physiologists, sociologists, and psychologists have tried to interpret the causes of alcoholism. Blane's (1968) investigation found that, to date, biophysical causes of alcoholism have not been identified. Also, his paper stressed that the results of controlled studies led to the conclusion that there is insufficient evidence to indicate that an alcoholic personality exists. The current hypothesis is that alcoholism has multiple causes involving physical, social, and psychological components. Treatment of alcoholism over the centuries has been almost comical, albeit tragic. Techniques from prohibition to smoke dances have been tried with little or no success. Eis (1961) tells of a seventeenth century German treatment that included daily doses of cabbage salad with oil and vinegar. Modern remedies include drugs, shock, antabuse, psychotherapy and lay self-help groups. Many theories are put forth to explain the alcoholic. Freudian theorists claim the alcoholic was fixated at the oral stage of development. Miller (1961) says most alcoholics are ego-centric oral neurotics who when under stress regress to the reaction of the infant who is pacified by the mother with milk and nipple. Learning theorists consider the alcoholic as a person with a behavior disorder. Lazarus (1966) states that consumption of alcohol is a response to stress that may develop into a conditioned reflex and start a vicious circle because the increase in drinking behavior raises new conflicts which may eventually lead to compulsive drinking. Existential theorists say the alcoholic is suffering from Anomie or a sense of normlessness, futility and aimlessness. Krill (1969) postulates that the alcoholic has lost contact with many basic human realities that they must accept and understand if they are to have a sense of personal direction

or meaning in their lives. The literature is replete with theoretical positions to explain alcoholism. Seigler et al. (1968) describes four more models of alcoholism, thus adding to the profusion of hypotheses.

The point to grasp at this juncture is that the counselor in this field is working with an ill-defined, difficult to explain or understand anomaly. There is an over-abundance of theories and a paucity of successful treatment methods generated by them. The counselor is confronted by questions such as: What phase of alcoholism is the patient in? What type of drinker is he? Is he ready for treatment or should he be motivated by creating a crisis? Should treatment focus on the patient's past, present or future? Should concern be placed on controlling variables in the environment or on understanding internal psychic phenomena? Should therapy deal with thoughts, feelings or actions? The answers to these and to other questions will determine the techniques the counselor will use. Counseling the alcoholic is truly a challenge to a practitioner's skill and ingenuity. There is no one way to work with alcohlics.

Having explored some of the intricacies in counseling the alcohlic, a shift of emphasis will be made to focus on counseling methods. First, a distinction must be made between lay therapy and professional therapy. Lay therapy is represented by such organizations as Alcholics Anonymous and Synanon which do not employ professional therapists, although professional therapy techniques can be used. Professional therapists include doctors, psychiatrists, psychologists, and social workers as well as other disciplines. Second, alcoholics may have initial contact for counseling through doctors, hospitals, churches or community agencies. Third, techniques vary from counselor to counselor and setting to setting. Drugs, shock, medications, and other specialized concomitant treatments may be employed. Therefore, the position will be taken that counseling is involved

in both lay and professional therapy; it is practiced in settings that define its limits, and it includes many diverse techniques. Goals and procedures used in doctors' offices, hospitals, rehabilitation centers, pastoral settings, social agencies, industry, Alcoholics Anonymous meetings, and other settings will be elucidated now.

Most often alcoholics show up first at a doctor's office with some alcohol related complaint. Fox (1958) states that the basic attitude of the physician must be mature, tolerant and understanding of the alcoholic's stresses and handicaps. The importance of the first interview cannot be overemphasized. No matter what the circumstances of the first contact, the doctor as a counselor must take time to start building the relationship then. Some facts about alcoholism should be given so that the patient will accept the diagnosis without rancor. Drugs and hospitalization may be applicable if the patient is in the acute or chronic phase of the illness. The patient should be reassured and referred to appropriate community resources for further treatment. Among those resources are psychiatrists. Fox (1966) says that for successful therapy two things are needed: a degree of insight, both cognitive and affective, by the alcohlic into his personal problems, and the will to get well. The psychiatrist needs to be kind but firm, and sympathetic. To the alcoholic who has been alternately scolded and threatened, misunderstood and given uncomprehending variations of the carrot-and-club treatment, a psychiatrist's interest and regard are therapeutic in themselves. Moreover, counseling offers the alcoholic the opportunity to talk about his problems, to see the things that concern him as specific ideas clothed in words rather than as nameless, formless, emotional dreads. As he comes to understand that his overpowering emotions are something that the doctor obviously understands on the basis of experience with other

patients, the alcoholic gains confidence in his ability to surmount them, master them, control them. Although Fox feels analysis is the best treatment she believes it may not be possible to use this method because the alcoholic has a difficult time recognizing his problem, analysis is expensive and time consuming, the patient must maintain sobriety during treatment, and the depth of the neurosis may extend to early infancy. She recommends antabuse as an adjunct to therapy as well as tranquilizers, vitamins and other drugs. Antabuse is a chemical that was accidentally discovered in Denmark which has the property of making anyone who takes it sensitive to alcohol to the point where they become violently ill. It insures sobriety as long as the patient continues taking it.

By the time an alcoholic reaches a federal, state, or general hospital there usually has been physical social and psychological deterioration. Due to varying lengths of stay, counseling techniques differ from institution to institution.

Moore et al. (1966) describe counseling alcoholics in a state hospital. Admission is by a doctor's referral, request of a patient and/or relatives. The patient on entering is interviewed by both a psychiatrist and a staff social worker. The first interviews establish the patient's problem and develop a plan for continued care in overcoming that problem. Efforts are made to meet the alcoholics immediate needs. The length of stay is entirely dependent on the individual. The primary emphasis of counseling is to help the alcoholic to manage his own life and to respond in a satisfactory manner to current tensions. Records of medical and personal histories are taken, followed by a week long group orientation series after which a plan is decided upon for each patient. A counselor is assigned and together on a one-to-one basis they designate a discharge date toward which to work. Patients elect officers and have a great deal of influence

upon the operation of the hospital producing a desirable sense of responsibility and worth. The counselor encourages the patient to actively participate in community programs on alcoholism when he is discharged. Alcoholics Anonymous is always recommended as an activity to help the patient meet and handle everyday stresses.

Behavioral counseling is used extensively in state hospitals in this country and abroad. Techniques include conditioning of a reflex to alcohol and using aversive stimuli such as emetics, drugs, electric shock, and hypnosis. Also, specific non-drinking behaviors are substituted and rewarded. Mossa (1959) in Italy; Strel'chuk (1957) in Russia; Jacobsen (1962) in Germany; and Serebro (196?), Miller (1959) and Kepner (1964) in the United States have employed these techniques with varying results. Kepner states that counseling of the alcoholic should begin by making sobriety and the treatment situation a rewarding experience. To help the alcoholic acquire the responses which will build a pattern of sobriety, the process is broken into a series of graded tasks. If successive and closer approximations to the final goal are consistently rewarded, the new pattern of sobriety may eventually be firmly established. Some of the rewards which may be provided for the patient by the counselor include: an acceptant attitude emphasizing that drinking is a serious problem but not a moral one; encouragement of the patient to find substitute satisfactions to replace drinking; encouragement of the family to make sobriety a satisfying way of life for the patient. At the same time, negative reinforcers or aversive stimuli can be used to weaken and eventually eliminate the drinking response: creating a crisis (e.g. trial separation by the wife); recognition of the drinking problem and awareness of the probably consequences of continued drinking. The counselor helps the alcoholic realize

that he has been using drinking as a means of avoiding emotional and personal problems. A careful investigation of the frequency, timing and locale of the patient's drinking uncover the "punishment" he has been trying to avoid through the use of alcohol. Counseling the alcoholic begins with treatment of the symptoms, and the exploration of this problem often provides the leads for further psychotherapy.

Moore (1966) in a nation-wide survey of treatment techniques and results in state hospitals found that whether traditional or contemporary techniques were used, the estimated over-all rate of improvement was 60% at discharge, 39% up to a year after discharge, and 33% for periods over a year after discharge. He postulated that a lack of adequate aftercare is probably a leading cause of poor results.

Counseling the alcoholic in a general hospital setting is different from counseling in a state hospital setting because the patient is usually acutely intoxicated and remains hospitalized for a shorter period of time. Hospitalization is usually for a week to ten days. Counseling in this setting is described by Matkom (1969) as extremely challenging. The ideal time to begin a counseling program is when the alcoholic is in the withdrawal phase because he is in the midst of his problem, ego defenses are at a low ebb and he is usually much more amenable to commitment to a program of rehabilitation. At this time the counselor tries to educate the alcoholic to understand at the deepest levels these four things: 1) he is a typical alcoholic; 2) he can never drink alcohol again; 3) he can achieve lasting sobriety but not easily; and 4) after starting sobriety, he will need about two years in some kind of therapy to correct the personality deviations that he had previously tried to correct with alcohol. The program includes approximately three hours of group counseling per day in the form of didactic lectures and discussions. The group sessions

center around pertinent aspects of alcohol, alcoholism and the alcohol-related problems. They are designed to help the patient recognize the need for a continuing recovery program. This type of program is used at Borgess Hospital in Kalamazoo. Studies by Mulford (1965) show no more than approximately a 30% recovery rate in general hospitals.

For years it was felt that homeless or severly disoriented alcoholics were abandoned by society. Long term intense therapy in a home-like setting was needed. In response to this need halfway houses and mission houses were founded. One such place is the Gateway Rehabilitation Center in Kalamazoo. It is similar to the one described by Katz (1966) and Ingram-Smith (1967) but employs some new techniques. Residents live in apartments with four persons per unit. The normal stay is thirty to ninety days. They spend several hours a day in intensi ` one-to-one and group counseling situations. Several of the techniques will be elaborated on now.

Traditional group psychotherapy is the first technique. The sessions are conducted by para-professional counselors. Members of the group discusss their problems by seeing how the same problems afflict others. Usually the members of a group will make the kind of penetrating and incisive comment to one of their number that will be extremely helpful --more helpful than what the therapist himself can do. The group helps each alcoholic become socialized, in much the same fashion that Alcoholics Anonymous has done.

The second method is transactional analysis as outlined by Steiner (1969) and conducted by a counselor trained in "T.A." The counselor uses a group setting to explain that alcoholism is a game in the majority of cases. It is a series of transactions engaged in with the purpose of obtaining an interpersonal advantage. The therapist explains the games to the residents and shows how the payoff occurs after the drinking

episode when significant others who have been playing the role of persecutor or rescuer are put into the role of victims. Each game accomplishes this in a different manner. The therapist helps the alcoholic understand his alcoholic script for the game and then writes out a new script which is the antithesis of the game.

Group psycho-drama following the format adopted by Weiner (1965) is the third technique. The method is based on earlier work by Moreno (1921) called "Spontaneity Theatre." It reaches out to the individual, going beyond other therapeutic modalities, and probes deeper to the source of conflict and frustration providing valuable data. It also provides the individual with modes of acting through the power of practice, reliving and retraining, enabling him to gain greater personal freedom. It gives participants heightened encounters wherein mutual feelings of trust and support are generated and group members develop courage to show their covert attitudes, guilts and ways of living. It provides significant interpersonal relationships. Many alcoholics know what their problems are though they don't know how to cope with them. The counselor can begin the session with a warm-up exercise in which he will prepare the group for a drama experience. He can use verbal explanations and exploration, activities, spontaneity testing exercises, or group sharing techniques. This phase ends when the counselor selects a "protagonist" or main character for the drama. The drama proper is built around the problems, feelings and situations provided by the "protagonist." Drama can involve role reversal wherein the "protagonist" switches roles with another player who is playing a signifcant other, or mirroring wherein the other player or the counselor will stand directly opposite the "protagonist" and literally "mirror-back" his actions and

attitudes. There are many other techniques that can be used. In the final phase, the counselor uses reflection, resolution and group feedback to examine the thoughts and feelings brought out in the drama.

The fourth method is called the self-defeating-behaviors workshop conducted by a specially-trained counselor. It is adopted from a workshop conducted at Western Michigan University in Kalamazoo by Cudney et al. (1970). The counselor divides the workshop into two sections: (1) building understanding and the beginning of personalization; (2) facing up to and experiencing the deeper feelings behind the self-defeating behavior of alcoholism. The counselor conducts six one-hour sessions discussing the concepts; one one-hour individual counseling session; and three two-hour group counseling sessions.

The final technique is a one-hour group motivational session based on the work of Maltz (1968) and Hill (1960). Concepts of motivation are taught and discussed. The concepts include; know yourself; know your duties and responsibilities to others and have objectives or goals; have a plan of action; influence others by helping them get what they want; develop personal skills so you're ready when opportunity knocks; and put time in its place for daily and long-range goals.

Other one-to-one methods are used to counsel the homeless alcoholic to adjust to work, living alone and other aspects of a sober life. Alcoholics Anonymous is made available on a daily basis to all residents.

There is a dearth of published research on the efficiency of rehabilitation centers.

One of the earlies proponents of pastoral counseling in alcoholism from other than a moral standpoint was H.J. Clinebell, Jr. His book Understanding and Counselling the Alcoholic (1956) contains one of the

most comprehensive accounts of counseling goals and processes ever written. Clinebell concerns himself with answering three basic questions when approached by an alcoholic. What are the circumstances of contact? Is the alcoholic ready to admit the problem and ask for help? Is his alcoholism a cover-up for deeper pathology? The answers to these questions determine the initial relationship and approach. The author lists several general principles and techniques. Respect the alcoholic's anxiety. Relationships are hard for him to form because of his problem. Take more time in the first interview. The essence of counseling is the establishment of a certain quality of relationship, the relationship of acceptance or rapport. The counselor must not be anxious because if this is conveyed to the client, he will court and expect rejection. Let the alcoholic talk it out, but do not reassure. Listening is the keyword with a third ear to detect feelings that lie behind the words. Stay close to the alcoholic's ego because it is threatened by the feeling of being alone and being under scrutiny. Let him know you are with him emotionally by being emphathetic. Do not tell the client directly that he is an alcoholic. Present facts and let him decide. Present Alcoholics Anonymous in an unthreatening way by telling him about an alcoholic you know and how he found sobriety in Alcoholics Anonymous. Convey acceptance through the concept that alcoholism is an illness. Do not allow the alcoholic to become emotionally dependent as he may draw the counselor into the role of interpreter, advisor, and authority figure. If something goes wrong, then the client rebels and the counselor is blamed. Combine acceptance with firmness because the alcoholic's emotional immaturity can cause selfish, childish and irresponsible reactions. He may be this way because of an inadequacy of early relationships. Insist that people who are sick have an obligation to society to get treatment. Keep

the responsibility for recovering with the alcoholic. No one can do it to him or for him. Watch out for his grandiosity and treat the alcoholic as an adult. Try not to become involved in the success or failure of the counseling process. Avoid trying to save souls or collect spiritual scalps. The alcoholic's success or failure is his alone. The counselor is at best a catalytic agent. Recognize the fact that many alcoholics will relapse. They have a low frustration tolerance level and many do relapse. The counseling process is slow and tedious, and the therapist must be content with little successes. Wearing down the alcoholic's defenses of isolation and grandiosity is a long process. The alcoholic will come out of his shell when he is gradually convinced that there are substitute satisfactions in other ways of living. As the counselor patiently holds the reality situation before him, the client may see the real grimness of his alcohlic adjustment and become ready to accept the help he must have. The use of prayers, scriptures and sacraments in counseling come after rapport is established, if they are appropriate. The counselor can help him establish a mature faith in God. These counseling goals and processes set forth by Clinebell provide the basis for much of the counseling in alcoholism done today.

Family centered social agencies find that a good portion of their caseloads are filled with alcoholics. In a study by Kelly and Meeks (1970) they found that family interaction produces profound emotional changes in family members. The counselor involved the entire family unit in treatment and used family interaction therapeutically. The goals of counseling included total abstinence, improved relationships, healthier communication, and increased mutual support. The counselor centered his activity around dealing with resistance, avoidance transactions, scapegoating, and the effects of equilibrium shifts. The

results showed that family therapy promises to be a viable technique in work with alcoholics. Another study by Trotter et al. (1969) found that completion of hospital treatment by alcoholics and the recidivism rate are affected by the spouse's participation in a hospital family counseling series. The more the spouses knew about alcoholism and interacted positively with the alcoholic family member, the lower the rate of relapse.

A relatively new counseling setting is in industry. Dorris and Lindley (1968) have employed the concept of lay group therapy in industrial counseling. the process of getting a man into a recovery group involves the cooperation of supervisors who can spot alcoholic employees and refer them to the company alcoholism counselor. The employee can keep his job if he responds to treatment, but is terminated if he does not respond. Rapport must be established in the first session because the employee may be frightened, apprehensive, belligerent, or bewildered. The counselor explains the company policy on alcoholism and defines his role to help the employee find out about his poor work record. The client may bring up his drinking problem or the counselor may use the cart developed by Jellenik to show the symptoms and phases of alcoholism as a way of encouraging the alcoholic to talk about his problem. The counselor lets the client evaluate his own drinking behavior. The counselor refers the employee to appropriate agencies and lay groups to get further treatment. The counselor reduces the idea of social stigma attached to the problem by showing alcoholism is a recognized illness. The client is motivated to seek help with company backing or else he is asked to take a leave of absence until the problem is resolved. The final alternative is job termination. The counselor follows up on treatment progress with the alcoholic once he is back

on the job. The authors believe the concepts of Alcoholics Anonymous and those stated by Glasser (1965) concerning reality therapy can be utilized in lay group therapy. Sobriety requires insights and skills far beyond those needed merely to quit drinking. It is a creative discipline in the arts of freedom, responsibility, reality, growth, and of human relationships. The counselor lays the ground rules and conducts the meetings. The most important goal of therapy is to help the self by discovering the self and thereby help others. It allows those with emotional problems to select new ethics of living. Recognition of the possibility of change is imperative before the person can expect to change. The group contains ten to twelve members. Regular attendance is required. No one is allowed to participate while under the influence of alcohol or other drugs. What happens at the meeting stays there. Each member accepts personal responsibility for his behavior in and out of the group session. Each member is responsible for every other member. Active participation is required. Attacking the problems of the individual is the essential purpose of the group session. The beginning point in a group session is a willingness to be open, to disclose one's own ideas, opinions, shortcomings, and feelings freely and openly.

Because Alcoholics Anonymous and lay groups in general have been referred to throughout this tract, a few words on these non-professional therapy modes are in order. Alcoholics Anonymous is a fellowship of men and women who share their strength, hope and experience with one another in order to stay sober and to help other alcoholics gain sobriety. Its principles are embedded in its twelve steps to recovery. The program stresses honesty, humility, love and patience. The steps involve self-

knowledge, surrender, God-consciousness, confession, reparation, and helping others. The book Alcoholics Anonymous (1951) describes how the program works. Family members have help available through Ala-non and Ala-teen which are closely allied to AA. The publication "Ala-non Faces Alcoholism" (1965) outlines the purposes of these auxiliary organizations.

One final counseling setting needs to be discussed because it is unique. It is the courtroom. Judge Ray Harrison of Des Moines, Iowa, a recovered alcoholic, conducts a counseling session he calls an honor class. His students are chronic revolving-door skid row alcoholics. Classes are conducted weekly. Clients talk about their problems and troubles. Alcoholics who appear in court before the judge are given an invitation to the class in lieu of going to jail. Clothes are supplied if needed. Jobs are also arranged if possible. The class helps the alcoholic get a new perspective on life. The results are astounding. Drunk arrests dropped 30% for the city in the first year. The program has now been instituted in other cities across the country.

Although there are other counseling settings and techniques, the main thrusts in this field have been presented. Now an evaulation or pulling together of the data should give an indication of where counseling in alcoholism is and where it might be going.

The studies presented show that counseling alcoholism is relatively new and fraught with foreboding. There are numerous definitions, theories, assumptions and techniques for the counselor to choose from, but all the available research shows that the recovery rate, regardless of institution or method, is appallingly low with the most successful approach being Alcoholics Anonymous. Although these facts may be gloomy, there is a silver lining in the cloud of mystery surrounding alcoholism. In the past thirty-five years the recovery rate for alcoholics

has gone from approximately 1% to approximately 35%, a staggering increase. The National Center for Prevention and Control of Alcoholism (1968) identified one of the major future needs in the field of alcoholism: intensive, controlled studies on the various types of treatment now being used should be conducted to measure their relative efficacy, and determine the type of patient for which each is most suitable. Professionals have learned and are learning from such organizations as Alcoholics Anonymous. Research at centers such as Rutgers School of Alcohol Studies and Utah State University is beginning to show what direction counseling in this field should go. For example, Ottenberg's (1969) study showed that an eclectic approach to alcoholism therapy was the most successful way in a two-year study because the diverse talents of counselors from differing disciplines tapped a multitude of techniques that could be used as needed. Another point concerns basic counseling technique. Although the theories differed, the variables in the counseling interview were quite similar. Rapport, empathy, the counselor-client relationship, easing of internal and external sources of anxiety, and sobriety were primary goals. Further research may end such controversies as whether alcoholism is a behavior disorder or a disease; is a symptom of underlying pathology or a disorder in its own right; and treatment of the internal man or control of the environment.

In conclusion, counseling in alcoholism has been examined and related to theories and counseling methods, thus showing its value and significance in this field. It has not yet matured but shows great promise for the future.

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