Alcoholism

by

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Alcoholism

Introduction

Alcoholism has emerged in modern society as a unique and highly specific illness: it is a behavior disorder with severe medical, psychological, and social complications. It is estimated that alcoholism is the fourth most serious public health problem after heart disease, cancer, and mental illness. The first part of this paper will discuss some of the definitions of alcoholism and present facts on the use and abuse of alcohol in the United States; it will offer possible explanations as to the causes of alcoholism and society's attitude towards it; a discussion of the disease and its progression will be presented; the differences in alcohol abuse according to ethnic groups in our country will be cited; and problems alcoholism causes in the family system will be presented. The second section of this paper will focus on treatment programs. The difficulty of treating alcoholism will be discussed as well as treatment programs in general and the philosophy and work of Alcoholics Anonymous will be presented. The Alcoholic Rehabilitation Program at the Veterans Administration Hospital in Marion, Indiana will be discussed in detail and some case studies of patients who have utilized this program will be presented for illustration.
Definitions of Alcoholism and its Prevalence in the United States

Some ninety million adults use alcoholic beverages and perhaps six million of them are said to be alcoholics. It is estimated that one-third of admissions to mental hospitals stem from some variety of problem drinking, one-third of all crimes involve alcohol use, and one-third of all persons on public welfare use alcohol extensively.² It is evident that alcoholism is widespread in the United States and the disorders resulting from it are numerous. These disorders encompass all aspects of living: social, family, employment and financial, physical, and legal. Doris and Lindley in their book, Counseling on Alcoholism and Related Disorders, have obtained the following facts about alcoholism and alcoholics. Sixty-eight percent of Americans over eighteen drink with eighty-two percent being light to moderate drinkers and eighteen percent heavy drinkers. Out of the eighteen percent who are heavy drinkers, forty percent will contract the disease of alcoholism.³ The facts about alcoholics are: Ninety-seven percent are employed, family-centered individuals with only three percent Skid Row bums; fifty percent of all alcoholics attended or graduated from colleges; seventy-five percent are men; and of the employed alcoholics twenty-five percent hold white collar jobs, thirty percent are manual laborers, and forty-five percent are professional and/or managerial workers.⁴ From these statistics it is evident that no group or social strata is exempt from this disease.

Alcoholism has only recently been recognized as a disease.
At different times in the past it has been labeled as an expression of immorality, a basic personality defect, a disease process, a personal health problem, and a sociological problem. Today, however, most medical authorities, behavioral scientists, legal experts, and informed laymen consider alcoholism to be a disease. It was recognized as a disease and not a crime by the World Health Organization in 1951, the American Medical Association in 1955, the American Psychiatric Association in 1965, the Department of Health, Education, and Welfare in 1966, and the President's Commission on Law Enforcement and Administration of Justice in 1967.

Although alcoholism is now recognized as a disease the definition of who is an alcoholic remains undecided. Definitions range from this relatively simple one of Dr. E. Y. Jellinek, a noted authority on alcoholism, that alcoholism is "any use of alcoholic beverages that causes any damage to the individual or society or both" to more thorough definitions such as that given by the American Medical Association.

The A.M.A. Manual on Alcoholism states that it is an illness characterized by preoccupation with alcohol and loss of control over its consumption... by chronicity; by progression; and by tendency to relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistent and excessive use.

The World Health Organization, in 1952, defined alcoholics as: excessive drinkers whose dependence upon alcohol has attained such a degree that it results in noticeable mental disturbance, or in an interference with their bodily and mental health, their interpersonal relations, their
smooth social and economic functioning, or those who show the prodromal signs of such developments.

A sociologically oriented definition offered by Trice in 1966 states four facets of behavior which sets the alcoholic apart from other drinkers. First, his use of alcohol regularly deviates from the typical drinking standards of his key social groups - home, neighborhood, and job. Second, the performance of his role in these key institutions is impaired. Third, he suffers from emotional and physical damage from his regular excessive use of alcohol. Finally, he shows an inability to stop drinking once he starts, even though he may know his drinking impairs his life; thus his use of alcohol is beyond his conscious control.10

Although there are slight differences in definitions of alcoholism most would agree with Jellinek that alcoholism is any use of alcoholic beverages that causes any damage to the individual or society. In the remainder of this paper use of the term alcoholism will correspond to this definition.
Theories of Causes of Alcoholism and Differing Attitudes of Alcohol Use among Ethnic Groups

There is no such person as a typical alcoholic before he starts to drink. Margaret Bailey, D.S.W., states that it is possible to generalize only to the extent of noting that the alcoholic suffers from a defect in ego development, an inability to handle aggression, and a severe anxiety with which he has never learned to cope constructively. In a study of alcoholics conducted by Perry and associates some of the conclusions found tend to substantiate Bailey's generalization. This study found that a substantial proportion of alcoholics had dominant and in some cases overprotective mothers and a lack of an adequate masculine identification object; and a substantial proportion had limited experience in the development of social interaction skills during their childhood and early adolescence.

Psychosocial theory says that people who become dependent on alcohol are those who experience frustration, lack of fulfillment, or overgratification of specific needs during the psychosexual development of the individual. Other psychological theories state that alcoholics have a low tolerance for frustration, experience unusual amounts of stress, and have considerable difficulty in controlling impulses and establishing significant relationships with other persons. When people who do suffer from continual anxiety and depression, either because of realistic problems or because of underlying emotional insecurity and conflicts are unable to deal with this painful subjective state in a healthy
way, they will often use alcohol to relieve their psychic distress because it is easily available and provides quick relief.

Another psychological theory of the cause of alcoholism states that the alcoholic has a very weak ego with a low estimate of his own worth which can result from poor handling of aggression and guilt in childhood. The child needs to have the security that his parents will always stand by him and this security seems generally to have been lacking for the alcoholic. In treatment it is often found that the alcoholic always felt criticized and degraded no matter how hard he tried and he never had the feeling that he was wonderful and precious to his parents. For these reasons the alcoholic is basically depressed and the narcotic bondages begin when he discovers the relief from psychic pain which the alcohol gives him. The alcoholic’s perception of reality is so painful that this relief from psychic pain is greater than that for most people.¹⁵

A somewhat different view in understanding alcohol dependence is the attribution of a spiritual quality to alcohol. This theory states that the alcoholic or potential alcoholic has not recognized a basic spiritual need of man: the need for transcendence of self to the oneness of things and discovery of life beyond our bodies. The alcoholic, since he has not recognized what this need is, does not know how to satisfy it and so loses himself in alcohol. The need is satisfied for a time by drinking and so drinking serves a different purpose for the alcoholic than for the normal man. The alcoholic will continue drinking to recapture his original feelings.¹⁶
The final theory to be discussed in understanding alcoholism is sociological. In Joan Jackson's analysis of social problems and alcoholic beverages she found that the use of alcohol as a problem arises from the prevailing values of the culture, the inability of the intoxicated person to display socially acceptable behavior, and the inadequacy of social controls. Americans have seemingly lived with contradictions pertaining to alcohol use for a long time. A group of sociologists have made the following analysis of the attitude of ambivalence towards alcohol found in the United States. Based upon the Puritan Ethic a high value is placed on the individual's maintenance of control over his emotions and actions and alcohol is frowned upon because it causes a loss of control. However, in spite of the Puritan Ethic alcohol is accepted by society as a means of helping the individual cope with stress. Although the American culture accepts the use of alcohol, its control over the individual's drinking is weak, inconsistent, and poorly defined. Little is learned in the family regarding proper use of alcohol and thus there is an ambivalence regarding the use of alcohol in the United States.

This sociological theory of understanding alcoholism gains believability in the comparison of attitudes towards the use of alcohol in various ethnic groups in the United States. The rate of alcoholism is low in those groups in which the drinking customs, values, and sanctions are well-established, known to and agreed upon by all, and consistent with the rest of the culture. Conversely, alcoholism rates are higher among groups in which attitudes, practices, and sanctions pertaining to alcohol use
display much ambivalence. The United States with its high rate of alcoholism does have ambivalent attitudes towards the use of alcoholic beverages. However, some cultures have attitudes towards the use of alcohol that are rooted in tradition and do delineate acceptable and unacceptable behavior.

The following ethnic-cultural patterns of drinking are discussed in more detail in Barry Wilf's Basic Handbook on Alcoholism. Italian-Americans have long been regarded as heavy drinkers and in fact do drink a great deal - socially and not mainly with meals as is assumed. In this ethnic group strong approval is given to drinking and occasional drunkenness is tolerated but not condoned. This group has a low rate of alcoholism but it is noted that the rate is rising the longer the group has been away from the native country.

Another ethnic group with a low rate of alcoholism are the Chinese-Americans. Drinking is widespread but intoxication is deplored and the drunken person is ridiculed. Chinese-Americans usually drink alcoholic beverages within the family group and in ceremonies related to important social functions such as weddings and birthdays.

A third group with a traditionally low rate of alcoholism are the Jews. Jews drink a great deal but it is regarded casually as a normal part of living. However, drunkenness is abominated. Drinking wine is a part of many rituals and has a religious significance among Jews.

An ethnic group that has long been associated with heavy drinking and alcoholism are the Irish-Americans. This group does
have a high rate of alcoholism and there are many old Irish traditions that relate to this. In Ireland, drink is the synonym for hospitality. The Irish child grows up in an atmosphere of heavy drinking and begins participating early. Drowning one's sorrows becomes the accepted means of relief for men and the habit of treating the hour to drinks is social law. Other social factors found in the traditional Irish culture cause the men to seek escape from their female dominated homes and going to taverns is the most acceptable way out. These cultural norms have caused an atmosphere of acceptability among the Irish regarding heavy drinking and drunkenness and these traditions have seemingly carried over from the old world to the new.

In comparing these cultural attitudes towards drinking behavior one can see that in the groups with low rates of alcoholism - Italian-Americans, Chinese-Americans, and Jews - the group norms regarding drinking and intoxication are clearly defined and deviancy is controlled by social disapproval. The Irish-American group also has clearly defined norms of drinking behavior but this group approves of heavy drinking and no sanctions are brought to bear against those who become intoxicated. The American culture in general has a high rate of alcoholism but does not condone heavy drinking as do Irish-Americans. However, the ambivalent attitude towards drinking and drunkenness, and the contrast between the old puritanical standards of abstinence and the approval of social drinking leaves the American without clearly defined norms to follow. This lack of group control of drinking behavior leaves many in a quandry - drinking is
encouraged but alcoholics are condemned, drunkenness is regarded as entertaining at times and disgusting other times - and so the group member who may be drinking more and more heavily has no social rules to follow in regards to correct behavior. This ambivalence and lack of social control are perhaps reasons for a high rate of alcoholism to be present in the United States.
alcoholism and its progression

Alcoholism for most people begins with social drinking or moderate intake and progresses into addiction. The pre-alcoholic experiences a very pleasant physiological and/or psychological response to alcohol and gradually increases his consumption. This increase can lead to problem drinking which can lead to full-fledged alcohol addiction. Some hallmarks of problem drinking are: drinking in excess of customary dietary or social use, drinking which is activated by a need to feel important or to cure a feeling of depression, drinking which is engaged in for its own sake, drinking to escape reality or boredom, drinking to reduce tension, and drinking without regard to the responsibilities of the drinker or to the demands of his occupation. A drinking pattern such as this leads to the need for increased intake to produce the same effect and eventually the need to drink before the person can cope with certain situations. This increased intake causes a person to experience alcohol induced amnesia or blackouts and finally the person develops a physiological need for alcohol and is unable to abstain. Alcohol addiction has two components: tolerance and withdrawal illness. Tolerance means daily use of increasing amounts of the alcohol to which the body adapts and so requires more and more of to produce the effect sought. Withdrawal illness occurs when the drug is discontinued. The alcoholic experiences delirium tremens which are characterized by tremor, convulsions, and hallucinations. An effort has been made to identify stages of alcoholism
leading to alcohol addiction. The following phases of alcoholism are taken from Dorris and Lindley's *Counseling on Alcoholism and Related Disorders*.

The **pre-alcoholic phase** usually begins with social drinking. The pre-alcoholic often unconsciously seeks situations where drinking will occur and he soon becomes aware of the relationship between his comfortableness and his drinking and will then begin to seek this relief. The seek for relief gradually increases but does not result in intoxication. However, tolerance for alcohol increases. This phase begins with occasional relief drinking and progresses to constant relief drinking.

The **preconvoluted or early phase** of alcoholism begins when blackouts occur. A blackout is considered to be the first concrete evidence of alcoholism. This alcoholic amnesia is not a loss of consciousness but a failure of the memory banks in the brain to register what has happened. Following blackouts alcohol becomes a needed drug instead of a socially oriented beverage. The person becomes preoccupied with alcohol although he appears similar to others and able to control himself. It is still possible for this person to determine when he will drink if not how much.

The **crucial or middle phase** is identified by the developing alcoholic's involuntary loss of control over when and how much he will drink. This person's hangovers are characterized by shakes and morning drinking begins. His outside interests become secondary to his preoccupation with alcohol and there is a breakdown in family and job relationships. His body begins to deteriorate and eventually all his emotional ties with the past
are cut and he enters the final stages of the disease.

The **chronic or late phase** is marked by obsessive drinking. The alcoholic has no control over drinking at all and drinks for days or weeks until his body gives out. There is a marked ethical deterioration and impairment of thinking abilities. The alcoholic even loses tolerance for alcohol. Alcoholism can still be arrested in the chronic phase but if it is not arrested it will lead to death, insanity, or other physical deterioration.\textsuperscript{24}

The alcoholic, in going through these stages as the disease progresses does make some unconscious personality changes. Vernon Johnson, in his book *Ill quit Tomorrow*, describes some of these changes in the alcoholic. Johnson says this process is unconscious and the alcoholic is unable to perceive what is happening to him. As the alcoholic condition develops his self-image continues to deteriorate and his ego strength declines. For various reasons, he is progressively unable to keep track of his own behavior and is losing contact with his emotional self. The alcoholic’s defense systems continue to grow so that he can survive in light of his problems. These defenses become higher and more rigid as he suffers greater pain from the problems caused through being cut off from himself. As this emotional turmoil grows the alcoholic’s rational defenses turn into mental mismanagement which serves to erect a wall around the negative feelings he has about himself. The end result is that the alcoholic is walled away from these feelings and becomes unaware that such destructive emotions exist inside himself. Thus, the alcoholic is unaware of his highly developed defense system and his feelings of self-hate.
and his judgment becomes impaired. By locking in the negative feelings, the defenses create a mass of free-floating anxiety, guilt, shame, and remorse which becomes chronically present. Although one may hear of an alcoholic personality, it is only after alcohol has become the controlling factor of a person's life that this alcoholic personality begins to develop. These personality changes that Johnson has described begin after the person's life begins to revolve around alcohol.

Dr. Jellinek, a man who is considered to be an authority on alcoholism and who was an advocate for alcoholism to be classified as a disease, has divided alcoholism into four categories. Although the use of these labels to distinguish degrees or types of alcoholism may be questionable, the differentiation of individual reactions to alcohol abuse is interesting. These categories of alcoholism are described in detail in his book, The Disease Concept of Alcoholism.

Jellinek describes alpha alcoholism as a purely psychological continual dependence or reliance upon the effect of alcohol to relieve bodily or emotional pain. He says that this dependence does not lead to loss of control or inability to abstain and that the damage at this stage is restricted to the disturbance of interpersonal relationships. This type of alcoholism does not show signs of a progressive process.

Another type is beta alcoholism. Here there is not necessarily physical or psychological dependence upon alcohol but there are physical complications due to alcohol intake. These complications are a nutritional deficiency, lowered productivity, and a shortened
The most serious of Jellinek's types of alcoholism is gamma alcoholism. With this type one finds acquired increased tissue tolerance to alcohol, adaptive cell metabolism, withdrawal symptoms and physical dependence, and loss of control. Jellinek says this type is the most prevalent in the United States. Here there is a definite progression from psychological dependence to physical dependence; marked behavior changes; impairment of interpersonal relationships; and damage to health, financial, and social standing. 25

Jellinek's last classification is delta alcoholism. He states this type has the same characteristics as the gamma type but the alcoholic in the delta phase is unable to abstain. However, the alcoholic with delta alcoholism does not go through the social and psychological experiences of the gamma alcoholic and displays only a few of the behavioral changes of the gamma type. 25

In whatever manner alcoholism is classified in regard to type or degree it is a progressive disease that creates more and more problems for the alcoholic as it progresses. Dependency is an important factor in the problems an alcoholic faces. "As the pathology of the alcoholic progresses, he becomes increasingly dependent upon members of all social systems in which he participates—family, friends, and co-workers become involved as targets of his dependent functioning."30 Through this dependency interpersonal relationships are damaged and finally the alcoholic becomes financially dependent and a burden to the community.
Problems in Families of Alcoholics and Al-Anon

An alcoholic destroys more than himself in his abuse of alcohol. Many other people are hurt, directly and indirectly, but those hurt most are his wife and children. It has been said that no matter what the wife's personality structure, whether she was disturbed before her husband began drinking excessively or whether she was close to normal, she will become ill through the stress of living with an alcoholic. This experience damages the dignity and inner integrity of the wife.

There are several possible outcomes of alcoholic marriages. The marriage may continue indefinitely with the husband still drinking and the wife in the position of family head, divorce (divorce rate is higher among alcoholics than the general population), or recovery of the husband from his alcoholism and resolution of the mutually destructive relationship which characterizes alcoholic marriages. Whatever the outcome of the marriage, wives of alcoholics are encouraged to join Al-Anon. The purpose of this organization is not to try to stop the alcoholic from drinking but to enable the family to lead a saner, happier, and more productive life. Al-Anon grew out of Alcoholics Anonymous (this will be discussed in detail later) as the families of recovering alcoholics saw that they could apply the principles of A.A. to their own lives to help understand themselves better. Al-Anon helps family members cope with the problems of living with an alcoholic and with the problems of adjusting to a recovering alcoholic.
Wives of alcoholics are sensitive to the hurt their husbands cause them and their families and may retaliate instead of realizing they are dealing with sick people. In this process of retaliation or in the process of trying to hold the family together in the face of all the problems an alcoholic causes, the wife usually becomes mentally sick also. Al-Anon enumerates the possible outcomes of this: wives may lose faith in life and in themselves; feel self-pity; believe there is no hope and become aesthetic; forget the alcoholics good qualities; begin to view everything negatively; begin to feel self-righteous and arrogant; take on the role of mother to a wayward child; and become dominant and nagging. Al-Anon provides a place for wives of alcoholics to go and share their common problems. It also helps the non-alcoholic achieve a healthier frame of mind to become active in an area outside the problem which has absorbed all of her time and concern. Al-Anon can provide this release as it opens up new friendships and activities for the wives and family members of alcoholics and encourages them to live their own lives.

Whatever the outcome of the marriage may be, Al-Anon helps family members learn to understand themselves better and cope with life in a healthier way.
Difficulty of Treatment

"Many think that an alcoholic must hit bottom before he is able to be treated. However, "recovery from alcoholism is possible at any point if the alcoholic or incipient alcoholic can recognize his problem, admit it, and accept proper treatment without fear of social ostracism." Early intervention means less damage to the alcoholic's mind and body. Most authorities agree that it is essential that the alcoholic admit his drinking is beyond his control prior to beginning any form of treatment.

Alcoholism cannot be cured but the disease can be arrested. There is an ever-present danger that the dry alcoholic will relapse into destructive drinking. Because of this the goal of treatment should not only be total abstinence but also rehabilitation of the alcoholic as a total person - physically, mentally, emotionally - because he has been damaged through alcoholism and needs to learn new methods of coping with life.

Part of the difficulty in treating alcoholics is their facade of defense against the acknowledgement that they do need help. Rationalization, projection, and denial are the most common of these defenses. Denial of dependency on alcohol is the most prominent of the defense mechanisms used by alcoholic dependents.

In treating alcoholism the alcoholic must first be able to admit to being an alcoholic and must recognize the need for help in his recovery. Even after this is accomplished treatment is made difficult by the fact that in rehabilitation the alcoholic must be helped to learn new ways of coping with life and for some
alcoholics this seems impossible. Accepting a new way of living is always difficult but doing this and fighting alcohol addiction is doubly hard.
Types of Treatment Programs

"The goal of therapy for alcoholics is the restoration of adequate ego strength to enable the victim once again to cope with life situations - goal is not just abstinence."40 In other words, the goal of treatment of alcoholism is sobriety, but sobriety is more than the absence of alcohol. Sobriety requires insights and skills far beyond those needed merely to quit drinking: "Sobriety is a creative discipline in the arts of freedom, of growth, and of human relationships."41

In order that treatment be given wisely and fairly to all patients, there should be an assessment made of their present drinking, their physical and mental condition, and an estimate of their abilities to benefit from therapy. The selection of treatment should then depend upon these factors.42 Some types of treatment given to alcoholics are: individual psychotherapy given by psychiatrists, therapy given by a physician, casework therapy given by social workers, group psychotherapy, and chemotherapy.43

One aspect of treating an alcoholic is detoxification. For the alcoholic who cannot stay dry voluntarily for at least five days it is necessary that he be removed from alcohol by an outside source. The detoxification process takes from thirty-six to seventy-two hours and once this is over the alcoholic is ready to begin some type of treatment program.44

Drug therapy is one type of treatment used with alcoholics. The most common drug used in this type of therapy is antabuse. This drug, when introduced into the system of a person who has
been drinking, will produce an extremely unpleasant reaction which includes intense, throbbing headache; severe flushing; extreme nausea and vomiting; palpitations; fall in blood pressure; labored breathing and blurred vision. The alcoholic who is taking antabuse will refrain from drinking due to fear of the reaction. The alcoholic undergoing this type of treatment is administered the drug, given a small amount of some alcoholic beverage, and experiences a mild reaction. This is done with medical supervision. After the alcoholic experiences the reaction he will know what to expect and the anticipation of the reaction will keep him from drinking. This type of therapy can only be successful if the alcoholic remains motivated enough to continue taking his medication. After a few days all of the antabuse will leave his body and he can safely drink without having an adverse reaction. Drug therapy is probably most beneficial when used in conjunction with some other type of therapy.

Psychoanalytic group therapies are based on the presumption that the alcoholic is driven by feelings, motives, and urges of which he himself is unaware and which he therefore cannot direct to his best advantage. The group's processes are mobilized to bring about insight, emotional growth, and ego-development. This type of therapy would help the alcoholic greatly to get in touch with himself and learn new methods of coping with life.

Another aspect of treatment is vocational placement as soon as the alcoholic is ready. His self-concept requires the support of achievement and productivity of work, particularly in our culture which is achievement oriented and which equates masculinity
with the capacity to support oneself by earning a living. 47

Activity groups are another part of treatment or of a treatment program. The underlying goal of activity group therapy is to bring alcoholics out of their isolation, and to provide positive reinforcement for acceptable social intercourse. From a psychodynamic point of view, activity groups provide non-destructive and non-threatening outlets for aggression and competition, stimulate the growth of affection, and reduce fears of intimacy and tenderness. 48

Many communities are coming to see what their role should be in the treatment and rehabilitation of alcoholics. Some cities have set up detoxification centers to which alcoholics are sent instead of being arrested and some courts are sending alcoholics to treatment centers or hospitals instead of giving them jail sentences after committing alcohol-related offenses such as driving under the influence. Some large companies and industries have established special alcoholic treatment programs for their employees. 49

Half-way houses are an alternative to an institutional setting for treatment or can be used for follow-up treatment after an alcoholic leaves the institution. Half-way houses were born out of the institutional failure to cope with homelessness, social isolation, joblessness, and alcoholism. 50 They are a place for the recovering alcoholic to go to who has no other place and is not ready to return to the full mainstream of life. 51 Most half-way houses are privately owned, but some are supported by
church and civic groups. Residents contribute to the maintenance of the house and are expected to seek employment after which they are required to pay a minimal fee for room and board. The treatment offered generally consists of A.A. meetings. Half-way houses are successful in helping recovering alcoholics because one of the most important things a recovering alcoholic needs is identification with others.52

One of the most successful groups in helping alcoholics recover is Alcoholics Anonymous. This organization and its program of treatment will be discussed in the next section.
Alcoholics Anonymous

Alcoholics Anonymous, as defined by Marty Mann, founder of the National Council on Alcoholism, is:

- a loosely knit, voluntary fellowship of alcoholics (and alcoholics only) gathered together for the sole purpose of helping themselves and each other to get sober and stay sober. It is not involved in any movement to combat or restrict the use of alcohol in general and it espouses no causes, even causes designed to help alcoholics. 53

A.A. began in 1935 in Akron, Ohio when two alcoholics met and were able to offer each other support in combatting their alcoholism. Out of their experience the fellowship of A.A. was founded. 54 The A.A. preamble states "the only requirement for membership is a desire to stop drinking". There are no further limitations or restrictions on joining the program or affiliating with an A.A. group. There are no dues, fees, pledges, oaths, or minimum number of meetings to be attended. Membership is self-defined and self-maintained. 55 A.A. provides fellowship for alcoholics - an environment in which an alcoholic can feel secure and understood because the other members share his common problems. The primary purpose of A.A. is to enable its members to maintain sobriety and help others achieve this goal. A.A. is often referred to as a selfish program meaning that all activity in which the individual takes part ultimately helps his own sobriety. 56 For example, an A.A. member who brings a new person into the group will be helping that person reach sobriety and he will also be helping himself stay sober through the self-satisfaction he receives in offering help.
The A.A. program is based on the following Twelve Suggested Steps:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.57

A.A. groups have shown a marked success in dealing with alcoholics. A.A. members believe that only the alcoholic can fully communicate with another alcoholic and an empathetic bond of mutual suffering is essential for an honest understanding.58 The Big Book of Alcoholics Anonymous says that the recovered alcoholic, who is properly armed with facts about himself, can generally win the entire confidence of another alcoholic in a few hours and
that until this type of understanding is reached little or nothing can be accomplished.86

Following are some of the attributes of Alcoholics Anonymous which contribute to its success. Working with other people who have similar problems offers an opportunity to check personal feelings and opinions - it makes it more difficult to hide from the truth if others question motives and demand honest answers.80 A.A. asks abstinence from alcohol for only twenty-four hours at a time, not for a lifetime, and this short-term goal seems more attainable and not as impossible as planning a lifetime of sobriety. The new member is introduced to a series of activities and interpersonal relationships which have a great therapeutic value.81 These activities give him the opportunity to make new friendships, fill his time in meaningful ways, get involved in something outside of himself, and give him new ideas of how to cope with his problems. A.A. is a spiritual program and asks each member to believe in a power greater than himself to whom he can ask for help and strength in his fight for sobriety.

A genuine recovery from alcoholism requires changes in the alcoholic's self-concept and spiritual orientation: A.A. helps the alcoholic do this.82 The alcoholic must free himself from his arrested development by making an honest, personal inventory of himself as asked in the fourth step. This inventory requires a great deal of personal honesty but the end result is an awareness of the faults he has and the defective pattern in which his life has been revolving. When the alcoholic sees the entirety of his personality he can begin to build a new life on a more solid
foundation. A.A. provides the support an alcoholic needs to go through this painful self-awareness and growth process and continues to offer him support as he struggles to make a new life built on sobriety.
Alcoholic Rehabilitation Program at Veterans Administration Hospital
Marion, Indiana

The Alcoholic Rehabilitation Program at the Veterans Hospital in Marion is an intensive, eight-week program based on the philosophy that a man must change himself and his way of coping with life in order to combat alcoholism effectively. The program is open to any veteran who believes he is an alcoholic and wants treatment. The program is also used as an alternative by judges and courts in dealing with a veteran who has committed an alcohol related offense.

The patients are housed in one building and attend classes and groups there. The staff also have their offices in this same building. The building can house up to sixty-three patients. The staff consists of the director, two psychologists, two social workers, one medical doctor, two nurses, a chaplain, an alcoholic counselor, and nurses aids and secretaries.

The Alcoholic Rehabilitation Program (ARP) is based on group therapy. The patients are placed in the pre-program group as soon as they come to the building. The requirement for starting the program is that the patient must memorize the Twelve Steps of Alcoholics Anonymous. If he can do this he is placed in Group One on Monday - every Monday a new group starts. The group will retain the same men throughout the following seven weeks. The men are required to memorize the Twelve Steps of A.A. for three reasons: this shows the staff that the man is motivated enough to put forth an effort, it shows that the man is not too brain-damaged to profit from the program, and shows that his mind has
cleared up from his last drinking episode. The men remain in the same group throughout the program in order to allow them the opportunity to become close and feel free to talk about personal problems and feelings in their classes and discussion groups. The opportunity for close friendships to develop in the group also fosters a sense of belonging and caring that may have been lacking in the patients' lives until coming to the hospital.

The ARP is a structured program. The patients follow a schedule of classes, groups, and work assignments according to where they are in the program. It is felt that this structure will demonstrate to the patients the value of ordered living. The patients must get up at a designated time, eat on schedule, and have lights off at a designated hour. This helps them develop the habits of good health - three meals a day and enough rest - so that they will be accustomed to this upon leaving the hospital. The structure also helps the alcoholic in that before coming to the hospital, his life had no structure - he did not eat properly and neglected his health through other ways: excessive drinking, staying up late at night and sleeping late in the morning. This also caused him to get completely out of touch with the rest of the world. Following a structured routine is helpful to the alcoholic because he will be able to plan how to use his time instead of finding he has extra time with nothing to do but drink.

Another aspect of the program is educating the patient about the effects of alcohol. Many of the patients do not understand the physical addiction of alcohol nor the effects of heavy drinking on their bodies. The patients become aware, through movies, tapes,
and lectures, of the damage alcohol does to their bodies and of the progression of the disease.

An important part of the rehabilitation of the alcoholic is physical rehabilitation. Each patient is given a thorough examination and if necessary placed on a special diet. Most patients receive supplemental vitamins and some men while first adjusting to the absence of alcohol are given tranquilizers and sleeping pills. However, the men are encouraged to discontinue these medications as soon as possible. As mentioned previously, the routine of regular sleeping and eating also helps the patient gain physical well-being.

All of the patients are given a work assignment, educational or occupational therapy, or a combination. Patients work at their assignment approximately four hours every afternoon. These assignments are usually given according to interest or preference. For example, educational therapy is offered to patients who do not have a high school diploma and thus are able to work toward the GED equivalent. Some types of occupational therapy such as woodworking, leather shop, small-engine repair, etc. are offered either to help develop a hobby that would have carry over value or that would help improve skills that would be beneficial in obtaining employment upon leaving the hospital. Many of the patients are assigned to nursing service as patient aides. This is felt to be beneficial for several reasons. By working with the older patient who is in worse physical and mental condition the alcoholic patient is able to see the problems others have and is able to feel less sorry for himself and develop compassion.
for others. Nursing service helps the alcoholic patient develop interpersonal relationships, learn to feel empathy and concern, and makes him feel worthwhile and useful by caring for others. Many alcoholic patients are assigned as aides to a ward in which the patients are brain damaged due to chronic alcoholism. Seeing the eventual outcome of excessive alcohol consumption helps strengthen the alcoholic's determination to stop drinking. Regular working hours help the alcoholic patient develop or re-develop good work habits. Patients are also able to receive pay for their work according to need. If the patient has no income, no job to return to, and no place to stay upon leaving the hospital, he is eligible to receive from forty to sixty cents per hour for his work. This will give the patient approximately fifty dollars when leaving the hospital.

The philosophies, literature, and meetings of Alcoholics Anonymous are an integral part of the program. Two A.A. meetings are held in the building and attendance is mandatory. Another A.A. meeting is held in Marion and the patients are encouraged to attend but it is not required. Much A.A. literature is required reading for the patients: Alcoholics Anonymous (The Big Book), The Golden Book of Principles, and The 24 Hour Book. These readings are discussed by the men in their groups. The Twelve Steps, the spiritual awakening, principles, and slogans of A.A. are discussed and the men are encouraged to use these as tools in their recovery from alcoholism. The inventory the men are required to take is extremely important and is also part of the A.A. program—it is the subject of the fourth step. This
inventory forces the men to take an honest look at their past and enables them to see the pattern their lives have been following. From this they can see what personal changes need to be made. The patients are directed to an A.A. sponsor who will encourage them in their participation in A.A. activities. That the patients continue to be involved in A.A. activities after leaving the hospital is felt to be very important if they are to be successful in staying sober.

An extremely important part of the program is enabling the patient to obtain insight into his personality so that he can better understand himself and his problems. This is done through individual counseling, psychological testing, and group therapy. Each patient is assigned to a staff member as counselor and he will retain the same counselor throughout the program. This enables the patient to become comfortable enough with at least one member of the staff so that he has someone to talk to about personal problems. Psychological tests (specifically "SPI") are used for the benefit of both staff and patients. These tests help the staff to see what psychological problems the patient has and what areas he needs help in. The results are also revealed to the patient so that he too can become aware of his psychological problems.

Several types of group therapy and group approaches are utilized to help the patients reach a better self-understanding. The patients have classes and lectures concerning open communication, self-awareness, etc. They also are involved in a number of discussion and participation groups. Some of these include
Awareness Group, Action Group, Communication Group, Intensive
Group, Exit Planning Group. These groups are led by the
alcoholic counselor, social workers, psychologists, and nurses.
The groups concentrate on drawing the patients into discussions
of personal problems, attitudes towards coping with life,
feelings about themselves and others, and how to handle their
feelings. The group experiences enable them to become sensitive
to themselves and others. For example, topics covered in
Intensive Group include: what sort of man am I outside of the
alcohol, and what kind of picture did my parents paint to me of
myself as a child and how did it make me feel about myself. These
types of discussions do not attempt to pinpoint the cause of the
patients alcoholism but rather enable the patient to get in
touch with himself and come to know what kind of a person he is.

The patients are also helped to understand the psychological
needs of the family and are offered marital counseling if they
feel it is necessary. One marital enrichment group is held weekly
and another meets every other Saturday. Other means of involving
the family of the patient are through sending them information
about Al-Anon and inviting them to a relatives meeting that meets
monthly. Relatives are also encouraged to attend the open A.A.
meetings with the patients.

The patients meet with the entire staff three times during
the course of the program. The first staffing is the Program
Planning staff. The patient receives his work assignment at this
time and is asked to make a verbal commitment to stay for the
full program. During the third week the Progress Review staffing
is held. At this time the patient is questioned about his progress and asked what he has gained thus far from his participation in the program. The inventory is discussed and the staff questions the patient about the depth of his inventory and if it is helping him. The third staff is Graduation Staff. This occurs the day the patient leaves the program and is a formal farewell ceremony.

Vocational counseling is available for the patients through one of the psychologists. The psychologist determines which patients display a need for this when they are seen in staffing. Spiritual counseling is also available through the chaplain. Many of the patients wish to get back in touch with the church and are helped by talking with a chaplain. There is a Protestant and Catholic chaplain available to the patients.

Disciplinary measures are necessary for the patients who break rules or are caught drinking. The patient who has been drinking is set back one week in the program and is required to wear pajamas while on the building. If the patient refuses to cooperate with the staff and other patients, refuses to put forth any effort, and becomes a nuisance to all concerned, he is discharged.

Some patients come back to repeat the program and some patients leave early against medical advice. However, the success rate is considered to be 33%—one-third of the patients who complete the program will remain sober. This is a comparatively high success rate for alcoholic treatment. The other two-thirds, although they may not attain sobriety for long periods of time,
may obtain some benefit from the program that will help them lead a more productive and happier life.
Case Studies

The following are short case studies of a few of the patients I have known while working in the ARH during my social work placement. These are used only as illustrations of patients who go through the ARH and are not intended to portray the average or typical patient.

Mr. C. is a 52-year old veteran who came to the ARH for treatment after he and his wife separated. He had come to the V.A. for alcoholic treatment in 1968 but had left the hospital early when his wife sued for divorce. This is his second marriage and when he first came to the hospital he said he cared for his wife and wished to resolve their conflicts. He had lost his self-respect through drinking and felt he had to make some changes in his life. When Mr. C. began the program he was despondent and lacking in self-confidence. He seemed to be a passive person who was unable to channel his anger and aggression constructively and so turned it inward. After his second week in the program, his second wife sued for divorce. Mr. C. was quite depressed but after a while was able to accept this. After accepting the divorce he seemed to display more self-confidence and a more positive attitude. However, he seemed to feel as if he were an old man and life had passed him by. He became depressed again because of worrying about what he would do after leaving the hospital and also due to some physical problems. One week before his date of discharge a biopsy he had had taken showed positive signs of cancer. He was discharged early and transferred to the V.A.H.
in Indianapolis for an operation. Mr. J. was quite upset and frightened by this but managed to handle himself fairly well. He seemed to have gained some self-confidence and self-respect during the program and was better prepared to handle the ordeal of cancer.

Mr. K. is a veteran in his early 40's. This was his second time in the ARP. He completed the program about one year ago and came back, not because he had been drinking, but because he felt he was about to make a slip. Mr. K. is divorced from his wife and wishes to get custody of his two daughters. He is an intelligent man and entered college to study social work but dropped out because of his alcoholism. His father was a prominent man and Mr. K. grew up feeling he could not live up to the expectations of his family and the community. He and his wife had a stormy marriage—she is an alcoholic also—and have had many disagreements since their divorce concerning the children. Mr. K. feels guilty about his inability to take care of his children but recognized the importance of getting himself into a sober way of living before being able to take the responsibility of two daughters. Mr. K. has insight into his problems and is determined to remain sober and rebuild his life. He had no job to return to but went to a half-way house after leaving the hospital.

Mr. B., a 32-year old veteran, came to the ARP for the first time. He is divorced, has a ninth grade education, and works as an auto mechanic. His father has been active in A.A. for
approximately twelve years and has encouraged Mr. B. to seek treatment. Mr. B. handled his problems in an immature way. He is an only child and he felt he grew up without a lot of supervision and so went with a group of friends who were older than he. He began drinking heavily in his late teens. His father is also an alcoholic and Mr. B. felt his father was trying to force him to stop drinking. Mr. B. seemed resistive to A.A. and the treatment program because he connected these with his father and seemed to still be rebelling against his father. Because of his resistance to the treatment program it is doubtful if he gained much self-understanding. He returned to his parents' home upon leaving the hospital but had no job.

Mr. L. is a single, 41-year old veteran who served in the Navy for twenty-four years. When he began the A.R.P. he was very withdrawn and seemed wary of getting involved in his group. He gradually was able to relax and let down his defenses. He had been placed in a foster home at age four, and during the next twelve years was moved eleven times. At age sixteen he joined the Navy and spent the next twenty-four years there until he left due to his alcoholism. He had felt very hostile towards social workers because of his childhood and thus found it hard to relate to the staff of the A.R.P. Also because of the continual moves in his childhood he had been unable to develop any close interpersonal relationships. Although Mr. L. was quite withdrawn and aloof from his group and the staff, he was able to gradually open himself up and relate to his group and feel comfortable in the closeness of
their friendship. His group helped him greatly in being able to trust others enough to let down his defenses against interpersonal relationships. He has shown a marked improvement in the way he relates with other people. He plans to return to his brother's home and seek employment with the postal service.
Conclusion

Alcoholism is not only a disease but is also a social problem of great magnitude. Divorce and juvenile delinquency rates are high in families of alcoholics--these are social problems caused indirectly by alcoholism. The disease, in its progression, destroys the individual, his family, and people close to him. The alcoholic finally finds himself alone and dependent upon society because he is no longer able to care for himself.

In the past, alcoholism was regarded as untreatable and although it is considered to be a treatable disease now it is very difficult to arrest and it cannot be cured. A large part of the difficulty in arresting alcoholism lies in determining the underlying causes and conflicts within the alcoholic that led him into the disease. The symptoms may be treated but if the internal conflicts of the alcoholic are not resolved, a recovery from alcoholism is doubtful.

In order to arrest the growing rise of alcoholism the public needs to be made aware of the signs and symptoms of this disease and the eventual outcomes of heavy drinking. However, alcohol education in itself will do little towards arresting the growth of the disease. Cultural attitudes towards alcohol use and abuse will have to be changed and educational and treatment programs based on understanding and compassion will have to be utilized instead of those based on fear, guilt, and disgust. The concept of alcoholism as a disease, both mental and physical, will have to be accepted by society and the idea of it being a sign of
moral weakness and decay will have to be rejected for any true cultural attitudinal changes to come about. Many of the causes for the rise in alcoholism lie in the structure and value system of our society. Alcoholism may well be a symptom of deeper problems in our culture.
Footnotes


2. Earl Rubington, Alcohol Problems and Social Control, Merrill Social Problems Series, Charles E. Merrill Publishing Co., Columbus, Ohio, 1973, p. 11


4. Ibid., p. 7

5. Charles R. Carroll, p. 11


10. Ibid., p. 11


12. Sally L. Perry et al., p. 145-6

13. Ibid., p. 12

14. Charles R. Carroll, p. 42

15. Margaret B. Bailey, D.S.W., p. 25-27


17. Charles R. Carroll, p. 7

18. Sally L. Perry et al., p. 17
16 Charles K. Carroll, p. 43
21 Charles K. Carroll, p. 19
22 Ibid., p. 43
24 Robert T. Dorris and Doyle F. Lindley, p. 32-36
26 E.M. Jellinek, p. 36
27 Ibid., p. 37
28 Ibid., p. 37
29 Ibid., p. 36
30 Sally L. Perry et. al., p. 11
31 Margaret B. Bailey, D.S.M., p. 61
32 Ibid., p. 61
33 Living With an Alcoholic With the Help of Al-Anon, Al-Anon Family Group Headquarters, Inc., New York, 1966, p. 6
34 Ibid., p. 1
35 Ibid., p. 14
36 Robert T. Dorris and Doyle F. Lindley, p. 36
37 Vernon E. Johnson, p. 43
38 Margaret B. Bailey, D.S.M., p. 28
39 Sally L. Perry et. al., p. 7
40 Vernon E. Johnson, p. 60
41 Robert T. Dorris and Doyle F. Lindley, p. 1

Ibid., p. 54

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\(^{61}\) Robert T. Dorris and Doyle F. Lindley, p. 76

\(^{62}\) Ibid., p. 76

\(^{63}\) Ibid., p. 11
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