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Alcoholism treatment services and rehabilitation facilities available to the chemically dependent client

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Abstract

Alcoholism is recognized as one of the most devastating social and health problems facing contemporary society today (Krirnrnel, 1971). Alcoholism is also a major force which intensifies many of the other problems which face each individual and has become a target of much concentrated concern. Yet, alcoholism treatment has been the focus of few professional organizations and remains under the direction of law enforcement officials.

ALCOHOLISM TREATMENT SERVICES AND REHABILITATION FACILITIES AVAILABLE TO THE CHEMICALLY DEPENDENT CLIENT

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Chapter One

INTRODUCTION

Alcoholism is recognized as one of the most devastating social and health problems facing contemporary society today (Krimmel, 1971). Alcoholism is also a major force which intensifies many of the other problems which face each individual and has become a target of much concentrated concern. Yet, alcoholism treatment has been the focus of few professional organizations and remains under the direction of law enforcement officials.

> Almost 2 out of every 3 adult Americans--according to a recent opinion survey--know someone who "drinks too much." Over one-third of those polled said this drinker is "close to me"--either a relative or a friend--and that problem has existed for at least 10 years (Harris, 1981, p. 2).

Recently, the circumstances surrounding the alcoholic have begun to change as have the attitudes concerning alcoholism. The stigma attached to alcoholism has not been totally erased, but it has been extensively decreased. Today there is less pressure on physicians to substitute a nonstigmatized diagnosis and families have less of a need to conceal the alcoholic in their midst (Krimmel, 1971).

Society has not seen a rise in alcoholism; rather, we have experienced vast improvements in reporting such problems (Keller, 1969).

Statement of the Problem

The President's Task Force Report on drunkenness for the year 1967 established that the United States had the second highest alcoholism rate in the world (second only to France). The United States ranked eighth among industrialized countries per capita in all categories of alcohol consumption, falling to fifteenth in a group of twenty-six, 10 years later. This drop in ranking does not reflect a decrease in alcohol intake for American drinkers. Rather, it represents a more dramatic increase in alcohol consumption in other countries around the world (Kinney & Leaton, 1983).

Alcohol consumption in the United States has been on the rise since the 1960's when a 32% increase in consumption was reported. During the early 1970's there appeared to be a leveling off. Research indicated a 5% increase in a short two-year period, 1976-78. In 1978 it was estimated that the average American drinker consumed 2.6 gallons of liquor, 2.5 gallons of wine, and 26.6 gallons of beer. Since alcohol content varies in terms of 'absolute alcohol' it was determined that 39% of the alcohol came from hard liquor sources, 12% from wine, and 49% from beer (Kinney & Leaton, 1983).

When looking at the drinking population, it is estimated that two of every three American adults drink,

but 70% of the drinking population consumes only 20% of all alcohol and the remaining 30% of the population consumes 80% of all alcohol. Of that 30%, less than 7% of the total population consumes 50% of all of the alcoholic intake. That 7% of the total adult population consuming 50% of all alcohol is not necessarily the same 7% of adult partakers denoted as 'problem drinkers.' This 7% figure stems from those who admit to the presence of problems attending alcohol use (Kinney & Leaton, 1983).

New Attitudes

Alcoholism, as a major public health problem, has recently become the foundation for public concern and policy. Since 1960 alcoholism has been gaining extensive recognition by state and federal governments and has become the focus of significant parties. In 1971 the National Institute of Alcohol Abuse and Alcoholism was established to sponsor the research, training, public education, and treatment programs needed as a response to the American population's fascination with alcohol. The 1970's has seen a rapid increase in both public and private, residential and outpatient treatment programs. Federally funded community mental health centers are now required to provide alcohol services to those in need as determined by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and

Rehabilitation Act of 1970 (also known as the "Hughes Act"). Sponsored by former Iowa Senator Howard Hughes, himself a recovering alcoholic, it established a Bill of Rights for the alcoholic individual which stated that the alcoholic suffers from a disease requiring treatment. It also provides protection for the alcoholic patient from discrimination in hiring practices.

Intervention and Its Need

The use of mood altering chemicals is a matter of personal choice. When this concern becomes harmfully dependent, intervention becomes necessary. The Johnson Institute for the Study of Alcoholism in Minneapolis, Minnesota, stated that intervention must be presented in an objective, unequivocal, and nonjudgemental manner, confronting the alcoholic with the reality of his/her condition and its detrimental effects on one's family.

Intervention may also be referred to as "confrontation." Confrontation is most often used in the work place whereby the work setting is used to motivate the client to seek help to improve his or her job performance or to retain his or her employment. Through the use of "job leverage," it enables the alcoholism counselor to ensure cooperation with the employer to keep the client

motivated with the hope of retaining his or her employment. Confrontation, in this respect, may be seen as disciplinary action by one's employer.

Definition of Terms

Several terms will be used throughout this paper which require constant definitions.

Alcohol. Refers to any liquid which is derived through fermentation or distillation from organic sources and any intoxicating liquor containing the product alcohol. Alcohol will also be considered a depressant drug.

Alcoholism. Refers to a progressive, social, psychological and physiological condition in which a person becomes emotionally and physiologically addicted and dependent on alcohol.

Problem drinker. This term refers to an individual who is emotionally, although not physiologically, dependent upon alcohol.

Purpose of Study

The intent of the study was to review the current literature concerning the various treatment modalities dealing with the alcoholic. The major treatment modalities used within selected successful treatment programs will also be described, as will the treatment programs

themselves. Few of these programs are said to be totally successful with every population subgroup. However, those profiled here are among the most successful of the many programs instigated throughout the history of alcoholism treatment.

Limitations of Study

The study was limited because of the inability to determine the clientele accepted into the various programs as compared to those clientele not accepted into the programs. In addition, factors such as sex, financial income, occupational standing and length of the subjects' problems with alcohol were not taken into account.

Chapter Two

REVIEW OF THE LITERATURE

The literature and research reviewed was divided into five primary categories of alcohol treatment: 1) Detoxification, 2) Individual Behavioral Therapy, 3) Behavioral Family Therapy, 4) Drug Treatment-Lysergic Acid Diethylamide (LSD), and 5) Transactional Analysis.

Detoxification

Detoxification of the alcoholic client is the first step in any effective treatment program. Detoxification is the beginning of the end to what Pittman (1974) termed the "revolving door" syndrome. The "revolving door" syndrome refers to the hundreds of thousands of persons who have served 10-20 years of prison time through short-term sentences which have resulted from their 100-200 alcohol related arrests. "Recidivism rates clearly indicate the futility of the present system in dealing with the underlying socio-medical problems involved" (p. 8). Detoxification centers and units are based on the assumption that every community should have the capacity to treat cases of alcoholism in the acute stages in medical or paramedical facilities.

The detoxification process can be successfully completed within one to one and a half days of the initial intervention. Treatment needs must be evaluated immediately following the detoxification process to prevent complications of alcohol dependency (i.e., delirium tremens, hallucinations, etc.).

Sobel and Sobel (1978) described the use of a gas chromatography breath analyzer unit in the detoxification of patients. "A major component of this procedure concerns relating the patient's behavior with his/her actual blood alcohol content (BAC), thus allowing a rough estimate of when serious withdrawal symptoms might occur" (p. 164). This estimate is also valuable to therapists in deciding whether their client will be safe throughout the detoxification process.

Detoxification treatment programs include both inpatient and outpatient programs. The inpatient program best serves those with serious medical or emotional problems. Many alcoholism counselors feel a short "time out" period from daily life stresses and problems is an important component in treating the alcoholic client (Schuckit, 1979). The required time period for patients participating in this type of treatment program will vary with the individual client case and condition. Although the average length of stay is two to three weeks, there is

no scientific data to support this claim. Common sense will dictate that persons with severe medical or persistent organic brain syndrome or unstable life situations will require longer-term care. The most important drawback facing the inpatient treatment care program concerns the patient's treatment in an artificial environment whereas the lessons are learned but may not be readily generalized into the patient's current life situation or everyday living patterns.

The selection of a treatment program is a personal choice. Inpatient treatment programs usually cater to the wealthier clientele who are better able to cope with the loss of income on a temporary basis. Persons unable to admit themselves into an inpatient program may be better served through outpatient treatment programs and facilities. Clients opting for outpatient treatment programs must be carefully screened for serious medical problems (Feldman, Pattison & Sobel, 1975). "A prediction of the final degree of withdrawal symptomology must be achieved by correlating present symptoms with the blood alcohol level" (Schuckit, 1979, p. 61). Patients displaying severe shakes and autonomic dysfunctioning with "a rapidly decreasing blood alcohol level of approximately 100 mg %" (p. 62) may be expected to enter serious levels of withdrawal and will need immediate hospitalization. Other patients displaying

only minor tremors with a 0% blood alcohol level will be better and more appropriate candidates for outpatient treatment programs. During the detoxification process, the patient is treated in a day-hospital setting and receives medication by the hospital staff while an at-home family member or friend is provided with the medication to be dispensed to the client. Medical back-up via the telephone is provided if this should become necessary.

No specific treatment program has shown to be more effective than any other in the alcoholism field. The chosen treatment program must be a personal choice which takes into account the personal needs of the client. The client must also be aware of the risk involving "exposure to treatment center acquired infections, physical and/or emotional harm by patients or staff, loss of income or job, embarrassment, family dissolutions through the separation of time during the crisis period, etc." (Schuckit, 1979).

As said before, investigation of various treatment programs is essential if an individual is to find the program to best suit his/her needs.

Individual Behavioral Therapy

"Nonproblem drinking, once viewed as a radical departure from tradition, is now more than ever accepted by many in the alcohol field as both legitimate and

appropriate for 'some' individuals with alcohol problems" (Sobel & Sobel, 1978, p. 29).

Individual Behavioral Therapy (IBT) is the study of controlled drinking by alcoholics and problem drinkers, a concept that stands in direct opposition to the disease models of alcoholism and the philosophy of Alcoholics Anonymous.

IBT subjects are randomly selected and participate in the program on a voluntary basis. Researchers indicate that subjects successful in an IBT based project are also those individuals deemed to be capable of maintaining abstinence for extended periods of time and also those persons who would be the best candidates for any type of treatment programs. The pretreatment variable indicative of IBT success has proven to be the concept of prior hospitalization. "Subjects who have had a greater number of previous hospitalizations were less likely to successfully engage in controlled drinking" (p. 152).

Sobel and Sobel (1978) conducted a two-year research project studying the effectiveness of Individual Behavioral Therapy versus traditionally used abstinence measures.

> Based on drinking behavior and adjunctive outcome measures, it is clear that subjects who received the IBT program with a treatment goal of controlled drinking functioned significantly better throughout the two-year follow-up period than did their respective control subjects who received conventional abstinence-oriented treatment (p. 155).

Traditional behavioral approaches to the treatment of alcohol dependency have become popular and have shown to be effective due to the fact that these measures continue assessment procedures of both the program and the progress of their clientele in addition to the continued assessment of their evaluation techniques and the results collected from their program.

While Individual Behavioral Therapy is controversial, results are beginning to show its effectiveness when correctly matched and tailored to the client. With continued research and funding, IBT may prove to be an effective treatment technique for the alcohol dependent client.

Behavioral Family Therapy

Behavioral family therapy has shown to be the most effective technique in modifying alcohol consumption (Marlatt & Nathan, 1978). This new behavioral treatment program was introduced during the 1960's and when coupled with marriage counseling, significant results have been discovered. Paolino and MacCrady (1976) noted that although behavioral family therapy has been quite slow in developing the "combined treatment outcome coupled with marriage therapy in conjunction with alcoholism has shown a success rate of 70% or better" (p. 222).

Anderson (1977) outlined five major approaches to behavioral family therapy and applied them to the treatment of substance abuse. The five approaches include: 1) Psychodynamics, 2) Structural Family Therapy, 3) Communications Therapy, 4) Experiential Therapy, and 5) Behavioral Therapy. "Although these five approaches have borrowed greatly from one another to a point where there is substantial integration, there are nevertheless discrete differences which, at times, have led to conflict between them" (p. 255). A major goal of behavioral family therapy is to persuade the family to pull together to initiate the detoxification process while the patient is still hospitalized.

Psychodynamics

The Psychodynamic process begins with the construction of a personal history which will be used to uncover past actions that have inappropriately been transferred and applied to present situations. The therapist must then try and create change through insight achieved through cognitive or affective reencounters with the past. The basic tool of the Psychodynamic procedures is the genogram. The genogram is a pictorial chart of persons involved in a three generational relationship system which marks marriages, divorces, births and deaths (Guerin & Pendagast,

1976). "Once the names, ages and dates of the crucial events are filled in, other relevant facts can be added" (Kaufman & Kaufman, 1981). The genogram is used to depict such things as contacts, emotional cutoffs and toxic issues which may aid the family therapist in better understanding family functioning.

Structural Family Therapy

The second basic approach, Structural Family Therapy (SFT) refers to the "invisible set of functional demands that organizes the ways in which family members interact" (Kaufman & Kaufman, 1981, p. 260). "The goal of SFT is a more adequate family organization of achieved manipulation and rearrangement of present patterns of interactional sets" (p. 260). The family therapist functions as a boundary maker whose main task is to diffuse boundaries, opening rigid boundaries and helping to establish generational lines, particularly those separating family members.

Communications Therapy

Communications Therapy, the third approach, stems from the basis that shifting communication is an important aspect in all forms of family therapy. The goal of Communications Therapy is to correct the discrepancies in the communication process within the family structure.

This is achieved by "having messages clearly stated, by clarifying meanings and assumptions and by permitting feedback to clarify unclear messages" (Kaufman & Kaufman, 1981, p. 270). In this setting, the therapist acts as an objective observer who helps the family members learn to speak clearly and directly in a structured yet protective environment.

Experiential Therapy

The fourth approach is Experiential Therapy. According to Whitaker (1976) "most families of substance abusers are experiential in nature in that they deal with the immediate moment of experience between themselves and their families" (p. 182). In this model, the therapist is involved to the point that he/she becomes a full self-disclosing group member. The therapist is seen as a genuine person who has attained the use of common sense skills that help guide his/her fellow members in intimate conversation and whose goal is change.

Behavioral Therapy

The last major approach is Behavioral Therapy. Kaufman and Kaufman (1981) stated that much of the change achieved by successful family therapists involves the use of behavioral techniques. Stuart (1971), Malout and

Alexander (1974) are the leading proponents of a pure behavioristic approach. Their belief centers on a parent's response to a child. If a given response to the child is one that enables the child to continue an undesirable behavior, that behavior will persist and will engender itself in other aspects of the child's behavior. Wood and Schwartz (1977) suggest a modified behavioral approach in which the child is never punished since punishment may be interpreted by the child as an alternative to the desired behavior. Modified behavior occurs when a parent presents clear messages to the child with no alternatives available.

Drug Treatment-Lysergic Acid Diethlamide (LSD)

Lysergic Acid Diethlamide (LSD) in the treatment of alcoholism began in the early 1960's. Ludwig, Levine and Stark (1974) discovered hypnosis could produce states of narcotic drugs and withdrawal states resembling "the real" drug states in terms of behavioral, physiological and psychological aspects. Their observations determined that behavioral and subjective states could be reversed with the aid of hypnosis. In turn, they discovered that hypnosis could exert a "sobering up" effect to the person under the influence of alcohol. Through hypnosis, the effects of LSD could be controlled to the point that the patient did not enter into psychedelic and hallucinatory states. Ludwig,

Levine and Stark (1974) stated:

> With the opportunity for medical care, adequate nutrition, group discussion of their problems, exposure to antidrinking but emotionally supportive environment, and most important, the sudden cessation of drinking the perpetuation of sobriety for at least one month, the vicious circle of chronic alcoholism tends to be disrupted, enabling the patient to regain some self-confidence and gain social consequences of his/her drinking behavior (p. 239).

Rates of improvement or complete abstinence due to LSD treatment vary from one study to another. In 1958, Smith (1958) offered a 60% average rate of improvement over studies conducted to that point. Smith (1958) reported a 50% improvement rate while Chwelos (1959) reported that 15 of his 16 clients had improved and MacLean (1961) cited 46 of 61 improved cases.

LSD was introduced as a possible treatment for alcoholism with the hope that through hypnosis the client would better be able to confront his/her problems and with the aid of a therapist be able to prioritize and find solutions to the problems that are helping to perpetuate their drinking behaviors.

Transactional Analysis

Transactional Analysis (TA), a takeoff of the psychoanalytic model, stems from the frame of reference that postulated that alcoholism is neither a disease nor

a sin. Rather, it is a "life game" that is carried out repeatedly to advance a script that is determined by premature decisions about how to live made by the alcoholic early in their life in response to conflicting messages received from parental figures (Haykin, 1974). In order for a patient to benefit from this form of therapy, he/she needs to make a competent and informed committment to achieve a behavioral change.

According to Haykin (1974) heavy drinkers require 6-12 months of total abstinence from alcohol consumption before insight therapy is of any use. Insight therapy, in this instance, is an in-depth look into one's self while trying to learn and understand the factors that motivate them in their daily interactions. The goal of such therapy centers on the patients giving up the scripted behavior in favor of autonomous behaviors based on adult decision making while utilizing the best current information available.

Steiner (1971) described the beginnings of alcoholism as lying in the childhood condition and the child's response to these conditions. When the child responds to his/her environment in ways that make sense to him/her, he/she finds themselves in conflicts with parental expectations of what the child should be doing. To overcome these difficulties, the child adopts a lifestyle or script for himself/herself. This script is intended to counterbalance the child's

wishes and the parents' demands making the child feel better about himself/herself. For the alcoholic, Steiner (1971) determined that the lifestyle or script has been translated to mean "don't think." In order to achieve this state, the alcoholic has turned to alcohol as a means of facing the situations of his/her everyday life.

Transactional Analysis basically looks at the alcoholic as a game player who, depending on the personality type, can be placed into one of three categories or roles. According to Steiner (1971) in Games People Play, these roles include the distinctive categories ranging from an Aggressive Personality type to the Psycho-Social Self-Damager to the Tissue Self-Destructer.

The Aggressive component centers around the alcoholic who plays games with persons he/she perceives as being in the desired state of balance. This person would characteristically give off signals relaying the message of "drunk and proud of it." Persons in this category may be periodic drinkers although they tend to play persons around them as "patsies" or put them into the "persecutor" role. The alcoholic in this instance makes it a point to infuriate those around him/her until that person gives up on the situation whereby giving the alcoholic new reason and motivation to continue his/her drinking.

The Psycho-Social Self is the alcoholic most commonly termed a "lush." This role is most often played by the middle-aged homemaker, the white middle class and the aging homosexual. The sole purpose of this personality is to get those around him/her to feel sorry for the situation they have "unwillingly" been placed in. Persons in this category place those around him/her into the roles of "patsy" or "rescuer." This person must always be "saved" from the situations that they encounter in their day-to-day living.

The last type is the Tissue Self-Destructer. This person is the long-suffering alcoholic whom we view as the classic "wino." This person tries to emanate himself/herself as a sick individual who will not and can not survive without the generosity of others. This person puts those around him/her in the role of a "rescuer." This person typically lives in flophouses and survives by means of soup kitchens. This person will make no attempt to improve his/her condition, opting to spend his/her time putting his/her personal responsibility on others.

In summary, Transactional Analysis postulates that early learnings by children through their parents will dictate the way in which children cope with situations they face in their day-to-day lives. Coping measures are learned early on as is manipulation whereby the child gets

his/her parents and those around him/her to take care of the needs of the child. When the child successfully manipulates others to take care of his/her needs, the child does not learn appropriate coping measures and will focus their lives on having others fulfill their needs. Other times they will consciously ignore situations demanding their attention. The alcoholic, therefore, has found alcohol as a primary means of avoiding their situation and a reason to resist growing up.

Chapter Three

REVIEW OF THE TREATMENT FACILITIES

The treatment facilities reviewed are those available throughout the state of Iowa and those available in most major cities throughout the United States. The facilities include: 1) Fountain Lake Treatment Centers, 2) Salvation Army Social Service Centers, 3) National Council on Alcoholism, 4) Veterans Administration Hospitals, and 5) Schoitz Substance Abuse Program.

Fountain Lake Treatment Centers

Located in Albert Lea, Minnesota, Fountain Lake Treatment Centers provide full medical treatment, emotional, and mental health therapy as well as spiritual guidance to chemically dependent persons and their families. With satellite programs in Winnebago, Minnesota, Forest City, Iowa, and Eldora, Iowa, Fountain Lake Treatment Centers utilize the Alcoholics Anonymous philosophy within the treatment program. Patients entering the program are subjected to a rigorous 28-day treatment schedule.

Fountain Lake Treatment Center staff members educate patients and family members to chemical dependency as an addictive disease. The common element in this chemical dependency is the inability to cope with the demands of

daily living without the use of mind-altering drugs. This inability to cope is characterized by the loss of control in the presence of alcohol. While in the presence of alcohol, the chemically dependent person and their drinking become unpredictable.

Fountain Lake Treatment Centers hold regularly scheduled informational meetings designed to inform concerned persons on the subject of chemical dependency. These meetings help the concerned persons to better understand the problems associated with chemical abuse helping them to make the right and most appropriate decisions for themselves and their families. The Fountain Lake Treatment Center philosophy states that the chemically dependent person is suffering from a chronic, progressive, fatal, incurable but treatable disease. They stress that this disease is characterized by rigorous denial although this denial is penetrable which enables the dependent person to receive treatment.

The treatment program consists of group therapy, family groups, Alcoholics Anonymous participation, lectures and films, individual counseling and chaplain visits. Weekly orientation sessions with a family counselor and a Family Week is provided for family members where they concentrate on family relationships and learn they are not alone with the problem.

Admission requirements are open and anyone willing to work on a chemical dependency problem may be admitted 24 hours a day. Payment for such programs is made through the patient's insurance company which provides for the 28-day stay.

Salvation Army Social Service Centers

The Salvation Army Social Service Centers around the country provide inpatient treatment for the alcohol dependent client. The Salvation Army is capable of providing temporary and/or permanent shelters to those in need, daytime sheltered workshops to help the client improve himself, and halfway houses for those persons who do not have homes in which they may stay. The Salvation Army also provides information and referrals to persons who may not be in direct need of their services.

Admittance into the program requires a variable fee and is restricted to helping male clients only. Denial into the program may be instituted if the potential client presents evidence of acute intoxication, withdrawal symptoms, severe medical or psychiatric problems or when they have been previously admitted and are guilty of breaking established rules.

Once admitted, the client will receive diagnostic services and detoxification services if these appear to be

necessary. If detoxification is indicated, the staff at the Salvation Army Social Service Centers are authorized to dispense Antabuse and other medications that may be necessary. Once the detoxification process has been completed, the client will then be graduated to the individual and/or group therapy sessions where they will be able to discuss their problems with people in similar situations. Participation in the Salvation Army Social Service Center programs also includes participation in Alcoholics Anonymous meetings and help in providing general public education. After clients have gotten in touch with their chemical dependency problem(s) and begin to gain control over their own lives, they are encouraged to begin improving themselves and their marketability into the job market and society in general. Vocational and social rehabilitation is provided as is occupational and recreational therapy and a therapeutic community designed to help the individual grow.

Salvation Army Social Service Center referrals come from community agencies, the court system, prisons, persons demonstrating identifiable yet treatable handicaps, and walk-ins. Any person needing assistance will be welcomed by the Salvation Army Social Service Center staff for short-term and many times longer-term care. They will also make referrals to necessary community agencies which may be beneficial to the client.

National Council on Alcoholism

The National Council on Alcoholism is a general public education and information source. It also provides alcohol information to schools and drunken driving programs for community agencies. In addition, the National Council on Alcoholism also provides detoxification centers, aftercare, and halfway houses for clients in need of such services.

The National Council on Alcoholism provides day treatment services only and does not require variable fees for such services. There are not specific admission requirements and clients are only denied admittance if they are acutely intoxicated or are in the midst of withdrawal or have severe medical problems.

Services provided include nonmedical detoxification centers whereby clients have usually been referred through the local police departments. After the detoxification process, clients are encouraged to become involved in individual and/or group therapy sessions which progress to Alcoholics Anonymous meetings at the center and then within the community followed by an outreach program that checks on their progress. Once clients feel they have gained control of their life, they will be given educational and vocational guidance and social rehabilitation helping them to become productive members within society. After this step in the clients' life, they will be encouraged to

obtain and maintain regular employment. Support programs are provided as are cooperative industrial programs and employee programs that work with the various Alcoholism Councils in providing employment for persons with alcohol dependency problems.

Clients without shelter are provided with temporary or permanent shelters for the duration of their need. To be admitted to the halfway homes, a potential candidate must be at least 18 years of age and sober. Admittance to the residential housing units requires a 24-hour abstinence from alcohol. If clients elect to live at home, they are provided with a phone number to call if family or crisis intervention becomes necessary.

The National Council on Alcoholism provides a variety of services in their centers around the country. Many of the most popular services are provided on a regular basis with the more tailored services becoming available as the need arises. New services can also be provided if the need becomes apparent in individual cases.

Veterans Administration Hospitals

The Veterans Administration Hospitals of America are located in every major city around the country. Persons eligible for admittance must be a United States veteran requiring medical services. Veterans eligible for the

program cannot have severe medical or psychiatric problems. Admittance into the alcohol dependency program requires a primary diagnosis of alcoholism and be capable of self-care. Centers around the country may instill various specific requirements for admission to their programs.

Services available at the Veterans Administration Hospitals include both inpatient and outpatient care, detoxification centers, temporary shelter and aftercare. Services require no fee. In addition to the above mentioned services, local VA hospitals also provide a number of counseling services including individual counseling, group counseling, family therapy, occupational and recreational therapy, and Alcoholics Anonymous attendance.

Schoitz Substance Abuse Program

The Schoitz Substance Abuse Program, affiliated with Schoitz Medical Center, Waterloo, Iowa, is a satellite program of the Powell III Chemical Dependency Program based in Des Moines, Iowa. These programs provide both inpatient and outpatient treatment as well as family programs for the patients' concerned persons or persons with an alcoholic in their family although not pursuing treatment himself/herself.

The Schoitz inpatient program consists of a three to four week program based on Reality Therapy. Recovery

programs use the principles of Alcoholics Anonymous and Narcotics Anonymous. Prior to treatment incoming clients receive a medical examination and detoxification if this appears to be necessary. They proceed to counseling evaluations and group therapy sessions with other inpatients. Clients are then educated to the detriments of alcohol through the use of lectures and films. While involved in the program, clients receive both occupational and recreational therapy and are visited by the hospital chaplain on a regular basis. Clients are required to attend Alcoholics Anonymous and/or Narcotics Anonymous meetings while they are participating in the program and are encouraged to maintain their attendance at these meetings once they are released from the program.

The Schoitz Substance Abuse Program is divided into three phases. The first phase forces clients to take an honest look at their delusions and denial aspects of their chemical dependency problem. They gain an awareness of the behavioral effects their dependency problems have had on themselves and those around them. The second phase uses group therapy to help clients explore and deal with the emotional problems and conflicts within their lives. They are taught new coping strategies and techniques they can use to deal more effectively with their own feelings and new communication patterns they may institute into

their own family lives. The final phase continues with group therapy and inclusion into a continuing recovery growth group designed to help clients deal with their problems once they have left the program. Plans are also made for discharge and the clients return home. The main objective of this program is to help clients learn to handle life's problems in more constructive ways, the development of appropriate attitudes and better the relationships within the family and to remain abstinent of all mood-altering drugs and chemicals.

The Schoitz Substance Abuse outpatient program follows the construct of the inpatient program with the exception of the constant persistence and 24 hour a day support that can only be provided through the hospitalized setting. Outpatients meet three evenings a week for four-hour periods. Here, they discuss the same concerns and participation in lectures is encouraged. As in the inpatient program, participants are required to refrain from use of mood-altering drugs and to learn to cope with their problems in more constructive ways. Aside from the inpatient setting, the patient programs are equivalent.

Chapter Four

SUMMARY, DISCUSSION AND RECOMMENDATIONS

Summary and Discussion

Review of the literature and the interview research was conducted to determine the various treatment modalities in use for the treatment of alcoholism and/or alcohol abuse. In addition, a variety of treatment centers were reviewed to learn more about what is actually being done to help the alcoholic client. The study was conducted to examine present alcohol treatment methods and procedures and the various techniques incorporated into today's alcohol treatment programs. The treatment centers were reviewed to better understand what has actually been integrated and with what success.

Alcoholism has become a major problem in societies worldwide. A survey conducted for the National Institute on Alcohol Abuse and Alcoholism determined alcoholism to be rated fourth from a list of 16 personal problems facing Americans today. Only excessive smoking, overeating, and financial difficulties ranked higher. Harris (1981) found drinking problems listed more often than more common problems such as family quarrels, loneliness, and job troubles.

No statistical data was collected nor analyzed. Personal characteristics of problem drinkers were limiting factors to this study because a "classic" alcoholic cannot be found or described. With 10 million problem drinkers and alcoholics in this country, the typical alcoholic may be anyone we encounter in a normal day. Due to the expanding numbers and variety of persons characterized as problem drinkers or alcoholics, no one treatment modality may be said to be most effective.

The review of the literature, therefore, focused on five different treatment techniques (detoxification, individual behavioral therapy, behavioral family therapy, drug treatment and transactional analysis).

The literature regarding detoxification methods of alcoholism treatment confirmed the effectiveness of this method by allowing the client a short period of time in which to escape the pressures of everyday living (Schuckit, 1979). It was also determined that detoxification is the first step in any effective treatment program and allows for the screening of more severe medical problems (Feldman, Pattison & Sobel, 1975).

Individual Behavioral Therapy proved to be in the beginning stages with the effectiveness of the program yet to be determined. While still controversial, Sobel and Sobel (1978) are beginning to show its effectiveness when

matched with the appropriate clientele. Continued research and additional funding is necessary to conclude the total effectiveness of the Individual Behavioral Therapy program.

Alcoholism has proven to affect the entire family of the alcoholic in addition to the persons in constant contact with him/her. When the effects of alcohol begin to manifest itself, it is here that the family needs to begin to pull together and encourage the alcoholic patient to enter a treatment program on either an inpatient or an outpatient basis (Anderson, 1977). It is also agreed that the alcoholic family member has become a master of manipulation and has negatively rearranged the interactional patterns of the other family members (Minuchin, 1974). With the use of Communication Therapy, the family members can learn again how to communicate more effectively with the other members of the family and those affected by the alcoholic.

Drug Treatment using Lysergic Acid Diethlamide (LSD) as the primary drug in treatment methods with the alcoholic client has been under investigation since the early 1960's. Coupled with hypnosis, Ludwig, Levine and Stark (1974) have discovered a correlation between the effects of alcohol and LSD. They have proven that through hypnosis they are able to come to terms with the client and help that client to come to terms with the reasoning behind the attraction

to alcohol. Smith (1958), Chwelos (1959), and MacLean (1961) are also involved in proving the effectiveness of LSD treatment. Through the recognition of the reasons perpetuating the drinking behaviors, the therapist is able to aid the client in finding and prioritizing solutions to the problem.

Transactional Analysis (TA) postulates that alcoholism is a game in which the client makes premature decisions about life learned early on. The goal of this therapy focuses on the patient's learning new autonomous behaviors based on newfound adult decision making skills (Haykin, 1974). Transactional Analysis teaches parents that the ways in which they respond to their children will help the child learn coping skills useful for later life. Through TA the adult learns the detrimental effects their manipulation has taken on others and more fulfilling ways in which they will be recognized for their ideas (Steiner, 1971).

The treatment centers reviewed were those that were the most accessible to persons in society or those with reputations of helping the alcoholic to remain abstinent.

Fountain Lake Treatment Centers have the reputation of helping both the alcoholic and their families to better understand the problems of alcoholism and ways they can cope. Fountain Lake Treatment Centers address all aspects

of the alcoholic relationship and the members involved through medical treatment, emotional and mental therapy, as well as spiritual guidance for the alcoholic. A concerned persons program helps the family members to straighten out their thoughts and feelings and learn to live again.

The Salvation Army Social Service Centers provide inpatient care for the alcoholic. Temporary or permanent shelter is provided and daytime workshops provide help for the clients to improve themselves so that they can once again rejoin society. Males are admitted to the Salvation Army Social Service Centers where they are encouraged to take a complete look at their lives and engage in activities to better themselves on all levels.

The National Council on Alcoholism is typically used as a referral source for local police departments in states throughout the nation. Day treatment services are provided as is nonmedical detoxification processing. Anyone over the age of 18 who feels they may have a drinking problem is encouraged to participate in the group therapy sessions and individual counseling if the need is there. Clients are strongly encouraged to participate in Alcoholics Anonymous meetings in their own communities. Clients without employment are provided with vocational services intended to help them obtain and maintain productive employment. Homeless individuals are provided

with shelter as long as they meet the requirements of being 18 years of age and sober (Alcoholism Treatment Programs Directory, 1976).

The Veterans Administration Hospitals are located in every major city in the United States. Services include both inpatient and outpatient care facilities, detoxification centers, temporary shelters and aftercare services. The local VA hospitals require no fee for their services although participation in a foreign war is a requirement for services (Alcoholism Treatment Programs Directory, 1976).

The Schoitz Substance Abuse Program is designed to help the chemically dependent client obtain abstinence while also exploring the reasons for his/her addiction. Programs for families are provided so that they may receive the help they need even if the abuser refuses treatment (Schoitz Substance Abuse Family Program, 1983). Outpatients and family members are encouraged to attend Al-Anon meetings while they are participating in the program while inpatients participate in Alcoholics Anonymous meetings within the hospital setting and are encouraged to maintain their attendance when they are released. Occupational and recreational therapies are available to inpatients while they are also educated to the perils of chemical abuse.

Recommendations

Throughout the review of the treatment centers it was determined that the most effective programs included the use of Alcoholics Anonymous (Clinebell, 1968; Chaftez, 1970). Many substance abusers have attempted abstinence somewhere in their drinking career. Most, if not all, have failed. Alcoholics Anonymous encourages its members to "just try not to drink today. Take one day at a time. If you do not drink today, you cannot get drunk today" (Is A.A. For You?, 1973). According to Grayson (1951), "the individual who needs rehabilitation remains a poor prospect until he/she finally accepts his/her need for the rehabilitation procedures" (pp. 893-896). By attending Alcoholics Anonymous meetings potential clients will come to understand what their problem is doing to themselves and to those around them. They will also gain a sense of relief to learn that they are not alone in their problem-filled existence. Men and women of Alcoholics Anonymous learn to face their problems squarely while acting in good faith (Freedom From Despair, 1964).

Another important distinction included the treatment between the sexes. Although care facilities distinguish the need for separate centers for adults and adolescents, they have not, until recently, distinguished the need between men and women. Most facilities began treating the

substance abuser in much the same manner as the Veterans Administration Hospital, catering specifically to men (Alcoholism Treatment Programs Directory, 1976). New centers designed specifically for women are beginning to emerge in larger cities such as the Betty Ford Center located in Rancho Mirage, California, and the Women's Treatment Center located in Mercy Hospital in Des Moines, Iowa. Hospitals around the country are beginning to institute these programs into their curriculums. Other centers like the Schoitz Substance Abuse Center are recognizing the individual needs of men and women and treating them accordingly.

The most important point to be learned from this information is the need for the potential client to recognize his/her need for help. In order for the substance abuser to recognize his/her need for help, there are some important things that those around the chemically dependent person should not do. These include: 1) Do not treat the alcoholic like a child, 2) Do not check up to see how much the alcoholic is drinking, 3) Do not search for hidden liquor, 4) Do not dispose of his/her liquor as the alcoholic finds ways in which he/she can get more, 5) Do not nag the alcoholic about the drinking, 6) Never argue with the alcoholic when he/she is under the influence of alcohol, and

7) Do not preach, repreach, scold, or enter into quarrels with the alcoholic (So You Love An Alcoholic, 1981).

As with any major problem headway cannot be made without the person in question admitting that he/she needs help. The field of substance abuse is no different. Within the field, however, counselors have begun to recognize that persons around the alcoholic are just as sick as the alcoholic and in need of help regardless of whether the alcoholic has admitted there is a problem (Kinney & Leaton, 1983). Today, there are facilities for the chemically dependent and their families. Help is there for whomever needs it. Only the admittance to the problem and a willingness to work on that problem is necessary.

References

Adolescent substance abuse program. (1983). Waterloo, IA: Schoitz Medical Center.

Adult substance abuse program. (1983). Waterloo, IA: Schoitz Medical Center.

Alcohol, Drug Abuse and Mental Health Administration. (1981). Someone close drinks too much. Rockville, MD: Department of Health and Human Services, 2-15.

Alcoholism treatment programs directory. (1976). Information Planning Associates, Inc., 1-476.

Anderson, C. (1977). Lecture delivered at the Orange County Department of Mental Health. Orange County, CA: Oct. 6.

Bateson, G., Jackson, D. D., Haley, J. & Weakland, J. H. (1956). Towards a theory of schizophrenia. Behavioral Science, 1, 251-264.

Capps, M. J. (1982). Rediscovering values in the lives of severely alcoholic women. Counseling and Values, April, 26(3), 165-171.

Chaftez, M. E., Blane, H. T. & Hill, M. J. (1970). Frontiers of alcoholism. New York: Science House.

Chwelos, N. (1959). Use of d-lysergic acid diethlamide in the treatment of alcoholism. Quarterly Journal of Studies on Alcohol, 20, 577-590.

Clinebell, Howard J., Jr. (1968). Understanding and counseling the alcoholic. Nashville, TN: Abingdon Press.

Estes, Nada J. & Heinemann, M. Edith. (1977). Development, consequences and intervention. Alcoholism. St Louis: The C. V. Mosby Company, 81-82.

Fann, Wm. E., Karacan, Ismet, Pokorny, A. & Williams, R. L. (1980). Phenomenology and treatment of alcoholism. New York: Spectrum Publications.

Feldmann, D. J., Pattison, E. M. & Sobel, L. (1975). Outpatients detoxification: Initial findings on 564 patients. American Journal of Psychiatry, 132(4), 407-412.

Freedom from despair. (1964). New York: Al-Anon Family Group.

Grayson, M. (1951). Concepts of 'acceptance' in physical rehabilitation. Journal of American Medical Association, 145, 893-896.

Gross, D. & Capuzzi, David. (1981). The elderly alcoholic: The counselor's dilemma. Counselor Education and Supervision, March 20(3), 183-191.

Guerin, P. J. & Pendagast, E. G. (1976). Evaluation of family systems and genogram. Family Therapy. New York: Gardner Press, 450-464.

Harris, Louis. (1981). Survey. Someone close drinks too much. Rockville, MD: Institute on Alcohol Abuse and Alcoholism, 2.

Haykin, M. D. (1974). T.A. and the treatment of alcoholism. Therapeutic Approaches to Alcoholism, 303-310.

If you love an alcoholic or a drug dependent person. (1983). Eldora, IA: Eldora-Fountain Lake Treatment Center.

Is A.A. for you? (1973). New York: Alcoholics Anonymous, World Services, Inc.

Kaufman, E. & Kaufman, P. (1981). Family therapy of drug and alcohol abuse. New York: Gardner Press, Inc.

Keller, Mark. (1969). Alcoholism: Nature and the extent of the problem. The Annals of the American Academy of Political and Social Sciences, 315, 1.

Kellerman, J. L. (1980). Alcoholism: A merry-go-round named denial. Minnesota: Hazelden Foundation, 5-15.

Kellerman, J. L. (1983). Guide for the family of the alcoholic. Kemper Group, U.S.A., 1-12.

Krimmel, Herman. (1971). Alcoholism: Challenge for social work education. New York: Council on Social Work Education.

Kinney, Jean & Leaton, Gwen. (1983). Loosening the grip: A handbook of alcohol information. St. Louis: The C. V. Mosby Company.

Lowe, G. D. & Ziglin, Alan L. (1973). Social class and the treatment of alcoholic patients. Quarterly Journal of Studies on Alcohol, March-June 34, 173-184.

Ludwig, Arnold M., Levine, Jerome & Stark, Louis H. (1974). LSD and alcoholism: A clinical study of treatment efficacy. Charles C. Thomas Publishing, 47-55.

MacLean, J. R. (1961). The use of LSD-25 in the treatment of alcoholism and other psychiatric problems. Quarterly Journal of Studies on Alcohol, 22, 34-45.

Malout, R. E. & Alexander, S. F. (1974). Family crisis intervention: A model and technique of training. Therapeutic Needs of the Family. Springfield, IL: Charles C. Thomas Publishing, 47-55.

Manohar, V. (1973). Training volunteers as alcohol treatment counselors. Quarterly Journal of Studies on Alcohol. 869-877.

Marlatt, G. Alan & Nathan, Peter E. (1978). Behavioral approaches to alcoholism. New Jersey: Rutgers Center of Alcohol Studies, Publications Development.

Miederhoff, P., Ray, Scott, Brombach, C., Vogel, F. & Liston, Walter. (1981). A study of counseling students' attitudes toward drug abuse. Counseling and Values, October 26(1), 26-34.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Outpatient substance abuse program. (1983). Waterloo, IA: Schoitz Medical Center.

Paolino, T. J. & MacCrady, B. (1976). Joint admission as a treatment modality for problem drinkers: A case report. Journal of Psychiatry, 133, 22.

Pittman, D. J. (1974). The role of detoxification centers in alcoholism treatment. 20th International Institute on the Prevention and Treatment of Alcoholism. International Council on Alcohol and Addictions.

Satir, V. (1972). People making. Palo Alto, CA: Science and Behavior Books.

Schuckit, Marc A. (1979). Drug and alcohol abuse: A clinical guide to diagnosis and treatment. New York: Plenum Medical Book Company.

Smart, R. G., Storm, T., Baker, Earle F. & Solursh, W. (1967). Lysergic acid diethlamide (LSD) in the treatment of alcoholism. Canada: University of Toronto Press.

Smith, C. M. (1958). A new adjunct to the treatment of alcoholism: The hallucinogenic drugs. Quarterly Journal of Studies on Alcohol, 19, 406-417.

Sobel, M. B. & Sobel, L. C. (1978). Behavioral treatment of alcohol problems. New York: Plenum Press.

So you love an alcoholic. (1964). New York: Al-Anon Family Group.

Steiner, Claude. (1971). Games people play: The analysis of life scripts. New York: Grave Press.

Stuart, R. B. (1971). Behavioral contracting within the families of delinquents. Journal of Behavior Therapy and Experimental Psychiatry, 2, 1-11.

Substance abuse family program. (1983). Waterloo, IA: Schoitz Medical Center.

Watzlawick, P., Weakland, J. H. & Fisch, R. (1974). Change: Principles of problem formulation and problem resolution. New York: Norton Press.

Whitaker, C. (1976). A family is a four-dimensional relationship. Family Therapy. New York: Gardner Press, 182-192.

Wood, P. & Schwartz, B. (1977). How to get your children to do what you want them to do. Engle Cliffs, NJ: Prentice-Hall.