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Chemical dependency and rational-emotive therapy

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Abstract

Chemical dependency is a major health problem in the United States ranking third among major health problems and surpassed only by cancer and heart disease. The social costs associated with chemical dependency are estimated to be over $40 billion annually. These social costs are reflected by such factors as lost job productivity, the medical costs of treating alcohol and drug related illnesses and injuries, the property damages and 25,000 lives lost per year to intoxicated drivers, and the cost of administering justice to those who are arrested and convicted of chemical abuse related offenses (Zimberg, 1982).

CHEMICAL DEPENDENCY AND RATIONAL-EMOTIVE THERAPY

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Chapter One

INTRODUCTION

Chemical Dependency

Chemical dependency is a major health problem in the United States ranking third among major health problems and surpassed only by cancer and heart disease. The social costs associated with chemical dependency are estimated to be over $40 billion annually. These social costs are reflected by such factors as lost job productivity, the medical costs of treating alcohol and drug related illnesses and injuries, the property damages and 25,000 lives lost per year to intoxicated drivers, and the cost of administering justice to those who are arrested and convicted of chemical abuse related offenses (Zimberg, 1982).

The American culture has been described as a drinking culture. It is estimated that 70% of adult Americans use alcohol. Only 22% say they have never used alcohol at all. Ten percent of all drinkers, or 7% of the adult population, will become alcoholic during their lifetime. Another 15% of the general population will experience significant problems due to drinking without actually developing alcoholism (Johnson, 1980).

The World Health Organization views alcoholism as one part of the spectrum of drug dependencies. Instead of "alcoholism" they use the term "drug dependence of the

alcohol type" (Kramer & Cameron, 1975). The view of alcoholism as one type of drug dependency has lead to the currently popular term "chemical dependency."

Chemical dependency is defined as a pathological relationship between a person and the mood altering properties of alcohol and other drugs. Alcoholism is the most common form of chemical dependency (Schaefer, 1982). Chemical dependency is described as an illness that affects individuals physically, mentally, spiritually, emotionally, socially, and volitionally. It is viewed as a primary, progressive, chronic, and eventually, fatal condition. Chemical dependency affects the "whole person" (Wegscheider, 1981). It has been observed that those who use mood altering chemicals, such as marijuana, cocaine, amphetamines, and tranquilizers, experience the same symptoms and problems as those who are dependent on alcohol (Johnson, 1980).

Vernon Johnson (1980) explains the primary, progressive, chronic, and fatal nature of alcoholism and other chemical dependencies. Chemical dependency is viewed as primary since it causes other life problems, such as health problems, marriage problems, employment problems, legal problems, and financial problems. It is also viewed as primary because in most instances the resolution of secondary problems cannot be achieved until the alcohol or other drug problem is brought under control.

The chronic nature of chemical dependency is shown by the high rate of relapse experienced by chemically dependent persons following a period of sobriety. Once an individual crosses into alcoholic drinking or addictive drug use, there is no possibility of returning to normal, social drinking or drug use (Johnson, 1980). Other authors in the field dispute the chronic nature of chemical dependency. For example, G. Alan Marlatt (1983) summarizes the argument for the possibility of a return to "controlled drinking" and points out the emotional nature of the argument for alcoholism as a chronic disease. Marlatt emphasizes that the concept of alcoholism as a disease is really only a moral concept of alcoholism in disguise.

The prevailing viewpoint among chemical dependency treatment professionals is that chemical dependency is a chronic illness evidenced by relapse, or a return to active alcohol or drug use. A major focus of chemical dependency treatment is on "relapse prevention." Relapses are said to be the result of inability to manage personal and environmental variables which lead to a return to alcohol or drug use (Gorski, 1979).

Chemical dependency is viewed as a fatal disease because of its effects on life expectancy. Alcoholics die prematurely due to cirrhosis, hepatitis, pancreatitis and nutritional deficiencies. It has been estimated that anywhere from 15 to 50 percent of admissions to general

hospitals are due to the medical or surgical complications of dependence on alcohol or drugs. Chemically dependent persons are involved in a high percentage of traffic fatalities and household and vocational accidents. A significant number of suicides and murders are associated with alcoholism and other chemical dependencies (Zimberg, 1982).

Johnson (1980) explains chemical dependency as a progressive disease by describing four stages through which chemically dependent persons progress. The first stage is "Learning the Mood Swing." In this stage individuals learn that chemical use causes a pleasant experience which can be controlled by the amount of the chemical consumed.

The second stage is labeled "Seeking the Mood Swing" and is characterized by occasional, planned excessive use. During the second stage, the individual uses the chemical in appropriate ways and therefore does not experience any emotional costs.

The third stage, "Harmful Dependency," occurs when the individual begins to experience problems associated with alcohol and drug use. Johnson states that the individual experiences conflicts between values and drinking and drug use behaviors during this stage. At this stage Johnson says individuals chronically overuse defense mechanisms such as rationalization and projection in order to protect this chemical use.

The fourth stage that Johnson describes is "Drinking to Feel Normal." At this point the individual uses drugs and alcohol compulsively and all life decisions are made in order to allow the individual to continue using alcohol or other drugs.

Alcoholics and other chemically dependent persons have been described as perfectionistic, "workaholic," in need of maintaining control over their feelings and lives, and unaware of some of their most intense feelings. They are seen as dependent, lacking in self-esteem, and feeling inadequate (Zimberg, 1982). They are also described as experiencing chronic anger, resentment, fear, shame, guilt and depression (Wegscheider, 1981).

In the book Alcoholics Anonymous (1976), an alcoholic is described as a person, who, when honestly wanting to, cannot quit entirely, or when drinking, cannot control the amount consumed. It also states that "once an alcoholic, always an alcoholic" (p. 33). The alcoholic's ability to rationalize away the harmful consequences of drinking are seen as an important element of alcoholism. Alcoholics Anonymous (AA) sees daily sobriety as a necessary but insufficient goal for alcoholics. A program which emphasizes changing attitudes and behaviors is also necessary for recovery from alcoholism.

Chemical Dependency Treatment

The need for special institutions and treatment of "inebriates" has been recognized since the 1830s (Jellinek, 1960). The existence of "self-help" groups for alcoholics dates back to the 1930s (Alcoholics Anonymous, 1976).

Alcoholics Anonymous is one of the earliest and most enduring self-help program for recovery from chemical dependency. It has been called the "single most effective treatment modality for alcoholism" (Zimberg, 1982, p. 131). AA stresses abstinence from all mood altering chemicals. They also believe that recovery from alcoholism is a lifelong process and that no alcoholic can return to normal drinking. Involvement in AA consists mainly of attending meetings and working the "Twelve Steps of AA" (Zimberg, 1982).

The Twelve Steps of AA are offered as a guide for recovery. They are not required, but are suggested. The Twelve Steps are:

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, tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Alcoholics Anonymous, 1953, p. 5).

It is believed by Alcoholics Anonymous that maintaining abstinence from chemicals and following the suggested steps will lead to recovery from alcoholism (Alcoholics Anonymous, 1953).

Another approach to treating alcoholism and other forms of chemical dependency is residential or inpatient treatment. This is most often done in a hospital setting as part of a general hospital. In some cases it is part of a psychiatric unit or psychiatric hospital. In recent years freestanding, residential treatment programs have emerged. The majority of inpatient and residential programs base their treatment on a combination of AA philosophy and other general psychotherapeutic approaches. Program components usually include some combination of individual therapy, group therapy, medical care, education about chemical dependency, family therapy, occupational therapy, recreational therapy and onsite AA meetings (Zimberg, 1982).

Chemical dependency is also treated on an outpatient basis in public and private agencies. The outpatient approach usually consists of some combination of individual, group, and family therapies. The goals are to provide education, support, and the opportunity to resolve the life and relationship problems associated with chemical dependency. The specific treatment approach depends on the training background of the treatment practitioner, but nearly all chemical dependency therapists see AA involvement as essential or beneficial (Dominick, 1976).

The therapeutic approaches used by professional chemical dependency therapists vary greatly. Very few chemical dependency therapists are analytically or insight-oriented. Recent years have seen an increase in the number of treatment programs which emphasize family therapy. Behavior therapists have developed techniques which have been adopted by many treatment programs. Two cognitive approaches, Reality Therapy and Rational-Emotive Therapy have become increasingly popular (Forrest, 1983).

Summary

Chemical dependency is a major health problem in the United States. It extracts high costs from both the individual and society. The chemically dependent person may be affected in all major life areas. There are numerous treatment approaches being used in the United States. Nearly all treatment approaches incorporate the

Alcoholics Anonymous philosophy into their general psychotherapeutic approach.

Rational-Emotive Therapy

Rational-Emotive Therapy (RET) is an effective and efficient treatment for alcoholics and other chemically dependent persons. It has been implemented in several chemical dependency treatment programs and found to be very successful (Hindman, 1976). It has been asserted to be comprehensive in its approach to the treatment of alcohol and drug problems (Ellis, 1982).

Rational-Emotive Therapy was developed by Albert Ellis and first described in his book Reason and Emotion in Psychotherapy (1962). The basic idea of Rational-Emotive Therapy (RET) is that irrational ideas cause and sustain emotional disturbances. Ellis based his theory on the works of Epictetus and Marcus Aurelius, whose philosophy is that people are not upset by things, but by their thoughts about things. Ellis also cites the works of Immanuel Kant and Bertrand Russell as support for this theoretical view.

Ellis states that the central theme of RET is that humans are capable of both rational and irrational thinking. Because emotional and psychological disturbances are the result of thinking illogically or irrationally, we can minimize our unhappiness and ineffectiveness by becoming more rational in our thinking.

He states that it is the therapist's job to point out to clients their irrational thinking and to show them it is possible to learn new ways of thinking. Ellis asserts that people continually talk to themselves with internalized sentences. Positive emotions result from such internalized sentences as "This is good for me." Negative emotions such as anger or fear result from internalized sentences like "This is bad for me."

In Reason and Emotion in Psychotherapy Ellis asserts that there are 11 major irrational ideas which cause individuals to experience emotional disturbance. These ideas are:

1. It is a dire necessity for an adult human being to be loved or approved by virtually every significant other person in his community.
2. One should be thoroughly competent, adequate, and achieving in all possible respects if one is to consider oneself worthwhile.
3. Certain people are bad, wicked, or villainous and that they should be severely blamed and punished for their villainy.
4. It is awful and catastrohpic when things are not the way one would very much like them to be.
5. Human unhappiness is externally caused and that people have little or no ability to control their sorrows and disturbances.

6. If something is or may be dangerous or fearsome, one should be terribly concerned about it and should keep dwelling on the possibility of it occurring.
7. It is easier to avoid than to face certain life difficulties and self-responsibilities.
8. One should be dependent on others and need someone stronger than oneself on whom to rely.
9. One's past history is an all-important determiner of one's present behavior and that because something once strongly affected one's life, it should indefinitely have a similar effect.
10. One should become quite upset over other people's problems and disturbances.
11. There is invariably a right, precise, and perfect solution to human problems and that it is catastrophic if this perfect solution is not found.

In A New Guide to Rational Living (1975) Ellis and Harper introduce and present the process of Rational-Emotive Therapy. This method, called the ABC process, analyzes disturbing emotions and situations and corrects the irrational thoughts which cause the disturbances. In Ellis' language the A is the Activating Event, or the situation about which one is disturbed. B represents the Beliefs or thoughts about the Activating Event. C represents

the emotional Consequence or reaction to the Beliefs or thoughts about the Activating Event. It is important to emphasize that the Activating Event alone does not cause the emotional Consequence. Instead, the Beliefs about the Activating Event are what cause the emotional consequence. Ellis and Harper add steps D and E to the process. Step D is simply disputing the irrational beliefs with more rational beliefs and thoughts. Step E, the result of step D, is a new, more effective behavioral effect.

In A New Guide to Rational Living Ellis and Harper reformulate the basic irrational beliefs and eliminate what had been irrational belief number 10, the idea that one should become quite upset over other people's problems and disturbances. The bulk of the book describes specific methods of disputing the remaining 10 irrational beliefs.

Wessler and Wessler (1980) expand on the work of Ellis. They amplify the ABC process into what they describe as the "emotional episode." They more clearly delineate the practice of RET, going into detail about the structure and goals of RET in individual and group sessions.

Wessler and Wessler refine the idea of irrational beliefs. They state "irrational beliefs are composed of at least two of the following three components: awfulizing, demandingness, and evaluation of self and others" (1980, p. 40). They define awfulizing as believing something is 100% terrible, horrible and catastrophic. This is viewed

as irrational because, although something may be bad, there is always something worse that could happen. Demandingness is defined as "believing certain things must or must not happen; believing that certain conditions, such as success and approval are necessary" (1980, p. 42). Demanding statements often contain words or phrases like should, must, ought, or have to. Evaluation of self or others is seen as irrational because it involves rating the total value of a person, in such statements as "He's no good." It is seen as overgeneralization.

Wessler and Wessler state the goals of RET are emotional change and acquiring methods of maintaining that change. In order to accomplish these goals it is necessary to bring about attitudinal change. Wessler and Wessler assert that it is a mistake for Rational-Emotive Therapists to focus on behavioral change. They state that it is the therapist's primary responsibility to identify and point out the irrational beliefs which lead to a client's emotional disturbances.

Zwemer and Deffenbacher (1984) further discuss the need for therapists to identify the irrational beliefs of clients. They stress the need to identify irrational beliefs in order to specifically target interventions. They suggest empirically identifying the irrational beliefs of a targeted population which share a common problem. Such information about targeted groups "would be

particularly useful in the development of group programs in which individual assessment may not be readily attainable; intervention could be directed toward altering those beliefs that had been shown empirically to have the strongest link to the problem" (1984, p. 391). Zwemer and Deffenbacher successfully demonstrate how group interventions may be used with populations with the specific problems of anxiety and anger.

Summary

Rational-Emotive Therapy (RET) is a therapeutic approach developed by Albert Ellis. It focuses on alleviating emotional disturbances by changing irrational beliefs and attitudes. RET stresses the need to identify and dispute irrational beliefs. It has been found to be useful in working with the population of chemically dependent persons. It has been shown that identification of the irrational beliefs of target populations can improve the effectiveness and efficiency of intervening with RET.

Statement of the Problem

Treatment approaches using cognitive interventions usually do not consider the special characteristics of the chemically dependent population. Concommittantly, it is most important that treatment approaches consider these special characteristics in order to be efficient and effective. The purpose of the study, therefore, is to ascertain if a characteristic Irrational Beliefs profile

can be obtained for chemically dependent persons in order to better treat chemical dependency with Rational-Emotive Therapy.

Assumptions

It will be assumed that chemical dependency is a treatable disease. It is also assumed that chemically dependent persons must do more than change their relationship with the chemical in order to fully recover from the effects of their illness. It is further assumed that Rational-Emotive Therapy is a viable approach for treating chemical dependency. It is also assumed that Rational-Emotive Therapy is an effective method of changing Irrational Beliefs.

Limitations

One limitation is that definitions of chemical dependency vary greatly and depend mostly upon the clinical experiences of treatment practitioners. It is possible that various definitions of chemical dependency would be either too inclusive or too exclusive.

Another limitation is that subjects may have difficulty comprehending the surveys because of impaired mental functioning caused by chronic chemical abuse. Because of the difficulty in obtaining a large number of subjects it is not possible to adequately compare chemical use patterns with Irrational Beliefs profiles.

Definitions of Terms

For the purposes of this paper, the following definitions apply.

Chemical dependency refers to a pathological relationship between a person and the mood altering properties of alcohol and other drugs. Chemical dependency is a term which includes alcohol and other drug dependencies (Schaefer, 1982).

Alcoholism is a primary, progressive, chronic, and fatal disease. It is characterized by increased tolerance for alcohol and loss of control of the consumption of alcohol. It includes physical, mental, psychological, and spiritual deterioration (Johnson, 1980). It is the most common form of chemical dependency.

An Alcoholic is someone whose use of alcohol causes a continuing and growing problem in any life area (Mann, 1958).

Rational-Emotive Therapy (RET) is a cognitive approach which emphasized intervening in the client's belief system in order to affect change in emotions and behavior.

Irrational Beliefs are defined as beliefs which block, inhibit, or work against individual survival and happiness (Ellis & Harper, 1975).

Rational Beliefs are defined as beliefs which promote individual survival and happiness (Ellis & Harper, 1975).

Summary of Chapter One

Chemical dependency is a major problem in the United States and for the millions of individuals afflicted with it. All major life areas of chemically dependent persons are affected and intervention is necessary for individual survival and happiness.

Chemical dependency treatment is done in various settings. A wide variety of therapeutic approaches are employed, including Rational-Emotive Therapy. Rational-Emotive Therapy has been effectively used in the treatment of chemical dependency.

Rational-Emotive Therapy is a cognitive intervention which emphasizes changing irrational beliefs in order for individuals to become happier and more effective in their lives. Effective and efficient intervention is dependent upon identifying irrational beliefs. Interventions with the chemically dependent population will be more effective and efficient if the irrational beliefs common to chemical dependency can be determined. The problem this study addresses, therefore, is obtaining a profile of irrational beliefs for chemically dependent persons.

Chapter Two

REVIEW OF RELATED LITERATURE

Articles which attempt to apply Rational-Emotive Therapy (RET) to alcoholism and chemical dependency are scarce. Veronica Snyder (1975) writes that cognitive treatment approaches are seen as appropriate for the treatment of alcoholism. She emphasizes that any cognitive approach must stress that the client assume responsibility for his thinking, motives, and behavior (especially drinking behaviors).

Margaret Hindman (1976) notes that RET is being used in some treatment centers across the country. She states that RET can be used to change the irrational attitudes that precipitate drinking episodes. She indicates that it is also helpful in combating the poor self-concepts of alcoholics by teaching them to rate their behaviors instead of themselves. Hindman reviews several treatment approaches which utilize RET in working toward the goals of abstinence or controlled drinking. One program which combines RET with Alcoholics Anonymous (AA) believes "irrational thinking leads to irrational drinking" (p. 16). The same treatment program believes that many people use emotional hangups as an excuse for drinking and that RET can minimize the occurrence of those emotions.

Hindman also reports on the work of Maxie Maultsby, Jr. who presents an adaptation of RET called Rational

Behavior Therapy (RBT). Maultsby believes that social drinking is theoretically a learnable skill but that in practice abstinence is the most practical goal.

Maultsby and Knipping (1977) write about using Rational Self-Counseling as a method of preventing alcohol abuse. Rational Self-Counseling (RSC) is another adaptation of RET. It emphasizes teaching oneself to increase skill in reasoning. RSC is based on five rules for rational thought which are reflected in these questions:

1. Is my thinking based on facts or feelings?
2. Will this activity protect my life?
3. Will I feel good about this after I've done it?
4. Will significant others feel good about what I've done?
5. Will doing this get me what I really want?

Ellis (1982) describes the application of RET to the treatment of alcohol and drug abuse. Ellis writes that people make themselves addicted to alcohol and can therefore make themselves unaddicted. He further states that if alcoholics change the beliefs which cause them to be emotionally upset, they will change their use of alcohol. Ellis lists many of the techniques he uses to dispute irrational beliefs. Ellis asserts that the Rational-Emotive approaches which are successful in treating all disturbed persons are equally effective and appropriate with addicts.

Criddle (1977) presents a brief explanation of the application of the ABC process of RET to alcoholism. Unlike Ellis, Criddle assumes alcoholism is a primary, biological disease which results in "many problems that appear as emotional problems rather than what they actually are, the products of a mind made toxic by alcohol addiction and consumption." He states that many recovering alcoholics maintain irrational ideas about alcoholism and themselves. His writing focuses on identifying the typical irrational ideas alcoholics have about alcoholism.

Hafner (1981) writes about the ABC process and how substance abusers may resort to alcohol or drug use in order to change disturbed feelings. He also describes how the ABC process may be applied to the first two steps of Alcoholics Anonymous. Hafner states that failure to accept powerlessness over alcohol and the unmanageability of life reflects demand to control. Hafner states that using peers to identify and modify irrational thinking is a way of putting into practice the belief that a power greater than oneself can restore sanity.

Summary

The literature reviewed shows that RET has been used in chemical dependency treatment programs. RET and adaptations of it have been used to change self-concepts, minimized the occurrence of disturbing emotions, teach rational thinking, and dispute the irrational beliefs

presented by chemically dependent clients. An attempt to relate RET to AA has also been made. All of these approaches would benefit from the identification of the irrational beliefs of the chemically dependent population in order to more effectively and efficiently treat chemical dependency with RET.

Chapter Three

METHODS

As previously stated, the goal of this study is to determine if a characteristic irrational beliefs profile exists for chemically dependent persons. In order to make this determination the following methods are utilized.

Subjects. The 50 subjects described in this study are patients in three inpatient substance abuse treatment units in the state of Iowa. Thirty subjects are from the Alcohol and Drug Treatment Unit of a state funded Mental Health Institute. The other twenty subjects are from the substance abuse treatment units of two private hospitals. Participation was voluntary and confidentiality was assured as no data was collected which could identify individual participants. Subjects are selected and included based on meeting the criteria for chemical dependency as specified by the Michigan Alcoholism Screening Test (MAST). All subjects surveyed meet the MAST criteria, thus no subjects are excluded.

Instruments. The subjects were administered two instruments in a group setting. The instruments administered were the 25-item Michigan Alcoholism Screening Test (MAST) and the 100-item Irrational Beliefs Test (IBT). The MAST was developed by Melvin Selzer (1977) as a method of diagnosing alcoholism by identifying drinking related consequences. It consists of true-false statements that

concern medical, legal, and psychosocial problems, control of intake, and involvement with helping agents regarding excessive drinking. A total score on the MAST of 5 or more is diagnostic of alcoholism. The MAST was originally developed as an interview instrument but the reliability and validity of the MAST as a self-administered questionnaire has been established (Selzer, Vinokur, & van Rooijen, 1975).

The Irrational Beliefs Test, the IBT, (Jones, 1968) is based on a factor analysis of Ellis' (1962) system of irrational beliefs. Jones found the IBT validity, test-retest reliability and the construct validity coefficients for the IBT to be very high. The IBT is also the most common research instrument used to examine irrational beliefs (Zwemer & Deffenbacher, 1984). The IBT consists of 10 subscales which correspond to the 10 irrational beliefs described by Ellis and Harper (1975). The subscales are as follows.

1. It is a dire necessity to be loved or approved of by virtually every significant other. This is stated as demand for approval.
2. One should be thoroughly competent, adequate, and achieving in all possible respects if one is to consider oneself worthwhile. This is stated as high self-expectations.

3. Certain people are bad, wicked, or villainous and should be severely blamed and punished for their villainy. This is stated as blame proneness.
4. It is awful and catastrophic when things are not the way one would very much like them to be. This is low frustration tolerance.
5. Human unhappiness is externally caused and that people have little or no ability to control their sorrows and disturbances. This is emotional irresponsibility.
6. If something is or may be dangerous or fearsome, one should be terribly concerned about it and should keep dwelling on the possibility of it occurring. This is anxious overconcern.
7. It is easier to avoid than to face certain life difficulties and self-responsibilities. This is problem avoidance.
8. One should be dependent on others and need someone stronger than oneself on whom to rely. This reflects dependency.
9. One's past history is an all-important determiner of one's present behavior and that because something once strongly affected one's life, it should indefinitely have a similar effect. This is hopelessness for change.

10. There is invariably a right, precise, and perfect solution to human problems and it is catastrophic if this perfect solution is not found. This is perfectionism.

Demographic data were gathered in order to more fully describe the subjects. The subjects' sex, age, primary drug of choice, and number of previous hospitalizations for substance abuse treatment were obtained before the subjects completed the MAST and the IBT.

Chapter Four

RESULTS

Subsequent to the administration of the IBT, MAST, and the demographic questionnaire, responses were tabulated and the following descriptive statistics were obtained.

Demographic Data

Examination of the demographic data provided by respondents reveals the following information. There were 35 males and 15 females. The subjects ranged in age from 15 to 74 years of age with an average age of 32.1 years. Forty-one subjects indicated their primary drug of choice was alcohol; six indicated marijuana as their drug of choice; one each listed cocaine, amphetamines, and unspecified prescription drugs as the drug of choice. Twenty of the subjects indicated they had previously received inpatient substance abuse treatment. One subject had been treated eight times previously, but the mean number of previous treatments was 2.15.

MAST

The mean score for the MAST was 33.18. The scores ranged from a low of 16 to a high of 84.

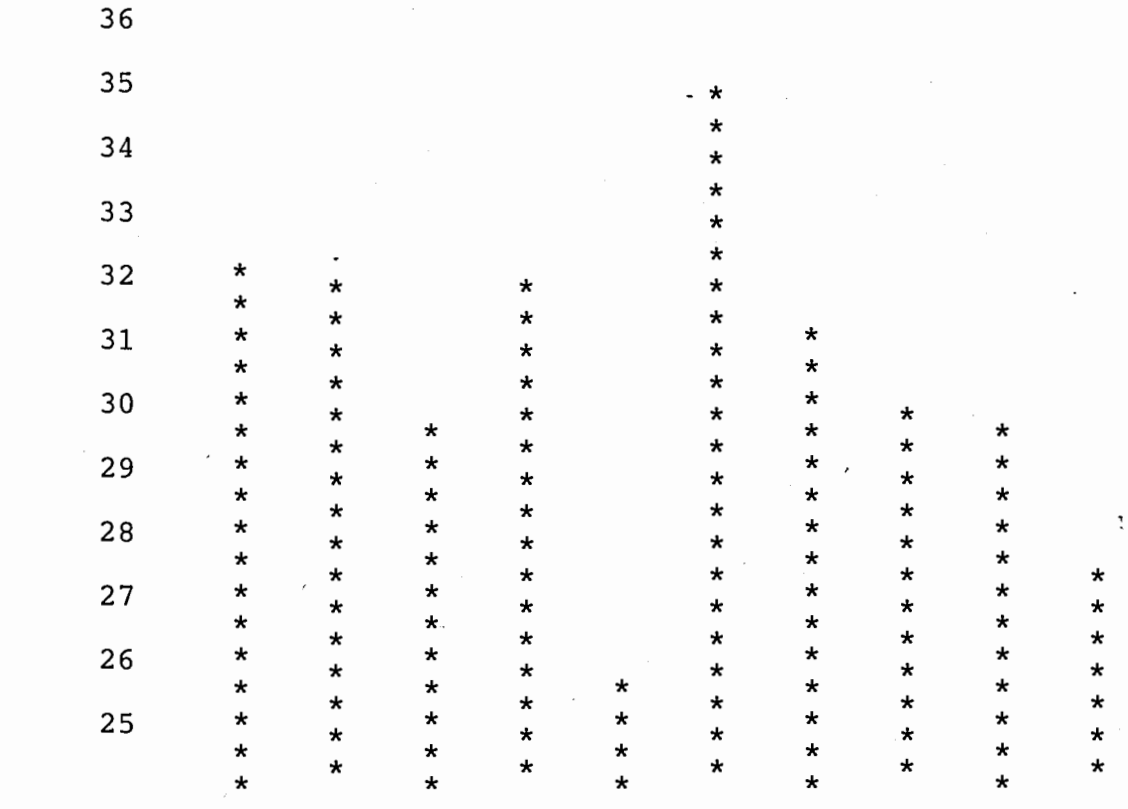
IBT

Table 1 following shows the mean scores for the IBT. Scores of subscales 6 were the highest (35.24), indicating a high degree of overanxious concern. Subscale 4 was the second highest (32.32), demonstrating low frustration

tolerance. The scores of subscale 1 were the third highest (32.04), indicating demand for approval from others. Subscale 2 was fourth highest (31.88), showing extremely high self-expectations. Subscale 7 was fifth highest (30.98), reflecting the belief that it is easier to avoid problems than to face them. A score above 30 is considered indicative of markedly elevated irrational beliefs. The two subscales with the lowest mean scores were number 5 (25.64) and number 10 (27.24). Subscale 5 measures emotional irresponsibility. This score indicates a tendency to reject the idea that emotions are externally caused. Subscale 10 measures perfectionism and the low mean score indicates the respondents did not endorse the idea that there is one best solution to problems.

Table 1

Means for Subscales of the Irrational Beliefs Test



Chapter Five

DISCUSSION

Data Evaluation

The results of the MAST indicate the subjects are clearly alcoholic or chemically dependent. Scores of five or higher are considered to be indicative of chemical dependency and all subjects scored above sixteen. The high MAST scores displayed by the study's subjects reflect numerous alcohol and drug related problems, including legal, health, family, and vocational problems.

The elevated Irrational Beliefs Test (IBT) mean scores suggest that alcohol and drug dependent persons tend to dwell on negatives, have little tolerance for frustration, demand approval from others, have inordinately high self-expectations, and believe it is easier to avoid difficult problems than to face them. This description of the irrational beliefs profile of chemically dependent persons is not surprising.

The elevation of subscale 6 described chemically dependent persons as worriers who are overly concerned with possible negative outcomes of their behavior. Results indicate that chemically dependent persons may frequently focus on future "what ifs." Johnson (1980) asserts that chemically dependent persons seek treatment only when faced with a threat or when fearing some negative consequence of their drinking or drug use. Therefore, the subjects in

this study may have been responding to the survey with very legitimate fears in mind. Other writers do describe alcoholics as having vague, undefined fears, especially in the later stages of addiction (Wegscheider, 1981). This subscale also suggests that chemically dependent persons fear taking risks and may, therefore, avoid attempting new behaviors. Such a belief could inhibit therapeutic change.

The high score obtained in subscale 4 indicates low tolerance for frustration. This is the idea that it is awful and catastrophic when things are not the way one wants them to be. This irrational belief is the opposite of acceptance. Many treatment programs stress the importance of "accepting things as they are" (Zimberg, 1982). Alcoholics Anonymous (1976) goes so far as to forward the idea that "acceptance is the answer to all of my problems" (p. 349). Chemical dependency treatment programs, therefore, teach the concept of "unmanageability" to dispute this irrational belief. Unmanageability refers to the idea that one should accept those things one has no control over, such as other people, the past and the future, and elements of nature (Johnson, 1980).

The elevated scores in subscale 1 reflect the demand for approval or the idea that it is a dire necessity to be loved or approved of by virtually every significant other. This irrational belief is often manifested in chemically dependent persons by an inability to express anger or

disapproval directly, openly, and appropriately for fear that the approval of others will be lost. The resulting pattern is that negative feelings are repressed when sober and aggressive, angry feelings emerge when intoxicated (Wegscheider, 1981). Persons who strongly endorse this irrational belief may often use alcohol as a way to express feelings which they otherwise find too risky to express.

The elevation of scores in subscale 2 reflect high self-expectations and the idea that one must be thoroughly competent in all areas in order to be considered worthwhile. This irrational belief depicts a tendency to negatively self-evaluate in an overgeneralized way. Chemically dependent persons frequently act in ways that conflict with their own values while intoxicated. They consequently label themselves as "no damn good" or "rotten." This often leads to feelings of hopelessness and suicidal ideations (Johnson, 1980). The endorsement of this irrational belief may result in the radical vacillation between inferiority and grandiosity that many chemically dependent persons experience (Forrest, 1983). Both inferiority and grandiosity are the result of the chemically dependent persons irrationally evaluating their entire worth instead of evaluating specific behaviors.

Identification of this pattern of irrational beliefs in chemically dependent persons provides the basis for the development of an effective and efficient model for

treatment using Rational-Emotive Therapy. The identification of irrational beliefs is a critical step in the use of RET. Applying the ABC process to the irrational beliefs pattern displayed by chemically dependent persons would lead to more rational thinking and thereby facilitate the maintenance of sobriety and the development of a more effective lifestyle.

Implications for Treatment

Vernon Johnson (1980) asserts that group treatment is essential in working with chemically dependent persons. He indicates that group work is most effective because of the group's power to confront the manipulation and defensiveness of chemically dependent persons and because it allows persons to transfer their dependency on chemicals to supportive peers. Zimberg (1982) states that group treatment of chemically dependent persons is the most widely practiced form of treatment. He also believes it to be the most effective and efficient method of treatment for chemically dependent persons.

Ellis (1977) states that RET makes considerable use of groups to effect a change to more rational thinking. He described group RET as being effective because several members of a group may be more effective in confronting irrational beliefs than a single therapist. Another advantage is that group members will see they are not alone in being troubled. Group members also get feedback

from other group members about their beliefs. They also have the benefit of seeing others progress and thereby obtain hope for change.

Wessler and Wessler offer support for the idea of using RET in groups. They point out that group work is cost efficient, that some activities can only be done in groups, and that most living problems involve other people and a group is, therefore, an ideal place to work on such problems. Wessler and Wessler state that it is the therapist's primary responbibility to focus on changing beliefs. Although a number of approaches may be used, it is suggested that RET groups employ as a major strategy the use of the ABC process (Wessler and Wessler, 1980).

In RET groups it is important to orient the members about basic RET philosophy. This includes the view that human disturbance is caused by irrational thinking. The therapist explains the common elements of irrational beliefs, demandingness, awfulizing, and evaluation of self or others. The ABC model is then explained so group members can begin to identify and discriminate between Activating Events (A's), Beliefs (B's), and Emotional and Behavioral Consequences (C's).

When the group has been oriented to the general use of the ABC process, group members can be taught to dispute irrational beliefs. Disputing is generally done by asking questions such as "Who says it must be that way?" or

"Where's the evidence to support that belief?" Another important part of the disputing step (D) of the ABC process is to replace the irrational belief with a more rational belief.

As Zwemer and Deffenbacher (1984) assert, knowing the pattern of beliefs associated with a particular problem allows RET group intervention to be directed toward changing those beliefs empirically linked to the problem. The common elevated irrational beliefs found in this study of chemically dependent persons are as follows. Overanxious concern is the most elevated irrational belief. It reflects awfulizing about possible occurrences and negative evaluation of self in the implied expectation that if something awful happens, I will not be able to handle it.

The second most elevated irrational belief among the subjects is low tolerance for frustration. This belief has an element of awfulizing and demandingness. "I must have it easy and it is awful if I don't."

The third most irrational belief of the chemically dependent persons in this study is the demand for approval. This irrational belief also reflects demandingness and awfulizing. "Everyone must love me and it is awful if they don't."

The fourth most irrational belief among this population of chemically dependent persons reflects extremely high self-expectations. This reflects

demandingness and evaluation of self. "I must be totally competent to be worthwhile."

The fifth most irrational belief reflects problem avoidance. This belief contains demandingness and awfulizing. "My life must be easy and it is awful if it isn't easy."

By breaking the above stated irrational beliefs into their components of demandingness, awfulizing, and evaluation of self and others, the disputing of the irrational beliefs is simplified. It is possible to substitute more rational beliefs for those highly elevated irrational beliefs by disputing the component parts of the general irrational beliefs of chemically dependent persons.

An additional advantageous method is to use AA terminology to dispute the irrational beliefs of chemically dependent persons. This has the advantage of using simple, easy to remember slogans and phrases that are a part of the AA program, and, these phrases and slogans will be continually reinforced as long as the person continues involvement in AA.

Zimberg (1982) has listed many of the key phrases and slogans used in AA. They include:

1. Live and let live;
2. Do first things first;
3. Easy does it;
4. Suspend judgement of yourself and others;

5. Accept responsibility for your actions;
6. Let go and let God;
7. Take one day at a time; and
8. Accept life as it is.

While Alcoholics Anonymous is sometimes criticized for simplistic attitudes, it appears many of the slogans and phrases used are effective disputing statements. AA disputes awfulizing with "one day at a time" which addresses the fact that many "awful" future possibilities never occur if one simply focuses on today or on the small steps necessary to achieve large goals. "Easy does it" reminds chemically dependent persons to slow down, step back, and realistically look at situations. "Let go and let God" means to have faith that situations will not turn out as badly as awfulizers fear. The reminder to "do first things first" helps put situations into a manageable perspective.

Demandingness is disputed with the AA slogan "Live and let live." This is a clear reminder to allow others to be as they are instead of demanding they conform to our own expectations and shoulds. "Easy does it" also encourages chemically dependent persons not to be so demanding. "Let go and let God" reflects acceptance of things as they are instead of demanding that they be the way one wants them to be. In the book Alcoholics Anonymous (1976),

demandingness is disputed with the statement "acceptance is the answer for all of my problems."

Negative evaluation of self or others is disputed by the slogan "live and let live" which encourages persons to be accepting of others' differing attitudes and behaviors. "Easy does it" can be interpreted as encouraging chemically dependent persons to be less judgemental. Again, the emphasis on acceptance disputes the tendency to judge oneself or others.

By applying these simple slogans to dispute the identified irrational beliefs of chemically dependent persons, Rational-Emotive therapists will utilize language congruent with the AA approach while effectively intervening with the ABC model of RET in group treatment.

Chapter Six

SUMMARY

Chemical dependency is a major health problem in the United States. It causes damage to dependent persons and to all of society. Social costs related to chemical dependency are $40 billion annually. Individuals' behaviors, attitudes, and feelings are adversely affected by chemical dependency.

Various methods of treatment have been used in working with chemically dependent persons. Alcoholics Anonymous is recognized as the most successful approach. Many treatment programs and agencies are successful in using a combination of AA and general psychotherapeutic approaches. One increasingly popular treatment approach is Rational-Emotive Therapy.

Rational-Emotive Therapy (RET), developed by Albert Ellis, is effective with a wide variety of human disturbances and has been described as effective with the specific problem of chemical dependency. The basic premise of RET is that emotional disturbances are caused by irrational thinking. RET therefore asserts that people can become happier and more effective human beings by becoming more rational thinkers. A method central to changing irrational thinking is the ABC process which enables individuals to identify specific beliefs and to dispute them.

It has been shown that identification of a pattern of irrational beliefs associated with a specific problem area, such as anger, can lead to more effective and efficient group interventions using RET. Thus, the goal of this study was to specify an irrational beliefs profile for chemically dependent persons.

In order to accomplish the goal of this study, the Michigan Alcoholism Screening Test (MAST) and the Irrational Beliefs Test (IBT) were administered to 50 individuals who were inpatients at three substance abuse treatment programs in Iowa. The results showed the subjects in this study to have a high degree of overanxious concern, low tolerance for frustration, demand for approval, high self-expectations, and a tendency to avoid problems.

The application of RET to group treatment of chemically dependent persons was discussed. The emphasis of this discussion was on using the ABC process to teach chemically dependent persons to dispute irrational beliefs. The use of AA slogans and phrases to dispute irrational beliefs was discussed. This approach appears to facilitate the use of RET with AA based chemical dependency treatment.

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Appendix

You have been asked to participate in a survey. Your participation is voluntary. All information you provide is confidential. No one who reviews your responses to the surveys will know your identity. Your participation or refusal to participate will in no way affect your treatment. There are no right or wrong answers to these surveys. Please answer as honestly as possible. Thank you for your cooperation.

Please answer the following questions before beginning the survey:

SEX: MALE_____ FEMALE_____

AGE: _____

YOUR PRIMARY DRUG OF CHOICE IS (Choose one):

ALCOHOL: _____

MARIJUANA: _____

COCAINE: _____

SPEED: _____

OTHER: _____

HAVE YOU EVER HAD INPATIENT SUBSTANCE ABUSE TREATMENT BEFORE THIS HOSPITALIZATION? _____

IF YES, HOW MANY TIMES? _____

Appendix Continued

INSTRUCTIONS:

This is an inventory of the way you believe and feel about various things. There are a number of statements with which you will tend to agree or disagree. There are 5 possible answers to each item. For each statement, you should circle the number which corresponds to your own reaction to the item.

Circle #1 if you STRONGLY DISAGREE
Circle #2 if you MODERATELY DISAGREE
Circle #3 if you NEITHER AGREE NOR DISAGREE
Circle #4 if you MODERATELY AGREE
Circle #5 if you STRONGLY AGREE

It is not necessary to think over any item very long. Circle your answer quickly and go on to the next statement.

Be sure to mark how you actually feel about the statement, not how you think you should feel.

Try to avoid the neutral of "3" response as much as possible. Select this answer only if you really cannot decide whether you tend to agree or disagree with a statement.

1 2 3 4 5 (1) It is important to me that others approve of me.

1 2 3 4 5 (2) I hate to fail at anything.

1 2 3 4 5 (3) People who do wrong deserve what they get.

1 2 3 4 5 (4) I usually accept what happens philosophically.

1 2 3 4 5 (5) If any person wants to, he can be happy under almost any circumstances.

1 2 3 4 5 (6) I have a fear of some things that often bother me.

1 2 3 4 5 (7) I usually put off important decisions.

1 2 3 4 5 (8) Everyone needs someone he can depend on for help and advice.

Appendix Continued

1 2 3 4 5 (9) "A Zebra cannot change his stripes."

1 2 3 4 5 (10) There is a right way to do everything.

1 2 3 4 5 (11) I like the respect of others, but I don't have to have it.

1 2 3 4 5 (12) I avoid things I cannot do well.

1 2 3 4 5 (13) Too many evil persons escape the punishment they deserve.

1 2 3 4 5 (14) Frustrations don't upset me.

1 2 3 4 5 (15) People are disturbed not by situations but by the view they take of them.

1 2 3 4 5 (16) I feel little anxiety over unexpected dangers or future events.

1 2 3 4 5 (17) I try to go ahead and get irksome tasks behind me when they come up.

1 2 3 4 5 (18) I try to consult an authority on important decisions.

1 2 3 4 5 (19) It is impossible to overcome influences of the past.

1 2 3 4 5 (20) There is no perfect solution to anything.

1 2 3 4 5 (21) I want everyone to like me.

1 2 3 4 5 (22) I don't mind competing in activities where others are better than I.

1 2 3 4 5 (23) Those who do wrong deserve to be blamed.

1 2 3 4 5 (24) Things should be different from the way they are.

1 2 3 4 5 (25) I cause my own moods.

1 2 3 4 5 (26) I often can't get my mind off some concern.

1 2 3 4 5 (27) I avoid facing my problems.

1 2 3 4 5 (28) People need a source of strength outside themselves.

Appendix Continued

1 2 3 4 5 (29) Just because something once strongly affected your life doesn't mean it need do so in the future.

1 2 3 4 5 (30) There is seldom an easy way out of life's difficulties.

1 2 3 4 5 (31) I can like myself even when many others don't.

1 2 3 4 5 (32) I like to succeed at something but I don't feel I have to.

1 2 3 4 5 (33) Immorality should be strongly punished.

1 2 3 4 5 (34) I often get disturbed over situations I don't like.

1 2 3 4 5 (35) People who are miserable have usually made themselves that way.

1 2 3 4 5 (36) If I can't keep something from happening, I don't worry about it.

1 2 3 4 5 (37) I usually make decisions as promptly as I can.

1 2 3 4 5 (38) There are certain people that I depend on greatly.

1 2 3 4 5 (39) People overvalue the influence of the past.

1 2 3 4 5 (40) Some problems will always be with us.

1 2 3 4 5 (41) If others dislike me, that's their problem, not mine.

1 2 3 4 5 (42) It is highly important to me to be successful in everything I do.

1 2 3 4 5 (43) I seldom blame people for their wrongdoings.

1 2 3 4 5 (44) I usually accept things the way they are, even if I don't like them.

1 2 3 4 5 (45) A person won't stay angry or blue long unless he keeps himself that way.

Appendix Continued

1 2 3 4 5 (46) I can't stand to take chances.

1 2 3 4 5 (47) Life is too short to spend it doing unpleasant tasks.

1 2 3 4 5 (48) I like to stand on my own two feet.

1 2 3 4 5 (49) If I had had different experiences I could be more like I want to be.

1 2 3 4 5 (50) Every problem has a correct solution.

1 2 3 4 5 (51) I find it hard to go against what others think.

1 2 3 4 5 (52) I enjoy activities for their own sake, no matter how good I am at them.

1 2 3 4 5 (53) The fear of punishment helps people be good.

1 2 3 4 5 (54) If things annoy me, I just ignore them.

1 2 3 4 5 (55) The more problems a person has, the less happy he will be.

1 2 3 4 5 (56) I am seldom anxious over the future.

1 2 3 4 5 (57) I seldom put things off.

1 2 3 4 5 (58) I am the only one who can really understand and face my problems.

1 2 3 4 5 (59) I seldom think of past experiences as affecting me now.

1 2 3 4 5 (60) We live in a world of chance and probability.

1 2 3 4 5 (61) Although I like approval, it's not a real need for me.

1 2 3 4 5 (62) It bothers me when others are better than I am at something.

1 2 3 4 5 (63) Everyone is basically good.

Appendix Continued

1 2 3 4 5 (64) I do what I can to get what I want and then don't worry about it.

1 2 3 4 5 (65) Nothing is upsetting in itself--only in the way you interpret it.

1 2 3 4 5 (66) I worry a lot about certain things in the future.

1 2 3 4 5 (67) It is difficult for me to do unpleasant chores.

1 2 3 4 5 (68) I dislike for others to make my decisions for me.

1 2 3 4 5 (69) We are slaves to our personal histories.

1 2 3 4 5 (70) There is seldom an ideal solution to anything.

1 2 3 4 5 (71) I often worry about how much people approve of and accept me.

1 2 3 4 5 (72) It upsets me to make mistakes.

1 2 3 4 5 (73) It's unfair that "the rain falls on both the just and the unjust."

1 2 3 4 5 (74) I am fairly easygoing about life.

1 2 3 4 5 (75) More people should face up to the unpleasantness of life.

1 2 3 4 5 (76) Sometimes I can't get a fear off my mind.

1 2 3 4 5 (77) A life of ease is seldom very rewarding.

1 2 3 4 5 (78) I find it easy to seek advice.

1 2 3 4 5 (79) Once something strongly affects your life, it always will.

1 2 3 4 5 (80) It is better to look for a practical solution than a perfect one.

1 2 3 4 5 (81) I have considerable concern with what people are feeling about me.

Appendix Continued

1 2 3 4 5 (82) I often become quite annoyed over little things.

1 2 3 4 5 (83) I usually give someone who has wronged me a second chance.

1 2 3 4 5 (84) I dislike responsibility.

1 2 3 4 5 (85) There is never any reason to remain sorrowful for very long.

1 2 3 4 5 (86) I hardly ever think of such things as death or atomic war.

1 2 3 4 5 (87) People are happiest when they have challenges and problems to overcome.

1 2 3 4 5 (88) I dislike having to depend on others.

1 2 3 4 5 (89) People never change basically.

1 2 3 4 5 (90) I feel I must handle things in the right way.

1 2 3 4 5 (91) It is annoying but not upsetting to be criticized.

1 2 3 4 5 (92) I'm not afraid to do things which I cannot do well.

1 2 3 4 5 (93) No one is evil, even though his deeds may be.

1 2 3 4 5 (94) I seldom become upset over the mistakes of others.

1 2 3 4 5 (95) Man makes his own hell within himself.

1 2 3 4 5 (96) I often find myself planning what I would do in different dangerous situations.

1 2 3 4 5 (97) If something is necessary, I do it even if it is unpleasant.

1 2 3 4 5 (98) I've learned not to expect someone else to be very concerned about my welfare.

Appendix Continued

1 2 3 4 5 (99) I don't look upon the past with any regrets.

1 2 3 4 5 (100) There is no such thing as an ideal set of circumstances.

Appendix Continued

	YES	NO
1. Do you feel you are a normal drinker or drug user? (By normal we mean you drink or use less than or as much as other people.)	—	—
2. Have you ever awakened the morning after some drinking or other drug use the night before and found that you could not remember a part of the evening?	—	—
3. Does your wife, husband, a parent or other near relative ever worry or complain about your drinking or other drug use?	—	—
4. Can you stop drinking or using other drugs without a struggle once you have started using?	—	—
5. Do you ever feel guilty about your drinking or other drug use?	—	—
6. Do friends or relatives think you are a normal drinker or drug user?	—	—
7. Are you able to stop drinking or using other drugs when you want to?	—	—
8. Have you ever attended a meeting of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?	—	—
9. Have you gotten into physical fights when drinking or using other drugs?	—	—
10. Has your drinking or other drug use ever created problems between you and your wife, husband, a parent or other relative?	—	—

Appendix Continued

11. Has your wife, husband (of other family members) ever gone to anyone for help about your drinking or drug use?

— —

12. Have you ever lost friends because of your drinking or other drug use?

— —

13. Have you ever gotten into trouble at work or school because of drinking or other drug use?

— —

14. Have you ever lost a job because of drinking or other drug use?

— —

15. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking or using other drugs?

— —

16. Do you drink or use other drugs before noon fairly often?

— —

17. Have you ever been told you have liver trouble? Cirrhosis?

— —

18. After heavy drinking or other heavy drug use, have you ever had Delirium Tremens (DT's) or severe shaking, heard voices or seen things that weren't really there?

— —

19. Have you ever gone to anyone for help about your drinking or other drug use?

— —

20. Have you ever been in the hospital because of drinking or other drug use?

— —

21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking or other drug use was part of the problem that resulted in hospitalization?

— —

Appendix Continued

22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker or clergyman for help with any emotional problem where drinking or other drug use was part of the problem? — —

23. Have you ever been arrested for drunk driving, driving while intoxicated or driving under the influence of alcoholic beverages or other drugs? — —

(If YES, how many times ___)

24. Have you ever been arrested or taken into custody, even for a few hours, because of other drunk/drug use behavior? — —

(If YES, how many times ___)