INTRODUCTION:

ALCOHOL USE, ALCOHOLISM, AND THE PROBLEMS OF TREATMENT

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Dynamic Approaches to the Understanding and Treatment of Alcoholism

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Introduction: Alcohol Use, Alcoholism, and the Problems of Treatment

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Perspective on Alcohol Use and Alcoholism

Public attitudes toward intoxicant use generally and alcohol use in particular are confusing and paradoxical. In one sense, people readily acknowledge that ours is a drinking society. But this comment generally carries with it the implication of excessive or abusive alcohol use. If asked what he meant by "a drinking society," the commenter would be likely to mention the auto accidents, criminal behavior, or interference with personal relationships and health associated with alcohol use, as if he did not know that the majority of American drink temperately and without causing problems for themselves or others. According to a 1979 Gallup poll:

> ... 69 percent of the adult population (18 and over), or nearly 102 million Americans, drink more or less regularly [and] only 5 to 10 percent overdo it. . . . Contrary to his public reputation, the adult U.S. drinker is commendably moderate. In 1978 he consumed 3.01 gallons of distilled spirits, 3.035 gallons of wine, and about 34 gallons of malt beverages, chiefly beer. At first inspection, the figures seem high. But they reckon out to a daily consumption rate of less than one ounce each of liquor and wine and a little less than one 12-ounce bottle of beer. . . . Among the world family of nations, the U.S. ranks a respectable twenty-third in per capita consumption of alcohol. [Koffend, 1979]

In fact, there are some who claim that moderate drinking is good for you. It is remarkable and important not only that the enormous majority of drinkers drink temperately but also how rarely in our current climate of opinion this fact is remembered. Further on, we will discuss the major issue of abstinence as a treatment goal. However, if one has not been an alcoholic, abstinence as a way of life can be deviant in the sense that most Americans cherish their right to drink. A requirement of abstinence impinges on a person's freedom and often his self-esteem.

The difficulty in facing the facts about alcohol use extends to the other end of the spectrum. Few people, professionals included, acknowledge that alcoholism is treatable and that, given the chronicity and tenacity of this addiction, the recovery rate is significant (Baekeland, 1977). It is as if there were a consistent, unconscious cultural effort to make alcohol even more fearsome than it is.

Yet at the same time, paradoxically, almost all subcultures have their own myths that support the use of alcohol: Different drinks produce different hangovers, so that if you avoid the wrong one, you will be all right. Alcohol promotes sexual performance. A “hollow leg” shows strength, power, and a capacity for control. Alcohol is good for shock and freezing cold. Alcohol is good for what ails you, especially snakebite. Frenchmen do not get drunk. Alcoholism is a vice (and a danger) mostly for the very rich. On and on the list

goes, including the oldest saw of all. In *vino veritas*.

The reasons for the paradox are straightforward, if not simple. As Zinberg points out in his chapter in this volume, drinking is far more valued than most people in this culture care to admit: thus the myths that support drinking. On the other hand, the social use of alcohol as a euphoriant, disinhibitor, relaxant, or mild anesthetic has little to do with alcoholic drunkenness, an experience which is painful in the short run and damaging over time. Concern over this long-term destructive power of alcohol and the accompanying, terrifying loss of control undoubtedly perpetuates the cultural exaggeration of the hopelessness of recovery.

Later on we will discuss the extreme difficulty in making an early diagnosis of alcoholism. It cannot be done from single episodes of drunkenness. Further, it is not made easier by the fact that it is hard to understand drunkenness at all. Nowadays people rarely set out to get drunk. They hope to get "high," they say, and at times neglect to stop when they should. There were historical eras when some people took periodic occasions to get drunk (Zinberg & Fraser, 1979).

Andrew T. Weil (1972) makes much of being high as a way of returning to the awesome vertigo of childhood twirling games. Perhaps drunkenness is the dark side of transcendence, a descent to a symbolic suicide and

apotheosis. Who could doubt that we all share a tropism toward such darkness? If alcohol merely made slobs or fools of us, the self-care Mack stresses in his chapter in this book would be sufficient protection against its abuse, but there is a fine line between self-care that blocks action to reduce danger and self-care that soothes and permits one to relax. Many flirt with the boundaries. Anyone who has had the experience of drunkenness knows that the familiar white magic of alcohol has the potential of evil for the depleted self. What else is the addict's enthrallment to self and his rejection of reality but evil?

Evil is not, of course, a scientific term. It is used here only to convey the sense of horror that alcoholism and other addictions raise. That sense of horror underscores the tenacity with which alcohol use in general and alcoholism in particular is considered a moral issue. The moralistic view of drinking in the United States goes back a long way. And it is not just those abstinent or abstemious descendants of the temperance and prohibition movements who moralize about the use of alcohol. Alcoholics cling to a moral model and eschew a medical one. In his chapter in this volume Vaillant has written of their loneliness, which they accept as deserved. They prefer guilt to abstinence.

It can easily be argued that this moral stance deters only the most controlled of drinkers. It certainly deters alcoholics only briefly. Such a stance

does, however, lead to the acceptance, though now less than formerly, of a criminal model for drinkers. (This does not refer to the criminal results of drunken driving or of any other crime committed under the influence.) If the out-of-control drinker is where he is either through lack of moral fiber or through an overt immoral urge to destructiveness, then why should he not be treated like any other criminal who takes the easy way out by stealing or what have you, who is, in other words, aggressively antisocial? If the drinker is bad, he should be punished.

This moral model of alcohol use directly opposes a disease model. A focus on the patient's experience may help to explain the fragmented picture of responses to the alcoholic. For example, the patient will, as a result of his drinking, have interactions with different pieces of the responding social system—a court, police, psychiatrists, or a hospital— depending on what his symptoms are (assaultiveness, depression, bleeding) and how these are interpreted by those around him. The patient is defined by a fragment of himself that interlocks with a particular responding unit. The central problem is how to turn that interaction into a situation in which the alcoholic has a large chance of getting help.

Because of the sin-illness muddle, the coping system is not clearly committed to the concept of alcoholism as a disease. The disease concept cannot be logically and definitively validated. It is a value position, proposing

comfort and effective treatment. One acts as if the patient has a disease, and certain effects follow. The problem is that the patient often rejects his sick role and the responding agent is often not clear about the usefulness of pushing him to accept this role. Many participants in the responding system have had no training in effective work with alcoholics. They drift from moral to medical model and back, and vacillate between doubt and conviction in their intervention. The position to be taken, that the alcoholic is ill, is peculiar and not logically obvious. Patients say it is painful, but not harmful. Cummings (1979) states this in the following way: "Addicts do not come to us to be helped for their addiction. They come to us because they are about to lose something or have lost something. . . . The therapist must start with the full realization that the client does not really intend to give up either drugs or the way of life."

Certainly those knowledgeable about and experienced with the chronic nature of alcoholism would recognize any contact with a professional or nonprofessional group by an alcoholic as a beginning, a transitional step necessary before any extensive reclamation work can begin. That the first steps are usually tentative, halting, and full of denial is recognized and accepted. However, if the people in the responding social system are not experienced with alcoholics, they are bewildered by clients-patients-applicants who love their "disease" and want more than almost anything in life not to be parted from it. Much of the confusion over the shift from the

criminal to the medical model has to do with the slow transition to an understanding that the alcoholic is not fully in control and purposively destructive. The mechanism of loss of control is not at issue here. It could be physiological or unconsciously psychological or of some other nature. But any disease model posits some such event as loss of control as the basis on which the patient is seen as sick, not bad. Psychosis underwent this transmutation to disease status around the turn of the century. Alcoholism is painfully undergoing it now.

The medical model can subsume a broader definition than "disease." Three of us use it freely: Bean uses it to describe the stages of alcoholism and their relationship to denial, which is seen not just as a defense in strict psychiatric terms but as a symptom, a chemically promoted consequence, and a perpetuation of the alcoholism. Khantzian assumes some kind of ailment, since all his cases "have it." Vaillant insists upon a strict disease definition as a practical basis for correct treatment and a protective umbrella against the patient's overwhelming guilt. For Mack the medical disease definition is antipsychiatric because it exempts the patient from responsibility and partly disqualifies us from understanding alcoholism by understanding alcoholics. But his psychiatric model, in which the process can be explained as partly psychological but not conscious and so not in voluntary control, is equally forgiving of the patient. The use of the disease definition is unfortunately restricted because distorted reporting, which sees only advanced alcoholism

as sick, has given alcoholism literature (which colors public attitudes) a limited notion of the disease which we find specious. Alcoholics are rarely seen for alcoholism per se, and if seen, are otherwise diagnosed or labeled until the advanced stage. By then, as Bean usefully shows, the disease has taken over their lives; their perceptions, behavior, and motivation are distorted, and they usually have physical symptoms.

Most confusing of all is the extent to which alcoholics, early in their condition and increasingly even after they have symptoms of all sorts, are able to deny their loss of control over drinking and the effects of it. Their loss of control and the damage that it is causing are so obvious to outsiders that nonalcoholics often think of the denying alcoholic as crazy or, if not, as infuriatingly obtuse. All the chapters in this volume deal with this complex and basic mechanism, which, more than any other single factor, fuels the continuation of the drinking. We will not treat it extensively here. Suffice it to say that the understanding of denial is crucial not only to the understanding of alcoholism but also to the understanding of the responses of others, professional and nonprofessional alike, to the alcoholic.

Social and Professional Problems with Alcoholism

Before we address the subtle problem of diagnosing the alcoholic and the perplexing problem of treatment, we will sketch the problem as it appears

to the milieu in which the drinker exists. First of all, it must be remembered that for everyone in the milieu, coping with alcoholism is no minor issue. The out-of-control drinker is deeply psychologically threatening to the huge majority of controlled drinkers. Many wonder, “Could it be true that there but for the grace of God go I?”

But the threat of the drinker in a modem technological society goes far beyond age-old social and psychological description. In the old days “the horse knew the way home”; today alcoholics drive cars. “The excessive use of alcohol,” in historical terms only recently called alcoholism,[1] “annually presents society with a staggering bill: somewhere between $25 billion and $40 billion, in terms of lost labor productivity, health and medical costs, highway carnage, criminal procedures, treatment, and welfare. Alcohol abuse is a factor in 40 percent of all traffic fatalities, accounts for 50 percent of criminal arrests, and fills one of four general hospital beds. By the most benevolent estimates there are at least 5 million chronic drunks in the United States” (Koffend, 1979). This sort of “linkage” reasoning is loose by scientific standards, but what the lawyers call substantiality—the necessity to believe your own eyes— makes it permissible in this area.

When alcoholism was seen as a private misfortune and not a public health problem, long-suffering families took much responsibility and bore the burden. Via burgeoning auto insurance rates, health costs, and taxes—since

control of alcoholism is vested not only in the treatment system but in courts, schools, the armed services, management, and labor unions—the burden is borne by all of us, and, gradually we begin to see, the responsibility as well.

Families, friends, teachers, co-workers, clergymen, physicians constantly are presented with early alcoholism but often cannot "see" it. It is no small matter to stigmatize someone as an alcoholic, and in this society that is still a fair way to describe what happens. As we will see in the discussion of diagnosis, it is hard to be reasonably sure which is the controlled heavy drinker and which the early alcoholic. But leaving aside for the moment the fear of making a mistaken diagnosis, consider the other issues. The alcoholic himself refuses to acknowledge that his drinking is out of control. Not only does he deny the problem but he consistently, with primitive cunning, obstructs any interference with his beloved evil. Drunks deserve their reputation for being able to manipulate their families, friends, and other aspects of their social environment. They may not be able to see what is going on in themselves, but their ability to bully, wheedle, charm, or otherwise elicit the misplaced kindness of some form of cooperation from others is remarkable.

Remarkable but understandable. Families of alcoholics see themselves as stigmatized by association, as do friends. There is guilt aplenty. Few of us are immune to the concern that had we done or not done this or that, the

friend, sister, husband would not have gone off on a toot. Worst of all is the sense of helplessness and uncertainty: just what to do, when and how to do it. Afterward, when things have deteriorated pathetically, it is easy to say that the family should have pushed harder or gone to Al-anon or a professional themselves. But earlier in the game the fear of making a bad situation worse, the hope that it is not as bad as feared, the sensitivity about one's own place in the community, and the terrifying degree of one's rage at the drinker combine with ignorance and misconception about available help and its effectiveness to immobilize us.

Under these psychological conditions many families, friends, and work associates join the alcoholic in his denial. A number of friends and family join him in his drinking as well. This is hardly surprising. Having threatened, persuaded, cajoled, and reasoned with him with no effect, they become increasingly disorganized. Alcoholism, as far as the drinking is concerned, may not be truly contagious, but its secondary problems affect everyone around the drinker (Jackson, 1962).

There was a time when, under these circumstances, the next part of our social environment's response system to be involved would be a clergyman. Today it is far more likely to be a physician. For one thing, physicians see alcoholics because they feel or look ill. For another, one of the most acceptable things people in the social environment can persuade a drinker to

do is “have a checkup.” If family, friends, or other associates accompany the drinker to his appointment and say they fear he has a drinking problem, at least the physician has something to go on. But usually, because of the designated patient’s denial of his alcoholism and his antagonism to his family’s and other’s concerns about his drinking, he comes alone.

That leaves it up to the physician to pick up the clues, and sadly, he is ill prepared to do that, both because of his lack of training in the area and because of the nature of usual doctor-patient interaction. A recent national survey of medical education on alcoholism, that was funded by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (reported by Pokomy et al., 1978) studied medical and osteopathic schools. In 105 of the 117 schools, the percentage of total required teaching hours devoted to alcoholism varied from zero to 3.1 percent, with a mean of .6 percent and a median of .4 percent. Elective courses were not offered in one-third of the schools, though where they were, the enrollment figures suggested “substantial student interest.” Only 17 of the 105 schools had any continuing education programs; almost half had no substance-abuse teaching for residents. The authors comment that “students who have completed medical education in the U.S. during the past few years do not feel prepared to deal with alcoholism and drug abuse. They frequently emerge from school with negative attitudes and an unwillingness to treat addicted patients. ”

At most medical schools, students' instruction about alcoholism is mostly in the classroom, though there are exceptions, such as the University of Minnesota, where all second-year students get "supervised tutorials" (Harris & Westermeyer, 1978). There is more teaching about substance abuse where faculty includes participants in the NIDA/NIAAA Career Teacher Training Program in the Addictions, established in 1971.

In the Macy Foundation survey of 1972, it was concluded not only that addiction problems should receive more curriculum time (Stimmel's ideal curriculum) but also that "departments of medicine [should] bear the primary responsibility for substance abuse teaching," in contrast to departments of psychiatry, which take most of the responsibility at present. Remarkably, the American College of Physicians 1979 recommendations for a library for internists "contained no specific references on alcoholism and drug abuse"(Novick & Yancovitz, 1979).

In an article written for general physicians, Burnett (1978) concludes that "failure to treat seems determined more by a failure to diagnose . . . than by desultory attitudes of health professionals toward alcoholics," and that "the prevalence of alcoholism as seen in general office practice is usually estimated as exceedingly low." Since the National Council on Alcoholism (NCA) criteria (1972), the subject of his article, were widely distributed in 1978, the continued "failure to diagnose" can be ascribed to faulty education

in history taking and, if not to a desultory attitude, then at any rate to a pessimistic or denying one. The low prevalence of perceived alcoholism can be partly accounted for by the fact that "most programs of medical education have continued to focus on alcohol-related disease without considering either the etiological significance of alcohol to specific illnesses or the importance of a drinking history to medical diagnosis and treatment" (Straus, 1977). Many doctors prescribe alcohol-interactive drugs because they do not diagnose alcoholism. Even among psychiatrists "only a handful," Zimberg (1978a) found, were "willing and able" to give office-based therapy to alcoholics.

Not only are most physicians not trained to diagnose or encouraged to treat alcoholics, but what training they do receive is on the most far-gone and deteriorated addicts. Another survey of medical school teaching on alcohol and other addictions (Zinberg, 1976) found an emphasis on extreme cases where the diagnosis was never in doubt and the treatment was absolutely necessary and relatively clear-cut. These case studies, usually from a psychiatric ward or an alcoholism or addiction center, are no help in identifying cases of early alcoholism and, in fact, interfere with the investigation of less clear-cut syndromes by giving medical students and physicians in training the erroneous impression that they know what an alcoholic is when they see one.

Given the average physician's lack of background and training in

recognizing anything but these extreme cases, it is quite understandable that the physician is uncomfortable with intrusive personal questions that go beyond the ostensible presenting complaint. Many physicians will ask a patient about his ethanol intake but will accept the patient's response without further question if it is innocuous and if the physical condition is not yet so severe as to brand the answer automatically as evasion. In many respects, the physician unconsciously colludes in the denial of alcoholism. After all, usually his patients work with him to ferret out a problem, not to obscure it, and he treasures that model. Also, as in most human interactions, he wants to be able to accept people, including patients, at their own estimate of themselves. Stirring up difficulty that is not presented almost feels like making trouble, and, usually correctly, physicians adhere to Osier's first rule of medicine: "Don't give the patient anything he didn't have before" (Osier, 1928).

In addition, the physician does not want to damage his relationship with the patient by appearing to be suspicious of him and thinking "ill" of him. Even acting as if one were *about* to label another person an alcoholic would weigh heavily on a relationship where cordiality and good feeling are valued. One can add to that, without in the least questioning the physician's ethics but merely admitting his humanity, his desire to hold on to the patient and not do things that would drive him away.

Overshadowing all else, however, is the painful question of what exactly

to do with the patient if one does suspect alcoholism. How to find out "for sure," and then what? One bugaboo that appears immediately is the problem of confidentiality. Usually family members are aware of a patient's drinking problem, but the patient may be very reluctant to bring this issue to them. Should the physician simply tell the patient what the diagnosis is and let him decide whether to act on it or not? Or does the physician have a greater responsibility to the patient? That is, should he see that someone responsible is informed?

In this day of third-party payments and employee assistance programs, the problem is even stickier. How sure does the physician have to be before he reports a diagnosis of alcoholism? One need not look further than the physician mentioned by Vaillant (1977) who accepted brain surgery rather than a diagnosis of barbiturate addiction to appreciate how socially catastrophic such a diagnosis still seems to many people.

Another issue alluded to by Vaillant is less frequently named but very real. Alcoholics often are not nice patients. They telephone at unreasonable times; they make promises and break them, leading to embarrassment and disappointment all around. Their pain after a drinking bout and their potential physical deterioration are very real, so that the physician feels he must do something, but what to do with this uncooperative person remains confusing.

Psychiatric referral is high on the list, but this too is not a clear-cut recourse. Just as physicians see alcoholics because they feel or look ill, psychiatrists see them because they feel or look depressed, upset, or guilty. Here we return to a central theme in this volume. Does an emphasis on these emotional symptoms act to increase the difficulty in recognizing alcoholism, as Vaillant states unequivocally,[2] or does this psychiatric approach offer a way to begin with hard-to-reach patients, as Khantzian contends? The physician is hard put to know. Few psychiatrists want alcoholics as patients—even Khantzian would acknowledge this— and few, if they see such patients, do very well with them. Most of the training issues discussed apropos physicians apply equally to psychiatrists, and if general physicians' schedules cannot cope with the uncertain and erratic nature of contacts with alcoholics, psychiatrists are even more rigidly scheduled.

Active alcoholics find accommodating to such schedules difficult if not impossible. They are hard put to be interested in themselves and their pain. When they are drinking, they care only about the drinking; when between bouts, they care about the suffering from the drinking and how to prevent it, not about the intricacies of their personality conflicts. To a certain extent, social work has moved in to take up the slack in many areas. Social workers are professionally trained, schooled in patience, and likely to have more flexible schedules than psychiatrists. They too, however, run into the same problem of inadequate training for dealing with the complexities of this

patient group.

Under these social circumstances professional approaches to alcoholism have lagged until recently, while A.A. has flourished. A.A. ingeniously avoids many of the professional pitfalls. It begins by presuming a disease concept of alcoholism which is quite different from the medical model but carries many of the same implications. The alcoholic is considered to be in the grip of disease and therefore unable to deal with his drinking. Changing the concept of alcholism from one of vice, weakness, or lack of will power or judgment to one of disease makes the "treatment" more acceptable socially and helps to alleviate his guilt. Though insisting that alcoholics have to become abstinent to recover from their disease, A.A. is not prohibitionist. It prescribes abstinence only for those who cannot handle alcohol as most others can.

Most observers agree that the alcoholic's denial of his problem is the greatest obstacle to his recovery (Bailey & Leach, 1965; Bean, this volume). A.A. has no magic but many techniques to approach this psychological block. When a drinker contacts the organization, members work patiently to show him that his symptoms indeed indicate a disease called alcoholism. His increasing acceptance of this fact allows the new member ("pigeon") to talk about it openly as a speaker at meetings or in small groups. This discussion breaches a basic inhibition against self- awareness and often permits the new A.A. member to go still further. Once these matters, which had seemed so

sordid, are talked about, the new A. A. member feels more comfortable. A member working through A.A.'s twelve suggested steps of recovery will see how the same type of defense mechanism, which limits self-awareness, may be operating in other aspects of his personality. The twelve suggested steps of A.A. are the following (Alcoholics Anonymous, 1977);

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

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

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

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

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

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

7. Humbly asked Him to remove our shortcomings.

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

9. Made direct amends to such people wherever possible, except

when to do so would injure them or others.

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

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

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

A. A. retains the focus on the one issue, alcoholism, and leaves the rest of the personality alone. It recognizes, as many psychiatrists do not, that the job of stopping alcohol intake is a necessary underpinning for any further psychological understanding.

As an organization, A.A. offers the great benefit of fellowship to alcoholics, surely some of the loneliest people on earth (Trice, 1957). Those who have had the experience of alcoholism are suspicious of depending on others. Joining the fellowship of A. A. permits intensely personal relationships such as sponsorship—a close one-on-one apprenticeship for the process of recovery—and it also allows for more structured impersonal relationships such as those in large meetings.

The program is arranged so that every time a member calls for help, a

different person can easily answer the telephone and take up the "twelve-step" work. The suggestion that a member remain in constant touch with the organization even when he is traveling answers his great need for company and minimizes his feelings of isolation and guilt. Perhaps even more important, twelve-step work provides a chance for those being gratified to gratify others and thus to make something positive out of the experience of alcoholism. This not only relieves guilt; it encourages self-esteem.

A. A. refers to itself as "the last house on the street. " This means that the alcoholic who judges himself harshly and constantly and who correctly perceives that he is so judged by most of his peers has one place which will not turn him away, no matter how degraded or despairing he may appear. A. A. says that he need never be without help and that he will not be judged in that place no matter how often he succumbs to his "disease." He can always turn into the "last house" and find acceptance from others.

An important tenet of A.A., basic but little understood, is the view that an alcoholic is always recovering, never recovered. One is sober from minute to minute, from day to day; and because the next drink is always imminent, overconfidence is dangerous. An A.A. member may stay sober, but by his awareness of what he must overcome, he is always potentially a drinker.

Understanding that he has an abnormal response to any alcohol is a

remarkable insight. The alcoholic may be biologically different, genetically or as a result of addiction, from moderate drinkers. He also has a highly ambivalent relation to alcohol; he loves and hates it intensely. A. A. recognizes that the alcoholic has two fears which are so strong as to be phobic: the fear of drunkenness and the fear of sobriety. These fears continue to appear all the way from detoxification to the last stage of recovery. The alcoholic, despite his pleas that he likes to drink, that drinking makes him feel better or better able to exist in his own skin as well as with other people, comes to loathe and fear his drunkenness. Will he once more defile and degrade himself physically, emotionally, and socially by getting and staying drunk? Even in the depths of alcoholic torment in a detoxification ward, he will frequently wish or even believe that some day he can become a controlled drinker. Will he be deprived of the soothing power of alcohol, the palliation of the sickness of withdrawal? Whatever drink supplies—imagined social ease, Dutch courage, emotional distance, respite from sorrow—it is much prized; to an alcoholic, life without drink is terrifying, even phobic (Zinberg, 1977).

A.A.'s method is to "allow" the imminent danger of drinking to continue as a fantasy-fear. This leaves the A.A. member with an ongoing desire for whatever value he obtained from drink as well as an awareness of his moment-to-moment conquest of the desire to drink. Thus the reality of early sobriety, which at first seems so frighteningly gray, is balanced by the stimulating fantasy of drinking. Unfortunately for the alcoholic, his drinking

memories fasten upon that one moment when the ethanol-engendered glow allowed him to feel like a king and screen out the sullen, surly, deteriorated aftermath, whereas his view of sobriety focuses upon the moment when he felt most inadequate. In time, however, the safety, physical recovery, release from withdrawal, and social and psychological advantages of sobriety tip the balance toward abstinence; the experience of being in control of oneself and able to interact with people directly rather than through a boozy haze becomes reinforcing. Unlike the members of the straight world, to whom the advantages of sobriety are self- evident, A.A. does not underestimate the alcoholic's fear of being sober. Instead, by insisting that the alcoholic is always recovering, never recovered, it keeps the possibility of drinking always at hand but still a hand's breadth away.

A.A. in effect sees the patient as a whole person who has great difficulty in coping with a particular chemical. He is free and responsible, but his conflict is experienced as overwhelming, and thus he turns to a ''higher power," in A.A. parlance, which many understand as another of A.A.'s heuristic devices. There is nothing in A.A.'s view of a ''higher power" which is incompatible with psychiatric understanding. There are, however, psychiatric points of view that see the patient somehow as inherently defective—not physiologically, as one with an allergy to alcohol, but as having a defective or impaired ego or personality structure (Knight, 1937b; Brill, 1919; Rado, 1933). That the most deteriorated alcoholic can, at times, pull himself

together for a special event or to get a welfare check is usually ignored because these psychiatrists have moved away from a conflict theory of human functioning. This defect theory has profound implications for the psychiatric relationship. Having an ego or personality defect or lack is far different from the notion of a physiological allergy or response to alcohol such as the flush that occurs characteristically in Orientals after alcohol is ingested (Ewing et al., 1974). Such psychiatrists find it hard to point out to a patient that he is not making use of personality or ego capacities available to him, for, in effect, they see him as not having certain capacities. This theoretical position forces A.A. toward an antipsychiatric stance and, in our view, makes it more important for the organization to present the disease concept as if the disease were literally contagious rather than as a way of expressing what has happened to the alcoholic.

Diagnosis

Many of the problems of diagnosis have already been mentioned. Obviously the most difficult, as Zinberg's cases show, is differentiating the heavy drinker, who manages his intake empirically and, in his view, with more or less pleasure, from someone who is heading into difficulty.

Controversy surrounds the definition of alcoholism. "Drinking that does harm" is a reasonable and usual rule of thumb, but it is often hard to

determine genuine dysfunction, which varies with amount, rate, purpose, and practical circumstances. Drinking that would get an Italian-American ostracized may be normal for someone of Irish background; what can jeopardize a bus driver's job may pose no threat to a handyman's. It is not just a matter of what alcohol abuse makes people do or how it affects their relationships or whether they feel sick in the morning. If it were, more people would react to drinking by identifying it as a problem and making the intrusive effort to get the drinker to a physician, a treatment facility, or A.A.

It is much easier to say that someone drinks too much than to say he is an alcoholic. One can go simply by quantity, as in the former statement. But eliciting from the patient or client a history of frequent drinking to drunkenness, drinking that interferes with the capacity to function at work or to relate to colleagues, friends, and family, or long periods of memory deficits during drinking, known as blackouts, requires patience from all concerned and considerable alertness to and knowledge about alcoholism. To make a diagnosis of early alcoholism, such a history is necessary because many of the above symptoms usually precede the physical damage and deterioration characteristic of later alcohol addiction.

It is rare to get a straightforward history of such difficulties. Rather, the person seeking to diagnose alcoholism must go beyond such questions as "How much do you drink?" and "Does your drinking cause you difficulty?" He

must go to questions designed to focus on the drinker's own concerns about control—"Do you ever decide before you go out just how many you can have?" and "Have you ever decided to stop drinking for a while?" and the like. Such questions, if answered in the positive, arouse the suspicion of alcoholism.

Differentiating between heavy drinking and early alcoholism is not the only diagnostic problem. Alcoholism must be differentiated from simple intoxication. A study of "serious events" (crime, accidents, and suicide) highly correlated to alcohol abuse suggests that in some events drinking is not so much the cause of trouble as a releaser of action in some symptom-prone people and a cause of impairment or disability in others (Diesenhaus, 1980).

Even well-advanced cases of alcoholism, which one would think easy to diagnose, can be problematical. Since the early 1960s there has been an enormous increase in the use of psychoactive drugs, both licitly, for medical and psychiatric treatment, and illicitly. As a result of the attention given to the potential of drugs to alter consciousness states for the better, many troubled people, sometimes entirely unconsciously, have experimented with drugs as self-medication for severe emotional disorders. Alcohol has been no exception to this trend, and with its powerful addicting potential some people who attempt self-medication end up with alcoholism which masks their original condition. This is exactly the reverse of the case Vaillant cites in his

chapter in this volume where the severity of the alcoholism led to a mistaken diagnosis of psychosis.

Often attempts to distinguish the self-medicating alcoholic with an underlying psychosis or other serious disorder from the "straight" alcoholic occur when the drinker is withdrawing from alcohol, which is a serious complication. It may be necessary to distinguish ordinary alcohol withdrawal from withdrawal complicated by the physical illnesses common in alcoholics. Chalmers and Wallace (1978) say that the patient may appear psychotic, hallucinating, and frightened in early withdrawal. If he does not recover from these symptoms in the course of a few days, the differential diagnosis includes concurrent psychosis, continued withdrawal, and medical illness. "Continued withdrawal [may be] evidenced by such signs as tremor, agitation, sweating, illogical thinking, depressed mood, anxiety, and, on occasion, a sudden and unexpected delayed seizure" (Chalmers & Wallace, 1978). These authors add, "The therapist should be alert for such symptoms as persistent headache, dizziness, difficulty in breathing, cardiac arrhythmias, flushing, sudden drops in energy, difficulty in waking, memory deficits, complaints of abdominal pain, and poor appetite. These may reflect continued withdrawal, but they may also indicate chronic conditions and diseases of increased likelihood in alcoholics (e.g., hypertension, liver disease, gastritis, ulcer, carbohydrate-metabolism disorders, brain dysfunction, anemia, heart disease, polyneuropathy, emphysema, and stroke)" (Chalmers & Wallace,

1978).

In our view, making the diagnosis is the beginning of treatment; it makes possible movement toward a genuine therapeutic regimen for the condition. The next step, which is crucial to getting someone into active treatment, is conveying the diagnosis. This is an extremely difficult problem. First and foremost comes the question of whether the patient continues to drink. Until the drinker's mind is clear, hope for his acknowledging alcoholism is very small indeed. As we have mentioned, discussions with the family, while necessary because sometimes they are more willing than the drinker to talk with someone or go to Al-anon, result often in denial and a sense of helplessness.

It is not usually helpful to talk to the drinker while he is drinking, and even after he is no longer intoxicated, he will have some confusion and memory loss for a time. For many long-time drinkers the usual five-day detoxification period may not be adequate to allow the central nervous system to recover enough to enable them to have a rational and objective discussion. They may feel sick because of medical complications, but even if they are not yet physically disabled, they feel too poorly to make much sense about the future. Sadly, a longer hospitalization for medical complications is an excellent opportunity to discuss the diagnosis with an alcoholic, as a case of Bean's in this volume illustrates exactly. All too often the luxury of having

the alcoholic drug-free long enough for some genuine clarity is simply nonexistent.

This is, of course, one more example of the painful and frequent dilemmas that make this group of patients so difficult for professionals in the field. A physician understandably wants to tell the patient what is wrong and what to do about it, which begins with "Stop drinking." If the patient feels sick, the physician thinks there is even more reason for the drinker to follow this excellent advice. It is hard for a nonalcoholic to understand that to the drinker the best "medicine" for his sickness is as close as the nearest bar. If the patient is actively drinking, he will promise anything just to get away from the doctor.

What professionals are gradually recognizing and what A.A. has known for a long time is that postponement is pointless. Bean points out that sometimes, although rarely, it is true, even a single confrontation can be significant. Usually it takes many encounters because alcoholism is a chronic condition replete with remissions and exacerbations. Preferable to the postponement and maintenance of denial would be for the drinker to seek the deep understanding of the thinking of the alcoholic from the inside, as it were —A.A. members or the sophistication of a general physician or psychiatrist trained in alcoholism who would bypass the denial of drinking and take up any area that seemed open. At any rate, the most important thing to remember is that once the diagnosis is made, the patient must be told and

told again. This is difficult for most of us. The physician needs to believe that it is a good thing to talk to a patient about his drinking. This is not obviously true, because it is clear that the interaction is painful to the patient, and he tries to avoid it. If it were not so conflic- tual to accept the diagnosis of alcoholism and the treatment for it, patients would not be so resistant to hearing it. Nevertheless, entering the drinker's conflict on the side of his having a serious condition which is treatable is a basic therapeutic move and is too little recognized as such.

The Move to Treatment

Once the drinker begins to move toward the treatment system, whether professional or nonprofessional, what will generally happen is influenced by a number of factors: who made the diagnosis, whether the patient has insurance coverage, what facilities are available, and what treatment philosophy the staff subscribes to. The stage of the patient's alcoholism is obviously important. In the late stages care may be little more than custodial. Different situations may require different treatment approaches. What awaits the patient at home, if he has a home? Will the family cooperate in treatment? Do they need help themselves? The diagnosis is likely to have been complicated by related factors of mental or physical health, which will affect the caregivers' priorities for treatment. The age of the patient makes a difference. For instance, "clinical depression and anxiety are not common

problems in young, healthy male alcoholics" (Hamm et al., 1979). Sex also matters: young women alcoholics are more likely to be depressed (Tamerin, 1978). Social and ethnic patterns will have an impact. Any previous attempts at treatment and the degree of successful recovery in the past are also essential elements.

The greatest controversy about alcohol treatment services for almost a half century has been about the primacy of professional services rendered by physicians, psychiatrists, nurses, psychologists, social workers, and the like in a variety of inpatient and outpatient settings and those services made available by nonprofessional volunteers, chiefly Alcoholics Anonymous. The phenomenal growth of A. A. since its founding in 1935 in Akron, Ohio, by "Bill W." and "Dr. Bob S." attests both to the need for such a service and to its efficacy. Except for the treatment of direct medical complications A. A. does not rely on other professional services, and, as Vaillant shows in his chapter in this book, some members actually regard many of them as deleterious to the treatment of alcoholism.

Whether because of the traditional reluctance of the professional groups to treat alcoholism, the alien philosophy of A.A., the most successful treatment modality, the cultural insistence that alcoholism is a moral dilemma, or because of a combination of all three, it is only in the past decade or two that there has been a growth of professional interest and investment

in the treatment of alcoholism. At this time when there is a moderate increase in the availability and effectiveness of alcoholism treatment services (although not yet a commensurate increase in satisfactory objective studies to provide empirical data about various treatment techniques and modalities), the alcohol field has been assailed by demands involving special populations, and this is creating a new and tendentious conflict. Groups such as women, blacks, Hispanics, criminal offenders, American Indians, the aged, and the unemployed have demanded special attention. While it can be argued that groups which have common social, psychological, or legal characteristics may well have intrinsic drinking patterns and problems of rehabilitation, there are growing questions as to whether such characteristic issues warrant separate treatment situations in each case.

This controversy over the potential fractionation of treatment services heightens the contrast between various competing, often feuding professional groups and A.A., which, despite considerable diversity among different groups, retains its more or less monolithic reliance on the credo of the "Big Book" (Alcoholics Anonymous, 1939). Two other controversies, where empirical data are skimpy, plague emerging professionally oriented treatment services. First, many questions are raised about the efficacy of inpatient services, including inpatient detoxification, except for patients with obvious medical complications. As inpatient services are vastly more expensive than outpatient services, unless their superior efficacy for many

cases can be demonstrated, any insistence on inpatient settings can be interpreted as an insistence on professional hegemony.

Second, the enormous increase in the use of both licit and illicit psychoactive drugs raises the questions of whether to treat alcohol and other addicts in the same facility and, of even great difficulty, what to do with those people who have another addiction along with alcohol. Both of these questions focus attention on an inherent difference between A.A. and professional services. Although the concept of alcoholism as a disease is essentially heuristic, in practice it suggests a segregation of those who suffer that disease. A.A. has uneasily accommodated people with dependence on other drugs, and it remains doubtful whether they have the same disease.

The usual professional approach, on the other hand, while acknowledging fully that alcoholism is a biopsychosocial condition, has been to treat chronic alcoholism as a psychological problem, except for active intoxication, withdrawal, and medical complications. Whether individual psychological problems are precursors to or the result of the alcoholism is of little practical consequence. What are of consequence are the family, job, legal, social, intrapersonal, and emotional difficulties concomitant to the long-standing dependence on alcohol. In a basic sense that is Mack's point in this volume. Approaching all these complex consequences of alcoholism from a psychological stance, in the absence of empirical data supporting this

approach, requires considerable sophistication and training. That requirement has not been met. Hence most detoxification and residential treatment programs as well as most aftercare and employee assistance programs refer their clients to A.A.

The most recent estimates (Vischi et al., 1980) claim that 1.7 million people participated in formal treatment programs in 1977 and 671,000 participated in A.A. in the same year. There is considerable overlap in these figures as the huge majority of those participating in A. A. at one time or another had contact with a formal treatment program. No one has a clear idea of how many actual alcoholics there are, so there is no way of knowing what fraction participated in some form of treatment. The figure most often used for the number of alcoholics is 5 million, but as Zinberg points out in his chapter in this volume, the definition of an alcoholic or problem drinker decides who is called what, and some authorities who see anyone who drinks alcohol regularly as a problem drinker use a much higher figure, while those who insist that seeking some form of treatment determines alcoholism use a lower one.

Referral to Treatment

Obviously, the most desirable referral situation is self-referral. The drinker recognizes a problem, assumes the responsibility of seeking an

appropriate therapy, and expects to cooperate. Membership in A.A. depends —initially and forever—upon self-identification as an alcoholic. "The only requirement for membership is a desire to stop drinking" (Alcoholics Anonymous, 1977). In medicine in general and even in much of psychiatry the self-labeling model is the rule, and while resistance and lack of compliance with a treatment regimen often occur, the conflicts take place within an overall alliance between therapist and client. In the early stages of alcoholism, this model is the exception. Not that self-referral does not occur, for it does. Most, if not all, alcoholics have at one time or another a distinct awareness that their drinking is out of control. In such lucid moments they may turn to a treatment situation. This is particularly true when the person has had previous treatment.

There is some indication (Diesenhaus, 1980) that if an active community mental health system is in place and easily available, self-referrals are more likely to occur. As near as can be told to date, based more on clinical experience than on hard data, these referrals tend to be like those from physicians and clergymen. The drinker does not necessarily go in and announce himself an alcoholic. The denial and pain at the thought of giving up alcohol are too great. But he does go to see someone and says that something is wrong. Hence it is necessary for the person or agency consulted to be sufficiently aware of the possibility of alcoholism to make the diagnosis and sufficiently well trained and sophisticated to steer the drinker to A.A. or a

formal alcohol treatment service.

Another major referral source is families of alcoholics, usually after some participation in Al-anon. In the early years of A.A. Al-anon and Alateen were developed by the wives and families of members, for people who cared about, or lived with, an alcoholic. They focus on direct alcohol education, understanding what factors in the family perpetuate drinking, and helping family members learn a set of techniques of interaction with the alcoholic that make continued drinking less likely and acceptance of treatment more so.

Even when the referrals come from families, clergy, or physicians, the element of coercion is far greater than with most other sorts of problems. Usually these referral sources do not begin by threatening but become more coercive when the natural assumption—once the drinker has been told of the damage to himself and to others, he will do something about his drinking—proves false.

Other referrals to any form of treatment are more coercive. The most coercive are police and the courts. Since the decriminalization of drinking, if alcoholics are picked up by the police, they are usually not jailed, but are taken to a detoxification center. Often they can be jailed because of something they did while drinking, and they are less likely then to be referred to treatment. All too often the handling of the drunk is left to the individual

officer, and again the problem of the level of training and sophistication emerges. Sometimes a knowledgeable judge can use his power to get an offender into treatment. This has been particularly true in recent years with the existence of drunk-driver programs.

In the past the drunk driver was usually given a warning or two, and after another offense had the book thrown at him, with loss of license or jail. Today in many states judges on any driving-while-intoxicated charge will insist that the culprit attend a certain number of A.A. meetings, participate in an alcohol education course or an alcohol counseling program, or do some combination of these. This approach brings the drinker into some part of the treatment system.

The most important and effective use of coercion has been the development of employee assistance programs in industry that train supervisory personnel in dealing with drinking in the work place (Heyman, 1978). Drinking on the job, absenteeism, and poor performance because of drinking are common. In the past, and all too often in the present, employers offered the drinker a second chance unaccompanied by a recommendation of treatment. When the drinking recurred, their patience was exhausted and they fired the drinker. The growing concern of both employers and unions about this procedure, which offered no assistance to those in trouble, led to the acceptance of a coercive approach. The employee is faced with his poor

performance and the assumption that this performance resulted from his drinking. The emphasis is on job performance and he is told that if his performance does not improve, he must enroll in a treatment program or be fired.

This procedure reaches an important segment of the population. Workers are per se a selected group; they are still actively employed and ostensibly value that employment. The threat of job loss is powerful coercion indeed. For this threat to be maximally effective, an actual employee assistance program should be in place or reasonably available. It is a great added advantage if families of employees can be included in these programs, and in more enlightened companies such coverage has been arranged.

The same model has been attempted by the armed forces, in particular the navy, with similar success. Other attempts, however, have not been so effective. Impaired-physician programs also offer a powerful threat, loss of medical license if treatment is refused, but the success of these programs is difficult to judge because of the traditional secrecy within the medical profession. Programs for incarcerated drinkers are also difficult to measure. Efforts of teachers and school health authorities to find young drinkers early and coerce them through their wish to remain enrolled apparently have been unsuccessful in making referrals that stick. Perhaps these questionable efforts have not found the right incentive.

Detoxification

If a patient has been drinking heavily, and is addicted to alcohol, when the alcohol use stops, he will go through the physiological symptoms of a withdrawal syndrome. The purpose of detoxification is to bring the drinker safely, and as comfortably as possible, through the sickness of withdrawal. Most drinkers go through withdrawal repeatedly without detoxification. Different types of detoxification procedures are available. They may be inpatient or outpatient, with drugs or without, with nonprofessional or with professional staff, usually both, with counseling offered toward the end of the period or not. They may be embedded in a larger alcohol program with aftercare and further treatment available, or simply in a free-standing center offering only detoxification itself or, as often occurs in hospitals, offering little but treatment of the complications of addiction, such as liver disease and trauma.

The decision about the type of facility often depends as much on what is available and the bias of the referring source as it does on a careful clinical decision. Reports in the literature do try to set some standards. For outpatients, Imboden et al. (1978) recommend four or five days on central nervous system depressants, plus thiamine; the patient should be seen at least weekly and tranquilizers tapered off after two or three weeks. Many recommend a much shorter period—three days except in complicated cases.

Imboden et al. (1978), writing for the general physician, state that hospitalization is mandatory if there is disorientation, hallucination, the shakes, dehydration, fever over 101°, medical or neurological complications, or seizures in the nonepileptic patient. If d.t.'s occur, they say, patients "require a level of medical and nursing care comparable to that of an intensive care unit," since most cannot take liquids by mouth. Most alcoholics need a better diet, with large amounts of thiamine to offset their malnutrition.

Almost all acute detoxification procedures call for palliative psychoactive medication to ease withdrawal. Problems about medication arise because some symptoms of withdrawal can continue for months and years. It is understandable that the recovering alcoholic may ask for drug relief of these symptoms, and, as Tamerin (1978) points out, in office practice many are given minor tranquilizers. Among the writers in this volume Khantzian might agree with this procedure, particularly if the symptoms include prolonged anxiety and sleeplessness. Other writers in this volume—Vaillant, Bean, and Zinberg—agree more with the A.A. position except in certain cases. This clinical position holds that the prolonged use of such medication beyond the acute withdrawal stage acts first as an alternative to drinking, but soon is experienced as tantalizing and, especially as tolerance develops, invites a return to drinking for the full desired effect instead of the feeble alternative of low doses of tranquilizers. It is a difficult dilemma for both the caregiver and the recovering drinker, and probably in the long run

more an issue for treatment than for the detoxification procedure; but the reason given for the prescription is often detoxification purposes.

Treatment

There is no generally accepted notion of exactly what alcoholism treatment is. It is worth saying quickly that while most people think of a medical model as specific—for example, prescribing penicillin for pneumococcus pneumonia—in fact for most conditions decisions about when to treat what and how to do it are far more diverse and conflictual than is generally acknowledged. Hence alcoholism treatment, with its enormous diversity and conflicts, can be seen as a paradigm for all of the biopsychosocial conditions. Thus far in this discussion we have indicated that treatment actually begins with the recognition of the alcohol problem by significant others or by the individual himself. If others, then the drinker must be made aware of the problem and referred to some professional or nonprofessional treatment situation. During that introduction to treatment, beginnings are made by the drinker; his family and his job, if he has retained one, are in a sense being prepared for treatment proper, which may take weeks, months, years, or, as A.A. believes, a lifetime. Probably most authorities on alcoholism would agree with that time frame. There may be some value, however, in separating treatment into periods which are not entirely dependent on duration. The first is the period of active treatment,

where the drinker must face his destructive behavior patterns and learn to live without depending on alcohol, no matter how long that takes. The second is the time necessary for him to consolidate and integrate these changes into a life style and a personal view of himself not drinking, as Mack theorizes in his chapter in this book.

This generalized overview of treatment encompasses programs as diverse as the A.A.-oriented program described by Vaillant and the direct psychiatric treatment approach described by Khantzian in this volume. The pigeon in A.A. must find a sponsor, attend meetings, get the message about his destructive behavior patterns and learn to live without his dependence on alcohol. Whatever the vast difference in approach, the patient-neophyte-pigeon going the psychiatric or counseling route must find a therapist, meet with him regularly, and begin to understand about destructive behavior patterns and learning to live without his dependence on alcohol, so that at some level of consciousness these issues can be articulated.

In practice today most recognized alcoholics are referred to one of the 16,957 existing A.A. groups (Diesenhaus, 1980). A.A. members participate either as volunteers or staff at many of the active detoxification centers, and much of the counseling offered by non-A.A. members aims at getting the drinker into A.A. Nevertheless, as Baekeland (1977) correctly points out, even with the enormous growth of A. A. it still accounts for only a fraction of the

alcoholics. Probably an equally small fraction spend a long span of time in active counseling or psychiatric programs aimed at working out the emotional issues associated with dependence on alcohol. Certain very specialized treatment concepts such as behavior modification probably account for a handful. Where are the rest?

To understand the apparent discrepancy between the number of alcoholics in treatment and the number of alcoholics requires an understanding of the disorder itself. As we have noted, many who would be classed by others as alcoholics refuse to see themselves that way and stay away from treatment. More central is that the above-mentioned figures of 1.7 million in formal treatment programs and 671,000 in A.A. are not a count of static groups (Vischi, 1980).

The recently sober alcoholic is terribly vulnerable. Most detoxification programs do not allow enough time for recovery, and many only treat the complication of withdrawal, without referral to treatment for the underlying drinking problem. “The rate of drinking relapse following inpatient treatment is discouragingly high, and of those who relapse, more than 80 percent do so within two months after discharge. Furthermore, the dropout rate from outpatient treatment is typically greater than 50 percent. On the other hand, it is known that if an alcoholic can remain abstinent for one year, his chances of remaining abstinent are excellent” (Chalmers & Wallace, 1978). Writing for

the general practitioner, Imboden et al. (1978) utter a necessary reminder: "Alcoholism is a chronic illness and, as with any chronic illness, there may be relapses after varying periods of remission. The occurrence of a relapse does not mean that the treatment plan has been a total failure." But it does mean that the 671,000 people in A.A. in a given year or the 1.7 million in programs may represent many who, at least the first few times around, stayed only a short time.

Another factor, more encouraging, of which far too little is made, is spontaneous recovery. Studies by Waldorf and Biemacki (1978), Lemere (1953), and Kendall and Stanton (1966) on addiction show that this occurs far more frequently than has been acknowledged. The drinker who decides to stop often has a "reason" such as a religious revelation or a response to a death or illness, but investigation often reveals similar occurrences earlier that had no effect on the addiction. Study of spontaneous recovery is of great importance to any concept of alcoholism treatment because just as there are chronic alcoholic recidivists, so too are there many who respond surprisingly favorably—given the tenacious nature of alcohol addiction—to relatively brief treatment.

Vigorous programs that reach alcoholics before they are entirely in the most severe (gamma) stage (Jellinek, 1960) report excellent results. For example, the navy has a model rehabilitation program begun by Zuska

(1978), with reported success at two years' follow-up of 84 percent for patients twenty-six and older, 50 percent for patients twenty-five and younger. Officers and enlisted men attend the same group therapy sessions; Antabuse is usually prescribed; and attendance at A. A. meetings is compulsory. Initiated quite informally by Zuska and a retired, sober alcoholic commander, the program at first met stiff opposition. Two witnesses to the navy's open-mindedness are the program's quick expansion (facilities to treat 20,000 men per year, if necessary) and the fact that petty-officer graduates have a slightly higher than average rate of promotion to chief petty officer. Certainly a study of such a program in the armed services that included the role of overt or covert coercion would be most interesting. Many active employee assistance programs report similar results.

Another factor which accounts for alcoholics not in treatment is access. Although, as stated earlier, all figures to do with alcoholism are highly suspect, several studies over the years indicate that the poor and particularly the poor of certain ethnic groups, such as blacks, Hispanics, and American Indians, have a disproportionately high percentage of alcoholics. These people have the least access to treatment. Zimberg (1978b) not only documents the existence of large numbers of black and Hispanic alcoholics who have never been in treatment, even briefly, but also discusses their responses to treatment programs, once even the most minimal demonstration projects have been established. He shows that the poorest

alcoholics are more likely to be diagnosed psychotic or brain-damaged than alcoholic, which also deprives them of proper treatment. This is an important finding. In order for us to know how responsive they might be in treatment if it were more widely available, Zimberg's work deserves attention, for there is little documentation about work with this neglected and underserved group.

For example, Zimberg (1978b) describes a demonstration day- hospital program set up in Harlem (black) and in East Harlem (mostly Puerto Rican). The staff were recovered alcoholics from the area, plus social workers and a psychiatrist; the clinics gave "medical examinations and treatment, psychiatric evaluations and treatment, individual and group therapy, and disulfiram (Antabuse). Patients graduated from the day-care program to the more intensive treatments that were available. . . . " The Harlem day program (black) gave alcohol education, provided social opportunities and outings, and so on. When patients had been sober for a reasonable time, they got vocational training and eventually jobs, at which point they became so anxious that some relapsed and all needed a great deal of support. If they stayed sober, there was a once-a-week follow-up, Antabuse if needed, urgings to go to A.A., and weekend clinics for support; they could come back any time.

The program for Puerto Ricans was a bit different: more family therapy, less A.A., less Antabuse. The men thought it manly to drink; the women were not supposed to drink, and if they did, they felt tremendous guilt; families

were much closer. Of course, the staff had to be bilingual. Zimberg points out that if the drinker had nothing to lose by drinking, he would go on doing it, and that he had difficulty finding new or improved jobs for his recovered patients.

The most important recommendations about treatment for alcoholics have a high level of agreement. Such questions as whether to use A. A. or a professional and whether to see people individually, in a group, or in a family setting evoke strong conflicts, but observers agree that once sober, alcoholics prefer, as Wallace (1978) says, "a state characterized by a moderate-to-high activation level. Witness the enormous amounts of stimulating drugs, e.g., caffeine and nicotine, consumed by sober alcoholics. Even the so-called states of serenity of many sober alcoholics are intensely focused states of moderate-to-high activation rather than low. . . . The problem ... is not to reduce obsessional energy, an often impossible task, but to switch the focus of the obsession."

This statement is as true of any A.A. meeting as it is of any professional detoxification center or day-care facility. Once the alcoholic is sober, his energy must be channeled into something that he can feel is worthwhile so that his life is meaningful. It is this that makes Zimberg's concern about the paucity of available jobs so poignant. Authorities agree that the time of newly won sobriety is a crucial period. A. A. advises the most tender care of oneself;

Wallace (1978) says ‘‘self-centeredness” is useful and desirable. Once in A.A. or any other treatment, alcoholics increasingly learn to “surrender” their resistance. They acknowledge loneliness and dependency needs. Thus, as Mack and Khantzian say in this volume, they may not have too severe an impairment of the self, and it may be rebuilt.

Abstinence as a Treatment Goal

The question of whether alcoholics can ever drink again safely is one of the most emotionally fought battles in the field. Proponents of each view sometimes behave as if the answer will be settled by the group which can muster the largest numbers or be the most vocal, rather than by posing questions and doing research to answer them. Perhaps the intensity of the controversy will seem more comprehensible given a context. Many of the pro-abstinence group are A.A. members or steeped in the A.A. philosophy. They have seen or felt the ravages of active alcoholism. They also know from vivid and repeated experience that almost all alcoholics wish with poignant intensity to be able to drink without harmful consequences. The wish is so intense that some are not able to acknowledge that it is a fantasy that they repeatedly attempt to bring about in reality, often with disastrous results. It is clear that for some alcoholics, the attempt to drink is dangerous, excruciating, or both. The amount of pain and destruction to life, job, self-esteem, and family from a relapse may be enormous.

This group tends to see anyone who says that an alcoholic may be able to drink safely as an ally of the disease and possibly a sadistic, deliberate saboteur of the alcoholic's comfort and safety. It is important to remember that A. A. has received little or no help from professionals at any time and that many alcoholics have received what they considered poor treatment at the hands of professionals, such as being given drugs that provoked craving and precipitated a relapse or established a second addiction. Understandably, they are self-protective and suspicious.

Many of the proponents of moderate drinking as a possibility for alcoholics are professionals with research backgrounds. They see themselves as genuinely curious about objective reality, with no ax to grind, and with the intention of working to provide real information about the nature of the disorder, with the hoped-for consequence of improved understanding and care of alcoholics.

When some of these researchers announced their findings that some alcoholics could return to moderate drinking, at a press conference prior to publication of *Alcoholism and Treatment*, the so-called Rand Report (Armor, et al., 1976), they were naively appalled to find themselves vilified and attacked. The Rand Report suggested that "some alcoholics can return to controlled drinking, and in fact that for one group—men under 40 who are not yet 'highly dependent' on alcohol—those who returned to social drinking were

less likely to relapse into alcoholism than those who abstained," and that "alcoholics who attend A.A. are not more likely than others to be freed of their dependence." The study was conducted by the Rand Corporation for NIAAA, whose directors rejected the report and continue to insist that abstinence is "the most important goal" and that alcoholics who can return to social drinking may never have been real alcoholics anyway, which takes us back to the inevitable question of the definition of alcoholism. Much other research, as Gitlow (1979) points out, tends to support the possibility of a return to social drinking. But ambiguities in methodology, the unspecific qualifier "some alcoholics," and the disastrous results when some alcoholics try to drink socially raise questions. Many authorities insist that any sober alcoholic who wants intensely to drink, even "socially," may be about to relapse. The controversy leads to flat polarized statements of each point of view.

For all practical purposes, at the present time abstinence is considered the goal in the treatment of all alcoholics. Zimberg says that "alcohol is not necessary to life, and it is quite possible to live and even be happy without consuming alcohol" (1978a). More wryly, Gitlow says, "1 must confess to some surprise that we have spent so much money and time during the past decade to realize that some alcoholics can drink alcoholic beverages some of the time" (1979).

If these comments seem harsh on those who advocate some return to

drinking, it should be noted that they respond to the points of view of those who have felt virtually destroyed by alcohol. Some recovering alcoholics believe that many advocates of a return to social drinking are nonalcoholics who unconsciously wish to protect and justify their own controlled drinking. It is extremely difficult for the alcoholic, whether recovering or not, to conceive of the importance to many controlled drinkers of moderate drinking. The alcoholic, whether he admits it or not, and many do. may see moderate drinking as too little to do much good and too much to allow an independent life.

We take the position that this view is probably right. Some alcoholics, probably those with shorter histories of alcoholism, few symptoms—less than seven or eight positive answers to the twenty-six NCA questions (National Council on Alcoholism, 1975)—and little or early addiction, may be able to resume social or moderate drinking, though often by reliance on external devices such as tallying drinks (National Council on Alcoholism, 1975). But other alcoholics appear from clinical experience to lose control of their drinking if they try this and should be expected to need to be completely abstinent. All of the authors in this volume stress the importance of abstinence, Khantzian at the outset of treatment in particular. He goes on to emphasize an approach that considers the possibility that therapist and patient can work together toward a resumption of controlled drinking.

Though a life of abstinence seems unimaginable and unattainable to many alcoholics at the outset of treatment, the work is usually less harrowing and easier for both therapist and patient if abstinence is established at the start. For practical purposes, most of us take the position that it is a mistake to let the possibility of controlled drinking in the future come into question until late in treatment (one of us, Bean, may suggest that the patient wait five years before considering it, and by then it is rarely an issue). Perhaps the best way to deal with it, unless and until the patient is deemed ready to choose, is to say, "We don't know, but we doubt it." "An issue as critical as controlled drinking for alcoholics requires extensive, rigorous, ecologically relevant, and methodologically sound research. Laboratory studies of drinking behavior lack ecological relevance (Mello, 1972)" (Wallace, 1978). Recent research on the existence of naturally occurring substances such as the endorphins raises questions about what unknown physiological changes may result from prolonged addiction that would leave an individual with quite different capacities to tolerate a particular substance. "Anecdotal reports (Davies, 1962) and recent large-scale survey research methods on treatment outcome (Armor et al., 1976) lack methodological rigor" (Wallace. 1978). Moreover, these studies are addressed principally to the separate issue of spontaneous remission. "While controlled drinking remains a theoretical possibility for some unknown number and equally unknown type of alcoholic, it has no practical application in alcoholism treatment at the present time" (Wallace,

1978).

Where Do We Go from Here?

As we hope to have conveyed, there is no tight blueprint, no Manhattan project, to direct future work on alcoholism; nor, in our view, should there be. Alcohol use and its sometimes destructive consequences are themselves too intertwined for a clear path to emerge. Obviously, what we and everyone else would like to see is a direct assault on the destructive consequences of drinking, without assaulting the cultural assessment of the usefulness of drinking. All too often in the past, both in this country and in other parts of the world, the assaults have been monolithic— prohibition—and unsatisfactory.

The development of social policy ignores at its peril the ancient and obvious fascination of Western culture with drinking. No topic, except perhaps sex and, in the past, religion, has so large a slang vocabulary as drinking; and slang coinage is a folk art of sorts, a way of manipulating import, ascribing meaning, evoking—or modulating—emotion, aggrandizing or minimizing, veiling awe, mocking fear, touching taboo. Consider the Bacchae, the Orphic mysteries, superstition, and Christian sacrament. Some kind of magic is certainly involved, and it survives (even now it is thought unlucky to offer a toast in water).

Drinking songs have long abounded in this culture, but most, rather than invocations to intoxication like “Lucy in the Sky with Diamonds,” are formal poems like “Anacreon in Heaven,” the original words for “The Star-Spangled Banner” melody. This too suggests the extent to which this culture is in transition. While in all probability the startling growth in the number of people who regard themselves as “born again” indicates that the death of religion was announced too soon, this culture has secularized its most profound fascinations, including sex and drinking. They are “studied” nowadays, though the studies are still hobbled by superstition and anxiety, suggesting that the transition has some way to go.

“Higher authority” is no longer an article of belief; and with it has gone the sustaining trust in an afterworld, where one had counted on discovering at last, and if need be restoring by atonement, the worth and the meaning of one’s life under the divine plan. The only “plan” we can gloss takes place in the mortal inner world to whose richness and riotous conflict we were directed by Freud. This brings us down to Mack’s concept of the self, in which social interactions, as they serve, by back-and-forth mirroring, to define the individual, are not merely a surround or matrix, but an essential part of the self; down, moreover, to his perception of A.A.’s “higher authority” as fulfilling a profound need of the impaired, alcoholic self.

Certainly A.A.'s willingness to place that higher authority in the context

of “God as you understand Him” makes it possible in many chapters to separate A.A.’s notions from more formal religious views of God. A.A.'s entire tradition of volunteer service, anonymity, and acceptance of suffering humans, no matter what their condition, is compatible with modern evangelical practice and strengthens A.A.'s authority. In A.A. an alcoholic contracts for the rest of his life “to atone for his failure—to combat his disease” (Alcoholics Anonymous, 1939; Alcoholics Anonymous, 1955). This reliance on a moral core is far too little understood by most of the “self-help” organizations that have attempted to copy one or another aspect of A. A., many of which, while using words like “anonymous” in their titles, are profit-making ventures.

The economic aspect cannot be overemphasized in its implications for the future. Just as we must attempt to protect moderate alcohol use while we struggle against alcoholism, so must we protect A.A. while we attempt to upgrade professional services which need greater financial support. Everything we hope for from the future will cost money. The development of employee assistance programs, the integration of alcoholism services into the general medical system, the improvement of detoxification and follow-up services for the indigent, the inclusion of alcohol problems in third-party payments, and, in particular, the expansion of special services for special problems such as those of pregnant women, minorities, and non-English speakers—all these can be reliably expected to save money in the long run

but require initial major investments.

That alcoholism services save money in the long run is no illusion, and this is not only true of industrial and military programs which reduce absenteeism and other costly lapses. Zimberg (1978b) notes the economics of a program for "the treatment of chronic alcoholics in a hostel-type' alcoholic rehabilitation program compared to the involvement of the patients with the criminal justice system through arrests for public intoxication. This study was carried out by graduate students in Monroe County, New York.[3] The study determined that the alcoholism rehabilitation program generated a benefit of $147,556 greater than the cost of the program through the patients' increased productivity, work-program operation, jail-costs savings, reduced judicial caseloads, and increased public services. . . . Adding variables related to the social, health, welfare, and criminal-justice system costs of no treatment can demonstrate that alcoholism treatment for the poor can have major economic impact for society beyond the help for the particular patient in treatment."

For the investment to be made, the public and various official agencies must be sufficiently aware of the problems of alcoholism, what it does to our society, and the grounds for cautious optimism about its treatment. To create such awareness requires, of course, an initial investment. We cannot in this chapter delineate all of the educational and research efforts that we believe will encourage such awareness, but we would like to mention a few that

might be crucial.

In so many respects the role of physicians is critical. There is ample evidence that when a career teacher or a career researcher operates within a medical school, the space in the curriculum for that person's specialty expands. The NIAAA program in this area should be expanded, and efforts to recruit people into this heretofore unpopular field need thoughtful attention. If our previously presented finding is taken seriously—that courses about alcohol use usually present only obvious cases, so that the range of issues is hardly understood by the students—a whole change in the philosophy of this teaching will be accomplished.

Certainly the increased involvement of health care professionals should not be limited to physicians and certainly not to psychiatrists. Nurses are a crucial group and must not be neglected. Williams (1979) reminds us that nurses dislike alcoholics even more than the general public does, and there is little doubt that in part this is due to the paucity and poverty of the training they receive in this field. The training of nonprofessional vocational and occupational workers and counselors recruited from both recovering alcoholics and nonalcoholics is absolutely necessary.

Some of the best work in the health field is being done by psychologists, sociologists, social workers, biostatisticians, and even anthropologists. But

education must go beyond the health care workers and the professional disciplines to reach the general public. The National Commission on Alcoholism, which began its work in February 1981, will have much to say about this central goal. Such education goes beyond simplistic warnings about harm to the greater sophistication of ways to manage alcohol use responsibly, abstinence being only one of those ways. There is little doubt that one of the Commission's recommendations must be for greater cooperation between the public and private sectors.

Research will require similar levels of cooperation. Medical research is usually ambiguous in this field because it is so difficult to set up controlled studies, because baselines are difficult to determine (what is a "normal" drinker?), because one cannot induce disease in humans in order to study it, because "informed consent" is a peculiarly tricky matter, because pathologies do not come singly, but in clusters (and in alcoholism the clusters can include almost anything), and because socioeconomic factors are always present and difficult to evaluate. In addition, alcoholism is hard to define (Zinberg's chapter), self-reports are suspect (Vaillant's chapter), and physicians know very little about experimental design and statistical techniques.

Physicians are often forced to rely on anecdotal reports—e.g., alcoholism-linked zinc deficiency in exactly two patients (Williams et al., 1979). Moreover, though clearly the number of reported alcoholics is very

large (though not in proportion to the population), as we pointed out earlier very little is known about spontaneous remission. In any case here are a few general suggestions for research:

1. Prospective studies of predisposition to alcoholism, including genetic, physical, social, emotional, ethnic, and racial factors

2. Studies of untreated alcoholism and "spontaneous" recovery

3. Epidemiological, cross-cultural, psychological, and sociological research on the natural history of alcohol use

4. Studies of special subgroups of alcoholics—e.g., psychotics, children, women, and families—including initial presentation, rates of progression, types of clinical courses, and different stages and types of disturbances

5. Studies of efforts to refine the NCA criteria and other classification systems in order to allow more accurate predictions

6. Studies of different treatment methods, including the treatment of different types and stages of alcoholism, and studies of the process by which different patients-clients select or are matched with different types of treatment

7. Studies of selected examples of successful intervention, e.g., A.A., behavioral, psychiatric, and psychoanalytic studies of the recovery process

8. More and better studies of the abstinence issue

One final caveat. The suggestions we offer for education and research are fairly specific and indicate that broadening our knowledge base and promulgating our information about alcohol use and alcoholism will afford better prevention and treatment of problems and safeguard formal and informal social controls over use. In the field of the study of intoxication there are overwhelming imponderables. The years 1962 and 1963 are usually given as the beginning of the drug revolution (Weil, 1972; Zinberg & Robertson, 1972). The general classes of drugs such as psychedelics, cannabis, opiates, and cocaine have been available for many years, but despite occasional bursts of social concern, their use in this country before 1962-1963 had been sharply limited to small, usually deviant groups.

Since the early 1960s very large numbers of people have tried many of these drugs: perhaps 50 million have tried marijuana, 10 to 15 million, cocaine. In the early to middle 1960s psychedelics were the rage, then cannabis; then we had a heroin "epidemic," and now cocaine is in the forefront. When the wave of preoccupation with one or another of these drugs has passed, the use of that drug continues. Perhaps not many of those now caught up in the quick spurt of stimulation from cocaine care much about psychedelics (although most of them have used marijuana), but there is a legacy of interest in psychedelics that continues in this culture. The folklore about its use remains alive, and there are flurries of revival of interest. A case can be made that these waves of use of different intoxicants and the residue

of users are an inchoate social effort to test the impact of a variety of intoxicants on our social structure and learn how to integrate and institutionalize such use.

If this is so, then this effort must be in a very early stage. Except for a brief period in the 1960s when "heads" (marijuana users) put down alcohol use except for a little wine, and "juicers" (alcohol users) were violently opposed to marijuana use, all of this drug use has been accompanied, sooner or later, by alcohol use. It is very hard to guess what effect increased drug use will have and in particular what the integration of the use of other drugs will have on alcohol use and the development of alcoholism. Predictably, most attention and concern have been directed to the potential for the development of dual addictions. It is our hope that studies of the social synchronization of these factors in our culture will not limit themselves to the damaged end products alone.

Finally, it is possible that novelists and poets may give us access to the inner experience of the alcoholic, as the last century's *poetes maudits* and the popular singers of the 1960s did for the drug addict. As the critic Alfred Kazin (1976) has noted, it was not until this century that alcoholism became an occupational hazard for creative writers. If today's creative writers write more about their experience of it than they have so far, then their productions will put into words necessary information about the changing influence of

alcohol on our culture. The use of alcohol has been with us for millennia, but its influence in degree and kind constantly changes and requires constant monitoring.

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Notes

[1] The word “alcoholism” was coined in 1852 (Onions, 1952).

[2] ”In a recent survey, 23 percent of a random sample of psychotherapy patients seen in a large metropolitan mental health center were suffering either from addictive problems or from emotional problems substantially exacerbated by alcohol or drug abuse, and only 3.5 percent of these were so identified by their own therapists” (Cummings. 1979).

[3] Monroe County, New York, has one large city, Rochester, population about 350,000, and is otherwise fairly wealthy and suburban.