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COUNSELING THE ALCOHOLIC
AND DRUG ABUSER

by

Carolyn B. Yaple

A Project Report
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Specialist in Education Degree

Western Michigan University
Kalamazoo, Michigan
April 1976
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Carolyn B. Yaple
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CHAPTER I

THE PROSPECTUS SUBMITTED PRIOR TO
THE INTERNSHIP EXPERIENCE

The January House Drug and Alcoholic Rehabilitation Unit, Veterans Administration Hospital, Battle Creek, Michigan, provides treatment for approximately 120 men having substance abuse problems; about 10 percent of these men have a drug dependency other than alcohol.

The program consists of a nine-week involvement in a therapeutic community. The residents take part in two hours of group therapy daily and perform daily work assignments. A physical fitness program and educational and occupational workshops are further therapeutic activities in which the men are involved. Each resident is a member of a group of 10 to 12 persons who advance through the treatment program together, often establishing close personal relationships.

The primary goal of January House in treating the drug dependent veterans is to assist the men in effecting positive changes in their lives, e.g., learning more appropriate social behavior, improving communication skills, and developing a perception of alternate ways to deal with life's stresses.

During my internship at January House, I plan to be involved
in group therapy and to be available for individual therapy. I expect to become more skilled in facilitating group processes, in effecting the development of therapeutic client-client encounter, in using the group as a method to alter maladaptive strategies, and in refining my communication skills especially as they pertain to group therapy.

Institution

Veterans Administration Hospital, January House Drug and Alcoholic Rehabilitation Unit, Battle Creek, Michigan

Adviser

Dr. Kenneth Engle, Professor, College of Education, Counseling and Personnel Department

Supervisor

Lynn Becker

Time Period

Winter Semester, 1975 - total hours 366

Rationale

The January House program will afford me the opportunity for concentrated experience as a co-leader in group therapy. This internship will be especially valuable by enabling me to work both with alcoholics as well as with abusers of other drugs. To me this
is an important consideration because I desire to become knowledgeable and experienced in helping both of these groups. The scope of the program is advantageous because it provides greater exposure to drug and alcohol problems. I believe the large staff (about 25), with diverse experiences and educational backgrounds, will further add to my growth as a counselor and co-leader of groups.

Goals and Objectives

1. To become skilled in facilitating group processes.

2. To become skilled in interpreting group dynamics.

3. To become skilled in effecting the development of therapeutic client-client encounter.

4. To become skilled in using the group as a method to alter maladaptive strategies.

5. To become skilled in assisting group members to move at approximately the same rate.

6. To refine communication skills especially as they pertain to group therapy.

7. To become more familiar with additional group techniques.

8. To gain an understanding of intake, or admitting procedures.
   a. Information to be obtained during first contact
   b. Dynamics of intake interview

Method of Goal Achievement

1. Observation of the group process and group dynamics.

2. Participation in group therapy sessions.
3. Observation of didactic sessions.

4. Participation in didactic sessions.

5. Observation of intake or admitting procedures.

6. Involvement in in-service education.

Cognate Goals

1. To become informed regarding agency policies and procedures.

2. To become informed regarding agency services and the place of the agency within the community.

3. To understand agency philosophy and rationale for the specific approach to the substance abuse problem.

4. To identify, with the assistance of the supervisor, selected problems and service gaps in agency operation.

5. To become skilled in record keeping and data collection.

Note:

Having worked with substance abusers for a few weeks, I feel the need to formulate two additional objectives.

1. To gain a clearer insight into the personality characteristics and special treatment difficulties of the alcoholic client.

2. To gain a better understanding of the personality characteristics, developmental needs, and special problems of the young drug abuser.
CHAPTER II

REVIEW OF SELECTED LITERATURE

This chapter includes a review of selected literature related to personality variables and treatment modalities of alcoholics and drug abusers.

The review is devoted to areas relevant to the author's internship and individual needs in an effort to enhance learning and experience.

Personality Traits of Alcohol and Drug Abusers

Studies have failed to produce evidence pointing to a distinct set of personality traits related to alcoholism and drug abuse. Though there has been some consensus among investigators, the agreement seems to be on superficial characteristics which are found among other emotionally troubled persons. Roebuck and Kessler (1972), in their review of studies of alcoholic personalities, state some correspondence on: emotional lability; escape from conflicts through the use of alcohol; deterioration and regression; dependence on others for psychological and economic support; and difficulty in handling strong affect. It is evident that the above personality variables lack specificity and may be found in non-alcoholics who have various personality problems.
"Keller's Law" asserts that "the investigation of any trait in alcoholics will show that they have either more or less of it (Keller, 1972:1147)."

Since most studies of personality variables are ex post facto, it is not certain whether the personality traits concluded to be related to alcoholism are precursors to alcoholism or the result of alcoholism. Gale and Frances (1975) assert that "the deterioration of chronic, severe drinking is a great equalizer so that patients who began the journey with varied personality types and reasons for drinking come to look very much alike (p. 241)."

Longitudinal studies are necessary to determine cause and effect of alcoholism and to answer the question of whether a particular set of personality traits predispose to the development of alcoholism. Roebuck et al. (1972) discuss McCord's longitudinal study, published in Origins of Alcoholism (1960). McCord studied the interrelationships between prealcoholic boys and their mothers and through an analysis of the behavior pattern of 29 boys determined a prealcoholic personality type. He concluded that prealcoholic boys experience a strong conflict between the desire to be independent as prescribed by society and an equally strong need to be dependent proscribed by society for males. The dependency need continues into adulthood where the male is faced with the
quandry of either suppressing it or expressing it. This expression may incur censure from society and the loss of the individual masculine image. McCord states that there are several alternatives to this dilemma whereby the male will not have to suffer continual repression of his dependent needs: he can marry a strong domi-
neering woman; join the army; enter a monastery; or go to jail. Another alternative is excessive drinking whereby the male may believe he can satisfy dependent desires yet maintain a masculine image.

Cross-cultural data supporting the dependency conflict hypothesis have been re-analyzed by Bacon (1975). Frequency of adult drunkenness is related to an insufficient gratification of the dependency needs of the infant and child, to excessive emphasis on achievement (established in childhood), and to the intolerance of dependent behavior in adulthood. Results from 53 societies strongly support the dependency conflict hypothesis.

Conversely, evidence indicates that in societies where sobriety is the norm dependency needs of infants are satisfied by many people, demands for achievement are not stressed, and dependent behavior by adults is accepted.

Alcoholics obtained higher dogmatism scores as measured by the Rokeach Dogmatism Scale (more closed-minded) than non-
alcoholics (Butts & Chotlos, 1974). Feelings of helplessness and
a strong need for power are characteristic of those who are closed-
minded. To the degree that a person is alienated and helpless, he will form closed systems of beliefs and disbeliefs. The alcoholic attempts to overcome these feelings of isolation and helplessness by excessive concern for power and status.

These findings have some important implications for therapy. The closed, stereotype thinking must be dealt with before learning and behavior change can take place. Butts et al. (1974) point out that with closed-mindedness not only are new information and self-directed demands for change avoided, but changes in the self-concept may be evaded. They further suggest that a program focusing on helping the individual experience a sense of power may assuage the closed-mindedness by encouraging a re-evaluation of self-concept.

Minnesota Multiphasic Personality Inventory (MMPI) profiles of alcoholics and narcotic addicts were examined by Overhall (1973). He found that neither the alcoholic nor addict belonged to a homogeneous group. The alcohol addict can be distinguished from the narcotic addict because of a larger proportion of neurotic depressive profiles. The alcoholic is seen as neurotic, depressive, anxious, passive and dependent. He exhibits tearful crying behavior, depressed and labile emotional tone, and feelings of inferiority and guilt.
The narcotic addict displays sociopathic, psychopathic character disorders. His profile is antisocial, amoral, impulsive, irritable, and hostile. His history reveals emotional instability and childhood behavioral problems.

A particular personality pattern of the drug abuser emerged in a study by Cohen, White, and Schoolar (1971). They describe the drug abuser as domineering and critical, openly defying authority figures, having the inclination to be passive and suspicious, avoiding personal and social responsibility, and rejecting traditional values, preferring nonconformity. The addict may see no redeeming features in society's values, or perhaps he does not perceive any possibility of achieving such values--therefore, protecting himself by rejecting them.

The most significant finding of this study is the discrepancy between self-rating and the underlying character structure (passive and hostile). The discrepancy suggests a state of tension and anxiety beyond the individual's understanding of this experience.

The authors believe that this gap in development is of long duration. They suggest that Erikson's (1969) conception of identity diffusion is particularly significant for drug abusers. Their behavior may be an effort to establish some kind of identity, negative if necessary, in order to escape the pain of no identity. The drug abuser now has a place in the world and consensual validation
from his subculture.

Those who are to help the drug abuser must be aware of his severe identity problems, despair over his perceived inability to be important and recognized in this society. The therapist must be able to accept acting out, often used to test acceptance, and must be capable of dealing with rejection.

Focus on drug abuse itself is believed by Cohen et al. to be counter-productive: (1) the patient is not able to verbalize in a cause and effect manner and is adept at using words to prevent real communication, and (2) focusing on one aspect of behavior may encourage his negative identity and discourage a perception of himself other than as a drug abuser.

Through administration of the MMPI and information elicited regarding previous contact with mental health agencies, Smart and Jones (1970) studied personality characteristics and psychopathology of 100 LSD users and 46 non-users. There was a considerably higher incidence of pathology among LSD users than among non-users; 96 percent of the profiles of the LSD users were judged to be abnormal (having a T score of 70 or above on one or more of eight clinical scales), while 46 percent of the non-users' profiles were judged abnormal.

Eight special scales were also used in this study which showed a significant difference between the groups. From these subscales
the LSD users "show a greater tendency or desire to escape from restrictions, have higher incidence of familial discord, more authority problems and feel more socially-alienated and self-alienated than the non-user (Smart et al., 1970;290)."

From the interview data it was determined that the majority of LSD users, 51 percent, had previous psychiatric treatment and that most of the contacts predated LSD use, while 17.4 percent of non-users had previous psychiatric treatment.

The LSD users sought help for behavioral problems, excessive anxiety, depression, hallucinations, paranoia, suicidal tendencies, and homosexuality whereas the non-users sought help from school problems such as inability to concentrate and test anxiety.

These researchers conclude:

Lower ego-strength and higher tendency toward psychoticism suggest that their (drug users) emotional difficulties may be of long duration. Some of these differences may have developed or increased after drug use, but they would seem to present major barriers to change (p. 291).

In attempting to understand the alcoholic, Garitano and Ronall (1974) make a distinction between cultural life-style (observable characteristic mode of living) and Adler's concept of individual internal life-style (subjective world based on personal experience of self and the world).

Having evaluated a large number of patients for therapy, the authors observed three character traits that were representative of
their population: (1) a deeply felt sense of inadequacy which emerged in earliest childhood memories; (2) hypersensitivity, notably in the area of interpersonal relationships; and (3) immaturity described as low tolerance for frustration with a need for instant solutions.

Because of these character traits the individual perceives himself as isolated, rejected, and helpless. He attempts to relieve these painful feelings by attributing to himself special qualities and by setting goals that will define him as worthwhile. He becomes self-critical and easily discouraged when he becomes aware that the goals are unattainable. In an effort to protect himself from further pain, he adopts a passive stance, a life-style of flight from others and eventually from himself. Such a person who lives in a society that encourages drinking for pleasure and relief of discomfort will adopt a cultural life-style of heavy alcohol use. The alcoholic cultural life-style is compatible with the individual life-style. Ultimately the alcoholic moves from using alcohol as a coping mechanism to using it as a substitute for performance. Alcoholism becomes the focus of the alcoholic's life, alcoholic symptomology replaces neurotic or psychotic symptomology and assumes a momentum of its own.

The above concepts have significant implications for treatment. Garitano and Ronall assert that alcoholism must be seen not as a symptom but as the primary problem. Alcoholism will not be eliminated when underlying neurotic symptoms are dealt with. It is the
task of the therapist to help the individual accept his alcoholism and find some substitute for its analgesic effect (AA, satisfactory employment). The therapist must be aware of the alcoholic's fear that his previous symptom will reemerge if he maintains sobriety.

Having helped the individual modify his cultural life-style, the therapist must then turn to the contradictions and self-defeating behaviors of his client's individual life-style. Since the cultural and individual life-styles have been so completely meshed, the therapist must be able to accept the almost inevitable relapses and must have the patience to start from the beginning as often as needed.

Birjerot (1972) asserts that drug dependence is an artificially-induced drive, having the character and strength of a natural drive, and developed through chemical stimulation of the pleasure center. He sees the development of addiction as "short-circuiting of the pleasure-pain principle" in which the addicting drugs supply gratification without the expending of effort but at the expense of adjustment. He agrees that abuse of drugs and alcohol are symptoms of psychological and sociological disturbances, but when addiction supervenes, the craving for drugs or alcohol becomes a morbid condition of its own. The individual loses the power to master the drive character of his craving. He has not lost all voluntary control over his addiction; he always retains some power to arrange the
details around its consumption. But it is as difficult to suppress his addictive behavior as it is to suppress his sex or hunger drive.

It is suggested that the therapist working with addicts accept the fact that addictive behavior can best be understood when it is recognized as a deeply-rooted biological phenomena. The addict will protect this drive as one would a sex drive; there is little free will functioning once dependence has developed. Treatment and motivation together must be stronger than the craving if there is to be success. Risk of relapse is especially present during the first few years off drugs.

Craving is conceptualized as psychological in nature by Ludwig and Stark (1974) who designed a study to determine what alcoholics themselves think about this debatable premise. As they point out, it is difficult to ignore the importance of an experience which occurs in 78 percent of their sample. Ludwig and Stark believe that the concept of craving has as much "phenomenological validity as hunger, anger, or sex desire." It is suggested that craving is a conditioned "cognitive label" which alerts alcoholics to the most dysphoric emotional states, providing them with an acceptable excuse to resume drinking.

A connection between craving, anxiety, and depression, as well as between craving and recent drinking, is reported by Hore (1974). Those in his study who reported craving were more likely
to have drunk in the last month and least likely to have been abstinent in the last three months. Hore believes a rigid division between physical and psychological craving is not tenable.

Summary

It is generally recognized by those in the field of alcoholism and drug abuse that alcoholics and drug abusers are a heterogeneous group, and that the term alcoholism denotes a multiplicity of pathology. Nevertheless, the passive-dependent personality is frequently associated with alcoholism.

Other personality traits of the alcoholic are: closed-mindedness, a tendency to be depressed, hypersensitivity in interpersonal relationships, and low tolerance for frustration.

There is some evidence to indicate that personality patterns of alcoholics are discernible during early adolescence, frequently developing because of a dependency conflict.

The drug addict exhibits sociopathic and antisocial behaviors. Much of the pathology of this group may be the result of a severe identity crisis.

Treatment of Alcoholism

A multidisciplinary approach to the treatment of alcoholism is essential because of the diversity of personality types and because the goal is not only abstinence but improved functioning in
all aspects of living.

An historical review by Keller (1975) deals with the multifaceted nature of alcoholism. Keller's hypothesis of the etiology of alcoholism incorporates: genetic or constitutional factors (a general vulnerability or immunity to the development of alcoholism); difficulties in the infant relationship or childhood development resulting in psychological vulnerability; the maldevelopment taking the form of overdependent or dependency-conflicted personality; and misdirected maturation during the adolescent phase, social and cultural phenomena being a significant influence. The vulnerable youth--having feelings of inadequacy or an insecure self-image--is rewarded for his heavy drinking by peer-group admiration and internal comfort. This double reward results in a subsequent learning or conditioning process with a negative balance of interpersonal relations; finally, the pharmacological properties of alcohol assume a dominant role in the individual's way of life.

Since the etiology of alcoholism is multifaceted, no one discipline or profession can hope to deal with the problem. Keller (1975) suggests that all disciplines must be involved in understanding, preventing, and treating the condition.

While recognizing the usefulness of a diverse number of treatment modalities, this review will only deal with the more recently published research and experiments in treatment. To advocate a behavioral orientation to the treatment of alcoholism and drug
addiction is not intended. However, this orientation has received much recognition in the field, and its value in helping the addicted individual must be recognized.

Regardless of intervention, it is absolutely essential to establish a warm, human relationship in which the client realizes acceptance and the knowledge that his feelings and experiences are understood (Rogers, 1961). The characteristics of a beneficial therapist-client relationship (as described most recently by Truax and Mitchell, 1971) are requisite to the therapeutic process, regardless of philosophical orientation. These are genuineness, non-possessive warmth, and accurate empathy.

The professional literature customarily deals with the treatment of drug addiction and of alcoholism separately. Consequently, the review of treatment modalities will be presented in two sections--treatment of alcoholism and treatment of drug addiction. The writer contends that many of the approaches and techniques used for one population may be used for the other and that both populations may be treated together.

The combination of humanistic and behavioristic psychology in the treatment of addiction is considered by Sorensen (1973). Humanistic psychologists believe that persons can choose to change their life-styles, and that each individual has control over his environment, although to a limited extent. The behaviorist believes that
behavior is learned and, in order to change, a person must unlearn the behavior.

These two approaches are seldom used complementarily in the same program; however, Sorensen asserts that they can be compatible. He suggests that the entire staff alternate between humanist and behaviorist techniques (depending on the goal desired) or that some of the staff may be humanist and others behaviorist. He describes a therapeutic community, Alpha House, where both approaches are used successfully.

Group therapy is usually used as part of a treatment program for alcoholism, which may include individual therapy and drug therapy as well as other types of rehabilitation treatment. The setting may be in a therapeutic community or on an outpatient basis. Many different approaches may be incorporated into the group therapy. The didactic approach is often incorporated early in group sessions. Confrontation, psychodrama, and transactional analysis are other popular forms of group therapy. The treatment techniques reviewed in this section are applicable to the group setting or therapeutic community.

In his discussion of behavioral techniques in Community Psychiatry, Parlour (1975) notes that behaviorism is universal and its principles operative in all aspects of animal life including treatment methods. He describes various techniques, the application of
which strengthens treatment, particularly with the unsophisticated and the sociopathic clients.

Contracting is fundamental to this approach; the client and therapist identify the behaviors to be changed and each make commitments that will facilitate such change. The rewards for the desired change are explicitly included in the contracts.

"Graded Privilege and Responsibility" (GRP) is closely related to the contract. GRP encourages clients to meet treatment commitments by providing privileges for accepting responsibility.

Time budgets help the client structure his behavior more responsibly and support his efforts at self-improvement. The therapist is able to quickly elicit valuable information regarding the source of the problem.

The Responsibility Inventory identifies possible responsibilities; the client then decides what behaviors must be added in order to achieve acceptable performance.

It is further suggested by Parlour that clinics establish voluntary or paid job opportunities as part of therapy.

In an attempt to restore the self-esteem (accompanied by feelings of guilt) in alcoholic patients, Burtle, Whitlock and Franks (1974) recommend two concurrent approaches: (1) training in new ways to view oneself—freeing the self from the effects of stigmatization; and (2) training in techniques of social interaction, developing
the ability to cope with difficult situations in the community.

In a pilot project to accomplish the above, the authors added several innovative procedures to relaxation, desensitization, and assertive training: (1) Outcome Reversal--the patient must create a new and positive outcome for each past situation that elicits guilt; (2) The Trade Last Game--a player is asked to leave the room while the group makes favorable comments about his personal attributes. Upon returning, the player must guess which of his positive attributes were talked about and received a majority vote. The player is thus forced to see some good things about himself; and (3) desensitization to the intensity of the patient's own guilt elicited by previous actions.

Behavioral techniques are a viable means to bring about extinction of destructive guilt and to improve self-perception of alcoholics.

Self-confrontation, using play backs of tape-recorded therapy sessions (Davis, 1972), and audio-visual self-image feedback (Paredes, Ludwig, Hassenfeld, and Cornelison, 1969) have proven helpful in breaking through defenses and in lessening the discrepancy between how an individual thinks he appears and how he actually appears.

In an effort to contain the anxiety of a group of alcoholics, Yalom, Brown, and Bloch (1975) discovered the written summary to be the most effective among several approaches. The summaries
contain a narrative account of the meetings, and the therapist adds many of his observations, hunches, confusions, and, at times, discouragements about therapy. The summaries are mailed out in time for the patients to read them before the next session.

The summaries not only served to reduce anxiety but helped in other ways: clarified events of the group, reinforced gains, tended to prevent undesirable developments by discussing the possibility of their occurrence (absenteeism and binges), subtly encouraged participation of silent members, increased cohesiveness by focusing on similarities and on the degree of caring among members. After a six months trial the authors were convinced of the benefits of the written summary.

Broad spectrum approaches are described in Hamburg's (1975) critical evaluation of behavior therapy. He suggests that they are more effective than many of the conventional methods which are based on the tension reduction hypothesis such as aversion therapy, and systematic desensitization. It is his contention that evidence does not support basing therapy exclusively on tension reduction, since the reduction of psychological tension is alone not adequate to account for the maintenance of alcoholic behavior. He points out that treatment approaches relying entirely on this hypothesis will neglect other factors that are crucial to sustaining alcoholism.

Broad spectrum approaches based on analysis of specific stimuli
(break down of complex problems into separate behavioral components) are more effective.

Johnson (1975) analyzes some successful behavioral approaches for group therapy while noting the advantages of measurement, specificity, and evaluation of progress inherent in these approaches. He explains how the fundamental concepts of reinforcement and modeling are important in facilitating group attractiveness and cohesiveness.

A framework for conducting a behavioral group is outlined by Johnson. He refers to a variety of techniques as described in other papers. However, he makes three additional suggestions: individual behavioral analyses, expectancy-placebo manipulations conducted on each client, and a formal plan for each session.

From the numerous behavioral techniques that are employed in the treatment of the alcoholic, a few will be cited.

There is evidence that as an individual increases his social skills and learns to appropriately assert himself his anxiety is reduced (Wolpe, 1969). As a result of eight to ten assertive training sessions, Rose (1975) was able to obtain both behavioral and attitudinal changes in most of the participants in five separate groups. The groups were conducted under the auspices of five different social agencies and the clients came from a wide range of backgrounds.
"Individualized behavior therapy for alcoholics," which is a broad-spectrum alcoholism treatment method, has been researched by Sobel and Sobel (1973). Treatment consisted of electric shock avoidance to promote abstinence or appropriate drinking behaviors (goal decided by patient). These procedures were combined with stimulus control training, determination of stimuli eliciting heavy drinking, development of effective alternate responses, evaluation of the consequences of new responses, and practice of the most helpful responses. Subjects treated by individualized behavior therapy functioned significantly better after discharge, not only relative to drinking behaviors but in other areas of living and experiencing. Experimental subjects were able to generalize their new behaviors to new settings and events not considered in treatment. Sobel and Sobel (1973) discuss the results as evidence that alcoholics can learn to control their drinking.

A study to determine whether moderate drinking could be maintained when the opportunity for a drink was available was undertaken by Cohen, Liebson, and Faillace (1973). An enriched environment (work, phone, recreation, regular diet, reading) was used to reinforce moderate drinking. Punishment for excessive drinking was an impoverished environment (no work, no phone, no recreation, pureed regular diet, no reading material). Results indicate that moderate drinking by chronic alcoholics is possible even when heavy
continuous drinking is accessible. The authors suggest that such reinforcement contingency could be applied to a residential treatment setting where privileges are contingent on moderate drinking.

In a study conducted by Skoloda, Alterman, Cornelison, and Gottheil (1975), alcoholics were given the option to drink or abstain during a six-week inpatient program (Fixed Interval Drinking Decisions Treatment). Out of 98, 55 chose to drink; at follow-up 15 percent had maintained abstinence. The authors point out that these results are comparable to other treatment programs where abstinence was mandatory. Though the majority of patients completing this program had shown improvement in drinking behavior and psychosocial functioning, the nondrinkers were apt to show more improvement at follow-up.

Skoloda et al. point out that voluntary abstinence during treatment may have predictive value for treatment outcome. This is the first study done in which it was possible to observe the relationship between free choice drinking during treatment and treatment outcome. Further research in this area will serve to increase understanding of the variables related to drinking and also to develop an objective predictor of treatment outcome.

In an earlier study, Alterman, Cottheil, Skoloda, and Grasberger (1974) determined that a group of alcoholics who participated in group discussions in which abstinence was reinforced and in which they
were able to state publicly that they would not drink, subsequently drank less. Of those stating intentions to abstain, 14 of 15 patients were successful. The researchers were surprised that discussions that subtly suggested drinking had no appreciable effect on statements to drink or on the actual drinking behavior of the patients. This study clearly demonstrates the effectiveness of subtle, nondirective, social reinforcement within a group setting. Social factors are particularly significant in influencing drinking behavior.

Having established similar results with controlled drinking, Parades, Gregory, and Jones (1974) observed that a client who has successfully controlled his drinking during treatment will find it difficult to attribute drinking to "loss of control" or to blame alcohol for his problems. He will be less able to disregard personal responsibility.

The supposition that one drink will initiate an insatiable craving and loss of control for the alcoholic has been investigated by Engle and Williams (1972). Subjects in the study were hospitalized patients with histories of uncontrolled drinking. They were divided into four groups and given alcoholic and non-alcoholic drinks on their fifth day in the hospital. Group I, control group, received a flavored "vitamin" mixture previously tested as a concealant for alcohol which contained no alcohol. Group II received the same mixture with one ounce of 100-proof vodka in it. The mixtures were given as routine medication and the recipients were not advised of
their content. They were told that the staff wanted to learn how to
more effectively help the person with alcohol problems. Groups III
and IV were told that they had consumed alcohol equal to one drink.
All subjects were advised that if, at any time before 12 noon, they had
an unusually intense desire for a drink of alcohol, they could request
one at the alcohol therapy room. Forty minutes after drinking the
mixtures subjects were given questionnaires which measured the
dependent variable for that specific time. Breakfasts had been
delayed to allow the ideal degree of alcohol absorption. Second ques­
tionnaires measured the dependent variable when the effects of
alcohol were no longer measurable. "From the estimated approxi­
mate time of highest blood alcohol concentration (7:40 AM) until
noon each subject had the opportunity to request a drink of alcohol
from the investigator or his assistant at the alcohol therapy room." One subject from Group IV asked for a drink.

Results of the study indicate that the alcoholic's desire for
alcohol is intensified when he believes he has consumed alcohol
(whether he has or has not). A physiological relation between one
drink and an increased desire for alcohol is unfounded. The allergy
or hypersensitivity theories--one drink initiates a physical response
increasing the craving for alcohol--are not substantiated.

The authors conclude that the implications of therapy are not
definitive. Possibly the idea that one drink may endanger abstinence
could be beneficial to the alcoholic for whom one drink could be disastrous. On the other hand, belief in the physiological influence of one drink might prevent the alcoholic from working out a more desirable adjustment than that of total abstinence.

Summary

Syndromes of alcoholism may be primarily psychological and social; syndromes of alcoholism may be physiological when addiction has set in. Treatment should be determined by the level of the alcoholic syndrome, the attitude and personality of the client, as well as by social and cultural influences. Unsatisfactory treatment results may be the consequence of inadequate matching of treatment to the particular needs of a unique human being.

Further evaluation of the relationship of abstinence to therapy is indicated. Reconsideration of the criteria of treatment success is also recommended. For some individuals, moderation of excessive drinking may be the desired goal. Abstinence does not always indicate improved social, vocational and psychological activity. It may be maintained at the expense of total life functioning.

Evidence contradicts the belief that one drink must always result in loss of control; it strongly suggests that environmental factors often determine loss of control (Keller, 1972) rather than some uncontrollable force. Environmental contingencies can be arranged that will support controlled drinking.
Treatment of Drug Abusers

Three philosophical concepts regarding the nature of addiction account for the diversity of methodologies in treatment according to Davis (1970). The three models he identifies are:

Symptom Model: The addict is an emotionally disturbed person and drug abuse is a symptom of underlying, unconscious, psychological disturbance. Because of internal conflicts, he is propelled toward addiction whereby his passive dependent longings are relieved and frustrations and despair are blocked from awareness.

Those who accept this symptom model advocate insight-oriented psychotherapy. It is imperative that the addict understand the underlying causes of his maladaptive feelings, thoughts, and behaviors. The result will be altered attitudes and emotions into behavioral change. Focus of treatment is primarily interpersonal relationships, and the therapist is more apt to be psychologically supportive and less psychologically demanding.

Victim Model: The addict is viewed as essentially normal before using heroin. Addiction occurred as a result of typical psychological phenomena: adolescent curiosity, desire for peer acceptance and unfortunate sociological circumstances such as a neighborhood with high drug usage.

A modification of this model is that of a metabolic deficiency that requires the individual to obtain increasingly larger quantities
of heroin in order to assuage his physiologically-induced craving. He has become a victim of heroin because of physiological consequences. The addict's physical makeup is primarily responsible for susceptibility to heroin.

Treatment consists of environmental manipulation. The addict is helped to overcome or to eradicate unhealthy life circumstances. In a therapeutic milieu the addict is able to mobilize his inherent capabilities. Treatment focuses on behavioral changes with little emphasis on insight; the belief being that change in behaviors bring about changes in feelings and attitudes.

A medically-oriented approach is utilized for the victim of metabolic deficiency. Methadone is employed to correct the disturbance that was induced by heroin.

**Hustler Model:** The addict is perceived as a relatively normal but morally depraved individual who chooses to use heroin in order to escape responsibility (in pre-addictive state).

Treatment makes heavy psychological and behavioral demands on the addict; he is forced to face the reprehensible behavior and to accept responsibility for his present circumstances. This is accomplished through brutal confrontation. Only when his deceptions and manipulations are exposed will the addict be able to make constructive changes in his behavior.

Though there is a predominant philosophy in specific treatment
programs, several models do coexist within the same program. Davis (1972) points out the necessity of matching addict to the program best suited to the individual's needs. He believes that insight therapy may be the choice for the intelligent, verbal, willing clients or those who view their addiction as a symptom of psychological problems. The addict who is forced to seek treatment or who is not especially uncomfortable may benefit most from the Hustler model.

In his discussion of the psychotherapy of drug dependence, Glatt (1970) also contends that addicts are a heterogeneous group and that there is no single best treatment modality for all addicts. He also reminds his readers that drug dependence is not only a relapsing disorder, but the therapist may have to be satisfied with limited results.

Since there are multiple factors accounting for the etiology of addiction (mental, physical, environmental, and pharmacological), there must be a multidimensional therapeutic intervention by a team of workers. Psychotherapy must exist adjacent to physical, pharmacological, social and spiritual approaches.

Though drug treatment may be absolutely essential, especially in the early phases of treatment, Glatt emphasizes that it must be considered only an adjunct to the psychological and sociological approaches. He sees the goals of treatment as an understanding of the most predominant defense mechanisms, an increase in
socialization, the development of effective communication, and a better understanding and adaptation to reality. Restructure of the personality and deep insight into the psychological conflict may be possible only in a few cases.

The "average" addict is likely to be severely emotionally disturbed. Glatt notes that although there are all types of personalities they can roughly be divided into predominantly psychoneurotic, predominantly psychopathic, and "normal." The so-called "normal" personality may run the risk of alcohol abuse since society condones and even encourages the use of alcohol. It is less likely to find an originally stable individual among the drug addicts.

Maddux (1969) identifies six features of current treatment approaches to drug addiction: (1) continuity of treatment (half-way houses as an important part of rehabilitation and community mental health centers for continuity of care); (2) civil commitment to a treatment facility as the result of the Narcotic Addict Rehabilitation Act of 1966; (3) methadone maintenance which prevents the euphoric effect of heroin and eliminates the craving and drug-seeking behaviors making treatment possible; (4) narcotic antagonist (Cyclazocaine) which does not prevent the euphoria and craving but does prevent physical dependence should the addict intermittently use heroin; (5) mutual help, i.e., Addicts Anonymous, Synanon, and Daytop; and (6) religious experience in which rehabilitation has been
facilitated by renewal of religious faith or involvement in evangeliastic movements.

A philosophy of psychotherapy, which serves as a guideline for therapists working with drug abusers, is the contribution of Adams (1974) who presents six basic imperatives:

1. Confrontation of faulty character defenses--A network of defenses has often been used even before involvement with drugs, and these have become refined and reinforced through survival in the drug sub-culture. Adams asserts that these defenses cannot be confronted directly through interpretation and challenge since the addict has not reached a level of emotional maturity where he can benefit from such an approach. Direct confrontation may serve to strengthen the defense or may precipitate aggression or psychosis in the borderline patient.

2. Prohibitive--Certain "junkie" behavior is prohibited such as drug taking and needle and pill stories.

3. Active--The therapist must act, react, and interact with the group in a genuine fashion. He will quickly be labeled as weak and phony if he "must hide behind his role as therapist." Interaction must be on a sincerely feeling as well as on a cognitive level.

4. Relative--Therapy is directed to the addict's degree of
progress toward recovery. At least one and even more relapses are to be expected. After being drug-free for months, a relapse must be considered not as a failure but as regression to a former, more comfortable method of coping.

5. Repairative--Change to a more positive self-image is imperative for the addict to grow beyond the "junkie" image and behavior. New experiences far removed from drug taking will aid the patient in viewing the self in a novel and different way.

6. Manipulative--The therapist must be a manipulator, skilled in playing brinkmanship and remaining "one up" on the patient. The therapist pits his and society's value system against the value system of the drug abuser in an effort to manipulate the patient to replace his value system. It is Adams' belief that the patient initially begins to change because of need for love and approval from the therapist rather than because of neurotic suffering. It is only after some positive experiences in managing life differently that the addict begins to change for himself.

The Reality House Program in Manhattan is described by Kaufmann (1972). This is a unique nonresidential center treating the addict daily on an outpatient basis and leaving him to cope with
the problems of everyday life. There is no methadone treatment, and confrontation is not a basic treatment concept as it is in many programs. Reality House emphasizes the acceptance of responsibility for one's own behavior and stresses "love and concern" as a reward for desirable behavior (mature and giving behavior).

Residents of this program progress through five treatment levels, each emphasizing group psychotherapy: (1) orientation lasting two weeks during which the patient attempts self-withdrawal and is referred for detoxification if the attempt fails. He must admit to problems other than drug addiction; (2) pre-therapy lasting six to ten weeks during which emphasis is on current interpersonal relationships and problems of daily living. Cop outs are exposed and the addict must admit that he has chosen this existence. During this stage the staff provides support in crises at any hour and any place; (3) preshop, consisting of workshop experience during which the addict's capabilities are examined and vocational plans formulated; (4) B-Level, usually lasting six to seven months, consisting of work groups and group psychotherapy with a psychiatrist and ex-addict; and (5) A-Level, involving the patient in vocational training, i.e., computer programmer, printer and college.

Kaufman points out the advantages of this kind of program for addicts who wish to avoid methadone, those with close family ties, and those who cannot tolerate brutal confrontation.
A hospital program for young adults (18-25 years) developed at the Psychiatric Institute of Michael Reese Hospital, Chicago, is reported by Seigel (1970). This is a unique and distinct program differentiated from adolescent programs in that an attempt is made to meet the developmental needs of young adults during a stage intervening between adolescence and adulthood. Many of Erikson's (1969) concepts are employed in an effort to understand and deal with issues peculiar to young adulthood such as the core issue of intimacy versus isolation. The young adult moves away from the intrapsychic level of dealing with choice and begins experimenting and testing his newly-found identity. A focal issue of youth is the relationship of the staff and of the social role to the structure of society--individualization versus alienation. Failure at this developmental level results in alienation from the self or society.

The goals of this program are to provide opportunities to meet developmental problems and to deal with issues appropriate to the age. The staff attempts to relate to the patients as young adults and to provide a minimum of structure in order to aid the ego task in appealing to the mature and healthy part of the ego.

The effect of contingent reinforcement techniques with heroin addicts in a milieu treatment program were studied by Glicksman, Ottomanelli, and Cutler (1971). The Earn-Your-Way system rewarded desired behaviors--academic performance, group therapy
participation—with credit units paid bi-weekly in the form of a pay check. Credit units bought discharge from the institution, thereby making each resident responsible for determining the length of his stay. Treatment was designed to encourage the development of internal controls, the resident having the option to defer immediate gratification for the more meaningful reward of early release.

Residents participating in the program obtained their release on the average of four months as compared to seven and one-half months for the other residents on the ward. Moreover, morale had been improved and management problems were reduced.

LaRouche and Donlon (1970) found greater success with addicts who primarily received medical treatment with methadone maintenance and milieu therapy than with a group who received milieu therapy, social service casework with the family, and rehabilitation planning. All of the non-medical group became readdicted following discharge while the medical group was involved in an aftercare program or was gainfully employed. The authors attribute the success of the medical group to a blocking of the craving for opiates and the patients' inability to get high on opiates. They also point out that methadone does not eliminate the drive toward criminal behavior if such behavior is present in the pre-addictive state, but it assuages the compulsion toward sociopathy to finance heroin addiction.
The use of a video tape monologue with adolescent psychiatric patients is summarized by Wilmer (1970). The patient is alone in the room and is requested to say or do anything he wishes for a period of fifteen minutes. The video tape is played back while the patient is alone and he has the option to have it erased or to review it with the therapist at a later date. Wilmer states that this is a special opportunity to observe the patient’s inner speech when there is no one to prod. He also notes that some patients are able to talk about painful material that they were previously unable to relate to the therapist, thus giving the therapist an objective register of material to study.

In an earlier paper, Wilmer (1969) states:

"We neither preach the evils of drugs nor attempt to force adjustment to the world; we try to let the patients see themselves through their own eyes, our eyes, and the eyes of television. The experience of confronting one's own image on the television screen produces what I call "self-awakedness," a sudden turning on to the self; it differs from ordinary social awareness, in which the individual may turn to others for verification."

Bernsten (1975) describes an innovative treatment program for the young addict at the Youth Clinic in Copenhagen, Denmark. The addict enters the program through the contact center; the center works with street addicts and is open to everyone. The addict remains anonymous and has the opportunity to become acquainted with the treatment staff and to participate in some recreational activities. At this point there is no prohibition against drug use.
When the drug addict is confident in the program and with the staff and appears motivated to change his life-style, he may begin the detoxification tour. With five to seven other addicts the youths move to the country where they begin methadone detoxification. During this period of about three weeks, the goal is to rid the body of drugs and improve physical well-being. The staff from the Youth Clinic, a recreation therapist, and a group dynamics leader visit regularly.

The next step is the stabilizing period lasting one to two months. The youths begin to substitute some positive recreational experiences (camping, sailing, mountain climbing) for the drug encounter and learn the give and take of living together.

Following stabilization the clients are moved to "activity centers" where they begin a stringent resocialization process. Demands made on the client include work, training or education outside or inside the center, participation in household activities, and group meetings. The clients remain in these centers from six to twelve months.

**Summary**

It is apparent from this brief review of selected literature that there is no one particular treatment modality for treating drug abusers. Treatment must focus on all aspects of living: social,
psychological, physiological. Because many addicts have not com-
pleted the normal developmental tasks of adolescence, selected 
maturational experiences must be provided. Therapeutic communi-
ties, either residential or non-residential, seem to be a viable means of encouraging emotional and social growth.

It is imperative to discover and develop new methods, facili-
ties, and techniques designed to meet the needs of the addict at whatever his level of development.

Essential to successful rehabilitation is adequate after-care planning, vocational success, living quarters away from slum areas and the drug culture, new friends and new leisure time activities.

Summary and Conclusions from Review 
of Selected Literature

Personality traits of alcohol and drug abusers are not definitive, 
many of the same traits being found in members of the general popu-
lation having personality problems. The alcoholic is seen as neurotic, 
depressive, closed-minded, hypersensitive, anxious, and easily frus-
trated. The passive-dependent personality is frequently associated 
with alcoholism, and there is some evidence to indicate that the 
personality patterns of alcoholics are detectable during adolescence and are developed because of the dependency conflict. The drug 
addict manifests sociopathic, psychopathic character disorders. 
His profile is antisocial, amoral, impulsive, irritable, and hostile.
Childhood behavioral problems and emotional instability are characteristic. Much of the pathology of this group may be the result of a severe identity crisis.

The alcoholic syndrome may be primarily psychological and social, becoming physiological when addiction has been established. To be effective, treatment should be adapted to the client's individual personality and the level of the alcoholic syndrome. For some alcoholics abstinence may be the only deterrent to self-destruction, while for others moderation of excessive drinking may be the desired goal.

Treatment of drug abusers must focus on all aspects of living—social, psychological, physiological. Selected maturational experiences must be provided in the case of addicts who have not completed the normal developmental tasks of adolescence. Therapeutic communities may be a viable approach to effective treatment.
CHAPTER III

LOG OF EXPERIENCES

Winter and Spring Semester 1975

The focus of the experience during my internship at January House was group therapy. I did not attempt to keep a precise record of the time spent in various duties. The following is an estimate of the percentages of time spent in different areas:

- **Group Therapy**
  - (Including time spent in preparation and processing group therapy) 40%

- **Individual Therapy** 15%

- **Records** 20%

- **Staff Meetings**
  - (Including staff education and development) 15%

My goal was to gain maximum experience as a co-leader in group therapy. Therefore the time I spent at January House (average 20 hours per week), although flexible, was arranged with this consideration in mind.

In addition to the above, I spent three weeks involved in screening and admitting veterans to the program and two weeks in a group marathon which met four days a week for five hours each day. This group included men from throughout the hospital.
Week of January 15 - First Week of Group Therapy

Monday. -- I accompanied Lynn Becker on grand rounds on ward seven. Grand rounds are conducted every two weeks for the education of the hospital staff. The ward's medical physician sees most every patient and discusses their diagnosis, progress, and treatment. Ward seven is a medical unit which is also used for detoxification of substance abusers.

An impromptu staff meeting was called; Lynn Becker and Jim Moody explained a new method of collecting data for Codap (evaluation agency). The staff was concerned that this new method might require increased paper work. I liked the way Lynn Becker gave consideration and feedback to the staff's input. This meeting, conducted while the staff was eating lunch, was truly casual and relaxed.

Tuesday. -- I observed in pre-group led by Charley Theigpen. Pre-group is composed of new admissions and transfers from the hospital and is essentially an orientation to the therapeutic community and group therapy. Initially, many new residents are incapable of benefiting fully from group therapy due to slowed mental and physical processes resulting from alcohol, other drugs, and withdrawal medication.

The period of time during which the veteran remains in pre-group is highly individualized. Withdrawal varies from a few days
to several weeks, depending on the drug abused and the physical and psychological condition of the resident.

It was interesting to note how well the two generations of men related; eight young men, though seated together, interacted friendlily with the older men.

All the men were especially accepting of me as an observer, and Charlie made it a point to include me in the discussion.

During lunch, I talked with Maggie Clay, PhD, from the University of Michigan who is a consultant on program evaluation with expertise in communication. She discussed the distinction between research to test a hypothesis and exploratory research to build a hypothesis. She also discussed some considerations relating to internal evaluations.

Thursday. --Lynn was ill and Art Anderson undertook my orientation. We toured the hospital and talked with various staff members. I obtained a better perspective of the Veterans Administration Hospital as a whole and the place of January House in this large bureaucracy.

I also gained some insight into the difficulties involved in screening veterans for our program through the hospital's general admission procedures, and understood some of the problems in referring veterans to our program from the hospital. A lack of understanding of our function and the philosophy of the program is apparent. Improved communication is necessary to correct mis-
conceptions. Moreover, our staff requires a better understanding of the difficulties encountered by the nurses and others working with the alcoholic on the functional wards.

I have considered the expediency of grouping most of the drug abusers on a common ward, thus decreasing the probability that personnel would respond to them as "mentally ill" or that the men would view themselves as "sicker" than they actually are. It is possible that, if substance abusers were on the same ward, their adjustment to the hospital might be facilitated, ward personnel might gain more expertise in dealing with these patients and be more inclined to view themselves as an important part of the total treatment team. I believe we should encourage and promote this concept.

During the staff meeting today, inadequate communication among the staff and between the staff and Dr. Sinclair was observable. Dorothy sensed that the staff was interpreting a particular role differently and asked for some statement of agreement. However, the staff was easily distracted and frequently digressed from the issue; considerable time was spent on this and on other staff misunderstandings. The staff did seem aware of the problems existing because of deficient communication. It was apparent that they were working for improved rapport.

Because of my recent involvement in this program, I realize that my perceptions may be invalid. However, it is most valuable
that I be able to view some of the very real problems that occur in such a vast program where effective communication is especially important.

Week of January 20 - Second Week of Group Therapy

Monday. -- I was assigned to work with two other therapists, John Gilmore and Mike McCarthy. I participated in pre-group with John today. I felt that John and I would be able to work closely and effectively together. He is an open and friendly person--I felt his respect for me as a counselor.

Wednesday. -- Dr. Zucker, resource person in group dynamics from Michigan State University, met with January House staff this morning. I benefited from his discussion concerning the role of the individual therapist and the group therapist and the importance of remaining aware of this distinction during group therapy. Many ideas were discussed and we were left with much to think about.

Initially, in the meeting I sensed resistance from the staff. However, after Dr. Zucker communicated his expertise, much interest was evident resulting in a high degree of interaction and communication and an apparent anticipation of a return visit.

The policy to bring in resource persons for staff growth and development is significant. However, this opportunity should be maximized and arrangements made so that all the staff could attend these meetings. I realize that smooth operation of the program is a
priority; however, the program would profit from the continued growth and development of the staff.

**Thursday.** --Today I had my first structured meeting with Lynn. I became more familiar with January House as a political system and gained better understanding of the reasons underlying the imperfect communications and rapport between staff and administration. I was amazed at Lynn's complete candor when discussing some politically sensitive areas, as well as her frankness when describing her perception of her role and capabilities within January House. I really liked her apparent trust in me.

**Friday.** --Mike, John and I screened men for core group.

This procedure had an emotional impact on me, making me aware of bias affecting my judgment and of my excessive sensitivity to the men's need to move out of pre-group. I was cognizant of my inclination to accept two young men, sincerely feeling that they wanted to help themselves and that they were ready for group experiences. Also they were drug addicts (with whom I preferred working) and were particularly personable.

Two of the older men (alcoholics) impressed me as being insincere. The behavior of one man in particular (whining and blaming) really alienated me. With the realization that I was stereotyping these men and that I was influenced by prejudice, I made a conscious effort to perceive these men as individuals with specific needs, and
I succeeded in empathizing with them.

It was extremely difficult rejecting any of the men for the core group. We ultimately chose fourteen men. I need much more experience in this area to develop my objectivity.

Week of January 27, 1975

The week was spent at the Midwest Institute of Alcohol Studies.

Week of February 3, 1975

Monday. -- I participated in my first group therapy session which was the second week of group therapy for the men. Bob D., a twenty-three year old who had begun drinking at thirteen and had used LSD and heroin, attempted to discuss his drug and alcohol problem as it related to his criminal activities. Bob was in a precarious position and seemed disappointed with the subsequent interaction with the group and with the therapists. My awareness that Bob was asking for help made me extremely uncomfortable, and I was confused as to how I should respond.

Charles, a thirty-three year old black alcoholic, dominated most of the first hour. Much of what he said was repetitive and superficial; he was quite skilled in his attempts to avoid specificity. I confronted Charles regarding his flippant attitude. This was followed by a brief period of tense silence during which one of the men suggested getting coffee. This successful avoidance tactic
annoyed me. After a discussion with my co-therapists it was decided that in the future there would be no coffee breaks during the discussion of emotionally sensitive issues—the importance of this rule to be discussed with the group. Note—the group was slow to get started and there was limited interaction among the eight men. A preliminary group exercise might have helped facilitate a sharing attitude.

**Wednesday.**—Stan was acutely depressed today, his verbalizations slow and in a monotone, his eyes extremely sad, and his countenance otherwise expressionless. His worry centers on his possible confinement to Jackson Prison and the ready availability of heroin there.

During the course of Stan's discussion, the intrusion of two new employees (for the purpose of observing) irritated me. Though John asked the men if the presence of the newcomers was acceptable and they answered in the affirmative, I considered this to be an invasion of Stan's privacy, especially since the visitors appeared disinterested (one sat with his head back and his eyes closed).

**Thursday.**—Dr. Zucker was present today. More staff attended and there was a considerable increase in staff participation with more sharing of disappointments and frustrations. Dr. Sinclair joined the group in order to clarify some of the issues and the areas of difficulty in the direction of this large program, with the attendant necessity of satisfying the central office and meeting the needs
of the staff.

Group was short today because of a resident meeting. I shared my feelings regarding yesterday's intrusion, and the men concurred, stating that they too did not feel comfortable with the visitors. I pointed out that John had asked their permission and that they had the right to express their true reaction. Apparently these men lack basic appropriate assertive responses. It was decided that future visitors would be welcome if they were on time and were active participants.

Some members suggested dividing into two groups so the frequency of their interaction with the therapist could be increased. I thought we might have erred by choosing such a large group. The final decision was to remain as one group. The men felt they could be of more help to each other and would benefit more from sharing with the entire group. I was pleased with this group cohesiveness.

Week of February 10, 1975 - Third Week of Group Therapy

Monday.--Today was an emotionally exhausting day. James, a thirty year old former heroin addict, now an alcoholic, returned to January House on Sunday evening with liquor on his breath. The policy of January House is total abstinence from alcohol or unauthorized drugs during the period of rehabilitation whether on or away from the unit. Violation of the policy may result in discharge, though individual circumstances are considered by the therapists, Dr.
Sinclair and the group before a determination is made.

James admitted having one beer. His rationale was to determine if he could stop. This admission was followed by considerable confrontation from the therapists and some of the men. In my view, James seemed to be playing the "poor me" game in an attempt to manipulate the men to rescue him. However, many of the men chose not to assist him.

My feelings regarding James' discharge were extremely ambivalent. From the beginning I had instinctively liked James. He elicited my protective feelings, and yet, as I became conscious of insincerity in much of his communication, I suspected that he was not taking the program seriously. James seemed to be repeating a pattern of behavior. His retention in the program might not be as therapeutic as forcing him to face—possibly for the first time—the consequences of his behavior. It was an intensely painful conflict before I decided for discharge.

Stan, who had been extremely quiet and apparently depressed, startled all of us with the admission that he too had drunk over the week-end. He had had a glass of wine during dinner and hadn't thought much about it since alcohol had never been a problem. Stan was confronted by the group who subsequently supported him as well as James.

Discharge for Stan did not seem appropriate in view of his depression and need of much support in order to understand himself.
The program should assist him.

Stan's admission saved James from discharge. While the men were able to rationalize his behavior, the therapists were not. The group strongly urged that the two men be allowed to remain in the program, stating that they could be better helped and that discharge would be detrimental.

In return for the privilege of having James and Stan remain in the group, certain conditions were agreed upon. James and Stan would forfeit all passes until the seventh week of group therapy. Group members agreed to a contract stating that violation of the abstinence policy would result in immediate discharge regardless of any extenuating circumstances. Group agreement was unanimous except for some hesitation from Charles.

After this experience, I felt emotionally spent. I was relieved that it was not necessary to discharge James, yet uncomfortable that he had succeeded in "getting off easy." I was sorry for Stan since I believed that he especially needed time away from January House.

Wednesday.--The men signed the contract today. The majority seemed disturbed about the consequences for Stan, who planned to meet with his lawyer during the week-ends. They considered the punishment extreme since Stan had volunteered the truth. Nevertheless, the reality that there are consequences for behavior and that Stan would profit from learning to accept responsibility for his
actions was acknowledged in making these determinations. However, I would have approved of a lesser punishment for Stan.

**Friday.** --Each week the therapists write progress notes on each man in the group. These are called SOAP notes and cover four areas: S = statement of the veteran; O = observation made by the therapists; A = the assessment of the therapists; and P = plan for therapy.

Mike suggested that the three therapists discuss the progress of each man prior to writing the notes. However, Mike was very busy and was unavailable for this discussion. After John frequently expressed concern regarding the writing of the notes, I undertook to write them without any input from Mike.

I proposed that we therapists meet following each group encounter in order to discuss our perceptions of what had just occurred. I also expressed my desire to meet before each therapy session in order to determine what we wished to accomplish for the day.

**Week of February 17, 1975 - Fourth Week of Group Therapy**

**Wednesday.** --We completed progress clinic today. During progress clinic, each man is evaluated individually by a team of five therapists. There is in-depth questioning regarding progress to date, and an attempt is made to elicit specific goals for the next four weeks. Confrontation is sometimes truly "heavy"; maladaptive
behaviors are attacked and rationalizations are stripped away.
Demands and conditions are placed on those men who appear to be
"sliding" along.

I voiced my concern to John regarding the extra attention being
given to the younger, more verbal drug abusers while neglecting the
older. More growth on the part of these men might have been
realized had the therapists spent more time with them. Since I
became aware of this, I have acquired a more positive attitude and
empathic response toward the older resident.

It is apparent that this therapy group is too large to enable each
man to receive the help to which he is entitled. It is extremely frus-
trating to realize that, in our attempt to prevent men who were ready
for therapy from remaining in pre-group for an extra week, we
chose too many to move into the therapy group--thereby preventing
them from receiving maximum benefits from therapy.

Thursday. --I met with Lynn for the second time. This was a
helpful session for me. We talked about some of my concerns regard-
ing group process and therapy. During our discussion on reflection,
Lynn pointed out that reflection may not always be helpful to the
alcoholic since he tends to accept the therapist's words and interpre-
tation rather than his own, being inclined to agree with the therapist
even though the reflection was not exactly what he meant.

I discovered that I have a different philosophy regarding
medication from that of John and Mike. They had asked Ralph, a 28 year old alcoholic, to discontinue his nighttime dose of Thorazine. Ralph was extremely resistant to this request, stating that he could not sleep because of many uncomfortable thoughts.

I talked to Ralph subsequent to his decision to leave the program. I suggested that since he could not share his concerns with the group, he might consider individual counseling. He rejected this suggestion, stating that in previous attempts to share his worries, he was told it was his imagination.

I was very sorry to have Ralph leave the program and felt strongly that he should not have been asked to discontinue his Thorazine before discussing this with the physician. Was the medication controlling his delusional thoughts so that he could deal with his alcoholic addiction? Ralph had made an effort to participate in group therapy and had been getting along fairly well.

I became increasingly aware that not all men could benefit from this kind of therapy and that, prior to the group experience, consideration should be given to individual counseling for some men with apparent strong defense systems.

**Friday.** --Bob F., a 22 year old, addicted to heroin in Germany, left overnight without permission. He had become upset following a visit from his wife. When he failed to reach her by phone later in the evening, he impulsively went to find her.
Dr. Sinclair suggested that Bob remain in the program and that the group decide the consequences for his behavior. The group was extremely lenient and assigned Bob KP duty for a week. They indicated that they understood his uncontrollable need to find his wife and responded with compassion, the older men in a fatherly manner.

I was happy that the group responded so empathically. However, I had some apprehension that KP duty, because of its minor consequences, might result in the behavior being modeled.

We were able to reach Bob D. today. He was more open and shared some of his concerns and fears regarding returning home to his large family and alcoholic father. I had been perturbed about Bob since the first week when I feared we had failed him. My concern was dissipated with today's encounter.

It was satisfying to see how the older alcoholics responded supportively yet confrontingly to this young drug abuser. It was especially worthwhile having both drug abusers and alcoholics of varied ages working together for mutual help. Note: Bob B., a 45 year old alcoholic, could truly see the pain experienced by the child of an alcoholic parent. On the other hand Bob D. had the opportunity to see a "hopeless" alcoholic attempting to help himself.

Week of February 24, 1975 - Fifth Week of Group Therapy

Monday. -- The group dealt with George, a 56 year old alcoholic, who during confrontation became short tempered and walked out,
stating that he was leaving the program. The situation had become very uncomfortable prior to George's departure. His answers had been evasive and some of the men were apparently having too much pleasure "coming down" on him.

George subsequently returned to the therapy session. At this time he announced that he was definitely leaving on Friday because his mother needed him. At this point Al told George to get out because the group did not want him. I expressed my annoyance at Al, since the group had made no such decision, and also my irritation with the men for passively accepting Al's determination. It was apparent that many of the men were upset with the events of the day and appreciated the opportunity to share their distressing feelings.

I was amazed when some of the men voiced concern about the difficulty they were having avoiding certain customary language when I was present. I had been completely unaware that swear words were not being used. Evidently, the men's perceptions and expectations of women are traditional.

Wednesday. -- At Dr. Sinclair's request, I sat in on a conference with George regarding his decision to leave the program. His rationalizations for leaving changed from those expressed earlier and continued to change from moment to moment. I became irritated with George's actions and displeased with myself for suddenly not caring whether he left or not.
Thursday. -- Bob F. came to me today for individual counseling. I appreciated this opportunity as I had sensed that he was having difficulty revealing his concerns and difficulties to the group. His marital problems have been of extreme concern to him, and he appeared eager to attend family therapy sessions on Saturday.

I have been frustrated and dissatisfied about the progress of many of the men in our group. It would be expedient for each man to formulate specific, personalized goals for therapy; these goals should be objective and observable so that the effectiveness of therapy could be determined. The men should also be exposed to more than confrontation. They are asked to reveal themselves without being supplied tools for exploration or modeling the expression of feelings. Assertive training, communication, empathy training, and awareness exercises could benefit these men.

I appreciated the opportunity of expressing the above views to Dr. Sinclair. We discussed a program with levels or steps, each level having specific behavioral objectives. It would be possible to observe each man's growth as he moved through the levels.

Staff meeting today concerned the evaluation of the Tuesday program, during which the men are assigned to specific treatment groups such as Gestalt, Transactional Analysis and Encounter. The meeting was initially frustrating because there was no closure on one subject before the introduction of another subject. After an
hour and a half, the staff decided to incorporate the Tuesday program into the core groups. The rationale for the change was presented to and accepted by Dr. Sinclair.

Only one hour daily is scheduled for group therapy during the seventh and eighth weeks. I expressed my disapproval of the choice of priorities as the last two weeks of the program are exceptionally important. The men are anxious and more motivated to work on their problems and to make realistic plans for discharge. Virgil suggested that the men be allowed the option of increasing the length of the group therapy or of attending other activities.

I was disappointed with the progress of our group. Five weeks of group therapy should have been more productive. Too much time was spent on solving the mechanical problems of living together—possibly this was an escape from the real, more painful issues. The cooperative, problem-solving experience was valuable but, possibly, more of this could be dealt with in resident, government meetings.

Week of March 3, 1975 - Sixth Week of Group Therapy

Monday.—John and I made rounds in order to observe the men from our group engaged in such activities as machine shop, woodworking, music, and education workshops. The men were pleased to see us and were grateful for the recognition. (Al and Jay, a 50 year old alcoholic, reminded me of children requesting
their parents to observe a special accomplishment.) It was valuable to see these men outside of group therapy.

I enjoyed the long walk with John which gave me a better opportunity to know him. I admire John. He is truly dedicated to these men. He is capable of being tough during confrontation; yet his concern for and interest in these men is obvious and he never misses an opportunity to give positive feedback. John and I have a positive relationship which enables me to be open and forthright in disagreements about strategies for therapy—we may not agree but he accepts my right to differ.

Bob D. came to see me this morning. He was depressed but could not identify the cause for this mood swing. He stated that, if he were on the streets, he would quickly alter his mood with drugs or alcohol. He expressed concern that he had not been adequately helped and would like more assistance before release. He talked about flashbacks and feelings of having been there before. He stated that his probation officer had suggested a psychiatric evaluation and that he would like to be evaluated to make sure he wasn't crazy.

We video taped the group session this afternoon. James' noncommittal and evasive attitude was quite evident to him on the play back. The playback made me acutely aware that I had interrupted Mike before he was through with his intervention. Although I had consciously attempted to "stay with" both therapist and resident,
this had been a difficult area for me. It was not always easy to
determine when Mike had finished.

_**Wednesday.**_ James was more involved in group today. He
was supportive of Al and made an attempt to understand Al's pain.
James made me aware that I was projecting my values on Al, a
behavior I abhor and believed I had been avoiding. I acknowledged
my pleasure regarding James' assertiveness.

Jay was troubled today as he related the circumstances of an
unfortunate incident with the unit's nurse who had behaved aggres-
sively toward him. Jay completely lacked the skills to deal with
this unprovoked incident, but he talked admiringly about John's
ability to manage the situation with the nurse.

**Note**--I plan to spend extra time with five of the men to work
on the area of assertive training.

Bob D. seemed very frightened and confused about his future
and his ability to cope with society's demands. Because I didn't
believe that Bob would be ready in two weeks to meet the demands of
living in an unstructured environment, I talked to the social worker
about a halfway house for Bob.

**Note**--I have been confused and frustrated by my two co-ther-
apists' and the social worker's negative response to the idea of a
psychiatric evaluation for Bob. I am aware of the consequences and
the possible destructiveness of a psychotic label. However, I
strongly sense that a psychiatric evaluation is indicated and don't understand the reluctance of the staff to use this resource since January House is part of a psychiatric hospital.

During individual counseling, Bob F. revealed a new confidence. He felt relieved following his open and honest talk with his wife. I had been concerned that Bob did not seem to be aware of the dangers of socializing with drug-using friends and relatives.

Week of March 12, 1975 - Seventh Week of Group Therapy

Monday. -- The men were able to verbalize their anxiety and apprehension about discharge and the lack of employment opportunities.

The group, expressing concern, confronted Bob D. relative to his statement that he was considering a six month drug program. The group discounted this as a "cop out" and the avoidance of the reality of work. Bob was extremely uncomfortable and was easily persuaded that his idea was not desirable. I believed that Bob had expressed a feasible option, worthy of consideration. I confronted him with his lack of conviction and faith in his knowledge of his own needs. (It has been 11 years since this young man has functioned without the use of chemicals; there is much learning to be done.)

Wednesday. -- Maggie Clay was here today. She talked for two hours, saying the same thing in a variety of ways. She seemed to be avoiding direct statements. John F., social worker, expressed
his confusion, and Maggie attempted to clarify the issues. She recommended that a small group represent the interests of the entire staff. This task force would work directly with Dr. Sinclair. Five members were elected to this group.

Thursday. --I began an assertive training group with five especially inhibited men. I was amazed at the many major and minor injustices endured by these men because of anxiety or the inability to express themselves assertively. The men appeared to enjoy the small group, and group interaction was greater and more effective. Jay made reference to this on several occasions. Note --Some of the younger men indicated that they felt left out because they were not invited to join this group.

Bob D. came to see me twice today. He was depressed and confused. He talked about leaving the program early if he could get into a half-way house; later he talked about remaining at January House for two extra weeks. He expressed the belief that he had not been adequately helped and frequently talked about prison with the expectation that he would eventually be incarcerated. (Apparently he has poor ego control when under the influence of drugs.)

I was surprised and uneasy when Bob stated that it was not any fun around there when I was gone (Tuesdays). As he left the office, he joked and punched me on the shoulder suggestive of a twelve year old showing a girl he liked her. (I had been careful not to encourage
this kind of reaction.)

**Week of March 17, 1975 - Eighth Week of Group Therapy**

**Monday.** -- Assertive group was active today. Bob L. surprised me. He was much more articulate even though it took much effort for him to relate a story. He had been conscientious about doing homework assignments.

Jay appeared to thrive in this small group. His need for acceptance and validity was better realized.

James was cooperative and particularly studious as revealed by his serious and relevant questions.

I was gratified by Jay's behavior in the large group. He was truly confrontive with Mike after having been given "permission." Apparently he was proud of himself and his new behavior.

Bob D. came in for individual counseling. He had avoided weekend passes stating that he was not interested in being with his family. However, his recent weekend at home seemed to have effected a more positive attitude about himself and his family.

**Tuesday.** -- The group met in the audiovisual room for a second video tape. Each man spent three minutes describing his perceptions of the program and the behavioral and emotional changes that had taken place. This was my day off but I came in to view the video re-run which was a particularly rewarding experience. Jay stated that he had gained more from the small group experience than he had.
from any previous therapy experience. Bob F. affirmed that the therapists had been of great help to him, especially Carolyn, who had helped him with a problem which had really bothered him.

**Wednesday.** --I spent considerable time with Bob D. preparatory to his visit to Gateway Villa where he will be expected to identify specific goals for therapy. I assisted him in specifying needed behavior change. Bob has defined himself as inadequate and has been operating on that assumption for many years.

Stan came in to talk about his impending legal problems and to share his concern for his wife who is now in jail.

The men were excited about graduation the next day; they were milling about in the halls or lounges indicating a desire to "rap" with anyone who had the time.

**Thursday.** --Graduation Day! All the men at January House attended the graduation. Each therapist and graduate said a few words to the group. This was a very emotional experience and I was aware that each man had become a part of me in some way and that I had profited from knowing each of these men. Graduation was followed by a reception for the men and their families. The relatives seemed reassured and confident that their lives would be different.

**Week of March 24, 1975**

**Monday.** --Driving to January House this morning was a
different experience for me. I missed the anticipation of group therapy.

Bob D. talked to me before he left today. I was extremely disappointed that he had decided against a half-way house and attempted to point out to him the pitfalls of returning to his previous environment, having no job and only drug-using friends. I struggled with myself, wanting to pressure him to accept further help; yet believing that this was his decision. I wondered if I should use the positive relationship to influence him in the direction that I perceived as therapeutic or less destructive. I did not believe that he had had enough help to make a wise decision.

I met with Lynn and discussed the remainder of my internship, three weeks to be spent with Jim learning the intake and screening procedure and two weeks to be spent in Marathon group.

Note--I will discuss the three weeks learning the intake and screening procedure as a total experience, commenting on specific examples where appropriate.

I began the experience by first observing the screening process, then sharing the responsibility, and finally screening alone.

One of the first men to be screened was referred from a closed ward. His speech was slow and confused. He was unsteady on his feet and was unable to remember his past treatment. He indicated that he was unable to spend nine weeks in the January House program.
and that his primary concern was Social Security insurance and new shoes.

I could not understand the rationale for sending a person from a closed ward who was unable to reach January House unassisted, expecting him to benefit from a self-help type program. I wondered when he had had his last Librium and the dosage.

There seems to be misunderstanding by ward staff of the criteria to be used when referring men to our program. We may not have communicated our program effectively. Explicit guidelines for the referring staff are indicated. Moreover, January House staff would benefit from attending progress clinics at which the decisions for referral are made.

It would be expedient to have a more thorough explanation of the rationale for rejecting men from this program. In addition, it would be prudent to make a phone call to the referring ward immediately following a man's rejection, briefly explaining the decision and referring the ward coordinator to the progress notes.

Jim and I have had some rather vigorous discussions regarding criteria for acceptance into the January House program. Although my thinking relative to this issue has been greatly clarified, there is still no concurrence on how the men are perceived or how important the place of motivation is in indicating a successful treatment outcome.
I believe strong motivation to be of extreme importance. However, its evidence during the intake interview may not be absolutely essential. Hopefully, the therapeutic environment will encourage the veteran to use therapy constructively and intensify the alcoholic's motivation for sobriety. To deny a person admission because his motivation is not evident is to reject our responsibility for developing that motivation or for working with men whose motivation for self-knowledge or change is low.

Mr. X. was brought to January House by a counselor from the alcohol unit at Owosso Hospital. This man was extremely depressed and fearful and ambivalent about our program. He stated that he had been spoiled at the Owosso Hospital where little was expected of him. (Even his meals were served in his room.) Although he was lonesome and wished to return home, his wife expected him to complete the January House program which he chose to do fearing that she would not accept him until he had fulfilled her conditions.

Jim was not prepared to accept Mr. X. into our program and suggested that he obtain lodging elsewhere in the hospital and call his wife the following day. I strongly objected. I was concerned about putting this deeply depressed, frightened man on a functional ward. Moreover, I was not convinced that he would not benefit from our program. His strong need to keep a promise to his wife might provide the adequate motivation.
Jim and I discussed a 58 year old man whom Jim wished to reject because of his lack of motivation and sincerity. I was astonished since I had not detected these characteristics and questioned Jim's justification for this decision. When asked to clarify, he admitted that much of his decision was based on intuition but reminded me several times of the poor risk of this age group for rehabilitation.

In one screening experience, I spent two hours attempting to justify my decision to Jim. Three weeks earlier a young man had been denied admission to the program. Jim considered him to be emotionally disturbed and suggested that another unit might provide the needed therapy. The man refused to be admitted to a functional ward, returned home, and sought help at a community mental health agency. He had returned believing that he was now able to function in our program. There was considerable disagreement between Jim and me in this case as Jim considered the man to be delusional. After extensive probing, I decided to admit the veteran. Though I was apprehensive, I preferred an error in judgment to refusal to admit.

Three weeks of screening made me acutely aware of the importance of the intake procedure and of the necessity of establishing explicit guidelines to be used by the staff in the screening process—such guidelines to minimize personal bias.

With Lynn's assistance and with the guidance and approval of
Dr. Roisum (Chief of Staff), Jim and I prepared a statement outlining the rehabilitative services provided by January House, the unit's philosophy, and the admission screening criteria. We further developed screening guidelines to be used by the January House staff.

The weeks of my internship, during which I was working with Jim, were difficult, since Jim and I work from a different frame of reference. At times I experienced frustration and impatience which (I am sure) Jim also endured. However, this was a positive growth experience from which I gained extended insight into my own strengths and weaknesses. I know I must be constantly aware of the distinction between sympathy and empathy while, at the same time, I am striving for objectivity.

Week of April 14 and April 21 - Group Marathon

Participation in Marathon group was one of the most gratifying of my internship. Marathon runs for two weeks, Monday through Thursday from 8:30 A.M. to 3:30 P.M. Men are referred from throughout the hospital. This is Dr. Jochem's group. However, he is assisted by four other psychologists who alternate their services so that two psychologists are scheduled for each meeting.

Marathon is essentially a confrontation therapy where maladaptive behavior is consistently attacked and exposed to the view of the entire group. Rationalizations and harmful defenses are stripped
away, and the veteran is encouraged to express anger and hostility as well as more positive emotions. The men receive support and positive feed-back (when appropriate) from both the psychologist and other group members. Hopefully, the veteran becomes aware of his self-defeating behavior patterns, aware of his actual social image, and finally, aware of the necessity for effecting change in his behavior.

Observation of the different therapists working in a group was most beneficial to me. However, I was somewhat distressed when I perceived some styles of confrontation to be sarcastic and demoralizing. Fortunately, this was not a frequent occurrence.

The veterans, though anxious, recognized the importance of this painful procedure and, at times, verbalized this recognition and actually appeared appreciative for the new insight. It was most rewarding to see the warmth and understanding given the veteran following an apparently tormenting experience.

The group members soon learned to model the behavior of the therapist and some became adept at confrontation. A few men projected the verbalizations and mannerisms of the psychologist.

Behavior in the marathon group was quite different from the behavior of my group at January House. Although the men came to know and trust each other, they (January House) were specially protective of each other, and most of the alcoholics were slow in
developing the ability to confront their peers. The alcoholic finds most assertive behavior difficult when sober or not angry. Although, initially, the young drug abuser seemed to find confrontation difficult, he appeared to learn this behavior with more ease.

As a result of my experience in Marathon, I have a new appreciation of the value of confrontation and believe I have improved my ability to be confrontive in a more positive manner. I have particularly improved in the ability to perceive sequences of behavior leading to difficulty and in the skill to focus the veteran's attention on these patterns.

Comments on the Internship Experience

My internship has appreciably increased my knowledge of the world of the alcoholic and drug abuser. I have an improved comprehension of treatment difficulties that arise when dealing with this population as well as more insight into their special needs.

I believe that I have reached each of my stated goals and objectives, some to a greater degree than others. I need to perfect my skills as a group therapist, but believe that I have the tools for continued growth in this area.

January House provided me with valuable exposure to both drug abuse and alcoholism. The most significant aspect of this internship was the tremendous change in myself. The experience increased my self-confidence, both as an individual therapist and as a group
therapist. My perception of and sensitivity to the needs and concerns of the alcoholic were considerably altered. Working with these men was a most gratifying and rewarding experience, and I feel that I contributed positively to many of their lives.
I. In addition to the objectives previously submitted, I have formulated two others: to gain a clearer insight into the personality characteristics and special treatment difficulties of the alcoholic client; and to gain a better understanding of the personality characteristics, developmental needs, and special problems of the young drug abuser.

II. I have just completed the seventh week of group therapy in which I was a co-leader. Out of the 16 who began the program 11 will be graduating next week. There are five young men in this group, four of whom are drug abusers.
and the fifth, an alcoholic, having been addicted to heroin.

I have done some individual counseling with two of the drug abusers and some assertive training with a small group of alcoholic men.

III. I have gained a great deal of insight into the world of the drug abuser and the alcoholic, both through my readings and through personal contact with these men over an eight-week period. I perceive myself as more effective in using the group as a method to identify and alter maladaptive behaviors and uncomfortable emotions.

IV. The January House offers a valuable exposure to both drug abusers and the alcoholic clients. I feel that it is a growth experience (although at times frustrating) to work with such a large staff who differ a great deal in experience and philosophical leanings, as well as educational and cultural background.

January House, its chief, and the staff are in the process of change and growth. I consider this an excellent opportunity to observe in process the use of effective and ineffective communication, constructive and destructive interpersonal relations, the use of a negotiator and, hopefully, the resolution of some of the difficulties and resulting tensions and frustrations.

I am investing myself maximally in this educational experience;
my role as both individual and group therapist has benefited me personally and professionally.

I hope to further develop my skills as a group therapist, to become more knowledgeable of the substance abuse field and to keep current with relevant literature.

Final Field Education Evaluation

Carolyn Yaple

January House, Alcohol and Drug Rehabilitation Service
Veterans' Administration Hospital, Battle Creek, Michigan

Lynn Becker, Field Supervisor

Winter Semester - 1975

Clock Hours, 160

My final hours of internship involved three weeks of screening for admission to the January House program and two weeks in the Marathon group.

I worked with Jim Moody, first observing the screening process, sharing the responsibility and finally screening alone. I became acutely aware of the importance of having a qualified person doing the intake screening as this process becomes quite involved when there is a questionable admission.

During this time I contributed to the preparation of guidelines to be used by the functional units in their determination of referrals to the January House.
Participation in Marathon Group was one of the highlights of my internship. Marathon runs for two weeks, Monday through Thursday (9:30 A.M. - 3:30 P.M.); men are referred from various units throughout the hospital. This is Dr. Jochem's group; however, there are four other psychologists who alternate their services. It was especially beneficial to observe the different therapists working in group. I believe I further improved my group techniques, particularly my ability to perceive sequences of behavior leading to difficulty and the skill to focus the men's attention on these patterns.

I believe that I have reached each of my stated goals and objectives, some to a greater extent than others. I feel a need to further perfect my skills as a group therapist and believe that I have the tools by which I can continue to grow in this area.

I met the additional objectives that I had formulated after beginning my internship through my review of the literature and personal contact with the men.

Field Education Evaluation
(Completed by Field Supervisor)

Name of Trainee: Carolyn Yaple

Agency, Organization, or Research Assignment: VA Hospital, Battle Creek, Michigan

Field Supervisor: Lynn Becker

Semester: Winter 1975
Date of Evaluation: 3-17-75

Clock Hours To and Including 3-6-75: 168

I. Description of trainee orientation and training experiences:

1. Participation as co-therapist in regular eight-week group.

2. Record keeping and documentation as required of role.

3. Participation in staff meeting - training sessions- consultant visits.

4. Individual counseling with residents as appropriate.

II. Description of trainee's goals and objectives:

1. Learning co-therapy role and group leadership.

2. Gain cursory understanding of VA policy, procedure, and agency mechanics.

3. Observe and participate in teaching sessions - TA groups, etc.

4. Learn and assist with admission process.

III. Description of trainee's work activities:

Carolyn has a minimum of three group sessions per week, two hours each, blocks of time daily in communication with her co-therapists and staff as well as one or two sessions of record keeping for group of over 12 members.

She attends the mandatory staff meetings and participates both on and off the unit in available training sessions.

There are numerous routine and supplementary tasks.
associated with the group therapist responsibility which Carolyn has carried out as a staff member would.

IV. Assessment and discussion of professional performance. Reference should be made to the trainee's progress to date, fulfillment of goals and objectives, work habits, utilization of resources, if applicable, knowledge and performance as pertains to role in agency, attitude, assets and liabilities, leadership skills, and suggestions for professional development:

Carolyn has been an outstanding student. Her persistence in inquiry about program and techniques in group has emerged as the focal point of these first weeks of the term. She demonstrates growing skills in group process and intervention technique and has made interesting observations of group as compared to individual work. The most overwhelming task has been to understand and find her place in the dynamic process of the staff. This has been further complicated by the pending employment here. She is doing well in developing her position. She has gained respect from the group by actively involving herself at staff meetings and will be a welcome staff person. She has made good use of the library here and interacts in many ways more as a co-professional than as a student. The next task we will undertake is to have her work in the admission area and make room for her to utilize some of her nursing background.

Lynn Becker
Final Field Education Evaluation  
(Completed by Field Supervisor)

Name of Trainee: Carolyn Yaple

Agency, Organization, or Research Assignment: VA Hospital  
Battle Creek, Michigan

Field Supervisor: Lynn Becker

Semester: Winter, 1975

Date of Evaluation: 4-22-75

Clock Hours: 240 plus

I. as before and add:
   5. Admission and evaluation - 2 weeks
   6. Marathon group experience with Dr. Jochem in  
      Psychiatric Hospital Unit - 3 weeks

II. as before and add:
   5. To learn admission and screening procedures
   6. To participate in alternative type group sessions

III. as before

IV. Carolyn continues to participate well at the professional  
level. Her employment here is confirmed and many anxieties have  
subsided. She did an outstanding job in the evaluation and admission  
portion of her work and helped in the preparation of a new standards  
circular to be distributed throughout the hospital.
June 6, 1975

Chief, January House Rehabilitation Unit

Staff, January House Rehabilitation Unit

CAROLYN YAPELE, SPADA student

1. There currently exists a SPADA student receiving practical training in our unit who we, the staff, feel should be recognized for her special abilities.

2. This student, Carolyn Yaple, has demonstrated a sincere interest in helping our veterans complete their rehabilitation. She has proven to be both intelligent and resourceful in dealing with the substance abuser. She has consistently maintained a high degree of professionalism while establishing an effective rapport with both staff and residents. In general, she has exhibited all those characteristics which we find to be desirable as a counselor and colleague.

3. Therefore we, the staff, would like to recommend Mrs. Yaple for your consideration in any new appointment to the staff.

Lola M. Wells
Virgil Prince
James W. Moody
Yvonne Gibson
Bea Kelley
Dave Perkins
Gerry Hartman
J. Michael McCarthy

William Chandler
Dale Lester
John Gilmore, Sr.
Edward J. Gora
Charlie Thigpen
Thomas Hicks
Art Anderson
Colleen Schier
Mary M. Ablan
REFERENCES


Hore, B.D., Craving for alcohol. British Journal of Addiction, 1974, 69, 137-140.


APPENDIX

Department of Counseling and Personnel
Western Michigan University
Kalamazoo, Michigan 49001

APPLICATION FOR PERMISSION TO ELECT

720 Specialist Project 4-6 hours
(Indicate your plan for enrolling in the course)

Semester: Winter Year: 1974 Hours: 3 1st Enrollment

Name: Carolyn B. Yaple Social Security Number: 377309601

Address: 450 East Gull Lake Drive, Augusta, Michigan 49012

Degree Program: Specialist - Counseling and Personnel

Description of Independent Study

Internship at January House, Alcohol and Drug Rehabilitation program at Veterans' Administration Hospital, Battle Creek, Michigan. Exposure and experience in one to one and group counseling and other miscellaneous duties.

Name of interning organization: Veterans' Administration Hospital, January House

Name of organization supervisor: Lynn Becker

Thomas K. Williams
Signature of Faculty Sponsor
under whom study is to be completed

Signature of Student

Ken Engle
Signature of Faculty Advisor

W. Martinson
Signature of Department Head
APPLICATI ON FOR PERMISSION TO ELECT

720 Specialist Project 4-6 hours
(Indicate your plan for enrolling in the course)

Semester: Winter Year: 1975 Hours: 3 2nd Enrollment

Name: Carolyn B. Yaple Social Security Number: 377309601

Address: 450 East Gull Lake Drive, Augusta, Michigan 49012

Degree Program: Specialist - Counseling and Personnel

Description of Independent Study

Continued internship at January House, Alcohol and Drug Rehabilitation program at Veterans' Administration Hospital, Battle Creek, Michigan, involving about 130 men who participate in group therapy. I plan to continue my experience as co-leader of group therapy and to be available for individual counseling. I expect to become more adept in facilitating group processes, in effecting the development of therapeutic client-client encounter, in using the group as a method to alter maladaptive strategies, and in refining my communications skills especially as they pertain to group therapy.

Carolyn Yaple __________________________
Signature of Student

Ken Engle __________________________
Signature of Faculty Advisor

W. Martinson _______________________
Signature of Department Head