



8-1984

## Alcoholism: The Insidious Disease

Van Bruggen

Follow this and additional works at: [https://scholarworks.wmich.edu/masters\\_theses](https://scholarworks.wmich.edu/masters_theses)



Part of the Counseling Commons, and the Substance Abuse and Addiction Commons

---

### Recommended Citation

Van Bruggen, "Alcoholism: The Insidious Disease" (1984). *Master's Theses*. 3323.  
[https://scholarworks.wmich.edu/masters\\_theses/3323](https://scholarworks.wmich.edu/masters_theses/3323)

This Masters Thesis-Open Access is brought to you for free and open access by the Graduate College at ScholarWorks at WMU. It has been accepted for inclusion in Master's Theses by an authorized administrator of ScholarWorks at WMU. For more information, please contact [wmu-scholarworks@wmich.edu](mailto:wmu-scholarworks@wmich.edu).



ALCOHOLISM: THE INSIDIOUS DISEASE

by

Kathryn Van Bruggen

A Project Report  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
Degree of Specialist in Education  
Department of Counseling and Personnel

Western Michigan University  
Kalamazoo, Michigan  
August 1984

ALCOHOLISM: THE INSIDIOUS DISEASE

Kathryn Van Bruggen, Ed.S.

Western Michigan University, 1984

The purpose of this study is to describe alcoholism as a disease, its likely etiology, symptoms, methods of treatment and prognosis. Problems due to alcoholism are reported as they affect not only the alcoholic but the family, job and community as well. Education will help identify an alcoholic problem before it becomes too advanced. Various treatment modalities are discussed, including Alcoholics Anonymous. This study relates to the impact on the family and how the family can exacerbate the problem. Conclusions are based on observations of alcoholics and families of alcoholics in a therapeutic setting and literature review.

## ACKNOWLEDGMENTS

I would like to express my appreciation to Dr. Nathan Lowe, Dr. Datun Chung, Mr. Paul Parlow, and Miss Patricia Murray for their support and assistance in this study. Special thanks go to the New Day Center of Battle Creek.

I would also like to express appreciation to my husband, Johannes, who patiently supported me in pursuing these studies.

Kathryn Van Bruggen

## TABLE OF CONTENTS

ACKNOWLEDGMENTS . . . . .	ii
INTRODUCTION . . . . .	1
ALCOHOLISM--THE DISEASE . . . . .	3
What Is It? . . . . .	3
Some Facts of Alcoholism . . . . .	6
Signs and Symptoms . . . . .	8
Job Related Symptoms . . . . .	11
THE ALCOHOLIC FAMILY . . . . .	13
What the Family Sees . . . . .	13
THERAPY . . . . .	18
Alcoholics Anonymous Influence . . . . .	18
One Treatment Center Program . . . . .	20
Family Treatment . . . . .	25
Prognosis and Pitfalls . . . . .	26
CONCLUSIONS . . . . .	28
APPENDICES . . . . .	29
A. Jellinek's Chart Modified . . . . .	30
B. The Twelve Steps of Alcoholics Anonymous . . . . .	32
C. Components of One Treatment Center Program . . . . .	34
D. Steps Required of Patients in One Treatment Center Program . . . . .	37
BIBLIOGRAPHY . . . . .	43

## INTRODUCTION

People become dependent on alcohol because of physical, psychological, social, and economic reasons. When this overwhelming need is present it is considered alcohol abuse or alcoholism. Consideration needs to be given to prevention and control by better public education beginning very early in life. Removing the social stigma of alcoholism would diminish the barriers to seeking help.

It is estimated that 95% of the alcoholics live at home and have respectable jobs. An alcoholic no longer has to "hit bottom" before seeking treatment. It is found, however, that many have lost their jobs, family, and friends, as well as much of their financial security and health. The most significant pressures that result in seeking treatment are from their employers and/or the courts.

Alcoholism has been called a family disease because it seriously affects the entire family. Families will admit to this; however, few realize that by their actions they may be prolonging the condition.

The family can help the alcoholic seek treatment earlier by recognizing the signs and symptoms. The family will be able to avoid the pitfalls as the "enabler" with information about the disease of alcoholism. They must realize they have no control over the alcoholism and they must let go.

The earlier the treatment starts the better the chance of recovery. *The usual determinant for the alcoholic to seek treatment*

is forcing a crisis or confrontation: the spouse deciding to leave, the employer threatening termination, involvement with the court, or serious health problems. Alcoholism may be well advanced before this occurs.

## ALCOHOLISM--THE DISEASE

### What Is It?

The National Institute of Drug Abuse (1981) defines alcoholism as "A condition which is characterised by the drinker's consistent inability to choose whether to drink at all, or to stop drinking when he/she has obviously had enough" (p. 10).

More specifically people are problem drinkers if they cannot control their drinking, are dependent on alcohol, and/or if it negatively affects their lives. Drinkers are able to determine whether they have a problem by using this simple definition. Alcoholics tend to find one fact that might not apply to them and decide they do not have a problem.

Alcoholism has been classified as a disease by the American Medical Association and World Health Organization. As a disease, it has an etiology and pathogenesis. It has predictable, progressive symptoms; it is treatable and it has a prognosis.

Whitacker (1980) discussed alcoholism as having a biochemical basis. Research shows that alcoholics metabolize alcohol differently than nonalcoholics. A liver enzyme converts alcohol to acetaldehyde. This is further broken down to acetic acid and then to water and carbon dioxide. In the alcoholic some of the acetaldehyde enters the brain where it combines with dopamine, a natural compound, to produce TETRA-HYDRO-ISO-QUINOLINE (TIQ) or (THIQ), an opiate-like substance. This is also found in the brain of heroin



addicts. It differentiates the alcoholic from the nonalcoholic. (Some people refer to this as the X-Factor.)

Many theories have been offered for why some people become addicted to alcohol while others remain social drinkers. One theory is that time plus quantity develops an idiosyncrasy to alcohol. People who have indulged in large amounts for many years seem to become alcoholics. There is also a tendency for children of alcoholics to become alcoholics. This may be due to the availability of alcohol in the home so they start drinking very young or it may actually be a familial predisposition (genetic theory). The nutritional theory relates to a metabolic deficiency and results in a craving for alcohol. Some treatment centers replace deficient essential components in the body with change in diet and vitamin, mineral, and amino acid supplements. This is called the orthomolecular approach and results in decreasing the craving for alcohol. The endocrine theory postulates an endocrine imbalance causes the individual to drink uncontrollably. Behavior disorders due to anxiety, immaturity, compulsiveness, perfectionism, and low frustration level are also considered causal. Combinations of these theories are usually used as a basis for treatment.

The addictive personality has some or all of the following characteristics:

1. Has a weak value system, is hedonistic and is unable to stand pain (psychic and/or physical).
2. Has poor self-esteem which becomes even lower because of the shame and guilt caused by drinking.

3. Usually has unsatisfactory emotional relationships. This also deteriorates as they drink excessively.
4. Resists or is unable to admit the need for help.
5. Is unable to relate to authority.

Psychological problems may be involved. The client must be evaluated to establish that alcoholism is the primary problem. Personality and psychiatric problems may be masked by the irrational behavior of the alcoholic. Permanent brain damage may already have occurred from the alcohol. These problems must be identified before treatment for alcoholism can be started. Effective treatment can only be started after detoxification which begins to eliminate alcohol from the system.

Alcohol acts on that part of the brain that relates to self-control and learned behavior. These areas of inhibition are lost first. This may lead to aggressive, maudlin, lethargic, or apathetic behavior.

Alcohol affects people differently. Physical, mental, and environmental factors are involved when anyone takes psychoactive drugs such as alcohol. The drinkers' reactions are affected by how much they drink and whether it is before or after eating, as well as weight, personality, mood, and surroundings.

When alcohol interferes with interpersonal relationships, general health, mental ability, and/or causes legal or financial problems, there is a drinking problem.

## Some Facts of Alcoholism

There is a paradox in that some social drinkers consume more alcohol than advanced alcoholics. This is due to the tolerance level of the alcoholic. Tolerance to very large amounts diminishes to getting very drunk on small amounts in the advanced stages of alcoholism.

One out of eight drinkers develops alcoholism. Only 3-5% are "gutter" or "skid row" alcoholics. Some people believe only "skid row" drunks are alcoholics.

Alcoholics can "fall off the wagon" several times but can still be rehabilitated if they develop the right attitude. Many will admit to the problem but say "I can handle it."

Barbiturates and other drugs combined with alcohol are a lethal combination and lead to an overdose. Synergistic (interaction potentiating effects of each) actions make the combination more potent than when taken separately.

One may be a reliable worker on the job and still be an alcoholic. Alcoholics tend to protect their jobs by spacing their drinking, hiding their drinking, or drinking only off the job. Those in less skillful jobs can hide it for a longer time.

Any person who has experienced adverse affects on his life due to alcohol is a problem drinker. Others control their drinking when it means negative consequences.

Beer, wine, and liquor are all alcoholic and can result in alcoholism. Society feels beer and wine are less potent. When

alcoholics switch from liquor to beer or wine, they are still drinking alcohol. One beer is equal to a cocktail or a glass of wine.

An alcoholic does not have to "hit bottom" to start recovery. A crisis can cause a change in attitude.

Stopping problem drinking is not a matter of willpower. The alcoholic usually wants to stop but cannot.

Alcoholism is a fatal disease if untreated. It is insidious and progressive, but treatable.

The spouse of an alcoholic unknowingly prolongs the alcoholism by "enabling." Although the family is the victim, it is also persecutor and enabler.

Using Valium or Librium to assist alcoholics through the first year of sobriety only substitutes one drug for another and can result in becoming addicted to the tranquilizer.

An alcoholic with several years of sobriety cannot take even one social drink. The alcoholism flares up as though there had been no intervening sobriety.

Alcohol is a depressant. As the system attempts to control the depressing action the drinker gets "rebound." The body tries to counteract the action of the alcohol. Rebound causes them to be even more alert, and they take more alcohol to get the tranquilizing effect. This becomes a descending spiral. Eventually they need to drink just to feel normal.

All alcoholics do not have the same pattern of drinking. There are weekend drunks, after-work drunks, 24-hour-a-day drunks, and binge drinkers (drink 3 or 4 days straight then stop for a period of

time).

An alcoholic is never cured, only in remission. This can be triggered by even a little alcohol.

Alcohol can kill almost instantly by drinking a quantity in a very short time. Competitive drinkers refer to this as "chug-a-lugging" in which someone downs a pint or more of alcohol at once. This acts on the respiratory center of the brain, and as they pass out, their respirations cease. Delirium Tremens are the signs of alcohol withdrawal and can result in convulsions, coma, and death.

Some alcoholics are cross-addicted by using other drugs as well as alcohol.

Institutionalization due to insanity or the courts, death due to accidents or health (liver and brain damage), or recovery without cure, only remission, are the only outcomes to alcoholism.

### Signs and Symptoms

Jellinek (1960) has identified signs and phases of alcoholism. These are not always found in an exact order. Alcoholics may skip various phases and later show these signs or may not have some of the signs at all.

Jellinek's chart (Appendix A) indicates the progressive nature of alcoholism starting with increasing amounts of alcohol to obtain the same euphoria. The drinker then starts "blackouts." This means that although they are apparently functioning normally it is impossible for them to recall later what occurred.

The problem drinkers start to sneak drinks. They go out to

assist the host and get an extra "belt," or drink when no one is looking. They become preoccupied with drinking by being sure that their supply never runs out. They do not go to parties or restaurants where there might not be drinking. Nondrinking friends are avoided. They gulp drinks and avoid reference to overindulgence (denial). Soon they lose control; once they start drinking they cannot stop. Alibis and lies are used to cover up the problem. They lose control in areas of their life, such as handling money responsibly. They give unremembered loans, splurge, or have money stolen ("rolled") while incapacitated. They vacillate from aggression to remorse and promise to reform. They try to change their drinking pattern such as drinking only after a certain time, i.e., 5:00 p.m. or only on weekends. Sometimes they will not drink at all to prove to themselves as well as others that they are not "drunks" only to start uncontrollably again. Old friends start to avoid them because of personality changes and unpredictable behaviors. On-the-job problems become part of the picture. Absenteeism due to hangovers and blackouts and poor general health interferes with dependable job performance. The family becomes more aware of the problems and starts to fall into the "enabler" mold. This is when the family, especially the spouse, attempts to control the drinking. They take responsibility for the alcoholic by trying to limit the drinking and by making excuses or covering up. Pouring out alcohol, hiding bottles, and withholding money are ways they try unsuccessfully to control the problem.

Sometimes at this point the alcoholic will seek help. Usually

there is still some denial and they are not serious about wanting to change. They really believe they can control it. They also believe they are not hurting anyone.

Physical and psychological changes become more pronounced. The liver and brain are most affected by the excessive drinking.

Systematic effects of alcohol:

Gastro-intestinal--esophagitis, gastritis, pancreatitis, diabetes mellitus, hepatitis, and cirrhosis. Hemorrhage may occur from varices.

Cardio-vascular--hypertension, arrhythmias.

Central nervous system--polyneuropathy, Korsakoff psychosis, cerebral degeneration and atrophy. Behavioral, intellectual, and affective changes.

Skin--seborrhaic dermatitis, acne rosacea, and psoriasis.

Hemato-immunologic--anemia, lowered resistance to infection, especially the respiratory tract.

Nutrition and avitaminosis are also problems. This is due not only to the chemical irritation but also from not eating properly. Not eating helps maintain the good feeling when drinking. Alcohol also has calories that eliminates the desire for food.

Psychological changes interfere increasingly with family and friends. During the dry periods they become irritable due to their need for the alcohol and soon revert to drinking. Sometimes the alcoholic has a more pleasant personality when drinking.

Ethical deterioration becomes evident. Stealing for money for drink, unreasonable jealousy, and paranoia become a mode of behavior. Lying becomes a way of life.

Gradually it will take less alcohol to become drunk as their

tolerance starts to decrease. They develop tremors and need a drink just to remain "normal." They seek religion, and other ways of controlling their need for alcohol.

These symptoms repeat over and over going from drunkenness to attempts at sobriety and back.

The only possible outcome for an alcoholic is recovery, insanity, or death. The latter two might be arrested by the system when they are institutionalized by the courts. On the other hand, death can be earlier due to accidents while under the influence. Fifty percent of fatal accidents involve alcohol and include fires, drownings, home accidents, falls, flying, and automobile accidents. Murders, assaults, rape, suicides, fights, and child/spouse abuse are largely related to drinking.

#### Job Related Symptoms

Alcoholics are not able to complete morning tasks, and have a spasmodic work pace. They have safety problems on the job. There will be frequent absences and lateness due to hangovers and binges. They avoid associates, hide on the job, and sneak drinks. They exaggerate their accomplishments, make mistakes due to poor judgment, and become resentful when faced with their actions. Performance is below expected level.

At times the person who is responsible for the worker on the job will become an "enabler" and cover up poor work performance. When it becomes obvious this will not help, the worker is confronted with the ultimatum to get help or get fired. It appears more alcoholics



seek help after this type of pressure than when threatened by divorce. Businesses are becoming more aware of the true problem. More employers will now offer employees a chance to go for treatment rather than terminate them.

## THE ALCOHOLIC FAMILY

### What the Family Sees

The family tries to ignore or downplay the problems caused by the alcoholic. Appointments are not kept. Promises are made and broken repeatedly. Bills are not paid both because of poor income due to job problems and neglect. Personal appearance becomes slovenly. The alcoholic is uninterested in sex or has become impotent or inorgasmic. Home duties are neglected. Tension is felt by all with the unpredictable behavior and moods of the alcoholic and the reaction of the spouse. The family sees defense mechanisms such as denial, projection, and rationalization concerning the drinking as well as neglect of family responsibilities.

Denial is used by alcoholics to minimize the amount of alcohol they have had or that they are incapacitated at all. They deny they have an alcohol problem. They can "handle it." The family also uses denial trying not to admit there is a problem. Denial is used to put up a front in public because of the stigma of alcoholism. Usually others know of the problem long before the family will admit it even to themselves.

Projection is used to put blame on some other person or situation. It puts the self-hate and guilt on others. Blame is often expressed against and accepted by the spouse. This can be devastating since the spouse may already feel some guilt.

Rationalization is used to show there is a good reason for being drunk. These alcoholic alibis eventually become ridiculous: "I've had a hard day," "I had a good day," "it is Monday," "it is Friday." These excuses sound logical to the alcoholic.

The spouse says "If you loved me, you would stop drinking." The drinking cannot be controlled by willpower. Alcoholics will stop drinking periodically to prove they have no problem. The first taste of alcohol will set off the uncontrolled drinking.

The family tries to ignore the first signs of problem drinking. The first reaction is denial to the cumulative crisis. They hide the problem from family and friends by covering up for the alcoholic. Social stigma produces secrecy and protection. If work is missed due to drinking or a hangover, they will call in for the alcoholic to cover with an excuse. The spouse is both blamed and considered a victim of the alcoholism. The family experiences more stress as the alcoholic denies the problem or becomes apologetic and swears to change only to relapse again and again. The reaction of the family tends to perpetuate the problem. Since it is so insidious, the persons involved do not realize there is a problem till it has become advanced.

Al-Anon labels the family or spouse as "enabler" or "co-abuser." Society tends to have the attitude "he/she drives her/him to drink." The alcoholic in denial also blames the spouse. This adds more anxiety to the already unbalanced family situation. The family tries "home remedies." They will hide the booze, pour it down the sink, and limit funds so more can't be purchased. They will nag,

threaten, and rationalize. None of these home remedies work. The alcoholics hide their supply. They take money from the piggy bank or wallet to buy more. One alcoholic told how he filled his windshield washer container on the car with booze. He then put a tube through the dashboard. He had become very ingenious in maintaining his supply. It becomes a losing game between alcoholic and spouse which results only in frustration. Alcoholics are always able to get alcohol. They support each other and when one can't get it another will provide it. It becomes a power struggle between the family and the alcoholic. The spouse tries to protect the alcoholic from outside confrontation by protecting him/her from the consequences of the alcoholic behavior. The spouse withdraws from activities in the community, does not report abuses to self or children, and does not follow through with divorce or court action. They will bail the alcoholic out of jail instead of making them face the consequences. These actions are not only to protect the alcoholic but the family and job as well. These are called "rescuing operations."

Family disorganization and chaos eventually follow and the spouse finally seeks help. The family has broken down.

Financial problems may become serious with job instability and irresponsible handling of what is available. The spouse takes over the responsibilities of the alcoholic. A wife might take a job, pay bills, and take over the duties usually handled by the husband. The husband of an alcoholic wife may have to get meals, care for the children, and take on the other duties usually handled by the wife. It is noted that husbands seek divorce from an alcoholic wife

earlier than when it is reversed.

As the alcoholic becomes slovenly with no interest in self or surroundings the spouse retreats. Refusal of sex may not be just a power struggle but also repulsion. The verbal and emotional abuse cannot be forgotten the next day. An aroused alcoholic is often impotent resulting in frustration for the marriage partner.

Often the alcoholism is thought to be the only problem in the marriage. The family feels if the alcohol were removed things would be all right. They may suddenly realize that the marriage would not work even with sobriety. The alcoholism has broken down the trust, love, respect, and consideration usually shown in a family. Frequently the marriage is dissolved even after the alcoholic becomes abstinent. The alcoholic has not been there at times of family emergencies which have had to be handled without their help. The family has made decisions and taken over the responsibilities. The role of both the father and mother falls to the abstinent spouse. The family has been able to function without the alcoholic, therefore, may decide to rid itself permanently of that person's presence.

Discipline of children is especially bad. The alcoholic has extreme mood swings from being overly indulgent to abusive. The spouse under stress is irritable and overdemanding of the children. The children don't know how to handle it, become troubled, and problems develop in school.

The children react in a typical way to the disintegration of the family due to alcoholism. They are careful not to attract attention of the alcoholic not knowing what the mood will be. They

feel that they are guilty of causing the alcoholism. The oldest assumes more responsibility for household chores and tries to make up for the alcoholic's lack of caring and help. They withdraw from family and community interaction. They do not have friends over because of the shame of previous alcoholic encounters. The middle children may become problems at home and school. The nonalcoholic parent is wrapped up in the problems of handling the household, a job, finances, and protecting the alcoholic. They become more demanding and difficult as their own emotional problems increase. They lean more on the overly responsible child and ignore the younger ones or try to overcompensate. This results in delinquency and/or withdrawal by the children. Younger children become very introverted and try to avoid confrontations by being inconspicuous. Sometimes both parents are alcoholics and the older children maintain the household. In later life they are over-controlling and insecure.

Children of alcoholics tend to become alcoholics themselves or marry alcoholics. It is also found that former spouses of alcoholics remarry alcoholics or pre-alcoholics. It is not known whether it is a personality attraction or a need to control that causes this.

## THERAPY

### Alcoholics Anonymous Influence

The multiple inconclusive causes of alcoholism make alcoholism a disease difficult to treat. The most effective therapy has been with Alcoholics Anonymous. Many treatment centers use this strategy in their mode of treatment.

Treatment cannot be effective until the alcoholics admit to themselves that they do have a problem and sincerely believe it. They must also realize they will never be cured, only in remission. This is true with other diseases such as diabetes mellitus. Alcoholics must learn to cope with everyday problems also.

Treatments relate to what the therapist considers the cause. Combinations of treatments will sometimes be used.

Tranquilizers may be used by some therapists at least to help the alcoholic through the acute withdrawal stages. Nutritional and endocrine studies and replacement are also used.

Most, however, rely on individual and group therapy as a major part of the treatment. The family is usually included in treatment. This is an essential part of the course.

Most treatment centers use the 12 steps of Alcoholics Anonymous as the basis for treatment.

Alcoholics Anonymous (A.A.) is a group with no formal organization. It is readily available by being listed in the telephone book in most cities. It is based on the theory that an alcoholic cannot

control his/her drinking. Help from "a Higher Power" and others who have had the same problem leads them to maintain sobriety. There is no fee and most meetings are closed except for those who are admitted alcoholics. They choose a sponsor from the group to help when needed. The sponsor has experienced what the alcoholic is going through so they can be very helpful.

Basic to the theory is to take one day at a time. When people worry about the future or the past they are less capable of handling the present. The "rest of my life" can be too overwhelming.

The 12 steps of A.A. start with the admission that they are powerless over alcohol (Appendix B). Other steps relate to a belief in a greater Power on whom they can depend for help and turn their lives over to this Higher Power. They will make a list of their shortcomings and the problems they have created for themselves and their families. The fifth step is admitting to God and the group what they have done wrong. They ask help in removing these faults. A list of persons they have wronged is made and a pledge to make amends. Wherever possible, they will try to make amends except where it would hurt them or others. The tenth step is continuing to take inventory and correcting wrongs. Eleventh is to seek to improve contact with their "Higher Power." The last step is a pledge to practice these principles and carry the message to other alcoholics.

A.A. has become one of the most effective treatment modalities available to the alcoholic. Drug addicts, gamblers, overeaters, adolescent delinquents, and others have used the A.A. formula for



helping each other. This has proven effective with their problems also.

Few doctors have been trained in treating alcoholism. Too often this results in prescriptions of other drugs, such as Antabuse or tranquilizers. The patient then becomes addicted to the tranquilizer and often ends up cross addicted.

#### One Treatment Center Program

In one treatment center program (Appendix C), alcoholics are admitted to the detoxification unit for about 5 days for the purpose of medical and psychiatric evaluation. If withdrawal symptoms require medication, tranquilizers may be given. Usually no medication of any kind is given. The objective is to get the patient off all drugs as soon as possible. Antabuse is not recommended as part of treatment. It only causes the patient to rely on another drug. It can also cause serious illness and death if combined with alcohol.

During the detoxification period visitors are not allowed. The patient should be isolated from all former problems.

After this period the patients go to a unit where they stay for about 28 days. Participation in treatment in this unit is required. When they first arrive they show much resistance. The patients have a form of Ward government in which they watch each other, and aid each other in fulfilling the objectives of the treatment. Officers are elected. There are basic rules necessary when such a mixed group lives so close. Men and women from all social strata live

together 24 hours a day. They have a roommate but no one else can enter their rooms. They are discouraged from becoming emotionally involved with other members. Visitors may come to visit after the data session one or two evenings a week. There are other basic rules for living together that are spelled out and to which they must agree.

Early in the treatment they sign an agreement to follow the treatment. They are able to leave but it is considered "Against Medical Advice" (A.M.A.). They will usually not be able to return to treatment if they leave under these circumstances. Later in treatment, they are permitted to leave for short periods.

They attend lectures describing alcoholism, its causes, symptoms, and resulting problems. They see films on various aspects of alcoholism including job and family complications. Lectures also teach patients skills in positive confrontive communication.

The participants attend discussion groups in which a therapist guides the discussion. A data session is one such discussion. A significant other (spouse, friend, or family member) attends this session. Prior to the session this significant other has had a private talk with the therapist who leads the group into discussing the patient's alcoholic behavior. The guest frequently has a different viewpoint than the patient on things that have happened. The theory is that no one can effectively reason with someone who still has alcohol in their system, thus it is done after detoxification. This data session occurs during the first week after being released from the detoxification unit. The alcoholic is confronted with his/her

"insane" behavior, some of which occurred in a blackout. They are not aware of some of the things they did.

The discussions at times are brutally candid. The counselors and older members of the group keep it from being destructive. They are able to point out the denial, self-pity, and rationalization without attack.

Discussion groups meet twice a day for 1 to 2 hours. The patients have all had similar problems and are very skillful in seeing the defense mechanisms of one another, and in doing so help themselves. It is remarkable to see the change in patients in the following 3 weeks. Sullenness, lying, projection, self-pity, and denial gradually fall away under the barrage of their peers. The group knows all the games since they have played them all. Self-confidence, understanding, and desire to change develops.

Individual therapy sessions are held with each patient. Some of this information may be brought to the discussion groups.

Progress of each patient is evaluated by the team of therapists, psychologists, and psychiatrists every morning. The nurse also attends these meetings. Suggestions are made for assisting with treatment when necessary. Records are kept on the treatment plan and progress of each patient.

The patients must write and present the first step of A.A. to the group (Appendix D). When they have completed the first five steps they are ready to graduate. Each presentation may be challenged in the discussion group. It may be rejected and the patient has to do the work over. The fourth step relating to the "Higher

Power" and personal inventory is done in private with a chosen counselor or the Chaplain. The fifth step requires admitting to the group what has been wrong in their lives due to alcohol.

Emotions previously submerged are brought to the surface by group confrontation. Automatic thought processes resulting in cognitive distortion are pointed out. Help in making rational responses is given by pointing out how they jump to conclusions, overgeneralize, label, blame, or have "all or nothing" thinking.

The therapist guides the discussion in helpful ways. New patients learn how to be confrontive without causing damage to the person confronted. Ways of positive communication are taught. These skills will prove helpful in dealing with others after they have been discharged.

A very important and well kept rule is that nothing is discussed outside or with outsiders. Since all are vulnerable, this rule holds up well.

Evenings the group attends an "Abuser" meeting similar to the A.A. meetings. Families of patients attend a group meeting in the evening, as "Co-abusers," and members of the families are individually counseled.

Realistic goals are set for after discharge. Potential problems are discussed, such as former drinking companions and hangouts. Divorce, court, and/or job problems must be faced.

At graduation a medallion is presented. There is an After Care group or Recovery group to attend. They are expected to attend this group once a week for a year as part of the treatment. They are

also expected to attend A.A. meetings once or more a week.

At the end of from 3 to 9 months and a year of sobriety they receive a medallion at a special ceremony. This marks a very significant step in their rehabilitation.

Positive thinking is essential. Negative attitudes are destructive. Self-esteem must come with sobriety and doing things that will make them feel, look, and act better.

This program gets the patient and family in touch with feelings which have been distorted and suppressed. These feelings must surface and be dealt with or they are destructive.

It has been found that from 5 to 7 weeks and 5 to 7 months after treatment they may have a reaction or plateau. They feel a great need for a drink. They must be prepared for such instances. This is why the After Care group is important.

Another phenomenon of the recovering alcoholic is the "dry drunk." In this case they will act or speak as though they had been drinking even though they have not. This creates problems if the family or boss accuses them of drinking. The alcoholic will likely return to drinking thinking "What's the use?" Preparing the family and alcoholic concerning this is important.

Patients are taught there are four basic needs in life. Physical satisfaction relates to food, sleep, and warmth. Emotional or security needs are love and affection. Social needs relate to acceptance and approval. Achievement needs are concerned with mastery and self-approval. Goals may be set too high; perfectionism is common in alcoholics. A positive attitude for good mental health

includes accepting oneself and others, not setting goals unreasonably high, not being compelled by shoulds, oughts, and musts.

Alcohol has been used to adjust the four basic needs. Some require more of one basic need than others. Alcoholics turn to drink when one or more need is not met. They need to be taught how to cope without the bottle and fill their basic needs without alcohol.

### Family Treatment

Since alcoholism is a family problem the whole family needs therapy. Individual and group therapy is done with each member. This also follows the guidelines of A.A. Al-Anon is for spouses of alcoholics and Al-Ateen is for the children. Sometimes the family seeks help before the alcoholic. This may or may not influence the alcoholic to seek treatment.

Precipitating a crisis is one way to bring realization to the alcoholic that there is a problem. The family and friends plan a group confrontation with the alcoholic who is confronted with what he/she has done when drunk. Having several people telling these incidents makes them believable. The alcoholic can no longer deny there is a problem and hopefully will seek help.

The following list has some basic suggestions for the family in coping with alcoholism:

Don't try to cover up by making excuses or trying to organize things. This prolongs the alcoholism.

Don't make moral judgments about it. It only creates guilt and a need to escape through alcohol. Nagging, preaching, and lecturing are not helpful.

Don't appeal to their willpower. They cannot will away the problem.

Don't say "if you loved me." They have to stop for their own sake.

Try to see the alcoholic as a truly sick person. They need help and understanding.

When an alcoholic starts treatment, don't expect overnight success. It was a long time developing and will take a long time recovering. There will likely be slips.

Learn facts about alcoholism. It will help you understand the illness better.

Another person's alcoholism is no reason for embarrassment for you. You cannot hide it anyway.

Since you are not responsible for the drinking, do not feel guilty.

Seek help from persons with knowledge and experience. You need support and understanding.

Don't criticize the alcoholic. They are very sensitive and react to hurt.

Forgive, be patient, and let go.

### Prognosis and Pitfalls

Many recovered alcoholics will fall victim to false beliefs after being abstinent for weeks, months, or years. They will try again to drink as a social drinker. Although they may drink controllably one or more times, eventually they revert to alcoholism. The THIQ does not diminish with abstinence. A slip may bring them back for treatment or they may go on as before to death or

institutionalization.

Recovering alcoholics must be made aware of the need to change their lives. This includes making new friends. Old alcoholic friends can present a problem when they urge drinks or "slip them a Mickey." It includes breaking old habits and avoiding old hangouts. This means not stopping at the bar with friends after work, not having alcohol available, and forming different social patterns.

It is important for recovering alcoholics to attend A.A. meetings. Those who do not seem to forget their lessons and they soon revert to alcoholism.

Problems occur not only with alcoholic drinks but also with many other supposedly innocuous substances. Some over the counter drugs contain alcohol. Sleep aids contain as much as 50% alcohol. Cough syrups, mouth washes, etc. also contain alcohol. It is even thought that rubbing alcohol used externally could trigger alcoholism. The alcoholic must be alert to such pitfalls.

More and more insurance companies as well as Medicaid are covering treatment for alcoholics. Employers have found that salvaging a good employee is worth the time and cost.

A final suggestion is made in treatment. If one should slip they should try again and not give up.



## CONCLUSIONS

Alcoholism is increasing in the United States. It is causing irreparable damage to families and communities. It is creating problems on every socioeconomic level. It causes death and destruction to alcoholics and nonalcoholics alike. Very young children are becoming alcoholics. The problem is expanding.

Massive education and publicity needs to be directed to this problem. At present the Seventh-day Adventist Church and the Church of Latter Day Saints have short powerful segments on television and in periodicals. Mothers Against Drunk Driving (MADD) are also contributing to publicity. Much needs to be done to help people, especially families of alcoholics, to recognize the signs and help them change their own approach to alcoholism. Education will help these families earlier.

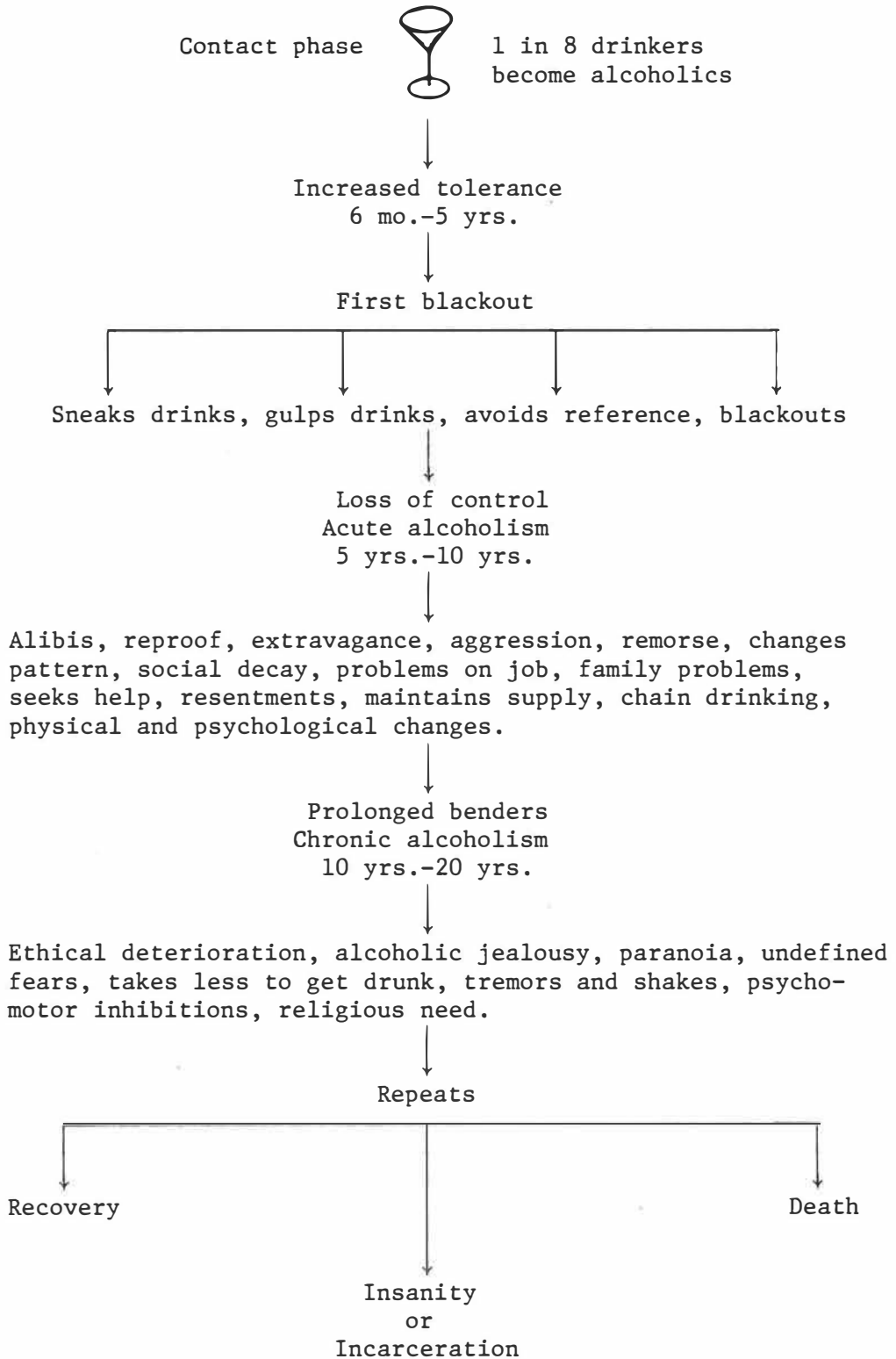
Alcoholism is a predictable, progressive but treatable disease. More needs to be done about it!

## APPENDICES

Appendix A

Jellinek's Chart Modified

Symptoms of Alcoholism



Appendix B

The Twelve Steps of Alcoholics Anonymous

The Twelve Steps  
of Alcoholics Anonymous

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our short-comings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. ("This is A.A.," 1953, p. 20)

Appendix C

Components of One Treatment Center Program

## Program Components

### I. Inpatient Component:

This unit delivers services to the chemically dependent adult and his/her immediate family. The 28 day program addresses the needs of the individual and his/her presenting problem areas. The program will strive to meet the following primary goals of inpatient treatment:

1. A treatment staff trained specifically in chemical dependency.
2. A treatment milieu designed to provide structure, clear expectations and limitations on the behavior of the patient.
3. Didactic lecture material geared to patients' life-style to be presented in an informal, individualized manner.
4. A recreational and physical fitness component focusing on the needs of the group.
5. A family program designed to assist families struggling with a chemically-dependent person and their resulting family problems.

Measurement of progress of the levels of achievement in the inpatient program are determined by the following indicators:

6. The alcoholic's acceptance of his/her disease and willingness to comply with the treatment program.
7. The alcoholics' responsibility for their recovery shown by changes in attitudes, behavior, thinking and feeling.
8. The patient's willingness to change shown by:
  - (a) Risk taking and confrontation, showing concern for others;
  - (b) Development of self-esteem and positive peer and family relationships; and
  - (c) Serious involvement in the treatment program.



9. The patient's willingness to maintain new lifestyle as evidenced by:

(a) Active attendance and participation in A.A. or N.A., and

(b) Acceptance of aftercare plan as recommended by staff.

## II. Aftercare Planning:

Aftercare planning designed to assist the patient in maintaining goals of recovery initially through:

1. Regular attendance/involvement in A.A. or N.A.
2. Responsible behavior within the family environment.
3. Responsible behavior on the job.
4. Implementation of a chemically-free lifestyle.

The basic goal of aftercare planning is to provide the patient with an ongoing supportive atmosphere to continue in their recovery program. Aftercare planning focuses on specific plans for individualized recovery needs, including aftercare transitional groups available to provide ongoing support with personal issues and a network of sober people to meet socialization needs.

Appendix D

Steps Required of Patients in  
One Treatment Center Program

## First Step Guide

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

It would be impossible to overestimate the importance of the First Step because your recovery cannot succeed unless you accept the seriousness and totality of your illness. In doing your first step, you are required to give specific examples of your destructive behavior resulting from your chemical use in each of the following areas.

In the first three categories, draw your information from Early, Middle, and Late stages to show the progression of your illness. Avoid giving an autobiography or "drunk-a-log." BE SPECIFIC.

A. Kinds, amounts, and frequency of chemical use.

<u>Dates</u>	<u>Kind</u>	<u>Amount</u>	<u>Frequency</u>
Early years (Sample) 1950- 1961	beer, wine, liquor, or comb.	(how much)	(how often) week- ends, daily, etc.
Middle years			
Late years			

B. Preoccupation with chemicals. (Such as hiding bottles, buying ahead, planning, etc.) Did you look forward to drinking at lunch, or stopping at the tavern after work for a good "cold one"? Plan for a party and buy the booze ahead of time?

C. Attempts to control. Did you cut back on your drinking, switch from hard liquor to wine or beer? Go to A.A.--seek medical help? What happens when you attempt to control your drinking? How long are your periods, if any, of controlled drinking?

D. Effects on work and finances. Break down the costs. Include both employment for pay and work around the home that you are responsible for. Include in the cost such things as: DWI's, medical help (doctors), accidents, lawyer's fees, also any hospital programs, plus this one. How has drinking affected your attendance, promptness and attitude at work or school? How has it affected your motivation to do different things at work? Compare your work record when sober and when drinking. Have you ever quit any jobs to avoid being fired?

E. Effects on physical health and appearance. What did you look like when you were drinking--eyes red, face flushed, clothes soiled, etc. Also include the results of your admitting blood test. Ask your doctor for these or the ARS nurse.

F. Effects on family and concerned persons. Talk about how your alcoholism has affected your family. List each member of your immediate family and/or significant others, and give a minimum of three examples of how your behavior (chemical) adversely affected them; i.e., my kids ignore me because I haven't followed through on my promises with them.

G. Effects on social life. Did you stop going out? Did you lose friends? Did you terminate or lose interest in hobbies, sports? If so, which ones? How did your social life change? Include three specific examples: We belonged to a social club. I got drunk and my spouse refused to attend anymore.

H. Sexuality and sex life. How did you feel about yourself as a man or woman? How did your spouse or girlfriend/boyfriend react to you when you were drinking?

I. Effects on feelings. How did your feelings change when you were drinking? How did this compare to your feelings when you were sober? What feelings made you decide to drink? How do you deal with unpleasant feelings when you are not drinking? Some examples are: When I drank I felt anger toward my wife. I'd hit or shove her. At the office I'm a real people pleaser, but when I get home I'd take my anger out on my family. When I drink I'm withdrawn and go stay by myself.

J. Insane behavior. This includes accidents, falls, injuries, verbal-physical abuse, suicide attempts, loss of memory. At least 10 specific examples.

K. Effects on character.

<u>Qualities</u>	<u>Actions when sober</u> vs.	<u>Qualities</u>	<u>Actions when drinking/drugging</u>
(Example) <u>(honesty)</u>	(don't lie)	<u>(dishonesty)</u>	<u>(lied to my wife about where the money went that I had spent on booze)</u>

AVOID GENERALITIES. BEING SPECIFIC HELPS. Write the first step out in your spiral notebook, but don't hand it in. Let your group counselor or nurse know when you will be ready to give your step, but don't wait until you have it prepared to ask to give it that day. Project may be a day or two ahead. It is given in group. It cannot be given until you have had your data session.

## Second and Third Steps Guide

Answer the following questions on a separate sheet of paper. Work these out by yourself. The answers need not be complicated, but they must be honest.

Part I

1. What is meant by "Higher Power"?
2. How do you know?
3. Do you believe in a Power outside yourself?
4. Specifically, how does a Higher Power affect you? How do you know?
5. Can you make contact with (get in touch with) your Higher Power?

Part II

1. Define the following pairs of words: (give examples of each)
 

good . . . . . bad

right . . . . . wrong

sane . . . . . insane
2. What is meant by control?
3. Are there things in your life which you can control? Specifically, what are they?
4. Are there things in your life which you cannot control? Specifically, what are they?
5. Do you believe that a Higher Power can restore sanity? Why/why not do you believe this?
6. If the answer to No. 5 is "Yes," how specifically does the Higher Power do this?
7. Is it possible to seek a Higher Power?

Part III

1. Define the following: (Remember your definition of "control")  
decision                      life  
will                              faith/trust
2. What is meant by "turning over to a Higher Power"?
3. What, specifically, can somebody "turn over" to a Higher Power? What can't be?
4. How do you know if you have really "turned over" something to a Higher Power?
5. Is it possible to know if you are being "restored to sanity"?
6. Give at least two situations which turned out badly for you. How could you have handled them differently?
7. Specifically, what will be your basis for taking inventory in Step 4?

## Instructions to "4th Step Inventory"

### A. PERSONALITY DEFECTS

What to do: Give two (2) very specific examples from your life that show how that defect was a part of your life.

### B. THE 7 CARDINAL SINS

What to do: Write a paragraph on each cardinal sin describing how it has been a part of your life.

### C. THE 10 COMMANDMENTS

What to do: Give two (2) very specific examples showing how you have broken each of the 10 Commandments. Read carefully the definition of each commandment.

**\*\*\*STOP!!! THINK POSITIVE IN THE NEXT 4 SECTIONS!!! BE POSITIVE!!!\*\*\***

#### D 1. THE DIVINE VIRTUES--FAITH, HOPE, AND CHARITY

What to do: Write a paragraph on "faith," a paragraph on "hope," and a paragraph on "charity/love." DESCRIBE THESE VIRTUES AS YOU SEE THEM IN YOUR LIFE NOW--not last year or sometime in the future.

#### D 2. THE LITTLE VIRTUES--THE BUILDING MATERIAL

What to do: Choose three (3) virtues that you see in yourself and write a paragraph on each one describing it in your life.

#### D 3. ATTITUDES

What to do: Write a paragraph on each section (God, Myself, Family, Work, Friends, etc.) describing your feelings.

### RESPONSIBILITIES, Your Personal Goals

What to do: Write a list of your goals for each section (God, Myself, Family, Work, A.A.). Be very, very, very specific about how and what you are going to do in each of these areas.  
**NO GENERALITIES!!!**

Remember: Put your goals in a list.

## BIBLIOGRAPHY

- Aguilera, D., & Meesich, J. Crisis intervention. St. Louis, MO: C. V. Mosby, 1982.
- Alcohol issues. Kalamazoo, MI: New Directions Alcoholic Services Center, no date.
- Bailey, M. B. Alcoholism and family casework. New York: Community Council, 1968.
- Bailey, M. B. Alcoholism and marriage: A review of research and professional literature. Quarterly Journal of Studies on Alcohol, 1968, 22, 81-97.
- Blades, S. Alcoholism as a family problem. In D. Hymovich & M. Underwood-Barnard (Eds.), Family health care. New York: McGraw-Hill, 1979. Pp. 360-374.
- Bowen, M. Alcoholism as viewed through family systems theory and family psychotherapy. Annals of N.Y. Academy of Science, 1974, 233(April), 115-129.
- Burgess, A., & Baldwin, B. Crisis intervention theory and practice. Englewood Cliffs, NJ: Prentice Hall, 1981.
- Burton, M. An alcoholic in the family. Philadelphia: Lippincott, 1974.
- Christian, A. The family in the crisis of alcoholism. Unpublished master's thesis, Western Michigan University, 1983.
- Clinical highlights. Hospital Medicine, 1980, 16(8), 59.
- Ditzler, J. Alcoholism: A family illness. Nursing Times, 1980, 76, 1103-1105.
- Estes, N. Counseling the wife of an alcoholic spouse. American Journal of Nursing, 1974, 74, 1251-1255.
- Fiddle, S. Portraits of a shooting gallery. New York: Harper & Rowe, 1967.
- Fine, J. The family approach to crisis intervention. Ch. 8 in R. J. Wicks, J. A. Fine, & J. J. Platt (Eds.), Crisis intervention: A practical guide. New York: C. V. Slack, 1978.



- Flanzer, J. P., Gregory, M., & O'Briaen, L. Family focused treatment and management: A multi-discipline training approach. In J. S. Madden, R. Walker, & W. H. Kenyon (Eds.), Alcoholism and drug dependence: A multi-disciplinary approach. New York: Plenum Press, 1977. Pp. 239-261.
- Glaser, F., Greenberg, S., & Barrett, M. A systems approach to alcohol therapy. Toronto, Canada: Alcoholism and Drug Addiction Research Foundation, 1978.
- Hanson, K. J., & Estes, J. Dynamics of alcoholic families. In N. Estes & M. Hieneman (Eds.), Alcoholism, development, consequences and interventions. St. Louis, MO: C. V. Mosby, 1977. Pp. 67-75.
- Hoff, E. Aspects of alcoholism. Philadelphia: Lippencott, 1963.
- Jackson, J. K. The adjustment of the study to the crisis of alcoholism. Quarterly Journal of Studies of Alcohol, 1954, 15, 562-586.
- Jellinek, E. M. Types of alcoholism. In The disease concept of alcoholism. New Haven, CT: Hill House Press, 1960.
- Knight, J. The family in the crisis of alcoholism. In S. E. Gitlow & H. S. Peyser (Eds.), Alcoholism: A practical treatment guide. New York: Grune & Stratton, 1980. Pp. 205-228.
- Krimmel, H. E. The alcoholic and his family. In P. G. Bourne & R. Fox (Eds.), Alcoholism: Progress in research and treatment. New York: Academic Press, 1973. Pp. 297-310.
- Lemert, E. M. The occurrence and sequence of events in the adjustment of families to alcoholism. Quarterly Journal of Studies of Alcohol, 1960, 21, 679-697.
- Manual of alcoholism. Monroe, WI: A.M.A., 1977.
- National Institute of Drug Abuse. Let's talk about drug abuse (Pub. No. 81-706). Washington, DC: Department of Health and Human Services, 1981.
- Orford, J., Guthrie, S. et al. Self-reported coping behavior of wives of alcoholics and its association with drinking outcome. Journal of Studies on Alcohol, 1975, 36, 1254-1267.
- Poley, W., Lea, G., & Vibe, G. Alcoholism: A treatment manual. New York: Gardner Press, 1979.
- Sager, C. J., & Kaplan, H. S. (Eds.). Progress in group and family therapy. New York: Brunner-Mazel, 1972.

Sedgewick, R. Family mental health theory and practice. St. Louis, MO: C. V. Mosby, 1981.

Spencer, C., Nichols, L., Waterhouse, J. et al. Clinical pharmacology and nursing management. Philadelphia: Lippincott, 1983.

Thinking about your drinking. Kalamazoo, MI: Western Michigan University Health Services.

This is A.A. New York: Alcoholics Anonymous, 1953.

Van Gee, S. J. Alcoholism and the family: A psycho-drama approach. J.P.N. and Mental Health Services, August 1979, pp. 9-12.

Vitamin C used in controversial alcohol, drug treatment. Kalamazoo Gazette, March 15, 1984, p. 12.

Whitacker, G. (Producer). A disease concept of alcoholism. Bellville, IL: Gary Whitacker Co., 1980. (Film)