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Counseling the abstaining alcoholic.

Charles Travers Harrell
University of Massachusetts Amherst

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COUNSELING THE ABSTAINING ALCOHOLIC

A Dissertation Presented

By

CHARLES TRAVERS HARRELL

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of DOCTOR OF EDUCATION

September 1931

School of Education
ABSTRACT
Counseling the Abstaining Alcoholic
(September 1981)
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M.A., University of Michigan
Ed.D., University of Massachusetts
Directed by: Professor John Wideman

A presentation of a counseling approach, introducing the concept of "Third Person." The conclusions and recommendations to counselors of abstaining alcoholics who have attained and sustained without interruption a period of alcohol abstinence is based upon an original report covering the period of 1973-1979 of the responses of one hundred thirty-seven self-admitted alcoholics.

An examination of the scope of alcoholism on a national, state and local level is presented followed by an examination of the various views of professionals, academic and social, of the nature of the problem of alcoholism with attention given to misconceptions maintained by the general public.

A discussion of the characteristics of the alcoholic person is presented which is primarily based upon data obtained from interviews from the sample. Atten-
tion is directed to the inner world of the alcoholic, the "Inscape."

Possible solutions to the problem and a brief discussion of some current modes of treatment of alcoholism are presented with comment as to the limitations and efficacy of the modes. Considerable attention and critique is given to the program of Alcoholics Anonymous.

An examination of a humanistic, existential, client-centered approach to counseling the abstaining alcoholic is detailed with the introduction of the "Third Person" concept as a phenomena that results from the successful application of this approach.

Client-counselor relationships are discussed with special attention given to the presence of empathy, positive regard and congruence. Additional comments are made as to unrestricted honesty which must be maintained by the counselor.

Frustration and fear as impelling characteristics of alcoholism and their resistance to being extinguished is discussed.

A schema is presented based upon Maslow's schema for safety-risk.
The work concludes with a presentation of the attitudinal and assumptive set necessary for the approach with recommendations to the counselor of the abstaining alcoholic as to its substance and practice.
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INTRODUCTION

This work is concerned with counseling the abstaining alcoholic and is limited in its purpose to consideration of the adjustment problems, problem presentations and the possible resolution of those problems.

It is hoped that some insight and information for further inquiry can be stimulated which will be productive for both the counselor and the client.

Attention will be given to the definitions of "alcoholism". A philosophical premise will be suggested from which the counselor may proceed. It is desired that the information can stimulate the counselor toward the determination of a model which can serve for effective support to the alcoholic in his attempts to adjust to problems generated by alcohol abuse and to those problems which have been carried over from the pre-abuse period into the abstinence period.

We are primarily concerned with the adjustment of the alcoholic to a life of sobriety, which requires total abstinence from the use of alcohol or substitutes for non-medical purposes.
Problems in Counseling the Alcoholic

Attempts to counsel an alcoholic who is at the time of counseling using or abusing alcohol are fruitless.

(1) The active alcoholic cannot conceptualize his problems nor is he capable of assorting them into a discrete arrangement for examination.

(2) The alcoholic who is drinking is unable to distinguish between that which is "real" and that which is "fantasy."

(3) The active alcoholic is usually unable to distinguish between his own individual problems and those which are assumed to be generated by people, places and things which are environmental. He is a victim of projection.

(4) The denial mechanism is endemic to the active alcoholic who is unable to face the realities of drinking and the resultant damage which continues to be intensified by drinking.

(5) The active alcoholic swings from one polarity of emotion to another. What seems to be a pressing problem at one time becomes lost in a maze of "new" problems.

(6) The active alcoholic is usually convinced that he can control his drinking and that he can
exercise discretion as to what he drinks, the amount he drinks, and the effects of his drinking.

(7) The active alcoholic is unaware of the devastating effects his dependency has upon himself, his family, his friends, his occupation, and his community.

(8) The active alcoholic will resist the concept of alcoholism viewing his maladaptive behavior as "accidental" or "usual" or "special."

It is for these reasons which are plentifully documented in the literature on alcoholism that counseling the abstaining alcoholic should be severely regimented until the client has been without the drug for a period of at least thirty days. Abstinence is the only goal for the counselor during the initial thirty day period.

Problems in Counseling the Abstaining Alcoholic

The alcoholic is an ill person. The nature of the illness, its diagnosis, treatment and prognosis will be discussed in the body of this work. The etiology is unknown.

The illness is paradoxically simple and complex. If the client does not drink alcohol, he will not abuse it. If he does not abuse it, he will not become alco-
holically disabled.

However, to the alcoholic, not drinking is a terrifying prospect and the process of establishing abstinence is one that requires the intense concentration for the thirty day period. To repeat: the maintenance of abstinence is primary. It is vital to the exclusion of all other considerations. Without abstinence, help is at best severely inhibited and usually ineffective.

Hence, we are not concerned with the attainment of abstinence; we are directing our effort at the maintenance of abstinence and we are attempting to develop a counseling approach that will permit the client to confront the array of problems he will face in daily living, problems which may have been generated prior to alcohol abuse, during abuse, or following the attainment of abstinence. There may be genetic or biological factors involved, but for this work we are directing our main attention to those environmental and existential factors which contribute to his stress, anxiety and disorientation.

Problems of the client can be roughly grouped into three prognostic opinions: (1) the problems can be eliminated; (2) the problems cannot be influenced; (3) the problems can be tolerated.

This work attempts to give clarity to the difficul-
ties of the alcoholic client and eventually to lead the counselor to a humanistic, existential, client-centered approach to counseling which has given evidence of success in the counseling field.

The Organization of the Material

The structure of the work generally is as follows:

1. The Dimensions of the Problem of Alcoholism.
2. The Nature of the Problem of Alcoholism.
3. The Examination of Treatment Programs.
4. The Development of an Approach to Counseling the Abstaining Alcoholic.
6. The Concept of the Creation of the "Third Person" Phenomena.

What are the dimensions of alcoholism in the United States? What is alcoholism and how is it viewed culturally, societally and individually? What are the factors of the internal life of the alcoholic which produce discomfort, stress, anxiety, and behavioral extravagancies? What are the treatment programs available and what effect have these programs on the abstaining alcoholic? What is especially significant about the program of rehabilitation and abstinence maintained by Alcohol-
ics Anonymous?

After an examination of these questions, an approach to counseling the abstaining alcoholic that is concerned with the attitudinal and assumptive sets necessary for that approach is proposed, leading to the "Third Person" concept after the attitudinal and assumptive sets necessary have been examined by the counselor.

The work concludes with observations on the counselor as a client, and the client as counselor, and the product of that interaction.

The Scope of the Study

A sample was taken during a period of interviewing and monitoring alcoholics (self-admitted) from 1973 through 1979.

The distribution of the sample covers thirty-seven states.

The distribution geographically by states follows:

<table>
<thead>
<tr>
<th>State</th>
<th>Number in Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>41</td>
</tr>
<tr>
<td>New York</td>
<td>13</td>
</tr>
<tr>
<td>Ohio</td>
<td>11</td>
</tr>
<tr>
<td>California</td>
<td>11</td>
</tr>
<tr>
<td>Michigan</td>
<td>10</td>
</tr>
<tr>
<td>New Jersey</td>
<td>8</td>
</tr>
<tr>
<td>Texas</td>
<td>8</td>
</tr>
<tr>
<td>Maine</td>
<td>6</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>5</td>
</tr>
<tr>
<td>West Virginia</td>
<td>4</td>
</tr>
<tr>
<td>Florida</td>
<td>4</td>
</tr>
</tbody>
</table>
Vermont 3
Washington, D.C. 3
Rhode Island 2
Wisconsin 2
Washington 2
Louisiana 1
Indiana 1

Other
Ontario 1
British Columbia 1

Note: Both Canadians were United States citizens residing in Canada.

The sample was a selective one and only those who presented sufficient information to be included in the collective data were used.

The total number interviewed or monitored was in excess of fifteen hundred. Of that number, one hundred thirty-seven were selected for this study.

Those rejected were eliminated for one or more of the following reasons:

(1) The individual was incomplete in the answers or insufficiently revealing to present clear information.

(2) The individual refused to answer a sufficient number of questions to warrant inclusion.

(3) To protect the anonymity of the individual, some were not included at their own request.

(4) Death or a relapse into drinking prohibited a complete interview or monitoring.
The subject too often indicated that the answers were being manufactured.

The subject refused to answer any questions.

The responses by the subject were so vague or muddled that a concise statement of the response was impossible to synthesize.

More than six hundred Alcoholics Anonymous meetings were attended during the data collecting period.

It is not intended that the sample should be regarded as a scientific entity and no attempt should be made to relate the statistical data acquired to national community trends or averages.

The data included in the body of this work should be regarded only as an indicative sample pointing to additional research in the areas of discussion.

**TABLE 1**

**The Sample**

\[ N = 137 \]

<table>
<thead>
<tr>
<th></th>
<th>( N )</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males:</td>
<td>88</td>
<td>64</td>
</tr>
<tr>
<td>Females:</td>
<td>49</td>
<td>36</td>
</tr>
<tr>
<td>Married Males:</td>
<td>37</td>
<td>27</td>
</tr>
<tr>
<td>Married Females:</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>Living Arrangement with Opposite Sex (Male):</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Living Arrangement with Opposite Sex (Female):</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Table 1, continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Arrangement with Same Sex (Male):</td>
<td>N</td>
<td>Percent of Total</td>
</tr>
<tr>
<td>Divorced Males:</td>
<td>41</td>
<td>30</td>
</tr>
<tr>
<td>Divorced Females:</td>
<td>22</td>
<td>16</td>
</tr>
<tr>
<td>Multi-Divorced Males:</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Multi-Divorced Females:</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Single Males:</td>
<td>34</td>
<td>25</td>
</tr>
<tr>
<td>Single Females:</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average Number of Divorces per Person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average Number of Children Parented:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not entered into high school</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>Entered high school but did not graduate</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>Graduated high school only</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>Entered college or post-secondary school</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>College graduate</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>Graduate Studies (of college graduates)</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
</tbody>
</table>
### TABLE 1, continued

**Occupational Status:**

<table>
<thead>
<tr>
<th>Status</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Skilled labor</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Unskilled labor</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

**Assortment:**

<table>
<thead>
<tr>
<th>Profession</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Academic</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lawyers</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Writers</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Plumbers</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Sales</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

**Age:**

<table>
<thead>
<tr>
<th>Age</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20-30</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>30-40</td>
<td>27</td>
<td>17</td>
</tr>
<tr>
<td>40-50</td>
<td>30</td>
<td>22</td>
</tr>
<tr>
<td>50-60</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Over 60</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

(Note: These figures are based upon estimates by interviewer as well as responses of those interviewed. The figures are not statistically accurate, but they are reasonably indicative of the age strata.)

**Additional Data:**

- Number of hospitalizations because of alcoholism: 202
- Number of rehabilitation centers entered for treatment: 73
- Number of jailings: 52
- Average period of abstinence for entire sample: 2 years, 3 months
<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longest period of abstinence of individual in sample</td>
<td>24 years</td>
</tr>
<tr>
<td>Shortest period of abstinence of individual in sample</td>
<td>3 months</td>
</tr>
<tr>
<td>AA members</td>
<td>133</td>
</tr>
<tr>
<td>Self-enforced abstinence</td>
<td>4 (all males)</td>
</tr>
<tr>
<td>Average number of relapses in total sample:</td>
<td>2 per member</td>
</tr>
<tr>
<td>Number without relapse</td>
<td>49</td>
</tr>
</tbody>
</table>

(Relapse is defined as a discontinuance of total abstinence.)
CHAPTER I
SOME DIMENSIONS OF ALCOHOLISM IN THE UNITED STATES

"We think according to nature. We speak according to rules. We act according to custom."
--Francis Bacon

Society's view of the complex illness of alcoholism and the alcoholic is emotionally textured. The public regard of the alcoholic has a sad and soggy history. The word "alcoholism" as an illness has only recently come into frequent use: "Town Drunk," " Fallen Woman," "Lush," "Drunken Bum," "Wino," have been some common descriptions. Open disapproval continues, condemnation and rejection are still common; but today there is a substantial societal desire to help rather than to punish or ignore the alcoholic.

It is common for people to view with amusement and/or scorn that which frightens or discomforts them; yet actors are able to earn substantial incomes by doing a "drunk act." It is a well-established rule of playwriting that if one has difficulty with an act in a comedy, it is useful to inject the "drunk scene"; plays which have been salvaged by "drunk scenes" range from The Male Animal by Elliott Nugent to Plaza Suite by Neil Simon.
Today fewer comedians regale their audiences with portrayals of "drunks," telling jokes about what one drunk said to another, or describing "pink elephants" or the "d.t.'s." It would be helpful to the counselor if such comedy would become universally inappropriate; it is no longer acceptable for speech defects, spastic movement, epilepsy or physical impairment to be used as basic comedic material; perhaps alcoholism will someday be proscribed.

Yet, the famous "Drunken Porter" scene in Macbeth makes the Porter a subject of human sympathy. Falstaff, a prototype of the drunken wastrel, is a person of considerable humanity; his tribulations evoke our sympathy. But Shakespeare is not of our time alone.

Another societal view which is without validity from both a medical and a psychological view is that alcoholism can be cured. There is no substantial evidence that a cure can be accomplished, yet many in our society accept the invalid notion that all that is needed are facilities to effect "cures." It is not yet uncommon to hear the phrases: "He used to be a drunk," "He is a reformed drunk," "He used to be a drunk, but he got cured." To repeat, there is no substantive evidence that alcoholism can be "cured." During the 1920s a prominent treatment, the Keeley "cure," was marketed.
The "cure" involved a generous application of medicine which was a fifty percent alcoholic concoction. Grandmothers often consumed Nervene for the relief of tension. It worked as Grandmother was usually mildly intoxicated and relieved.

It is interesting that folk-song and myth play an important part in American alcohol consumption. Tales are told in many Southern states extolling the heroism of the rural distiller outwitting the revenue agents. Kentucky, which is a major state with "dry" communities under local option, is the largest producer of alcoholic beverages. Texas, which cultivates a "hard drinking" image for its citizenry, is second to Kentucky in local option "dry" communities. The ambivalence in American society is obvious.

The use of alcohol permeates our daily conversation. When one says to another, "What will you have to drink?" an alcoholic beverage is usually proffered. Alcoholics are often described as wise, witty and amusing. Alcohol consumotion is casual and routine. Excessive alcohol consumption is a social expectation.

"Wine that maketh glad the heart of man" does not indeed make glad the life of all people; but at social interchange meetings, drinking is "normal." The commercial songs are contagious; as this is being written,
the radio is broadcasting a singer crying "Whiskey be my Woman." In effect, drug taking is normal.

"In the United States the age old problem of excessive drinking is taking a disturbing new turn in affecting new kinds of victims. On a New York subway train, a school-bound 15-year-old holds books in one hand, a brown paper bag containing a beer bottle in the other. He takes a swig and then passes bag and bottle to a classmate. In a San Francisco suburb, several high school Freshmen show up drunk every morning, while others sneak off for a nip or two of whiskey during the lunch recess. On the campuses the beer bash is fashionable once again and lowered drinking ages have made liquor the "high without a hassle."1

San Mateo Public Schools in California conducted a survey which indicated that eleven percent of the ninth grade had consumed some form of alcoholic beverage fifty or more times during the preceding year.

In a survey conducted at the Minnechaug Regional High School of Wilbraham, Massachusetts, for this study, "frequent drinkers" numbered forty percent. The size of the survey was extensive, numbering over two hundred students in all four grades. One cannot help but conclude that the figure of fifty percent of the population being a "frequent drinker" is a reliable one.2
To capitulate, these comments are to suggest the awareness and use of alcohol in America:

(1) Drinking begins at an early age, is encouraged by parents, and the law has little effect upon the drinking habits of Americans.

(2) Drinking meets with parental approval, although interviews with the parents of three hundred and twenty-four children who had consumed an alcoholic beverage prior to the age of twelve, did not produce one parent who approved of drinking prior to high school age. Yet 322 of the 324 students had received their first drink from their parents.\(^3\)

(3) Of 100 boys who had a drinking experience, 73 of them associated alcohol consumption as indications of masculinity and social maturity. Motion pictures, television, plays, and stories have for years equated drinking with "masculine strength." (Is there anyone who does not recall the image of the thin, short, bespectacled man who coughs, wheezes and possibly faints when he takes his first drink?)

It is not the purpose of the foregoing remarks to suggest that alcohol is to be completely avoided; there is no society that does not maintain a recreational drug
of some sort, alcohol is as good as any.

This work concerns itself with an illness caused by or resulting from the consumption of alcohol. It is, however, despite the previous comments, a socially unacceptable illness.

The alcoholic in the conventional social interchange within or outside of the family context, affects the lives of at least four other people thus leading to a statement that alcoholism is directly damaging to twenty percent of our American society.⁴

Our society is a society of drug-users for recreational purposes. A 1972 survey by the National Commission on Marijuana and Drug Abuse, published in the New York Times in 1973, reveals the following:

Between the ages of twelve and fourteen, twenty-four percent of our youth had used alcoholic beverages within the previous seven days; of adults eighteen years of age and older, fifty-three percent had used alcohol within the previous seven days. In the use of proprietary sedatives, tranquilizers and stimulants for non-medical use, six percent of the youth and seven percent of the adults had used them during the previous seven days. Ethical tranquilizers had been used by three percent of the youth and six percent of the adults; indications are that these figures are rapidly rising. Ethical stimulants were used by four percent of the youth and five percent of the adults.⁵

Alcoholism is a prominent illness. Estimates of
the number of alcoholics vary between 7,500,000 and 12,000,000 in the United States. A common figure is five percent of the total population, roughly 11,000,000 or more.

Alcoholism does not confine itself to any one segment of our society. How strange that an illness that affects five percent of the total population has resisted analysis and largely been ignored by remedial agencies and the medical profession for so long a time. It is only within recent years that there has been positive change.

The American Medical Association acknowledges that it has failed to accomplish much in the treatment of alcoholics. It openly admits that the medical profession has been remiss in recognizing alcoholism as an illness and that in practice they (the physicians) have tended to dismiss the alcoholic as a hopeless or, at best, an unpleasant, nonpaying patient.6

However, there are changes occurring. A listing of the various agencies, departments, commissions, institutes and organizations concerned with alcohol abuse and alcoholism is impressive. In 1971, the National Conference of Commissioners on State Laws adopted an Alcoholism and Intoxication Act, the essential features of which are being implemented in most states. It is
no longer the policy of states to punish the alcoholic by jailing. Current policies regard the alcoholic as in need of protective custody, referral to detoxification units maintained by the state, or other agencies and rehabilitation through counselling. Much legislation now generally recognizes alcoholism as an illness rather than a crime and mandates the provision of treatment services. However, alcoholism has a relatively low priority in federal and state funding for research and treatment. Although funding rose significantly during the seventies as it now appears to be falling.

The public does not regard alcoholism as an exotic "drug" addiction. The drug, alcohol, is usually not even regarded as a "drug." It is legally available, its use is socially acceptable. It is deeply embedded in the fabric of the daily lives of most people.

Sixty-five percent of our population consumes alcohol. This is an impressive figure, but it is not as intriguing as the devotion of twenty-one times the amount of public money for the detection, identification, apprehension and incarceration of fewer than 500,000 heroin-dependent people. 7

Within the medical profession there is a growing awareness that alcoholism is a serious health disorder and that the patient is a sick person. When one repairs
to the physician for help, the very act itself is that of one who regards himself as sick.

Research has compounded in the past few decades and there have been a few new ideas, some fresher approaches, and some deeper insights regarding the problem of alcoholism. Intensive treatment centers for alcoholics are now available in almost all urban centers and in many smaller communities. More and more general hospitals are admitting alcoholics under the diagnosis of alcoholism and providing treatment. State hospital programs and community mental health center programs are expanding, focusing on the special needs of alcoholics. There is impressive evidence of the increase in the number of programs maintained by corporations, labor unions, voluntary groups and others for the purpose of developing means with which to deal with this age-old problem.

This trend has been in response to a specific demand that someone do something about something which has become *societally expensive*.

Recent surveys show the following:

(1) the use of alcohol as a beverage by youth has radically increased but has slowly increased among adults;

(2) the use of tobacco and cigarettes has in-
creased substantially among youth and declined slightly among adults;

(3) the use of proprietary sedatives and tranquilizers has radically increased by both youth and adults;

(4) the overall use of ethical sedatives, tranquilizers and sedatives, and stimulants has radically increased;

(5) the use of marijuana by youth and adults has been rapidly increasing;

(6) the use of hallucinogens is declining;

(7) the use of cocaine is showing a spectacular increase;

(8) the use of heroin has remained at a relatively stable figure.$^8$

Max Weissman, an accepted conservative psychiatrist, has described the current situation as "Six percent of our population consumes fifty percent of our alcohol."$^9$

The Drug Dependency Institute conducted by the School of Medicine, Department of Psychiatry, Yale University, used as a base figure that ten percent of any given culture or society will abuse drugs and half of those will become dependent, i.e., five percent. Although these figures are not exact, "ten percent
abuse and five percent depend" seem to be within reasonable limits. By the most generous assessments available, seven and one-half percent of our society is composed of drug abusers or persons sufficiently involved in drug consumption as to be described as drug-dependent or addicted. The estimates that there are ten million alcoholics or more in the United States is reasonable, and for our purposes the figure will be placed at five percent.

This study will confine the use of the word "addiction" to dependency upon narcotics: i.e., drugs based upon opium and opium synthetics. "Dependency" will be used to describe dependency upon drugs not opiate-based and alcohol in particular.

The National Safety Council states that eighty-five percent of all automobile fatalities involve the consumption of alcohol either by the victim or the perpetrator. 10

Many young people perceive the consumption of alcohol as desirable for acceptance into the adult community.

A survey of alcohol use conducted in Hampden, Massachusetts, at Thornton W. Burgess Intermediate School (grades 4-8), in 1976, by the writer, produced the following data:
TABLE 2
Hampden, Massachusetts Elementary Schools Study

<table>
<thead>
<tr>
<th>Grade</th>
<th>Have Tasted a Drink</th>
<th>%</th>
<th>Been Drunk Once or More Times</th>
<th>%</th>
<th>Drink Weekly</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 (134)</td>
<td>4</td>
<td>2.9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5 (132)</td>
<td>17</td>
<td>12.9</td>
<td>6</td>
<td>4.5</td>
<td>4</td>
<td>3.0</td>
</tr>
<tr>
<td>6 (141)</td>
<td>32</td>
<td>22.7</td>
<td>11</td>
<td>7.8</td>
<td>9</td>
<td>12.7</td>
</tr>
<tr>
<td>7 (127)</td>
<td>104</td>
<td>81.9</td>
<td>38</td>
<td>29.9</td>
<td>41</td>
<td>32.2</td>
</tr>
<tr>
<td>8 (121)</td>
<td>116</td>
<td>95.9</td>
<td>87</td>
<td>71.9</td>
<td>63</td>
<td>52.1</td>
</tr>
</tbody>
</table>

N = 645

Every student in grades 7 and 8 was interviewed in person and privately; confidentiality of the responses was assured. Grades 7 and 8 seem to be the "tide level" mark for the persistent use of alcohol.

(The town of Hampden is a semi-rural community of approximately 5,000 population, located near an urban center. The economic structure is middle and lower-middle class.)

A study titled Teen-Age Drunkenness made in Norfolk County, Massachusetts, by Myron Fowell, Program Director for the Churchman's League and Associated Agencies and the National Conference of Christians and Jews of Massachusetts, was published by the League in May, 1979. Among the findings were the following: of those survey-
ed, twenty-nine percent were abstainers, fifteen percent were infrequent drinkers, and fourteen percent were heavy drinkers. Allowing for moderate drinkers presenting occasional problems as developmental alcoholics, the fourteen percent figure of heavy drinkers seems to be close to our "bench-mark" of five percent alcoholics. Fowell's study showed that of 23,000 New England university students, ten percent were "problem drinkers," probable or potential alcoholics.11

A survey made by the U.S. Department of Transportation reveals that half of high school students were attending drinking parties at least once a month with one-fourth of them admitting they had been passengers in automobiles being driven by other young people after drinking heavily. Fifteen percent of the total number had been drunk at least four times during the previous month.12 An Illinois study revealed that 42.6 percent of children in secondary school were having trouble with alcohol.13

The Illinois figures of the report mentioned reveal that the percentages of young people who get drunk four or more times a year is eight percent of grade seven and thirty percent of grade twelve. One of each twenty teen-agers now gets drunk at least once a week. In 1977, 3,932 drivers of automobiles in the United States
were under the influence of alcohol and were involved in highway accidents in which 4,657 individuals died.\textsuperscript{14}

In 1978, 114 automobile drivers in Massachusetts under the influence of alcohol were involved in highway accidents in which 123 people died. Sixty percent of those killed each year in traffic accidents are under the age of twenty. The number of drivers under twenty involved in fatal automobile accidents in Massachusetts increased during the past two years. Highway accidents are the number one killer of young people in the United States; suicide is number two. Twenty-five percent of all suicides are committed by alcoholics and eighty-five percent are alcohol related.\textsuperscript{15}

A conservative estimate is that two percent of our pre-adolescent people are already problem drinkers or alcoholics. Pre-adult arrests for driving under the influence increased four hundred percent between 1960 and 1974.

A U.S. Department of Mental Health survey states that 92.7 percent of high school students use alcohol and that 59.4 percent of them were getting drunk frequently.\textsuperscript{16}

Alcohol related crime by pre-adults is placed at one arrest for each 144 population unit in comparison to one arrest for each 1,050 population unit non-alcohol
related.\textsuperscript{17}

On the basis of these unconnected studies and an assortment of information from many other surveys, one can safely conclude that the introduction to alcohol use is typical prior to the age of fourteen. It is also significant to note that in all interviewing done in connection with local or statewide surveys, a conservative estimate is that ninety-six percent of those children introduced to alcohol are introduced to it by their parents. This statement was affirmed by the Hampden study.

It was also learned in the Hampden study that over seventy percent of the parents had never talked to their children about the misuse of alcohol.

The acceptance of alcohol as the preferred recreational drug is overwhelming, a preference shared by young and old.

If the evening of Friday, November 15, 1974 is representative, the presence of alcohol and is consumption are pervasive on prime time television programming. Between eight and eight-thirty P.M. on network A there were four references to "winos" and two drinks consumed; on networks B and C there was no reference to alcohol. Between eight-thirty and nine P.M. on network A, there were three scenes showing alcohol use as a release from
tension; the principal character was a warm, attractive alcoholic. On networks B and C, there were no references to alcohol. Between nine and ten P.M. on network A, there were five scenes in a bar with the principals drinking; on network B, there were three scenes showing bar-drinking; on network C there was no reference to alcohol. Between ten and eleven P.M. on network A, there were twenty-one references to excessive drinking, all made with expressed approval, plus a comedy "drunk" episode; on network B, there were five scenes in which the principals drank; on network C, there were four scenes in which the principals drank. As the evening progressed, so did the drinking.

In a survey made for this study of the major television networks during one week of 1979, the longest period of time during which a performer did not take a drink of alcoholic beverage was forty-six minutes. During that week, on forty-two percent of the sport shows, reference was made to enjoying a drink after the game. The standard beverages for Americans as reflected by television are alcohol and coffee, both drugs. It is possible that we may be able to add carbonated beverages in time; perhaps in the future we will be able to regard water as a special drink reserved for the sophisticated. (In 1979, Perrier water made its American
social debut to the middle-class.) It would be amusing to be invited to a party at which the principal attraction would be water.

In a popular news magazine with a total of one hundred and fifteen columns of advertising there were 24.5 columns devoted to alcoholic beverages. This is significant in that the magazine is widely used by schools and is representative of the "family appeal" magazine. This particular issue of *Time* magazine of April 22, 1974, featured a major article on alcoholism with "new" views and "new" treatments. The advertising department does not work in concert with the news department.

The variety of alcoholic beverages is seemingly endless. The distribution list provided to retailers by the Massachusetts state alcohol pricing bureau lists from a single distributor three blended whiskeys, three Canadian whiskeys, eight bourbons, two Irish whiskeys, four domestic gins, two imported gins, nine domestic vodkas, one imported vodka, ten Scotch whiskeys, one domestic rum, thirteen imported rums, nine domestic brandies, ten varieties of imported brandies, ninety-four varieties of cordials, twenty varieties of imported liquors, one domestic specialty, eighteen pre-mixed cocktails, twenty one imported sparkling wines, eighty-
six domestic wines, eight varieties of domestic vermouth, six imported vermouths, thirteen varieties of Champagne, twenty-nine imported ports and sherries, three varieties of apertifs, one Portuguese wine, sixteen varieties of Spanish wine, thirty-eight varieties of Italian wine, eighty-five varieties of French wine, three varieties of Alsatian wine, ten varieties of Rhone wine, forty-eight varieties of German wine, twelve varieties of Hungarian wine, seven varieties of Greek wine, twenty-one varieties of Israeli kosher wine, one Japanese wine, one domestic beer, and eight imported beers. These beverages were offered by a single distributor in Massachusetts.

The proliferation in the varieties of alcoholic beverages is pronounced. In the early 1970's the "pop wine" was introduced: a sweet fruit and water combination with nine percent alcohol. Beer is now the beverage of choice with many adolescents and youths.

Forty proof wines have now entered into the competition with those beverages which were developed particularly for the poor and the young.

The names are exotic and provocative: "Irish Wild Rose," "Apple Snap," "Wild Mountain," "Strawberry Ridge," "Bali Hai," etc. These varieties are usually priced low, permitting the drinker to become intoxicated
for an investment of slightly more than three dollars. The pressure to sell alcohol in the competitive market is intense. Vodka as an acceptable drink in America dates only from 1950. Prior to the 1950's sales were trivial.

Extensive advertising created a vodka market and it was keyed to a new drink called the "Moscow Mule," invented by Ray VirDen of the advertising agency for the vodka company. Exploitation created a market that emphasized the "lessening of the tensions of the Cold War."

The Gallup Poll showed that the percentage of American adults who drink is at the highest it has been in thirty five years: sixty-eight percent. The proportion of increase for women drinkers has been twice than that for men. The vitality of the industry is great: the subtleties for merchandizing are many.

Alcohol abuse by the young is on the increase. A national survey undertaken by the National Institute on Alcohol Abuse and Alcoholism, later to be referred to as NIAAA, and published in 1975, states that seventy five percent of the adolescent population (grades 7 through 12) have had a drink more than two or three times in their lives. Of adolescents surveyed, one half of whom are under sixteen, 54.8 percent drank once
a month or more often; 23.3 percent drank once a week or more often. These figures are impressively higher than previous studies. Beer is the most frequently chosen beverage.

Of the scales available to indicate problem drinking, adolescents reveal according to NIAAA:

(1) One out of four (24.1 percent) reported having been drunk four or more times during the previous year. This frequency for drunkenness is three to four times greater than that for all drinkers.

(2) Forty percent of the students reported drinking in cars and 15.9 percent report driving after having consumed a "good bit to drink."

(3) Thirty five percent of the students said that they drank "some times."\(^{18}\)

Applying these figures to the studies conducted at the Minnechaug High School, Wilbraham, Massachusetts, the statistics are on the conservative side.

The NIAAA survey also indicated that boys drink with greater frequency and greater quantity than girls. However, there appears to be a more noticeable increase of adolescent girls drinking alcohol than in previous samples.\(^{19}\) The shift was reflected in the Hampden study as well.
As expected in the local surveys, the frequency and quantity of alcohol consumption increased with age. There is a dramatic shift between abstainer and drinker and it occurs between the ages of 11 and 16. The NIAAA evidence places the dramatic shift as occurring between 13 and 17.

There are however epidemiological variations which stem from differences in age, sex and cultural background, vocation, etc., that may correlate in the manifestation of alcoholism. Because the figures are inconclusive and evidence contradictory, precise conclusions can not be drawn. The counselor, however, must take into consideration the age, sex, cultural background and vocation of his client, for there are clearly socio-psychological factors which are influential.

Sometime in the history of man he discovered that fruit or honey left too long in a warm place fermented and when consumed produced internal effects.

It is significant that wine is an integral part of religious ceremonies. Pasteur called wine the most helpful and hygienic of beverages.

Alcohol is a recreational drug of trust, but compulsive drinking is increasingly troublesome to the public and the professional. It is a folk myth that alcohol is less damaging than other drugs. The most
devastatingly abused drug is alcohol and the effects of its abuse are great. From 1960 to 1970 there was a twenty seven per capita consumption of alcohol to the equivalent of 2.6 gallons of "straight alcohol" per adult per year. It has been on an increasing scale and now is at an all time high. It is probable that we are surpassing previous periods in our history. It is well-known by social commentators that there are "wet" eras in history. The periods between 1850 and 1860 and between 1920 and 1930 are significant high points in the per capita consumption of alcohol. Apparently, we are in a new decade of "wetness."

Some professionals are saying that alcoholism is our greatest national health problem. Most deaths caused by alcoholism however are hidden by medical language such as heart failure, cirrhosis of the liver, causing 13,000 deaths per year. An alcoholic's life span is shortened by ten to twelve years.

(In Springfield, Massachusetts, death by cirrhosis of the liver ranks second as a cause of all deaths.20)

Recent investigations show clearly that alcohol causes certain types of heart disease, it will eventually damage the brain. In fifty percent of all homicides in the United States fifty percent of the criminals or victims have been drinking. Twenty five percent
of all suicides have significant amounts of alcohol in the blood stream. People who use alcohol have a sevenfold higher rate of separation or divorce. The dollar cost of alcoholism is placed by the AMA at twenty five billions of dollars per year. It is a problem of scope; at least fifty percent of the 55,000 automobile deaths and fifty percent of the 1,000,000 major car injuries can be traced to the driver or the pedestrian being influenced by alcohol consumption.  

Today's child arriving home drunk is sent to bed. In the Hampden study, 132 parents reported that knowledge of drinking by their child was discussed after the child was asleep. All but thirteen said this was preferrable. Parents are willing to accept drinking as a desirable substitute for the use of marijuana, unaware that the cross-use figure is slightly under eighty percent.

"Pop Wines" for the pre-adolescent make the transition from carbonated beverages to alcohol an easy step. The Director of the Texas Council on Alcoholism in Houston, has stated that this so called "kid stuff" contains over nine percent alcohol, twice that of beer. After the pop wine fad is over, the transition to more conventional alcohol is simplified as the child enters adolescence.
The AMA twenty five billion dollar estimate is a mosaic of absenteeism, health and welfare services, property damages and medical expenses.

In the San Mateo, California, school system in 1970, it was found that eleven percent of the ninth grade boys said that they had drunk some kind of alcoholic beverage fifty or more times the past year. In 1973 this figure had jumped to twenty three percent. Among senior class boys during the same time span the figure rose from twenty seven percent to forty percent. Senior class girls drank less but they are catching up fast, as twenty nine percent said that they had drank fifty or more times in 1973 compared with fourteen percent in 1970. San Mateo represents a sociological spectrum from welfare to upper middle class. The drinkers came from all categories.\(^ {23} \)

It is useful to remember the role of liquor in the genocidal effort to destroy the American Indian. We not only destroyed our enemies, but we also used alcohol to keep struggling pioneers on the job. Inhuman jobs, such as clearing and settling land by hand became bearable with alcohol available. In our larger cities, the use of alcohol to purchase votes is traditional. Britain during the eighteenth century deliberately used surplus wheat for gin in order to get surplus labor.
China was opened to the West by the control of opium and many American fortunes have been based upon the opium trade. Some of our contemporary leaders in world affairs initiated their careers in the underworld dealing in opium. Vast opium fields exist in Burma, Laos, Viet Nam and Turkey and are used as political instruments. It would be adolescent to assume that alcohol is not similarly used.

In our own country, alcohol is traditional in acquiring cheap labor, particularly among Mexican migrant workers. It does not require a long memory to remember the various camps in the South devoted to lumber and turpentine production which were maintained and kept orderly by alcohol availability, sometimes disguised as medicine. In the Ozarks of Missouri, the daily consumption of a bottle of Nervene or an elixir called Hadacol was helpful in keeping the female labor force active. We have used alcohol as an instrument in preparing for the transition of our land from a crude primitive state to one of efficient and rationalized "civilized business."

It is a matter of popular knowledge that South American Indians in Peru are kept productive in labor intensive jobs at small wages by encouraging chewing of the cocoa leaf from which cocaine is extracted. The
explanation for justifying such activity is "you can't make an omelet without breaking a few eggs."

One of our former presidents, now happily departed, instituted the operation Intercept which was to step up the war against marijuana salesmen. It was done at the expense of the heroin salesmen. Children made the quick observation that by curtailing the sale of marijuana, it would be wiser to switch to alcohol. There is a mystique about drinking. It is an enormous growth industry, part of what Forbes magazine calls the sybarite market. Young people today are dreary, diminishing their cultural and class differences with a uniformity of clothing and talk. Alcohol serves to reinforce the unisex culture. There is a mystique of community. In secondary school segregation one is a "druggie" or "square;" "druggie" is out to "boozer;" squares are out to both. Young people are still a dependent class and they fail to understand the generalized hostility by which older people regard their cultural investments. The use of depressants and stimulants in pill form is related directly to the increased consumption of alcohol among the young: it supports true tribal communism and it is a method of unification of the groups. We are shocked when we hear of our young revolutionaries speak of young terrorists: it is more convenient to speak of
a generation of forty year old drunks. Perhaps battle lines are being drawn.

There is a class factor to dependency. Dependency has its mystiques, rites, status, symbols of possession; it produces sudden riches, guilt, insecurities, excitement. And what advantages to the government! More policemen are required. It would be a disaster to police departments for youth to give up alcohol and drugs. The number of people with vested interest in the legal enforcement of silly laws has become a pyramid. The impact in the use of heroin has produced a bouncy bureaucracy in which increased traffic is necessary to the sustenance of the law enforcement agencies and their vested interest. Police forces are now separate political entities, exercising voter impact and contributing a huge impact on political power. Lowering the drinking age increases the crime rate, raising it also makes a contribution. One has only to decide in which direction to travel, the end result will be similar.

In the wake of the creation of apparatus of social workers, counselors, referred alcoholics, psychiatrists, book writers and publishers, political and administrative clerical jobs, job retraining for a whole new group of social and poverty workers, whose situation could be threatened by a system of alcoholic dependency control
in a single process.

The pattern is familiar: the weakness and temptations of self-indulgence rise and fall and redemption by recognition of one's self as a child of the original sin of alcoholism. Christian's journey in The Pilgrim's Progress is one of self-degradation and self-negation, the trip through Hell by public confession, self abasement, the blinding insight and the revival of salvation is oftentimes evoked and is becoming increasingly popular among fundamentalist and orthodox Christians, particularly in the Southwest and California where bizarre antics are usual.

After countless meetings with hundreds of alcoholics, it is a conclusion, although unproven, that women suffer the effects of the illness with greater severity than do men. This is accounted for the social vulnerability of women and the development of a new aggressiveness in men. The dual standard still applies.

Increased alcoholic consumption is a status symbol among groups. One encounters frequently the statement: "Well, I suppose in your kind of business not drinking is impossible." Some observers have indicated that many initiate immature acts imitative of someone they admire. It does not seem to be unreasonable, many do drink to emulate hero figures. Occupation, geography,
pride all apply to drinking habits. In a series of interviews with the workers at the Schlitz Brewery in Milwaukee, who have immediate access to beer, the worker's personal prestige was conditioned by his ability to consume large quantities of beer while working. In the Napa Valley of California, at five separated wineries, interviews revealed that there were no employees of a winery who do not drink the beverage they produce.

To repeat:

(1) We must recognize that alcoholism stems not from a single cause, but a complicated interplay of physiological, psychological, sociological factors.

(2) The counselor who fails to consider the possible societal factors contributing to the alcoholism of the client will diminish or block sufficient counseling support for the post-drinking problems which have arisen.

We know that violent behavior because of alcohol abuse is involved in sixty four percent of all homicides; forty one percent of all assaults; forty one percent of all rapes; thirty percent of suicides and sixty percent of child abuse.24

Major industrial firms have stated that the alcoholic employee loses about twenty-two more working days
per year than the non-alcoholic employee, suffers twice the number of accidents, has a life expectancy some twelve years shorter. 25

Statistics are of lesser importance to the counselor as his view is within the parameters of tragedy, misery, suffering, unhappiness, the squandering of life that this illness brings to its victims and to their families. We must direct our attention beyond figures.

Conclusions

(1) The consumption of alcohol as a recreational beverage is culturally endemic to our society.

(2) Epedemilogical information on alcohol consumption indicates that alcohol abuse is initiated in the pre-adolescent period.

(3) Our society expects its members to drink alcohol. More than half of our society responds to this expectation by drinking.

(4) There is a huge economic matrix regarding the benefits of alcohol consumption which our society maintains and reinforces through social interaction.

(5) There is strong evidence toward the proliferation of the varieties of alcohol available to stimulate alcohol consumption.
(6) Although moderation in alcohol consumption is encouraged, there is a societal ambivalence which labels the alcoholic as a moral pariah.

(7) There is a trend toward increasing alcohol abuse and indications that abuse is initiated at the pre-adolescent ages. The span of fourteen to sixteen seems to be the years of initiated alcohol abuse.

(8) The range of ages in alcohol abuse is not specific, but frequent abuse has been noted in ages prior to twelve.

(9) Parental toleration of alcohol consumption by children probably is general.

(10) Our society differentiates between alcohol and "drugs" and does not regard alcohol as a drug, but rather as an approved beverage.

(11) The extent and intensity of alcohol consumption may be increasing, but the number of alcoholics conservatively remains at five percent.

(12) There is a "mushrooming effect" in that the proliferation of alcoholic beverages also has made easy the introduction of other drugs into societal use. In particular, the use of cocaine shows a marked increase.

(13) There is an increase of concern over alcohol abuse.
during the past two decades which has influenced attitudes and activities of political entities, businesses, and public and private social agencies to regard alcohol abuse as a problem which must be remediated. There is a decrease in the view that alcohol abuse indicates a "moral lapse" which must be punished.

(14) The supply of statistical information regarding the number of alcohol users and abusers is readily available from the literature. Despite the plethora of statistics, the number of alcohol abusers remains non-specific and accurate information is not available.

(15) The economic cost of alcohol abuse is affecting economic productivity; the human cost is increasing; and the number of mechanisms for restraint and rehabilitation are increasing.

(16) There is no "cure" for alcoholism.
CHAPTER II

ALCOHOLISM: WHAT DOES WHAT TO WHOM

What is Alcoholism?

"If we take habitual drunkards as a class, their heads and their hearts will bear an advantageous comparison with those of any other class. There seems ever to have been a proneness in the brilliant and warm-blooded to fall into this vice. The demon of intemperance ever seems to have blighted in sucking the blood of genius and generosity."

--Abraham Lincoln

Is alcoholism really an illness? There is still debate over this question, but the preponderance of evidence points to the conclusion that alcoholism is an illness. The American Medical Association, the World Health Organization, and other professional groups regard it as a specific disease entity. Court decisions now recognize it legally as a disease. In so doing, the shift in responsibility for the care of the alcoholic has moved away from law enforcement agencies to the medical and health professions.

There are some authorities who disagree as to the definition regarding alcoholism as a manifestation of an underlying psychopathology.

Alcoholism has been described as a symptom which
intensifies and eventually achieves such a magnitude as to become an illness. However, present evidence leads one to describe it as a complex illness; it is so regarded in this commentary.

Of the dozens of definitions of alcoholism, many have been accurate enough to be helpful, but each of them usually represents the viewpoint of a particular investigator or methodology of treatment. None have been distinguished by universal acceptance.

An interesting definition is given by Dr. E.M. Jellinek, one of the pioneer writers on the disease concept of alcoholism. He completed his studies in 1957 and has published a most complete book on the disease concept. Jellinek defines alcoholism as a genus with many species. He has termed alcoholism as "any use of alcoholic beverages that causes any damage to the individual or society or both."¹ This statement is vague and open to the criticism that it has little operational value. However, Jellinek makes the point, "Obviously there are species of alcoholism so defined which cannot be regarded as illnesses. One may well say that such a vague definition is useless. But in the uselessness lies its utility, for it forces us to single out species of stringent terms. We must be particularly definite about those forms which constitute
illnesses. Furthermore we cannot say that alcoholics are those who suffer from alcoholism as defined above. We shall have to make a distinction between alcoholism and alcoholics.\textsuperscript{2}

Jellinek refers to four species of alcoholism by using four letters of the Greek alphabet:

Alpha: Purely psychological, symptomatology includes continued dependence or reliance upon the effect of alcohol to relieve bodily or emotional pain, but it does not lead to loss of control or the inability to abstain. There are no signs of a progressive process. Alpha alcoholism in today's terms would probably be called "problem drinking."

Beta: Alcoholic complications occur: Polyneuropathy, cirrhosis of the liver. There seems to be no physical or psychological dependence upon alcohol. There is an incentive to heavy drinking that leads to complications. When the alcoholic desists from drinking he does not suffer from withdrawal symptoms.

Gamma: In this form, an acquired tissue tolerance to alcohol is manifest. Adaptive cell
metabolism and withdrawal symptoms and cravings, i.e., physical dependence and a loss of control, are involved. Progression from psychological to physical dependence and marked behavioral changes. Alcoholism does occur. Alpha and Beta may develop into Gamma. This is the predominant alcoholism species in America. Abstinence can be maintained for a while.

Delta: This form shows the first three characteristics of Gamma, instead of loss of control there is an increase of an inability to abstain for even a day or two without the manifestation of withdrawal symptoms. The ability to control the intake on any given occasion remains intact. There is an incentive to high intake. A genus with many species.³

Despite the many studies of alcoholism, the causes are largely unknown. Most investigators suspect that a single cause explanation is inadequate to deal with the phenomenon. There is a rather complex linkage theory that accounts for some behavioral observations. There are antecedents to alcoholism and there are biochemical, psychological and cultural factors that work together
which produce unique combinations of alcoholism. Physicians who are alcoholic persistently refer to alcoholism as an illness, etiology unknown.

Alcoholism does, however, interfere with the client's mental and physical health and in particular, in his adaptation to his environment.

The dependence factor could be described as sedative-hypnotic and there is a cross tolerance with alcohol and barbituates and other sedative drugs. Indeed dependence on alcohol and sedative drugs is often found to be present in the same individual. Of four hundred alcohol physicians and doctors (dentists, etc.) present at a conference in Cleveland, Ohio, in July of 1981, the preponderant number were dual-dependent upon alcohol and drugs.4

Certain behavioral signs may lead one to a diagnosis of alcoholism. Drinking alone, drinking early in the morning, or drinking only one kind of brand of alcoholic beverage cannot be used as positive diagnosis of the disorder. Many people do some or all of these activities and are not alcoholic. It is a common myth that a person who does not drink in the morning is not an alcoholic. During the hundreds of interviews which have been conducted, the phrase, "He can't be alcoholic, he doesn't drink during the day," was consistently
heard. It is not uncommon for alcoholics to use these public fictions concerning alcoholism as proof to themselves that they are not alcoholic.

There is also a public view that the alcoholic lives on a "skid row" or that he exhibits irresponsible or erratic behavior. Current information has demolished this opinion. Bizarre behavior may be a part of the disorder or not a part of the disorder.

A practical definition that emerges is: Alcoholism is an illness in which the patient drinks alcohol in sufficient quantity as to impair himself. Impairment may be manifested by physical, mental or social dysfunction. Alcoholism produces in the victim compulsive and obsessive drinking.

Or, we are also on secure ground when we accept the definition given by the American Medical Association: "Alcoholism is an illness characterized by significant impairment that is directly associated with persistent and excessive use of alcohol. Impairment may involve physiological, psychological or social dysfunction." 5

The Rutgers University Center for Alcohol Studies offers a concise definition: "An alcoholic is one who is unable to consistently choose whether he shall drink or not, and who if he drinks is unable to choose consistently whether he shall stop or not." (There are almost
as many "alcoholisms" as there are alcoholics.) Some behavioral scientists object to even attempting a strict definition in the belief that drinking is a continuum and none can draw a precise line between the alcoholic and the severely troubled drinker. Yet, behavioral psychologist Don Gahalan of the University of California at Berkeley states: "No one has ever found a way to turn a non-alcoholic into an alcoholic."\(^6\)

To repeat, alcoholism is a form of drug dependence of pathological extent and pattern and it ordinarily interferes seriously with the client's mental and physical health, and his adaptation to his environment. As stated previously, the dependence can be accurately described as sedative-hypnotic and with cross-tolerance to barbituates and other sedative drugs.

The American Medical Association states that no one can accurately state how many alcoholics there are. There are a number of ambitious and extensive investigations which have been undertaken but consistent standards have not been applied to most epidemiological studies. There are difficulties involved because the definition is difficult and responses must be weighed carefully against a characteristic of all alcoholics: typical and liberal use of denial mechanisms.

In this study which encompasses twenty years of
direct personal contact with people who describe themselves as alcoholics, all of the 137 case studies of self-admitted alcoholics stated that the use of denial as to excessive drinking in quantity and frequency, or even as to the type of beverage consumed, was always employed. Therefore, any figure that states there are a certain number of alcoholics is inevitably suspect. There simply is no precise way in which the number of alcoholics on a national basis can be determined. The preceding statements reiterate the conclusions of Chapter I.

The use of a set of symptomatic indicators must also be regarded as unreliable as to the determination as to whether or not the client is an alcoholic. Inquiry is usually met with denial or subterfuge. However, there are some opinions generally accepted by professionals:

(1) Alcoholism appears to be more prevalent in larger cities than in less populated or rural communities. The differences are probably not great.

(2) Alcoholism appears to be considerably more common among men than women although there is a movement toward an equilization of these figures.
(3) Socially, female alcoholics tend to be more protected, less open to exposure because of home consumption. The figures on the number of female alcoholics are less reliable than the figures on general alcoholism. Among many professionals it is agreed that the increased number of female alcoholics who have joined organizations promoting sobriety indicates that the increase in female alcoholism has been radical and impressive during the past twenty years.

(4) The pattern of alcohol abuse by women tends to differ from the patterns by men. Statistics do indicate that women in their thirties and forties show a higher incidence of alcohol abuse while men experience abuse problems more often in their twenties. Based on figures supplies from a variety of pharmacological studies:

(1) The consumption of one highball, or cocktail, 5-1/2 ounces of wine or two bottles of beer produces an alcoholic percentage in the blood of .03 percent. This alcohol is discharged from the body within two hours. There is slight change in feeling.
(2) Two highballs, two cocktails or eleven ounces of wine or four bottles of beer, produces an alcoholic concentration in the blood of .06 percent. There is a generated feeling of warmth and mental relaxation.

(3) The consumption of three highballs or cocktails, 16-1/2 ounces of wine, or six bottles of beer will produce exaggerated emotional behavior. It increases the vivacity of the drinker, who may become noisy or morose. The concentration level is at .09 percent. Six hours are required to discharge the alcohol from the body.

(4) Four highballs, four cocktails, twenty-two ounces of wine or eight bottles of beer produces an alcoholic concentration of .12 percent and results in clumsiness and unsteadiness in standing or walking.

(5) When the level reaches .15 percent, five highballs, five cocktails, 27-1/2 ounces of ordinary wine, or a half pint of whiskey, the result is gross intoxication and requires ten hours for the alcohol to be discharged.\(^8\)

The amount consumed is not a determinant as to whether or not a person is an alcoholic. The alcohol
courses to the central nervous system where it serves
to anesthetize brain activity. As noted, alcohol is a
depressant. However, the initial subjective feelings
are just the opposite, as the barrier of inhibitions
and restraint are lifted, the drinker does or says
things that his controlled sober-self would forbid.

Despite all folk cures for hangovers, none are more
than superficially effective. The hangover symptoms of
depression, headache, nausea and fatigue are also un-
known as to cause. However, social drinking can have
long range effects upon the body.

According to Dr. Peter Stokes, a psychobiologist
at Cornell Medical College, the liver becomes fatty and
therefore less efficient after only a few weeks of
drinking three or four drinks a night. In the early
stages of drinking, the liver damage level can be re-
versed. More moderate imbibing which can be limited to
two drinks a night with meals does little or no harm to
most people.

Some new studies linking excessive drinking to
heart damage and linkage to the brain are interesting.
Dr. Edward Noble of the University of California at
Irving has shown that alcohol inhibits the ability of
brain cells to manufacture proteins and ribonucleic
acids which some researchers believe play a role in
learning and memory storage.

After twenty or thirty years Dr. Noble states that two or three drinks a night on an empty stomach may impair a person's learning ability. Both Stokes and Noble show irretrievable and irreversible destruction of brain cells after years of heavy drinking. This conclusion is now generally accepted by the medical profession.

It is notable that in our study of abstaining alcoholics, all expressed the opinion that their memory had been affected by their drinking and all attributed the memory loss to their alcoholic history.

How quickly the alcohol takes effect depends upon many factors: one person may be "drunk" after a glass, another stays relatively sober after several. The reason is simple: alcohol is diluted in the blood, and a two hundred pound man can tolerate more than a one hundred and ten pound woman. Food also retards absorption of alcohol from the gastrointestinal tract. A few ounces taken with a meal are less effective than an equal amount downed an hour before. Some drinks with food in them have less effect than straight drinks, e.g., egg nog.

The quantity of alcohol and the rate of consumption determines the rate of tolerance of the alcoholic level
in the bloodstream. A scotch and water has the same effect as a scotch "on the rocks," or a scotch and soda, if all three were consumed at the same speed. Drinking slowly gives the system a chance to eliminate some of the alcohol. Of our 137 self-admitted alcoholics, 135 described themselves as "gulpers;" 135 had difficulty in understanding why anyone would sip a drink. A common response (81, or 59 percent) was "Why not gulp? I want the jolt."

It is folk-lore that mixing of drinks by kind produces a different kind of intoxication. Beer, wine and whiskey mixed does not have an effect on the alcoholic content in the bloodstream. It might make the consumer ill because of substances other than alcohol, but it will not increase the drunkenness.

Many studies on alcohol consumption have not been universally accepted throughout the medical profession, but the physical effects of heavy drinking are beyond dispute. A pint of whiskey a day produces 1,200 calories, half the energy requirements, with no food value. As a result, alcoholism usually produces weak appetites and alcoholics often suffer from malnutrition and vitamin deficiency. It might be noted that the slack cannot be taken up by an increase in the intake of vitamins. Heavy alcohol consumption impairs the body's utilization
of the vitamins. At the same time, heavy alcohol consumption impairs the function of certain disease-inhibiting white blood cells, giving the alcoholic a low-par resistance to bacteria.

The alcoholic develops a fatty liver and his chances of developing cirrhosis, a condition in which fatty cells have been replaced by fibrous scar tissue, are at least one in ten. A severely damaged liver cannot efficiently manufacture bile which is necessary for the digestion of fats and as a consequence the alcoholic often is weak and suffers from chronic indigestion. The most common form is gastritis caused by irritation of the sensitive lining of stomach and the small intestine. The troubles of the alcoholic do not end there, and through damage to the central nervous system and hormonal imbalance, it is known that alcoholism may often produce impotence.

The alcoholic's preoccupation with drinking leads him to organize his life around drinking. The interviews in this study all have certain common themes: great pains to obtain, insure and conceal the supply and consumption of substantial amounts of alcohol. However, even frequent intoxication is not necessarily equatable with alcoholism. There are alcoholics who consume less alcohol over a period of time than do other
It is not the quantity of alcohol consumed that is essential to a diagnosis of alcoholism; it is rather the effect upon behavior that is the pervasive factor.

The adjustment to living by the alcoholic is impaired. The impairment may precede, contribute to or even be developed by alcoholism. It is a "circular syndrome" contributing to the alcohol progression and resulting from it at the same time.

Physical disabilities are well known. Usually, however, there is a progressive deterioration as a direct result of drinking, although such deterioration is not always clinically evident.

The genetic factor may be present in some alcoholic individuals. However, there is, as noted before, no conclusive evidence at this time.

It has been proposed that inherited traits may help ward off alcoholism by causing unusual subjective distress when alcohol is ingested, possibly through the excessive production of acetaldehyde in the metabolic process.

The assumption has to be made that in families where alcoholism is a frequent problem non-genetic factors probably are contributing or initiating stimuli.

The medical view does have some interesting par-
ticular observations:

It must be accepted that the medical profession accepts the concept that physiological factors probably contribute to the origin of alcoholism: none as yet have been identified as causative.

There have been a variety of physiological causes of alcoholism hypothesized: none have been conclusive and many are at variance with each other. They are surrounded by marked uncertainty. Here are a few of them:

(1) Alcoholism results from a predisposing biologic dysfunction which alters sensitivity to alcohol.

(2) Alcoholism is caused by psychoendocrine cortical existing a priori, e.g., pituitary adrenal cortical insufficiency, hyper- or hypo-thyroidism, imbalance of the hypothalamic-pituitary feed-back systems, or hyper-gonadism.

(3) Alcoholism is caused or aggravated by nutritional factors such as hypoglycemia, thiamine deficiency and abnormal cerebral glucose metabolism or a metabolic deficiency of certain trace metals (zinc) and/or electrolytes (sodium and magnesium).

(4) Alcoholism is determined by a basic sensitiv-
ity to a basic food stuff, the symptoms of which are relieved specifically only by alcohol.

(5) Alcoholism is caused from defective function of an "alcohol appestat" in the hypothalamus causing uncontrollable thirst for ethanol.

(6) Alcoholism is caused by an imbalance of acetylcholine receptor sites in the ascending in the reticular formation of the brain-stem, leading to the need for the binding of alcohol to the excess of the number of receptor sites.\(^9\)

If the physiological factors were of primary importance there would be a need established for an individual to drink.

Lack of knowledge of the physiological factors is a handicap, but we can accept the fact that there are physiological factors present in the progression of alcoholism, and those have been well established.

**Alcoholism and Allergy**

Twenty-seven (20 percent) of the one hundred and thirty seven were convinced that the alcohol consumed was allergenic. This is at variance with current medical information. It is true that the aromatics and
additives to alcohol to obtain palatable drinking could be allergenic, but there is little evidence, none of which is acceptable, which would indicate that these are responsible for causing alcoholism. When present, the additives, etc., must be considered separately. According to current medical opinion there is no acceptable evidence indicating a correlation of alcoholism and known allergies.

**Alcoholism and Psychological Causes**

Psychological factors in the causation of alcoholism are significant. It is generally agreed that the psycho-pathological factors predominate in the development of the illness. Attempts to define them often are hindered by the fact that most alcoholic clients are evaluated only after long periods of alcoholic abuse. The problem is further complicated in trying to determine whether observed behavior and psychological functioning are causes or results of the illness. Alcoholism is a disorder with strong emotional components. The psychodynamics associated with this condition are highly complex and cannot be categorized.

From the psychoanalytic theory and the learning theory views, there are overlaps that can be observed in some areas. The psychoanalytic theory holds that alco-
holism is the result of early emotional disturbances and deprivations with consequent emotional immaturity. It is worthy of note that 81 (59 percent) of the 137 describe themselves as emotionally "immature." The alcoholic relies on alcohol to relieve the feelings of anxiety, hostility, inferiority, depression and many other manifestations, all of which reflect a deeper and unrecognized pattern of marked insecurity, rage and guilt. The use of alcohol to obtain relief is reinforced through repetition and its abuse evolves as a habitual response to discomfort.

Early emotional trauma as perceived by the child with environmental reinforcement is seen as one key element of the illness.

Alcohol as a depressant on the central nervous system is determined in length and intensity by the amount ingested, and the time over which it is consumed. After the alcohol is metabolized and this effect wears off the nervous tissue reacts with a proportional period of excitability. A clinical manifestation of the depressant effect range from relatively simple psychological phenomena such as relaxation from minor tensions to the suppression of the vitals centers and death.

The clinical signs of the secondary excitability are in the hangover tremors and agitation which follows
the drinking. These are relieved temporarily by the ingestion of more alcohol. The amelioration of this excitation phase by reintroducing alcohol into the system to get relief becomes increasingly more welcome and important to the alcoholic as his disorder progresses. Eventually it becomes a necessity. Physical as well as psychological dependence upon the drug has then been established.

In this study, 72 (53 percent) stated that there were psychological and physiological aberrations continuing for days and weeks, and in six instances, months, after the cessation of drinking.

It can be seen that dysphoria upon the continual intake of alcohol may play a key point in the spiraling progression of the illness.

The point where one crosses over from choice drinking to dependent drinking has not been determined. There is a suspicion of the involvement of both physiological and psychological mechanisms, as yet unproved.

It should be noted here that 93 (68 percent) of the 137 described in considerable detail traumatic experiences that occurred in their childhood. The severity of alcoholism is thought to be contingent upon the level of psychological adjustment attained prior to the initiation of the illness.
Psychoanalytic comment suggests that alcoholism stems from strong oral influences in early childhood and under this formulation alcohol provides mood alteration, redirection of thought processes, and ultimately regressive levels of thinking. The gratification by the effects of alcohol in this view is unrelating to logic and represents an escape from reality. Elaborations of this hypothesis have emphasized such features as the erotic qualities of the dream-like state induced by alcohol. Of the 137 cases, 68 (50 percent) described their fantasies while "under the influence" as "erotic." Further, this hypothesis permits acting out of otherwise unexpressed impulses which would be related to the frequency with which alcoholics assume roles in society among strangers when they feel safe from detection. The almost magical changes that alcohol brings about in increasing self-esteem, relieving misery and elevating mood is an elaboration of this same hypothesis. Even the physical characteristics of liquid nourishment which generate a sensation of warmth and satisfaction can be seen as being psychologically important.

It has been commonly pointed out that alcoholism has marked self-destructive aspects. It can also be viewed as having avenging features which permit the client to punish by chronic suicidal effort that which
he perceives to be a rejective, cruel and disappointing environment.

It is a theory that self-destructive urges are thought to originate in a person's forgotten childhood belief that he has been betrayed or failed badly by his parents. It is noteworthy here that 82 (60 percent) of the 137 came from homes in which tranquility, support and loving attitudes were either severely damaged or non-existent. The wish to destroy the parents coupled with the fear of losing them and the great need for gratification by release from them compel the child to redirect his rage from his parents to himself according to some psychoanalytic theory. This leads to the development of feelings of guilt and worthlessness and a need for self-abasement, self-punishment and ultimately self-destruction. It is common among alcoholics that self-destruction plays an important factor in their psychic life. These dynamics of depression set the stage for self-destructive behavior and symptomatology.

It is a common expression among abstaining alcoholics that they have to avoid giving vent to anger or resentments against people, places and things. Psychoanalytically this is described as other persons, objects or situational factors which replace the offending parents as a target of hostility when in the course of time
basic disappointments seem to reflect or duplicate the circumstances of the original conflict, i.e., projection. On these occasions the process that is repeated is essentially of the same psychological mechanics and sequence. The basic pattern is established in the beginning of the disturbance and the results in clinical manifestations are modified by environmental and developmental influences. Strong masochistic trends are then seen as arising from the guilt a person feels when reacting to the hostile fantasies and is directed against those who fail to recognize immediate needs. Alcohol may not only permit his awareness or expression of this hostility, but also may serve as a punitive destructive and perhaps the exciting agent.

The configuration of the alcoholic's family and the personal characteristics of its members should be regarded as significant. Among the 137, inconsistent fathers and/or over-protective mothers who responded to the infant's demands by expressing excessive oral gratification were factors that may have been significant as to foster extreme dependency and to prevent learning of adequate means of self-control. The net result of this combination is seen as a life-pattern characterized by great emotional needs, unavoidable failure caused by external sources to fulfill and satisfy them and reac-
tion to the engendered frustrations with infantile rage and oral pacification.

So much for the psychoanalytic view. Current theorists in learning often see alcohol dependence as a learned behavioral pattern. This is the basic formulation: A drive sets the emotional responses which, at the same time, are influenced by cues from other stimuli of lesser magnitude and force. A response unrewarded by a reaction that decreases the intensity of the drive causes a diminution of that response and the emergence of another, a rewarded response strengthens the relationship between the cue and the response and enhances the predominance of that response. The strengthening of this cue-response connection is regarded as the essence of learning.

Some persons find that the ingestion of alcohol relieves anxiety and fear. All of our sample speak of alcohol as relieving anxiety and fear, providing pleasure more rapidly than other learned patterns. According to the learning theorists, an emotional reward, i.e., the reduction of painful feelings and the enhancement of pleasurable ones is thus achieved through meeting a crisis through alcohol. It provides a reinforcement each time it is used for that purpose. This conditioned response of drinking then becomes strengthened
as it begins to predominate over other behavior. Continued attempts to adapt to stress by this means eventually establishes drinking as the learned behavior in the majority of situations the individual faces. This perpetuated pattern then becomes the illness. To a counselor, learning theory is especially valuable. It is well documented that this is a pattern well-established by many alcoholics. This dovetails in several ways with previously described physiological factors. The theory also proposes that it is possible to unlearn alcoholism under proper circumstances. It is therefore thought that the essential value of group therapy is a process of "unlearning" alcoholism.

One cannot hope to examine all of the various theories, because it is not essential within this work's parameters.

However, the psycho-pathological factors are regarded as being of importance to the parthenogenesis of alcoholism.

Considered alone, however, psychological theories fail to answer too many of the questions concerning alcoholism's etiology and progression.

(1) Few persons, if any, survive childhood without emotional trauma, often severe.

(2) Many endure early emotional disturbances and
deprivation without crippling signs of immaturity; the dynamics of depression may lead to life-long depressive symptomology without alcoholism.

(3) Any variety of psychological considerations applying to alcoholics may be observed in patients of other illnesses. Some make comfortable and adequate adjustments.

However, for the counselor to ignore these considerations and to relegate them to secondary importance is to court defeat in providing a facilitation of change.

Alcoholism and Societal Considerations

There are also sociological factors that influence this illness. We have mentioned how alcohol serves vastly different functions within society, its culture and its sub-cultures. It has been used as an instrument of great importance among certain ethnic and religious groups. The attitudes concerning alcohol range from extreme permissiveness to total abstinence. Thirty (22 percent) of the sample came from homes that were totally abstinent. Abstainers can be found among "permissive" families; conversely, abstinence does not always assert itself to each member when abstinence reigns within the family. Religious, culinary, psychic, ceremonial, he-
donistic, traditional, social and medicinal purposes for alcohol use can be found. The standards for acceptability of alcohol vary according to occasion, age, sex, cultural background and social class. Among certain cultures drunkenness is regarded as "sinful." In others, the failure to drink excessively is socially unacceptable.

Societal response has a marked influence on the use of alcohol and is an important consideration in the etiology and development of alcoholism.

There are four general types of social attitudes toward alcohol:

(1) Total abstinence, which stems from religious conviction or traditional concepts. The consumption of alcohol is regarded as a serious anti-social act without justification and is characterized as immoral and sinful. Usually, people accepting this view will not tolerate an exception and infractions are totally unacceptable and thoroughly condemned. Those who view alcohol in this light usually perceive little difference between the social drinker and the alcoholic. The social drinker is often regarded as inevitably becoming an alcoholic. When total abstinence is the pre-
vailing attitude in a group, alcoholism is rarer among its members. Among our 137, 17 (12 percent) came from families which regarded the consumption of alcohol as "sinful," immoral, and anti-social. It was not permitted in the home, nor were the children permitted to associate with children of parents who did consume alcohol. (It might be parenthetically noted here that in Salt Lake City, which bans the sale of alcohol and is a Mormon dominated city which regards alcohol within the parameters of the Mormon view of total abstinence, there are several AA meetings per week. At one meeting the number present was in excess of fifty, all present were Mormons.)

(2) The second social attitude is "ambivalence" in which there is a strong conflict among value structures relative to the use of alcohol. Mixed feelings prevail: this ambivalence occurs when the rate of social change is so rapid that previously stable attitudes concerning alcohol disintegrate and vague new ones emerge. We are experiencing this ambivalence in a general cultural swing at the present time in the United States. The ac-
ceptance of alcoholic consumption at the youth level is far higher than it was during the twenties. This ambivalence is also common in situations in which there is a close cultural contact between groups having totally different values such as abstinence and permissiveness existing in close proximity to the other. There is strain and stress when those of group one live in close contact with those who are permissive. Because of other pulls toward association, it results in an occasional modification of rigid views regarding total abstinence. It is interesting to note that those with a strongly fixed abstaining view also develop an ambivalence in which they act out their frustrations by drinking. Alcohol becomes a potent symbol of rebellion against the socially closed group of family, religious leaders and associates.

In a series of interviews held in the center of an Amish community in Iowa, an abstaining group eighteen miles from Iowa City, it was found that although alcoholism was not prevalent or even a substantial problem in the so-called Amish "Five Towns," alcoholism was
present. Abstinence is a key ethical demand in Mormonism, which dominates Salt Lake City. It was possible to meet with a number in excess of sixty Mormons, all of whom were self-admitted alcoholics and had developed their childhood attitudes toward alcohol as a reaction against family and religion. (It might be noted that among the group none were interviewed for this study.) There were frequent references to extreme guilt which reinforced their progression toward their alcoholism. Where there is ambivalence, alcoholism is likely to become a problem.

(3) The third view is that of permissiveness. Several religious, ethnic and cultural groups have highly permissive attitudes toward the use of alcohol. Although variations are noted, a prominent feature including the child's early exposure to the use of alcohol and consumption of alcohol under adult supervision is frequently encouraged and rewarded. Custom and tradition play an important part and the use of alcohol as part of ceremonial rites is frequent. Religious tolerance, custom and tradition, and an intolerance to var-
iation of prescribed uses or overindulgence is allowed within the framework of established "permitting" standards.

In thirty-two states with a population texture ranging from a high concentration of ethnic groups in the East, South, Southwest, and Northwest, it was found that very few Jews are in therapeutic groups. (In contrast, one Swede, now being counseled, is having family difficulties because he does not drink to the point of oblivion and has been ostracized by his family because he does not drink at all. The client, not included in this study, is a professor at an eastern university.)

The pathology arises from the excesses are acceptable. Acceptable intoxication seems to be encouraged by certain festive occasions when drunkenness is the norm: Mardi Gras in New Orleans, St. Patrick's Day in the East, New Year's Eve, etc. There is also the view that the early use of alcohol is characteristic of early maturity with overindulgence and aggressive anti-feminine behavior as an expected prelude to "settling down" to marriage and moderation. Mountain areas lend themselves readily to this view. In the Ozarks and the Blue Ridge Mountains, alcoholism seems to be quite prevalent as a "rite de passage" to manhood. At a Centennial Celebration held in Marlington, West Virginia, on a
Saturday, the village, nestling in the mountains, was jammed with over three thousand people. Only one person was observed in a drunken condition, she was in her seventies and dancing to one of the many family Blue Grass music groups playing. On Saturday night, the entire village was drunk with not one sober person observed. On Sunday the collective "hangover" was so severe that the one restaurant open asked the customers to pour their own coffee as no waitress was capable of stooping over to pick up the coffee pot. The drinking was a ritual.

A similar occurrence, however, on a larger scale was observed in Mitchell, South Dakota on a Saturday, when the drinking on the street at the American Legion Hall and in the cafes began with a precision at five thirty p.m. By eight o'clock, the city was prostrate. There was no special occasion to celebrate.

Our society establishes expectations of behavior from infancy, to pre-adolescence, adolescence, maturity, and senescence. The expectations vary from one sub-culture or geographical area to another.

The essential point is that a standard for acceptable drinking, acceptable behavior, vary for different age-groups and from sub-culture to sub-culture. These patterns seem to have a positive and a negative bearing
on the parthenogenesis of alcoholism.

It has been frequently expressed, naively, that an early introduction to alcohol by itself will immunize the young to alcoholism. "If one is to drink, drink at home and early, under parental supervision, it may serve as a protective immunization to the alcoholic process thus preventing excess in later years." There is no supportive evidence to this conclusion.

In the Hampden study it was discovered, not unexpectedly, that the introduction of alcohol into a child's life with its disproportionate emphasis on being a forbidden pleasure, constitutes a handy instrument by which young people can assert their independence and express their rebellion against authority at the same time. This attitude by the young as an instrument of rebellion can effect future drinking problems. There is substantial evidence, particularly from safety councils, that lower drinking ages produces increased problem drinking. The urge to be "mature" is lowered, when alcoholic consumption is permitted, it implies approval. With approval will come use.

It is also naive to regard a sharp difference between that which is legal and that which is illegal. We think in positive and negative terms, failing to understand that like numbers, legality and illegality
are not opposed, but a part of one system. Heightened illegal activity is a response, a matter of keeping options open for the creation of a new sub-society. The rise in adolescent alcohol consumption is a response to changes in the social structure. It is a model for confusion. The adolescent alcoholic has not so much raised his hand against society, rather he has evolved in "on-the-job training" to take part in a drinking society.

It might be well to comment that the American history of intoxicants has been regarded as a civilizing force.

**Alcoholism and Subjective Responses**

Of our sample, an attempt was made to determine the subjective causes of the opinions of the alcoholism. There was no consistency in the responses received. Frequent questioning and requestioning revealed no single substantive cause over others with any degree of consistency. Among those mentioned were the following:

- Alcohol abuse by adults
- Sense of alienation
- Alternate to "success"
- Boredom
- Confused value system
Disillusionment
Cover for personality problems of inadequacy and deficiency
Desire for a mystical experience
Dissatisfaction with environment
Difficulty in gaining acceptance by others
Disturbed family relations
Emotional immaturity
Enjoyment and pleasure
Experience of euphoria
Experimental propensities
Escape from difficulty
Fear of struggle or defeat
Feeling of futility
Frustration and annoyance
Hedonistic interests
Help in meeting problems
Feelings of inferiority
Influence of friends or peers
Influence of friends who made alcohol available
Lack of self-confidence
Lack of creativity
Lack of a satisfactory religious experience
Lack of goals
Lack of a sense of meaning in life
Lack of a strong parental influence
Lack of a sense of worth
Lack of a sense of vocation
Loneliness
Medical problems
Mental inadequacies
Ethical confusion
Membership in counter-cultural groups
Overstimulation
Parental indulgence
Personality disorders
Reactions to hypocritical situations
Rebellion
Rejection by age group
Repression
Self-punishment
Alcohol as a satisfactory deterrent to suicide
Television and radio indoctrination
Unhappiness
Unsatisfactory accomplishments
War and legalized violence
Weak family loyalty
Weak super-ego

The preceding is a partial listing of responses to the question: What do you think caused your alcoholism?
Forty-three (31 percent) believed they were born alcoholics. Common to all of the 137 was a desire to obtain relief from something burdensome and unpleasant. There was a belief on the part of the younger, below thirty group, to accept the societal acceptance of alcohol as a solution to problems.

There is a common confession that none of the sample ever thought they could not stop drinking once they wanted to do so. No one believed that during their drinking careers they were obsessive or compulsive regarding alcohol.

Alienation from the family, or associates, a sense of rebellion against the hypocrisies so characteristic of our contemporary life tempt many of our young people to seek refuge in alcohol.

In addition the reverse is true, alcohol becomes an attractive lure and the bar is "the place," where inequities are erased, injustices and hypocrisies become hidden, in which a momentary artificial society is agreed upon as a refuge by and for the participants.

Certain truisms do exist. Alcohol by itself does not cause alcoholism. It is the essential ingredient in its development. To argue that it is the causative agent seems to be as illogical as saying that sugar causes diabetes or that consuming fats causes obesity.
One might as well argue that the cause of divorce is marriage.

There is the belief that certain alcoholic beverages are more stimulating to the alcoholic's physical demands than other beverages, e.g., martinis are more potent than scotch highballs.

A lack of purpose in life is frequently indicated as a justification of the use of alcohol to excess. A comparison of the physical and psychological dangers of alcohol abuse and the numbers of people adversely affected by the abuse in comparison with other dependency drugs used for recreational purposes is impressing and depressing. The problem of legality becomes an issue.

**Diagnosis of Alcoholism**

"Mosaic" has frequently been used to describe alcoholism. How then is one to determine whether or not one is an alcoholic?

The question is deceptively simple. It is often asked by "heavy drinkers" and those who only drink occasionally and who are fearful of becoming alcoholic.

In physiological diagnosis, the physician looks for the development of characteristic deviant behaviors associated with prolonged consumption of excessive amounts of alcohol. The assumption is that the illness,
of undetermined etiology, is insidious but will show recognizable symptoms and signs proportionate to the severity.

The assumption is that social drinkers drink with their friends. Alcohol is a part of their socializing process but not essential, and they do not tolerate disturbing drunkenness. Intoxication is rare and usually occurs at events where excessive drinking is permitted.

Social alcoholics, by comparison, are frequently intoxicated but maintain some behavioral controls. There are "expectations" as to drinking (prior to lunch, prior to going home after work, etc.). They avoid bars featuring entertainment and seek those known for their generosity. Camaraderies with others is based upon a high tolerance for alcohol. The drinker frequently falls asleep after dinner and does not experience "hangovers." The pattern of drinking slowly evolves over many years and rarely is evident before forty-five or fifty years of age.

The alcoholic is identified by severe dependence and a cumulative pattern of behaviors associated with drinking:

(1) Frequent intoxication with an interference with the individual's ability to socialize and do work.
(2) Drunkenness may lead to marriage failure and loss of employment.

(3) One seeks medical treatment for the drinking.

(4) Apprehension for driving while intoxicated may occur.

(5) Physical injury from drunkenness may occur.

(6) Arrests for drunkenness may occur.

(7) Hospitalization for delirium tremens or cirrhosis of the liver may occur.

It is assumed by the physician that the frequency and severity of these symptoms and the age at which they occur are valid measures of the alcoholic's illness. The earlier in life these behaviors are evident the more crippling is the disorder.

Four or fewer of the listed symptoms are indicative of the "employed alcoholic." More than four are indications of the "indigent alcoholic." The assumption is that in time, the individual will become a member of the "skid row" segment of the alcoholic population.

The diagnostic model described is faulty. Too many questions and too much evidence exist to accept the model as definitive. The larger number of alcoholics are not headed for or are residents of "skid row." Alcoholics, male and female, are more frequently to be found within the confines of the home or maintaining a
social life in the community. Although the deterioration is evident, the physical dessication is not consistent. Further, none of the symptoms describe sufficiently the "binge" drinker who will abstain from alcohol for a long period of time, in one instance from our sample, eighteen months or longer, and then drink himself into insensibility for a period often lasting as long as three months.

The "secret" alcoholic has a high incidence in the alcoholic population.

The "week-end" alcohol who will abstain during the work week and then drink excessively, producing incapacitation from Friday evening until Monday morning. It is a characteristic of this type of alcoholic to lengthen his week-ends until he is productive only one or two days a week. The progressiveness of his consumption usually becomes of such proportions that he becomes unemployable or socially non-functionable.

Physiologically the etiology is unknown and the physician usually looks for psychological hypotheses for a supportive diagnosis.

However, a specific diagnosis with specific indications and contra-indications is physiologically difficult and probably impossible.

Comment on the physiology and pathology of alcohol
ingestion can be brief. Alcohol is absorbed directly into the blood, where it accumulates because absorption is more rapid than oxidation and elimination. Depression of the CNS is a principal effect of alcohol. From five to ten percent of ingested alcohol is excreted, the remainder has been oxidized to CO₂ and water. The rate is slow and each ml furnishes about seven calories. Since its oxidation rate cannot be accelerated in response to energy demands, alcohol cannot serve as an adequate food.

Organ damage is somewhat more specific with cirrhosis of the liver, peripheral neuropathy, brain damage, pancreatitis and cardiomyopathy common. Alcohol seems to have a direct hepatotoxic effect which may exacerbate gastritis and pancreatitis. Irreversible impairment of the liver, prevention of adequate glycogen storage may promote hypoglycemia. Sugar tolerance may be reduced. Nerve degeneration of the peripheral type and brain changes from diminished nutrition, thiamine in particular, occurs.

There is a direct toxic effect on the heart muscle. Cardiomyopathy in which there is high output failure is prominent and disturbances can occur related to mineral and electrolyte imbalances. Acidity is common.

Auditory illusions and hallucinations, usually of
a paranoid nature and frequently accusatory and threatening, apprehension and fear are common.

Withdrawal of alcohol produces a continuum of symptoms usually within twenty-four to forty-eight hours although there have been numerous instances of the symptoms occurring after three weeks. Tremor, weakness, sweating, hyperreflexia and gastrointestinal symptoms occur. Delirium tremens begins with anxiety attacks, increasing confusion, poor sleep, increased sweating and a profound depression. The pulse rate is affected and gross disorientation and cognitive disruption is common.

Hallucinations and nocturnal illusions causing fear and restlessness occur. Visual hallucinations involving animals are frequent, inciting terror. Spatial orientation is present, i.e., moving walls, floor, etc.

Grand mal seizures may occur, tremor of the hands results, a marked ataxia is present. The risk of death is between five and fifteen percent. The period of acuteness persists from two to ten days but can last longer. Delirium tremens begin to clear within twelve to twenty-four hours.

Others may develop dull, lethargic, and stuporous "flapping" tremors of the extended arms usually associated with cirrhosis and impending hepatic coma. Korsa-
Koff's psychosis and Wernicke's encephalopathy may occur.

Psychological diagnosis is not appropriate at this time as extended remarks on the psychopathology of the patient will be covered in a later chapter.

The difficulty is that the various physiological manifestations and the psychological manifestations do have one common element: the symptoms fit other illnesses and the common identification factor is the ingestion of alcohol.

Alcoholism is an illness that requires the patient to diagnose himself. A variety of indicators are known which can assist the patient in self-diagnosis. The illness requires this self-diagnosis as the denial mechanism to be discussed later prevents the patient from accepting the information given him by another party, physician or psychologist.

Self-diagnosis has the increased benefit of encouraging the alcoholic to seek remediation of his alcoholism.

Frequently a physician may be able to diagnose alcoholism, initiate treatment and utilize the assistance of other professionals to rehabilitation. Treatability depends upon a number of factors: early intervention and continuing attention, the latter is of greater im-
portance. However, the patient who does not accept the diagnosis will resist and commonly resists any treatment other than the initiation of "self-control."

Of the sample in our study, 122 resisted any intervention in their drinking life. Rarely does the alcoholic want to respond to a program that requires abstinence. Recognition of this response is now generally accepted by the medical profession.

**Self-Diagnosis**

An excellent tool for self-diagnosis by younger people is the questionnaire.

1. Do you lose time in school because of drinking?
2. Do you use drinking to lose shyness and build up self confidence?
3. Is drinking affecting your reputation?
4. Do you drink to escape from study or home worries?
5. Does it bother you if somebody says maybe you drink too much?
6. Do you have to take a drink to go out on a date?
7. Do you ever get into money trouble over buying alcohol?
(8) Have you lost friends since you started drinking?
(9) Do you hang out now with a crowd where stuff is easy to get?
(10) Do your friends drink less than you do?
(11) Do you drink until the bottle is empty?
(12) Have you ever had a loss of memory from drinking?
(13) Has drunk driving ever put you into a hospital or a jail?
(14) Do you get annoyed at classes, lectures or discussions on drinking excessively?
(15) Do you think you have a problem with liquor?\textsuperscript{10}

However, age is not important. This survey found two grade five children who were grossly intoxicated from Friday afternoon until Monday mornings on a regular basis each week. They obtained their alcohol from older brothers and sisters. They paid an extra dollar to each legal purchaser, family member of friend, for the vodka or wine. They often stole the money from their parents.

Age is a minor factor and difficult to diagnostically assess. If the fifteen questions listed above secure a substantial number (three or more) of affirma-
tive answers, that young person is in alcoholic difficulty. Three or more indicate incipient problem drinking; if unchecked almost certain affliction of alcoholism will occur prior to the age of twenty-five.

For adults there are questions with assist in self-diagnosis.

(1) Have you ever decided to stop drinking for a week or so but only lasted for a couple of days?

(2) Do you wish people would mind their own business about your drinking, stop telling you what to do?

(3) Have you ever switched from one kind of drink to another in the hope that this would keep you from getting drunk?

(4) Have you had a drink in the morning during the past year?

(5) Do you envy people who can drink without getting into trouble?

(6) Have you had problems connected with drinking during the past year?

(7) Has your drinking caused trouble at home?

(8) Do you ever try to get extra drinks at a party because you did not get enough?

(9) Do you tell yourself you can stop drinking
any time you want to even though you keep getting drunk when you don't mean to?

(10) Have you missed days of work because of drinking?

(11) Do you have blackouts?

(12) Have you ever felt that life would be better if you did not drink?

Affirmative answers to four or more of these twelve would probably indicate difficulty with alcohol and if more than four, one can assume that that person is afflicted with alcoholism.

In California's Alameda County, Contra Costa County, Marin County and San Mateo County, some therapeutic groups have their own twenty questions. These questions are directed to people close to a person with a drinking problem. The questions are directed to the possible alcoholic or to themselves.

(1) Do you ever worry about how much they drink?

(2) Do you complain about how much they drink?

(3) Do you criticize them for the amount they drink?

(4) Have you ever been hurt or embarrassed by their drinking?

(5) Are holidays unpleasant because of their drinking?
(6) Do they lie about their drinking?

(7) Do they deny that drinking affects their lives?

(8) Do they say or do things and then deny saying or doing them?

(9) Has drinking become more important to them than you are?

(10) Do they become angry if you mention their drinking?

(11) Do all their social activities involve drinking?

(12) Do you spend as much money on liquor as food?

(13) Does their drinking cause financial difficulties?

(14) Does their drinking keep them away from home?

(15) Have you threatened to leave them because of their drinking?

(16) Have you ever lied for them because of their drinking?

(17) At parties, have you urged them to eat instead of drinking?

(18) Have you ever stopped drinking for a period of time, then started again?

(19) Did you ever think of calling the police because of their drinking?
(20) Does drinking cause problems for them?

These questions provide an internal and an external appraisal of the possibility of the presence of alcoholism.

The essentials of the self-diagnosis of alcoholism is to be found in the admission by the alcoholic that he or she is powerless over alcohol and that their lives have become unmanageable. This is the basic admission for any successful therapy for the drinking alcoholic.

The definition of alcoholism as developed by the Joint National Council on Alcoholism and the AMA Committee on Definition as published in the Annals of Internal Medicine, December, 1976, issue: "Alcoholism is a chronic, progressive and potentially fatal disease. It is characterized by tolerance and physical dependence, pathologic organ changes or both, all of which are the direct consequences of alcohol ingested," merits close examination in relationship to the questionnaire.

(1) Chronic and progressive means that the physical, emotional and social changes that develop are cumulative and progress as drinking continues.

(2) Tolerance means brain adaptation to the presence of high concentrations of alcohol.

(3) Physical dependency means that withdrawal
symptoms occur from decreasing or ceasing the consumption of alcohol.

(4) The person with alcoholism cannot consistently predict on any drinking occasion the duration of the episode or the quantity that will be consumed.

(5) Pathologic organ changes can be found in any organ, but most often involves the liver, brain, peripheral nervous system and gastrointestinal tract.

(6) The drinking pattern is generally continuous but may be intermittent, with periods of abstinence between episodes.

(7) The social, emotional and behavioral consequences of alcoholism result from the effects of alcohol on the function of the brain. The degree to which these symptoms and signs are considered deviant will depend upon the cultural norms of the society or the group in which the person lives.

The National Council on Alcoholism has published from the British Journal on Addiction a chart indicating the process during the course of the onslaught of alcoholism:

(1) Occasional relief drinking.
(2) Constant drinking commences.
(3) Increase in alcohol tolerance.
(4) Onset of memory blackouts.
(5) Surreptitious drinking.
(6) Increasing dependence upon alcohol.
(7) Urgency of first drinks.
(8) Feeling of guilt.
(9) Unable to discuss problems.
(10) Memory blackouts increase.
(11) Decrease of ability to stop drinking when others have.
(12) Drinking bolstered with excuses.
(13) Grandiose and aggressive behavior.
(14) Persistent remorse.
(15) Efforts to control fail repeatedly.
(16) Promises and resolutions fail.
(17) Tries geographical escapes.
(18) Loss of other interests.
(19) Family and friends avoided.
(20) Work and money problems cause trouble.
(21) Unreasonable resentments.
(22) Neglect of food.
(23) Loss of ordinary will power.
(24) Tremors and early morning drinking.
(25) Decrease in alcohol tolerance.
(26) Physical deterioration.
(27) Onset of lengthy intoxications.
(28) Ethical deterioration.
(29) Impaired thinking.
(30) Drinking with inferiors.
(31) Indefinable fears.
(32) Unable to initiate action.
(33) Obsession with drinking.
(34) Vague spiritual desires.
(35) Exhaustion of alibis.
(36) Complete defeat admitted. 11

Other diagnostic charting has been attempted by various hospital groups and individuals but, in general, they following this pattern which on the basis of our sample, is regarded as reliable. There will be certain overlaps, some omissions, and some "skipping around," but in general the onslaught of alcoholism follows this pattern.

The commonalities are as follows:

(1) Initial relief drinking.
(2) Constant relief drinking.
(3) Onset of memory blackouts.
(4) Memory blackouts increasing.
(5) Decrease of ability to stop drinking when others do so.
(6) Onset of lengthy intoxications.

(7) Complete defeat admitted.

These seven seem to be more commonly expressed by our sample as to importance and indigenous alcoholic development. No statistical effort was made to select these seven commonalities, but in checking with hundreds of alcoholics and our sample, a general acceptance was noted.

There are alcoholics who are convinced that at the time of their drinking certain beverages were more "effective" than others. Of the sample, 41 (30 percent) spent several years convinced that they were not alchoholically dependent because the beverage of choice was beer, on the faulty assumption that beer contains less alcohol than is usually found in a single mixed drink. "If one drinks a lot of beer, one drinks a lot," however, is true.

As the illness progresses, a discrimination in the selection of the drink becomes lessened. A typical response to the question of "What did you drink?" brought forth answers such as, "I preferred bourbon, preferably sour mash." "I did not like beer." "I liked martinis, but only at noon." "As my drinking progressed, I drank any alcoholic beverage available, but I continually refused to drink scotch." "At the close of my alcoholic
drinking, I drank anything that had alcohol in it. I could only afford cheap wine, so I drank sherry, it's 40 proof, and inexpensive. I drank about a gallon a day. When that ran out, I drank after-shave lotion."

Of the 137, 79 (58 percent) produced similar case stories of drinking patterns as the illness progressed. There were over 50 (36 percent) who stated that anything containing alcohol was consumed regardless of the brand, kind or quality.

Conclusions

(1) Alcoholism is an illness. Its etiology is unknown, although there are physical, psychological and societal factors which contribute to its initiation and intensification.

(2) The illness is progressive.

(3) Impairment affects the physical, mental and social function of the individual directly associated with persistent and excessive use of alcohol. The impairment involves physiological, psychological or social dysfunction or a combination of any or all of these entities.

(4) The quantity of alcohol consumed is not essential to the diagnosis of alcoholism. The
Effect of alcohol on the physical, psychological and social functioning of an individual is the pervasive factor.

(5) Alcoholism produces behavior that is maladaptive and deviant.

(6) Alcohol is a chronic illness with a tendency toward relapse.

(7) Consistency in alcoholic drinking may be on a continuum or may be interrupted by a period of time during which abstinence may be maintained. However, the alcoholic will resume his excessive ingestion unless interventive processes are instigated.

(8) Physiological assessment is useful in a diagnosis of alcoholism, but it is insufficient to present a definitive diagnosis.

(9) Self-diagnostic systems are valuable and they have the additional effect of encouraging the alcoholic to seek treatment.

(10) The alcoholic will resist treatment if he is drinking and cannot be depended upon to follow medical, psychological or personal advice from another person.
CHAPTER III
SOME CHARACTERISTICS OF THE ALCOHOLIC

"Take from me the hope that I can change the future, and you will send me mad."

--Israel Zangwill

Many have written about the "so called" alcoholic personality, and considerable effort has been made to delineate an alcoholic personality. There have also been attempts to describe an alcoholic personality in relationship to the causes of alcoholism. Such efforts have not produced substantive results and it has been a discouraging area of research. Descriptions of the "typical" alcoholic have been variable, misleading, and as a rule, ambiguous. It is true, however, that there are certain commonalities among alcoholics; but one can assume with confidence that there are as many different kinds of people who are alcoholic as there are different kinds of individuals. Individuality is one of the more impressive characteristics of alcoholics; and there are as many varieties of alcoholic behaviors as there are alcoholics.

On close examination of our sample, there was as great a divergence of personality "structures" as one
could find among any group of people who are ill, asthmatics, or amputees. However, there are some feelings and behavioral characteristics that seem to appear more frequently than others. The sample did not reveal a uniform alcoholic personality. The phrase does not fit a total personality type pathogenetic to the illness.

It is the view of this study, that alcoholism has some distinguishing characteristics and that these characteristics become more prominent as the illness progresses. However, masking characteristics is a trait of many alcoholics.

In the Hampden study of children, an effort was made to determine who might become a future alcoholic. Despite a careful and analytical personal examination ranging from the use of Cattell's Children's Personality Questionnaire to the Thematic Apperceptive Test (Children-Human), there was no single isolate, a provable characteristic that could be used as a diagnostic standard.

It is true that alcoholism is frequently a family illness, more so than many others. There is a suggestion toward family sensitivity to alcohol, there have been variables in an individual's physiological responses which might indicate genetic transferrence and susceptibility. Studies at Washington University, twins
studies, and adoptive studies, are interesting, but most are lacking in control groups and are thus suspect.

Alcohol has been used for a variety of reasons, but in the main it has been an instrument for coping with life. Of the sample, each member had devoted years to the use of alcohol as a means of internal or external adjustment. Life became centered on drinking. Despite examination and inquiry, it was not possible to determine the length of time required for the obsessive-compulsiveness factor of the illness to emerge. There are those who found themselves ill within months of taking the first drink.

One of the more interesting individuals did not take a drink until attaining the age of sixty-five, she found herself compulsively-obsessed with drinking within two weeks. She was hospitalized within three months. Others in the sample began drinking at an early age. Initial dependence shows some signs of developing between the ages of 12 and 14.

In the Hampden study, two individuals were found who drank compulsively as "binge" drinkers, i.e., excessive consumption with intervening periods of abstinence, at the age of nine. These two children were able to avoid alcohol or a demand for alcohol during the school week, Monday through Friday. Invariably they became
drunk on Friday evening and remained drunk (their own description) until Sunday night when there was a complete break-off from drinking. Incidentally, the alcohol was obtained by stealing, parental cooperation (open bottles of alcohol available in the home), or by the purchase of alcohol by legal purchasers. Most of the purveyors in this group were in their early twenties and were drinking companions of the children.

Of the sample not one expressed himself as being "tolerant" of frustration and all described themselves as being "intolerant" of frustration. All related "frustration" to anxiety.

The frustration of the alcoholic is a "first aid" component which usually precedes sobriety. Max Glatt points out that therapeutic treatment by the doctor must also not ignore a basic alcoholic attitude for frustration relief that if one injection or pill helps, four will be better. So it is with drinking: if one drink is good, four will be better.

From our sample, the following figures are useful. Question: What are the most deep-seated emotional feelings of discomfiture you have felt prior to the onset of persistent drinking? In other words, feelings that you could describe as long-lasting and persist during your drinking period. Name no more than two which you
The list of self-descriptions is not complete, but it does indicate a community of feelings which the alcoholic feels during or prior to drinking.

Whatever the reasons for alcoholism (physical, psychological, social) the drinking career reveals personality deficits which persist. The defenses against such feelings are the defenses of denial, projection,
rationalization, and over-compensation, producing what is described, however inadequately, as the alcoholic personality.

Maslow has suggested that it is often possible at times for an individual to be stimulated by physiological needs and seek to reduce tensions, sometimes he is stimulated by self-actualizing tendencies, and at other times he is stimulated by social needs for praise and respect. This view by Maslow has importance in the relationship between the abstaining alcoholic and his pre-abstinence problems. The almost universal response among abstaining alcoholics is that there is an overwhelming desire for approval by peers and to a slightly lesser degree by others. Personal self-concepts by which the alcoholic regards himself as "out of the main stream" are almost endemic. The lack of inner confidence, the avoidance of risk, the fear of disapproval are almost overwhelming. Alcohol with its lowering of inhibition, stimulated sense of well-being, and depression of "true" feelings is an attractive "cure."

Psychological theory of personality is as varied as color. A casual listing of some of the more obvious ones may be in order:

(1) Man is a creature of instinct.

(2) Man is a social creature.
(3) Man possesses free will.

(4) Man has little or no control over his behavior other than that which is pre-determined.

(5) Man is a mechanistic creature.

(6) Man not only is mechanistic, but his relationship to self and others is simple.

(7) Man is mechanistic, but his relationship to self and to others is complex and dynamic.

A theory that emphasizes the conscious and free will may be an expression of a view of man as an organism that reasons, chooses, decides—a rational master.

The determinist may emphasize instinct and view man as an organism that is driven, compelled, irrational.

And there is the view that man is a machine that responds to stimuli from outside activating fixed patterns of stimulation.

Some have modeled theory on an understanding of computer functioning.

In addition, there is the basic conflict regarding learning theory: Is alcoholism a learned behavior or not?

The view of this work is that of the humanist. It is man-centered. It is phenomenological rather than scientific, pragmatic or empirical.

The urging here is to consider the alcoholic's
world as it is experienced by the victim, without bias, attempting to achieve as a goal an understanding of the world as it is perceived by the alcoholic and not as it may be defined by the scientist.

We may be erecting a model more philosophical than psychological. The goals of objectivity, reliability, standardization and validity are not useless, but understanding has been demonstrably more productive than empirical explanation or process.

The alcoholic experiences or has experienced a complete loss of freedom of choice. There is no greater harm to the living than to be denied options regarding destructive behavior.

The drinking alcoholic literally has no choice: he drinks to live and he lives to drink. The psychological and physical damage under such a compulsion is obvious. Entrapped within these restraints, the future is bleak.

Freedom is basic to man. He is able to see himself, to be self-determining, to reflect, to be aware of being aware, to question his awareness and seek meaning in awareness. Remove these choices and a severely damaged person results.

Pervin has put it in terms that viewing the alcoholic from his point of view, existentialist, assumes
that each person has a world-design or reference point from which he interprets everything that exists. The goal therefore, is an understanding of the existence of a particular person at a particular moment in his life.¹

This study is openly idiographic. The uniqueness of each individual requires unique perceptions if one is to capture the richness of his human individuality.

Reluctantly, it should be stated that personality theory has minimal value to the person who would understand the alcoholic as theories are influenced by personal factors, the Zeitgeist, and by philosophical assumptions characteristic of cultural membership. To some extent, we all talk about ourselves when we communicate from theoretical assumptions.

Of our sample, 92 (57 percent) stated that anxiety producing the absence of positive regard by peers, superiors, family or friends was a major factor which encouraged the alcoholic to resort to alcohol in order to ameliorate a sense of self-inferiority. Many of the sample expressed a view that an inward sense of inferiority was persistent and unremitting in their daily lives despite successful efforts to mask those feelings from others.

The alcoholic has a damaged sense of self-esteem
without exception. Aggressiveness, stylistic manipulation, cultivated self images do not remove these feelings and the only method that the alcoholic can use with confidence is alcohol. Even after a period of abstinence, there emerges a sense of "bareness" with a substantial residue of low self-esteem. The amelioration of this condition is substantially influenced by others who possess the capacity to communicate a positive regard without conditions.

Anxiety

An examination of the responses listed previously indicate rather obviously that there is an anxiety producing component in nearly each response.

From our sample, not one alcoholic failed to respond that he experienced anxiety daily and usually on a continuum. Anxiety was always coupled with frustration or to fear.

Anxiety is a difficult subject to understand or discuss although the alcoholic certainly knows what it is. Clearly it is an indice of why people use alcohol and it is a major indice as to why people abuse alcohol.

There is a simple explanation: alcohol ingestion changes the way a person feels. Alcohol makes the user feel "good" or "better." In negative explanation: al-
cohol relieves the unpleasantness of anxiety by making one feel less anxious, i.e., better.

W.H. Auden once described our age as the Age of Anxiety. Our society merchandizes books and systems to acquire peace of mind, happiness, freedom from tension, relaxation. Religious cults are formed and Eastern philosophical concepts have become popularized to rid the individual of anxiety.

For our purposes the best definition that seems to be workable is that anxiety is an exaggerated feeling of apprehension. Anxiety differs from fear in that fear takes an object.

It is also characteristic of our sample that the anxiety that is usually described is defiant of definition. Anxiety is usually future-oriented and has a quality of anticipation. But not always. It can center on future events with an overlay of doom, producing a sense of hopelessness, and helplessness. Kierkegaard called it the "nameless dread."

To the alcoholic the most difficult component of his anxiety is indecision about whether to face up to the object (if known) that is anxiety producing, or to avoid it. The alcoholic is frequently vague or ignorant of what it is that he is feeling anxious about. Avoidance is almost always preferred.
Further, if one ounce of alcohol produces relief, two will eliminate it completely, three will sustain the relief and four or more will keep the euphoria constant for an unforeseeable time.

These statements were affirmed by our total sample with only a single exception.

Rollo May in his "The Meaning of Anxiety" notes that subjective conflict is always present with neurotic anxiety and it is the activation of this conflict which cues off the neurotic anxiety.

Without discussing the details of May's definitive work, these neurotic fears are frequently present in the alcoholic's escape as revealed by the sample:

(1) Fear of failure.
(2) Fear of disapproval by parent or peers.
(3) Fear of exposure before groups.
(4) Fear of death.
(5) Fear of siblings.
(6) Fear of poverty.
(7) Fear of "loneliness."
(8) Fear that one is unloved.
(9) Fear of illness.
(10) Fear of aggressions by others.
(11) Fear of ridicule.
(12) Fear of peer regard as "ugly."
(13) Fear of disease.
(14) Fear of "unhappiness."
(15) Fear for the health of children.
(16) Fear of leaving home.
(17) Fear of disapproval.
(18) Fear of being afraid and exposed by the fear.

All of the above were expressed as subjective conflicts that were presented singly or in company with other fears producing a high anxiety level.

It should be mentioned here that six of our sample expressed a fear of "success," i.e., a sense of "undeserved approval."

One fear that is anxiety productive was mentioned by seventy-two of our sample: the fear that others would know that they possessed the fears experienced. It corresponds to number eighteen on our list.

Add to these inner conflicts, societal considerations, cultural expectations and values as expressed by norms, mores, and laws when society itself is in conflict over its own values, then anxiety becomes the usual rather than the unusual. When the alcoholic ingests alcohol he discovers the miracle cure for anxiety, it is immediately reduced. Even the anticipation of a drink has a calming effect if the alcoholic knows that a drink is available.
Whatever the causes of anxiety, memory of past failure, projection to future discomfiture, sexuality impoverishment, or sexual impairment, it is not (for the alcoholic) important. He knows only that alcohol reduces the anxiety and the more alcohol ingested the greater likelihood of a sustained euphoria followed by the blessed relief of insensitivity.

The non-alcoholic learns that he can live with contradictions in his society and his culture, that he can live with contradictions within himself, in short, he learns that he can live with being human. The alcoholic is sufficiently distraught that he does not believe that he can live with these contradictions and that there is immediate relief available, relief that is legal, approved, and acceptable. When the discovery is made, the thrust toward more frequent and greater consumption of alcohol is set in motion which leads to his eventual incapacitation.

The urge to avoid anxiety by alcohol consumption is reinforced by the alcoholic's knowledge that he does not know with certainty what it is he is trying to avoid.

It is pertinent to mention that our sample produced an odd insensitivity to the awareness of the limitations of living, the length of the life span and that there
is a constant process of creativity. Our sample, and follow-up inquiry, reveals that the alcoholic has a dulled sense of living, i.e., responding to the stimuli of awareness. His concerns are immediate and pressing. To our earlier list could be added the fear of living. However, none of the sample expressed itself in those precise words.

With the fear of living is a component: there is death, a future of non-life. The alcoholic has a profound sense of death, sometimes a fleeting desire for it, an occasional impulse to seek it, and perhaps, his alcoholism in itself is a lengthy and complicated action toward death. The other part of the process is buried, ignored or even forgotten, death is an ending to living and the alcoholic has little concern for the experience of living beyond the relief of his complex anxieties presented at any given moment. Of our sample, suicide attempts totaled 142.

**Self-Esteem**

It is possible that the lack of self-esteem may be the fundamental source of alcoholic anxiety. The essential conflicts of living and how we are expected to face the conflicts in terms of the value system of our culture is a disturbing element in our psychic life. If
one divides self-esteem into components, it becomes clearer as a sense of being effective, a sense of worthiness, and a sense of being more than what one is and at the same time a sense that one is less than what one is.

When the sample was asked to review their drinking histories and to describe their sense of self-esteem, some of the responses were as follows:

**TABLE 4**

<table>
<thead>
<tr>
<th>%</th>
<th>N</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>64</td>
<td>110</td>
<td>&quot;I had none.</td>
</tr>
<tr>
<td>72</td>
<td>99</td>
<td>&quot;I detested myself.</td>
</tr>
<tr>
<td>64</td>
<td>88</td>
<td>&quot;I knew I was not like others, I did not want to be like others, and it bothered me when I was with others.&quot;</td>
</tr>
<tr>
<td>61</td>
<td>84</td>
<td>&quot;I could not live with the knowledge that I was a total failure.&quot;</td>
</tr>
<tr>
<td>44</td>
<td>56</td>
<td>&quot;I was successful in society's terms, but I knew it was a 'con job' and I was faking it. I just did not measure up.&quot;</td>
</tr>
<tr>
<td>41</td>
<td>56</td>
<td>&quot;I was a door-mat.&quot;</td>
</tr>
<tr>
<td>39</td>
<td>53</td>
<td>&quot;I could not stand being me.&quot;</td>
</tr>
</tbody>
</table>

When pressed, although no statistical extraction was made, it was common for the sample to fantasize as to being "other" people and publicly to invent roles for themselves that were acceptable and approvable. Some of the roles were so fanciful that only another
alcoholic could possibly believe the tales told of the individual's societal role. (One of the sample was a fictional pitcher for the Cincinnati Reds and another was a U.S. Senator whom he resembled.)

It is noteworthy that the projection of fantasy on the "outside" world was more common among men than among women although both sexes shared the capacity to fantasize as an improved, elevated, and respected person, to the extent that they would assume the labels of specific people who were socially approved.

Meeting cultural expectations within the society in which one lives may be a triggering effect for alcoholic anxiety. It is important, however, to this work to know that alcohol has the immediate effect of increasing one's sense of worthiness and will mask or dull the interior belief of one's lack of worthiness. It was expressed by several from our sample that drinking to excess was to them an expression of expiation of their unworthiness.

Guilt

Our organized religions create guilt. Only three of our sample expressed an absence of "feeling guilty" about the way they lived, the damage they sensed they were doing to themselves. Alcohol provided immediate
relief from those feelings.

Although it is impressive as to the number of alcoholics who felt guilty about the self-damage, only three expressed a sense of awareness of the damage they were doing to others (family, associates, etc) while they were drinking.

Guilt probably is a component of the lack of self-esteem. It is an overwhelming persistent feeling for the alcoholic who drinks that persists into the early stages of abstinence.

From a psychological viewpoint, it is a matter of great concern that alcoholics in general tend to be greatly damaged by feelings of inferiority and inadequacy and that the greater problem is one of under-evaluation of self, rather than over-evaluation. The exceptions to this statement from our sample were the physicians.

Yet, even with the physicians, there was an accompanying feeling that with their over-evaluations, they felt a profound guilt that they were not living up to their own expectations as well as the expectations of their profession and society. They were willing to take the bows, they loved the applause, they were well-rehearsed and competently directed, but the performance was "not real."
It is certain to the sample that self-esteem and guilt has a direct causal relationship to anxiety.

**Grandiosity**

It is characteristic of our sample that when they objectively accomplished something that was worthwhile, they felt unusually good about it. The duration of these feeling was short. There was a sense of emptiness about the complex of their feelings after the act.

The usual response to this emptiness was the generation of a new accomplishment to prove in one fashion or another that they were worthwhile.

If the alcoholic was unable to accomplish anything worthwhile, there was a high capacity to invent or fantasize a worthwhile accomplishment. Alcoholics seemingly cannot give an objective and concise statement about their worthiness or accomplishment. It is either exaggerated to ridiculous proportions if it is "good," or reduced to minimal proportions or exaggerated to magnitude if it is "bad."

By cross-questioning, this assessment was confirmed. Thirty-four percent (64) of the sample used such language in self-description and were quick to magnify family accomplishments, financial earnings, or awards which they may or may not have received.
Our sample has a high percentage of those who characterized themselves as hypochondriacal. Fifty-six percent (77) admitted to such exaggeration of imagined illness. Now toleration of physical pain was mentioned frequently by the "hypochondriacs."

All of the sample indicated that the "pendulum effect" was present. Situations were presented to others as being greater or better than they were or smaller or worse than they were and that adherence to a system of polarization of self-description was common.

Yet, when questioning became intense, the sense of self-worth and the self-image was always at a low level, and in most instances damaged. The extravagences were related to low self-esteem.

**Relations with Others**

It was impossible to determine personality traits that would lead unmistakably to either open or closed communication.

However, an overwhelming number, 115 (84 percent), spoke frankly of either being unable to be open even though they possessed the verbal tools for communication, or of being shy and withdrawn, even without alcohol. As alcohol released the inhibitions, the shy became more gregarious and the communicators become over-
weening bores. Alcohol tended to adjust the two factors, bringing the shy into an interfacing and encouraging the outward thrust of the communicators to boorishness. An attempt was made to relate the latter group to violence without success.

But, there is an unmistakable repetition of the "polarization" of behavior when alcohol is involved.

Paranoia

Simply put, all of our sample expressed paranoid feelings concerning the disapproval or adverse criticism of themselves by others, feelings which were alleviated, diminished or extinguished when alcohol was ingested.

Depression

Again simply put, without alcohol the alcoholic is depressed. With alcohol, the depression is alleviated, diminished or extinguished. There were instances of alcohol increasing depression but increasing the ability to tolerate it. This was confirmed by the entire sample.

Polarized Emotions

All feelings are extreme with alcoholics. All capabilities to control and direct emotions are impaired
with all alcoholics. The entire sample confirmed this blunt statement.

Projection

The sample also without exception stated that the cause of their distress when drinking was always placed on people, places or things. Until they realized that they were dependent on alcohol, no alternative was considered. Personal responsibility for their actions was always, without exception, minimized or ignored. Whatever the difficulty, the alcoholic will not responsibility for his actions. The sample confirmed this conclusion.

Conclusions

(1) With only a sampling of anxiety components catalogued, the presence of anxiety is universal among alcoholics.

(2) The response to anxiety and its relief is alcohol ingestion.

(3) The multiplicity of factors productive of anxiety is manifold and another work would be required to list them in near completeness.

(4) A damaged self-concept is endemic to the alcoholic.
(5) The "alcoholic personality" eludes precise definition.

(6) The presence of anxiety is found among most alcoholics, abstinent or not.

(7) There is a conglomerate of fear to be found in most alcoholics, abstinent or not.

(8) Low self-esteem is endemic to the alcoholic, abstinent or not.

(9) Guilt is a cultural presence in the life of the alcoholic; it is probably related to low self-esteem.

(10) Grandiosity is common among alcoholics.

(11) Relationships with others is blunted by confused pre-dispositions to open or closed communication. Extremity in communication is expressed in a polarized manner.

(12) Depression, polarized emotions and projection are endemic to the alcoholic, abstinent or not.
"...The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such..."

--Hippocrates

Are alcoholics treatable? The answer is "yes."

According to the AMA the illness is a chronic disorder with a tendency toward relapse, alcoholism should be approached in the same manner as other chronic and relapsing medical conditions. The aim of treatment from the medical modality is viewed more as one of control rather than cure.

There are a variety of ways to deal with the illness and today there are a host of treatment centers in the United States. However, it is only recently that alcoholics were thought to be other than psychic lepers. Doctors would often refuse to treat them, some still do; the law previously looked upon them as human debris who had to be swept off the streets and thrown into "drunk tanks."

Some of these outmoded attitudes still persist.
But no vaccines have been found; it is unlikely such will be found. But there are a number of treatment modalities which offer some chance for alcoholic control by the victim.

There is an assumption in this work that alcoholism is an **incurable** illness and we accept the goal of treatment as **control** rather than **cure**.

The use of the word "cure" can be damaging. Despite the evidence that alcoholics who have abstained for a lengthy period of time do not always look upon themselves as "cured," but rather as "controlled," there is considerable evidence that the public thinks of the non-drinking alcoholic as "cured." It is a dangerous conclusion.

Of our sample not one alcoholic suggested that he or she was cured, each assumed that he had an incurable disease. The sample views as a goal for any treatment control, coinciding with the AMA view. Such a view, control rather than cure, is reflected by most agencies dealing with alcoholics.

**Detoxification**

Detoxification describes the brief period of time during which the physically impaired alcoholic is placed in a health center for the purpose of waiting until the
body has utilized or eliminated the alcohol ingested. After the alcoholicly impaired person has recovered, the alcoholic is directed to a treatment facility or modality where he can begin the struggle to maintain "being sober."

The period of time in detoxification is usually limited to five days and in some instances may last as long as fifteen to twenty days.

The purpose is to detoxify the patient.

The rehabilitative process may or may not be initiated.

Detoxification centers are usually supported by federal and state governments, but may be sustained at the county or local level. Private centers are plentiful.

Max Glatt describes the detoxification process as getting the alcoholic healthy enough so that he can resume his drinking. The professional alcoholic community is adversely critical of the "revolving door" policy by which the alcoholic enters the detoxification unit, becomes detoxified and is rushed out the doors to make room for incoming patients. He is prone to return promptly and in an intoxicated condition.

In our sample, 7 (5 percent) had been detoxified over one hundred times, 13 (9 percent) had been detoxi-
fied between seventy and one hundred times.

For the sample as a whole, the total number of detoxifications had to be estimated as most of those who had been frequently detoxified could not remember the number of times with a sufficient degree of certainty.

The entire sample had been detoxified at least once, and of the total number, 42 (31 percent) had been detoxified at a public or privately supported detoxification center. The remainder had been detoxified at home, in hospitals when admitted for other causes (accidents, related illness, etc.), or in company with friends or individuals who assisted them through the period of withdrawal.

The deficiencies of the detoxification process are obvious:

(1) They are expensive for hospitals to maintain without substantial infusions of money from private or public sources.

(2) The personnel administering detoxification units are often untrained and comprised of volunteers or poorly paid employees.

(3) They do not require a competent health examination for the victim and alcoholics with other illnesses are discharged after detoxi-
fication when they should have been retained.

(4) The access to rehabilitative centers, either private or public, by hospitals is limited.

(5) The benefits of detoxification are immediate but insufficiently supportive to initiate or sustain a continuum for rehabilitation.

(6) The value of detoxification units is vague and not easily definable. (It is suggested that if one has been detoxified twenty times at a detoxification center, Glatt's comment is validated.)

(7) There is no system of enforced detoxification. Patients frequently discharge themselves after twenty-four hours. Many times they discharge themselves within an hour following a bath and a nap in a bed.

(8) There is a stigma attached to having entered a detoxification unit and the "non-street" alcoholic resists the risk of being identified. Therefore, when placed in a detoxification unit, the urge is to leave quickly and quietly.

It is noteworthy that at present the number of detoxification units in Massachusetts is declining although the alcoholic population is remaining relatively
stable. Small hospitals can no longer afford the units as the money return is lower because of the instability of continuation of treatment. Veterans hospitals estimate that almost 30 percent of their populations are composed of alcohol abusing patients yet the emphasis is on detoxification rather than rehabilitation.

Rehabilitation

Chit Chat Farms, west of Reading, Pennsylvania is representative of many private units treating alcoholics, i.e., group support units for establishing controls. The director states that we tell the patient it can be done, and one does not have to go it alone. It is Chit Chat's experience that looking into the "whys of drinking" has no positive effect. The concentration is on how one can stop.

At Lutheran General Hospital, northwest of Chicago, there is also an interaction, patients and staff, and patient and patient with no utilization of in-depth therapy. (The use of psycho-therapy for alcoholic treatment is regarded by many professionals as a waste of time.) In the opinion of Dr. Nelson Bradley, psychiatrist at Lutheran General, classical psychoanalysis is of limited help for most alcoholics. The patient at Lutheran General is treated for withdrawal and given a
medical assessment within five days. On the sixth day, there is an assignment to a 25-patient team that meets with families, children and employers in sessions designed to help the patient to adjust to living a lifestyle in which it is not required that he drink.

There is a two to three month follow-up.

However, some patients are given psycho-therapy for problems generated by drinking.

Lutheran General estimates success at about fifty percent after three years. Dr. Bradley states that in order to raise the fifty percent figure, there must be involvement of family and employer. With these added factors the success rate can go as high as eighty percent.

Group therapy is common to most rehabilitation units.

There are other models that employ hypnotic suggestion with behavioristic aversion therapy, the use of electric shock and drugs, to make the odor of liquor abhorrent. One of these is Seattle's Schick-Shadel Hospital which offers an eleven day program in which each patient is taken to a bar maintained in the hospital with enough bottles of alcohol to satisfy a regiment. The patient is given a glass of nausea inducing drug and then handed a glass of his preferred brand.
He sniffs, swirls, and is sickened. The common drug is anabuse. The patient is told that he should take anabuse in liquid form daily, the effects will last for twenty four hours, and that if he should drink, he will produce severe physical complications. Of our sample for this work, 25 (18 percent) had tried the anabuse conditioning method. (Anabuse was given to one of the 137 clients who when told by his doctor that anabuse would be helpful in sustaining his sobriety, promptly swallowed the anabuse and retired to the nearest bar for a double shot of whiskey. He was in convulsions, with an accelerated heart beat, florid of face, he fell to the floor so ill that he was convinced he was dying. On recovery, six hours later, he stated: "I shall never try that anabuse stuff again, it can kill you.")

The patient at Schick-Shadel goes through the process for four times during his stay, at the end of which he will associate nausea with liquor and have a long time aversion to alcohol, so they believe. Their success rate is not known.

Schick-Shadel's director, Dr. James W. Smith, tells his incoming patients: "You are dealing with a fatal illness. In other fatal illnesses such as cancer, surgery is often called for if it gives the patient the best fighting chance for survival. At the moment this
is the best we know of. The method that will do the best job in the shortest time."

Aversion therapy has been widely criticized and most alcoholic physicians see aversion as useful in gaining time, but of little value in sustaining detoxification. Physicians who emphasize aversion therapy are misguided if they claim they are "curing" alcoholics by giving them medication which makes them sick. No stable statistics are available on these kinds of programs, but the experience and our sample confirms that aversion therapy is at best short-lived.

Another therapy that draws even more criticism is one in which the "cure" for alcoholism is by giving drinks to alcoholics. Dr. Edward Gottheil oversees such a program at Coatesville, Pennsylvania, Veteran's Hospital. He describes his work as "controversial." He argues that doctors study alcohol without alcoholics or alcoholics without alcohol, but not drinking itself. The idea of complete abstinence interferes with research.

At Coatesville, patients are given a variety of therapies in seminars but are allowed one to two ounces of alcohol once an hour, on the hour, from nine a.m. to nine p.m. by asking for it. If the patient drinks the allowable maximum every hour the patient can acquire a
considerable state of intoxication by nine p.m. More importantly, thirteen times every day he must make a conscious decision whether to drink or not. In the follow up study of the first group, Dr. Gottheil claimed that after six months, fifty percent were either abstaining or drinking less than twice a week. His claims are suspect.

This study regards these figures as unacceptable without a weekly follow-up on each patient for at least five years following his treatment. Follow-up is not done at Coatesville. There has been unremarkable silence from the professional community as to the acceptability of Gottheil's treatment.

The conclusion to be reached by this study is that for the alcoholic to reach a position where he can return to society and maintain an interchange life with others is total abstinence. Not one of our sample believed there is an alternative.

There was no alcoholic capable of safely returning to social drinking.

Richard Leibman, head of the Alcoholic Treatment Center of Chicago's Grant Hospital states: "One drink will not push the alcoholic off the wagon, but if he takes another drink three weeks later, he is gone."

To return to the medical goal: return the alco-
holic so that he may learn to deal effectively with his life problems and to adapt to his environment in a reasonably mature manner without using alcohol. At the same time, effort should be made to correct the complication of his illness.¹

Dr. Drober V. Seliger of Baltimore, Maryland uses the following formula in the Little Hill Alena Lodge, operated by the Little Hill Foundation Corporation, Inc., in New Jersey.

Little Hill Alena Lodge is representative of the majority of detoxification-rehabilitation entities, either public or private, which have shown remarkable success in rehabilitating alcoholics. It is worth repeating what the alcoholic must learn and it is related to the maintenance of his sobriety. According to Seliger:

"(1) The alcoholic must be convinced as a result of his experience that his reaction to alcohol is so abnormal that any consumption constitutes a totally undesirable and impossible way of life.

(2) The alcoholic must be completely sincere in the desire to stop drinking once and for all, one day at a time. The alcoholic who does not recognize his lack of powerlessness over
alcohol and who does not accept his inability to manage his life cannot be assisted in this therapy.

(3) The alcoholic must recognize that the problem of drinking is not a problem of dissipation, but a problem of a dangerous pathological reaction to a toxic drug. (Again this is a reference to the illness as being potentially fatal and incurable.)

(4) The alcoholic must learn that once he has passed from social to pathological drinking, he can never learn to control drinking again. (This statement points to the conclusion that the only treatment that is successful is complete sustained abstinence.) There are other aspects that bear comment which go beyond these essentials: the alcoholic must be brought to understand that the substitution of fantasy for genuine achievement in living is senseless and absurd.

(5) The alcoholic must recognize that once free from obsessive-compulsive drinking, personal problems are primarily individual.

(6) Alcohol produces under all conditions unhappiness for the individual who is afflicted.
(7) The motive behind drinking has been to gratify the immature desire for attention, escaping unpleasant reality, or a form of self-expression used to avoid disagreeable states of mind or body.

(8) The alcoholic must understand that ancestry is an excuse and not a reason for abnormal drinking. (Heredity has to be researched more before acceptable statements can be made.)

(9) The alcoholic must try to acquire a mature sense of values in recovery and learn to be self-disciplined in recovery and not emotionally impulsive.

(10) The alcoholic must realize that in stopping drinking he does not become a hero or a martyr. There is no entitlement to make demands upon others to satisfy individual wishes because of illness control.

(11) The alcoholic must reject the concept held in society that liquor can be handled like a "lady" or a "gentleman" and persuade himself that he can do likewise.

(12) The alcoholic must learn the importance of eating and a structured living in general.
The best prevention for the tired nervous feeling which precedes drinking is to consume some protein prior to the nervousness. A structured life for eating, sleeping and eating between meals is a necessity.

(13) The alcoholic must learn relaxation without drugs.

(14) The alcoholic needs to learn to avoid the enemies of sobriety: needless hurry, exhausting fatigue. A schedule is necessary.

(15) The alcoholic must not neglect any portion of physical health for this is important to rehabilitation. A physical examination once a year or more often is suggested.

(16) The alcoholic must carefully follow a daily self-imposed schedule which will aid in creating an organized personality and assist in developing habits to replace old destructive habits in a new rhythm of living.

(17) He must realize that any reasonable and sufficiently intelligent person who is willing to make a sustained effort for a long enough period of time is capable of learning to live comfortably without alcohol.

(18) He must learn that any imbibing of alcohol
creates a relapse.

(19) He must never be so foolish as to think that he can drink only beer and avoid those beverages which are suggestive of beer or wine, e.g., charged grape juice, "near beer," etc.

(20) The alcoholic must never be childish enough to accept temporary boredom as an excuse for taking a drink. Boredom is essentially a self-centered laziness.

(21) He must eliminate any illusions that alcohol sharpens the wit and intellect.

(22) He must learn to be tolerant of others without becoming emotionally disturbed.

(23) He must learn to disregard ill-timed and inappropriate advice from relatives and friends without becoming disturbed emotionally.

(24) He must learn to avoid daydreaming about past good times, favorite bars and clubs, and vacations.

(25) He must learn to balance success as well as failure, pleasant and unpleasant emotions can stimulate the desire to take a drink.

(26) The alcoholic must be particularly on guard against the appearances of changes in life, i.e., jobs, vocations, deaths, etc.
(27) The alcoholic must learn never to become lax in his determination in order to eliminate such things, places or conditions that create a desire for a drink.

(28) The alcoholic must not feel discouraged by a feeling of discontent during the early stages, but must turn these feelings into an incentive for action.

(29) The guard must never be relaxed especially during the first year when the reorganization of life becomes so difficult.

(30) Abstinence is not the goal; a content and satisfying life is.

(31) The alcoholic must regard his illness seriously and regard it as the most important factor in his life.

(32) The alcoholic must realize that those seeking help are usually above average in intellectual endowment regardless of their measure of education; drinking means failure; abstinence means success.

(33) He must learn that he requires help from others to sustain his sobriety for the remainder of his life."

It is desirable to maintain help and a positive
relationship with others who have recovered from alcoholism.

It is a move in the right direction that an increasing number of health insurance programs are including some provision for the treatment of alcoholism, although few of them offer benefits on a par with other illnesses; however, such opportunities have grown appreciably.

It is more desirable to identify alcoholism early and treat it on an ambulatory out-patient basis than to wait until the medical sequellae become manifest requiring in-patient hospital care under a diagnosis of pathology. It is desirable that treatment programs become accredited as medical entities.

It must be stated here that all treatment programs regardless of the methodology employed owe a large debt to Alcoholics Anonymous, the oldest, largest and the most successful alcoholism therapy program. It is so recognized in medical and psychological circles. The professional literature almost universally recognizes this last.

The membership in Alcoholics Anonymous, hereafter referred to as AA, is probably close to one million. (Even Gottheil states that the AA approach continues to merit our admiration and endorsement.)
Sociologists Harrison Trice and Paul Roman state: "Despite lay leadership, AA has apparently achieved successfully greater results than those of professional therapies." 3

There is a great deal of misunderstanding as to what AA is and what AA does. The therapeutic value of AA has been examined by physicians, psychiatrists and psychologists. It is a simple modality.

An AA member is anyone who considers himself a member. Hence, self-diagnosis. There are no required dues. Contributions are held to under $300.00 a year. Instead of solely using professional therapists, the members help each other. Alcoholics are available to come to the aid of others. The treatment is nothing more sophisticated that the gathering together of alcoholics who share their histories and admit to themselves and to each other that they are powerless to control their drinking. There are certain practices which have become established as part of the therapy.

1. Ninety meetings in ninety days.

2. Members are urged to attend meetings whether they feel the need or not.

3. In the later years of their sobriety, assuming that it has been maintained as a continuum, members meetings as they feel the need,
but never less than once a week.

**Conclusions**

(1) Detoxification is vital to the alcoholic's recovery, but insufficient alone to maintain the recovery.

(2) The total health of the alcoholic is important and no detoxification process should be undertaken without a thorough health evaluation and follow-up.

(3) Rehabilitation may employ a variety of modalities to sustain the sobriety of the alcoholic, but one constant is to be found in most treatments: the alcoholic must totally abstain from the use of alcohol. There is no possibility of occasional, or social, drinking, by the alcoholic with safety.

(4) Alcoholics Anonymous is generally viewed as the most successful of all rehabilitative modalities and is viewed by the health profession as the best means for the maintenance of sobriety.
CHAPTER V

ALCOHOLICS ANONYMOUS

"God grant me the serenity to accept
the things I cannot change,
Courage to change the things I can,
And wisdom to know the difference."
--Alcoholics Anonymous "Serenity" Prayer

Is Alcoholics Anonymous significantly different from other therapeutic entities? Is AA, as it is commonly called, genuinely unique as to method and substance?

It is obvious from the previous chapter that a number of differing modalities exist, but the goals are the same and the essential differences are limited to "tapering off," aversion methods, "cold turkey" with help from other drugs or "cold turkey" without drug assistance plus counseling. Whatever method is employed, breaking the continuum of alcoholic dependency is the goal.

It is the experience of the sample that "cold turkey," i.e., cessation of drinking any alcohol as quickly as possible is the most effective.

(1) Seventy-four (54 percent) abruptly stopped drinking and endured severe withdrawal symp-
toms.

(2) Thirty-one (27 percent) progressively reduced their drinking over a period of five to seven days and experienced severe withdrawal symptoms.

(3) Thirty-two (24 percent) required over five days to stop drinking and experienced severe withdrawal symptoms.

It is noteworthy that the entire sample regarded the "stress of withdrawal" as a beneficial experience, serving as a reminder that the pain of withdrawal was traumatic and to be avoided if at all possible.

The high regard the medical profession has of AA has been frequently expressed. Dr. Marvin A. Block, past chairperson of the American Medical Association's Committee on Alcoholism states:

Perhaps the most effective treatment in the rehabilitation of the alcoholic is a philosophy of living which is compatible with the individual and his family, an absorbing faith in himself which comes only after he has learned to understand himself, and a close association with others whose experiences parallel his own. The physician's cooperation with Alcoholics Anonymous is one way of obtaining these things for his patient. There are enough chapters of this organization for any physician to contact them on behalf of his patient, and he will find them willing and able to help the patient at all times. Their thorough understanding of what the patient is experiencing cannot be overes-
timated, and their sympathetic attendance at trying times is of great therapeutic value. In cooperation with the physician, AA forms an indispensable adjunct to the treatment of alcoholics and . . . they help to give the patient a faith in himself and his fellowmen which is often lacking in alcoholic individuals.

Dr. Karl Menninger of the Menninger Foundation, Topeka, Kansas, has expressed his view of Alcoholics Anonymous in these terms:

I have the utmost respect for the work AA is doing, for its spirit, for its essential philosophy of mutual helpfulness. I lose no opportunity to express my endorsement publicly and privately where it is of any concern.

A similar tribute has been voiced by Dr. Merrill Moore of Boston, Massachusetts, who has had extensive experience in the treatment of alcoholics:

From the beginning I have believed strongly in Alcoholics Anonymous and have supported it as an indispensable member of the therapeutic team. The cooperation of Alcoholics Anonymous with physicians also is valuable and commendable.

Dr. John L. Norris, nonalcoholic, then chairperson of the board of trustees of Alcoholics Anonymous, made the following comments to a gathering of the American Medical Association in Washington, D.C., October 1973:

The goal of treatment for the alcoholic
person must be lasting recovery—physical, emotional, spiritual, and social. Recovery requires a remolding of the personality into a constructive pattern of life with meaningful others. It is this molding through time, persons, and society which is the core of treatment. This, Alcoholics Anonymous has provided for hundreds of thousands of people now leading happy, constructive lives.

The following suggestions are made to facilitate working with Alcoholics Anonymous.

1. Remember that we professionals are students, learning from the experience of others. Changed lives are facts that our theories must include.
2. Call the central office of AA in your home community, introduce yourself, and make an appointment to meet several members.
3. Attend meetings, so that you may know the kinds of groups and types of meetings available. At meetings, you will find people you may call upon to help with patients whom you wish to introduce to AA.
4. Become familiar with AA literature, and make it available to your patients.
5. Time spent in going to an AA meeting with your patient may be time well spent—saving your time in the long run, and improving results.

As a final medical endorsement the quotation from AMA's Manual on Alcoholism: "One of the organizations most successful in helping alcoholics has been Alcoholics Anonymous, self-help group started in 1933."¹

The sources of AA's success are conspicuously avoided in the manual.

What is AA?

AA's statement of purpose and function is accurate
and efficient: "Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism."

AA is not associated with any religious or political group and avoids controversy.

The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership: we are self-supporting through our own contribution.

AA is not allied with any sect, denomination, political organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety."2

The AA program of therapy is The Twelve Steps:

"(1) We admitted we were powerless over alcohol, that our lives had become unmanageable.

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

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

(4) Made a searching and fearless moral inventory of ourselves."
(5) Admitted to God, to ourselves, and to another human being, the exact nature of our wrongs.

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

(7) Humbly asked Him to remove our shortcomings.

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

(9) Made direct amends to such people wherever possible except when to do so would injure them or others.

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

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

(12) Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.³

Coupled with these twelve therapeutic steps are the Twelve Traditions:

"(1) Our common welfare should come first. Personal recovery depends upon AA unity.
For our group purpose there is but one ultimate authority, a loving God as He may express Himself to our group conscience. Our leaders are but trusted servants; they do not govern.

The only requirement for AA membership is a desire to stop drinking.

Each group should be autonomous except in matters affecting other groups or AA as a whole.

Each group has but one primary purpose to carry its message to the alcoholic who still suffers.

An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.

Every AA group ought to be full self supporting, declining outside contributions.

Alcoholics Anonymous should remain forever nonprofessional but our service centers may employ special workers.

AA, as such, ought never be organized, but we may create Service Boards or committees
directly responsible for those they serve.

(10) Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.

(11) Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio.

(12) Anonymity is the spiritual foundation of our traditions, ever reminding us to place principles before personalities.⁴

In addition to the Steps and Traditions, and although not incorporated into official AA literature, are the "slogans" which exercise great influence on the members: Think, First Things First, One Day at a Time, Easy Does It, But for the Grace of God.

It would be inappropriate to comment further on the AA therapy without the reader having previously informed himself about AA through the "basic" books Alcoholics Anonymous and Twelve Steps and Twelve Traditions.

AA Success and AA Uniqueness

No single entity has done more to rescue individuals from alcoholic destruction than AA. No combination of statistics from any rehabilitation or detoxification
center concerning the maintenance of abstinence even approaches the success of AA.

Twenty years ago it was a frequently expressed opinion in AA that of every four who tried AA, two succeeded, one would have difficulty for a period of time, and one would be unable to attain abstinence.

There are no figures available concerning those who attained abstinence without AA, i.e., did it on their own by self-imposed denial.

Of our sample of 137, 8 (6 percent) obtained abstinence by medically enforced or self-imposed denial, 129 (94 percent) obtained and sustained their abstinence through AA. These figures cannot be taken as statistically accurate. Many of the 129 came into AA by way of a rehabilitation center which had an AA component of varying importance in the treatment. No satisfactory figures are available as to rehabilitation centers which do not maintain a close relationship with AA. This study found one of the seventeen rehabilitation centers visited that did not have AA meetings held on the premises. But a systematic study does not exist of rehabilitation centers and AA.

However, the sample, although heavily weighted toward AA by numbers, covers a large portion of the United States.
Parenthetically, there are three common methods employed by alcoholics to attain sobriety: (1) AA; (2) a medical-psychiatric, or analytic program; (3) self-enforced sobriety, i.e., "staying on the wagon." Of all three, the last named is the most painful and the least successful.

There is considerable evidence that the anxieties, family and/or social problems, and adjustment problems which the abstaining alcoholic faces are overwhelmingly conditioned and in most instances created by the method used in attaining sobriety. The method employed in obtaining sobriety has a direct relationship to the problems encountered after sobriety.

It is obvious that the Twelve Steps do not bear careful scientific scrutiny. But, they are suggestions closely related to current successful psychotherapy in alcoholism treatment.

Groups in AA

AA is primarily dependent upon group development. The dynamics of groups are similar. There are a number of theories about group development which do not require comment here, but an AA group moves as a "group" participating in the same dynamics present in most groups.

The groups start as children, experiencing growing
pains as maturity is asserted. The ongoing life is sustained by communication in an atmosphere of indecision and uncertainty. The AA group begins with communication; open, free and usually uninhibited. It is outside the normal consideration of group development without authority figures or directors. Personal relationships emerge; leadership emerges from mutual trust and security coupled with the continuum of sobriety.

There is little evidence of power struggles; AA precludes personal authority.

The methodology of the steps are suggestions, not requirements to be met. The therapy does not move from authority to personal relationships; it starts with personal relationships. The intimacy and individuality are contributors to healthy group relationships. The resolution of the group's problems is usually done as a group entity.

Admission of alcoholism is the only requirement for admission, beyond that single admission no requirements exist.

Disenchantment may occur to an individual: No roles to play, some personal dependency, no structure. High intimacy is encouraged. The alcoholic's resistance to an authority structure is eliminated. Those who avoid intimacy are often regarded by AA members as "in
need." No catalyst is required: the steps serve as the single catalyst.

External factors will play a part: rural or urban areas, the religious convictions of the members, domination by a sex, but since there is no agenda, either implied or supplied, stress is usually minimal.

There is no distribution of power because no power exists. There is no dependence on leaders as there are none. It is in many ways a safe home to members. Although individuals may be assertive, one speaks through and of his own experience which permeates the entire group. Of the sample, many of the most educated have been helped greatly by near illiterates. There is no required activity, thus avoiding self-consciousness and self-aggrandizement. There are no goals other than the individual's maintenance of sobriety. Rebellion is low, although there may be arguments. Cliques may develop, but they are usually short-lived. There are dissatisfied members who may form their own group, or withdraw from a group.

The AA group experience is unique. The group is a gathering of these who have discovered that they cannot control alcohol and their lives have become unmanageable. They, as individuals, must be continuously abstinent if they are to avoid the con-
sequences of this "fatal, incurable illness."

It is the conclusion of this study that there is only one therapy by which the drinking alcoholic can be helped: he must become an abstainer. The abstaining alcoholic can be counseled; the drinking alcoholic cannot benefit from counseling.

We are not concerned with counseling alcoholics who continue to drink. This decision is not because of a lack of concern, it is simply that the drinking alcoholic cannot successfully deal with the problems of human adjustment while he continues to drink. Denial, chronic fantasizing, low self-esteem, paranoia, anxiety, etc., are dominant, preventing honest communication.

AA as a counseling mechanism is without reservation superb. The group therapy is efficacious simply because it works. To repeat, it has an impressive history of helping people achieve abstinence. Its present membership is estimated as between 600,000 and 1 million members, no accurate figures are available. There is no American area without AA availability.

There is also a program for "loners" who are unable because of illness or remoteness to attend AA meetings.

One cannot evaluate the counseling function of AA except by examining its stated steps toward sobriety. The membership is enthusiastically supportive of the
program. To them, AA is the Twelve Steps. It involves one-on-one counseling, but it is primarily by the group process that positive results are obtained.

**Evaluating AA Counseling**

To evaluate the counseling efficiency of AA requires an examination of the Twelve Steps with some objectivity:

**Step One:** We admitted we were powerless over alcohol—that our lives had become unmanageable.

During the compilation of this work, not one abstaining alcoholic was found who did not accept this step without reservation whether he had become abstaining through AA or not. A few were found to be on medication, particularly anabuse, to help them maintain abstinence, but anabuse was regarded by most as a crutch to give the alcoholic time for full acceptance of the first step.

Step One is a powerful statement and demands of the alcoholic a surrender. It is most difficult to admit to being powerless over destructive behaviors. From a few heroin addicts interviewed at various hospitals, this admission was relatively easy to obtain. The addiction was overwhelming. They knew they were powerless.
But the alcoholic lives in a society in which alcohol consumption is regarded with approval. He is dependent. To deny that one is in control of a substance that is controlled by the majority of people, and used by approximately half of them, is to require a most difficult decision.

But the surrender must be made if one is to control the illness.

It is often humiliating to one's self and there is resistance to the admission. It is an easily hidden illness; it can be hidden in the home, at work, and the social disintegration may not be obvious to non-alcoholics for a long period of time.

With the admission is the insistence that every AA must first hit a "bottom"? From the interviews in this study it was confirmed that few will sincerely try the first step without hitting bottom. If there is a chance to drink successfully the chance will be sustained.

A "bottom" is that point in life when the alcoholic believes that he can go "down" no further, that his degradation is so great that he prefers death to a life of alcoholic dependency. Bottoms can be classified.

(1) Financial ruin is so overwhelming that the economic disaster is unbearable by the alcoholic.
(2) Family disintegration is irreparable and the alcoholic is the cause.

(3) Mental disorientation is so great that the alcoholic is convinced of his insanity.

(4) Emotional distress is so great that death is preferred over life.

(5) Physical impairment is chronic and acute and a life of institutionalization is the only prospect.

(6) Social rejection and social demands for incarceration have been exercised or soon will be.

(7) Suicide has failed.

(8) If none of the above, singly or in combination, have occurred, the conviction that one or more will occur, can produce a "bottom."

The AA common phrase is, "I became sick and tired of being sick and tired."

Few doctors have made a longer or more intensive study of AA therapy in action than the late Dr. Harry M. Tiebout, of Greenwich, Connecticut. His paper "Therapeutic Mechanism of Alcoholics Anonymous," originally prepared for the 1943 meeting of the American Psychiatric Association, marked a milestone in growing medical understanding of AA.
As a psychiatrist, Dr. Tiebout had been interested in one element of the AA program: the fact that alcoholics who hope to recover must "surrender," without reservation, their irrational desire to "run things," to dominant events and people.

Dr. Tiebout's observations had convinced him that "compliance" with the AA program is not always enough for the alcoholic. He must be willing to admit total defeat before he can move toward recovery.

One fact must be kept in mind, namely, the need to distinguish between submission and surrender. In submission, an individual accepts reality consciously but not unconsciously. He accepts as a practical fact that he cannot at that moment conquer reality, but lurking in his unconscious is the feeling 'There'll come a day'--which implies no real acceptance and demonstrates conclusively that the struggle is still going on. With submission, which at best is a superficial yielding, tension continues. When, on the other hand, the ability to accept reality functions on the unconscious level, there is no residual battle, and relaxation ensues, with freedom from strain and conflict. In fact, it is perfectly possible to ascertain to what extent the acceptance of reality is on the unconscious level by the degree of relaxation which develops.

Dr. Tiebout applied this basic concept to alcoholics in these terms:

An alcoholic, at the termination of a long and painful spree, decides that he has had enough. This decision is announced loudly
and vehemently to all who will listen. His sincerity cannot be questioned. He means every word of it. Yet he knows and so do those who hear him that he will be singing another tune before many weeks have elapsed. For the moment, he seems to have accepted his alcoholism, but it is only with skin-deep assurance. He will certainly revert to drinking. What we see here is compliance in action. During the time when his memory of the suffering entailed by a spree is acute and painful, he agrees to anything and everything. But deep inside, in his unconscious, the best he can do is to comply—which means that, when the reality of his drinking problem becomes undeniable, he no longer argues with incontrovertible facts. The fight, so to speak, has been knocked out of him. As time passes and the memory of his suffering weakens, the need for compliance lessens. As the need diminishes, the half of compliance which never really accepted begins to stir once more and soon resumes its sway. The need for accepting the illness of alcoholism is ignored because, after all, deep inside he really did not mean it. Of course, consciously the victim of all this is completely in the dark. What he gets is messages from below which slowly bring about a change in his conscious attitudes. For a while, drink was anathema, but now he begins to toy with the idea of one drink, and so on, until finally, as the non-cooperative element in compliance takes over, he has his first drink. The other half of compliance has won out; the alcoholic is the unwitting victim of his unconscious inclinations.

It is only when a real surrender occurs that compliance is knocked out of the picture, freeing the individual for a series of whole-hearted responses—including, in the alcoholic, his acceptance of his illness and of his need to do something constructive about it.

When the victim of the illness is ready to do anything to lift the obsession and compulsion then the first step is operative. He surrenders.
Of our sample, it is interesting to note that two of the self-abstaining alcoholics admitted they were "probably powerless" over alcohol but all four admitted their lives had been unmanageable.

Step Two: Came to believe that a Power greater than ourselves could restore us to sanity.

Members of AA usually approach this step within the context of their acquired religious beliefs. Of our sample, 31 (23 percent) spoke of the power of the group or of the power of another individual who assisted them along the way as their Power.

From the sample, 28 (20 percent) do not believe in a personal God. Fewer than half of this group had admitted such a conviction in an AA meeting and generally avoided the issue of a Power intervening in their lives.

The literature of AA does not demand that anyone believe in anything. The Twelve Steps are regarded only as suggestions. Yet meetings from coast to coast are filled with members who speak warmly and convincingly of the intervention of an external mystical Power that had brought them to AA and had provided the assistance needed to get them sober. In Roman Catholic dominated communities this is most apparent. In Protestant dominated communities the comments were less emphatic, but seemingly represented the views of the majority of the
members.

The principal slogan of AA is "But for the Grace of God." It is no trivial slogan as the phrase is rote-ly repeated by many members. The sign usually hangs in the most conspicuous meeting place. The Grace of God, i.e., an unmerited gift from God, gave these members AA sobriety.

In fairness, the literature of AA gives assurance that the quest for spiritual assistance may travel in-numerable paths.

There is an implied threat in the AA literature that if one does not find a faith, usually regarded by the membership as a belief in an interventional God, the result is drunkenness.

The alcoholic is a defiant person and the literature of AA suggests that this defiance is a barrier to becoming sober. To most AA members the acceptance of a "will of God" is basic. To repeat, 28 (20 percent) of our sample had no belief in a will of God that would direct their lives. Of that group perhaps the most trenchant statement was, "If it was the will of God to get me sober, it must have been the will of God to get me drunk. I can't believe in such a God."

Not included in our sample are seventeen interviews with alcoholics who were still drinking. All suggested
that they had rejected AA because of the rejection of "That damn God business."

If one can and does admit of a Power greater than himself, he introduces humility.

The self-centered qualities of the alcoholic are tremendous, a reduction of his own sense of importance by a surrender to the presence of the illness and of a need for help, from whatever source, may be the beginnings of his acceptance of Step Two. Forty-three (31 percent) of our sample stated that they translated the word Power into the "power of the group" and had submitted themselves to the group dynamic which provided them with the necessary ingredient of self-surrender.

However, it must be noted that the dogmatic, fundamentalist, orthodox statements of many AA members causes many an alcoholic to reject the program as a theistic one. It is suspected that theism is the single most important factor accounting for the failure of AA to help those who reject it.

The literature of AA is so vague and amateurishly written regarding Step Two that in some instances it results in confusion rather than clarification.

AA is predominantly white, orthodox, and formalized as to concepts of God. Power as a substitute for God is made without embarrassment by the literature of AA.
Howard Thurman, former Dean of Boston University Chapel, in a talk once said, "In our time the only place where a man can find refuge is in another man's heart." Roman Catholic, Baptist, Unitarian, agnostic or atheist, the Power could be located there. But in AA, with its often meandering and precociously sentimentalized writings on Power as a will of God, this view is for a substantial number an alien thought.

The sample was questioned as to what they thought the Power greater than themselves was. It was further requested that they indicate whether or not they were comfortable in AA with their description. None expressed dissatisfaction with their view of the Power, but the divergence of views in AA is significant, indicating a looseness of definitions which permits greater comfort. The "Big Book," Alcoholics Anonymous, does not lay down definitions and the step itself neither prescribes nor proscribes.

(1) Power was thought to be an interventive God who directed and controlled the alcoholic's life by the exercise of His Will. (76) (55 percent)

(2) Power was the group. (In some instances an individual in a group.) (32) (23 percent)

(3) Power was thought to be a God (elaborated as
a spirit or order), but non-interventive.

(26) (23 percent)

(4) Power was a mystery, incapable of description.

(3) (2 percent)

There is a curious statistical over-lay by the panel in that 48 (35 percent) of the sample described themselves as "agnostic."

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

There is little room for variation here.

However, a trial at variation can be made. The most useful statements from AA literature lead to a conclusion that each decision regarding drinking has led the alcoholic to turn his life over to the care, protection and guidance of God.

The question emerges as to whether AA is a Providence or not. Seventy-two (53 percent) described AA as God-given.

Although AA accepts the illness definition of alcoholism, there is much palaver concerning self-will as a cause of the illness. The interchange between cause and effect is cloudy.

Perhaps AA is a soteria.

A soteria is a converse of a phobia. The term was coined by Laughlin in 1956 to describe the dispropor-
tionate comfort some people get from certain objects or situations. The word derives from the Greek *soteria* denoting a festive entertainment given on a person's recovery from illness or escape from danger.

Examples abound: toys, stuffed animals, talismans, and charms. Phobic patients may develop a soterial attachment to an object or a situation which reduces their fear, e.g., some get comfort from carrying around a bottle of smelling salts in case they feel the danger of fainting, while others are comforted by the knowledge that they have a supply of sedative drugs in their pocket, and this reassures them without their having to take the drug. The same soterial attachment to alcohol occurs occasionally with the alcoholic.

If one attends an AA meeting, the quantities of coffee and carbonated beverages consumed is startling to the non-alcoholic.

Within the terms of Step Three, the meeting is the soteria, the feelings of membership is the soteria, and the group membership is the soteria.

This is not an adverse criticism, but it is a recognition that the practice of Step Three is largely a device with which one can set aside problems which seem at the moment to be unmanageable.

Bitterness, envy, anger, financial insecurity,
panic, loneliness can be placed aside for a while while
the process of self-management is attempted.

It is here that the Serenity Prayer which opens
this chapter can be a practical device to alleviate the
distress.

Of the sample, 61 (45 percent) stated that the
Serenity Prayer was the most useful device in dealing
with their capacity to surrender to a "will" that might
in AA terms be expressed as the Will of God.

Despite the orthodox and dogmatic statement by AA
that "Our whole will had been the misuse of will power.
We had tried to bombard our problems with it instead of
attempting to bring it into agreement with God's inten-
tion for us"\(^6\) and the unctious assumption that the
will of God is an absolute, a member of AA spoke the
following words which can be of help to the person un-
willing to accede to the laborious and vague statements
of AA.

I want the mind to be free to soar beyond
the coercions and crudities that inevitably
beset all orthodoxies;
I want the heart free to extend that
larger love to all men, unencumbered by no-
tions of dogma, tradition, race, religion,
country or class.
I want to be free to work and create for
the cause of brotherhood and the hope of
peace.
I want my spirit to be free to open,
stretch, discover, develop, deepen, change
and grow, always and continuously and progressively.

I want the rights of individual conscience and action guarded with vigilance, out of the belief in the fitness of diversity, the liberty to be different, out of eternal hostility against every form of tyranny over the mind of man.

I want the resident glory and potential of our ear to be enjoyed and celebrated, not denied or blasphemed in the name of sin or spurious escapes to another world.

I want the promise of man nurtured, supported and blessed, and never cursed, degraded, or despaired of.

I want the faiths by which men live regarded as important enough to be examined and related and checked against the tests of experience, the canons of logic, the methods of science.

I want social action to improve the life of all living things.

I want the whole person entering fully into the spiritual mood without insult to reason or irrelevance to daily life.

I want the whole person to utilize, without reservation or cant, the rich resources of his own best tradition, whatever his particular religious heritage is or is to be.

I want people to be themselves in joy, in sorrow, in the struggle for the Self to be born, in the resolution of some great issue, in the witnessing to high ideals, in living and dying, in seeking and finding and serving.

I want to learn, to grow, to sing, to stand.

I want to be an authentic self.

I want to encounter, reckon, judge, accept and be accepted.

I want to be challenged by new insight and be reminded of what one already knows.

I want to respond to a vision of preciousness, all arts, and other depths.

I want to be with others in co-creating with God, the Mystery.

I want to provide conditions for the coursing of the Creativity which vivifies, heals, and makes all things new."
These statements are precise. Between them and the statements regarding Step Three there may be less of a difference than appears. However, too frequently, the membership of AA takes the Third Step as a literal statement of the conventional orthodoxy of today.

Step Four: Made a search and fearless moral inventory of ourselves.

Unfortunately this word "moral" is confusing. It will serve better to use the word "ethical" interchangeably with the word "moral" to find a common ground.

The AA literature abounds in regarding sexual expression as a moral issue. Because most alcoholics have engaged in uninhibited or bizarre sexual exploitations of others and themselves, it is a disturbing concept. But ethical examination of self is a continuum and a valuable activity for everyone, alcoholic or not.

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

The implications of this step are considerable. Step Three permits considerable variability by the alcoholic in that the thought of God is not sharply defined and the variabilities are such that many, possibly most, alcoholics can maintain some equanimity despite imprecise feelings, agnosticism, or even atheism. The magic phrase is "as we understood Him," although the tradi-
tional, historical and culturative factors are present in the earlier steps. However, Step Five allows for no such variability and it probably causes more defections from AA than the previous steps.

Since AA's inception, this step has had strong religious connotations for members although the reiteration of "spiritual rather than religious" is almost a monody in AA literature and at AA meetings.

Some clarity is possible by referring again to Dr. Tiebout's paper:

A religious or spiritual awakening is the act of giving up one's reliance on one's omnipotence. The defiant individual no longer defies, but accepts help, guidance and control from outside. And as the individual relinquishes his negative, aggressive feelings toward himself and toward life, he finds himself overwhelmed by strongly positive ones such as love, friendliness, peacefulness and pervading contentment, which state is the exact antithesis of the former restlessness and irritability. And the significant fact is that with this new mental state the individual is no longer literally 'driven to drink.'

The therapeutic value of the Alcoholics Anonymous approach arises from its use of spiritual force to attack the fundamental narcissism of the alcoholic . . . In other words, AA relies upon an emotional force, religion, to achieve an emotional result, namely, the overthrowing of the negative, hostile set of emotions and supplanting them with a positive set in which the individual no longer need maintain his defiant individuality, but instead can live in peace and harmony with and in his world, sharing and participating freely.
Dr. Tiebout emphasized that there is "all the difference in the world" between a true spiritual motivation and the vague, groping, skeptical intellectual belief which passes as a religious feeling in the minds of many people.

Regardless of his final conception of that Power, unless the individual attains in the course of time a sense of the reality and nearness of a Greater Power, his egocentric nature will reassert itself with undiminished intensity, and drinking will again enter into the picture. Most of the individuals who finally reach the necessary spiritual state do so merely by following the Alcoholics Anonymous program and without ever consciously experiencing any sudden access of spiritual feeling. Instead, they grow slowly but surely into a state of mine which, after it has been present for a time, they may suddenly recognize is greatly different from the one they formerly had. To their surprise, they discover that their point of view and outlook have taken on a very real spiritual coloring.

Tiebout, despite his assurance, is concerned with an inexactitude which will remain clouded.

Too much has been the subject of speculation over the past five thousand years for this step to be taken literally. However, it suggests what counselling is about: venting of feelings.

Step Six: Were entirely ready to have God remove all these defects of character.

What is character? What is a character defect?
As to admitting such defects to God we have the peculiar situation of asking the unknown to remove the unknown from the unknown.

Of course, what is desired is a revised set of personal values and the expectation that "God" can remove those which are disturbing and that a new set will be mysteriously created as a replacement in a repetition of thee religiosity boldly stated in Step Five.

The sample was questioned as to their views of Step Five and Step Six which are so closely linked.

**TABLE 5**

"Do you find Step Five effective in either acquiring sobriety or maintaining it?"

<table>
<thead>
<tr>
<th>%</th>
<th>N</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>59</td>
<td>Yes, I accept the step without reservation.</td>
</tr>
<tr>
<td>25</td>
<td>34</td>
<td>I accept the step but my relationship with God is such that it is unimportant to me except for the admission to another person.</td>
</tr>
<tr>
<td>23</td>
<td>31</td>
<td>I've never taken the step in a formal sense.</td>
</tr>
<tr>
<td>14</td>
<td>19</td>
<td>I've used the step only in relationship to another person.</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>Unclear response.</td>
</tr>
</tbody>
</table>
TABLE 6

"Do you believe God can remove your defects of character as stated in Step Six?"

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>68</td>
<td>Yes.</td>
</tr>
<tr>
<td>28</td>
<td>39</td>
<td>No.</td>
</tr>
<tr>
<td>22</td>
<td>30</td>
<td>Ignore the step or do not accept it.</td>
</tr>
</tbody>
</table>

Step Seven: Humbly asked Him to remove our shortcomings.

The identical comments that are made in reference to Step Six can be made in reference to Step Seven. The responses to questioning were within one percentage point of the Step Six responses.

AA literature mentions that the chief activator of our defects has been "self-centered fear"—primarily fear that we would lose something we already possessed or would fail to get something we demanded. "Living upon a basis of unsatisfied demands, we were in a state of continual disturbance and frustration." 8

However, regardless of the power of the fear and frustration, it would seem to be more practical to extinguish the fear and frustration through a sharing process with another person. It is possible that He won't, doesn't want to, or doesn't know the alcoholic has them.
Step Eight: Made a list of all persons we had harmed, and became willing to make amends to them all.

A good step for everybody if he knows whom he has harmed. The ones that come to mind and can easily be determined can be dealt with. It provides a therapeutic relief.

Step Nine: Made direct amends to such people wherever possible, except when to do so would injure them or others.

A reasonable step for everybody.

Step Ten: Continued to take personal inventory and when we were wrong promptly admitted it.

Another reasonable step for everybody.

Step Eleven: 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.

This step is strongly related to Steps Two, Three, and Six. The same questions come to mind.

Prayer is aspiration as well as communication. Despite the urging by many members of AA that one must get on his knees in the morning and night, 62 (45 percent) stated that they did not do so, and would not do so, meditation is therapeutically valuable. Later comment will concern itself with this step.
Step Twelve: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice the principles in all our affairs.

It is strongly suggested here that if the client has attained sobriety and is on his way to sobriety there is a "paying back." It produces a sense of satisfaction for the alcoholic that makes the effort more fulfilling and elevating.

The AA program is based upon the acceptance by the membership of certain "spiritual" values: a concept of accepting a Power greater than one's self as necessary for abstinence. However, the individual member is free to interpret spiritual values as he thinks best, or not consider them at all if he so elects. The literature, although dogmatic, acknowledges that the individual alcoholic is free to accept and practice the steps within the parameters he chooses.

The most common transference occurs when the alcoholic regards alcohol as a power greater than himself and transfers the control of his alcoholic dependency to some other "higher power." As previously stated, this may be God (either interventive or non-interventive) or in many instances be the group itself.
Conclusions

(1) Alcoholics Anonymous is the most effective instrument for the alcoholic to break the continuum of alcoholic compulsive-obsession.

(2) Despite the seemingly dogmatic statements of AA's Twelve Steps, neither the literature of AA nor the "official" programs of AA prohibits great flexibility to the individual alcoholic to adopt himself to the "program" or the "program" to himself.

(3) The capacity for a diversified perception of AA's steps is supportive to a substantial number of alcoholics.

(4) The failure to perceive the opportunity for diversification may diminish the alcoholic's capability of response to the "program" or the acceptance of the superficial dogmatism may in itself be a reinforcement of the need for a stable "program" for initial sobriety.

(5) The area of greatest confusion concerns the "spiritual" aspects of AA's therapy.

(6) The group therapeutic model is helpful but may be insufficiently responsive to the alcoholic.
CHAPTER VI

SOME CONSIDERATIONS OF A HUMANISTIC, EXISTENTIAL, CLIENT-CENTERED APPROACH TO COUNSELING THE ABSTAINING ALCOHOLIC

Woe to the man who seeks to shed a brilliant light in a place where people want to keep in darkness and shadow. --Benedetto Croce

Definitions limit, but there are two that should be made at this time and the limitations are necessary.

(1) Sobriety is a state of total abstinence from the use of any drug for recreational purposes and the sustained avoidance of any drug for changing of the emotional in-scape of the user. Tranquilizers and sedation drugs for precise medical treatment following strict medical instructions by a physician do not break a "sobriety continuum." Sobriety is continuous. Sobriety ceases with the intake of any alcohol or substitute for recreation. Sobriety may be restored by a resumption of abstinence for a substantial period of time.

(2) "Being sober" is a state in which one may or may not totally abstain on a continuum. "Being sober" may be of short or long duration;
it may occur frequently, interrupted by periods of recreational drug usage.

The Thirty Day Period

Our concern is with the alcoholic client who has remained sober for a minimal period of thirty days, and whose intent is to achieve sobriety during the foreseeable future.

The abstaining alcoholic by this definition is one for whom a period of at least thirty days has been alcohol or substitute free and expects to remain alcohol or substitute free.

We are concerned with the maintenance of sobriety and the counseling of the client concerning his adjustment that may be encountered from the experience of sobriety.

The Thirty Day Requirement

There is a time span needed for the alcoholic to attain some cognitive, emotional and physical stability; the time required is for the purpose of attaining a state of health when he can be described as "sober," and sobriety is possible. As soon as the alcohol is discharged from the system the user is sober. Thirty days is a minimal period during which the process of
abstaining, however difficult, must be sustained to attain some sobriety. Fewer than thirty days is an extension of "being sober;" more than that time may be an extension of sobriety.

The thirty day period has been determined mainly on the basis of experience in counseling alcoholics. However, thirty days is a reasonable starting point toward the initiation of sobriety. It is an agreed upon figure by 91 (66 percent) of the sample.

There is a catalogue of problems that assail the abstaining alcoholic in the early period of abstinence. The alcoholic frequently discovers emotional distortions for which he wants immediate remedy.

It requires a period of time for the alcoholic to recover from the shock of alcohol withdrawal. The alcoholic has been like a log floating free in a river, going where the river has taken him, incapable of exercising control over the direction, the pausing, the speed or the jamming that has occurred.

As indicated earlier, there is a diagrammatic projection of the process of alcoholism which is generally affirmed as to its accuracy by the sample. From the same source, there is also a diagrammatic projection in attaining sobriety.

(1) The obsessive-compulsive drinking continues
in a cyclical or circular syndrome until the client experiences an honest desire for help.

(2) There is a learning that alcoholism is an illness.

(3) There is a learning that dependency can be controlled and arrested.

(4) Ingestion of alcohol is stopped.

(5) Association with former dependents becomes a normal and a rewarding experience.

(6) Personal assessments followed by a personal inventory is initiated.

(7) The beginning of the elimination of socially dangerous and threatening thinking.

(8) Emotional needs are examined.

(9) Physical examination by a physician is made.

(10) Onset of hope for control and direction.

(11) Start of group therapy.

(12) Discovery of the options for a changed way of life.

(13) Diminishing fears of the unknown.

(14) Systematic nourishment is established as a regular routine.

(15) Beginnings of return of self-esteem.

(16) Diminished fantasy and "realistic" thinking is beginning to be established.
(17) Desire to escape diminishes or disappears.
(18) Establishment of systematic rest and sleep.
(19) Beginnings of adjustment to family needs.
(20) Beginnings of appreciation by friends and family take place.
(21) New interests develop.
(22) New circle of stable friends created.
(23) Re-birth of ethical considerations.
(24) Courage to face facts increased.
(25) Appreciation of human values established.
(26) Increase of emotional control.
(27) First steps toward economic stability.
(28) Confidence of fellow-workers established.
(29) Increased care of personal appearance.
(30) Contentment in sobriety.
(31) Rationalizations are recognized in self and others.
(32) Increasing of tolerance and acceptance of others.
(33) Continuation of group therapy and mutual help to others and other alcoholics.
(34) Enlightened and interesting way of life is open to levels seldom before experienced or possibly imagined.¹

There has been some editing in this listing in
order to simplify some of Dr. Glatt's language. But in
essence, the pattern of recovery follows these steps in
a relative progressive order.

The key points of recovery with this listing are:

(1) The honest desire for help.
(2) The onset of new hope.
(3) The increase of emotional control.
(4) First steps toward economic stability.
(5) Enlightened and interesting options for living.

It is an essential point in the British Journal
listing that before recovery can begin there must be an
admission of defeat. This admission is almost identical
with the first step of AA.

Hence, the insistence upon a period of time for
the alcoholic to become aware of the adjunctive problems
of the illness is important.

The crucial phase of development of alcoholism be-
gins with the loss of other interests other than drink-
ing and extends through tremors and early morning
drinks. The chronic phase begins with the obsession
with drinking and the exhaustion of all alibis. The
rehabilitation process shows greater stability with the
return of self-esteem and continues through the appreci-
cation of family and friends in expressed appreciation
of the effort.

It must be born in mind that the alcoholic is "dependent." He has lived a period of time not only dependent upon alcohol, but dependent upon the success of his denial mechanisms. Denial is automatic when drinking. If the client resumes drinking, the denial is re-stimulated. Hence, denial in this sense is not only denial of the drinking experience but it is also denial of the character of the very emotional problems presented and of the limits, extent and intensity of the problems after drinking has ceased.

From our study of the sample, 130 experienced strong desires to drink during the maddening initial period. There is substantial evidence that the compulsion to drink has persistency, but the compulsion is not consistent. The following table indicates some of the variations in our group:

**TABLE 7**

Compulsion to Drink

<table>
<thead>
<tr>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>130</td>
<td>95</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>77</td>
<td>56</td>
</tr>
</tbody>
</table>

No desire to drink during the initial thirty day period.

Strong desire to drink during the initial thirty day period.

No desire to drink after the thirty day period.

Strong desire to drink after the thirty day period.
TABLE 7, continued

<table>
<thead>
<tr>
<th>N</th>
<th>%</th>
<th>Desired to drink at least once a week for six months following the initial period</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>15</td>
<td>Desired to drink at least once a month following the initial period</td>
</tr>
<tr>
<td>24</td>
<td>18</td>
<td>Desired to drink during first year after initial period and the desire to drink following an experience causing emotional stress after first initial period</td>
</tr>
<tr>
<td>72</td>
<td>53</td>
<td>Desired to drink during first year after initial period when experiencing &quot;unnamed fears&quot; and when anticipating an unpleasant confrontation</td>
</tr>
<tr>
<td>81</td>
<td>59</td>
<td>Desired to drink during first year after initial period when anticipating sexual experience</td>
</tr>
<tr>
<td>79</td>
<td>58</td>
<td>Desired to drink during first year after initial period when lonely</td>
</tr>
<tr>
<td>86</td>
<td>63</td>
<td>Desired to drink during first year after initial period, cause unknown</td>
</tr>
<tr>
<td>92</td>
<td>67</td>
<td>Desired to drink during first year after initial period, cause unknown</td>
</tr>
</tbody>
</table>

These figures indicate that the desire to drink remains for an undetermined period of time.

One of our sample after twenty-four years of sobriety still experienced a desire to drink when in a drinking environment.

It should be noted that the longer sobriety is maintained the frequency of the desire to drink lessens. Of our sample, 48 (35 percent) stated that the desire to drink had not been experienced after a five-year period of total abstinence.

There are additional reasons for the thirty day
delay. There seems to be no precise description that can be given with assurance as to the general behavior of the alcoholic during the initial thirty day period. However, despite the multiple stress situations that may occur during the period, the alcoholic must have a single goal: **total abstinence.** The goal may not be reached: there may be relapses and when these relapses occur, the thirty day period should be started again.

Until a thirty day period has been maintained by the client, there is only one problem for the alcoholic: sustaining and nourishing total abstinence.

During the initial period of "getting sober," the client is assailed by the conventional withdrawal symptoms. In broad terms they involve tremors, nausea, disorientation, depression. Although in some instances if the physical discomfiture is not too pronounced, after a few days a feeling of euphoria is frequently experienced. The period involving the physical adjustment to abstinence varies from person to person, but none of our sample group failed to experience some chronic physical discomfiture. Of our sample group the time for the passage of the physical withdrawal symptoms varied from two days to four weeks. A representative alcoholic probably will require at least one week for physical orientation to abstinence. Regardless of the time required for phy-
sical adjustment, the attempt to deal with any problems other than abstinence will be seriously hampered. The attempt to clarify problems (emotional, physical, financial, etc.) may also present a **prolongation** of the disorientation during the period.

During the initial period, the alcoholic is confused, filled with remorse, and experiences guilt for his past bizarre behavior. He is so physically weakened that he cannot muster sufficient physical or mental strength to sort out his problems.

It is almost universal that he thinks that the problems he is facing are monumental, unsolvable and unique. There is an inhibition of the ability to muster a list of priorities. The response to stress, obligation, responsibility and accountability was alcohol which lessened or eliminated the stress, increased the confidence in the ability to discharge obligation, assured the alcoholic of an adequate assumption of his responsibilities, and enabled him to develop a fantasy that there would be no accountability, but if such accountability should occur, it could be easily eliminated. He was convinced that he could manipulate society, individuals or groups, into achieving his desired goals. Among the sample it was familiar to hear the phrase, "I had the ability to con," or "We are all con artists,"
and "Self-deception was easy."

It is also common during the period of initial sobriety for the alcoholic to convince himself that everyone does what he does, takes the action that he has taken. It is frequently a period of self-justification. It is easy for the alcoholic to develop quickly a sense of self-pity and self-abnegation by referring to his own alcoholic behavior as unusual and particular with the common phrase, "Why did this have to happen to me?"

In short, the initial time is to be used in getting comfortable with abstinence. The alcoholic, if he is responding well, will discover that his behavior was ill, his irresponsibility for the harm done to himself and others was not an ethical failure, there was no "sin," and the triggering of his illness was his taking the first drink. The cliche, "One drink is too many, one thousand is not enough," may then become meaningful and the decision can be reached that the alcoholic is powerless over alcohol and that the unmanagability of his life is a direct result of his alcoholic consumption.

Sedation may be required as insomnia almost always accompanies withdrawal. During this period anemia may be present because of a number of factors, such as neglect of food intake, restriction of folic acid in the
diet leading to its deficiency in the blood, poor absorption of food, liver disease, and suppression of red blood cell formation. The disturbed formation of platelets and white blood cells may be important factors in the alcoholics' tendency to bruise readily and to bleed internally and in their poor resistance to infections. With the resumption of normal food intake and the maintenance of formerly missing nutrients, normal blood formation can start again, once abstinence is sustained. There is always the possibility of polyneuritis, Wernicke's Encephalopathy and a variety of gastro-intestinal disorders.

Time is needed for proper assessments to be made of the physical damage incurred and the adjustment of the body to the radically changed intake method and distribution. A full and complete physical examination during the initial period is valuable.

Time must be taken for the alcoholic to acquaint himself with his changed physical situation. Once the physical and/or psychological assessments have been underway, the alcoholic needs time in order to change his way of thinking: his self, his environment, his interpersonal relationships with others.

Perhaps the first psychological difficulty that the alcoholic will experience is to accept the singular
fact that he is ill, that his behavior is the result of his having acquired an obsessive-compulsive illness which is incurable and if not controlled, probably fatal.

To repeat some previous comments: our social attitudes still regard the alcoholic as a social pariah; the societal attitude toward alcoholism is different from the attitude toward other illnesses, such as diabetes, cancer, or the common cold. Many of our religious bodies, organizations and institutions still maintain the conviction that drinking is a "sin" and the alcoholic is a "sinner." Redemption is to be found from "God" or the minister.

There are incredible societal pressures brought to bear upon the alcoholic to regard his situation as other than the result of an illness. The silly belief that the alcoholic drinks to excess because he lacks "will power" still has considerable acceptance. (The reverse is true: the alcoholic possess an incredible amount of will power in that he will drink in the face of physical, psychological and social disaster. The alcoholic will find a drink when no drinks are available. Four of the sample reported easy access to alcohol in Moslem dominated countries where alcohol is banned; in Iran where Islamic law presumably prevails, there are a num-
ber of flourishing liquor dispensing establishments in Tehran.)

To secure a drink when no drinks are available, that is "will power."

However, the client may very well be one convinced of the truth of such concepts and has applied them to himself. He has been told often that he is a social scavenger. He has, in most instances, regarded himself as such. Wives, children, relations and friends have assailed him as worthless. It is important to note that belief in the existence of the illness does not mean acceptance of the illness in the face of the societal attitudes.

Twenty-three (17 percent) of our sample stated that they knew they were alcoholics when drinking and had given only slight thought as to "how, or why, or extent" of their illness. They assumed that they had "alcoholism": "I am an alcoholic, but I shall continue to drink. I must."

The best description of this attitude can be given in a synthesis of statements by the twenty-three: "I knew I was a drunk. But I also knew there was nothing I could do about it. I had to drink. I knew it was not good for me, but I had to drink. I did not want to have happen what did happen, but I believed that no
matter what I did or what was done by others, I had to drink and I had to continue drinking." Three of our sample used identical phrases: "I thought that if I did not drink, I would die." "I felt that I wanted to die, but I also wanted to live." "I was in agony, I drank to live and I lived to drink."

Learning that he is ill, that his illness is controllable, that the only control of its progression is total abstinence (which he does not believe he can accomplish) produces a disorientation that persists.

During the critical thirty day period the alcoholic may learn that he can live without alcohol happily and with contentment, but it is by no means an assured reaction.

The time span varies radically. From our sample, 17 (12 percent) took as long as six months to free themselves of the continuous compulsion; 21 (15 percent) felt that definite diminution of the compulsion occurred after three months; 39 (28 percent) expressed the opinion that the compulsion did not show pronounced diminution until six months had elapsed; 60 (44 percent) extended the time period to one year or longer. One member of the sample had been totally abstaining for twenty-four years and felt a compulsion to drink "at least once a year."
It can be stated, therefore, with certainty that thirty days is a modest time requirement of abstinence before attempts are made to assist with the collateral problems produced by the alcoholism and/or the abstinence and it is essential to bear in mind that the initial period of abstinence is no more than a preliminary step in rehabilitation and resocialization.

**Nutritive Aspects**

The alcoholic has emerged from a state of starvation: the deprivation of food, vitamins, minerals and proteins, in particular, but also of fluids, rest and sleep. He may have experienced malnutrition, dehydration, salt depletion, and be bothered deeply by restlessness and insomnia. It is useful to know of some of the nutritional support systems that are employed.

James J. Lukes, M.D., Assistant Professor in the Department of Family and Community Medicine and the Department of Medicine at the University of Massachusetts Medical Center, Worcester, and a consultant to the NIAAA and the National Institute of Drug Abuse, in the Springfield Republican, March 9, 1980 writes:

Alcoholism has been successfully treated by the use of niacin, with its Vitamin B3. Niacin seems to contribute to the alcoholic's ability to attain and maintain alcohol absti-
nence by helping to prevent the craving for alcohol. Nutrient programs would involve a high protein diet. Large (mega) doses of niacin, Vitamin C, Vitamin B6 and occasionally Vitamin E have all been used successfully in treating more than 5,000 alcoholics in all stages of the disease. Niacin is usually given with equal doses of Vitamin C. It should be administered after meals to minimize flushing and nausea. A person taking niacin treatment is not necessarily taking a "mega" dose at all, but merely the minimum daily requirement for the particular body chemistry. This niacin therapy within the broad spectrum of nutrient therapy which involves the collateral use of trace metals, vitamins and other nutrients in addition to niacin, seems to be far reaching in the number of symptoms of alcoholism that can be alleviated. The alcoholic patient can be placed on a medical regimen consisting of a hypoglycemic or low sugar diet, prescribed rest, exercise and megavitamins. Malnutrition is common among alcoholics because alcohol, which does not contain a significant amount of nutrients, displaces foods containing proteins, vitamins and minerals. Chronic alcohol consumption also results in maldigestion and malabsorption of nutrients. At the same time, it is important to note the contribution that alcohol makes to the daily supply of calories, as every gram of alcohol releases 7 kilo calories of energy. Therefore, an ounce of 100 proof alcohol provides 100 calories and, if used in place of food in one's daily diet, would produce "empty" calories deficient in other nutrients.

It should be noted also that thiamine (Vitamin B1) deficiencies appear in alcohol-abusing individuals due to the inability of the individual to convert thiamine in the intestine, to allow for its absorption. Another B vitamin, riboflavin, may also be deficient. Folacin,
Vitamin B12, Vitamin B6 and iron status may also be deficient in alcoholics. Sodium, potassium and magnesium may also be deficient minerals.

Dr. Lukes concludes:

So, the nutritional status is extremely important in the alcohol abusing individual, and the assessment and corrective measures should be aimed at protein, thiamin, riboflavin, folacin, niacin, pyridoxine, Vitamin B6, Vitamin B12, Vitamin C, Vitamin A, Vitamin D, Iron, Zinc, Magnesium, Potassium and Sodium balance.

As noted previously by Max Glatt: "If the treatment were to stop short at the step of sobering up the drunken alcoholic, unfortunately, as so often has been the case in the past, it would have achieved no more than rendering him fit again to resume his drinking career."  

Cultural Aspects

The intake of alcohol is not always determined by the appetite for ethanol. It can also be a consequence of the acceptance of cultural rules.

In some social groups, of which the abstaining alcoholic will probably remain a member, drunkenness is not only accepted, but constitutes a part of the ritual of celebration, or is considered as an expression of
virtuous virility. In other groups the state of euphoria is a must at social gatherings, because the lack of inhibition allows a greater degree of spontaneity in interpersonal relations. It is clear that in all these circumstances alcohol is taken because of its pharmacological effects. Nevertheless, the motivation of many of those who drink alcoholic beverages in these circumstances is not a true pharmacological appetite, but rather the acceptance of the norms peculiar to a group.

The alcoholic will probably remain a member of the socio-cultural group of which he was a part during his drinking period. From merely admitting to having a drinking problem and, later on to being an alcoholic, to the emotional acceptance of this fact, is a huge step. Not one member of our sample felt comfortable with the personal conclusions regarding self reached during the initial period. The alcoholic has great difficulty accepting the fact that he is an alcoholic "once and for all." Throughout his life this attitude will be challenged again and again; the strength of acceptance will be tested and re-tested on numerous occasions so that the reaffirmation of the progressiveness of the "problem-illness/incurable-illness" which is such a factor in the unmanageability of his life requires persistent attention.
There have been personality deficiencies which have been of great effect in the production of the illness; the deficits may be neurotic and psychopathic, but this knowledge by the victim is of minor importance. Cultural demands further blunt this perception.

Culturally, refuge in alcohol produces the conditions and prevents, paradoxically, the recognition of the conditions.

What is sought through abstinence is a reversal of the alcoholic's use of alcohol as a means of alleviating his anxieties and the satisfaction of his emotional needs by the "non-use" of alcohol as a tool for life or cultural adjustment.

Again, in the words of Max Glatt: "Thus, one of the alcoholic's first tasks is to learn what alcoholism is, that the down-and-out and the surgical spirit drinkers constitute only a small minority among alcoholics and that the great majority still have a foothold at home and at work."³

Vera Efron of the Center of Alcohol Studies, Rutgers University, State University of New Jersey, New Brunswick, New Jersey has capsulized these factors in a paper read at the International Symposium on Alcoholism held in Santiago, Chile, in 1970.

Ms. Efron stated in her paper a number of signifi-
cants factors concerning the etiology of alcoholism.

Excerpts from her comments include:

It is not possible to discuss abuse of alcohol without discussing its normal use. These norms differ widely from society to society, and even among ethnic subgroups within a society; what is considered abuse in one group may be normal drinking behavior in another. [Note: Although not discussed in her paper, drunkenness in Iceland is not only permitted in children, but school functions are frequently held to permit the youthful students, pre-adolescents, to get drunk, i.e., unconscious.] It is normal for an Italian to drink a tumblerful of wine with his midday meal, but it would seem suspicious behavior, indeed, in many North American groups. The taking of cocktails before a meal and without food is regularly done by many North Americans but would be highly deviant behavior, especially for women, among Russians who always have a bit of food with their vodka, even just a crust of stale bread, if nothing better is available.

Drinking customs in some groups are accompanied by well-defined ritual, either specific to the drinking or related to some other forms of societal customs. Or drinking may be restricted to certain occasions, such as weddings, or fiestas, as in Latin America. The rituals which accompany drinking may be simple or elaborate. [There follows a description of a formal drinking occasion in Tbilisi, Georgian Soviet Republic, U.S.S.R.]

... Examples of differing customs which accompany drinking can be multiplied almost indefinitely. And so can examples of individual drinking behavior which fall within the norm of one group but are deviant to another. As the norms differ, so the abuses take on different forms. 4

Efron's paper suggests a striking example of the rejection rates of military recruits in the Boston area
during World War II. The same rejection standards for alcoholism were applied to all ethnic groups, but the rates were 3 percent among the Irish, 1.2 percent among the Italians, and 0.2 percent among the Jews. The Irish rejection rate for alcoholism, in other words, was more than twice that of the Italians and 15 times greater than that of the Jews. 5

We are concerned here with what happens in America, and it should be emphasized that what "works" in America will not necessarily work with other countries.

It is well known by counselors that alcoholics with a Catholic upbringing do not react to counseling with the same or similar responses as those who come from other or no religious orientation during childhood. The structured Catholic training has a granitic character which persists.

It is, however, the view of this work that all alcoholics are alike in that they are all subject to the laws of nature, both physiological and psychological. Despite the differing paths that alcoholics have followed in reaching a state of life unmanageability and powerlessness over alcohol, they end up with attributes which are the same throughout the world. The effects of alcoholism are the same among Protestants and Catholics, agnostics, atheists and the unaware. Rich or
poor, educated or non-educated, intelligent or stupid, culturally receptive or isolated, the alcoholic drinks repetitively in a way that suggests there is something wrong about his drinking and the injury that he experiences does impair his health and his social and economic functions. What unites all alcoholics, from whatever area, is their helplessness in the face of alcohol (loss of control or inability to abstain) and their suffering because of it. These are universal elements confirmed by too many studies to enumerate here.

The goal is not to be less miserable, but to be free, with serenity in sobriety. However, in the initial stages he encounters his personality deficits and more importantly he begins the long and difficult process of gaining his satisfactions from working towards the realization of his "real self" as Karen Horney or Mazlow would describe it. He must accept the hope, in vain, of becoming his "glorified self."

Thus far we have considered the necessity for a period of abstinence by the alcoholic, the goal of counseling during the initial period, the acceptance of his illness by the alcoholic and his awareness of powerlessness, the physical impairment that needs consideration and an awareness that the illness is affected by cultural, societal and familial attitudes.
This effort has been made to prepare the counselor for a clear perception of factors which produce the need for help. Further analysis will be attempted at this time to prepare for a modality of counseling that is effective in assisting the alcoholic toward the eventual goal of self-actualization or possible a preferred statement: serenity.

Abstaining alcoholics learn quickly that regardless of their past experiences, encyclopoedic in variety, there are sufficient similarities in their histories which not only describe accurately how they felt prior to the self-recognition of their illness, and which persist after they have maintained a period of abstinence.

In addition, alcoholics drink in a variety of modes: there is the daily drinking who is in an alcoholic haze during his waking hours; there is the "binge" alcoholic who will abstain from alcoholic consumption for a period of time, ranging from five days to two or three months, and then drinks around-the-clock until his body refuses to take the alcoholic input and he is forced by physical incapacity to taper off to abstinence; there is the "binge" drinker who may go for as long as eighteen months without drinking and then drink around-the-clock until he is hospitalized and detoxified; there is the erroneously described "control"
drinker who drinks only on week-ends when his drinking does not conspicuously interfere with his work; and there is the alcoholic who may from time to time behave as each of these groups or all of them, varying his drinking from mode to mode.

The point being stressed is that there is no satisfactory explanation of a pattern of alcoholic history, behavior or drinking, but there are commonalities permitting group understanding. As previously mentioned, there is a mosaic of drinking behavior and formalization as to drinking habits, patterns, etc., are not significant.

This work, therefore, assumes that there is a self which has been damaged by alcohol to such an extent that the alcoholic joins the subgroup known as alcoholics.

Of our sample, extensive and intensive questioning was done to determine what commonalities in attitudes, opinions, feelings, expressions of behavior, etc., persisted.

In the discussion which follows, these commonalities have been sorted.

The question asked of the sample was a simple one: "Can you tell me what feelings you experienced when you were drinking which still persist? I am interested in those feelings which were alleviated promptly by your
drinking and which seemed to either diminish these feelings or eliminate them entirely? Use your own words, but do not attempt to explain or define the words."

The 137 who were questioned were also asked to list what they considered the most impactive feeling. The listing and discussion which follows is the result, with the most frequently expressed self-generated opinions.

**Frustration**

Each abstaining alcoholic expressed a feeling of frustration during drinking, a feeling which was alleviated by alcohol and one which persisted during their abstaining life.

Despite the often wandering descriptions and/or definitions of what frustration was, it can be generalized that frustration is a condition which exists when goals desired are interfered with.

With this definition in mind, what goals are desired by the abstaining alcoholic causative of frustration. The obvious comes to mind: the goal is continuous abstinence. Any threat to that goal therefore produces frustration.

It is an almost comic aspect of alcoholism that other goals of the drinking alcoholic are often trivial and that any interference is frustrating. Resumptive
drinking can result from myriad frustrations.

One of the sample remembered getting drunk because he broke a shoelace while attempting to dress; another because a plate with the picture of William McKinley painted on it was dropped and broken; another insisted that he missed the anniversary of the founding of the American Crow Hunter's Association and was so frustrated that he could not celebrate on the appropriate day that he drank for a week. He ended the week with four weeks of hospitalization.

On a larger scale however, goals may be subtle or massive: the reality of a marriage that fails to reflect years of a fantasy; the failure of a child to behave as the parent wishes; the employment for a period of time in a job that is beneath the expectations of the worker.

Usually the damage to career development of the alcoholic has been great and employment during abstinence is often at a much lower economic level than achieved during the drinking period. Frustration results.

Dollard has postulated an assumption of a relationship of frustration and aggression; the frustration-aggression theory assumes a causal relationship between frustration and aggression. He states that if the
individual anticipates punishment for a given act of aggression the less likely it is that the act will occur.  

It is interesting that drinking can be assumed to be an aggressive act against one's self and/or others. Incident after incident is reported from our sample suggesting that their previous behavior was to avenge their self perceived frustration with people, places or things. There were also many reports of drinking resulting from frustration caused by environmental factors. (Dislike of the town, isolation on the farm, frustration against a country which does not followed desired political actions, e.g., the Viet Nam experience.)

If Dollard et al.'s theory is sound and further that drinking can be perceived as a possible act of aggression against self provoked by frustration caused by one's self-perceptions of inadequacies, limitations, and dislocations within the individual's personal behavior parameters, alcoholic drinking is self-punishment.

Abstaining may be a calculated and desired frustration. The problem-presentation by the alcoholic then becomes more complicated as he experiences the frustration and attempts to modify or extinguish the aggressive
drinking acts against himself or others.

But sober or not, the alcoholic wants what he wants when he wants it and he wants it now.

**Fear**

As with frustration, the entire sample spoke of a continuum of fear experienced while drinking and continuing following abstinence.

There seems to be no established pattern of fear as to time of day, day of the week, or seasonal factors. It "comes and goes." But it is universally experienced. When the fear is identified, i.e., an attributable cause of the fear is given, it is most frequently financial. The absence of money for debt payment, regular obligations such as mortgage, telephone, utilities, etc., which have frequently been left unpaid for long periods of time produces a fear of objects and communication devices in some instances. It has been noted that the ownership of large sums of money also produced fear of its loss.

Some of the fears experienced are listed.

1. Fear of the telephone. Fifty-one (37 percent of the sample spoke of being unable to answer the telephone while drunk or sober and that the fear of the telephone persisted into ab-
stinence. One member who had been abstinent for over twenty-three years continued to experience fear, bordering on panic, when the telephone rang.

(2) Fear of casual visitors. Forty-two (31 percent) experienced fear when the door bell rang or a strange car drove into the driveway. This fear persisted into abstinence and of the 42, 14 stated that a strange car in the driveway still produced strong feelings of apprehension and they were strongly tempted to avoid entering their own homes.

(3) Fear of confrontation. Sixty-one (45 percent) of the sample experienced fear when superiors at work, strangers, or imagined threatening figures spoke to them or approached them for what might be a casual conversation. Twenty-seven (20 percent) of the sample avoided eye contact during the interview for this study, 41 (30 percent) had difficulty maintaining eye contact for other than brief period of time, usually 10 seconds or less. It is interesting to note that an abstaining alcoholic of over twenty-three years' abstinence still experienced fear when spoken to by a superior
at work and consistently avoided talking with or meeting individuals with whom there might be a confrontation. He noted that he was especially troubled by fear if the matters involved included debt payments, threats to his living comforts, rent, car services, etc.

(4) Scattered fear. There are a variety of scattered fears experienced by the abstaining alcoholic and although our sample is insufficient to extract a statistical indication which can be regarded as valid for all alcoholics, the fear of animals, children, fear of fear itself, fear of cars, traveling, crowds, and a fear of movement were all expressed by one or more of our sample.

An example of this is one abstaining alcoholic who experienced a fear of crowds that would even to the uneducated observer be regarded as neurotic and possibly phobic. She was also frightened of dry food and although she was taking medication in capsules, she would empty the capsule in a spoon, moisten it and then take the medicine. Questioning revealed that she was frightened of swallowing as she related swallowing to death. After seven years of abstinence, she is now able to ride in a car and if her husband will sit beside her,
she will drive the car. Going to the local grocery is a daily traumatic experience for this alcoholic. Incidentally, she can now swallow medication in pill or capsule form without moistening, albeit she experiences difficulty.

It is competent to state, however, that these scattered fears, scattered in the sense that there seems to be little or no relationship of one fear to another, are present in the drinking alcoholic's experiences and persist into the abstinence period.

(5) Unknown fears. Of our sample, 121 (88 percent) experienced during their drinking nightmares, fears on awakening and fears during the daytime hours of the "unknown," i.e., the subject did not know what he was afraid of and could not locate the source of his fear. The descriptive phrases were vague: "I don't know what I was afraid of, but I was afraid," "I was suddenly frightened and I don't know why," "I was afraid of waking up and I was afraid of going to sleep," "I lived a lifetime of being scared." Each of the 121 stated without reservation that the ingestion of alcohol diminished the fear and usually removed the feeling entirely. Abstinence does not always
eliminate the fear, but all 121 stated that after diminishing and then abstaining from alcohol for a period of time that the fear diminished. However, fear of the unknown or an unlocated cause of fear recurs in many instances, but for only a short period of time, and by contact with empathetic and responsive individuals diminishes quickly.

(6) Fear of drinking. Without exception each of our sample continued to experience a fear of a return to drinking. This fear has positive effects on the maintenance of sobriety. One of the sample puts it in an interesting way: "I was for months frightened that I would be struck drunk. When it did not occur after six months, the fear went away and I now know that if I get drunk it will be because of a specific act of my own. The commentator had been abstaining for a period of nine years.

Every man has experienced fear. The word itself comes to us from OE, 'faer' for sudden danger or calamity. In OED it was later used to describe the emotion of uneasiness caused by a sense of impending danger. In ME it denotes a state of alarm or dread. It is a normal response to either an active or an imagined
The subjective feelings are of terror, heart pounding, muscular tension, trembling, dryness of the throat and mouth, a sinking feeling of the stomach, nausea, perspiration, irritability, aggression, the urge to cry, run or hide, difficulty in breathing, feelings of unreality, weakness of the extremities, a sense of faintness. For healthy people there is fatigue, depression, a slowing of mental process, restlessness, aggression, appetite loss, trembling, avoidance of frightening situations, insomnia and nightmares.  

Phobia is a special kind of fear. It can be defined as (1) fear out of proportion to the situational demands, (2) fear that cannot be explained or reasoned away, (3) fear that is beyond voluntary control, and (4) fear that leads to avoidance of the feared situation.  

Phobia produces an overwhelming anxiety, sweating, tremor, pallor, rapid breathing, nausea and vomiting and other symptoms of a more precise physiological nature. Phobic patients have been found to often rehearse their frightening experiences in their minds until they experience fearful anticipation about the next time they will have to meet the object of their phobia.  

Escape from such anxiety and avoidance of the phobic manifestation is a reasonable explanation of the
devotion to alcohol by the alcoholic. It has been noted that phobic patients become married to the phobic object.¹⁰

Fear-ridden people are sensitive to the lack of understanding among "normal" people. From our sample, this view was expressed by every member. They are ashamed of their fears, as has been previously noted, they resent ridicule, and they often suffer in silence. The denial mechanism is so strong among alcoholics that they almost without exception will hide their alcoholic consumption from others. They manifest a suffering in silence and hiding the symptoms from their unsympathetic environment as long as they can. Seventy-four (54 percent) of the sample expressed the opinion that they were mentally disturbed during their drinking and considered themselves insane. It has been reported by Marks that they can obtain great comfort by meeting with other patients with the same phobias and problems as themselves.¹¹

Phobic patients are secretive and the hidden drinker is secretive from his peers, friends and family. (Confirmed universally by the sample.)

We are not concerned here, because of limitations of space, with the physiological changes caused by fear and phobia. However, the components of fear and phobia
are congruent and what a patient says he feels is correspondent to what the counselor observes as visible behavior. There is a subjective inner state felt by the patient and an outer aspect visible to the observer.\(^\text{12}\)

Anxiety is an emotion closely allied to fear and phobia. The word is derived from the Latin *anxius* and dates from the seventeenth century OED when it was used to suggest a condition of agitation and depression with a sense of disturbing suspense.

And, although this historical and immediate comment may have interest to the general, it is caviar to the counselor who is confronted by the alcoholic with a history of fear and phobia. It is suggested that alcoholism may be a manifestation of a phobia. Certainly the research that has been produced could show a relationship of alcoholic response to phobic manifestation.

Because it is impossible to locate the cause of the phobic reaction on the part of the alcoholic, clinical studies of the origins of fear have little value in counseling.

There are innate and maturational elements in fear. The variability among mammals is such that the genetic aspects of timidity are not well known. Further experimentation and knowledge of all three aspects of the etiology of fear are needed.
We do know that fear is an innate emotional response and that it occurs in many situations as we mature and learn, timidity has an important genetic component in animals and probably in man, that situations vary in fear production as a result of innate tendencies to fear particular stimulus configurations rather than particular objects and that some of these fears require maturation before they are expressed.

We also know from studies that in man fears of similar kinds of stimuli occur regularly independent of experience and thus are probably the result of inborn mechanisms that take time to mature. And possibly in adults the traces of the inborn mechanisms are largely obscured or clarified by learned behavior.

There is an enormous amount of literature on the way fears are learned, yet it has been noted that no single theory covers all the data and that the mechanism involved differs from one kind of learning situation to another.

Dollard and Miller have shown that drugs reduce tension in an approach-avoidance conflict. Further they have shown that fear reduction acts as a reward.\textsuperscript{13}

Alcohol is a drug and it reduces fear in animals. Sedative drugs and alcohol reduce fear but do not extinguish it. When withdrawal occurs it is often ac-
companied by a reemergence of fear. The entire sample confirmed this conclusion.

Without detailing the many studies on the subject of fear and phobia, we know that there is a complex of genetic, sexual incidence, psych-physiological factors which have bearing upon fear and phobia.

Whether alcoholism is a learned behavior or resultant from another behavior is still unresolved, but the preceding comments describe with accuracy our sample of alcoholics, all of whom were abstaining and were able to verbalize their experiences of the past. All of them stated that fear was almost always present.

Our sample provides sufficient information to conclude that the single most important emotional conditions present in the alcoholic, abstinent or not, is frustration and/or fear.

If the manifestations of fear are apparently phobic and of such intensity and depth as to warrant clinical intervention, the counselor should be prepared to refer the client to a physician or psychoanalyst capable of dealing with the manifestation. It is strongly advised that the counselor should not attempt to deal with manic-depressiveness, schizophrenic symptoms, or specific phobias requiring medical intervention. The role of the counselor is to assist the client in avoiding the inges-
tion of alcohol and to help him to return to "normal" living within the parameters of a developing self-awareness, self-direction and self-actualization.

**Anxiety**

The entire sample spoke of suffering anxiety during their drinking period and that this anxiety persisted into the abstaining period. Despite the years of abstaining anxiety was a persistent threat and was usually experienced daily. For the alcoholic, drinking or abstaining, anxiety is a constant factor which must be dealt with. In the study of our sample, not one expressed an opinion that he would ever live without anxiety and devoted his attention and effort to living with anxiety as a condition not subject to change.

**Dislocation**

Dislocation is used here to describe in a single word those feelings of being non-associated with an entity with which one cannot escape contact. In general, the sample revealed a high incidence of dislocation, but there was insufficient reference made to a single entity to warrant any conclusion as to what that sense of non-association was directed. Dislocation can be experienced with a variety of entities. The sample
revealed the following:

Those expressing a feeling of family dislocation stated that they did not feel from an early age membership in the family that was on an equal footing with other members. Frequently they were the "scape goats" within the family because of their behaviors exhibited in school, in the community when not in school, or within the family itself. Later, following childhood or adolescence, when drinking became a principal activity in their lives, the non-association was greater and confirmed to them by remarks or behaviors exhibited by other family members. None of the sample asserted that siblings or the lack of siblings seemed to have relevance, although in families where the number of children was two or more they felt that they were regarded as the inferior child. Single child families also communicated similar feelings to the child and the child had a prevalent feeling of being an intruder. In the few members of the sample who were adoptive children, four, all stated that alienation, or dislocation was intensified by knowledge of their adoption.

It is noteworthy also that no member of the sample attributed the dislocation to a single parent, either father or mother, unless one of the two or both parents were alcoholics.
A sense of dislocation within the family was cited as a common feeling and this sense of family dislocation persisted in the abstaining years.

Of the total sample, 121 (88 percent) stated that they had a feeling of dislocation, 41 (30 percent) indicated that it was a dislocation from the family.

During the sampling the same abstaining alcoholic would indicate that the dislocation feeling was generated by the father, then later remark that the whole family seemed to generate the feeling. All of those indicating familial dislocation mentioned a lack of nurturing and love in the family, but did not direct the cause of the lack to a single member except under unusual situations produced by separation or divorce.

It is interesting to note that following abstinence, the number of the group indicating familial dislocation did not wish to maintain close family ties with either parents or siblings. The generalized feeling was that because of their continued effort to abstain they did not want to risk a close relationship with the family and were prepared to maintain a separation from the family in their sobriety. Association with family or siblings was perceived as a threat. Sixty-two (45 percent) had made little or no effort to reestablish close family relationships. If there was a substantial dis-
tance between the alcoholic and the family some effort was made by a few, but the effort was casual.

The feeling of dislocation by the abstaining alcoholic persists. Of the 121, not one expressed a sense of loss of family separation. For many of the 121, substitute families were created and this was particularly true of those who attained their abstinence maintenance through AA.

Some interesting groupings were found in the inquiry:

Of the 121, 40 were only children and 23 of the 40 had been raised by other than the natural parents (adoption, grandparents or institutional care).

Eighty-one came from families with more than one child and of the 81, 34 had more than three brothers or sisters. Of the 34, more than half, 19, had sisters or brothers who were alcoholic and of those who were alcoholic, only 10 percent had been abstaining alcoholics for longer than 90 days.

The causes of family dislocation are obscure. Some of the reasons given by the respondents were:

(1) The family considered me ugly.

(2) The family did not consider me as an equal member with my brothers and sisters.

(3) My father was an alcoholic; my mother was an
alcoholic.

(4) The family did not care about me.

(5) School was a place of horror to me and the family insisted that I go to school without regard to my feelings.

(6) The church was boring. I hated the church and my family insisted that I go to church regularly with them.

(7) My family was always criticizing me for things everyone else did.

(8) My family kept calling me fat.

(9) My family was more interested in television than they were in me.

(10) My brothers and sisters always were treated better than I.

(11) If anything went wrong, I was always blamed.

(12) None of the family let me do anything I wanted to do.

(13) My mother slept with other men.

(14) My father slept with other women.

(15) My family prevented me from bringing home my friends.

(16) My mother and father were always fighting.

(17) Whenever I got into trouble the family got me out of it and then blamed me and punished me.
(18) I was beaten.

However, it can be assumed that familial dislocation is usual with the alcoholic whether drinking or abstinent.

**Anger and Resentment**

The entire sample stated that anger was a genuinely present emotion during drinking and the control of anger was a difficult and an omnipresent problem. The entire sample stated that anger was usually responded to with alcohol and further that the anger was intensified and internalized when drinking, but subjected to control. If, however, the anger was triggered for release, the controls were inoperative.

Of course, anger and hostility are used interchangeably within this work. It is noteworthy that oftentimes when the alcoholic is drinking and expressing ebullience and geniality, he may be masking his hostility which will emerge in hostile verbalizations designed to injure another person.

The generalization of anger is more common with the abstaining alcoholic and is a threat to abstinence:

One of our sample underwent a series of operations which required five months' hospitalization. Although abstinent for over ten years, he dreamed about drinking
and thought about drinking every time a doctor or nurse entered his room. He expressed contempt for the physician, the hospital, the nurses and his family. Although the operations were life-threatening, he steadfastly refused to acknowledge to others that the processes were other than trivial. On emerging from the recovery room after the final operation which required seven hours to complete, his first request, although heavily sedated, was for a drink. He explained his actions later as generalized anger.

Another of the sample suffered a slight cerebral hemorrhage which rendered him unconscious for three days. He emerged from the coma for a period of ten minutes. His first request was for a drink. He suffered a severe cranial aneurism and relapsed into a terminal coma. The member of the sample had not been abstaining or he had resumed drinking on the day of his stroke.

The genesis of anger or hostility is vague. However, it can be stated with some certainty that all alcoholics, abstaining or not, experience high-level sensitivity to anger and are provoked by incidents that non-alcoholics would often ignore or remain unaware of.

The proclivity to anger remains endemic to the illness and there appears to be no diminution of anger by
abstinence. The abstaining alcoholic, however, is able to exercise internal controls to diminish the anger, sometimes suppressing it and later with assistance, extinguishing it. The important issue within this context is that anger or hostility is a constant in the life of the alcoholic.

Anger and hostility are emotional situational factors that must be regarded as renewable and consistent throughout the alcoholic's life. The abstaining alcoholic again seeks methods of discharging his resentment so that it ceases to be a threat to his abstinence. It is a primary cause of a resumption of drinking if resumption occurs. Whether real or imagined, the sample reported without exception, resentment against people, places and things which provoked more intense desires to drink unless discharged or ameliorated.

Of our sample, a significant number, 61 (45 percent) stated that one of their principal reasons for getting drunk was to tell somebody off. Simply put, to the alcoholic, alcohol permits the drinking alcoholic to express resentment which would not be comfortably displayed when abstaining. Abstinence then becomes a frustrating experience in the repression of resentment. There have been some medical reports that suggest that alcohol produces body changes permitting the accompan
ing resentment and/or anger. Alcohol does, without question, relieve the uncomfortable feelings of resentment within the alcoholic and alcohol does in many instances create a feeling of power over others. Alcohol encourages a verbal discharge of resentment which is relieving.

Seventy-one (52 percent) of our sample confirmed that alcohol did create within the person a feeling of power over others and accompanying the feeling was a fantasy that by the discharge of that power the resentment could be diminished to the alcoholic's satisfaction.

The statistics reflecting the close correlation between drinking and assaults and homicides are impressive and there has been no satisfactory study made as to whether the perpetrator of the act was drinking or the victim was drinking. However, the presence of alcohol has been accurately noted. Excessive drinking has been reported frequently in relation to rapes, it is usually productive of domestic quarrels, it is related to child abuse and armed robbery.

Note: One of my favorite stories taken from our sample is of the alcoholic who fashioned a gun from a bar of soap, dyed it black, held up a convenience store and perspired so excessively that the gun slipped out
of his hand and hit the store owner who without much difficulty wrestled the robber to the floor.

Fierce anger and deeply imbedded resentments accompany alcoholism. To the abstaining alcoholic the triggering device has been removed, but the capacity to fantasize the anger and the resentment remains and persists throughout the initial years of abstinence. To repress the resentment is difficult and to repress it without discharge is almost impossible. A study would be welcome which would relate the feelings of resentment and anger to the instinctive feelings for the maintenance of survival. There is a possibility of an interesting relationship between alcoholic behavior and instinctive survival.

Resentment need not be always destructive. Resentment and hostility to poverty, hunger, illness and injustice can produce improved living for many.

However, within our sample of abstaining alcoholics there was no expression of positive social resentment. The excesses of resentment productive of violent behavior were those uppermost in the minds of the abstainers.

To the abstaining alcoholic bottling up the resentment can cause serious problems in the maintenance of emotional health. It is important that the client obtain a release. The obvious danger of retention in-
ternally is depression and at times neurotic and psychotic behavior can be produced by the restraint.

Resentment is a universal problem, but to the abstaining alcoholic it produces a special threat: it produces a desire to drink and the correlation is extremely high. Of our sample, none denied that resentment and anger produced a desire to drink.

The listing of resentments is impossible with any hope that the list could be a complete one. However, there are some resentments that seem to be more prevalent among alcoholics than others:

Intolerance
Distrust
A false sense of superiority to others
Contempt
Rigidity of beliefs
Envy
Cynicism
Suspicion of others
Self-pity
Discontent with "life"
Jealousy

The abstaining alcoholic now is confronted with dealing with these feelings without the releasing effect of alcohol.
To the abstaining alcoholic, *justifiable resentment* is very difficult to handle. It is self-generative and progressive. Few alcoholics escape the feelings of "righteous" anger or resentment.

The abstaining alcoholic when he has carefully examined his feelings of resentment and anger will be able to determine quickly that the presence of these feelings are self-destructive and a threat to abstinence.

Abstinence does not always bring a suppression or extinction of these feelings. Abstinence does, however, provide a denial of the usual mechanisms and other modes must be found which will prevent the resumption of active drinking.

**Polarities of Action**

The alcoholic reacts with extreme to many, some say all, situations regarding his daily living. When he drinks, he gulps. When he eats he over-eats. (There was not one alcoholic encountered in this study which covers a period of almost twenty years who sipped his drinks. Further, the alcoholic is not inclined to overlook the last few drops in the glass or bottle.)

The alcoholic lives at the extremities. If he is happy, he is deliriously happy; if he is unhappy, he is in the depths of despair. Of our sample, all of them
without exception, described their emotional extremes as compulsive; further, the compulsiveness is not always related to action. If he acts, he acts compulsively in attempting to over-achieve. If he refuses to act, he will frequently do nothing other than minimally sustain his life. If he watches television, it becomes an obsession. If he does not enjoy television, he will not look at it and is annoyed when others do. The alcoholic, drinking or abstaining, can be depended upon to over-react. He rushes heedlessly. He is impatient to achieve what is to be achieved.

Another often repeated phrase was, "One drink is too many, one thousand is not enough." Years of conditioning have gone into his life style.

All of our sample was asked at what speed they drove on super-highways. The average speed was in excess of 65 mph. Only 9 (1 percent) described themselves as scrupulously observing the national 55 mph limit.

The alcoholic cannot accurately describe the intensity of his feelings because he will either maximize them or minify them during the process of recounting his feelings. Again the compulsive components of his illness instigate a strong desire to move hurriedly or not move at all.

The alcoholic is inclined to over-commit himself,
he has not learned to say "yes" or "no" as a result of a reflective decision resulting from an examination of the conditions requiring an answer.

It is frequent for the abstaining alcoholic to schedule events far in advance and then deliberately neglect the obligation until the pressure forces some sort of action. Others list their obligations and then drive themselves to finish all of them, with little regard for time or effort. He then concludes that lists are valueless.

Concepts of the middle way, avoiding the mountain-top and the valley, are alien to the alcoholic.

Perhaps the compulsiveness to extravagant feelings and unscheduled or uncontrolled actions is indigenous to the illness. Studies in this area are limited and sketchy.

Again we have to resort to our sample. Perhaps the most revealing report was a recounting of an alcoholic's calling a counselor asking for immediate help as she thought she was going to take a drink. The counselor asked if she could abstain for 20 to 30 minutes until he could reach her. The alcoholic replied, "You told me that if I wanted to drink to call you immediately and there is not a minute to lose. Come now!" The counselor asked, "How long have you had this compulsion?" The
reply was, "Since the day before yesterday."

To the alcoholic, a smile is an invitation to intimacy; a frown is a display of rejection. A modest job on the loading dock leads to the Chairmanship of the Board, the Chairmanship of the Board is temporary and a return to the job on the loading dock awaits him unless he is very careful.

The characteristics of these polarities of action and feelings often lead to obvious symptoms of manic-depressiveness. The alcoholic is manic and often depressive. He experiences mood swings that are inexplicable.

Cross-Dependency

Of our sample, 37 (27 percent) were cross-dependent upon a variety of drugs, mood-altering substances, or personality altering drugs ranging from marijuana to heroin. There is no reasonability as to the selection of the drugs. Cross-dependency presents so many variables that a separate work would be required to deal with the subject adequately.

However, some simple conclusions can be drawn:

The alcoholic is prone to dependency upon medication. Drinking is self-medication; the alcoholic drinks to feel better or to feel less sick. Amphetamines coun-
teract hangovers, sedatives calm nervousness, bromides help sleep, chemistry for better living is a reality.

There seems to be a need for mood-changing with the alcoholic which is deeply embedded in his life habits. His attitude is conditioned by his drinking habits: if one pill is good, two are better and many are fine. So he behaves while drinking.

Of our sample 12 were over-eaters and chronically obese.

Two were anorexic.

One might assume that there is an "oral magic" that is reserved for the alcoholic.

Of our sample two were dentists who were dependent on nitrous oxide which has become a serious problem in the dentistry profession. We seek pain-killing drugs, just as we seek mood altering drugs and the alcoholic is basically attracted to any medication, prescribed or otherwise, that accomplishes the goal of mood alteration.

There is singular evidence of "dependency proneness" with the alcoholic. One of our sample became dependent upon Alka-Seltzer, consuming 50 tablets a day; another munched aspirin. Eating to excess and dieting to excess seems to parallel with the strong dependency upon anything that will affect our psychic
life. He has no tolerance for delayed gratification.

There are a number of theories concerning cross-dependency, but the potential is not subject to theoretical evaluation. It is present in the alcoholic and persistent during his entire life whether drinking or abstaining.

**Sense of Re-Birth**

Many abstaining alcoholics are so surprised that they can abstain that they attribute their abstinence to a spiritual rebirth. It is not uncommon for the alcoholic to embrace the mainstream religious concepts, or to bury himself in what has been unacceptable in his past (Christianity, etc.).

He is also "cult" prone.

A reasonable explanation of the so-called rebirth is the immense sense of relife that the alcoholic experiences when he learns that he is ill and that he is not responsible for the past behaviors exhibited when he was drinking. A new awareness seems to sweep over him, he finds himself reacting to his environment with a new sense of incredible awareness. The simplest manifestations of the environment which have been readily recognized by others since birth are to him new experiences.
Of our sample, this sense of "newness" was described in a variety of details. However, reduced to simple terms it was the experience of being a "new person." Of the sample, 91 (66 percent) expressed a new sense of awareness and a recognition of "beginning life over" with the cessation of drinking.

Coping with these new dramatic learnings presented many problems to our sample, most of which were related to a conflict by what had been taught in childhood to what had now been learned as adults.

In summary, Frustration, Fear, Scattered Fear, Anxiety, Dislocation, Anger and Resentment, Extremes of Response to Situations (Polarity of Action), Cross-dependency and a Sense of Rebirth are some of the more frequent constancies which persist from the drinking period to the abstinence period and remain present during the months or years of abstinence, diminishing in time, for some, and extinguishing themselves in time for others.

We have discussed some of the persistent attitudes and feelings that carry over from drinking into abstinence and that could in the alcoholic's framework of action present counseling problems. There are a personalization of these views which merit consideration.
World View

Although our sample offers no precise information on this subject, it is evident that the alcoholic has a love-hate relationship with the world.

Frequently, his relationship to life reflects the polarities of action or response which has been previously discussed. The alcoholic is presented with a serious question, if abstinence is not an improvement in living, why not drink?

If alcoholic drinking was caused by the world or the external environment in which the alcoholic functioned, then is the world to blame.

The abstaining alcoholic if he is financially secure, emotionally tranquil and in a rewarding relationship with his environment, is enthusiastic about life and regards the world as an almost perfect place in which to exist. His inner liberation has made the world non-threatening, his community undergoes a change so that the world is a "glorious orb" in which he is privileged to live.

Both views present polarities of response.

Accepting the world as it is, recognizing that what is on earth is a product of man, an objective view of the reality of existence is most difficult for the ab-
staining alcoholic as he swings from one extreme to another with easy unpredictability.

The sense of impending doom which haunts the drinking alcoholic rapidly diminishes with abstinence. The relationship is not clear, but the sense of disaster lurking in the misty future is real to the drinking alcoholic. Of our sample, 83 (61 percent) expressed this feeling while drinking, and 71 (52 percent) spoke of the diminishing of the feeling within the first 60 days of abstinence.

Of those who experienced the feeling of impending doom, they stated that the "love-hate" swing in feelings about the world persisted into abstinence. Of the total sample 91 (66 percent) stated that they were aware of changes in feelings following abstinence and a sense of confusion regarding the world whether they were among those who had "impending doom" feelings or not while drinking.

The hate is a distrust of, alienation from, and dislike of the world, with a sense of helplessness in regard to functioning within the world community. He may become convinced that he cannot live in the world. Suicidal feelings or a longing for death may accompany the hate relationship. No abstaining alcoholic of the sample spoke of a desire for death. However, during
the preparation of this work, two of the members of the sample committed suicide. One hung himself after being notified that he had a serious emotional disturbance which would require a brief hospitalization, the diagnosis was manic-depressiveness, and the other killed himself by an over-dose of barbiturates. He left a note stating that he did not drink alcohol following the ingestion of the barbiturates and died sober. It was written with a tone of pride.

The love-hate attitude, feeling, or mode, seems to diminish after lengthened abstinence. The rate is uncertain, but for those who had been abstinent for ten years or longer, there were none reporting continuance of the love-hate.

He feels at odds with the rest of the world and when in company with fellow alcoholics is inclined to believe that he is different from his fellow victims as well as others. There is a kind of exclusivity that seems to accompany the "doom and gloom" feelings. As has been previously noted, the alcoholic believes that he is truly alone with his feelings and that they are not similar to the feelings of others. It is particularly so with impending doom feelings. Time seems to heal the poignancy of the feeling.

There are a number of behaviors which abstaining
alcoholics report with sufficiently impressive frequency that should be noted, although there is not a statistical extraction available from our sample.

There is a strong sense of "letting things be" and avoiding conflict with the society in which he lives or with the sub-groups with which he is associated. The submissiveness is not supine, it is an unwillingness to confront, oppose or strongly oppose the will of a group.

Other Feelings

There are two lesser, lesser in the extent of evidence, views which are deserving of comment. The alcoholic has a chronic and acute inability to deal with grief. He frequently resorts to a recounting of the past and grievous actions which have occurred and although there is not sufficient information in our sample to speak of it in detail at this time, the ability to deal with death is severely inhibited.

The alcoholic is lured by financial dishonesty. During the transition period from being sober to the attainment of sobriety the alcoholic has difficulty in facing his financial obligations and he is most devious in his efforts to avoid confrontations regarding matters of money. Many of the problems presented by abstaining alcoholics which seem most pressing at the time can be
traced to financial insecurity and the inability to deal with finances in an orderly fashion. Money is frequently ignored as an unnecessary part of the alcoholic's life by the alcoholic; or, money is regarded as vital to the alcoholic's continued sobriety.

Despite the previous remarks there is a propensity for the abstaining alcoholic to find and maintain friends. The fear of loneliness which has characterized much of his previous life is compensated for in abstinence with a desire for attachment to individuals who are often incorrectly perceived as close personal friends. Our sample reports this behavior frequently, although the entire sample was not questioned on the matter. It is noted however that seemingly undying friendships are cemented within the framework of abstinence only to have them disintegrate quickly and disappear. The abstaining alcoholic has the capacity to quickly replace the lost friend with another attachment, and so it goes, a never ending sequence of friends always changing but always cherished at the time.

Accompanying abstinence is a frequently expressed compulsion to achieve. It is suspected that this desire to achieve, which is intense, demonic and immediate, is related to a sense of making up lost time or undoing some of the damage that has been done in the past by
the drinking alcoholic's behavior.

Admittedly these remarks are somewhat general and that they have no statistical validity, but they have been sufficiently discussed by our sample as to warrant consideration.

The sample revealed that an inordinate, even impressive number of abstaining alcoholics expressed feelings of paranoia regarding work associates or acquaintances, a sensitive reaction in which the fear that actions and words of other people refer to oneself when they don't.

The feelings were expressed by 21 (15 percent) of our sample and were only alleviated by professional help within the medical modality. If the paranoia is so severe, to the point of preventing productive behavior and abstinence maintenance, then referral to a physician is required.

Abstaining alcoholics also respond to polarities of sexual behavior. One abstaining alcoholic may find himself in a sexual frenzy after refraining from drinking and another will become sexually passive and avoiding sexual relationships or associations. From our sample a significant number fell in the latter group. Fourteen (10 percent) found themselves sexually stimulated by their abstinence and 47 (34 percent) found
themselves sexually apathetic following abstinence. Of the 47, 31 found that after a period of two years their sexual apathy diminished and a more active sexual interest occurred.

It is suggested that there is a need for a study of the differentiation between men and women alcoholics as to sexual responses following a period of abstention. It seems following our examination of the sample that women seem to suffer more damage than men and that it might be attributable to the social impact and exploitation by males of women who are drinking alcoholics.

Alcoholics resort to drinking after events of rejection. Sixty-seven (45 percent) of the sample spoke extensively concerning their inability to handle rejection of any sort while drinking. After abstention, the same figures were revealed for the same group. Rejection is endemic to the alcoholic and when rejection is a major stimulus to drinking, after abstention the inability to accept rejection persists. In connection with the interviewing of the sample regarding rejection, 77 (56 percent) described themselves as hypersensitive regarding rejection.

The sample was unanimous in describing itself as insecure, with a poor self-image (all felt they were ethically and socially damaged), and perfectionists who
were never satisfied with the results of their efforts whether drinking or not. Accompanying the poor self-image was a generally recognized concern with self that again reflected the polarity of reaction: they either believed they could do anything or were incapable of doing anything.

Twenty-eight (20 percent) had attempted suicide while drinking.

All described themselves as victims of self-pity which persisted during and after drinking.

In short, the abstaining alcoholic is frustrated, fearful, anxious, dislocated during his childhood or youth, angry, resentful, under stress and tension, prone to manic-depressive swings, easily dependent upon other drugs, confused as to his spiritual center or lack of it, alternating between a love and hate for the world in which he lives, submissive, anticipating an impending doom, socially unstable with propensities for withdrawal or compulsion to achieve, financially irresponsible, paranoid, sexually dysfunctional or sexually driven, aggressive, morose because of rejection, hypersensitive, perfectionistic, suicidal, unrealistic in both his ambitions and his sense of failure, procrastinating, intolerant of discomfiture, and filled with self-pity.

He can be all, some, or any of these.
Conclusions

(1) "Being sober" usually is temporary.
(2) Continuous abstinence produces sobriety.
(3) There is a diagrammatic process in alcoholism development and there is a diagrammatic process to attaining sobriety.
(4) A thirty day period of abstinence is important prior to the initiation of counseling.
(5) The process of attaining sobriety is time consuming.
(6) "Will power" has little relationship to sobriety.
(7) An assessment of nutritional damage by alcoholism is important.
(8) Cultural influences may inhibit sobriety.
(9) Frustration and fear characterize the illness; both present a mosaic of feelings, not discrete.
(10) Frustration and fear may be phobic.
(11) Anxiety is endemic to alcoholism.
(12) Dislocation is frequent among alcoholics.
(13) Intolerance is frequent among alcoholics.
(14) Polarities of emotional expression are endemic to alcoholism.
(15) "Dependency on others" and the denial mechanism are endemic to alcoholism.
(16) Sobriety produces a Sense of Re-Birth.
(17) The alcoholic possesses a "love-hate" relationship with the world.
CHAPTER VII

SPECIFIC DIMENSIONS OF A HUMANISTIC, EXISTENTIAL, CLIENT-CENTERED APPROACH TO COUNSELING THE ABSTAINING ALCOHOLIC

"Self-interest is but the survival of the animal in us. Humanity only begins for man with self-surrender."

--Henry Amiel

Despite the fact that every event is unique, if only because events take place in time and space and no two events can occur at the same time and in the same place, there may be sufficient similarities among disparate events to consider them related. It is possible that there may be similarities between the counselor and the client fostered by cultural, social, familial and possibly genetic factors.

All alcoholics differ and the illness does not alter all of their differences. We seek similarities to permit the development of some direction through counseling toward agreed upon goals.

We are, however, concerned with the differences that distinguish one alcoholic from another. Our society has taught us that common conceptions of alcoholics are faulty, conditioned by history, cultural attitudes, past events and past theories.
We have been concerned with characteristics of the alcoholic which internally and externally produce a common reference as to the consistency of an alcoholic individual's responses to a variety of situations. There was no effort to group these characteristics into types. Types may exist, but current theory and practice does not distinguish one characteristic from another with clarity or completeness.

The counselor would do well to limit his pre-conceived notions, eliminate them if possible, and confine his observations to those which he can immediately and confidently perceive. Understanding the client, identification with the problem-presentation, and unfettered communication of that understanding is of greater importance than a prediction of the abstaining alcoholic's behavior. Prediction for the counselor is an exercise in futility. Predictions on the basis of study of many simply do not apply to the individual alcoholic. "The changes of a hypothetical average man for survival or death are all the insurance business wants to know. Whether Bill himself will be one of the fatal cases it cannot tell--and this is what it wants to know."¹

We are now led to prime considerations:

1. The abstaining alcoholic seeks counseling for his immediate needs, needs which he conceives
of as not being capable of satisfaction without external assistance. He recognizes, as he has learned from his attempts to bring his drinking under control that he cannot do "it" alone, he needs help and he is willing to seek help. His abstinence has in a measure altered him and later educated him to self-awareness, and from that self-awareness, change in behavior through self-direction and self-examination attempted without external help has been usually non-productive. There is an amiable climate for counseling if his suspicions of the professional have been diminished through supportive help by others.

To the abstaining alcoholic personal life experiences are of greater importance than an understanding of the importance of other kinds of experience, i.e., experiences of other individuals. Therefore, personal determinants become not only the counselor's method, but also that of the abstaining alcoholic client.

Locke and his tabula rasa is Anglo-American; Leibnitz and his self-active responder to constitutional and instinctual forces working from within is European. Roles are important to the Anglo-American; instinct drive is European in character. American views are
pragmatic, empirical and optimistic. Europeans are philosophical, involved in the total uniqueness of the individual, and pessimistic. And both of these cultural attachments have avoided the new learnings of the East which Alan Watts has so interestingly and productively explored. The counselor should set aside such considerations as he pursues the personal.

Essentially, the abstaining alcoholic counselor must lean to the personal, the private uniqueness of the illness.

In counseling the abstaining alcoholic we come to a second consideration.

(2) Counseling the abstaining alcoholic from a theoretical stance will interfere with the personal interchange that the client has already learned is his major, perhaps only, process in his adjustment to living. The counselor must be free to explore, exchange and enrich through the process of empathetic sharing. The client by this process provides his own mechanisms for coping with the client's problems, as it is by such process that the client learned to discontinue his drinking.

The question naturally arises: Is there a comprehensive, parsimonious and relevantly researched theory
which can be of value within the counseling encounter? It has been pointed out by others that a theory is not true or false but it is useful or not useful. In this context the counselor is advised to be eclectic, pursuing and practicing theories, in whole or in part, that enhance the personal interchange with the alcoholic. The client should be encouraged, assisted or permitted to create a differing inscape to achieve the goal of tranquility which is the ultimate objective following the achievement of abstinence.

Thus, to repeat, the immediate goal of the counselor is to assist the client in the sustenance of the client's sobriety.

There can be no cessation in counseling of the repetition of the definition of alcoholism as an illness which has produced life unmanageability and which is activated in self-destructive behaviors when any alcohol is ingested. A number of alcoholic investigators believe that the alcoholic can be brought to a level of "social drinking," but the statistics are meagre and the conclusions largely speculative. Total abstinence, on the basis of this study and those of others active in the field, notably LeClair Bissell, M.D., and others, is vital to the health of the abstaining alcoholic client.
It is of interest that two reported recognizable help from professionals (psychiatrists and psychologists) who had not experienced alcohol dependency.

Alcohol dependency is not a requirement for counseling the abstaining alcoholic, but the experience of dependency is useful and professionally helpful.

Empathy on the part of the counselor may, it has been suggested by the literature, have a deleterious effect upon the alcoholic's change. This statement is not confirmed by our sample which, without exception, stated that empathy, sustained empathy, is vital to their inner change activity. Empathy in this context is not a reflection of feelings, but rather the acknowledgment of a sharing of feelings, either from earlier experience by the counselor, or currently experienced by the counselor. The counselor merges his experiences with those of the alcoholic, shares in a reflection on those common experiences, and competently removes himself from a judgmental attitude, an attitude that is seriously damaging to the alcoholic client. Intellectual understanding may be of value, but emotional identification is to be treasured. An interchangeability of emotional feeling is what is being described.

It is suggested that there be unconditional positive regard exhibited and with it a communication of
human warmth and understanding as principal vehicles for communicating this human respect.

Further examination of this is not required at this time, but both individual and group support for the alcoholic is highly visible to the alcoholic and the absence of unconditional positive regard by the counselor is quickly ascertained by the alcoholic. The sensitivity to the absence of positive regard is related to his previous experience which was influential in his illness at the very beginning.

There are some learnings which are of importance:

(1) The counselor must be honest with himself. Failure to maintain this honesty is easily recognized by the client.

(2) The counselor should avoid verbalizing or communicating in other ways his awareness of his own self-honesty. It is a state of being, not an acquired "taste."

(3) The counselor should assume that the alcoholic wants to believe that the counselor is honest with himself.

(4) Failure to be honest with himself should be revealed immediately to the client. The client is capable of assisting the counselor to readjust to a condition of self-honesty.
There are certain simple practices that can be followed. With the help of a psychiatrist who has been alcohol and drug dependent for over twenty years and has been abstaining for over twenty years, we have been able to determine some learnings which can serve as minor guideposts to the initial encounter with the alcoholic:

(1) Never talk about the past and if the client insists on dealing with the past, reinforce the concept that the alcoholic is ill and activities done while ill are socially forgiven. Our society does not punish or force guilt upon those who are not responsible for past actions because of illness. Some societal institutions do reinforce feelings of guilt, but in the comfort of the person-to-person relationship those efforts should be discounted. The results will be an increasing awareness of the primary consideration that alcoholism is an incurable illness. A regurgitation of past "sins" only serves to lessen the desire for control.

Do not plan for a lengthy future. Goals should be regarded as desirable only if they are achievable in a foreseeable future. The past has memory, the future
either hope or despair, if not clouded by the mist of fantasy. The present is without memory and it is the present that is important. In the words of one of our sample: If one lives with one's foot in the past and another foot in the future, one urinates on today.

(2) Never neglect the presence of the possibility of change. It is possible to change one's unhappy and degrading life into a happy and fulfilling life despite years of despair. Although it cannot be done quickly, it can be done. The counselor and client should be ever-mindful that time is required and the amount of time that is required is not predictable. The client will resist this view.

(3) If the alcoholic has made a commitment to abstinence, the same commitment can and probably will be made to people. It is at this level that the alcoholic is easily confused as he possesses a history of inability to relate the abstract to the concrete and the concrete to the abstract.

(4) It is satisfying to the counselor to please the client; it is satisfying to the client to please the counselor. This process enriches the empathic "third person" which
will be dealt with later.

(5) Physical contact through hugging and kissing, or other selected physical expression, is reassuring to the alcoholic. However, the decision as to the receptivity of such physical expressions must remain with the alcoholic.

(6) A concept of "love," meaning total acceptance of the individual as he or she is, although difficult to absorb, is of great therapeutic support.

(7) Relationships with other people are best learned by observations of other people's relationships, not from the counselor. The alcoholic can be encouraged to choose and select desirable relationships which are open and supportive.

(8) The alcoholic has long held the opinion while drinking that there are great inner human differences between men and women. Abstinence encourages the awareness that both sexes need love and security and both are sensitive to its presence or lack.

(9) Despite familiarity, courtesy is desirable within marriage, relationships of an intimate
nature, and with people outside of the close intimate relationship. Courtesy opens the door to consideration and respect and diminishes the alcoholic's propensity for immediate expression of anger.

(10) The best element in an intimate relationship is friendship, including the counseling relationship.

(11) Sexual problems are mainly produced out of a faulty love relationship with one's partner. Sexual activity for the fulfillment of one's partner rather than the satisfaction of one's self is therapeutically helpful.

(12) The alcoholic is not the only person who feels miserable, isolated, overly communicative or uncommunicative, boring, guilty, loveless, clumsy, sexy or sexless individual. These adjectives apply to alcoholic and non-alcoholic individuals.

(13) The alcoholic does not have to love anybody. One can go through the motions of acting lovingly. However, it is necessary to learn to love one's self. Love is a gift that happens. It cannot be created any more than a plant can be created from a seed by an
effort of will.

(14) The client-counselor relationship is an "us" relationship. Each within himself can grow as the "us" relationship prospers.

(15) Counseling from actual personal and immediate personal experiences are the best.

(16) Good relationships are complex. It takes a long time to know what to do and how to put the newly found knowledge into practice. Relationships are not confined to two or more people. With the alcoholic it is more than likely that the more rewarding relationship is the relationship of self-to-self.

(17) "I share with you the awesome feeling of being on the verge of really knowing another person. (I place a great deal of emphasis on people really listening to each other, to what a person has to say, because one seldom encounters a person capable of taking either you or themselves seriously . . .)

Do you know what shameless thought just bullied its way into my consciousness? That I deserve you, that I deserve to know you and to communicate with you, that I deserve to have all this happening. What have I done to merit this? I don't believe in the merit system. I
Am That I Am. No, I will not hurt you."

The preceding seventeen statements, although of a general nature, are all expressions which are useful for the counselor in establishing the empathic, positive regardful and unabashedly sincere relationship which is essential to the alcoholic-counselor relationship.

One does not learn how to be empathic, nor does one learn positive regard. These are processes which must be created if they do not exist, and nurtured if they are formative. It is imperative that the counselor constantly question his own inner life, examine his own inner feeling to establish confidence that he himself is honest. With these three characteristics present, therapeutic counseling can prove to be of immense value to the alcoholic. A diagram of the relationship is possible.

Stage I

In the initial encounter and often during the subsequent encounters the alcoholic usually manifests dif-
fidence despite his self-recognized need for help. He is suspicious of others as a result of his illness and he has been through a period of keeping public awareness of his illness private. The counselor who imparts a feeling of receptivity quickly and reduces his attitude
Stage I
Empathy Awareness
Increasing Confidence
Abstaining Alcoholic

Stage II
Empathy Awareness
Increased Confidence
Abstaining Alcoholic

Stage III
Empathy Awareness
Increased Confidence Commitment
Abstaining Alcoholic

Stage IV
HONESTY
Abstaining Alcoholic
of detachment as much as possible, may generate an awareness on the part of the client that the counselor is "understanding" of his, the client's inner disturbance.

If the counselor is an abstaining alcoholic, this process should be initiated immediately. The counselor should reveal his alcoholism as quickly as possible.

The alcoholic experiences a sense of relief, almost a feeling of comfort, if he is aware of a shared illness. It seems reasonable that this community of shared difficulty is accountable for the success of group therapeutic gatherings of alcoholics. Of our sample, all of them experienced a diminution of tension when they became aware that both the participants were also ill. A number of the sample, 62 (45 percent), stated, however, that there was a residue of suspicion that non-alcoholics were present at their initial encounter with a group of alcoholics gathered for sharing and that this suspicion persisted for a number of weeks. Outside of the sample, alcoholics who had been abstaining from alcohol for less than ninety days, and in many instances less than one week experienced even greater suspicions.

There is a persistent suspicion of the motives of the counselor, or wariness of the counselor's actions, which seem to stem from certain constancies in the pre-
abstinence period:

(1) The alcoholic has long experienced a deep shame that he has been dependent and this shame has been reinforced by adverse activities by members of his family, society in general and his sub-societal group in particular.

(2) The denial mechanism, which is universal to all alcoholics, will remain as an option for use by the alcoholic during a long period of time whether abstinent or not.

(3) It is the rare alcoholic who does not believe that his alcoholic problems are peculiar to him and are not shared by others whether alcoholic or not.

(4) The alcoholic is especially wary of exchanging confidences with members of the opposite sex.

(5) The alcoholic is difficult to convince that there is any possibility of change in his lifestyle or his inscape.

Empathy is the most effective process to diminish these pre-conceived attitudes. Once the counselor has made it clear to the client that "he has been there" or if not an alcoholic, that his emotional responsiveness is sufficiently acute to assure the client that he "understands" how the client is experiencing emotional dis-
tress, there is a movement of client toward the counselor or permitting a closer examination and a resultant closer common recognition of concern.

**Positive regard is essential.** The alcoholic client, however, will find it difficult to recognize the positive regard. He has had a lengthy history of social condemnation; further, he has been for some time condemning himself. The confidence which the alcoholic desperately wants to experience comes very slowly. His drinking period has taught him that others are not to be trusted, yet one of the phenomena exhibited by the alcoholic is to persistently place his trust and confidence in those who will do him damage.

The abstaining alcoholic will usually be assailed for a lengthy period of time by an intense desire to drink. It (the desire) is usually of short duration, but it can sustain itself for a number of hours and even days. New stimulations which are suggestive of old patterns and stimulations encourage the abstaining alcoholic to resort once more to the perceived relief of a drink.

Some illustrative cases from our sample are given here.

(1) An abstaining alcoholic who had maintained his sobriety for one year was driving to a city
to arrange for the final details relative to a foreclosure on his home. With high resolve he embarked on the trip to the bank. After twenty minutes he was suddenly seized with a compulsion to drink which was sufficiently strong as to cause severe tremors. The alcoholic knew that he was to pass a liquor store on the highway and without pausing to consider, he parked in front of the store. After considering what he was doing, he purchased six bottles of an orange flavored beverage and six candy bars. He drank all six bottles and ate the candy. Becoming nauseated, he regurgitated and felt "an overwhelming sense of peace, yes, even victory." He continued to the bank after borrowing another car as his tremors had shaken the steering wheel from the car as he was parked in front of the liquor store.

(2) An abstaining alcoholic was given by mistake a cocktail at a party. Thinking that he was drinking a non-alcoholic drink, he gulped down the cocktail and immediately realized that he had consumed alcohol. His immediate reaction was to desire another drink. His reasoning
was simple: having taken one drink, his continuous sobriety had been broken, so he might as well have another. Happily, he resisted, but he was immediately sickened and had to leave the party.

(3) An abstaining alcoholic had the electric meter removed from his home because of non-payment of the bill. In order to telephone the utility to restore the meter, he poured a drink and was ready to drink it prior to making the call. The fumes from the drink were so enticing that he paused prior to taking the drink and during the pause decided that he would not break his continuous abstinence and poured the drink down the sink. He felt immediately relieved and proceeded with the telephone call.

There is a principle underlying abstinence support: the client should at all times be given every assistance in avoiding threats to his abstinence. Whatever event, emotional distress, or perceived threat, whether rational or not, must be considered by the counselor. Of our sample 126 (92 percent) agreed that threat avoidance was essential to the maintenance of abstinence. At times the decision to avoid threat is productive of genuinely
painful decisions. If the wife or husband, the job, friends, parties, social contacts, church, religious convictions, or financial worries are threatening, the client would be well-advised to rid himself of the threat. The logic is not complicated. Sober, the client had an opportunity for adjustment after a period of time; non-abstaining, the client has no opportunity for adjustment.

If one regards the counseling as a pyramid, the base is the maintenance of abstinence. Dr. Robert Linn in You Can Drink and Stay Healthy acknowledges the reports that it is possible for the alcoholic to drink safely, in effect, to become a social drinker. However, of our sample, 86 after a period of abstinence tried to drink under self-imposed control and not return to compulsive drinking. Not one single person of our sample succeeded in drinking safely and only complete abstinence permitted them to behave in what "society" would describe as normal behavior. Although this work is based upon a sample of 137, it has been the experience of the writer that he has never encountered a self-admitted alcoholic who was able to drink without returning to the "alcoholic behavior" that characterized his pre-abstinence period.

If, therefore, one accepts the opinion that the
maintenance of abstinence is the basic block upon which counseling is constructed, the basic center of that block is the avoidance of threat to abstinence.

The critical variable in counseling of the abstaining alcoholic and the maintenance of a productive therapeutic climate is empathic understanding. To clarify the empathic understanding involves the capacity of the counselor to perceive and share experiences and feelings and their meaning and to communicate to the client during the moment-to-moment encounter. To attempt to make a diagnostic formulation of the client's experiences or to reflect by rote to what the client is expressing is threatening and so perceived by the alcoholic. One of the unusual situations in the field of alcoholic counseling is that with the removal of training considerations, age, sex and other obvious factors, the alcoholic counselor who has maintained his abstinence for a substantial period of time is usually more effective and more in demand for counseling than the non-alcoholic counselor.

To the alcoholic counselor who has "been there," relating to the emotional or psychical dislocation of the client is easier to achieve. The question, "Is experience with alcoholic dependency necessary, probably necessary, or not necessary to the alcoholic counselor?"
was asked of 125 physicians, psychologists, dentists, and doctoral level health professionals at a meeting of the Southern New England Professional Group of alcohol and/or drug dependent health professionals at a meeting in Sturbridge, Massachusetts. One hundred and two selected the word necessary.

**Stage II**

Stage II is evidenced when both the counselor and the alcoholic are aware that both of them have achieved an empathic attitude and that the counselor's positive regard has produced an increased confidence in the counselor by the alcoholic. This stage is critical for the continuance of the counseling process. If it is not reached, it is unlikely that positive change will be effected. Some alcoholics have described this stage as the "manufacture of miracle" in which alcoholic and counselor not only share empathically, but the positive regard of the counselor is no longer subjected to question and/or suspicion by the alcoholic.

This stage completion is easily recognizable by the counselor as the alcoholic is now presenting problems without inner constraints and the feelings are being expressed in greater detail. There is an increasing use of the words, "I don't know exactly, but sometimes
I feel that . . ." It now requires little prompting by the counselor to elicit considerable detail concerning the activities of the alcoholic, the details are almost eagerly presented, but they are without embellishment and the alert counselor will seek additional confirmation from the client detailing that what the alcoholic is presenting represents an accurate description of the events, feelings or responses.

Frequently the alcoholic will volunteer the information that he is feeling comfortable with the counselor, that he enjoys sharing what is being offered with the counselor, that he respects the counselor, etc. It is at that time that the counselor is urged to accept such expressions quietly, or with a conscious expression that what is transpiring is usual, not peculiar to their relationship, indeed, it is an expectation. It is also useful for the counselor to state clearly his gratitude that the alcoholic feels the way he does and that he is properly proud of their relationship. Humility is needed. It has been noticeable in a number of counseling situations that if the counselor expresses pleasure that the alcoholic feels as he does toward the counselor and expresses that pleasure a sense of wonderment that it has occurred, and a delight that there is a sharing, it is quickly absorbed by the alcoholic with expressions
of gratitude that the process is occurring.

If Stage II, the movement of counselor and client toward each other, is not reached, or, after a period of time, it has not been recognized by both the alcoholic and the counselor, the counseling sessions should be terminated by graceful and friendly expressions that insufficient progress is being made and continued counseling would be better done by another counselor.

Frequently the alcoholic will resist termination. If termination is resisted, it is suggested that the counselor "give in" and gently suggest that they try again. The counselor should reveal that he senses a lack of movement on the part of the alcoholic, suggest that the client may be presenting problems preventing movement, but stating the conclusions in a non-dogmatic manner so that the door is open to a greater effort.

There is a sorting out of the problems process:

(1) Deal with first things first. This can be translated into a time sequence. The most important disturbance of the alcoholic may not be a first thing in that it is not immediate. The counselor should consider almost without exception the problems that are presented now. Many of them will be trivial, some will be of dramatic proportions which are
for the moment hidden within the consciousness of the alcoholic. But, in general, the counselor should look for those problems which are immediate. Despite the seriousness of withheld problems or problems deeply imbedded within the client, the counselor should deal only with the immediate.

The idea of first things first also serves as a reminder to the counselor that he should look for those threats to the abstinence of the alcoholic and exert his counseling effort toward their elimination, then proceed to the immediate problems.

It requires little skill to find the "first" item. The alcoholic is anxious to present the immediate problem early in the counseling relationship.

The counselor should make every effort to "stick to the problem" and not allow himself to be diverted to a consideration of other problems that are not of immediate recognition.

(2) Deal with one issue at a time. Under no circumstances should the counselor attempt to cluster the problems presented, but rather to deal with the issue presented and deal only with that issue.

The alcoholic has great difficulty in sorting his
problems, he has little skill in perceiving deep underlying stimuli to his emotional distress. His concentration should be directed toward the maintenance of abstinence, failure to do so will present the possibility of a renewal of drinking and if this event should occur, the counseling is fruitless anyway.

(3) The counselor should avoid long-term projections as to the future emotional balance of the alcoholic. Usually the initial presentation of distress is of short-term duration and can be remediated within a brief time span. Couple this intense desire for immediate relief on the part of the alcoholic with the maintenance of his abstinence, the removal of threat, and progress can be made toward the consolidation of the relationship between the alcoholic and the counselor.

(4) Despite the previous statement, the alcoholic must be directed toward an acceptance of "time span." He must be assured that there is no quick and ready solution to any problem and that time is required. The emphasis on slow change must take precedence over the quick and easy remediation of the problem presented. The alcoholic should be directed toward his
historical activity of impulsive action and be strongly reminded that impulsivity has frequently, perhaps usually, ended in disaster regarding his drinking.

Stage II presents this opportunity to establish a modality. If the alcoholic has resisted responding to the empathy awareness of the counselor, or the counselor is unable to develop an empathic movement toward the interchange, and the threat of termination of the relationship has been discarded, progress can still be made toward the developing of an improved counseling relationship.

It should be mentioned here that as empathic awareness and positive regard increases by both counselor and client, there is a resulting increase in confidence on the part of the alcoholic to deal with his problem with some hope of success or at least amelioration.

Three cases:

(A) Dennis has lost his wife and children through divorce brought about by his alcoholism. He has a car and has obtained employment attending a golf course. His salary is low, but the financial demands by the wife and children are not excessive and he is able to meet the court-ordered payments. He dislikes his work although he delights in being outdoors. He is very uncom-
fortable in his sub-average financial status. He feels depressed and angry. His anger is not directed toward any person, thing or place, but to the situation in which he finds himself. He is under court-ordered restraint as a result of kicking down the door of his home to plead with his wife to take him back. The incident occurred while he was abstaining. He now regrets his previous behavior but he is angry. He hopes to reach his wife to plead a return to the home. Every previous effort has failed. He is permitted to visit his children one day a week, he finds the experience very pleasing.

He is convinced that if he had more money, his wife would take him back to the family and he would be able to live a "normal, sober life."

He is unable to sleep at night because of tension and depression.

He is in counseling and he feels comfortable with the counselor and has expressed often his confidence in the counselor.

Conclusion: The counselor should express an understanding of his feelings, but not express an opinion or observation regarding his family relationship. It is apparent that Dennis is in a "bind" in that he enjoys his work somewhat, but is intolerant of his "poverty."
The focal point of the counseling should be on obtaining more rewarding work for Dennis so that his immediate financial distress can be relieved. The counselor did succeed in learning that Dennis was a machinist and enjoyed the work. With encouragement and support by the counselor, Dennis obtained a new job working as a machinist assistant. He was discharged after one week for fighting. Dennis was chagrined by his actions and thought it was because he worked indoors.

The counselor advised him to find another job as a machinist if possible. After three weeks, Dennis was employed as a machinist assistant at another plant at double his previous income. Within three days, he wanted to quit the job. With counseling support he was urged to "hang on" for another day, then week, then a month. After three months, he expressed a pride in his work and a satisfaction over his increased income. His relationship with his former wife improved and he looked forward with pleasure to his day with the children. His appearance improved dramatically; he trimmed his weight and bought new clothing. His hair is combed and he is shaven. He receives approval from his fellow alcoholics as to his "progress" and his communication with the counselor has moved into Stage III.

B. Mary has been raped. She expresses a strong
compulsion to drink. The male counselor listens to her presentation without judgmental remark.

Conclusion: The male counselor refers Mary to a female counselor and spends the initial meetings reinforcing the empathic relationship and the positive regard. He avoids any specifics regarding counseling concerning the rape, but stresses the necessity for the maintenance of abstinence if Mary hopes to assuage her "problem." The male counselor gently shifts the counseling relationship from his own participation to another alcoholic counselor, but offers to help as best he can with the recurring compulsions to drink. The responsibility of a continuance rests with the alcoholic.

C. John has become impotent. He seeks counseling and sees little relationship between his twenty years of alcoholic drinking and his loss of potence. He speaks freely of his inability to respond sexually.

Conclusion: The counselor shares his own experiences with sexual dysfunction. He considers psychiatric referral, and in concert with the psychiatrist if possible, continues the counseling. He establishes the probable cause of impotence. If no physical damage has been found he regards it as a learning problem. For the majority of alcoholics alcohol and sexual activity
have been paired. Remove the alcohol, sexual desire diminishes.

The counselor persists in abstinence maintenance and assures the alcoholic that conditions will change, in time. With gentle sharing, the alcoholic will place the sexual activity into an appropriate place on the priority list and usually finds that the sexual dysfunction will diminish with improved social interchange.

The previous cases were selected from our sample as Stage II presentations wherein the counseling relationship is at its most tenuous.

**Stages III and IV**

It is difficult to distinguish between III and IV and it is important that a clear-cut distinction be made.

After a period of counseling, usually three months on a once weekly basis, a new factor emerges. It is commitment.

The commitment is not only to the counseling process, but of the counselor to the alcoholic and the alcoholic to the counselor. A synonym for this commitment is unbroken sharing.

At these levels the counselor is encouraged to present to the alcoholic his own problems, seek a common
ground of mutual assistance and in turn attend to the problems of the alcoholic.

Both counselor and alcoholic should by this time be deeply involved in examining the truth (honesty) of their own feelings. No small detail should be excluded in the sharing. They, if the mutual empathy, positive regard, and self-confidence have been nourished and maintained, are now capable of "opening up" without self-editing to a commitment to assist each other. It is a phenomena that the alcoholic now is committed to assist the counselor and the counselor to assist the alcoholic. The problems presented by both become diversified and selective. Both are capable of looking at distress not only with an objective view as to the seriousness of the problem, but with a joint examination as to whether the problem is in the area of solubility.

The alcoholic will continue to have emotional distress about matters concerning which there is no solution. Years of damage have been emotionally costly and it is the counselor who can assist in laying aside those problems that cannot be coped with and to select those problems which can be ameliorated or "solved."

There is a Third Person created, made up in part of the alcoholic and in part of the counselor. The sharing has become so intimate and open that an objec-
tification occurs in which both counselor and alcoholic are able to observe in the abstract, the Third Person sensing in this person a part of each. The counseling process is now functioning at its highest level without restraints other than the maintenance of private identity. Fear on the part of the alcoholic has diminished or disappeared; suspicion on the part of the counselor has now disappeared, and the two function in part as a single third person.

This is a maintenance level of counseling without a regular pattern of meeting, without planned confrontation of emotional dislocation, but rather an open sharing of common problems in which both are devoted to the assistance of the other.

It does not occur easily.

Absolute and unremitting honesty with one's self is, if not impossible, extremely difficult. Neither counselor nor alcoholic seeks to dissemble and problem presentation can be objectified by both if this honesty is present.

These are dangerous stages, III and IV, as emotional factors may produce emotional commitments which can lead to intimacy that neither party can control or keep at a professional level.

It is strongly suggested that if intimacy or emo-
tional commitment invades the private inner life, the inscape, of either, that both parties break off the counseling process to avoid a relationship that presents emotional damage to either. The alcoholic may be presented with a threat to his abstinence by the intimacy, the counselor may find that his professional activities have ceased and he is reacting to the alcoholic not as a counselor but as a lover, friend, mistress, husband or wife. Among our sample, 16 (12 percent) found themselves in this predicament in which counseling could no longer be afforded. All 16 found the relationship a threat to their abstinence and by recalling previous discussions, threat removal was of paramount importance. Termination was necessary.

If such a relationship should develop, group therapy is an option which permits a generalization of the commitment and the Third Person ceases to exist.

Everybody cannot create a Third Person.

One extraneous comment: Non-directive methodology is an option. Behavioral modification is permissible if it fits the alcoholic and the counselor and is specifically related to the problem presentation. Behavior modification does not work to maintain abstinence. Psycho-analytic methods may be helpful in gathering information that the alcoholic and the counselor may
share, but it is not a "relieving" event regarding specific emotional distress.

Trait and type classification is of no value. The only common universal trait of alcoholics is that they drink.

Conclusions

(1) The counselor must possess an empathy for the alcoholic.

(2) The counselor must maintain a positive regard for the alcoholic.

(3) The alcoholic should develop an awareness of the empathy sustained by the counselor.

(4) The alcoholic should be encouraged to become increasingly aware of his confidence in the counselor.

(5) There is a dynamic in the relationship that moves the counselor and the alcoholic toward each other.

(6) There is a point at which the alcoholic and the counselor make a commitment to each other.

(7) When this commitment becomes sufficiently intense and healthy, the productive and progressively successful counseling can be maintained.
(8) When the commitment is made, absolute and unremitting honesty toward the client and within one's self should be sustained, examined, edited, and selected as occasion demands.

(9) When the commitment becomes a "threat," counseling should be terminated. Group therapy is a possible option.
"So act as to treat humanity, whether in thine own person or in that of another, in every case as an end, never only as a means."

--Immanuel Kant

Earlier in this work the concept of the "third person" was developing a creation out of mutual movement of the client toward the counselor and the counselor toward the client through empathic interchange with positive regard and unremitting honesty on the part of the counselor was discussed.

There are a number of propositions that should be examined. As has been mentioned, the alcoholic does not live for far goals in a distant future. He is too busily engaged in the activity of the moment. Abstaining alcoholics live, they are not preparing to live. But abstinence permits a preparation for better living which can be predicted as sustained abstinence continues. In addition, unlike the "child" of Maslow, the abstaining alcoholic is trying to grow to change step by step. Growth is not a goal that is ahead; growth, or change, is a happening. There is an inner direction although the inner state is only temporary, even momentary. As
has been suggested by Maslow, change that represents a step in any direction if it is subjectively more satisfying that the previous placement is the way we know that the change has been an improving one.

We don't do it because it is good for us, or because psychologists approve, or because somebody told us to, or because it will make us live longer, or because it is good for the species, or because it will bring external rewards, or because it is logical. We do it for the same reason that we choose one dessert over another. I have already described this as a basic mechanism for falling in love, or for choosing a friend, i.e., kissing one person gives more delight than kissing the other, being friends with a more satisfying subjectively than being friends with b.1

There is a schema which Maslow has put together that describes the mechanisms of change in an uncomplicated way.

Enhance the dangers Enhance the attractions
Safety ← PERSON → Growth
Minimize the attractions Minimize the dangers

Therefore we can consider the process of healthy growth to be a never ending series of free choice situations, confronting each individual at every point throughout his life, in which he must choose between the delights of safety and growth, dependence and independence, regression and progression, immaturity and maturity. Safety has both anxieties and delights; growth has both anxieties and delights. We grow forward when the delights of growth and anxieties of safety are greater.
than the anxieties of growth and the delights of safety.²

To the drinking alcoholic, alcohol is safety and anxiety and the dangers are maximized. There is the bind.

The experience of abstinence is monumental simply because the alcoholic has not previously believed he could abstain.

To return to the counseling encounter, the counselor who exhibits a genuinely empathic response invites the client by his behavior to return the same response. All of the sample confirmed an urge to share, and sharing empathically with anyone was reported as an invitation to a rewarding and joyful interchange. The openness of the counselor is the initiating signal.

To apply the Maslow formulation to the alcoholic and to relate it directly to the counseling of the abstaining alcoholic, we arrive at a formula that has the following elements:

1) The alcoholic, who is spontaneous by his very nature, in that spontaneity, from within out, in response to his inner Being, reaches out to the counselor in wonder and interest, and becomes expressive if the counseling environment is reassuring.
The reaching out occurs to the extent that the alcoholic can diminish his fear, to the extent that he feels safe enough to risk.

If in this process, that which gives him the delight-experience is fortuitously encountered, or is offered to him by the counselor, the client is reassured.

He must be safe and capable of self-accepting enough to be able to choose and prefer these delights, instead of being frightened by them.

If he can choose these experiences which are validated by the experience of delight, then he can return to the experience or problem, repeat it and discharge it.

At this point, he shows the tendency to go on to more complex experiences, if he feels safe enough to dare.

Such experiences or problems of experience when discharged have a feedback effect on the Self, in the feeling of capability, mastery, self-trust, self-esteem.

In the never ending series of choices of which life consists, the choice may be generally schematized as between safety (or,
more broadly, defensiveness) and change, and since the safety (alcohol) has been eliminated, we may expect the choice to be made by the change-need, i.e., growth-need, client. Only he can afford to be bold.

(9) In order to be able to choose in accord with his own nature and to develop it, the alcoholic must be permitted to retain the subjective experiences of anxiety, fear, frustration, as the criteria in making the choice in terms of the wish of another person, i.e., the counselor.

(10) If the choice is a really free one, we can ordinarily expect, if abstinence has been maintained, to choose positive change (growth).

(11) The evidence indicates that what delights the alcoholic is also, more frequently than not, "best" for him in terms of future goals as perceivable by the counselor.

(12) In this process the environment (counselor) is very important, though the ultimate choice must be made by the alcoholic.

(13) In this way the psychology of Being and the psychology of Becoming can be reconciled, and
the alcoholic, simply being himself, can change positively (problem-presentation solving).

In the counseling process itself, if the counselor is able to open up to the alcoholic, it has been found that the alcoholic is less likely to erect defenses. The most significant feature of the process that is mentioned by our sample is the relief that the counselor is able to generate in the alcoholic, that the counselor has a knowledge of the alcoholic's feelings and can communicate that knowledge by a frank admission of an identity of feelings. It is not sufficient to say, "I understand." A more direct, although non-didactic, expression is required.

The alcoholic needs to believe that the counselor does understand, but if that understanding can be buttressed by the knowledge that the experiences have been shared, then the knowledge is more dependable and a measure of safety is felt by the client. Perhaps this is the uppermost confirmation of the efficacy of alcoholic counselors who are also alcoholics.

A method of counseling our sample was tried on 21 of the members. For ten of them, the counselor adopted a professionally expected manner, made rather formal expressions of greeting, and then moved promptly to the
problem presentation by the alcoholic. Of the ten, only two were able to express what was distressing them and it was doubtful to the counselor that the genuine reason for the requested counseling session was revealed. It was suspected by the counselor that superficial distress may have been invented by the client to avoid discussing the real issues at hand. The problems were presented in a matter-of-fact way and the acuteness of the client's pain was either not expressed at all or, in the opinion of the counselor, minimized. A restatement of the dialogue between counselor and alcoholic can serve as a model for the ten so interviewed:

C: Hello, Jim. I'm glad to see you.
A: I didn't know whether you had the time to see me. I'm glad you can. [Pause]
[Pause]
C: Well, what's on your mind?
A: Well, I . . . well, I got a lot of problems and somehow I feel that I just can't handle them. I get so discouraged.
C: How long have you been sober?
A: I'm in my fourth month.
C: Good. Keep at it. Any trouble with wanting to drink?
A: Not much. Oh, once in a while I get the urge. But I usually just sweat it out and then it goes away.
C: It will get better.
A: No. Taking a drink is not my problem.
C: Good. What is bothering you so much that you came to see me?
A: It's my job.
C: What are you doing now?
A: I'm working for [deleted] Golf Course and it's a pretty good job. I'm outside a lot and I like that.
C: What kind of money are you making?
A: I put in about 60 hours a week. It's minimum.
C: Minimum pay?
A: Yes.
C: Then you're taking in around $250.00 a week, before taxes.
A: Around that.
C: Well, it's a hell of a lot better than you were doing.
A: Yeah. But it's not enough.
C: You need more money?
A: No. Not so much that, but well, the people I work with aren't very nice. I don't get along too well with most of them.
C: How come?
A: Well, they aren't very friendly and I just feel uncomfortable around them.
C: I thought you were working outside. Do you work alone?
A: Usually with one other fellow.

The remaining period of the session was spent in discussing the job, other opportunities for employment and perhaps there could be a job change in the future which would be more pleasant. At the close of the session the counselor expressed pleasure at the client's sobriety and suggested that before they meet again some thought should be given by the client as to what kind of work would be satisfying.

Another client in almost identical straits and with similar feelings was received in a different manner by the counselor. The following indicates the major difference in the problem presentation:

C: Hello, Jim. It's good to see you, it's been a long time.

A: Well, I've been working and I've wanted to see you but somehow or other, I felt you were too busy and other things and couldn't see me.

C: Jim, we can always find the time. You just have to let me know and we'll work it out. [Pause] You look good.

A: Jesus, how can you say that. These clothes stink and I think I look like hell.

C: [Laughing] Well you could look a little better, but it's just the clothes. You have ... well, you look better, clothes or not. No beard. Is that a moustache you're growing?
A: Trying to.

C: Better luck than I had. God, I tried to grow a beard and it came in in splotches. I don't have much of a beard and the damn thing looked like a patch of weeds. The moustache was pretty good until my wife told me it made me look older. That did it.

A: What color was it?

C: The moustache was gray, the beard was gray and I was gay.

A: [Laughing] I wonder what mine'll be like.

C: Time will tell, Jim. But I like it so far. Trimmed and in shape you'll look very distinguished. Do you want that?

A: If you knew about my job you'd never hear me call it distinguished.

C: The job. Sounds like you don't like it.

A: Oh, I do. It's just that, well, I'm not comfortable with it.

C: I can understand that. [Laughing] Would you believe that I once was a wheat inspector in Kansas?

A: No. You!

A: Yes. I took this job because I couldn't get anything else and it was terrible. 110 degree temperature in the box cars and there were hundreds of them. We had to crawl in and weigh a sample to grade the whole car. I hated it. I hate any exercise.

A: I like being out in the open and working.

C: Is that what you're doing now?

A: I'm at the [deleted] Golf Course doing
landscape work.

C: Sounds okay. I'd be terrible at it, but you have the skill for it.

A: Oh, I have the skill okay. And I like the work. But there are other things . . .

C: Usually are. [Pause] Something is getting at you. Stayed away from the sauce?

A: Now in my fifth month.

C: Better fifth month than the last fifth you drink.

A: Right.

C: You mentioned other things bothering you . . . yet, you like the job. Pay okay?

A: Enough, I guess.

C: Good. It'll be a struggle for you for awhile to get along on what you make. but it's going to get better in time, Jim. [Pause] Well, if the job is okay and the pay enough, it must be your boss, the people you work with, or for, or something.

A: It's the people. I just don't have any friends there. I don't like any of them, and I know they don't like me.

The remaining part of the session dealt with the client's discomfiture with th people with whom he worked, an incipient paranoia and loneliness. At the end of the session, the client decided to take more time to assess his situation and stated he would be back soon to share how he felt in a couple of weeks. The essen-
tial problem was one of loneliness and an inability to relate to non-alcoholics whom he suspected of being unfriendly because he did not drink.

The beginnings of an empathic relationship are not subtle. The most important step is the first one, that of creating an environment in which the alcoholic begins to comprehend emotionally that the counselor has made a similar emotional "trip" to the one the client is making or that comprehension is obvious.

The display of shock, anger or impersonal response will damage the initial search for common ground. A quiet concern based upon a common interchange of experience is a first step toward the creation of the third person.

There is a willingness for the alcoholic to share even the most shocking and intimate details of the past, if he is convinced that the counselor is receptive and has an emotional understanding of what has transpired. If the receptive basis is created then an examination of present difficulties becomes much easier. As the common ground enlarges, the relationship becomes more intimate and sharing. The client can then feel confident that he can move on to the high priority problems which are disturbing to his abstinence.

The counselor must be patient as the alcoholic has
through years of experience learned to travel a circuitous route to reach a controlled revelation of genuine feelings. He may discuss and expose to examination a myriad number of details concerning his daily life, disorganized and without apparent congruency before exposing his imminent problems. The same mode must be maintained by the counselor to these unessential recounts as he would maintain if the principal issue were being presented. It is often through attention to the unimportant and the trivial that the path to the important is found.

From our sample, there is a good example:

Ray, a policeman, was suspended for an extended "drunk." His wife and children although not completely rejecting him were alienated. After he was detoxified, he was served with divorce papers. It was this event that led him to counseling. After three weeks of abstaining he sought help. Counseling was refused until he had obtained more "sober time." In the meantime, the counselor frequently discussed his situation and did offer help of a rudimentary nature, i.e., get a lawyer, find out about the suspension and get a hearing, find a room, take a bath, etc. After the period of sobriety had reached a thirty day period, counseling was initiated.

During that thirty day period, a delay in the divorce proceedings had been accomplished, his suspension was lifted and probation was instituted, he acquired a room and took a bath. All of the obvious advice given was regarded by the alcoholic as affectionate and understanding concern. Through conversations on the telephone and in person, experi-
ences of drinking were shared with the counselor (a non-alcoholic) and the client became convinced that the counselor was a close and intimate friend.

After the three months, the counseling experience had been highly productive and abstinence had been maintained. From his sense of oneness with the counselor, the probation was removed, his job restored without penalty, and his family accepted him back into the home, all accomplished by the client alone. A regular counseling time was established.

It was at this point in Ray's life that the most threatening experience occurred: a compulsion to drink in celebration to job and family. When it was made clear through shared experiences that the client's over-exhileration produced by abstinence and his return to job and family was over-reactive and could produce a threat to his abstinence, diminution of his problems resulted. The essentiality here is that an empathic relationship was established and a movement toward a single identity was initiated.

There are inhibiting factors toward empathic relationships. Differences in age, sex and education can be very influential. However, the inhibitions can be minified and eliminated in time.

Patience, quietness, listening, controlled reac-
tion, and acceptance are basic to the initial relationship between client and counselor.

After there has been established a confidence of understanding, the use of "tough love" can play its part.

It must be emphasized here that every alcoholic must find his emotional or mental "bottom" and the bottom has been reached prior to the abstaining alcoholic's search for counseling assistance. The counselor should recognize the bottom if exposed by the client but not examine it without a voluntary effort on the part of the client.

Experience has shown that the alcoholic client will reveal his "bottom" sometime during the sharing of his alcoholic history. The issue here is that it should be left to the alcoholic to make the decision to share the traumatic experience and it should not be initiated nor stimulated by the counselor. When the "bottom" has been revealed by the alcoholic, the counselor can assume that he has shared in the most degrading moments of the client's past. His reception should be empathic and sympathetic.

The sharing of the low point in the client's past is part of the reinforcement of the alcoholic's recognition of his life unmanageability and his powerlessness
over alcohol. It is a beginning point for the client, it is a precious moment for the counselor.

As counseling progresses there is an accretion that occurs. Past incidents are recounted. The counselor is advised to listen, refrain from judgmental opinion and dismiss the substantive matters as quickly as possible. The information should be stored, but the process is one of initiating self-revelation now by the alcoholic.

It is during this period of self-revelation that the counselor should begin to reveal himself. Problems which have in the past beset the counselor should be recounted and there should be no embellishment or restraint in the recounting. The alcoholic is quick to recognize that which does not "ring true." He is sensitive to "truth" in that he has long practiced the art of self-deception and manipulative deception of others.

No incident or traumatic experience should be "edited out" of the counselor's sharing except that when to edit could possibly be damaging to the relationship.

The recitation in dialogue of past experiences creates additional confidence and trust and slowly the client realizes that he and the counselor have much in common experience. The sharing becomes accelerated and the movement toward each other is strengthened. The feelings generated are of "safety."
As the process continues there will come a time when the experiences of the client and the counselor merge into a common bond.

Positive regard has been mentioned earlier and should be a constant during the movement of client to counselor and counselor to client. It was expressed by the sample that the alcoholic is easily impressed by the credentials, manner, style and appearance of the counselor. The very presence of the counselor is impressive to the alcoholic. The client is so lonely, so isolated, so imprisoned in his own history that unlike many others he is easily impressed by any socially approved person. There may be some resentment or hostility of the counselor's social standing and social approval, but after abstinence, these feelings, as been noted earlier, are usually extinguished.

Positive regard as it is used here is that of an unconditional positive regard. The counselor must communicate to the client a deep and genuine caring for him as a person, he prizes the client in a total, unconditional way. The lack of positive regard will inhibit and usually prohibit the alcoholic from exploring his intimate inner self. He is reluctant to display his "inscape" because of factors of shame, guilt, etc.

We are speaking here of factors that transcend
other forms of counseling and factors which are independent of the theoretical orientation of the counselor. Fiedler has studied a number of therapists using other modes of therapy and sorted them. He found that independent of orientation, there was a similarity among them in their ability to understand, communicate with, and to maintain rapport with the client.\(^3\)

Halkides has reported that the existence of the attitudes of congruence, positive regard, and empathy in the therapist were related to the therapeutic process.\(^4\)

It is obvious that the counseling process being described is closely related to Roger's emotional catharsis, insight, concluding to positive choices and decisions. It is also assumed by this process that the client moves from fixity to changingness, from rigidity of structure to flow, from stasis at one end of the continuum to changingness, flow, to process at the other end.

From Rogers' scale of measurements of the therapeutic change we can extract some commonalities. The alcoholic is not remote from his own experiencing although he may feel discomfiture that is unrecognized and express himself with difficulty. He may suppress. The comfortable alcoholic does not experience a high
degree of incongruence and engage in contradictory self-statements. He moves, he is as he expresses himself. He is also anxious to reveal himself to the counselor, if he is safe, and although he may be cumbersome in expressing his self-awareness, the abstaining alcoholic is anxious to explore himself. He often expresses amazement and delight at his new discoveries of his inner self, his inscape. He is not closed to change but lives his problem. He seeks the capacity to cope.

It is the desire of the sensitive counselor that the close relationship ceases to be dangerous and is welcomed by the client. Risk can be reduced sufficiently so that the relationship is solidified.

Positive regard requires that the counselor prize the client. Rogers has indicated that positive regard can be regarded by the client as indifference.\(^5\)

The attitudes described here are not likely to be experienced by a counselor unless he holds a philosophy regarding people in which such attitudes are congenial. The process is useless unless it is in a context of great respect for a person and his potentialities.

People as objects to be manipulated, people who are to be helped for the "good of society," or whatever, or for their own good, or to satisfy the counselor's need for power and control cannot be part of the counselor's
arsenal in helping the alcoholic with hope of returning to the abstaining alcoholic his sense of self-worth, his sense of self-preciousness. To repeat earlier considerations, the conditions of counseling should be congenial and natural in certain philosophical contexts.

Congruence is the first of Rogers' imperatives in his theory of genuineness. Comment on this aspect is not required within the context of this work, but in simple language, it means that the counselor is under an impelling, unalterable demand to say what he means, as best as possible, and mean what he says, as best as possible, to act as to what he says and say what he does. The counselor who does not perceive this as an essential to his relationship with the client should avoid counseling; indeed, he should seek counseling in that it can lead to an improvement in his own self-esteem and self-worth.

Although it seems simple, the client and the counselor in an amiable and productive relationship, observing the previous precepts, will in their movement toward each other finally touch. The touching is emotional, configurative, and not solely intellectual.

How does one know when the touching has occurred? It is when both client and counselor find that the sharing which is being experience has what appears to
have unlimited perceptual boundaries; there emerges a "give and take" which is non-conflicting and which is maintained without conscious effort. When an incident is revealed in the experience of either the client or the counselor, the emotional reaction is similar, sometimes apparently identical. Feelings of joy and pain, ecstasy and despair, comfort and discomfort, security and tentativeness are experienced by both the alcoholic and the counselor. It is no longer an "I understand" relationship, but rather an interaction mutually experienced by both.

This phenomena has happened frequently, does happen when the relationship is within the parameters of the process discussed.

It is difficult for the counselor. The drain on his emotional reserves is often severe. There often is a need for physical touching and physical expressions of the sharing by touching a hand, offering an embrace, or merely maintaining an eye contact that tells each that there is a mutual bond being established that can be sustained at the will of each. There will be times, as it occurs with greater frequency than the casual counselor anticipates, when the emotional touching is too great for either the client or the counselor to afford. Either may retire from the encounter because
of the cost. However, a spacing of the sessions and a temporary withdrawal of the possible emotional intimacy of the two can serve to temper the poignancy of the relationship.

As the touching continues there seems to develop an over-lap. The client and the counselor move so closely together that neither can impede the overlap in which a part of the alcoholic becomes a part of the counselor and the third person is born.

The third person produces certain characteristics which are provocative:

(1) The disclosure of the client's emotional and mental state becomes known to the counselor without verbalization.

(2) There is an intuitive relief experienced by both of common knowledge of the emotional or mental state of both: the relief accelerates the merging of the common bonds into a "person," a "person" of the parentage of each, yet not encompassing the totality of the personality of each.

(3) The third person becomes an objectification of part of the feelings, cognitions, and configurations of each and exists so independently that he is recognizable by each as being
one, yet separate from each.

It has been found useful to refer to this third person after he has been created. The counselor can then feel free to ask, "Considering the situation in which we are, what would the other person do? What should the other person do? What is likely to happen to the other person?"

In action it is often blunt rather than simple, unadorned rather than decorative. The third person allows both the client and the counselor to objectify the discomfiture and then proceed to try what is best or seems to be best for the third person. The client then is able to bring to his cognitive and emotional perceptions a depersonalization which reduces reluctance and extinguishes fear.

An example may provide clarification:

Roger and his wife were in deep conflict over the exercise of discipline over their fourteen year old daughter. Roger had been the principal in administering discipline and despite his twenty years of alcoholic behavior in the home, he was a person of authority, possessing a demeanor that commanded respect. He had been for years a Marine officer but his behavior had been tempered considerably by abstinence.

His wife was compliant, affectionate, easily forgiving of episodes, reluctant to administer punishment. She and the daughter had during Roger's alcoholic period banded together in mutual support against Roger.
Both daughter and wife were in a state of euphoria because Roger had become abstinent.

Yet the differences between the parents regarding discipline and Roger's intolerance of the disregard of "his" rules of behavior had produced deep conflict, angry exchanges and quarrels.

During the counseling of the two, the anger reasserted itself as Roger blamed his wife for the behavior of their daughter and the wife considered him cruel and unnaturally demanding.

Roger and the counselor had been maintaining a counseling relationship for several months and both of them had "touched." The third person relationship was emerging and both of them had a rapport that the wife accepted and understood. She was grateful for the changes in Roger's behavior which she attributed to the counselor.

During one family session as Roger and his wife visibly expressed their differences and were on the verge of an angry exchange the counselor observed:

"Roger, we know that you believe that discipline is your responsibility and we know that you enjoy that responsibility. But let's look at the situation as it appears to us. Do we believe that one who has been drunk for twenty years, squandered the family resources, physically assaulted his child, lived in estrangement from his wife during that twenty years can command respect from a young woman despite her seeing a sudden change in behavior, which to her is inexplicable. Do we believe that we can tell this child how to live her life, when we have made our lives such a disaster for such a long period of time? Do we believe that the child will believe us or listen to us when we try to tell her how to live her life?"

The tension was broken and both Roger and the wife broke into laughter.
Following this session, Roger stated that he believed that he should withdraw from an active participation in the administration of family discipline, and that he and his wife should share the responsibility, speak with one voice, and only after they had thoroughly and completely agreed on a procedure which would be constructive and helpful to the child. If there was no argument, the wife's suggestions would be implemented by both parents. We was the third person.

The third person can be evaluative. Would the third person get a divorce, change jobs, vent anger, pursue a sexual affair, etc.?

When both counselor and client create the third person, there are a number of avenues to pursue as they are presented. Both can enjoy the examination of feelings and possible behaviors which the third person might pursue.

There is little that is unusual in this structure, but when client and counselor have endowed the third person with similar or identical value systems a more rational examination can proceed.

To some it will appear as a minor technical device, but the person created should be real in the sense that both client and counselor recognize their own creation and accept the existence of the third person without "game playing."

Our methods of communication are verbal or body/
sound communication. One uses words, the other facial expression, body position, voice tone, muscle tonus and breathing tempo.

The voice may say one thing and the rest of a person may say something else.

Satir points out that double-level messages result. She holds that such double-level messages result from the following:

(1) Low self-esteem and bad feeling because of feeling that way.
(2) Fear about hurting another's feelings.
(3) Worry about retaliation.
(4) Fear of rupture of relationship.
(5) Fear of imposition.
(6) A lack of significance to the person or the interaction itself.

She states further that the person is unaware that a double-message is being given.

By eliminating these factors by empathy, a positive regard, honesty, or congruence, factors in the counseling relationship, the fears and double-message making is radically reduced. So it is with the third person.

What occurs?

The third person may be created which is capable of talking to himself. It is observable at Alcoholics
Anonymous meetings that frequently a speaker or a commentator is engaging in a conversation that may seem to be a monologue, but in reality is an interchange taking place within one's self. Others may listen and learn, but the incident is a self-dialogue.

The third person may be a questioning one, a doubting one, a reassured one, a dogmatic one, but above all a feeling one. The counselor who is able to share in the life of his own partial creation may eliminate the need for any questioning whatsoever of the client.

A paraphrase can be constructed: What are the most important things in my (our) lives? Ourselves. What is destroyed in our relationship with others if we fail to protect and nourish that self? The Self itself. What is Me? I am a person and I am a person who is related to all people. I exist only in terms of my perceptions of myself. To my self has been added a part of you, and I have become a part of you, so my self is not only what I perceive alone, but what I perceive in you. Your contributions to my perceptions of me and what I perceive in me and my contributions to your perceptions of you and what you self-perceived is The Third Person.

It is as in music, the over-tone, the tonal dynamic that the perceptive listener hears when notes are played. The conductor must, if he would be capable, hear
more than the notes. He hears a tonal dynamic that is unique and enriching, that is more than the single or combined notes. He hears a third sound.

Is it important that the third person develop?
Yes. But it is not necessary for help to be given and help to be received. It is the high moment when one sees that between two or more people there exists another person, containing part of both with a similarity of feelings and perceptions mutually shared.

It is the pinnacle of the counseling process of the abstaining alcoholic.
"Louie, you had a definition of jazz that I read. You said something like if you don't know what jazz is, you ain't never goin' to find out... something like that."

"What I was saying is there are some things you don't say anything about. You just do and it feels good, or it feels lousy. Then you know what it is. It's what you do an' how you feel when you do it that tells you what it is."

"Yes."

--From a conversation with Louis Armstrong at Storyville, Harwich, Massachusetts, 1961

"Blues is the poor man's heart disease."

--From a conversation with Woodie Guthrie

The quality of the relationship between the counselor and the client is of paramount importance in developing any facilitation of change. The quality requires attitudinal and assumptive sets.

Religiosity and Religion

The variety of gods available during the history of man is encyclopedic. Just prior to the fourteenth century, Thomas Aquinas, in his twenty-five volume Summa Theologica, published the consummation of twelve hundred years of Western thought, intellectual conflict.
and turmoil by contending factions. Aquinas wrote from the prevalent view that Jesus had been the Messiah whose coming had been so long expected by the Jews. He was viewed as the literal "only Son of God" for all human-kind. Later leaders of the Christian movement came to believe that Jesus had been God Himself incarnate in human flesh. The movement was a prosperous one and Christianity found its identity. God was a personal One who could and did intervene in the affairs of man.

Many controversies were brought to an end by the *Summa Theologica*. Aquinas fused the two great strains of Western culture: the Judeo-Christian and the Greek. He wove into a single system a tapestry of thought, reason and revelation, the secular and the sacred, the intellectual and themoral, the temporal and the spiritual. This system drew the best from the past, satisfied the demands of the present and pointed a way to the future.

However, the Christian edifice began to crack at the very time of its erection. Even as the great cathedrals were being completed, while Emperors bowed to Popes and the faithful crowded the churches, Avaroes, a Moslem and a student of Aristotle, had learned the Socratic skill of asking questions. In asking, he taught men to return to the Greek way, to seek out their own answers. Some began to do so. This Medieval reforma-
tion was destroyed for reasons that were intensely political; but four hundred years later the church which dominated the Europe of that time began to crumble. The West was in rapid and quixotic change: intellectually, economically, socially and politically.

The questions remain for the counselor: Is there an interventive God? Can one turn to a Higher Power for direct answers to questions? These speculations are discussed here because of the permeating influence in many alcoholic counseling entities of a modality of "asking for help" from non-human sources or a celestial entity.

The idea of God no longer holds meaning for us the way it once did. It is not outside the realm of possibility that a Godless religion may emerge in a variety of Christian secularism.

The movement known as Christian Secularism acknowledges the obsolescence of Christian doctrine but it places great emphasis on the role of religion in our secular world. We now use phrases such as "Post-Protestant" and "Post-Christian" and "Godless" as if to prove it.

The disappearance of the God of tradition is a restatement of what Walter Lippman was saying in his Preface to Morals:
There is a revolution in the realm of the spirit. Whereas men once thought they were living under the eye of an all-powerful spectator, today they are watched only by their neighbors and their own consciences.¹

Lippman urges us not to be frightened by the changes, but to stand up to them: "The mature man will take the world as it comes."²

Disbelief in the Trinity, doubts about the occurrence of miracles, and the presence of a host of doctrine cults are having their effect. How much have things really changed? That is a question for the theologian, but we are still engulfed by television and print urging us to regard the Bible as "God's Word." We still hear of petitions to the Almighty to intervene in the affairs of men and the same declarations of the belief in Him stated in the identical language of the Fourth Century or earlier.

Therefore, the question of God-existence and God-concept is important for the counselor. Does he believe in an interventive God who can, through supplication and prayer, be moved to change man as an individual, affecting his behavior so effectively that life becomes better? A counselor who believes in the existence of a personal God capable of receiving importunings, responsive to prayer, making specific moves to enlighten and
strengthen the efforts of an individual to change his behavior, has become a theologian.

The counselor need not be a minister. But it is common among many counselors to regard themselves as minister particularly in the counseling of the alcoholic. Counselors who do this still expend their best effort in an attempt to salvage what they can of yesterday's gods. There is an almost constant effort on the part of mankind to breathe life back into the gods of their fathers.

But Gods, like men, are mortal. They are born, they live for awhile, they do their work and then they pass on to wherever gods go when they die. Man has thought of the Deity in a variety of ways, but as time has gone on, his thought of God has changed, just as it has changed for today and will continue to change for tomorrow. Again we refer to the absolute upon which this commentary is based: change. Gods are mortal because the thoughts of the men who conceived them are mortal.

It is important for the counselor to examine his thoughts concerning his relationship to God and to consider with great seriousness his role in relationship to his God, should he happen to believe in It. In the event that God is rejected, is man to be left then with
his own thoughts, to worship with no guide for conduct, no understanding of the meaning of life? Perhaps so. We surrender often to the _Zeitgeist_, tugged this way, pushed another, by the forces of our time, unaware of the moving tides far beneath the waves upon which we ride. Our task is to see that this is so, and the task is to face up to the passing of yesterday's Gods, to see that we cannot _worship_ them when we don't believe in them. The great danger to the counselor is not in the abandonment of yesterday's gods, but in counseling in their honor, hoping to sustain a fading faith in which the counselor himself may or may not believe. It is a poor form of worship to place pretense upon the altar. To the counselor who no longer believes in an interventive god, it is suggested that this belief be laid gently aside with honor and respect because of what it meant to those who have preceded us. But, if the counselor still believes in the intervention of God into the behavioral affairs of man, a God that can alter man, make him "reborn," then indeed his counseling should be appropriately affected, and his counseling should be directed toward the importuning of that God. But if that belief has been rejected, it is suggested that the counselor make room for the gods who now live within our hearts and claim our allegiance today.
It is strongly suggested that one cannot worship what he chooses; he worships what he must.

When one reflects the Higher Power as being manipulative of man, it forces the responsibility for man's behavior upon himself, if he is healthy and emotionally capable of discharging the responsibility. When we are aware, we are responsible for what we do. When we are unaware, our society justly absolves us of that responsibility and thus removes the guilt. So it is in criminal actions; in alcoholic behavior, society is not frequently so generous. The individual must then absolve himself.

It is possible to believe that the traditional Gods are not personal but, rather, impersonal. The result is the same: the responsibility must for now fall upon man. The impersonal God, however, who permits "the rain to fall on saint and sinner alike," can be an ally in affecting change. This statement will be expanded upon later.

Are there Gods that can be of service to the counselor for today? We have given up the gods Jupiter and Juno who now inhabit our museums and not our temples. Mazda, Mithra and Dionysius have also been discarded. We have also given up the Yahweh who created the world in six days. There are as many reinterpretations and
reexplanations of ancient texts as there are texts. Michelangelo did not paint God, he painted an old man; he did not show us the first man, he showed us a young man.

It is difficult if not impossible to see one's own time clearly because time cannot be isolated. The Iliad can illustrate the point. Homer wrote of the heroics and defeats of the gods themselves as they tried to direct the fortunes of the Greeks and Trojans on the plains of Ilium. The Homeric picture of Zeus shaking with laughter as he watches the gods contending with one another over the hapless and hopeless Greeks and Trojans is magnificently remote from Yahweh constantly punishing His chosen people for violating His laws. Yet the time was the same.

The counselor who conceives of Deity as a dour moralistic cosmic ruler and applies this to man's behavior is in difficulty, for the counselor then becomes the instrument of God's activities among men. He becomes a device for the delivery of an unending chronicle of punishment to be meted out to disobedient clients.

The habit of asking questions and developing independent thought is characterized more by courage than be fear. An interesting quotation for the Sixth Century B.C. by Xenophanes in Athens is pertinent:
The Ethiopians say their gods are black and flat nosed; the Thracians say theirs are blue eyed and red haired. If oxen or horses could draw gods like men do, horses would draw gods like horses and oxen like oxen.  

Man has therefore created God in his own image.

Further, Xenophanes said:

There never has been nor will there ever be a man who has certain knowledge about the gods. For though he should happen to speak the whole truth, he himself would not know that he was speaking it.

To think independently is frightening. Even in ancient Athens this process was limited. In the Age of Pericles, Athens passed a law directed against those whose questions and problems would be said to be undermining belief in the Olympian deities. Anaxagoras was found guilty of blasphemy and was fined and exiled, for he taught that god was an abstraction.

Pythagoras wrote a tract on the gods, the opening lines of which read: "Concerning the gods I cannot say that they exist or yet that they do not exist." Euripides was prosecuted for impiety, and Socrates was put to death because he was an atheist.

A function of the counselor, therefore, is to determine where he stands in relationship to the spiritual world and its effect upon human behavior, if any.
The Emperor Julian, whom Christian historians call the Apostate because he reverted from the official Christiandom of the Empire to the worship of the ancient gods of his people, raised these questions in the Fourth Century A.D. An ascetic by nature and a stoic by conviction, Julian dismissed "the thousands of hair dressers and the innumerable cooks and eunuchs of his Christian predecessor."

For Julian, gods were forces, not persons. Under Julian, a man named Salustius issued a document designed to explain and justify the ancient gods for intelligent and high-minded Romans. It is a remarkable piece of writing. The opening paragraph speaks on the gods of the world:

Those who wish to hear about the gods should have been well advised from childhood and not have become habituated to foolish beliefs. They should also be in disposition good and sensible that they might properly handle the teachings. They should also know that common conceptions are those on which all men agree as soon as they are asked. That all God is good, free from passion, free from change. For whatever suffers change does so for the worse or the better. If for the worse, it is made bad; if for the better it must have been bad at first.

The myths of Olympus are not to be taken literally; they are allegories. The myths of the Bible do not so much state the truth as they reveal it. The supposition
that the roots of this kind of thinking is not Christian, but pagan, have not been sufficiently examined. The counselor should avoid allowing himself to assume that the gods of yesterday can serve as the gods of today, and that they can be reinterpreted to be abreast of contemporary thought. The failure to guarantee persuasion yesterday does not guarantee persuasion today. Julian was unable to bring Rome back to the foot of Olympus; neither can we be brought back to Eden, Gethsemane, the Sinai or the Mount of Olives by Paul Tillic or Reinhold Neibuhr.

Patchwork gods may please the minds of the pious, but they cannot feed the "soul" of either the counselor or the client.

If theology involves so much repetitive folly, why do we keep at it? Why are we concerned with it? Because behind it, beyond it and within it, lie the most important questions a man can ask: Who am I? Where did I come from? Why am I here? What is the meaning of my life and where am I going?

If we cannot worship the gods of today or bring them back to life from a far-vanished age, what should we do?

Perhaps this discussion about gods could be made more pertinent by putting it directly into the client-
counselor relationship. If the counselor has no center of conviction regarding the universe and power outside of himself, before what does he express his humility? It is suggested here that the answer is, "yes." There are several abstractions which are of importance to the counselor. There is nothing new or startling about these abstractions. They are old and familiar friends. But they are Truth and Virtue, Beauty and Justice, Mercy and Loving Kindness, Liberty and Honor. This list is not limited; it is not complete. It is offered here only to make the counseling concept clear.

It may seem odd to suggest to the counselor that ethical principles play an important role in his relationship to the client. But the suggestion has an honorable history.

The Greeks personified abstract principles in exquisite human form; we do not hesitate even in this shoddy century to set up similar statues. Justice sits atop the Supreme Court in Washington; Freedom stands atop the Capitol. Frequently one finds personifications of abstractions: Truth, Virtue, Brotherhood, etc., adorning public buildings. Parenthetically, it is interesting to note that most of them are women. Apparently our society identifies these abstractions as female whether or not women are willing to accept the
accolade.

This is not to suggest that the abstractions are feminine or even that they are human. They are Abstract Principles. The human form is used only in the metaphorical sense.

Abstractions, are very real in the sense that they are both in this world and beyond it, and yet unseen, operating as tremendous forces in life. They are spiritual in the sense that they do possess our minds and consume our hearts, and can lead both counselor and client to better things than they have know before.

They are God-like in the sense that they still issue commands. The vision of Truth demands that the counselor be truthful, and seek the truth in every aspect of his life. Beauty and Goodness, Justice and Mercy, Tenderness and Love, command us to be beautiful, good, just, merciful, tender and loving. The counselor may be false to these commands as one can be false to any god he worships. But, we cannot do it without a sense of wrongdoing. It is not necessary to call it "sin," although Menninger has asked in a recent book, Whatever happend to Sin.

The point being made here is that we as counselors must be loyal to these abstractions or we become disloyal to ourselves.
To perceive truth is paradoxical; often one perceives it by seeing falsehood and eschewing it. To see beauty is oftentimes to see ugliness and eschew it. To see virtue is to see vice, and in this sense virtue is seen as life creating, sustaining, enhancing and indeed maintaining. To see vice is to see that which shortens life, distorts it, perverts it. As virtue and vice are seen in juxtaposition, it is required that a choice be made between them.

The abstractions exist, and it is possible for both counselor and client, together, to touch them, even though they are abstractions.

The counselor can experience a sense of inescapability—that the concept or the notion that we ask for, and seek, for others, we must also ask and seek for ourselves.

From another view, the counselor can identify impelling abstractions with Nature: rivers, mountains, trees and animals. Inevitably Nature becomes identified with himself. This can be mischievous; it is the notion that a particular person becomes a "God," or the authority of God. The history of this world is literally drowned with the blood of those who dared to challenge the claims of those who claimed to know the will of God. The cries of the tortured rise from almost every page.
of history. History is the record of men imposing one's will upon others. Usually, it was done in the name of God.

It is a strange and colossal conceit that God created man in his own image. Perhaps the truth is that man created God out of despair with himself.

Why these speculations in a work on counseling?

It is for a precise reason: the effective counselor must know not only himself, but himself in relationship to the imponderables of existence.

In Frazer's *Golden Bough*, the opening passage reads:

In a sacred grove in Italy in ancient times there grew a certain tree, round which at any time of day and probably far into the night a grim figure might be seen to prowl. In his hand he carried a drawn sword and he kept peering warily about him, as if at every instant he expected to be set upon by an enemy. He was a priest and a murderer, and the man for whom he looked was sooner or later to murder him and hold the priesthood in his stead. Such was the rule of the sanctuary. A candidate for the priesthood could only succeed to office by slaying the priest, and having slain him, he retained office till he himself was slain by a stronger or a craftier. The post which he held by this precarious tenure carried with it the title of king; but surely no crowned head ever lay uneasier, or was visited by more evil dreams. For year in, year out, summer and winter, in fair weather and in foul, he had to keep his lonely watch, and whenever he snatched a troubled slumber it was at the peril of his life.5
Notice that it was a tree standing in the midst of the sacred grove round which this primitive prowled. In a later and less morose vein, the Greeks tell of a tree that grows golden apples, which stands in the midst of the garden of the Hesperides. And at the center of the Garden of Eden there is the Tree of Knowledge, bearing fruit which gave man the knowledge of good and evil. A thousand years before, the Sumerians believed in a tree of truth; in Buddhism we have the Tree of Enlightenment.

Trees are similar to each other as the virtues are similar. They stand together; they are interrelated, yet they stand apart as the trees of the forest stand apart. A tree is a living, growing thing. It is like the abstraction of virtue. The tree is born, lives and dies. It does not suddenly appear from nothing. A tree is one with all life. Its true beginnings lie beyond its own germination. The origins of any tree will force us to go back to the ferns of a Permian swamp, back to the brackish ponds where life chose to be the beginnings of earth time. A tree has its seasons; it is dormant, fills with life, grows, becomes lush, and strong and powerful. Then it faces dormancy again, clothes itself with unbelievable beauty and then is quiescent, sturdy and bare, in the face of storm and stress. And all the
while it is gathering its strength to begin its activity all over again.

Abstractions have their lives as well.

In California the great Sequoias are described as the oldest of living things. It is a natural cathedral, that forest.

When one meditates upon the elemental things in life they are enveloped in silence and loneliness. Everything is fragrant and alive, everything is warm and moist, colorful and clean. Standing among the Sequoias of California with no one to direct your thoughts, no one to challenge, ask yourself: What do I most deeply believe? What is the meaning of Life? What is the meaning of my Life? How shall I live? What shall I do, and why? It is in the contemplation of these questions that the skilled counselor receives his preparation.

It is in this temple grove that one can learn to grant honors to no one person that he is not willing to grant at all: a basic principle in dealing with the troubled. The tree of Mercy reminds the counselor how frail he is, and that the client is as frail; both must be willing to understand and forgive the frailties of each other and of all mankind.

The tree of Freedom will insist that we give to everyone all the freedoms we ask for ourselves.
The tree of Truth demands that we listen to everyone who thinks that his understanding of truth is clearer than ours because the search is the sustenance.

The tree of Love evokes in us the capacity to care for the client, in short to care for others than ourselves. If we do not obey, we feel strangely unclean.

That is why there is a slavish adherence to the principle that all things are subject to change and this chapter tries to direct us to questions which are part of the training for the recognition of change.\footnote{6}

**Cries for Help**

If one as a counselor responds to a cry for help, no matter how difficult our language, how sanctified our tone, if it is not in our heart as we offer it, it is of no help at all.

In the course of examining therapies for the treatment of alcoholics, we will find a wide variety of modalities. It is suggested here that we respond to the cries for help within the context of empathy, positive regard, honesty: in relationship to our gods.

There will be those who believe in a God, whether Biblical or scientific, who will hear prayers and decide for good reasons or bad which ones to answer. There will be those who believe in devils accountable for what
happens to them, and there will be those who do not believe that the universe operates at the direction of any celestial being, either benevolent or malevolent. There are as many views of God as there are God's views of man.

One cannot ask for help from that in which one does not really believe. Yet, the counselor can believe in aspiration. He can open up his own inner spirit, his own heart, to the reality of universal love. In so doing, he strengthens his own capacity to love. By aspiring to love, one increases one's capacity to love. Without love, counseling cannot take place.

Perhaps one is talking about prayer. Because the abstract principle of love is a process, love does not sit in a Heaven hearing a prayer and, if pleased, granting the request. It has not happened in real life, nor does it happen in the psychic life. If it does, one is still thinking of God as a cosmic superman. If God is a cosmic Superman, there is no need for a priesthood; there is no need for counselors.

The yearning for love brings love because that is the nature of man. If one could be helped by celestial factors alone, there would be no need to go to a doctor. It is suggested here that one apply the principle of love in the counseling relationship; it will be answered
in the asking for it. One does not pray to love, but prays for love.

These abstract principles for counseling lay a burden on the counselor that is sometimes too heavy to bear. But, they can lift one up to heights so high that they defy contemplation.

The Paycock in Sean O'Casey's *Juno and the Paycock*, the almost perfect dramatic comedy, whose absurdity is a carapace for life's terrors, declares that, "The whole world is in a state of chassis." He speaks an absolute: the whole world is in a state of change.

Clarence Meader, who provoked his students by his lectures at the University of Michigan, would often peer with his one good eye and, moving like a spastic gnome, proclaim, "Nothing is constant excepting, perhaps, numbers." He, too, was affirming the same absolute.

These are venerable thoughts, in symmetry with the thought of Marcus Aurelius Antoninus (A.D. 121-A.D. 180) in *Meditations IV*: "The universe is change; our life is what our thoughts make it." Perhaps Marcus Aurelius was echoing Heraclitus (575?-540? B.C.) who six centuries earlier in two fragments told us that, "All is flux. Nothing is stationary . . . . There is nothing permanent except change."  

This document has been written with some assump-
tions in mind of which the first is: An effective counselor attempts to assist the client to become aware of continuous change, change which is a process, and which occurs whether we desire it or not.

There is important evidence that Marcus Aurelius and Heraclitus are correct. Evolution never retraces its steps.

It requires little intelligence to observe that man changes physically during his life span. External observation of man provides simple evidence that he undergoes change. It is reasonable to assume, therefore, that the world within, the psychic world, the inscape is also in a process of change and is never static. The world within and the world without may seem to be radically different, but there is one characteristic in which they are identical: The world within is constantly changing just as the world without is changing. As we are aware of our existence, we are aware of our inner changes; we know that we are in a state of "feelings change." Every experience changes man internally and externally. Unfortunately, we are not always able to observe precisely what the internal changes are. It is often frustrating merely to try to identify those changes and even when the identifications are made we are not certain, and the information received is so
evanescent that we suspect it to be of dubious value.

However, change is experienced. The counselor's effectiveness is improved when he accepts the premise of constant change and can stimulate improved self-perception by the client of the changes, eventually using the awareness of change as a beginning point for enhancing life.

There are several serious societal pressures which inhibit the free and open observation of the change process. Some counselors assume that man moves "forward and upward" in his search for the ideal, subjected to the influence of Emersonian Nineteenth-Century thought. The psychological upward mobility of man as an assumption probably emerged from the tidy eighteenth-century acceptance of the "Eternal Fitness of Things."

Directions which are valued by individuals and society may be of lesser value as time transpires. "Human development" is too loose a phrase to describe human change. To find patterns in human development and to describe change in terms of development is similar to describing a vast mountain range as hilly.

We are on the earth a very brief period of time; we came on the earth from an unknown, we are here with limited knowledge, and we will leave without much effect on the ever-changing universe. It is, therefore, impor-
tant for the counselor to be aware that the basic question is: why is life not better than it is while we are here. The question can be examined and some answers, however nebulous and transient, can be perceived.

Thoughtful people have agreed that man is unique, but most of the basic questions which perplex us are unanswerable at this time.

How then should the counselor regard Man? It is all too common for man to be regarded as a "what" rather than as a "who." In the Book of Psalms, Number 8, the Psalmist sang:

What is man, that thou are mindful of him?  
And the sone of man, that thou visitest him?  
For thou has made him a little lower than the angels,  
And has crowned him with glory and honour,  
Thou madest him to have dominion over the words of thy hands;  
Thou has put all things under his feet,  
All sheep and oxen,  
Yes, and the beasts of the field;  
The fowl of the air, and the fish of the sea,  
And whatever passeth through the path of the seas.

David has erred. Man in the context of our fragile time is not a "what" but a "who": a somebody, some body, a who. This is a practical comment: to regard man otherwise is to assume that we are governed by forces so great and external to us that we cannot consciously alter the quality of our life. There is too
much evidence that by perception and examination of change, the quality of life can be altered.

In a larger context, the Psalmist is affirming that man, with all his power, is still himself only a creature compelled to live in an impersonal universe. It is a majestic and awesome concept: he is compelled to live within the universe, to draw from it meaning and purpose if he can. But to draw meaning and purpose from the universe is the province of the theologian. For the counselor, to draw meaning and purpose from one's own internal life is pertinent, from his inscape.

The suggestion is made here that the counselor become a facilitator of change, and that it is in his perception of man that his effectiveness as a facilitator is strongly affected. The counselor may be faced with the questions of whom he will influence, what means are to be used, what goals he hopes to assist the client to achieve, or what ends he seeks.

The question "Who is Man?" has produced mechanistic, behavioristic, humanistic, holistic, trans-personal, transactional, and countless other answer-theories. It is bewildering. However, often the individual who comes from a cultural and personal history in which man is considered a product of the supernatural; he has been strongly conditioned by a variety of theological dogmas.
Present literature in counseling gives too little consideration to answer-theories which are rooted in the supernatural.

**Sins, Wrongs and Evil**

Despite the variety of points of view suggested by twentieth-century theorists of psychology, biology, and anthropology, theologians have continued to hold sway over the thoughts and feelings of a vast number of people. It is still common in the organized Western church for the troubled to be thought of as individuals who have descended from the original state of the Bliss of Eden. The doctrine of the Fall of Man is still a doctrine of a Paradise Lost, with troubled Man as the victim.

Some Eighteenth-century theorists and scholars thought otherwise. They substituted for the Fall a series of steps upward, "human progress," in a somewhat systematized advance for the years that lay ahead.

In every part of the earth, the progress of man hath been nearly the same; and we can trace him in his career from the simplicity of savage life, until he attains the industry, the arts, and the elegance of polished society.  

Spenser, years before Darwin, made substantial his
theory that all scientific knowledge was leading toward evolutionism. Malthus, Montesquieu, Voltaire and Comte contributed to the idea of the eventual perfection of man. It is unnecessary to develop an incursion into anthropological and cultural positions prior to this century, but the idea of a competitive system leading to the eventual emergence of a Zarathustran prototype became part of our common history and persists today as part of our cultural thrust.

The counselor, therefore, must be prepared to interact with those who cling to the concept that man is a flawed Divine creation, flawed by original sin. The counselor who fails to prepare for such an encounter is naive. However, counseling can make use of the supernatural or the supra-natural.

We often hear an individual say that he is "getting in tune with" himself—a crude phrase. A sense of self coupled with a sense of other is precious. With a client aware of both senses, the counselor is handicapped if he is either ignorant of the concept of "other" or for reasons has rejected the other because of a slavish devotion to self.

Martin Buber's illustration from his Between Man and Man may seem appropriate:
When I was eleven years of age, spending the summer on my grandparents' estate, I used, as often as I could do it unobserved, steal into the stable and gently stroke the neck of my darling, a broad dapple-gray horse. It was not a casual delight, but a great, certainly friendly, but also deeply stirring happening. If I am to explain it now, beginning from the still very fresh memory of my hand, I must say that what I experienced in touch with the animal was the Other, which, however, did not remain strange with the otherness of the ox and the ram, but rather let me draw near and touch it. When I stroked the mighty mane, sometimes marvelously smooth-combed, at other times just as astonishingly wild, and felt the life beneath my hand, it was as though the element of vitality itself bordered on my skin, something that was not I, was certainly not akin to me, palpably the other, not just another, really the Other itself; and yet it let me approach, confided itself to me, placed itself elementally in the relation of Thou with the Thou in me. The horse, even when I had not begun by pouring oats for him into the manger, very gently raised his massive head, ear flicking, then snorting quietly, as a conspirator gives a signal to be recognizable only be his fellow conspirator; and I was approved. But once— I do not know what came over the child, at any rate it was child-like enough—it struck me about the stroking, what fun it gave me, and suddenly I became conscious of my hand. The game went on as before, but something had changed, it was not longer the same thing. And the next day, after giving him a rich feed, when I stroked my friend's mane he did not raise his head. A few years later, when I thought back to the incident, I no longer supposed that the animal had noticed my defection. But at the time I considered myself judged.10

The placement of Buber's recollection in juxtaposition to the concept of man as a flawed creation of the Divine, and as an improving species that will at some
future time near perfection, is not without purpose. The experience of Buber has an element of the experience of our collective past. We grew up with it. It happens to us in our searching for Gods to worship, our belief in Santa Claus, and in the many deities of our childhood who later turned out to be as flawed as we, but with whom we can eventually embrace and come into a new oneness because they are like ourselves.

To see man as separate and apart from the rest of creation is not repugnant to a concept of the Divine; it is difficult, but, if one can, there is that "soul" by which we and the unknowable can communicate.

So far, we have made two assumptions:

(1) The one constant is change, external and internal, in man.

(2) Man is special, is a "Who," and who may be separate from the rest of creation but, who, because of that "soul" by which he and the unknowable can communicate, is unique.

God or "The Higher Power"

Although one cannot, rationally or emotionally, ignore primitive origins and evolutionary history, nor sustain a priori theological assumptions, there are themes in the human fugue that remind us that Buber's
"I--Thou" and Maslow's "Self-Actualization" possess an intuition of common truths making possible the Third Person creation.

Although many of us reject much of previous thought concerning the separation of man from the cosmos, there is a cohesion behind the procession of personality-pictures of the gods of men and Man.

A synthesis of past speculation and more contemporary speculation is possible. Ralph Burdhoe has tried to express the syntheses:

"Even though some humanist and apologists for religion have supposed that the psycho-social sciences necessarily imply that religions are worthless myths, or that the physical sciences imply that man is an alien accident in a world that evolves without direction, some of the leaders of these and other areas of scientific culture have been pioneers in providing scientific grounds for understanding that religions are in fact repositories for wisdom and that man is not alien in the cosmos. Some . . . examples of specific beliefs that have had tremendous significance for morale and morals, and which may now be justified and revitalized by reinterpretations in the modern, scientific frame of reference, include . . . .

**God-Evolution**

1. The belief in a "transhuman, sovereign Power" that did create and does sustain, and ultimately determines, human destiny, a power characterized by laws which must be obeyed if man is to have life rather than destruction: such doctrines can be shown to correspond very closely with contemporary scientific views of
natural selection, adaptation and evolution at all levels from molecules to men.

**Immortality-Genotypes and Culture Types**

2. The belief in some effective continuity of an individual's significance (even for the pattern of his basic substance) beyond the grave finds large support in recent scientific views of the continuity of the genotypes and culture types of Homo Sapiens.

Rational grounds for various virtues become clearer through a scientific examination of the reality of man and his world. For example:

**Humility**

1. Humility arises naturally if one understands from evolutionary views that man's basic powers and skills for life are the heritage given him from a billion years of trial and error and a million years of cultural trial and error.

**Altruism**

2. Altruism and social concern are generated by the view that the sciences support as much as the poets, and with clearer evidence, the fact that no man is an island, but all are parts of the main. Ecological living systems are interconnected webs.

**Repentance**

3. Repentance comes more readily if one understands the notion that life and its advancement is necessarily a trial-and-error program of learning, that errors (something like "original sin") are inherent in the nature of the process, and that a system of reality of transcendent power, "natural selection," is daily and hourly scrutinizing
throughout the world, every variation, even the slightest, rejecting that which is bad, preserving and adding up all that is good. (That last description was written by Charles Darwin himself a hundred years ago.)

Joy

4. Hope, courage and joy in the search for life, in spite of seemingly overwhelming adversities, are more reasonable attitudes for those who understand that in spite of thousands of failures—in fact, often just by means of them—eventually a high level of life in which they themselves may actually participate is coming into being and will endure.

Motivation

Critical to the moral problem is motivation. Religions in the past have successfully evoked motivation through the hope of reward and fear of punishment by superhuman powers, which are no longer effective when no longer genuinely believed. But, we believe that the selective forces pictured by the sciences as inherent in the reality that has operated to structure and motivate human behavior throughout our evolution to date can be shown to constitute a superhuman sovereign power which men must heed. The relevance of the scientific for the religious revelations concerning the sovereign and ultimate powers determining human destiny can today be made clear in dialogue between scientist and theologians, and thus revitalize a religion that can more effectively motivate moral behavior by inducing genuine convictions about ultimate consequences."

Can the counselor privately believe that man is divinely and separately created, and that all mental and/or emotional distress is a display of weakness or a
movement away from God--i.e., sinful--and still regard the client seeking help nonjudgmentally? Or, at the polarity, can the counselor who believes that man is a primitive, albeit evolutionally-improved, individual, endowed with selection and reason, capable of mastering the abstract through conceptual creativity, but nevertheless a primitive possessing an id, a little higher on the evolutionary scale than the hyena--can that counselor still maintain in the counseling context an attitude of positive regard and empathy, or, in the genuine relationship between client and counselor, honesty?

A century and a half ago at the birth of modern India, Ram Mohan Roy, India's spiritual father, enunciated the principles of the Brahma Samaj:

We believe that this universe has sprung from, is sustained and governed by the will of a Supreme and Self-existent Being, infinite in power, wisdom, love, justice and holiness. We cannot conceive or comprehend Him except partially through His manifestations in nature and in man; but by means of our reason and instincts, our faith and intuition, we can sufficiently know Him, to believe in Him and worship Him.

We believe that worship, or conscious moral and spiritual intercourse with God, consisting of an attitude of love, gratitude, trust, and reverence is a most sacred and solemn duty on man's part and the way to Salvation.

We believe that the way to this Salvation is through love, which teaches the Soul
to seek the will of God as the highest good. It does not snatch the Soul away from temptations, nor violently uproot desires, but places it above them and beyond them by making them matters of indifference to its purpose or aim.

We believe that not only outward morality, but also the purity of the inward nature, producing singleness of mind and holiness on intention, is one of the first conditions of spiritual intercourse with God, and that the attainment of this holiness should be a matter of earnest prayer.

By prayer we understand that loving, trustful, and expectant attitude which the Soul naturally assumes toward God, when it feels itself weak and fainting in its struggles after spiritual progress.

We do not look upon the world as a delusion nor as a place of bondage nor as the heritage of fallen humanity and consequently an abode of sin and suffering; but we believe that the world is a nursery for the Soul, beautifully adapted for its growth and development, during the early stage of its existence; and that all the spiritual and moral ties that bind man to his family and to his kind are sacredly and divinely ordained.

We believe that true piety does not consist in outward ceremonies and ascetism, but in the strict purity of inward conduct, in the sanctification of the relations of life, and in the combination and harmony of faith and work, of communion and prayer, and of love and philanthropy.

We believe that religion is progressive; that all the religions of the world represent more or less imperfect attempts to spell out the common religious instincts and spiritual aspirations of mankind; that they have not been made but have grown out of the spiritual life of man, assuming different forms owing to differences of intellectual, moral, social and political condition. So there are truths
in all and we cheerfully accept them.

We regard the whole human race as a family, of which God is the Father, the world the abode, the great men, the elder brothers, the scriptures of all nations the depositories of spiritual treasure and the triumph of truth, love, and justice the ultimate goal.12

This statement was made by a friend of Emerson; it comes from a spiritual predecessor Ghandi, from the personal prophet of Rabindranath Tagore, from a social reformer who almost single-handedly accomplished the outlawry of the suttee. It is a statement from a Maharishi.

The purpose of the quotation is not to prescribe a philosophical position for anyone, but rather, to suggest that the counselor must examine his own deep beliefs that condition his attitude toward his fellow creatures. What these beliefs are will significantly influence his ethical standards, assist in developing the methodology suggested. The counselor must be able to be free of the popular culture of this day, must be aware of, but not submerged by Zeitgeist.

Alan Watts made it clear when he wrote:

Our mistake has been to suppose that the individual is honored and his uniqueness enhanced by emphasizing his separation from the surrounding world, or his eternal difference in essence from his Creator. As well honor the hand by lopping it off from the arm! But
when Spinoza said that "the more we know of particular things, the more we know of God," he was anticipating our discovery that the richer and more articulate our picture of man and of the world becomes, the more we are aware of its relativity and of the interconnection of all its patterns in an undivided whole. The psychotherapist is perfectly in accord with the ways of liberation in describing the goal of therapy as individuation (Jung), self-actualization (Maslow), functional autonomy (Allport), or creative selfhood (Adler), but every plant that is to come to its full fruition must be embedded in the soil, so that as its stem ascends the whole earth reaches up to the sun.13

So far we have set forth some views concerning Creation and Man. The nouns and adjectives are many: holy, sacred, creature-feeling, oblation, thanksgiving, mysterium tremendum, divine sense. These experiences can be accepted as real by Roman Catholic and atheist alike. We can also accept the empirical analysis that knowledge is incomplete, but that it must grow limited to man's earth-bound powers and limits.

To review the premises established so far:

(1) The single absolute is that all things change.

(2) Man undergoes change and is related to the universe. However, he possesses a characteristic that is unique: self-recognition of change. In that recognition he can perceive capabilities which will affect his life quality.
(3) It is not necessary to have a fixed theological position. It is, however, valuable to recognize man as special.

(4) Disagreement with the previous premises are not of great importance.

Maslow refers to religion as a local structure in local terms, species-wide, co-religious and transcendent. The truth of Brahma Samaj and the truth of the Judeo-Christian statement can become a truth for anyone. The statements that have been quoted are brief capitulations which lead to a conclusion that the universe possesses some kind of "meaning." Whether one calls this integration God, Absurdity, or Impersonality is a personal indulgence determined by one's personal history, one's personal revelations and personal myths.

The counselor should thoughtfully ponder:

(1) There is only one man, mankind.

(2) We seek, question, probe.

(3) We are not certain, and we are certain.

(4) We sense the tragic and the joyous.

(5) We feel the cold breath of approaching death and the passionate breath of life, living arrived.
Ultimate Values

When one cannot distinguish between the meaningful and the trivial, one becomes fixed with an orbit of his own making.

These concepts lead to a rather shocking conclusion: the far goal of our suggested counseling is the search for ultimate values but, values will change whether we desire it or not, and the world in which we live will change and have its effect upon us.

It is difficult to accept unreservedly the belief that truth is universal and absolute unless one experiences that universality and absolutism. It is appropriate to recognize that the counselor should avoid becoming a prophet of the consequences that may result from his ignorance or "violation" of "true absolutes;" he is risking damage to the client unless, which is unlikely, he is truly a prophet. The world has had its share of prophets and does not need the addition of a phalanx of Ph.D.s and Ed.Ds to prophesy.

Right-Wrong; True-False; Good-Bad

Absolute concepts of "right and wrong," "truth and error," "good and bad," are too binding, ignoring the necessity for a confession of ignorance. It is suggest-
ed here that the search can be the goal.

However, there is one assumption that is convenient to accept: wisdom will continue to be denied us. The determination of that which is indicated and that which is essential can be a constant lure and frustration. The paradox results from confusing the search and the goal. The paradox diminishes with the acceptance that the search can be an end in itself. The universal values are impersonal; the search for value is personal. Science has eroded so many absolutes and in so doing has led some of us into an examination of that which is transient, rather than that which is permanent. Because the ultimate is obscure, those who have embraced the transient have accepted pragmatism as the touchstone in determining value. They ask not what is true, but what will work. Pragmatism has its place somewhere, but not in the counselor-client relationship. Truth then becomes the result of generations of consequences and not antecedents.

The counselor who follows the path of pragmatism becomes caught up in the ambivalences of our society. As the absolutes of the past are discarded, the societal pressures of today's sanctions are impressive, for groups then become the final arbiters of what is right, true and good. The pragmatic counselor becomes a ser-
vant of the most vocal, the most powerful, perhaps even of the "society." If so, probably becomes damaging to the client. We are not yet ready to substitute the current popular pollster for Aristotle.

**The Third Force**

There is in the client-counselor relationship a third force. Briefly stated, it is a belief in a brotherhood of mankind that is an act of affirmation, a belief not subjected to accurate, scientific examination. However, the acceptance of "brotherhood of mankind" affirms a unity of human life. There is an experience of community which is the gross experience that can bind all life together. When this experience of community becomes a part of the conscious intention of the individual, i.e., a conscious effort to become a part of community, knowledge of one's own self can enhance the consciousness of the unity that binds all life together. This is a repetition of the concept that parts of life are identifiable with the totality of all life, the consciousness that binds all life together.

We are acutely aware of emotional and physical barriers that seemingly separate one form of life from another. This is what Buber is reaching for when he emphasizes the unity of the I-Thou. When we become
aware of our sense of separation from the "total life" concept, we paradoxically become conscious of the unity of all forms of life. It is not trivial to believe that the sense of separation we experience is productive of frustration, fear, or possibly emotional illness. Hate can described as a willing of the non-existence of a person, a thing, or of life itself. It is willing death. For the healthy person, consciousness of community is a desirable constant.

It is not necessary to resolve great imponderables to place one's self within this community. Because we are unable to conceptualize the totality of all existence, does not deny our capacity to conceptualize the totality of an existence. Not possessing the capability to perceive that which is external, we can turn to the conception of that which is internal. In so doing, we become aware of community. Simply, the Inscape is as pertinently revealing as the landscape.

Rollo May has expressed it this way:

That which is genuinely experienced on all levels of being, including what is called the subconscious and the unconscious and never excluding the element of conscious decision and responsibility, . . . only this truth has the power to change a human being.14

May's comment has within it a release from those
speculations which have bound man to the serfdom of rationality. Once freed from this slavery one may apply the sense of creation and community to human problems and humanity's shared griefs. In Buber's Other, one finds himself. It is there that the experience of identity becomes the sine qua non of the human nature. The Other is of the process of creating the Third Person.

Thus, what has been philosophically discussed here is meaningful to the counseling process. The desire to experience empathetically, positively and honestly with a fellow human being, becomes not only a personal structure, but at the same time nourishes within ourselves as counselors the contiguity of our existence.

There are philosophical statements which have within them mechanisms which sustain the counseling process:

(1) We have reason and choice. Some of the choices can be made by one's self. Where choice can be made, man can then assume responsibility for his own actions.

This does not mean that man is always aware of choice, but he can be assisted in becoming aware of the opportunity for choice. Nor does it mean that societal factors cannot so encrust an individual that he becomes unaware that he has a choice. It means simply that as man becomes aware that he has choice, he can choose.
In so doing, he can assume the responsibility for his own actions. But if man is unaware that there is a freedom of choice, if he has been so desensitized by his society, his actions or his thoughts, that he does not believe there is choice, then that responsibility for his actions is diminished and may be eliminated altogether. This statement has a special reference to the alcohol dependent client who when drinking does not believe he has choice.

(2) Since we are all within the family of mankind, then all society is of our personal value concern. The matrix of existence does not exclude that part of life which is part of all man's life. In short, all life is of value; human life is of great value, and not to the exclusion of life itself.

(3) The world is an impersonal place. It is man's sole abode. The threats to man by man exceed the threats to man by things. It is difficult, perhaps impossible, to change the things of life. When things cannot be changed they can be accepted with or without approval. Manmade threats are man-made and are therefore alterable because of the opportunity of choice. A meaningful life is one that exists
with as little physical, psychological or social threat as possible. Freeing man from threat either from within or without is a worthy goal for meaningful living.

(4) Behavior is a personal expression. Each person is unique to and of himself, so that his behavior can never be identical with that of others. Further, what he perceives as his own reality can never be completely perceived by others.

(5) Man is not good or evil; he is. Parenthetically, given a choice of behaving in a "good" or "evil" fashion, man will choose the good. Using as a touchstone freeing man from threat, we can apply evaluations to acts, things, objectives, styles, as being good or evil insofar as they free man from threat.

(6) Man is a totality of a universe within the universe. He cannot react solely intellectually or solely emotionally; these are not mutually exclusive however much we may desire them to be. Man is so integrated that his actions are the actions of a complete organization, part of a larger whole; to regard him atomistically can produce frustration and
anxiety. His change is constrictive unless the totality of his existence is involved.

An acceptance of these general statements or principles does not preclude the desire to cultivate reason or to admit the possible existence of universal values, or even to accept the existence of an absolute truth; it does not preclude developing interest in, or curiosity about, specific phenomena, placing value on empirical results, regarding the ultimate truth as dynamic, or seeing values as individual expressions. Acceptance of these general statements places a heavy emphasis on introspection, on humanity and humanism, and on the desire to develop individual awareness of freedom of choice; to sanctify all life as one sanctifies individual existence; to regard reality as a subjective area because of the fog of disengagement with Creation.

To activate these conclusions by the counselor requires change, i.e., a consistent effort to remove threat.

Ardrey, in his book *African Genesis*, poetically expresses some of these feelings:

I like to feel that strange life beating up against me. I like to realize forms of life utterly unlike mine . . . When my own life feels small, and I am oppressed with it, I like to crush together and see in a picture, in an instant, a multitude of disconnected
unlike phases of human life—a medieval monk with his string of beads pacing a quiet orchard, and looking up from the grass at his feet to the heavy fruit trees; little Malay boys playing naked on a shining seabeach; a Hindu philosopher alone under his banyan tree, thinking, thinking, thinking, so that in the thought of God he may lose himself; a troop of Bacchanalians dressed in white, with crowns of vine-leaves, dancing along the Roman streets; a martyr on the night of his death looking through the narrow window to the sky, and feeling that already he has the wings that shall bear him up...; an Epicurean dis coursing at a Roman bath to a knot of his disciples on the nature of happiness; a Kaffir witch-doctor seeking for herbs by moonlight, while from the huts on the hillside come the sounds of dogs barking, and the voices of women and children; a mother giving bread and milk to her children in little wooden basins and singing the evening song. I like to see it all; I feel it run through me—that life belongs to me; it makes my little life larger, it breaks down the narrow walls that shut me in.15

**Methods to Effect Change**

What methods might be the most effective in serving as a mechanism for facilitating change through self-actualization, with the objective of removing threat, a causal factor in producing frustration, fear and anxiety.

Just as there are traps in all good puzzles, there are traps in developing a methodology. The polarities are behavioral or experiential. Both involve risk: one the risk of inhumanity and the other the risk of becom-
ing self-serving in the exploration of the inner experiences of others. As Maslow has mentioned, such experientialism can, when exploited by the self, turn it into a sadism that is as inhuman as that of the behaviorist who makes little differentiation between his white mice and human beings.

There is no one conceptual framework for understanding, explaining or facilitating change.

George Kelly states in his theory of constructs:

Man looks at his world through transparent patterns or templates which he creates and then attempts to fit over the realities of which the world is composed. Let us give the name constructs for these patterns which are tried on for size. There are ways of construing the world.¹⁶

Kelly's theory is mentioned here as a supportive thought that "truth is what is perceived." His theory, like that of Rogers, is holistic. The first consideration of a personal construct theory of individuals is the total individual person rather than any part of a person, any group of persons, or any particular or singular process manifested in a person's behavior.

A counselor and client in interchange are two unique personalities each affecting the behavior of the other; each moment is a moment of change, each moment alters the perceptions of each, and it is in awareness
of the change and perceptions of the change, however small and incomplete, that behavioral changes are initiated. Thus, the interchange and interreaction of the counselor and client are the primary consideration.

The use of psychoanalytical ambiguity can be a useful tool, but it can also be a treacherous one. Such an inquiry into the inner world can be threatening to both counselor and client, and the classic transferrence may be a formidable obstacle to the objective of developing "humanness" through empathetic experience.

The analytic process is lengthy, time-consuming, limited and expensive. But with its emphasis on motivation--the emphasis on searching for that which is central--the psychoanalytical model can be a productive instrument for obtaining self-information. It is not, however, productive for the counselor who wishes to avoid a perjorative or interpretative technique.

In self-actualization, one also becomes aware of one's own cognitive thinking and recognizes that the cognitive aspects are related to the emotional reactions so intimately that separation is improbable, probably impossible. In that the goal of the psychoanalytical model is predominantly to assist the client in securing insight, the model is contributive. However, this hinders the self-actualizing counselor. The mechanisms of
the id, ego and superego, although interesting and innovative, are animistic in that the description itself is alien to the description of man as a totality. As such, it may interfere with the experiential thrust.

In the analytic process, it is the counselor who brings his professional expertise to bear upon the client who may or may not be giving the the counselor his true inner experiences or his true self-evaluation. He recounts what seems to be true. In any event, the counselor is placed in the role of an interpreter. As such, he intrudes upon situational factors, bringing by that intrusion a judgmental consideration. Therefore, he encounters resistance, cooperation, warmth, rejection, firm and ambivalent reactions.

There is a counseling view that sees man as capable of solving his problems by rational means. The counselor assists the client to think clearly or, at least, more clearly, in self-problem-solving. Thinking is valuable and useful; but to change behavior by thought, without regard to the totality of the organism, and assuming that clear thought will produce fulfilling behavior, is philosophically questionable. Under these circumstances counseling becomes an information-analysis process and, as such, it is better left to the statistician whose information must perforce be incomplete.
There is another disturbing consideration: the implication is that the informational counselor is to help the client to become a functioning and acceptable member of society. But if one is convinced that this society is a "sick" one, the non-functioning or maladjusted individual may be better internally adjusted by his non-functioning or rebellious behavior.

Counseling that depends upon regarding emotion as a disruptive factor that interferes with problem-solving is by its very definition dehumanizing. The counselor can win many skirmishes but he will have little effect upon the war. These criticisms are directed to those who believe that an examination of "personality traits" may provide sufficient clues to counseling help. Human personality has traits, but research that clearly defines those traits in sufficiently precise language for exacting use by another person is non-existent. Knowing about the interpersonal and intrapersonal traits of societies, groups and individuals may be useful, but applying that knowledge to one's own problems is quite another matter, a matter which merits thorough examination. The counselor who is interested in his client obtaining social enlightenment through self-understanding and self-direction, secured by "proper" thought and action, is a counselor to be avoided.
In the stated brief summaries, the role of the counselor is at variance with previous considerations of empathy. A counselor becomes an "expert," and in so doing he becomes a hindrance to the process of self-sensitization. The enriching relationship of the client to the counselor or vice-versa may very well be an end in itself. Counseling as a means to an end implies that goals can be well-defined and capable of precise definition and evaluation. Human goals are not so well articulated. Such a use of means is an invitation to manipulation. Manipulation is ethically disturbing and to be avoided with the alcohol-dependent client.

The individual is not denied the right to reach self-determination but he is within his rights when his decision is to make no decision at all.

In the humanistic, existential, client-centered modality, the counselor should provide alternatives, differing paths and differing goals; it is possible that he may be, in effect, society's representative seeking as a goal social adjustment, a treacherous goal. It is false to assume that with societal acceptance inner satisfaction is secured.

Both the analytic and the directive methodologies have their uses. Both are valuable: the analytic for strengthening the demands for central motivations; the
directive for the recognition of cognition as a viable tool for securing data.

There is additional criticism that is pertinent to this discussion. Analytic theory addresses a very broad range of behavior. It focuses attention on the individual as a whole. However, the Freudian model states that the organism seeks pleasure by the reduction of tension, overlooking the variable that the organism may often seek tension, and not respond satisfactorily to the absence of all tension. The Freudian model tends to make too many factors important and, possibly, equivalent. All behavior simply does not fit any model.

The directive model also may be criticized on the basis that it can intrude into the inner privacy of an individual, violating certain ethical concepts of privacy that many are unwilling to forego. Although the intrusion may produce interesting information, the information itself may be suspect.

There is an assumption on the part of many counselors that one person can understand another: One can help another and share with another only if one can determine those factors that make up the other's personality. Cattell's personality theory crumbles or is strengthened on the basis of factor analysis. But the factors are inexact and as one reads the descriptions
of these factors they become impressively imprecise. There is no precise definition of a personality factor and the theory fails to indicate the number of factors which are important and those which are of lesser importance. Once the information is known, the individual may become aware of some necessary change, direction or adjustment, but whether that is desirable or not is another problem.

Can social theory give us a satisfactory answer? Despite Adler's view of man as a social animal more than a biological one, and his emphasis on social interactions as a style of life, his theory is attractive as a speculation of some aspects of behavior, but it is incomplete.

**Social Learning**

Adler, Fromm, Horney and Sullivan's discussions of individuality imply that the individual personality evolves as a result of social learning. This view places tremendous weight upon communication between counselor and client; it is interesting and provocative; it can assist the counselor to participate in the client-counselor relationship. There is a rewarding aspect, too: the recognition of self-defeating behavior and the development of a mutual awareness of that behav-
ior. Fromm, in particular, with his emphasis on relatedness, creativeness, belongingness, identity and consistence, is well within desired perceptions of the individual.

It is impossible at this time to examine all the theories of personality. Those theories which have relevance to the emergence of a personal counseling theory must be considered within a frame of reference which permit the counselor ease in counseling, if not satisfaction. It is suggested here that Carl Rodgers is particularly relevant to one of the previously-stated goals of the counselor: removal of threat.

It is an over-simplification, but perceptions function to produce behavior; affecting perception is a legitimate aim. Perception has its variables: goals, values, self-concepts, help. Perception is affected by threat, for what one perceives produces what one feels. People can perceive what is appropriate for them. For persons seeking self-perception, every insight can be contributive to fulfillment.

The humanistic, existential, client-centered counseling modality is keyed to the individual who is centered on his changing world of experience. The phenomenological world is exclusive. An individual behaves as if that what he perceives is true. It is holistic:
a continuing effort toward total self-enhancement.

Emotion facilitates goal-directed behavior, and its intensity is related to the significance of what is perceived.

Rodgers' theorizing fits within the parameters of many of the previously-expressed philosophical expressions.

What then is the frame of reference for this statement on counseling the abstaining alcoholic?

It is eclectic.
CHAPTER X
COUNSELING THE COUNSELOR

"Will is wish, and liberty is power."
--Voltaire

There are some specific recommendations forthcoming from our sample. They may sound like commandments, but they are suggestions. This work would be remiss if the information was not shared:

(1) Alcoholic counselors are generally more productive than non-alcoholic counselors. Reported by 76 (55 percent).

(2) Non-professional counselors who are alcoholic and have attained at least three years of sobriety are possibly capable of counseling. Three years is minimal and the counseling proclivities are a matter of experience. Reported by 54 (39 percent).

(3) The non-alcoholic counselor should acquaint himself with as many alcoholics as possible even though they are not clients. The best possible source is the open AA meeting, the detoxification wards, and the rehabilitation centers. Reported by 81 (59 percent).
(4) If the client is a member of AA, deal only with those steps with which the client has acknowledged difficulty. Be wary of tampering with those beliefs which have been accepted by the client. Do not assume an adversary role regardless of the counselor's convictions.

(5) Women generally are better at counseling women and men at counseling men. There is a rapport between the sexes and despite great effort, sexual threat in our society is endemic. The information concerning women alcoholic reveals greater damage and assault from men than any other single entity. From our sample, women only, 80 percent spoke of assault, injury, anger and exploitation by men. Of the men, only 13 percent indicated any exploitation by women.

(6) After a client has been accepted by a counselor, there should be a constant reinforcement of the necessity of maintaining continuous abstinence and the reinforcement should be related to the single conclusion: no problem can be solved or ameliorated without continuous abstinence.

(7) Any modality is subject to revision to fit
the personality and needs of both client and counselor. Empathy, positive regard, and honesty are not subject to revision or modification.

(8) The eventual goal is serenity. The steps toward the achievement of that goal are abstinence, sobriety, and from sobriety the reward of serenity.

(9) In counseling there are no limits as to the interchange of feelings and thoughts if the interchange is free of management, exploitation and satisfaction of the need for power.

If this work is valuable the following remarks should enhance its value:

A. The counselor should have "found" himself in relation to the universe and developed a philosophical position which is subject to constant self-evaluation and reexamination. As new insights are discovered, and old ones dropped, the counselor should be the recipient of a stronger and more stable frame of reference permitting him to function freely without or with the approval of society. The counselor should be in a position to know himself so well that it is unimportant what the societal
pressures are.

B. The counselor should have determined some of the transcendent questions about life which have enabled him to reach tentative conclusions concerning the life outside of self and to have brought himself into partial harmony with that life. It is unimportant what the answers are; it is vital as to what the questions are.

C. The counselor should have structure in his relationship with the client and the dimensions of his counseling are suggested according to our model leading to the Third Person concept.

D. The model can lead to the supreme counseling situation, the development of the "third person," by which client and counselor think, feel and respond as one, yet each retaining his own identity and sense of selfhood.

If as a result of following these suggestions and practices it is possible for the client to achieve serenity in his life, the counselor has functioned at his highest level of achievement. Counselor and client have in the process found a need for each other and the need has been satisfied. It is even within the realm of
possibility that the counselor has created a new need, counseling for himself which could be a valuable experience in creating a community of help that transcends professional considerations.
Chapter I:


3. *Ibid*.


8. See note 5.


16. Ibid.
17. Ibid.
19. Ibid.
22. See note 1.
25. Ibid.

Chapter II:

1. See note 6, Chapter I.
2. Ibid.
3. Ibid.
5. See note 21, Chapter I.
6. See note 1, Chapter I.
7. Ibid.
8. See note 18, Chapter I.
10. Cost Contra County, California, AA Intergroup.

Chapter IV:

1. See note 21, Chapter I. The physicians' letters are from *Alcoholics Anonymous and the Medical Profession*. Alcoholics Anonymous World Services, Inc., 1955

2. Little Hill Alena Lodge, Little Foundation, Inc. New Jersey.

3. See note 1, Chapter I.

Chapter V:

1. See note 21, Chapter I.


3. Ibid.

4. Ibid.

5. Comments received from attending over 2,500 AA meetings.


Chapter VI:

1. See note 11, Chapter II.


3. Ibid.


10. See note 9.

11. Ibid.


Chapter VII:


Chapter VIII:

1. Maslow, A. Merrill-Palmer Quarterly. 3. 36-47. 1956.

2. Ibid.


Chapter IX:


2. Ibid.


4. Ibid.


6. These comments are strongly influenced by conversations with and lectures by Rev. Dana Greeley, Unitarian-Universalist Association, Boston.


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Note: Those books, monographs or pamphlets marked (*) are of special importance to the alcoholic counselor. Those marked with a double asterisk (**) are signaled as excellent background materials or for their insights into the personal problems of individual alcoholics.

Alcoholics Anonymous. Alcoholics Anonymous World Services, Inc. New York. (*)


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Note: The following materials are essential for the alcoholic counselor.


Note: The following books and articles are among the materials available for psychological understanding of the counseling process for abstaining alcoholics.


May, M.A. Foreword in Dollard et al., Frustration and Aggression.


Stock, D. An investigation into the interrelations between the self concept and feelings directed towards other persons and groups. Journal of Consulting Psychology. 13, 1949.


Note: The following list of organizations provide a wide variety of beverage alcohol information, most in pamphlet form. Most of the organizations listed publish catalogues of their materials.

AA World Service, Inc.
P.O. Box 459
Grand Central Station
New York, NY 10017

Al-Anon Family Group Headquarters, Inc.
P.O. Box 182
Madison Square Station
New York, NY 10010

Alcohol and Drug Problems Association of North America Education Department
1130 Seventeenth Street, N.W.
Washington, D.C. 20036

Allstate Insurance Company
Allstate Plaza
Northbrook, IL 60062

American Medical Association
535 Dearborn Street
Chicago, IL 60610

Blue Cross
622 Third Avenue
New York, NY 10017

Kemper Insurance Company
4750 Sheridan Road
Chicago, IL 60640

Licensed Beverage Industries
A Division of Distilled Spirits Council of the United States, Inc.
485 Lexington Avenue
New York, NY 10021

Metropolitan Life Insurance Company
1 Madison Avenue
New York, NY 10010
National Council on Alcoholism, Inc.
2 Park Avenue
New York, NY 10016

National Institute on Alcohol Abuse and Alcoholism
5600 Fishers Lane
Rockville, MD 20852

Publications Division
Rutgers Center of Alcohol Studies
Rutgers--The State University
New Brunswick, NJ 08903