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AN INVESTIGATION OF THE TREATMENT APPROACHES TO ALCOHOLISM

by

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ABSTRACT

The researcher feels that the necessary therapy for the treatment of alcoholism must be continuously researched and studied. The treatment process must be dynamic and thorough in order to be effective. The research in the paper considers two major approaches to the treatment of the alcoholic disorder.

The two major approaches are the behavioral approach which includes the conditioned reflex therapies and the barrier drug approach; and the psychotherapeutic approaches which include the individual psychotherapies and the group psychotherapeutic approaches.

This paper attempts to clarify the present methods in use for the treatment of alcoholism. The researcher makes recommendations for a specific treatment approach and recommends that this treatment approach be researched to determine its efficacy. The researcher feels that the alcoholic is an individual with an illness and should be treated as such.

The treatment method recommended by the researcher involves two specific steps. First, the alcoholic patient must be in a sober state. Second, he must have intensive psychotherapy in order to positively deal with his drinking problem. The psychotherapeutic method recommended by the researcher is the individual psychotherapeutic approach complemented by group therapy. The researcher feels that the psychotherapeutic approaches of Carl R. Rogers and Andrew Salter should be used in this second part of the therapeutic situation.

CHAPTER I

Introduction

Alcoholism at one time was considered an untreatable disorder and the alcoholic was thought to be a morally deficient individual who was difficult if not impossible to work with. (8:13) According to Dr. R. J. Catanzaro of the North American Association of Alcoholism Programs, "From time immemorial, alcoholism was looked upon as a voluntary excessive indulgence in drinking various alcoholic beverages. It was somehow associated with weakness of character and moral degraduation." (9:5) This extremely negative attitude toward the alcoholic still exists to some extent today but the professional view of the alcoholic has developed into a more positive and functional approach. Psychotherapists, psychiatrists and physicians have worked hard to present the notion that alcoholism is an illness and not a sin. (9:52)

The fact that the alcoholic disorder is now recognized by professionals to be a very complex and intricate illness has opened the avenues of modern research methods in the understanding and subsequent treatment of alcoholism. (1:5) The alcoholic problem affects every type of individual in our society from the upper-class professional to the lower-class skid-row derelict. Alcoholism knows no age or sex differences in the people it affects. The problem is one of national concern and has been "one of the oldest illnesses

known to mankind." (5:5) It has been noted that an estimated "seventy million people in the United States drink. Five million are alcoholics." (14:7)

Methods of treatment have been researched through a multitude of programs subsidized by the United States Government. Through this research the professional who treats the alcoholic is made aware not only of the latest research that investigates the various causes of alcoholism but also the various treatment approaches to this disorder. The researcher will investigate the specifics of two major approaches to the treatment of alcoholism in this paper. This study will also present recommendations for a specific treatment approach that could be facilitated in the total treatment approach to the alcoholic disorder.

Reason for Topic Selection

The problem presented to society by the existence of the alcoholic problem in society is one of major concern. The alcoholic must be aided in becoming a contributing rather than a dependent member of society. The subsequent treatment of the identified alcoholics is as varied as the alcoholic individuals themselves.(8:17).

Treatment methods must constantly be updated in light of recent research in this area. For example, an ideal treatment method does not as yet exist and new approaches toward treatment are constantly being studied and their efficacy tested. Furthermore, it is necessary that these various approaches be carefully analyzed, clarified and presented so that the

student of psychotherapy may evaluate these approaches and determine their usefulness within their specific frame of reference.

Summary

The identification and subsequent treatment of the alcoholic individual is a complicated and sometimes disheartening process. The tendency to ignore the problems of the alcoholic must be eradicated from not only the minds of the general public but also from the minds of professionals. New attitudes and energies must be directed toward this problem so that alcoholism will be viewed in the light of a treatable illness. Blum and Blum explain that

> "In view of the longstanding reluctance of the public and professionals alike to recognize the need for, and possibility of, providing treatment for alcoholics, and in view of the continuing ambivalence about working with them, it is surprising that there has been any successful treatment for them at all. American attitudes in this regard are a pecular blend of pragmatism." (8:17)

The treatment approach toward alcoholism must be regarded as a process as complex as the patients it is designed for. New ideas toward treatment need continual and exhausting research. Catanzaro states

> "We must bear in mind the involved, concatenated construction of the alcoholic. He is an individual with problems. He drinks in order to deal with these problems and, in the process, develops new problems, which he does not only understand, but about which he can do nothing - until he gets some help." (9:72)

CHAPTER II

Procedure Used

The investigation of two major approaches to the treatment of alcoholism will be presented in the following manner:

1. The two major approaches: The behavior modification approach and the psychotherapeutic approach will be defined and explained.
2. A review of literature will present the current thought regarding treatment approaches toward alcoholism.
3. The review of literature will specifically deal with the two major treatment approaches presented.
4. The researcher will present recommendations for a specific treatment approach to alcoholism and for further research in this area.

Material in the review of literature will be taken from current books and journal articles.

Limitations

This paper will study two major approaches to the treatment of the alcoholic disorder, the behavior modification methods and the psychotherapeutic methods. The behavior modification method will confine itself to the aversion type therapies and the conditioned aversion techniques utilized in

the treatment of alcoholism. The psychotherapeutic approaches will involve the treatment methods that utilize group therapy and individual therapy.

The researcher will limit the review of literature to articles and publications that have been published during the last 15 years.

Definition of Terms

The following general terms are defined as they will be used in this paper. Subsequent terms will be defined in the text of the paper as they will be used by the particular author of the reference cited.

> Alcoholic An alcoholic is defined as a person who has become dependent on the drug alcohol, consequently drinking more alcohol than the socially accepted norm for his culture; his excessive drinking damages his health and his relation to his family, friends and job.(9:6).

> Alcoholism Alcoholism is the name of the chronic disease from which the alcoholic suffers.(9:6).

CHAPTER III

Introduction

Chapter three of this paper will investigate two major treatment areas utilized in the treatment of alcoholism, the behavior modification approach and the psychotherapeutic approach, which includes both individual and group psychotherapy. The research concerned with these two therapeutic treatments will be discussed in three general sections. First, the two major treatment approaches will be defined. Second, a description of the principles and methods of treatment that are specific to the behavior modification approach will be presented. Third, the psychotherapeutic approaches that utilize group and individual psychotherapy will be described.

Definitions of the Two Treatment Approaches

According to Cyril M. Franks

> "Behavior therapy may be defined as the systematic application of any principles derived from learning theory and the experimental work in these areas to the beneficial modification of abnormal or undesirable behavior....." (13:187)

From this general definition of behavior modification therapy the other behavioral approaches to the treatment of the alcoholic disorder have developed. These methods include classical Pavlovian conditioning and methods involving operant avoidance training and reinforcement procedures, including reward and punishment. Thus, behavior modification used in the treatment of alcoholism is basically an aversive conditioning process. The alcoholic

patient is trained or conditioned to react to the drug alcohol as an extremely undesirable and potentially painful substance.(8:111). This particular approach is often subdivided into two general method types or classifications. The first, conditioned reflex therapy, is a method in which the patient is subjected to unpleasant stimuli that are presented in conjunction with an alcoholic beverage. This paper will examine several methods that use this specific type of therapy. The desired result of this type of therapy is that subsequent experience with alcoholic beverages of any type will produce an aversion response on the part of the alcoholic patient.(15:69). The second general method type in the behavior modification approach is deterrent or alcohol antagonizing drug therapy. This particular method utilizes a type of drug or drugs that have the unique property of remaining inert in the human body until it is combined with alcohol. The resultant combination of alcohol and the alcohol antagonizing drug produces a variety of unpleasant effects. Thus, if the alcoholic patient knows that his body will react violently to alcohol while this type of drug is in his system he will make a concerted effort to abstain from any form of alcohol while using this drug.(15:70). There are various types of alcohol antagonizing drugs or "chemical restraint" drugs used in these treatment methods. The various drug types will be specifically mentioned in section two of this chapter.

The group therapy approach is an exceedingly complex and varied concept in psychotherapy. Equally complex in use as well as definition is the

concept of "individual" psychotherapy. In this section general definitions of the process of therapy utilizing these two concepts will be presented. Group therapy basically involves a therapist or group leader and several clients. It may also involve several therapists and a single client. Individual psychotherapy involves a "one to one" relationship between therapist and client. The researcher will consider the representative types of therapy groups and individual psychotherapies in this chapter.

The Behavior Modification Approaches

Behavior modification therapy does not concern itself with any singular, specific method utilized in changing an individuals behavior. It merely refers to the act of modifying in a beneficial manner the undesirable overt behavior of an individual or client, and wishes to prevent any recurrence of the displaced behavior. The development of the basic process of aversive conditioning can be stated briefly.

> "An object or activity that is repeatedly associated with aversive experiences acquires some of the negative properties of the aversive stimulus. As long as the negatively conditioned stimuli retain their aversive effects, the individual will be inclined to avoid them." (5:502)

It should be noted that the conditioned aversion process can establish aversion reactions to undesirable objects and activities, but it can also establish aversive responses to neutral and even positive objects and activities. Although these various aversion reactions have been observed there has been no indication

of the "optimal conditions for creating persistent aversions." (5:502) Aversive conditioning has been in use for some time. The actual process is quite basic. The subject is conditioned to regard the undesirable experience in a very negative light. He associates the undesirable object or experience with undesirable results. The idea of conditioning is quite ancient. Clancy notes that writings from medieval times mention attempts to evoke an aversive response in drinkers who overindulged by putting emetic substances in their alcoholic beverages. (11:148) Pavlov's studies put this stimulus response type of reaction on a sound scientific basis. Continuing studies by Voegtlin and Lemere in the 1940's credit the first use of this conditioned reflex method of therapy to a Russian scientist of the 1930's who utilized the association of an electric schock with the desired aversive reaction toward alcohol in his alcoholic patients. The use of electric shock in conditioning therapy continues to this day. Aversive electrical stimulation has certain advantages in aversion treatment because it permits exacting control over the conditioning variables. Other advantages of the use of electric shock include the claimed negation of adverse physiological effects and the ability for the aversion therapist to present and terminate the negative stimulus for as long or as short as he wants the negative stimulus to occur. This permits the therapist to conduct many aversion trials in a short period of time. (5:504) The use of this electric shock therapy has experienced moderate success. In evaluating this "success factor" the criterion generally

utilized is how long the alcoholic patient stays completely dry after therapy has been completed. In Kantorovich's experiment using electric shock therapy with 20 subjects he noted that 82% of the alcoholics maintained complete abstinence for no longer than 20 months. (5:541) The above experiment took place in 1934. A replication of this experiment by Blake in 1967 using 25 subjects showed that 23% of the alcoholic subjects maintained complete abstinence for a period of only 12 months. This data indicates that the utilization of electric shock therapy alone does not facilitate the desired complete recovery from the alcoholic disorder. (4:541) The significant fact concerning this type of conditioning is that it does produce a state of sobriety in the alcoholic for a limited time. This is quite important from the standpoint that other psychotherapies might be successfully utilized or introduced while the alcoholic client is in this favorably sober state.

Conditioned Reflex Therapy

Cyril Franks (13:187), John Clancy (11:147-149) and Andrew Salter (21:188-219) indicate the idea that the patterns and actions of the alcoholic process have been learned. Clancy states

> "If, however, symptoms (of the alcoholic condition) are regarded as defects or pathological learned responses, then they are subject to the laws of learning, and as such may be unlearned by a technique which applies principles derived from learning theory." (11:147)

Salter states that we are the products of our conditionings and that the alcoholic is a product of his. Salter also provides a very concise definition of reflex therapy, "Direct education, through painful association, is the basis of the 'conditioned reflex method' of treating alcoholism." (21:196) And, as noted above, Franks has stated that alcoholism is a learned response. (13:187) Clancy and Franks both consider alcohol to be an anxiety reducing response and that the use of alcohol as an anxiety reducing habit is definitely learned. (11:148) Salter claims in his book, Conditioned Reflex Therapy, that alcoholism is a form of phoney excitation that induces the alcoholic to drink. He states that

> "By doing what we do we become what we are, and as the alcoholic - the inhibitory person, if you will - flexes his healthy emotional muscles they become stronger and stronger. He must build new patterns, and that always means going against the grain, at least at the start. He must break his habit patterns in the places he visits and with the people he sees." (21:203)

We note that Salter stresses breaking the "habit patterns", but as this paper will indicate later Salter does more than merely attack the alcoholic symptom as such. Salter approaches the alcoholic client as a complete human being and not as an alcoholic only.

The use of conditioned reflex therapy in this country is widespread and the most notable of these therapeutic programs is the program utilized by Shadel Sanitorium in Seattle, Washington. Two leaders in conditioned aversion therapy, Voegtlin and Lemere, and their group compiled their

results in the use of this type of therapy over a 13 year period. Compiling the results of follow-up studies of 4,096 cases treated at Shadel's over this 13 year period, they found that

> "44 percent have remained abstinent since the first treatment, 60 percent have remained abstinent for one year or longer, 51 percent for two years or longer, 38 percent for five years or longer and 23 percent for ten years or longer after their first treatment." 13:196)

With these figures in mind, it is apparent that Shadel's Sanitorium does have a degree of success in producing sobriety in the alcoholics it treats.

The conditioning process utilized by the Shadel Alcoholic Sanitorium provides the basic pattern of this type of treatment technique. This basic treatment pattern is described in the following discussion.

Initially, Shadel's clinic defines the alcoholic disorder as "an inability to cope with alcohol over an extended period of time without damaging effects." (2:1) After defining the problem they go on to state the desired goals that the alcoholic patient must attain. "First, he (alcoholic) must stop drinking and second, he must remain totally abstinent for the rest of his life." (2:2) The treatment process begins with the alcoholic patient being brought to a special treatment room that has been made relatively sound proof. The room contains a variety of alcoholic beverages that are set off to the side. Also provided are a comfortable chair and a large emesis or vomiting container. The alcoholic patient, who has maintained a 24 hour fast is advised

that "the liquor he is about to smell, taste, and drink is intrinsically obnoxious to the body" and that this will become reinforced and illustrated during the treatment session. He is then given an injection that will enhance the obnoxious quality of the alcoholic beverages he will use during the session. He is then given oral medication containing 1 1/2 grains of emetine with two glasses of water. This is followed by a "hypodermic injection containing 6 minims (0.37 cc) of a 40cc sterile aqueous solution containing 3.25 gm of emetine hydrochloride, 1.65 gm of pilocarpine hydrochloride, and 1.5 gm of ephedrine sulphate". The pilocarpine is utilized to facilitate perspiring and salivation. The ephedrine is used to counteract blood pressure drop that might harm the patient. The alcoholic patient is then presented an ounce of bourbon and 4 ounces of water. He is asked to inhale the smell of the liquor, take a small taste, savor it and then swallow the liquor. After this a second ounce of bourbon is presented to the patient and he is asked to repeat the previous procedure. Usually nausea occurs after this second ounce of liquor. After this nausea is induced the patient is given 2 ounces of bourbon and 10 ounces of water. This procedure usually brings on the reaction of vomiting or emesis. More bourbon or liquor drinks are given to the alcoholic patient, after the vomiting reaction has occurred two to four more times the session is concluded. The patient is then given a mixture of tartar emetic and beer to maintain a strong level of nausea in the subject. During the treatment

session the patient's pulse rate is checked frequently and if the pulse rate becomes quite high the treatment session is interrupted and then discontinued. A single session of this type usually lasts from fifteen to thirty minutes. After the session terminates the patient is then taken to his room. Subsequent treatments are longer than the initial treatment and usually last from twenty-five to thirty-five minutes. The dosage of emetine is increased gradually to fifteen minims (0.9cc), and the patient is offered a larger variety of alcoholic beverages. If the treatment therapist feels that at any time the alcohol is being absorbed into the patient's system, the patient's stomach is pumped. Depending upon the amount or degree of aversion needed to be established several of these aversion treatments are given. The usual number of treatments are from five to eight. Aversion is usually considered to be established when the patient becomes nauseated at the sight or smell of alcoholic beverages of any type, and also when emesis or vomiting occurs immediately after injection of the emetine hydrochloride. It is known that sedatives do inhibit conditioning, while conditioning processes are facilitated by stimulants. Thus, many therapists give Benzedrine sulfate before each treatment day as preliminary medication. This stimulant tends to aid in the reinforcement process of aversion treatment. Once the alcoholic patient has gone through this entire series of treatments he is strongly advised to return to the clinic

or hospital for "re-cap" or one-day reinforcing treatments. These "re-caps" are taken at intervals ranging in time from four to twelve weeks. During a one year period approximately six such treatments are given. There are several variations in this treatment method, but the basic process is present in most treatments that use the aforementioned aversive conditioning process. It must be noted that this form of therapy is not without drawbacks and dangers. It is strongly recommended that the alcoholic patient that undergoes this type of treatment have a good physical examination and preferably a good mental examination. Proposed clients for this type of therapy should not have "cirrhosis, esophageal varices, cardiovascular or renal disease, or with a history of hematemisis or ulcer." (11:147-151) This leads to the relative efficacy of this type of treatment. Andrew Salter states in Conditioned Reflex Therapy that

> "I think it is fair to say that a study of the literature makes inevitable the conclusion that the conditioning therapy is responsible for much of the success of the method. It is true, however, that there was a selective factor involved in the choice of patients, (Lemere and Voegtlin's patients) but when was it ever otherwise?" (21:194-197)

Clancy states a similar idea

> "Conditioning therapy is regarded as just another method to help the alcoholic attain abstinence, and any long-term success can only be effected by psychotherapy directed toward the underlying psychopathology." (11:146)

Salter indicates that although this therapy is indeed effective, many consider only the idea that conditioned reflexes are formed by direct association.

This is only one aspect of conditioning. Salter says

> "...it is my conviction that it (direct association) has paradoxically been responsible for stultifying the development of a system of reflex therapy. I say this because associationalism has blinded many excellent psychologists to the fact that correcting the inhibition-excitation balance is the key to the cure of psychological problems; while associativity is the key to the origin of psychological problems." (21:197-198)

Ullman and Krasner feel that the conditioning process is effective with approximately half of the alcoholics treated. They continue to state, however, that this figure could be increased by "use of intermittent reinforcement and booster courses prior to relapse" and the utilization of adjunct psychotherapy. (24:235) This adjunct psychotherapy is recognized by many to be of value in any conditioned reflex therapeutic program. Shadel's clinic not only uses the conditioning therapy but also maintains a staff of "Rehabilitation Counselors" to compliment the general treatment program. Shadel's Sanatorium does not claim to be the answer to the problem of alcoholism.

> "It (conditioned reflex therapy) does not make it impossible for him to drink but simply makes it possible for him not to drink, and as a result of this therapy the habit pattern, the compulsion, the urge for the drink is removed. Only through a deliberate or planned act can that urge or compulsion to drink be reestablished." (2:3)

The implication that if alcoholism is learned, it may be unlearned. But it is also implied that the unlearned action or habit may and could be learned again. A recent development in the treatment of alcoholism maintains that alcoholics might be trained to drink socially again. It was noted earlier

in this discussion that both Clancy and Franks consider alcohol to be an anxiety reducing drug. (11:148) Salter states that small doses of alcohol "produce a disinhibited, emotionally free state, which is why people drink." (21:189) Salter also states that fear (anxiety) is "the literary expression for inhibition, and is banished only by exposure." (21:203) Based on these foundations Halmuth H. Schaefer and his colleagues at California's Patton State Hospital found that the alcoholic responds to stress or anxiety by drinking to excess. Schaefer claims that "compulsive drinking is a learned response to anxiety and that it can be replaced with a different type of drinking behavior." (3:1) Normal drinkers, according to Schaefer, respond to anxiety producing situations through exercise, violence, and other overindulgences such as eating or smoking. Schaefer also says that "the notion that alcoholics are consumed by a physiological craving is not as real as people thought". In his treatment program, Schaefer allows his patients a choice between moderation and total abstinence. The alcoholic patients who choose the moderation route to sobriety are taught that the social stresses of daily living set off their alcoholic drinking bouts. They tend to gulp rather than sip their drinks and their goal is a drunken state. In Schaefer's treatment program the alcoholics learn to "practice restrained social drinking in a simulated cocktail lounge at the hospital". The success of this program is said by Schaefer to be a 50 to 60 percent cure rate in about

1,000 cases treated. This particular treatment program is unique in that it gives the alcoholic the choice between complete abstinence and a return to moderate or social drinking. (3:1)

S. Stojiljkovic, the Director of the Institute on Alcoholism, Belgrade, Yugoslavia, is one of the European leaders in the use of conditioned aversion treatment in alcoholism. Stojiljkovic claims to have a treatment method that has a longer lasting effect on the alcoholic. He assumes that alcoholism is a conditioned habit and the process of drinking is an attempt by the individual alcoholic to get rid of pressure and anxiety. The alcohol offers a relief from social pressure and is a way of seeking a solution for many inner conflicts. Stojiljkovic states in his article, "Conditioned Aversion Treatment of Alcoholics",

> "We started from the assumption that for a great number of patients alcoholism represents a conditioned habit, and that, by drinking, an alcoholic gets rid of psychic pressure and anxiety, creating a condition for easier social adaptation and for solving many of his inner conflicts. If, in these patients, alcohol is a factor which conditions the creation of a new psychological situation, then, in our opinion a lasting state should be formed in these persons, which would condition the appearance of an aversion toward alcohol whenever they feel a need for it." (22:901)

The therapy recommended by Stojiljkovic is basically similar to the treatment used by the Shadel Sanatorium. A singular advantage of Stojiljkovic's method is that, once released, the patients are given "recap" therapy over a much shorter duration than Shadel's does (30 to 90 days for recondition-

ing treatments). His results are quite interesting to note. Of 264 alcoholic patients who were considered untreatable by any other method, 136 became complete abstainers after intensive aversion treatment. Although Stojiljkovic feels that his treatment method is in many ways quite successful he does make a qualifying statement about his methodology that is most interesting

> "The shortcomings of our method are mostly the same as in all other medicative methods in the treatment of alcoholism. It has no effects on those factors which make a man an alcoholic, but only affects the patient's readiness to take alcohol. Accordingly, the patient is not freed of his inner conflicts and his personal weaknesses. Therefore, this treatment has to be combined with psychotherapy and sociotherapy." (22:904)

Albert Bandura of Stanford University presents the definition that best describes the genre of aversive conditioning therapies in his book, Principles of Behavior Modification. He states that the aversive conditioning or conditioned reflex therapy leads to the discussion of the pharmacologic treatment methods. The use of deterrent drugs is basic and important to this discussion of treatment methods for alcoholism.

Pharmacologic Treatment Methods

The utilization of drugs in alcoholism treatment is closely allied to conditioned aversion techniques. The drugs used in this treatment method are implemented as "barriers" to the ingestion of alcoholic beverages. Under the influence of a "barrier" drug, the alcoholic patient will experience

extremely adverse physical reactions if he drinks any alcoholic beverages while the drug is still in his system. The most popular of the "barrier drugs" or "pharmacologic fences" is tetraethylthiuram disulphide. This drug is more commonly known as disulfiram or antabuse. In this section of this paper it will be referred to as either disulfiram or anabuse. The "barrier" drug disulfiram is utilized in many different treatment methods. Disulfiram is sometimes used to establish a condition avoidance response to alcohol as well as it can be used to function as a pharmacologic fence. Blum and Blum (8:130-133) note that antabuse has been utilized as an implementary drug in conditioned aversion therapy, however, it sometimes produces adverse and even dangerous side effects. They state that persons with severe brain damage and patients suffering from liver dysfunction should not be given antabuse for any reason because persons suffering with one or both of these disorders have become psychotic during antabuse treatment. Blum and Blum also state that antabuse treatment should be given with a very cautionary and conservative viewpoint to chronic alcoholics. Ruth Fox (12:242-254) concurs with this opinion about the potential dangers of antabuse. Dr. Fox states

> "I believe there are few valid contraindications to disulfiram therapy except for an unwillingness on the part of the patient to take it. Of course, it should not be given to a full-blown psychotic or to someone seriously ill, or to the brain-damaged or deeply retarded person. Even persons with severe hypertension or coronary disease do well on disulfiram, but any experimenting

> with alcohol, either through a test dose or by the patient himself, might prove fatal." (12:246)

Dr. Fox also does not recommend giving antabuse to patients who are in the late stages of cirrhosis of the liver. She also indicates that disulfiram could never be considered to be a total therapy in itself because of the fact that alcoholism is a very complicated disturbance with "roots in the psychologic, social, and biologic depths of the individual". Blum and Blum indicate that Lemere and Voegtlin attempted to utilize antabuse experimentally at Shadel as a conditioning agent. They found that emetine was a far more effective drug for conditioning purposes and that disulfiram did not have the "specific, deep or long lasting effects" that they desired for their specific treatment purposes. (8:133) Blum and Blum also indicate that

> "Since there are other, safer, and more effective methods of establishing a conditioned aversion response to alcohol, we cannot recommend the use of disulfiram (antabuse) for that purpose." (8:133)

This leads us to the discussion of the use of disulfiram for a chemical barrier or a psychological fence. The utilization of disulfiram as an antidipsotropic or barrier drug is a more common practice. Antabuse is mainly used in this way as a chemical barrier against the ingestion of alcohol. This method of treatment does not deliberately attempt to utilize conditioning principles. The reaction to antabuse by a patient who has taken alcohol is quite severe. This is described in the following treatment operation that uses disulfiram as its basic deterrent agent. The alcoholic patient is given

1/2 tablet (0.25 gm) daily during the antabuse program. This is a relatively small dosage, but is quite effective for the purposes of being a barrier agent. The advantage of the small dosage is that it greatly reduces the adverse side effects of the disulfiram and these side effects tend to be mild and transient. When alcohol is ingested by the individual under the influence of this drug the effects vary in severity depending on the amount of alcohol taken and the amount of disulfiram in the patients system. Since the elimination of antabuse from the body is an exceedingly slow process (7 to 10 days) the 1/2 tablet dosage may build up in the body to produce an extreme reaction. The reaction itself is manifested in a mild reaction by flushing of the skin and a "heated feeling". Many people on this program experience little more than this. On the other hand, many individuals experience a very strong reaction. This is characterized by an extreme drop in blood pressure, weaknes s and nausea, headache of varying severity, sweating, palpitations of the heart, and in more severe cases, vomiting and fainting. Sanford Billet states that large dosages of antabuse and the ingestion of large amounts of alcohol very serious and severe reactions will occur. He continues to say that, "very severe reactions are rare when 0.25 gm daily is used." (6:169) This latter reaction is described by Ruth Fox when she first started using antabuse therapy in 1949. The drug was quite new at this time and research was somewhat incomplete. Dr. Fox was working with some very difficult alcoholic patients who had difficulty maintaining sobriety during psycho-

therapy. She describes the procedure

> "Disulfiram is dispensed as a scored white tablet of .5 gram, which crumbles in water and is practically tasteless. The original suggested dose, in 1948 and 1949, was 4 tablets on the first day (given after several days of sobriety), 3 on the second day, then 2 on the third and fourth days (a total of 5 1/2 grams in four days). On the fifth day the patient was put in the hospital and given, on an empty stomach, 15 cc. of whiskey. If no reaction occurred within 10 to 15 minutes, he was given a second 15 cc. Very rarely, a third dose of 15 cc. was needed to bring on a strong reaction." (12:243)

This amount of disulfiram given in these earlier treatment programs far exceed the amount in use today. Dr. Fox goes on to describe the reactions that occurred with 5 1/2 grams of disulfiram and 30 to 45 cc. of whiskey

> "The reactions to these test doses of alcohol were very severe. Within 15 to 20 minutes the patient would become markedly flushed, with redness of the eyeballs, a slight rise in blood pressure, severe tachycardia, sense of apprehension, pounding headache, precordial pain, and rapid breathing. After 10 to 15 minutes of this reaction, the blood pressure would fall, in some cases almost to zero, and the patient would show pallor, would feel weak, dizzy, faint, nauseated, and would usually end up vomiting and might even faint. It was necessary to have a special nurse and emergency equipment close at hand. There was no case in which the reaction was not sharp and definite, lasting usually from two to four hours, usually followed by sleep and a gradual return to normal." (12:243-244)

Dr. Fox also indicates, as Sanford Billet does, that the therapist who uses anabuse therapy should not be used with psychotic individuals. Ruth Fox also states that, "Its (antabuse) importance is that it maintains sobriety long enough to permit the deeper form of study and therapy to arrest the disease." (12:247) The results of treatment methods that utilize disulfiram

have, according to Blum and Blum (8:133-134) reported approximately 50 percent remission rates. Lemere and Voegtlin reported a 51 percent remission rate for 4,096 patients over a 13 year period, and for a one-year period 60 percent had remained abstinent. (8:133) The abstinence for a period of one year would give psychotherapeutic efforts an opportunity to be initiated. Hayman notes that the alcoholic patients that he has studied who have used antabuse in therapy have had a successful drying out period in 53 percent of the cases. (14:154) Hayman goes on to state his complete evaluation in a short summary statement

> "The conclusion thus far has been that drugs are of limited value in the symptomatic treatment of chronic alcoholics, and there is no evidence to indicate that they effect a change in chronic alcoholism as an entity." (14:164)

Ruth Fox indicates that the use of disulfiram is beneficial in promoting sobriety, but the antabuse therapy must be complimented by other programs such as individual and group therapies. She also feels that the alcoholic must be prepared to take the antabuse program. He should be helped in maintaining the attitude that antabuse is a step or a facilitating agent toward a long term goal and not a "crutch" that will be leaned on by the alcoholic as an emotional cripple.

Dr. Fox states that

> "Since every area of an alcoholic's life is adversely affected by his drinking, therapy should be total, directed at the

> alcoholic's physical state as well as his emotional and spiritual state." (12:254)

Sanford Billet states that 64 percent of the alcoholics in a study conducted in the Washington, D. C. Alcoholic Rehabilitation Clinic who used antabuse showed considerable improvement. He feels that antabuse must also be supplimented by other therapies in order to facilitate a complete and comprehensive approach to treating the alcoholic disorder. Antabuse, Dr. Billet feels, helps alcoholics to achieve their goal of a healthy "total adjustment to life." (6:174)

Chafetz and Demone feel that antabuse should be considered as a "useful tool" in the overall treatment of alcoholism. This particular should not be considered to be a cure but should only be utilized as a useful device to "help give the patient a proper measure of control over impulsive drinking". They stress the idea that disulfiram should be an adjunct therapy in the total treatment approach to the alcoholic disorder. Chafetz and Demone also feel that the use of antabuse should be used with "selective caution". (10:212-213)

The use of other drugs in the treatment of alcoholism has existed to some extent. The majority of the drugs studied have fall into several different catagories. Only two of these drugs will be mentioned in this section of the paper. These two general drug types are the antidepressants and the minor tranquilizers. The first drugs mentioned are the antidepressants.

Hyman states the antidepressant drugs have been used in the treatment of the alcoholic disorder with very few positive effects. He claims that the use of these drug types have little of the positive effects desired even in the depressed alcoholic. There is no supportive evidence that this type of drug aids the alcoholic in maintaining sobriety. (14:158-165) The minor tranquilizers have had a higher degree of success than the antidepressant drugs. The most notable of these is Chlordiazepoxide or Librium. Hyman feels that this drug has been quite useful in treating the acute withdrawal syndrome in alcoholics. It may, he feels, help to relieve tension and fear. Librium is a comparitively safe drug with a very low addiction potential. The research evidence with Librium is rather scant in relation to the treatment of alcoholism. In general, Hyman feels that

> "it has been reported that, except for Antabuse, drugs did not influence the outcome of treatment in an alcoholism clinic, although they may have influenced the patient to maintain contact." (14:164)

The feeling that conditioned aversion therapy and the use of barrier drugs in therapy should only be used as a part of the total treatment approach to alcoholism has been stressed continually. Albert Bandura states that

> "The major value of aversive procedures is that they provide a rapid means of achieving control over injurious behavior for a period during which alternative, and more rewarding, modes of behavior can be established." (5:555)

The supplementary and complimentary treatment approaches lead to the next major section of this chapter, the individual and group psychotherapies

used in the treatment of the alcoholic disorder.

The Group and Individual Psychotherapies

The utilization of group psychotherapy has been in use for some time. One of the more prominent alcoholic therapists, Dr. Hugh Mullan, has worked with alcoholics in groups and feels that this approach has many positive benefits toward helping the alcoholic individual. Dr. Mullan states that the alcoholic "is a product of a society in which he neither fully participates, nor consistently contributes." (17:5) The fact that the alcoholic is difficult to rehabilitate represents an extremely difficult challenge to Dr. Mullan. He feels that we deal with a culture that both condones and discredits alcohol. We try to drink socially while we discuss the problem of the alcoholic. Alcoholic beverages are easily available in our society. This coupled with the fact that alcohol has a dual property of being both addictive and anxiety alleviating properties. Thus, the availability and the gratifying effects of alcohol complicate the implementation of therapy for alcoholism. The implimentation of groups in the treatment of alcoholism has several advantages which will be discussed in this chapter. Initially the group aids in dealing with a large number of people at the same time. This statement is made with the provision that the group therapy must be supplimented by individual psychotherapy. The latter statement also implies that group therapy does not only mean a group of clients and one therapist, but also would include a

group of therapists involved with one client. A treatment group, then, would be a specific therapeutic situation involving more than one or two persons established with a specific purpose in mind. This specific purpose in this case would be for the treatment of the alcoholic patient who the group is designed for. These groups are characterized by "face-to-face association and cooperation" toward a specific goal, which is the ability to coexist with the drug alcohol in a non-detrimental manner. According to Dr. Mullan

> "The psychotherapeutic group is a special kind of treatment group. It is conducted by a trained group psychotherapist who carefully selects and prepares the alcoholic patients and proceeds to bring his psychotherapeutic methodology to bear upon the individual in the group." (16:12)

Thus, the specific groups that involve the alcoholic have one general goal in mind, the "mobilization of the alcoholic's inner forces to the point where he will be able to cope with the environment without drinking alcohol." (16:13)

Melville Thomas states that for a long time the use of groups in the treatment of alcoholism was merely for the facilitation of treating more people in a less amount of time. Now the alcoholic patient has more people to understand his problem in the group, more people to indicate the various and many ways in which he might approach and work with his problem. Thomas states that it is "asking a lot of the individual therapist to give the patient all the different views that might come up in a group." (23:127-145)

One of the processes that occurs in the group situation involving alcoholics is the principle of "consensual validation". Thomas describes and illustrates this phenomena

> "Consensual validation means that the people involved must reach a mutual agreement (consensus) about the nature of the problem (validity) before progress is made. The group provides a sample population to test one's ideas. The individual counselor is but one person. The alcoholic, for example might say to the therapist seeing him alone, 'You and I agree on this, but how do I know you're right. I'd like some different ideas'." (23:127)

Thomas goes on to claim that the individual alcoholic is very difficult to treat on a one to one basis. It is interesting to note at this point that the most operant opinion concerning the use of groups is that they should be definitely complemented and enhanced by one to one therapeutic situations.

The three major frameowrks of group therapy types that will be discussed in this paper are the Didactic Group, the Interacting Group, and the Nondirective Group. There are, of course, many other types of groups and a multitude of combinations of basic group types, but the major group types are the three that are discussed in this chapter.

The initial type of group is the didactic group. This group is basically a classroom type session. The functioning of this group ranges from the "moral lecture" type of group process to the "instructional" form of interaction. It is felt by many therapists that the accumulation of knowledge by the alcoholic concerning his disorder is potentially beneficial to the alcoholic patient. Others feel that the didactic group is best considered a step toward

the process of better group involvement and participation by the members of the group therapy session. According to Thomas, the teaching group is a step in the progression toward the expression of feelings by the group members. This is the initial process of interaction among group members. (23:128) Thus, many psychotherapists consider the next type of group to be the logical step toward the process of group interaction.

Interacting groups involve the process of intricate interactive processes among its members. With alcoholics the optimum number of members is from seven to ten members. The reason for this size of group facilitates participation from each member. Dr. Gertrude Baker of the Brentwood Veteran's Hospital in Los Angeles, California states that the alcoholic individual has experienced enough rejection as a result of his disorder and certainly does not need to feel any more rejection in therapy. (4:Interview Tape) As a result of this concept, Thomas feels that the moderately sized group allows individual participation, but the group that is too small fails to accomplish the purpose of group interaction. (23:128) The alcoholic becomes involved in an interacting group situation that is a case-centered model. The case-centered interacting group is described by Blocher

> "In the case-centered approach, the group is unified only in terms of its desire to help each other work through real concerns. The format of operation in this model is for group members to take turns in presenting their individual concerns, while the rest of the group act as helping persons." (7:176)

Dr. Baker supports this approach by stating that

> "A good group leader will encourage the patients to help each other rather than be the one who is always making interpretations and doing the therapy. He teaches the group to work as a therapeutic group." (4:Interview Tape)

In reference to the concept that alcoholics need only to work in group therapy as Thomas would indicate, Dr. Baker has this to say

> "Many people who are working with alcoholics today tend to feel that individual therapy with the alcoholic is a pretty hopeless affair. I don't agree with this. I think that some of the forms of psychotherapy that we've used with alcoholics are effective." (4:Interview Tape)

Blocher points out that the case-centered group has several advantages. The first advantage is that "multiple helping relationships" are developed. The group member functions not only as a client, but also acts as a therapist. He learns to operate in a "new set of roles and relationships" and thus develops enhancement toward new experiences in social learning. The second advantage of this type of group is that group members are interacting with individuals who profess and maintain "divergent perceptions and attitudes". The members express and examine their own views and the views of others in a situation "whose central purpose is to maintain a climate of warmth, acceptance, and permissiveness". The third advantage of this group type is that it has an "individually centered focus". The members present their own personal ideals and beliefs but all members of the group have the opportunity for social learning. Each member is "focused on" at one time in the sessions and thus "the presenting member

is allowed to meet his needs in a direct and immediate way." (7:177) The interacting group of this nature often utilizes a directive facilitator or director, thus utilizing the main property of the didactic or teaching group. This property of directedness often does not provide the answer to the members of the group. The members not only feel but need to experience the goals of the group therapy. The lecturer or teacher with his directive attitude allows the members of the group to learn from him but often fails to allow the group members to experience things that occur in the group for themselves. This group is quite effective for providing information and developing interactive processes, but the responsibility for leadership rests on the shoulders of the therapist. If we consider the fact that Dr. Baker and Thomas both feel that the alcoholic is initially mistrusting of the therapist and in many cases quite hostile, then we might question the effectiveness of directing the alcoholic in therapy. If the group members of any group therapy process resent the knowledgable "commander influence" of a therapist, who is to the alcoholic an outsider, then we might view the point of view of the nondirective group. It may be noted that the nondirective group with its dominant therapist is the antithesis of the nondirective group where the patients or clients are the directing forces of the group. It is true that the nondirective group involves the interactive properties of the interacting groups with the obvious exception of the directive facilitating leader of the interacting group. The members of the nondirective group decide for them-

selves "what to talk about or, for that matter, whether to talk at all". In the nondirective group the role of the facilitating therapist involves the qualities of acceptance of the members, a warm understanding of the members as individuals and the attitude of unconditional positive regard for the group's clients. In nondirective group therapy utilizes the framework and theory as presented by Carl R. Rogers. Basically the nondirective approach as indicated by Rogers involves the process of the self-actualizing tendency in the individual that chooses a set of responses that are basically goal seeking. As Roger says, "The organism has one basic tendency and striving-to actualize, maintain, and enhance the experiencing organism." (487-491) The therapy process involves the procedure of directing behavior that is compatible with the individual's self-concept as he perceives it. This development of the organism involves behavior that enhances, maintains and actualizes the individual. The use of alcohol is a form of misguided or falsely perceived enhancement similar to Salter's concept of alcohol ingestion as being false excitation. This concept of the client centered, nondirective approach will be examined more closely in the latter part of this chapter.

Dr. Baker in her alcoholic treatment program at the Brentwood V.A. Hospital in Los Angeles utilizes several of the group approaches in facilitating therapy for alcoholic patients. She states that initially we should consider the alcoholic as "an individual and not as the alcoholic". She feels

that the alcoholic is hostile toward the therapist and often does not relate to the psychotherapist. The groups that she utilizes involve the interacting group in its various forms. The use of psychodrama she feels is very beneficial if the alcoholic patient will participate. The Brentwood hospital uses a form of psychodrama that has its foundations in the theory of J. L. Moreno, the prime mover of psychodrama. The psychodramatic technique is described by Thomas

> "The theoretical roots of psychodrama lie in the assumption that the total involvement of the organism is a prerequisite for the therapy of the individual. In the actual process two or more individuals act out situations during which they become emotionally involved in the roles they are playing. In doing so their guarded behavior becomes unguarded, spontaneity is unleashed, and, in general, unconscious behavior rises to the surface. In effect, psychodrama is an animated projective technique in which the participants throw out or project personality components into the situation." (23:135)

This procedure is useful in that the preconditions for drinking might be understood and investigated. The process allows some insight into the conditioners that perhaps stimulated the alcoholics drinking pattern. Dr. Baker feels that the psychodrama is valuable in that it helps the alcoholic to experience catharsis and get the tension building anxieties out of the patients system. Baker notes that it is often valuable to look at the patients past conditionings and situation, but "to stay and dwell in the past is destructive to both the alcoholic and everyone else in psychotherapy". It does very little good to sit and "ruminate endlessly about the past". We should deal,

Dr. Baker claims, with the alcoholic individual with "a minimum of dwelling in the past, but with what is happening in the here and now". We should deal with a dynamic type of psychotherapy that actively helps the alcoholic today. (4: Interview Tape) Dr. Baker feels that the other groups at the Brentwood hospital are effective in dealing with the alcoholic individual. The groups involve the use of patients as participating therapists as well as staff psychotherapists. Because of the alcoholics lack of openness with the non-alcoholic staff member Baker feels that the alcoholics are more candid when they are in their own group with no outsiders. The patients then do function in a non-directive group with a more open attitude.

Dr. Baker states

> "Perhaps the best service that we give them in the case study groups is to teach them something about how psychotherapy is done so that they can do it with each other when we (the staff) are not around. (4: Interview Tape)

The utilization of group procedures does have some singular advantages in psychotherapy with alcoholics. The use of the various group methods involve almost any type of approach that might dwell in the imaginations of the therapists themselves, but the therapeutic consensus is that there is no approach existing that is a panacea to the ills of alcoholism. Thus, alcoholism must be treated by means of a total treatment approach that involves no one singular part of treatment. The use of supportive therapy is indeed necessary. The group approach, for example, becomes more

effective when it is complemented and supplemented by the use of the individual therapies.

The use of individual therapy in the treatment is a necessary adjunct in the total treatment approach toward alcoholism. This paper will consider two approaches that utilize one to one therapeutic methods. These are the theories and methods put forth by Carl R. Rogers and Andrew Salter. The psychotherapeutic method utilized by Andrew Salter involves a process that is founded on scientific conditioning theory. Salter deals with a process he terms as "conditioned reflex therapy". He feels that each individual in therapy should be helped to a psychological and behavioral state that he terms "emotional honesty". Salter states that we, as organisms, are the products of our past conditionings and are the end product of them. The concept of the unconscious mind is in essence conditioning. Verbal symbols act as stimuli of the "associative reflexes" which represent early past conditionings of the human organism. The lack of the proper conditionings lead the individual to a state of unhappiness, anxiety and a form of disequilibrium. Salter states

> "Many humans do not have a background of appropriate conditionings in which, as in physics, sympathetic vibrations can be produced. In psychotherapy, as we shall see later, we may proceed with such persons by training into them whatever conditionings are necessary to solve their problems." (21:6-7)

Thus, Salter is saying that we can replace faulty or poor past conditionings with conditionings that are more purposeful and compatible with the

individual. Salter considers the healthy personality to be "excitatory"; the unhealthy one he terms "inhibitory". The therapeutic process is basically a process of "disinhibition". Salter considers the process of disinhibiting to be the fundamental process of therapy

> "A person has feelings of frustration and conflict when his psychological skills are inadequate to solve the problem that confronts him. It is as if he were trained to open doors, and it is not so much that the emotional lock before him is a new one, as that the keys of inhibition are made of putty." (20:39)

Salter states that the healthy personality develops by the person's own emotional feeling state. Salter says, "I want free outgoing emotion to guide their logic. Self-control comes from no control at all." (21:42) This follows from the idea that conditioning in the organism is not an intellectual process, but a feeling state, a visceral process. The organism is initially born in a free state but societal conditioning limits his freedom. The process of disinhibiting (the replacement of past conditionings with new ones) leads to an excitatory individual. "Excitation is a matter of emotional freedom and has nothing to do with social participation", according to Salter. This is contrasted with the inhibitory personality "which suffers from constipation of the emotions". The inhibitory person is insensitive to others and is "discontented with himself" because "he is discontented with his relationships with others" according to Salter. (21:40-50) The description of the inhibitory personality describes the alcoholic who utilizes alcohol to provide him with a false feeling of excitation. Salter

states that the pre-alcoholic personality "is always distinctly inhibitory". Salter says this about the drinking person

> "Periodic drinkers are extremely inhibitory and are difficult to treat. Sober, they are almost inaccessible beneath their lacquer of receptivity. On a spree, they are no more accessible and usually sadistic. Their prognosis is bad, unless excellent rapport is quickly established, and this is usually difficult because of the thickness of their inhibitory scar tissue." (21:104)

It is interesting to note that Baker et. al. (4:Interview Tape) have noted the inhibitory qualities of the alcoholic patient. Salter also confirms the idea that the alcoholic must have the desire to work and that he must be sober in therapy. "The alcoholic we are interested in treating must have a sincere desire to cooperate, which simply means the intention to obey instructions." (21:195-196) Salter continues by saying, "When he is nursing a hangover, every alcoholic is full of firm resolutions; nevertheless this is no time for psychotherapy." (21:195) Salter also states that the alcoholic may be "dryed out" by behavioral and aversion type conditioning and that it is a "good beginning for further therapy" for the alcoholic patient. (21:197) A process of experience or conditioning put the alcoholic into his condition and a process of experience or conditioning will get him out of it. Thus Salter states that

> "He will not be playing the hypocrite when he acts excitationally. It is inhibition that is hypocrisy..... Mental health is a matter of balance between inhibition and excitation, although in therapy we emphasize the excitatory side of the picture." (21:199)

Salter believes in constant intervention on the part of the therapist to bring the alcoholic individual to the state of a balanced excitatory way of life. The therapeutic process that Salter utilizes to bring the inhibited individual to the excitatory state involves a system of disinhibiting exercises that the client puts into active practice. There are six exercises that he illustrates in his book, Conditioned Reflex Therapy. These exercises involve feeling talk or "the deliberate utterance of spontaneous felt emotions". The second exercise involves facial talk or the process of showing the experienced emotions non-verbally. Thirdly, the client is told to contradict and attack when he honestly feels that he should do this. "Do not simulate agreeability. Instead, externalize feeling, and contradict on an unprovable emotional basis". Fourth, Salter recommends the deliberate use of the word I. In other words, stand up for your rights and take both credit and responsibility for what you do. This leads to the fifth exercise, express agreement when you are praised. You deserve it, so accept it. Go so far as to volunteer praise of self, "this will not make you appear priggish, and will sound natural". Sixth, improvisation becomes the last exercise. "Live now, and tomorrow will take care of itself" is the precept to live by. Salter states, "These emotional exercises may seem juvenile, boring, and unimportant, but they are the very things that build a cure", they disinhibit by a process of reconditioning. This process leads to an environmental mastery, which is what we wish to accomplish with the alcoholic. (21:97-103)

Salter states that "The prevention of alcoholism is the prevention and reduction of excessive inhibition." (21:212)

He feels that

> "In therapy the individual gets rid of (1) Conditioned inhibitory reflexes by practicing (2) Deliberate excitatory emotional reactions which become (3) Conditioned excitatory emotional reflexes." (21:103)

Thus Salter summarizes his psychotherapeutic process

> "Therapy consists of getting the individual to re-educate himself back to the healthy spontaneity of which life experiences have deprived him. Inhibitory history stops repeating itself, and excitation regains its birthright. The objective of mental health is to 'be me, not them,' but the world is 'them', and overwhelmingly bigger. Society is the sworn enemy of mental health." (21:103)

Salter, in his therapeutic process, treats the client as an individual with his own personal set of conditioned inhibitions. He develops the therapeutic process to aid the individual human being who asks for help. A client is not treated as a thing with a stereotyped problem, but as an entity with a singular and specific personality.

Carl R. Rogers is not contrasted to Andrew Salter but is compared to Salter. Their purposes in counseling reflect common goals to be attained in the psychotherapeutic relationship. In his book, Counseling and Psychotherapy, Rogers states his basic hypothesis concerning counseling

> "Effective counseling consists of a definitely structured, permissive relationship which allows the client to gain an understanding of himself to a degree which enables him to

take positive steps in light of his new orientation." (20:18)

Everything done in the counseling relationship should lead toward developing this relationship. The client should develop a self-understanding through self-initiated, positive action. The counseling process should move the client toward "openness of experience" toward "acceptance of others" then toward a "trust of self". The client-centered approach to counseling sees man as an organism that is basically rational, realistic, forward-moving, and socialized. This is contrasted with the common concept of man as being irrational, unsocialized and basically self-destructive. The impulses of emotion are there, but the need for control of these emotions need not occur in the self-actualizing individual. Hostility, hate, and jealousy do exist, but Rogers considers these to be "reactions to the frustration of more basic impulses such as love and security". According to Patterson

> "There is, then, no need to be concerned about controlling his aggressive, antisocial impulses; he will become self-regulatory, balancing his needs against each other. His need for affection or companionship, for example, will balance any aggressive reaction or extreme need for sex, or other needs which would interfere with the satisfactions of other persons." (18:405)

Rogers presents his theory of personality and behavior in a series of nineteen propositions. These propositions describe the personality in its developmental states. The individual, Rogers feels, "has one basic tendency and striving-to actualize, maintain, and enhance the experiencing organism."

(19:487) Thus, the alcoholic may consider the process of ingesting alcohol to be a form of enhancing behavior. In Proposition XVI we can see an indication of the alcoholic's reaction to his environment. This proposition states

> "Any experience which is inconsistent with the organization or structure of self (as the client perceives himself) may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself." (19:515)

When the individual experiences a perception of threat to his self-concept, an anxiety response results. It was noted earlier that alcohol tends to relieve anxiety and is a detrimental method of self-enhancement. According to Rogers the alcohol would be a defensive response to threat and anxiety. Alcoholism, then, would be a form of defensive behavior. By the ingestion of alcohol "the awareness of threat, but not the threat itself, is reduced by the defensive behavior." (19:516) This process of threat and defense recur over and over. This recurrence process, then, may explain the actions of the alcoholic. The alcoholic's behavior might be termed a process of distorted symbolization complimented by the experience of continued anxiety. In the process of therapy, Rogers notes, the individual changes in three ways. First, the client will "perceive himself as a more adequate person" with the ability to function as a self-actualizing person. Second, the client will allow "more experiential data to enter awareness, and thus

achieves a more realistic appraisal of himself, his relationships, and his environment". Third, he sees objects as having neither inherently bad nor good, but "value is placed on it himself." (19:139) Patterson illustrates the actual process of this type of therapy. Initially the client is in "a state of incongruence, being vulnerable, or anxious". The therapist is congruent and maintains "unconditional positive regard" for the client and the therapist also maintains "an empathetic understanding of the client's internal frame of reference". With these in mind, the actual process of therapy continues. The client expresses his feelings more freely and refers to himself more than he refers to others. He is able to accurately symbolize and describe his feelings. Perceptive discrimination is more accurate and he notes the incongruity "between certain of his experiences and his concept of self". He notes the threat of this incongruence because he sees the "unconditional positive regard" of the therapist. He is able to experience perceptions that were distorted or denied in the past. His self-concept is reorganized and he assimilates and includes these otherwise distorted and unrecognized experiences. "Defensiveness is decreased", anxiety is decreased, and "his concept of self becomes increasingly congruent with his experiences". The client experiences the therapist's "unconditional positive regard" without threat. He feels more and more an "unconditional positive regard". "He reacts to experience less in terms of his conditions

of worth and more in terms of an organismic valuing process." (18:412-413) The results of this therapy give a more open person who is congruent and "more open to his experiences". His behavior becomes more compatible with his self-concept and the client experiences control over his behavior. The client is accepting of self and others and he is "more fully expressive of his own purposes and values". He becomes the truly "self-actualizing" individual. (18:414)

Summary

The process of rehabilitating the alcoholic is approached in many ways. Psychotherapists who treat alcoholics must realize that there is no panacea for this disorder. The psychotherapist must, however, be familiar with the various treatment methods in order that he might formulate a treatment approach that is suitable to his background, philosophy, and treatment concept. A proper treatment method must be devised to help these individuals who have alcoholism as a symptom of their problems.

CHAPTER IV

Summary

The professional attitude toward the alcoholic disorder has evolved from a moralistic attitude and perception of the alcoholic as being a weak person to the modern attitude that the alcoholic is a sick individual. A variety of approaches have been utilized in dealing with alcoholism. The behavioral approach uses a conditioned response learning that behavioral approach uses a conditioned response learning that tries to give the alcoholic patient an aversion to alcohol. Efforts have also been made to utilize group and individual psychotherapies to treat the alcoholic. Each approach has had varying degrees of success in treatment practice. This paper has presented and evaluated the treatment methodology in two major treatment approaches, because it is felt by the researcher that an understanding of the current treatment methods of alcoholic therapy should be familiar to the counselor who attempts to treat this disorder. The researcher has selected treatment methods he considers to be the more important of the many therapy methods. The references cited are useful in research as well as instruction for the therapist who wishes to investigate any singular treatment method mentioned in this study. It must always be kept in mind that specific treatment approaches are in the hands of the psychotherapist. The needs of the individual who is an alcoholic are the best indicators of the particular methods of treatment that should be utilized.

Conclusions

The researcher feels that a functional treatment approach to the alcoholic disorder involves several things. Initially, the alcoholic must be ready for therapy. If he is not, then he is wasting the time of the therapist as well as his own. Before the rehabilitation process can start the alcoholic patient must be sober. He must be in such condition so that he is coherent and able to understand the process of therapy. This "drying out" process may be accomplished in several ways. The conditioned aversion process will keep the alcoholic sober and "dry" a sufficient length of time so that psychotherapy may be initiated. The alcoholic may be committed to a hospital or program that will help him reach a sufficiently proper state of sobriety so that he is amendable for intensive psychotherapy. The stpe that follows the "dry out" period might be termed the "intensive psychotherapeutic" period. There are several ways in which this might be accomplished. The alcoholic client may either work in a group situation or an individual or one to one therapy situation. The researcher feels, however, that group therapy should always be complimented by individual psychotherapy. The last step is the form or type of therapy that should be used in the group and individual situations. The "method type" used in group and individual psychotherapeutic situations is of course entirely up to the therapist. The researcher feels that the therapeutic approaches utilized and theorized

by Carl R. Rogers and Andrew Salter have elements that would facilitate effective psychotherapy with the alcoholic individual. The advantages of these two therapies are that they consider the alcoholic to be an individual with alcoholism for a symptom of a personality disorder. The individual is treated as a person who is a human being with qualities in common with other human organisms. Both Salter and Rogers consider the alcoholic to be treatable for the simple reason that he is a human.

It is certainly not necessary for the therapist who investigates the teatment methods used by Rogers and Salter to emulate the personalities of these two men. This would more than likely be a mere caricature rather than a scientific approach to utilizing two commendable and workable theories and approaches. It is more important that the therapist utilize the foundations of these two theories within the framework of his own personality and counseling philosophy. It may also be noted that the efficacy of both theory has been tested by the results Salter and Rogers demonstrate. It is the contention of this researcher that the treatment method described in this section of the paper has more than limited advantages to recommend it. The method is based on theories that have a successful and operant treatment background. Their utilization for work with alcoholics per se needs to be further researched.

Recommendations

The researcher feels that any psychotherapeutic theory, no matter how well founded, must still be tested for its effectiveness. The treatment method outlined in this paper must be implemented and the results compiled. The research compiled is a step in the treatment processes that are intended to treat a complex and widespread disorder. The researcher recommends that the theories and treatment procedures should be researched by case study methods as well as interview and inquiry methods. It appears from the researcher's study of the literature that there has been a lack of longitudinal follow up studies and little replication of studies on the treatment of alcoholism. The researcher therefore recommends that such longitudinal studies and replications would be of value in the treatment of alcoholism.

SELECTED REFERENCES

1. Anonymous, Aspects of Alcoholism Volume 2. Philadelphia: J. B. Lippincott Company, 1966.

2. Anonymous, Shadel Hospital. Seattle, Washington: Information Pamphlet, 1971.

3. Anonymous, "Staying Off the Wagon", Behavior Today, 2:1, March 1, 1971.

4. Baker, Gertrude, Interview with Edmund J. Seitz, September 9, 1970

5. Bandura, Albert, Principles of Behavior Modification. New York: Holt Rinehard and Winston, 1969.

6. Billet, Sanford L., "Antabuse Therapy", Alcoholism, The Total Treatment Approach, Ronald J. Catanzaro, Editor. Springfield, Illinois: Charles C. Thomas, 1968.

7. Blocher, Donald H., Developmental Counseling. New York: The Ronald Press Company, 1966.

8. Blum, Eva M., and Richard H. Blum, Alcoholism. San Francisco: Jossey-Boss Inc., 1967.

9. Catanzaro, Ronald J., Editor, Alcoholism, The Total Treatment Approach. Springfield, Illinois: Charles C. Thomas, 1968.

10. Chafetz, Morris E., and Harold W. Demone, Alcoholism and Society. New York: Oxford University Press, 1967.

11. Clancy, John, "Conditioned Reflex Therapy", Alcoholism, The Total Treatment Approach, Ronald J. Catanzaro, Editor. Springfield, Illinois: Charles C. Thomas, 1968.

12. Fox, Ruth, Editor, "Disulfiram (Antabuse) as an Adjunct in the Treatment of Alcoholism", Alcoholism Behavioral Research, Therapeutic Approaches, New York: Springer Publishing Company Inc., 1967.

13. Franks, Cyril M., "Behavior Modification and the Treatment of the Alcoholic", Alcoholism Behavioral Research, Therapeutic Approaches, Ruth Fox, Editor. New York: Springer Publishing Company Inc., 1967

14. Hayman, Max, Alcoholism, Mechanism and Management. Springfield, Illinois: Charles C. Thomas, 1966.

15. Milt, Harry, Basic Handbook on Alcoholism. Maplewood, New Jersey: Scientific Aids Publications, 1969.

16. Mullan, Hugh, and Iris Sangiuliano, Alcoholism, Group Psychotherapy and Rehabilitation. Springfield, Illinois: Charles C. Thomas, 1966.

17. Mullan, Hugh, and Iris Sangiuliano, "Experiential Group Psychotherapy with the Alcoholic", Alcoholism Behavioral Research, Therapeutic Approaches, Ruth Fox, Editor, New York: Springer Publishing Company, Inc., 1967.

18. Patterson, C. H., Theories of Counseling and Psychotherapy. New York: Harper and Row, Publishers, 1966.

19. Rogers, Carl R., Client Centered Therapy. Boston: Houghton Mifflin Company, 1965.

20. Rogers, Carl R., Counseling and Psychotherapy. Boston: Houghton Mifflin Company, 1942.

21. Salter, Andrew, Conditioned Reflex Therapy. New York: Capricorn Books, 1961.

22. Stojiljkovic, S., "Conditioned Aversion Treatment of Alcoholics", Quarterly Journal of Studies on Alcohol, 30: 900-904, December, 1969.

23. Thomas, Melville, "The Group Therapies", Alcoholism, The Total Treatment Approach. Ronald J. Catanzaro, Editor. Springfield, Illinois: Charles C. Thomas, 1968.

24. Ullman, Leonard P., and Leonard Krasner, Eds., Case Studies in Behavior Modification. New York: Holt Rinehart and Winston, 1965.