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Enhancing the natural control of drinking behavior: catching up with common sense

BY HAROLD MULFORD

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This paper is about two approaches to the alcohol problem. One of them starts with nature and builds on it. The other starts with a concept and tries to make nature fit it. The first approach begins with doubts and seeks answers. The other began with certainties but is encountering doubts. Although the first approach is unique to Iowa, the second is not; and other states have carried it further.

The naturalistic approach

The first approach, the naturalistic, began in 1966 with a public meeting called by the Cedar Rapids, Iowa, Citizens

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Committee on Alcoholism. The group was concerned about the inhumanity of the revolving-jail-door handling of alcoholics and was frustrated with the expense and futility of sending them to the state mental hospital for long-term treatment. Some participants noted that a friend or an acquaintance had corrected his/her troublesome drinking habits without formal treatment. The group decided to hire a "community alcohol coordinator" to work with alcoholics and to help the community deal with them. A local psychiatrist, Dr. Leo Sedlacek, signed a $600 bank note to pay the first three months' office rent, and a retired recovering alcoholic volunteered to run the office on faith that local funds would be raised. During the next eight years, 43 Iowa communities similarly formed a citizens group, raised local money, and employed an alcohol coordinator.

Meanwhile, at the University of Iowa, a monitoring system had been developed to evaluate these centers' performances. Regular feedback reports were made to the centers' coordinators to help them learn from, and build on, their own and each other's experiences. The university also had a training program for community coordinators. In the absence of scientific evidence that a master's degree, a doctorate, a medical degree or any other degree confers on anyone a special ability to deal more effectively with alcoholics, it was a nondegree program. Since trainees were chosen mainly for their common sense and their empathy for alcoholics, they had varied backgrounds, ranging from a student just short of a Ph.D. in physics to a poorly educated person who had been a skid row denizen for 15 years. There were ex-nurses, ex-nuns, ex-farmers, some clergy, and the son of an Eskimo chief from Alaska. One student had been a Bunny in a Playboy Club. About three-fourths of the trainees were recovering alcoholics.

Part of their training consisted of supervised counseling of the hospitalized patients and then, after discharge, transporting them back home to their community coordinator. The trainees also spent two weeks locating and interviewing former patients as part of an ongoing treatment evaluation research program. The community centers, the monitoring and research system, the training program, and the hospital services for the few who needed medical attention were the four major components of an integrated system designed to help the communities to promote the natural rehabilitation of alcoholics and, perhaps, also to promote the natural prevention process.

The clinical intervention approach

By 1975, federal and state treatment funds had become available, to be administered by a State Alcoholism Authority according to federal guidelines, and the clinical intervention approach became dominant. The citizens' efforts, being built from the bottom up, were reprogrammed with directives from the top down. The centers' operations were soon standardized, professionalized, and thoroughly bureaucratized. At the same time, the training program was phased out; it was not considered professional enough to fit the disease-treatment-cure way of thinking. The new state authority designed its own monitoring system—not for research, but to police the centers' conformity to the state's directives.

Community center operations

We can get a sense of how the centers worked prior to reprogramming from a description of one center that has remained independent of the state program and whose performance I have been monitoring since 1974. The board of supervisors of Iowa's Washington County, a rural county of about 20,000 people, concluded that it would be less costly to fund their own center than to accept state and federal funds and meet the programming requirements. A state

district judge on the citizens advisory committee convinced the state attorney general that what was called the "Washington County Outreach Center" was not an alcoholism treatment center under the law. The judge maintained that the county was simply employing a coordinator to help the community deal with troubled drinkers. And, since the coordinator did not pretend to diagnose alcoholism, or to treat alcoholism, or even to counsel away alcoholism, the center was not subject to the law requiring state accreditation and licensing as an alcoholism treatment clinic.

Of course, there was no standard operations manual for the center, nor were there certification requirements for the coordinator, Bob Gray. It was simply expected that he would care about alcoholics and draw upon his common sense, experience, intuition and empathy to contact people with drinking problems and lend them a helping hand. Bob's approach to clients varies, depending upon the nature of the case. No two are treated alike. It depends upon the client's needs, and not upon Bob's need to practice one of the countless scientifically unverified therapeutic modalities he might have learned from a textbook or picked up at a therapy workshop. His office is not the corner store selling a commodity called "alcoholism treatment" or promising the alcoholic any type of fast fix. Nor is it a place for the community to dump its responsibilities to alcoholics. Bob explains to alcoholics that no one can give them, or sell them, a solution for their problem. They must get it the old-fashioned way—work for it. Any benefit they get from others' efforts to help them is in proportion to the effort they themselves put into the process. To encourage widespread responsibility, Bob does nothing for the alcoholic that the alcoholic can assume responsibility for, and he does nothing for the alcoholic that someone else in the community will take responsibility for.

The coordinator is an outreacher, a motivator, an advisor, a consultant, a friend, a confidant, and a follow-upper for people with drinking-related problems. He is readily available, and for the long term. Serving as a catalyst for the natural rehabilitation forces, he helps alcoholics restore and strengthen social relationships—through job, family, Alcoholics Anonymous, church and social activities. He also helps them use appropriate community services and resources to resolve whatever medical, legal, financial, religious, or other problems they might have.

Bob sees each client an average of about once a month; some much more often, some less often—again, depending on the case. Appointments are unnecessary, and there are no admission policies. Some clients drop in for a quick cup of coffee. Some stay two or three hours. Some stop for a chat on the street. Some go hunting or fishing with Bob. A high school student with a drinking problem voluntarily stopped by for a few minutes each morning on his way to school.

The reprogrammed state-controlled centers

Meanwhile, what progress were the reprogrammed state-controlled centers making? In an article published in 1979, I documented the following changes in the months subsequent to the state takeover: The number of centers was increased from 43 to 73. The total annual expenditures for all centers more than doubled. The State Alcoholism Authority's staff and administrative budget both increased approximately tenfold. Much time, effort and money were expended to formulate and annually update a state plan and to conduct countless conferences, workshops and training programs believed to improve administrative and counseling skills. The centers came under close scrutiny and constant review by the state. The tightened accountability increased the amount of paperwork some fivefold. The centers were required to meet JCAH accreditation and counselor certification criteria, and

also had to be licensed by the state. This included detailed requirements such as a treatment plan for each patient and 50-minute counseling sessions. One directive, since rescinded, even required that a physician must diagnose the client's alcoholism and prescribe treatment.

This impressive list of accomplishments in a period of about two years might appear to be progress, until one asks, "What's in it for the alcoholic?" Then we learn that during the same period the total number of new clients seen by the reprogrammed centers declined 51%. The centers were now spending twice as much money to serve half as many new clients. The illusion of progress became the triumph of form over substance, of means over original purpose.

During the past decade many well-intentioned people have sincerely labored to develop a state program to deliver the most effective treatment to Iowa's alcoholics. More treatment funds have been obtained, and many persons are being served. But two recent personal experiences will illustrate the high priority that institutionalization continues to give to form over substance. One evening a local businessman's wife—I will call her Mrs. Smith—called me at home, desperately seeking help for her alcoholic husband. She had just bailed him out of jail, where he was charged with drunk driving after having wrapped his car around a tree. He wanted to talk to someone about his drinking. She knew that the next morning he would feel better and would again deny his problem. She had phoned the reprogrammed local alcoholism center. A tape recording advised her to call back between 8 a.m. and 5 p.m. She called me instead. I gave her the name of an AA member, who visited her husband within the hour. Had Mrs. Smith called the center during normal work hours, she would have been scheduled for an appointment, where she would have completed some 15 to 20 pages of forms. Then, because the director's favorite treatment happened to be family therapy, she, not the alcoholic, would have been expected to attend weekly therapy sessions for eight weeks before her husband was scheduled for counseling—if he was still sober.

In another case, I helped a woman try to get help for her alcoholic ex-husband who had unexpectedly arrived in town that Saturday morning. Each of the two local long-term treatment facilities referred us to the other. The director of one of them wanted to explain his admission policies. I responded by recalling a time before the center had become a residential facility, when there was only a coordinator who carried the office files in his hip pocket and operated on an annual budget of $5,000. He had no admission policies, but he always responded to an alcoholic's call for help. "Now," I said, "with a budget of more than half a million . . . ." The director interrupted to boast that it was closer to a million dollars, which I took as an unwitting confession of the priority displacement that had occurred. Serving alcoholics had become secondary. As it turned out, the alcoholic got "I-80" therapy; the police bought him a bus ticket to return down Interstate 80, back to the mission in Des Moines where he had been staying. He has been mostly sober since.

The clinical interventionists' reprogramming of the local centers to fit the medical model was based not on scientific evidence, but on a reification of the alcoholism disease concept. That is, the concept came to be acted on as though it had a material existence. When the prohibition movement, based on the popular belief that alcohol was the sole cause of alcohol problems, lost public favor, the belief that a disease was the cause then captured the public imagination. Without waiting for medical science to identify the disease mechanism, or for other scientific verification of what Jellinek recognized as only a concept in his influential book, *The Disease Concept of Alcoholism*, the nation launched the alcoholism movement. Since diseases are treated by physicians, and physicians treat disease in hospitals, it was not surprising that Congress enacted legislation creating the

National Institute on Alcoholism and Alcohol Abuse (NIAAA) and mandating the establishment of alcoholism treatment centers. NIAAA soon institutionalized both the reified disease concept and the social reaction to it. Today we have a large and growing alcoholism industry operating as though the disease has been defined and the treatment is known.

Incidentally, Iowa first experimented with clinical intervention for troubled drinkers nearly a century ago. In 1903, Dr. Applegate of the Mount Pleasant State Mental Hospital reported that he was treating the inebriate not as a sinner but as "an unfortunate man suffering from a disease not fully recognized by an unjust public." He did not define the disease, the treatment, or recovery, but he did report a recovery rate of 29%, not unlike the rate for today's treatments. Two years later the state built a separate institution for the treatment of "inebriates and dipsomaniacs." However, 14 years later the daily census had declined from an initial 200 patients to only 11, and the facility was sold to the federal government for a V.A. hospital.

What we know, or think we know, is ultimately verified or disproved by the consequences. After a generation of experience with the alcoholism movement, and despite the proliferation of expensive alcoholism treatment centers, alcoholics and alcohol problems persist undiminished. Doubts are growing. Does the emperor really have any clothes on? For example, Dr. Enoch Gordis, NIAAA director, last year said, "Our whole [alcoholism] treatment system, with its innumerable therapies, armies of therapists, large and expensive programs, endless conferences, innovations and public relations activities is founded on hunch, not on evidence, and not on science." Actually the etiology, the diagnosis, the prognosis and the prevention of the hypothetical disease all remain scientific mysteries.

Momentum and strong vested interests will probably sustain the alcoholism industry for a while. But as long as the clinical interventionists' technological promises remain unfulfilled, the movement is vulnerable to unpredictable shifts in fickle public sentiment. It is not too soon, then, to seek a different way of thinking about, and an alternative reaction to, problem drinking. The naturalistic community alcohol coordinator approach may deserve further consideration.

The natural rehabilitation and prevention processes

The conventional Newtonian, deterministic, mechanical model of the alcoholic as a machine with a faulty part requiring technical repair has not been a fruitful way of thinking about troubled drinkers. An alternative is to suppose that becoming a recovering alcoholic and becoming an alcoholic (which are really just the dynamics of a person's drinking behavior) are coexistent processes representing the cumulative, subtle influences of a multitude of individually weak social, psychological, and biological factors that interact in complex ways we do not yet understand. When the 43 Iowa communities employed a compassionate, empathic alcohol coordinator to work with troubled drinkers, they were intuitively, albeit unwittingly, extending the natural prevention and rehabilitation processes. Although people generally do not think in such terms, the coordinator is an integral part of the natural process, much like Alcoholics Anonymous. Both essentially build on nature. They don't try to make nature fit an *a priori* belief.

The natural habilitation process

But what reason is there to postulate a natural rehabilitation process? Research is confirming commonsense observations that many alcoholics recover without clinical intervention. In fact, excessive drinking was being prevented and problem drinkers were being rehabilitated in the natural course of events long before modern medicine. The early American Puritans considered "chronic drunkards" prime candidates for redemption or rehabilitation.

So-called spontaneous remissions, however, are no more spontaneous than is the weather on a given day. "Spontaneous remission" is a euphemism for our ignorance of the forces at work. Like the weather, the recovering alcoholic's changing behavior is continuously being shaped by countless small forces. Consider, for example, some of the numerous forces involved in Mr. Smith's case. When the AA member arrived at his home that evening, they considered the available options. Mr. Smith chose AA. However, later he did visit a private treatment center for a couple of hours and was given a tour by the owner. That he remained sober following such minimal clinical exposure might suggest a very powerful treatment. But the credit must be shared. Getting drunk and wrecking his car probably contributed. Then the police did their part; they arrested and jailed him. There was the threat of losing his wife, and his "hangovers" were getting worse with age. The wife did her part; she recognized, and acted on, his readiness to talk to someone. Another private citizen (this author) connected the wife with an AA member, who promptly made a "12th-step call." (The local newspaper had made a contribution with a story that provided the wife with my name.) Such common human experiences and life events, plus many others unknown, all are forces to be studied if we are to understand the natural rehabilitation process. It is likely that a multitude of other experiences and events had already combined over the years—perhaps over his life span—to create a critical mass such that any one of the events I have mentioned might have triggered in Mr. Smith a hunger for abstinence and the determination to maintain it.

Closely related to the rehabilitation process is the natural prevention process. The persistence of alcohol use over hundreds of generations, despite the inevitable problems, suggests that the psychological pleasures of alcohol have a special appeal for many people. The ever-present excessive drinker suggests a tendency for overindulgence in the absence of constraints. Yet the survival of the species, the fact that no society is known to have drunk itself into oblivion, and the

wide variation in problem-drinker prevalence across groups and across time all suggest the presence of natural constraints on drinking behavior.

Individual psychological and biological factors probably play a role in the prevention process. Some people may have an inherent dislike for the taste of alcohol or for its intoxicating effects. Others may develop such a dislike. For some, the aging of the body and the changes in role expectations as they move through life may be constraining forces. A genetic factor may be involved. However, the natural constraints come mainly from integrating alcohol use into the culture through the endless development and informal enforcement of harmless drinking norms.

Building drinking norms

Integrating alcohol into the culture is a process of people forever talking with each other about it. It is a ubiquitous, ceaseless, dynamic, symbolic interaction process. Alcohol is one of the most talked-about subjects in our society. The process began with the caveman's discovery of the pleasures (and the problems) of "Kickapoo Joy Juice"—or is it "God's Good Gift," as it was to the Puritans, or "the Devil's Own Brew," as the Prohibitionists called it? Even naming the object is part of the dynamics of the norm-building discussion process. The ancient process continues down to this moment. A crucial product of this incessant palaver is the evolution of drinking norms; that is, consensus regarding who should drink what, when, where, with whom, how much, how much is too much, and on and on.

Informal enforcement

No less crucial is the informal enforcement of the drinking norms through mechanisms such as ridicule, embarrassment and ostracism. Depending upon the amount of agreement regarding a norm, informal enforcement can be very effective. You can demonstrate this for yourself the next time you are invited to dinner just spitting a big glob out into the middle of the di[illegible]

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Although the community coordinator is primarily a catalyst for the rehabilitation process, he or she also promotes the natural prevention process by involving as many community elements as possible in each alcoholic's recovery. This is done by contacting alcoholics mainly through community professionals, service agencies, employers and the courts. Involving the physician, lawyer, welfare office, general hospital, family, friends, clergy, employer, court, etc., in the alcoholic's recovery stimulates the community discussion needed to build consensus for responsible drinking norms and, in turn, strengthens their informal enforcement.

But does it work?

If the clinical intervention approach is promises unfulfilled, the alcohol coordinator approach is largely promises untested. We did compare the recovery rates for two coordinator centers with the rate of a six-week stay in a hospital-based treatment center. Consistent with other treatment comparisons, recovery rates did not differ. What *is* different is the coordinator's vastly greater rate base. The Washington County center has annually been serving about 250 individuals, including about 75 new clients, on an annual budget of less than $45,000. That would treat only three or four cases in a nearby hospital-based center, and only one or two in one of the more expensive clinics. The $15 billion that Americans currently spend annually to treat 1.5 million alcoholics would fund a coordinator in each of about 333,000 communities and neighborhoods throughout the nation. If each one annually served 250 persons, then more than 83 million Americans a year could be helped with a drinking problem, if they had one. But this is some four to eight times the total target population as estimated by NIAAA. The presence of a coordinator in so many communities and neighborhoods, working with so many persons in all stages of the alcoholic and rehabilitation processes, and involving so many community members, at least has potential for enhancing the natural prevention process.

Conclusions

To paraphrase the comic strip character Pogo, "We have met the alcohol problem, and it is us." All of us, including problem drinkers, share responsibility for the alcohol problem. We all are therefore responsible for constraining the problem. Each of us is responsible for restraining his or her own drinking behavior and everyone else's. Alcohol excess is a people problem, not a technological problem. We deceive ourselves if we expect to solve the problem with a technical quick fix such as a treatment pill or a preventive vaccine.

The alcoholism-disease way of thinking leads us to disown our responsibilities to keep each other reasonably sober as a part of the process of keeping each other human. Instead, it encourages us to relinquish our authority for informally constraining each other's drinking behavior to designated "experts" who are all too eager to assume the task.

Experts *can* be useful, when there is something to be expert about. An alcoholic who needs heart surgery or an automobile engine overhaul would be well advised to seek out an expert highly trained in the appropriate technology and certified to meet the highest professional standards. But the absence of a validated technology for correcting troublesome drinking renders professional training and alcoholism counselor certification criteria arbitrary and irrelevant. Common sense and cost-effectiveness concerns therefore direct one to go to Alcoholics Anonymous or to a community coordinator for help with a drinking problem. For the same reasons, nonmedical residential facilities are preferable to the costly hospital-based clinics. If all helping efforts give about the same small boost to the alcoholic's natural recovery, why

spend thousands of dollars for help when it is available for the asking from AA and for about a nickel from a community coordinator?

In all honesty, we could initiate the coordinator approach only with a frank admission of scientific ignorance of how it might enhance the natural rehabilitation and prevention processes. However, we should not be content with such ignorance. Instead, we should continuously and systematically study the program as it develops. As the research gradually reveals what works and what doesn't, the findings would be fed into the curriculum of a training program, which in turn should improve the coordinator's effectiveness.

Alternatively, we can continue down the illusionary disease-treatment-cure path into Alice's Wonderland, where we might expect to encounter the Red Queen running her own private alcoholism treatment clinic. She will be busily dreaming up innovative therapeutic modalities, upgrading her admission policies, composing television copy and other advertising copy, promising an 80%—if not 90%—salvation rate for alcoholics and no less for co-dependents and children of alcoholics, not to mention the grandchildren of alcoholics and anyone else she might entice to warm her procrustean treatment beds. She will also be completing forms that assure compliance with the latest accreditation, certification and licensure requirements. When we ask her, "What's in it for the alcoholic?", the Red Queen will smile and say, "Oh dear, oh dear, I'm late, I'm late," and she will hurry on down the path—still smiling all the way to the bank.

I leave you with these two thoughts: The Librarian of Congress Emeritus, Daniel Boorstin, recently told a national conference on creativity that "the main obstacle to progress is not ignorance, bu[illegible] illusion of knowledge." And the philosopher Fran[illegible] that "if a man will begin with certainties, he [illegible] but if he will be content [illegible]