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HELPING ALCOHOLICS: DOING WHAT COMES NATURALLY

by

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A condensation of a paper presented at the University of California San Diego National Conference on Financing Community-Based Recovery Services

March 23-24, 1990

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"There is compelling evidence that the results of our treatment were no better than the natural history of the disease." Research psychiatrist George Vaillant, Dartmouth Medical School, in his book The Natural History of Alcoholism: Causes, Patterns and Paths to Recovery, arrived at this conclusion after an eight-year experiment evaluating the effectiveness of his own alcoholism treatment clinic. Other controlled experiments have consistently yielded similar conclusions. Such experimental findings, together with research showing that most alcoholics eventually modify their drinking without formal treatment, suggest that natural forces, probably a multitude of them, constantly operate to influence an alcoholic's drinking behavior outside the four walls of a treatment clinic. These well established facts have prompted Vaillant and others to call for greater understanding of how to facilitate the natural healing processes. Meanwhile, the citizens of certain Iowa communities might gain much at little cost by helping alcoholics in ways that appear to be in tune with the natural rehabilitation processes.

One such effort has recently been developed by "We Care" and the Hardin County Alcohol and Drug Services Board. For some years the board served as a citizens advisory committee for the state-regulated local outpatient alcoholism center. In 1985 it was looking for a way to help more alcoholics at less cost. The board had become disillusioned with burdensome state regulations having no known relevance to helping alcoholics and with the ever more costly practice of sending alcoholics to hospital-based treatment centers only to see them return to drinking. The board endorsed a proposal by one of the present authors, Jergens, and board president Joe Huibsch to establish an employee assistance program (EAP) for small businesses in the area. Jergens approached the Dodger Holding Company of Eldora, Iowa and other local small businesses. He offered to work with their substance abusing employees as well as with the employees' family members for a set fee of $25 per employee per year. Agreements were soon signed with ten small companies. This provided an annual operating budget of $27,000 which paid for office rent, some part-time secretarial help, and travel expenses for the "community coordinator," Jergens, who volunteered his services.

The Population Served

The program called "We Care" covered a total of about 3500 citizens--employees and their family members. Program records show that during the first three and one-half years of operation We Care served

385 of those persons. About one-fourth, or 102, of the 385 calls for help concerned someone with an alcohol or drug problem. Three of the 102 were referred for medical detoxification and four were referred to residential substance abuse treatment centers at their request.

Thirty-six, or just over one-third, of the 102 substance abusers were employees, while the balance were family members. Of the 36 employee alcohol and drug cases, three quit their job, and three were eventually terminated; however, some 83% of them remained on the job with acceptable job performance.

Of the 66 substance abuser employee family members, 29 were adults and 37 were juveniles. One-third (10) of the 29 adults have remained abstinent more than one year, six are drinking less, and 13, or nearly half, have returned to their former habits. The outcome figures for the 37 juvenile substance abusers were virtually identical; one-third (12) of them have formed a young people's group in AA are staying clean. Five of them have moved out of the area, and just over half (20) of them are still having problems.

These outcome figures compare favorably with the 25% to 35% of alcoholics typically found abstinent following any treatment regardless of type, duration, intensity or cost. The four out of five alcoholic employees being retained in their jobs compares favorably with the retention rates reported for other EAPs. Still, we are aware that in the absence of a

controlled experiment we cannot know whether a similar recovery rate would have occurred without these helping efforts.

It is noteworthy that as word of We Care's services spread, the program coordinator received an additional 226 calls for help from persons having no connection with the client companies. About half of these calls involved alcohol or other substance abuse. So many calls from the community at large would seem to indicate an unmet demand for affordable informal assistance.

Evidence of community support for the program is seen in invitations from the United Ways of two towns in the area to apply to them for financial assistance as well as donations by several churches and by private citizens. Also, a number of additional companies have sought to join the consortium.

But Isn't Something Missing?

The prevailing alcoholism disease mythology leads people to expect that any respectable "real" alcoholism treatment must possess several characteristics that are missing from the Hardin County program: 1) there is no gleaming brick and mortar staffed by people in white coats surrounded by high technology; 2) there is no pretense that a physical disease is being medically diagnosed and treated; 3) no highly trained professionals, or academic degrees, or expert consultants dominate the activity; 4) there are no program accreditation, counselor certification, or

state licensure requirements; 5) there are no standard operating procedures; 6) there is no pretense that the action is scientifically grounded; 7) it is not the product of the biomedical, mechanical way of thinking about human beings; 8) finally, the exorbitant cost of hospital-based alcoholism treatment is also missing. But are these missing elements essential to the alcoholic's decision to modify his/her drinking?

Do we need brick and mortar? Numerous controlled comparison studies consistently find no overall advantage for residential over nonresidential settings in treating alcohol abuse.

Are medical diagnosis and treatment necessary? No. And a good thing, because medical diagnosis and medical treatment of "alcoholism" are myths. The typical alcoholism treatment package is more social than medical. The physical examination typically given new alcoholism clinic admissions, important as it is for the few with medical problems, is not the classic medical diagnosis of alcoholism that popular mythology believes it to be. No laboratory tests reveal a faulty body mechanism that explains chronic drunkenness. What is commonly believed to be a medical "diagnosis" is actually a legitimating clinical confirmation of the diagnosis already made by the family and others who cajoled, coerced, or committed the patient to enter treatment that he is an alcoholic.

The numerous so-called "alcoholism diagnostic instruments" that have been developed are mainly

researchers' descriptions of the drinking and related behavior of institutionalized alcoholics. They do not establish the objective reality of an alcoholism disease entity. These pseudo-objective "diagnostic instruments" merely reinforce the myth of an alcoholism disease "thing". Dr. Benjamin Rush did not discover alcoholism some 175 years ago. He invented a concept which only recently captured the public imagination. Although the alcoholism disease concept is central to the Alcoholism movement mythology, it remains only a concept in the mind of the observer, not a "thing" in the body of the observed.

Whether or not alcoholism is really a disease is of little consequence. However, the popular, but ill founded, belief that it is a disease has had tremendous consequences. Unfortunately, success in getting alcoholics to change their drinking behavior is not one of them.

Physicians treat alcoholics, not alcoholism. For want of a better medical explanation of the "alcoholic's" behavior "alcoholism" is attributed to him/her with the implication that there is a medical treatment for "it." After all, why else would the patient be in a hospital? In fact, however, there is no chemical, surgical, or other medical treatment shown to make any special contribution to the alcoholic's decision to change his life style. Being told by a physician that drinking is destroying his liver may concentrate the patient's attention and influence his

decisions. Beyond that, however, the physician's influence probably depends more upon how he relates to the alcoholic than upon his medical skills.

Are academic degrees or highly trained professional experts necessary? It has not been shown that academic degrees of any kind confer on anyone any special ability to influence the drunkard's behavior. In the absence of any formal treatment proven to be more effective than the natural recovery process the ability to relate to alcoholics along with some common sense faculty for helping them to use community resources to solve their problems is about all of relevance that there is to be "expert" about.

What about program accreditation, counselor certification and state licensure criteria? There is no evidence that a center which meets state-imposed program accreditation, counselor certification, and licensure requirements will serve any more alcoholics any more effectively than if it met some other arbitrary standards. In fact, they tend to get in the way of the counselor/alcoholic relationship.

Arbitrary standard operating procedures, such as preparing a treatment plan for every case and scheduling fifty-minute counseling hours merely create a Procrustean treatment bed. Procrustes, a fabled Greek highwayman, waylaid travelers on their way to Athens and insisted that his captives fit an iron bed he kept for them. Those too short he stretched. Those too tall he lopped off at one end. Alcoholism

treatment centers are more sophisticated. They make their captives' minds fit a prepared psychological bed.

To that end treatment center admission practices tend to screen out the most obvious misfits. If counseling or the administration of drugs fail to adjust the minds of any misfits who slip by the admission screening, they are soon discharged as "unmotivated and not appropriate for treatment." Furthermore, to keep them might adversely affect the center's claimed success rate, which all too often is based only on those patients who fit the treatment bed and who stay the specified number of days, which again is not a medical decision but one made by third-party payers.

Some treatment center patients are captured through deceptive TV commercials or other advertising claiming success rates as high as 90 percent and more. Other patients are actually waylaid on the highway, not by center staff, but by the State Highway Patrol. Those convicted of drunk driving are often sent to the treatment center by the court. That many of them are not alcoholic by any generally accepted criteria tends to be overlooked by the treatment center especially if there is an empty bed and there is assurance that their bill will be paid. Still other captive patients are employees identified by their poor job performance. They also often need some adjustment to fit the treatment bed. Actually, the minds of convicted drunk drivers and poorly performing employees will readily

adjust to fit any treatment bed when the alternative is a prison term or job loss.

Need it cost thousands of dollars to help an alcoholic? Not at all. The assistance of the We Care coordinator is readily available to alcoholics for an entire year for only a tiny fraction of the cost of only 28 days of attention in a hospital-based treatment center.

Another community coordinator program in Washington County, Iowa has been helping alcoholics for about $180 per case per year since 1977. The center, funded and controlled by the county, is staffed by a full-time paid coordinator and a secretary. It serves the entire county of nearly 20,000 population. With an annual budget of about $45,000 it annually serves about 250 individuals or about one-fourth of the county's estimated total alcoholic population .

What about scientific grounding? The belief that the Alcoholism movement is scientifically grounded is another popular myth. Enoch Gordis, current director of the National Institute on Alcoholism and Alcohol Abuse, has written in the Journal of Studies on Alcohol, "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."

Let's face it. The alcoholism disease concept and the Alcoholism movement are propaganda, news media, and

political achievements; they are not scientific achievements. There is no coherent body of scientific knowledge regarding drinking behavior. There is only a growing collection of fragmented, and often contradictory correlations with no coherent theory that makes sense of them or that explains drinking behavior. Such a state of affairs allows program directors, politicians and other policymakers to pick and choose those "scientific facts" that support whatever action appears to them financially rewarding or politically expedient. If we would understand the rise and growth of the alcoholism treatment industry, the disease to study is not alcoholism but "greedism."

Is the biomedical model necessary? As evidence that belief in the disease concept is unnecessary for a harmonious relationship between man and alcohol, consider first the self-evident truth that the human species somehow survived thousands of years of beverage alcohol use without the alcoholism disease concept, modern medicine, or the alcoholism treatment industry. Second, while most societies have used alcohol and other mind-altering substances for many generations, none ever drank (or drugged) itself into oblivion. On the contrary, anthropologists including Dwight Heath of Brown University tell us that most all societies have naturally evolved drinking norms and customs which, though they vary greatly across societies, generally result in a harmonious (if imperfect) relationship with alcohol.

Third, several contemporary societies have long enjoyed a relatively harmonious natural relationship with alcohol. Orthodox Jews and Italians, for example, have lived with alcohol for countless generations with few problems, as have most tribal groups.

Also, during early American colonial days, men, women and children drank heavily by today's standards. They drank throughout the day every day but with few alcohol problems. Even chronic drunkenness, which was disapproved and sometimes punished by the colonists, was not viewed as much of a problem. The alcohol mythology of the colonials gave far greater weight to the perceived benefits of beverage alcohol than to any problems that they saw associated with (but not caused by) its use. In short, the natural man/alcohol relationship, i.e., without highly structured, government intervention, appears to be a relatively harmonious but imperfect one.

According to historian Harry Levine of Queens College, New York, the harmonious relationship with the "good creature of God" enjoyed by the early colonists began to deteriorate into a sour relationship with "Demon Rum" in the late 1700s. During the 1800s and early 1900s the deteriorating relationship was accompanied by accelerating government attacks on alcohol as the supposed cause of alcohol abuse and alcohol-related problems. The attacks on alcohol culminated in the ill-fated Prohibition amendment to the U.S. Constitution in 1919.

During the past thirty or forty years alcohol problems have grown apace with, if they have not outpaced, the growth of the Alcoholism movement and the escalating attack on a postulated disease as the latest supposed cause of alcohol abuse. One need only follow the daily news reports to see that the Alcoholism movement has failed to diminish, much less solve, the alcohol problem.

A problem of perception. The alcohol problem is largely a problem of perception. The dominant ways of thinking about alcohol for nearly two hundred years have been useless at best. The failed Prohibition and Alcoholism movements were generated by a way of thinking that supposes that alcohol abuse is determined by a single causal mechanism. However, Americans seem unable to make up their minds whether the cause is the substance, the suppliers, the users, a faulty body mechanism in some unfortunate users, or perhaps the Devil. But does it matter? Concerted attacks on first one and then another of these supposed causes have all failed their purpose.

The War on Drugs

During most of this century, problems with drugs other than alcohol have also grown with the growth of government efforts to control them. In the current "war on drugs" our government is concentrating its attack on the suppliers as the supposed cause of the drug problem, but only the suppliers of illegal drugs and particularly the Columbian "drug lords." Alcohol

suppliers are not on the hit list as they were during the Prohibition era, not yet at least. Neither are pharmaceutical manufacturers or prescribing physicians, despite their significant contribution to our society's having become the drug culture that it is. Caffeine producers are not on the list, either. However, according to recent news accounts the U.S. Surgeon General proposes to add tobacco producers to the list. Notice that this government action comes only after the dramatic natural shift in American smoking norms and habits of the past two or three decades. This shift probably owes much to scientific research that informed the public of the health risks of tobacco use. New smoking norms evolved naturally, without the intervention of a Tobacco Prohibition movement or a "Nicotinism movement" or an expensive "nicotinism" treatment industry or even severe legislative controls. Most people who quit smoking do so without treatment. It will be interesting to see how alcohol fares as part of today's larger drug war. The steady decline in per capita alcohol consumption during the past decade may well indicate that Americans are naturally evolving more responsible, less harmful drinking norms and practices much as happened with tobacco use.

The history of man's relationship with mind-altering drugs as well as our recent experience with tobacco offer hope that if people are given honest and accurate information about the effects of alcohol use, they will naturally evolve drinking norms that

constrain their own and each others' appetites for the pleasures of alcohol and rehabilitate those who violate the norms. They will do so informally without (or perhaps despite) highly structured attacks on some supposed single cause of alcohol problems.

Informal efforts to help people with drinking problems as represented by the citizen actions in Hardin and Washington counties not only help alcoholics along in the natural recovery process but also improve the communities' overall relationship with alcohol. Because this approach represents the common sense, collective intuition of the people involved rather than the psuedoscientific "high tech" mythology of the Alcoholism movement, it is more in tune with the natural man/alcohol relationship than are the structured pseudomedical alcoholism treatments being offered. Since it keeps alcoholics out of institutions, they are not disengaged from the natural social processes or insulated from peer pressures or from the informal community processes that naturally shape human behavior. Also, the approach strengthens individual and community responsibility rather than concentrating it in medical experts. Everyone needs someone, but the last thing anyone needs is the debilitating and dehumanizing experience of turning responsibility for their problems and their lives over to someone else. Finally, to the extent that any effort to help alcoholics is in tune with nature, there is less risk that it will do anyone harm.

During the late 1960s and early 1970s some 40 Iowa communities each employed its own community coordinator to work with alcoholics, much as is still being done in Washington and Hardin counties. Local communities should again be encouraged to develop their own self-help approaches. With the $100 million that Iowans annually spend on chemical dependency treatment the state could be blanketed with 2,000 community coordinator centers like the one in Washington County. Every county in the state could have 20 of them with a few left over. Theoretically, 2000 such centers could annually serve more than 500,000 persons, or nearly three times the 180,000 Iowans who are substance abusers, according to Iowa Department of Health estimates.

Were we to pursue this social approach and if experimental studies ultimately reveal it to be as ineffective as the medical approach, then the worst that later generations might say about us is, "At least they had the good sense to choose the more economical of two approaches that didn't work."