ALCOHOLISM IN A SHOT GLASS

TREATMENT SETTINGS, PROGRAMS, AND NEW MODALITIES FOR ALCOHOLISM

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Treatment Settings, Programs, and New Modalities for Alcoholism

As research into the etiology, physiology, and psychology of alcoholism has burgeoned, treatment alternatives also have evolved and even taken on daring new forms. This final chapter explores some of these developments.

REHABILITATION PROGRAMS

During the past 15 years inpatient rehabilitation programs for alcoholics and other substance abusers have grown in number. Most programs are privately run. They usually last 28 days, since that is what most insurance policies have covered. With the advent of managed care, however, insurance companies have cut back their coverage and the average length of stay in rehabilitation units has been shrinking. Although the future of inpatient rehabs is in doubt, most units will probably survive and learn to work under the new, more restrictive conditions. For some alcoholics, recovery is not possible without inpatient treatment. Fortunately, there are also public programs, usually administered by state mental hospitals, that offer the benefits of low cost and the possibility of more extended treatment.

Inpatient rehabilitation programs have several functions: (a) they buy time for sobriety to take hold by providing external controls until internal ones can be established; (b) they provide an opportunity for intensive

education on the nature of alcoholism, emphasizing the disease concept of alcoholism, since belief in this concept reduces guilt and facilitates recovery, even if it should turn out to be a metaphor or a beneficent myth; (c) they provide a safe environment for the alcoholic to experience and express intense affects that have been anesthetized and repressed; (d) they create a therapeutic community in which patients have an opportunity to overcome isolation and gain self-esteem through a sense of common adventure; and (e) they introduce patients to and require attendance at AA meetings. Alcoholic rehabilitation programs also provide many models of both illness and recovery with which the patient can identify.

Inpatient programs are multimodal, utilizing didactic lectures; films; informal discussion groups; therapy groups; psychiatric evaluation and, if appropriate, treatment; nutrition counseling; recreational therapy; occupational therapy; family therapy; individual counseling; structured self-evaluative formats that the patient works on and then discusses with his or her counselor; and participation in AA and other twelve-step programs such as Adult Children of Alcoholics (ACOA) and Narcotics Anonymous (NA). Twelve-step programs promote growth and "lock in" sobriety. Patients are strongly urged to join an *after-care* group when they are discharged. Participation in the rehabilitation after care program, which is usually a weekly group session, is seen as an important, indeed vital, tool for recovery. After care groups concentrate on alcohol and the problems of early sobriety,

especially recognizing drink signals before they are acted on.

Although scientific outcome studies are rare and we don't really know how well these programs work or for whom, they have a large number of enthusiastic recovering alumni. Inpatient rehabilitation units see themselves as, and sometimes are, safe places to "let it all hang out." They often use treatment modalities that encourage a great deal of affective arousal and release. The most common is the *psychodrama* group. Led by a skilled facilitator, these groups are indeed effective forums for "decompression," allowing the barely sober alcoholic to discharge long-repressed emotions, which makes maintenance of sobriety immediately after discharge more likely. Conflicts are enacted instead of acted out. Psychodrama is also said to increase participants' empathy for their significant others by promoting identification with each of the actors in the psychodrama.

Although at present all the inpatient alcohol rehab programs with which I am familiar are AA, twelve-step oriented, programs of the future may offer alternate treatment options. I see this as highly desirable since many people find the AA ideology unpalatable and many are too schizoid or borderline to benefit from it. To mandate that a client attend AA or an AA oriented rehab, as happens fairly commonly, is rather like mandating that somebody attend church. Although AA is a nondenominational "spiritual" rather than religious program, one of its central tenets is the "higher power" and much is made of

the members' relationship to that higher power. To mandate that a person affiliate with a program with that much spiritual, or if you regard that as a fudge, religious content, seems to me to be a dangerous violation of that person's civil liberties. I say this even though I am in full agreement with the intuitive understanding of the dynamics of alcoholism that is incarnated in the AA Program and fully believe that AA affiliation vastly increases the likelihood of remaining sober.

STRUCTURED DAY PROGRAMS AND HALFWAY HOUSES

Some alcoholics are too damaged by their disease or were so impaired premorbidly that they cannot sustain a recovery in the community after discharge from inpatient rehab with only the support of AA and outpatient counseling. They need a structured day program that provides on an ongoing basis much of what an inpatient rehabilitation program provides. Day programs are looser and more informal. They serve as a place to hang out when structured activities are not scheduled.

Halfway houses are residences for recovering alcoholics and usually offer some form of treatment as well as providing for the basic needs of the residents. The contents of the programs provided vary widely, but almost all offer guidance, support, and structure in addition to food and shelter. Recreational activities are commonly offered. The residents either go to a day

program or have jobs. Antabuse and other medications are usually dispensed to residents if indicated. Many of these facilities are run by charitable agencies or religious groups.

With the cutbacks in third-party reimbursements, many inpatient alcohol and drug rehabilitation programs have started four-evenings-a-week intensive treatment programs aimed at employed alcoholics who would, in all probability, have been treated as inpatients a few years ago. If a patient relapses while in such a program, the rehab can then argue to the insurance company that that particular alcoholic really needs inpatient treatment. Frequently the strategy works and the patient is admitted. These evening programs differ from the structured day programs discussed above in that they are aimed at a different, more functional population. They do not target profoundly damaged alcoholics and are far less global in their approach. They offer a combination of educational didactic programs that teach the disease model of alcoholism and intensive group psychotherapy aimed at the breakdown of denial and the teaching of coping skills. They are Twelve Step oriented and push AA attendance hard. They are still too new for there to be any real sense of their efficacy, let alone rigorous outcome studies. In spite of this, they are said to be cost-effective and may well be the wave of the future.

TREATING CROSS-ADDICTION

Today it is rare to encounter an alcoholic who is not cross-addicted. This is especially true of patients under 35 years of age. Alcoholics are particularly prone to using other sedative drugs, such as barbiturates and tranquilizers. Alcohol and cocaine is also a popular combination, and marijuana smoking is all but ubiquitous among the young. Cocaine addicts frequently use alcohol to "come down" and become hooked on it also. Conversely, it is not uncommon for alcoholics to self-medicate the depression that is a consequence of alcohol abuse with cocaine. Speed (amphetamine) is used for the same purpose, and hallucinogens also are in widespread use. More rarely the counselor will encounter alcoholics crossaddicted to heroin or morphine, which are also sedating drugs, or to methadone, the synthetic used to wean addicts off heroin. It is not possible to use any drug safely once addiction to another drug is established. Therefore, alcoholics must be educated to the fact that the use of any mood- altering drug, with the exception of properly prescribed psychotropic medications, will sooner or later result in a resumption of active alcoholism. Cross-addicted alcoholics are treated in much the same ways as non- cross-addicted alcoholics. After detoxification from all drugs, educational and psychological interventions are used to build ego strength and to help the patient deal with feelings without resorting to drugs of any kind. Participation in a self-help group is also strongly encouraged.

SELF-HELP GROUPS

Twelve-Step Programs

Alcoholics Anonymous (AA) was the first of the self-help groups. Founded during the Depression by Bill Wilson, a stockbroker, and Bob Smith, a surgeon, both of whom were alcoholics, it has become enormously influential. Its basic concept—that there is something uniquely healing in their sharing of their "experience, strength, and hope" by people who are suffering from a common problem—has been widely imitated, to the benefit of people with diverse other problems. Members are enjoined to "identify, don't compare." The commonality of the alcoholic experience, which cuts across age, social class, gender, occupation, and race, is stressed. When a speaker "qualifies" (that is, tells his or her story), members are asked to identify with the feelings of the alcoholic speaker, not with the circumstances of his or her addiction. At some meetings, the evening's activity consists of speakers telling their stories to the group. Usually these meetings are open and nonalcoholics are welcome. Other meetings use a different format in which a brief qualification is followed by a discussion, often of a topic such as "dealing with tension" or "gratitude for recovery." These meetings are closed (that is, restricted to those "who have a desire to stop drinking"). Closed meetings are more like traditional group therapy than are open meetings, but they discourage "cross-talk," (lengthy interchanges between members) so again, identification with the storyteller is emphasized. Members are encouraged to have a "sponsor," a member with "time" (who has been sober

for a while) and "quality sobriety" who acts as a guide and mentor, and to follow AA's Twelve Steps of spiritual growth. Many different things occur in the process of AA participation, but the most important are cognitive restructuring (changing one's beliefs about alcohol and self) and unconditional acceptance, with its concomitant emotional support by the group as a whole and by individual members, including the sponsor.

Counselors and others working with alcoholics need knowledge by acquaintance with as well as knowledge about AA. They should attend open meetings. Reading AA's literature, especially *Alcoholics Anonymous* (known as the "Big Book") and *Twelve Steps and Twelve Traditions* (known as "the 12 and 12") (Alcoholics Anonymous World Services, 1952, 1976) is also a good idea. By reading this literature, one can learn the steps and slogans of AA, which are useful in relating both to stably sober and to active alcoholics. The AA concepts of "one day at a time" and "the first drink gets you drunk" are particularly useful in helping active alcoholics deal with their addiction. Although participation in AA is not every problem drinker's route to sobriety, it remains the single best way for most alcoholics to achieve and maintain sobriety. Some will reject AA, and others will become true believers. In general, the more emotionally disturbed the drinker, the less likely that AA will work. Nevertheless, an AA referral is always worth a try with active alcoholics.

AA talks about a higher power, and this spiritual side of AA turns some drinkers off. Of course, such a turnoff can be in the service of denial. AA sees alcoholism as a misguided quest for spirituality ("spirits instead of the spiritual") and actively encourages its members to "come to believe." For those who dislike AA's spiritual side, it is sometimes helpful for counselors to translate it into more secular terms. For example, AA's third step, "make a decision to turn our will and our lives over to the care of God *as we understand him*," can be secularized into "let it happen." AA's higher power can be interpreted as the AA group itself. AA stresses relinquishing control and can be seen as a group cognitive behavioral treatment for pathological narcissism with its concomitant need for omnipotent control.

There are other self-help groups that model themselves after AA and adapt its Twelve Steps. *Alanon* works with the alcoholic's significant others, and *Alateen* works with the teenage children of alcoholics. The populations serviced by *Narcotics Anonymous* (NA), *Overeaters Anonymous* (OA), and *Adult Children of Alcoholics* (ACOA) are apparent by their names. Like AA, these groups publish pamphlets listing the time and place of meetings. Meeting books are available for cities and most rural areas across the country.

Double Recovery Anonymous (DRA) is a twelve-step program with a difference. It is for dual-diagnosed patients and although it is a peer organization, its leaders receive training and guidance from mental health

professionals. It is reported to be effective with a population whose prognosis is usually regarded as poor.

There are also non-twelve-step self-help groups. The two most important are *Rational Recovery* (RR) and *Women for Sobriety*.

Rational Recovery

Rational Recovery (RR) is a self-help group founded by a disaffected AA member named Jack Trimpey. RR is based on the principles of *rational-emotive therapy* (RET), a cognitive-behavioral approach to the treatment of psychopathology developed by Albert Ellis (1962, 1988). RET teaches that psychopathology, including addiction to alcohol, is the result of irrational thinking. RET challenges—or as its adherents say, "disputes"—false beliefs and tries to replace them with more "rational" beliefs. Ellis, who started as an analyst, says that he was inspired by the stoic philosopher Epictetus who taught that nothing could hurt the wise man. Ellis and Trimpey believe that alcoholics have a rigid, absolutistic, commanding approach to life and that they are addicted to "*must*urbation" (Ellis is much in favor of masturbation). They must be liked, loved, and do well, none of which are necessary (although they may be desirable) for adult happiness. Becoming frustrated when these goods are not forthcoming, they drink. Pharmacology does the rest. Ellis's style is abrasive and encountering, but there are gentler cognitive therapeutic

approaches (such as Beck, 1976) that share Ellis's basic assumptions about psychopathology and its treatment.

RR does not regard alcoholism as a disease; rather, it sees it as a behavioral disorder resulting from faulty learning and irrational beliefs. It does not see alcoholism as progressive, believes that there is no such thing as loss of control, and that drinking (except perhaps in severe withdrawal) is a choice, and that no higher power is necessary for recovery. In fact, RR regards belief in the higher power and in most of the rest of the AA ideology as itself irrational. It takes particular exception to the AA notion that one is always recovering, rather than recovered, and requires lifelong treatment (in the form of participation in AA) in order to sustain recovery. RR sees its function as short-term education, support, and cognitive restructuring. It self-consciously teaches the exact opposite of AA, particularly in regard to the notion of powerlessness. The first of the Twelve Steps is "We realized that we were powerless over alcohol and that our lives had become unmanageable." RR's one and only step is, "We made a fearless evaluation of our most personal beliefs and chose the recovery program that made the most sense." (This mocks AA's fourth Step, "We made a fearless moral inventory"). RR teaches its members that they do have power over their drinking (not in the sense that they can drink with impunity but in the sense that they don't have to drink) and over their lives. In counterdistinction to the AA surrender and acceptance of dependency needs, RR inculcates self-sufficiency and seeks to

enhance self-efficacy. It teaches its members to dispute "The Beast," the inner voice that would lead them back to irrational, self-destructive behavior usually taking the form of picking up a drink. (Note, how close this is to the AA admonition, "That's your disease talking.")

RR rejects AA's view of itself as a spiritual program, seeing it as clearly a religion. It rejects such religiosity as a prerequisite to recovery. The principles of RR are set forth in *The Small Book* (Trimpey, 1989); its title is of course a self-conscious contrast with that of the AA *Big Book*, as *Alcoholics Anonymous* (Alcoholics Anonymous World Services, 1976) is usually called by Program members.

RR meetings are group therapy sessions that, although they are self-help groups in terms of ideology and ethos, have a leader who is an RET therapist and donates his or her time to lead the group. (Presumably they get referrals in return.) The members discuss their vicissitudes with alcohol during the past week and the ways in which The Beast led them toward irrational thinking or even to a drink. More rational thinking is encouraged and supported. There are RR groups in most major cities and some rural areas.

Women for Sobriety

Jean Kirkpatrick, another disaffected AA member, founded a self-help

group for women, *Women for Sobriety*. Less angry than Trimpey at AA, she sees much that is good in it and acknowledges that it helped her. However, she sees AA as a predominantly male organization whose treatment is right on target for male alcoholics, but somewhat off-center as a treatment for female alcoholism. Seeing the central issue in female alcoholism as low self-esteem, she too questions the AA admission of powerlessness as the only route to stable sobriety. She tells of the experiences that led her to found Women for Sobriety and explains the principles on which it operates in *Turnabout: Help for a New Life* (Kirkpatrick, 1977). Women For Sobriety has not caught on as well as RR has, but meetings can be found in the larger urban areas and some smaller ones. Kirkpatrick saw Women For Sobriety as meeting female needs not met by AA, not as antithetical to it. Many Women For Sobriety members also attend AA. Nevertheless, Kirkpatrick advocates exclusively female professional treatment programs, feeling that women get lost and are undertreated in the standard co-ed rehab.

OUTPATIENT TREATMENT

Outpatient treatment of alcoholism is conducted in clinics, social agencies, hospital and rehabilitation after care programs, and the offices of private practitioners. It is delivered by physicians, nurses, psychologists, social workers, and alcoholism counselors. Sometimes *Employee Assistance Program* (EAP) counselors are involved. EAPs are short-term counseling and

referral departments located in businesses, industries, labor unions, and government agencies. They assist employees with many kinds of problems, but their focus is usually on alcohol and drug abuse. Aside from medical interventions, outpatient treatment takes three main forms: individual counseling, group therapy, and family therapy.

This is not a book on counseling technique and reading and studying it will not make you an alcoholism counselor. Rather, it is a prolegomena— that is, a critical, interpretive introduction—to counseling. Counseling is best learned in a clinically supervised field placement. Notwithstanding this disclaimer, it will be useful to be introduced to some counseling approaches and techniques.

Individual Counseling

The essence of individual counseling is the building of a relationship. It is the emotional bond between client and counselor or patient and therapist that gives impetus to the treatment. It is what makes information conveyed by the counselor credible to and capable of being heard by the client. Individual counseling can be used to convey information about alcohol and alcoholism; to teach clients to recognize and abort drink signals; to help clients build affect tolerance, the ability to stay with painful feelings, and ego strength; and to help clients explore the inner world of feelings, thoughts,

memories, aspirations, and values. There are many different ways to do this. Some counselors work behaviorally, doing assertiveness training, teaching relaxation techniques, and using reinforcement to encourage sobriety. Other counselors work in a more cognitive behavioral way, endeavoring to change clients' belief systems (such as by challenging the belief that drinking is manly or the belief that other people's approval is always necessary). Still other counselors work more in the gestalt tradition, using confrontation to arouse feelings. Existential counselors focus on ultimate or ontological issues (that is, those intrinsic to the human condition) such as mortality, finitude and meaninglessness. Nondirective or client centered therapy reflects back the client's feelings in an atmosphere of unconditional positive regard. Counselors working in the psychodynamic tradition focus on the relationship (its transferential and its realistic aspects) to help a client understand his or her inner world, defenses, manner of relating, and the degree to which his or her past influences present behavior. Transference, as discussed earlier, is the reenactment of early relationships in a present one, for instance, experiencing the counselor as rejecting regardless of the counselor's actual behavior, because one or both parents were rejecting. Counselors interpret the transference to demonstrate how the client distorts his or her interpersonal perceptions.[9]

Alcoholism counseling has evolved out of all of the major counseling traditions into, it is hoped, an integrated and not merely random, eclectic

specialty that draws on the scientific research of recent years in formulating a treatment approach uniquely suited to its client population. Different alcoholics have different needs and the same alcoholic will have different needs at different times. The newly sober person who is barely clinging to sobriety does not need to learn about his unconscious wish to murder his father, at least not yet. The stably sober client who cannot figure out why he keeps provoking each new boss until he is fired—an occurrence that always makes him think of drinking, thereby endangering his hard-won sobriety—may very much need to know that he is simultaneously trying to murder his father and punish himself for that forbidden wish. Treatment deals first with maintaining sobriety and only later, if at all, with unconscious motivations.

Group Therapy

Group therapy is a popular modality in alcoholism treatment. Active alcoholics are usually treated in inpatient groups. Outpatient groups can be effective, however, with active alcoholics if their alcoholism is relatively mild and they are capable of and willing to abstain on the days the group meets. Such a group can be used to teach members about alcohol and its effects. The group can also be used to teach the disease concept of alcoholism. However important the conveyance of such information is, especially because it reduces guilt, it is not enough. The group must also be used to confront denial and to help members recognize, correctly label, appropriately express, and

deal with feelings. The goal with all members of a Stage 1 group (a group for active or very recently active alcoholics) is sobriety.

There are several reasons why group therapy is a very popular form of treatment. The use of a group is believed to dilute and make manageable the intensity of the alcoholic transference so that all too powerful feelings of love and hate do not get acted out by drinking or quitting treatment. Also guilt can be shared. The curative power of this sharing cannot be overemphasized, since alcoholics punish themselves for sins real or imagined, including their alcoholism, by drinking more. Another reason that groups are thought to be effective is that "it takes one to know one," which makes stage 1 groups extremely powerful devices to confront denial and unmask bullshit. At the same time, the sharing of a common problem makes relinquishing denial less painful. The sharing of painful experiences and humiliations acts as a balm for the narcissistic wounds that are an ineluctable concomitant of an alcoholic career.

Stage 2 groups focus on alcohol and the problems of early sobriety. They alter their members' responses to drink signals, provide support and mutual identification, and serve as a safe place to express feelings. They are settings in which maladaptive defenses quickly manifest themselves. In a Stage 2 group these defenses can be confronted and interpreted or they can be supported in such a way that they protect the alcoholic without being overly

destructive until the alcoholic is strong enough to relinquish them.

The Stage 3 group is a group of stably sober alcoholics usually with "time" (that is, sobriety of considerable duration). Such groups are homogeneous; all of their members are alcoholic. However, they do not focus on alcoholism per se. Rather, they seek to uncover and modify maladaptive defenses. They work far more psychodynamically than do Stage 1 and Stage 2 groups, using the group process in much the same way that transference is used in psychodynamic individual treatment. As an alternative to a Stage 3 alcoholism group, the stably sober alcoholic can join a heterogeneous, psychodynamically oriented outpatient group. If such a choice is made, something of the potential for identification found in the homogeneous alcoholism group is lost, but the possibility of identification with a broader range of human experience is gained.

Special population groups are also commonly used in alcoholism treatment. Examples would be a group for women alcoholics, a group for alcoholic cops, and a group for teenage substance abusers. Sometimes special interest groups are effective when more mixed groups are not. Homogeneity versus heterogeneity in group membership is an important treatment decision. Many clients benefit from participation in both types of groups.

Family Therapy

Family therapy is another popular form of alcoholism treatment. In fact, alcoholism is said to be a family disease, in that one family member's alcoholism powerfully affects the other family members. The children of alcoholics are often tragically affected and afflicted by their parents' alcoholism. Despite the drinker's pernicious effect on them, other family members often come to have an investment in the alcoholic's drinking, although they usually do not know it. Family systems theory looks at the way in which a family maintains its homeostasis, its equilibrium, be that equilibrium benign or malignant. Systems theory postulates that inertia causes any family system to resist change. Since an alcoholic's becoming sober is a profound change, it follows that the change will be resisted by family members. Family systems therapists look at who has the power, who has what effect on whom, who has what role, and how the role incarnations affect other family members and their roles. This thinking has been applied to the alcoholic family to describe a set of typical roles, one of which is the *parentified child*, or *hero*, defined as the child who takes care of the alcoholic parent. Other identified roles of children in alcoholic homes are the *scapegoat*, the *lost child*, and the *mascot*.

Family therapists see the family members together, and their interactions and interdependencies are worked with in various ways, depending on the therapist's theoretical orientation. An alcoholic family member's becoming sober will affect the entire system, and a readjustment of

roles and relationships—which may be far from welcome although this is almost always denied—will take place. Family therapy sessions help the family understand the ways in which the alcoholic family member's drinking affected it and the impact that sobriety has on the family. Family therapy often makes the family members aware of their *codependency* and of their denial of both that codependency and the alcoholic's alcoholism. (In its original meaning, a codependent was somebody who remained in a relationship with an active alcoholic because doing so met unconscious needs of their own. Codependents were said to *enable* the alcoholic to continue drinking. Unfortunately, the term has become so overgeneralized as to lose meaning. Today, if you say hello to your spouse, you may be labeled codependent.) In the case of the adolescent substance abuser, family therapy is considered highly desirable and often necessary for successful treatment.

Network Therapy

Marc Galanter (1993) of New York University Medical School has developed an intriguing treatment modality called *network therapy*. Since it is a recent development, there is no outcome study as yet (although there is a grant proposal for such a study); nevertheless, Galanter reports encouraging results. An outgrowth in some ways of family therapy, there are important differences. In family therapy, the family system and all of its members (who theoretically, although not necessarily in practice, are not focused on as

individuals apart from the system) are the targets of intervention. Not so in network therapy, where the entire system (family or otherwise) is involved in the treatment, but the alcoholic or substance abuser is the only patient. In family therapy, the identified patient is seen as the repository of all of the pathology in the system, and family therapy seeks to elucidate and make manifest the multifaceted ways in which the system and its members project their dysfunctionality onto the patient. In network therapy, the dysfunction—pathology in the system—is ignored and the "network" is exclusively used to assist the identified patient, the user or drinker, in achieving and maintaining sobriety.

This modality is most effectively used with patients who are motivated, however ambivalently, to stop drinking, but who have difficulties resisting cravings. They might be said to be the motivated impulse ridden. In that way, they resemble the population who benefits the most from disulfiram therapy; in fact, network therapy might be seen as interpersonal Antabuse. There is, however, an important difference. Antabuse patients have often destroyed their social networks or been affiliated with highly pathological ones, while the network candidate must either have an intact network or be able to create one that is sufficiently healthly and able to support and not undermine the patient from a stance of nonjudgmental positive regard. That is not easy to come by, so network therapy candidates, in spite of their ego and self deficits, may be assumed to have at least a modicum of ego strength.

In network therapy, the counselor is quite directive. Network is an abstinence therapy; no attempt is made to construct or evoke a network until the client has made a commitment to sobriety. At that point, the counselor explores whether the client can achieve sobriety on his or her own, even with program support (if the client is willing to affiliate with AA). If the answer is no, the counselor suggests eliciting the help of family, friends, teachers, bosses, and clergy to create a support network. Explicit danger points or situations are probed for and the counselor suggests ways in which the network can be used to get by these rough spots. For example, Bill always got drunk Friday night and gets very strong drink signals on Friday afternoons. He arranges with Uncle Henry to meet Fridays after work to play basketball which he enjoys. Sally always drank when she felt sad. She arranges with her friend Joan to call her whenever she feels sad and with Aunt Sadie to go shopping which cheers her up, when she's down.

The counselor meets regularly with the network, although less frequently than with the client. There are no secrets or privileged communications and everything pertaining to the client's sobriety is discussed. Galanter recommends that network therapy be used as one component of a multimodal comprehensive treatment program.

Neurobiofeedback

There have been reports (Peniston & Kulkosky, 1989; Peniston & Kulkosky, 1990) of high rates of recovery (prolonged abstinence and improved scores on psychometric tests) in chronic alcoholic patients with long histories of relapse using neurobiofeedback training. Peniston and Kulkosky first worked with Veterans' Administration Hospital patients who were long-standing alcoholics for whom no previous therapy had provided any sustained benefit. They were trained in *temperature* or *thermal* biofeedback, that is, to relax using skin temperature as an external cue. Once they had mastered the use of thermal biofeedback to increase relaxation, they were given *brain wave training* (BWT) in which *electroencephalograph* (EEG) measures were used to provide feedback so that an alpha and later a theta rhythm could be achieved. The EEG feedback was also used to teach the patients to increase the amplitude of their alpha waves. Alpha states are "serenity" states and the greater the amplitude and synchronicity of the alpha waves, the greater the serenity. Alpha is experienced subjectively as peace, calm, and deep relaxation. It is a pleasurable state. Theta rhythms are characteristic of deep meditation states.

Alpha BWT was suggested by the studies (Schuckit & Gold, 1988) reviewed in chapter 6 that show children of alcoholics to have low amplitude, poorly synchronized alpha waves that are improved by drinking, and by the studies (Porjesz & Begleiter, 1983) that show that Cloninger Type 1 alcoholics suffer deficiencies in alpha activity. It is also known that clinical alcoholics

manifest impaired alpha rhythms far into sobriety. The degree to which these findings are consequent or antecedent to the alcoholism is debated. The widespread use of relaxation training and meditation groups in alcoholic rehabilitation may also have suggested that BWT aimed at optimizing alpha and theta states would be an effective treatment modality for alcoholism.

The original protocol called for fifteen 30-minute sessions of alpha-theta BWT and no other treatment. The patients were first given *autogenic training* (Jacobson, 1938) a method of attaining a state of deep relaxation utilizing alternating tension and relaxation of body parts. ("Now tense the fingers on your left hand. Make them as tense as possible. Now let go and feel the tension leave your hand. Your hand is becoming more and more relaxed," and so forth until the entire body is brought to a state of deep relaxation.) The alcoholics were then given the pretraining in thermal biofeedback discussed above. Using their autogenic training to achieve deep relaxation, these patients become able to raise their external body temperature (measured by a finger device) to 95 degrees, the raised temperatures were used as feedback cues of relaxation. After their pretraining, the chronic alcoholics received alpha-theta brain wave training. EEG electrodes were attached to their scalps and the electrical activity picked up was used to provide aural and visual feedback. A hum signaled alpha activity. While in the alpha state the subjects were instructed to imagine themselves refusing drinks or getting through a situation of "temptation" without drinking.

In the Peniston and Kulkosky (1989) study, eight of ten chronic alcoholics were stably sober 13 months later as well as maintaining improved scores on psychometric instruments of various sorts. Interestingly, the subjects' serum beta-endorphin levels were not elevated by the alpha-theta BWT, while the beta-endorphin levels of patients receiving traditional alcoholism treatment became elevated, a condition correlated with high levels of stress. Peniston and Kulkosky concluded that traditional alcoholism treatment (such as group therapy) may increase stress to the point where chronic alcoholics drink (their patients had multiple admissions for alcoholism), while alpha-theta BWT lowers stress and facilitates the maintenance of sobriety.

This treatment model, often modified by the addition of sessions of cognitive behavior therapy and guided imagery, has been promoted by the Menninger Clinic and by biofeedback institutes. Two unexplained phenomena have been reported associated with neurobiofeedback treatment of alcoholism. Some patients spontaneously recover repressed traumatic memories, often with intense emotional upset. Others become ill if they drink; for them, BWT serves as a permanent Antabuse.

Although further study of outcomes is clearly needed, the equipment used is expensive, and the unexpected effects are disconcerting, neurobiofeedback appears to be a useful addition to our armamentarium of

techniques to treat alcoholism.

Acupuncture

Acupuncture (Smith, 1989) has been used to reduce craving for alcohol and drugs. This technique, pioneered by Lincoln Hospital in the Bronx, is structured as an on-demand walk-in protocol so that "non-traditional" patients, many of whom are homeless or stylistically street people, can avail themselves of treatment which they could not do if acupuncture were to be offered on a by-appointment set-time basis. Lincoln reports that many of these patients, who are schizoid, paranoid, or realistically leery of the "establishment," are able to develop rapport and connection in this minimally threatening environment and go on to more structured counseling experiences.

Drawing on traditional Chinese medicine, which believes that there are special relations between strategic points on the skin and various bodily functions, addiction acupuncture has established four points on the ear (see Figure 12.1) that reduce craving. The same points are used to reduce withdrawal symptoms and are sometimes the only treatment used. Although acupuncture has more often been used with drug users, it appears to hold promise in the treatment of alcoholism. Its use is spreading and it has been introduced as an adjunctive treatment in some alcohol rehabs treating

middle-class patients.

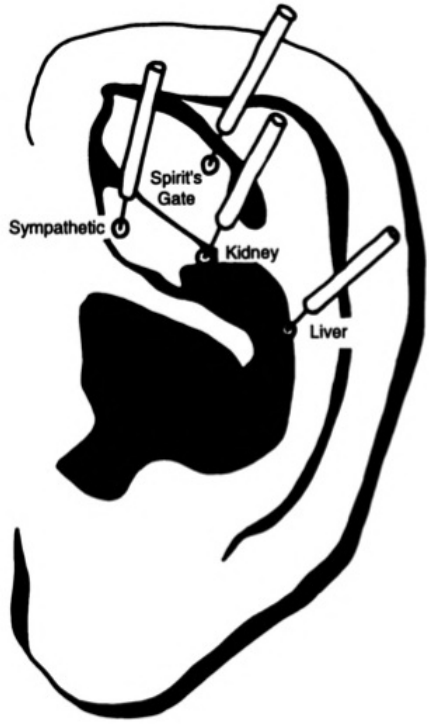

Figure 12.1 Acupuncture Points Reported to Reduce Craving for Alcohol and Drugs (Courtesy of Lincoln Hospital, Bronx, New York). *Spirit's Gate* and *Sympathetic* needles are inserted as shown to relax the body and adjust its chemical balance. *Kidney* and *Liver* needles are inserted as shown to strengthen the function of the two organs, key body systems in the processing of drugs and alcohol.

Treatment of Shame-Based Behavior

John Bradshaw is former priest who is a recovering alcoholic who has

had a tremendous impact on the community of recovering persons. He writes for the general public, and his popular books, and seminars have had wide influence. Although a "pop" psychologist, he has something important to say. His basic position is that addiction (including alcoholism) is the result of the repression of childhood shame experiences (Bradshaw, 1988). He calls this *toxic shame*. Bradshaw is not referring here to the shame that comes from or with addiction; rather, he is talking about the kind of shame that comes from having been abused as a child or from growing up in an alcoholic home particularly if the shame is anesthetized, denied, repressed, or acted out. One suspects that Bradshaw is primarily speaking to and about those alcoholics whose parents were alcoholic. Like all single factor theories, his is overly simplistic and his writings tend to be repetitious. They do however have the virtue of highlighting the centrality of shame in the dynamics of alcoholism. His treatment recommendations are a synthesis of the psychodynamic (such as recovery of repressed memories and dream work) and the cognitive behavioral (for instance, cognitive restructuring and self-efficacy training). He stresses work with the "inner child."

Bradshaw's formats of workshops and video presentations make for high states of emotional arousal and sometimes for intense feelings of connectedness. Like the marathon therapy groups of the 1960s and 1970s, people leave feeling good; however, the degree to which they change and maintain that change is unknown. Of course, a great meal or an orgasm does

not last forever either, yet may be an intrinsically positive experience. Perhaps that is also the case with participation in Bradshaw or Bradshaw-style workshops.

Relapse Prevention

Relapse prevention has always been a part of alcoholism counseling. After care groups have long focused on making conscious or increasing awareness of drink signals, as well as on teaching alternative coping skills to replace drinking as a way of dealing with dysphoria of various sorts. And AA has long taught that "people, places, and things" can get you drunk, with its implied admonition to change or avoid those people, places, and things. Like the character in the Moliere's play *Le Bourgeois gentilhomme*, we are learning that we have "spoken prose all our lives." However, in recent years *relapse prevention* has been formalized by G. Alan Marlatt and Judith R. Gordon (1985). Using a social learning model of addiction and relapse, they have highlighted five causes of relapse: feeling controlled by or unable to resist the influence of others; low self-efficacy (feelings of powerlessness, fatalism, and learned helplessness); availability of alcohol, particularly in social situations that encourage its use; lack of adequate alternate coping responses; and high expectancy that drinking enhances coping. They found that negative emotional states (frustration, anger, anxiety, and fear) caused 38% of relapses, craving and triggers 16%, and social context or conflict 20%, while

drinking to achieve positive affect (euphoria) accounted for only 3% of slips. In my experience most slips are rage reactions, the rage often being unconscious. The "fuck you martini" gets an awful lot of people drunk (again).

Marlatt and Gordon have devised protocols for dealing with each of these vulnerabilities to relapse using modeling (such as seeing a model refuse a drink), teaching new coping skills (for instance, assertiveness training), changing expectancies through *cognitive restructuring* (if we approve of changing someone's thoughts and values we call it cognitive restructuring; if we do not, we call it brainwashing); and suggesting environmental changes. In short, the entire range of cognitive behavior therapy technique is brought to bear on the prevention of relapse. The abstinence violation effect (AVE), "if I drink, I won't be able to stop and I will have to hate myself for doing so" (see discussion of AVE under criticisms of the disease model in chapter 5), is circumvented by teaching that drinking is a choice, that the taking of a drink does not compel you to take another, and that there are reasons for relapse, so that rather than taking the abstinence violation as a reason for self-hatred, its causes can be analyzed so that the slip becomes a learning experience. Thus, for example, if the slip resulted from social influence, the client could learn to say no or to change his or her associates. Although this conceptualization of slips as both freely chosen and as determined seems self-contradictory, it clearly has clinical utility (as Emerson said, "consistency is the hobgoblin of little minds"). So does the Marlett and Gordon approach as a

whole. Relapse prevention techniques are applicable to both abstinence and controlled drinking treatment models.

CONCLUSION

The techniques and modalities available to counselors are Stage 1 group therapy, Stage 2 group therapy, family therapy, network therapy, informational and educational interventions, behavioral counseling, cognitive restructuring, relapse prevention, gestalt therapy and psychodrama (with their emotional arousal and discharge of affect as well as opportunity to establish empathy with others), and psychodynamically oriented counseling. All of these have a place in the treatment of alcoholism. The trick is to know when to do what. The alcoholism counselor needs to ask: What does this alcoholic most need to know, learn, or experience now, and how can I facilitate that knowing, learning, or experiencing? The name of the game is to replace rum with relationship and then to use this relationship between client and counselor to assist the alcoholic in growing in such a way that alcohol (or other drugs) is no longer necessary to deal with feelings, maintain self-esteem, or reduce anxiety.

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Notes

[9] The reader interested in a more detailed discussion of the counseling process and counseling techniques is referred to Treatment of Alcoholism and Other Addictions: A Self-Psychology Approach (Levin, 1987). Since the literature on each of the counseling traditions is so voluminous and many excellent counseling texts are available, I have otherwise omitted references or recommendations from this section.