CHAPTER ONE - ALCOHOLISM.

The excessive use of alcohol (C_2H_5OH) leading to grave individual and community problems has been widely acknowledged. Precise definitions of the terms "alcoholic" and "alcoholism", cause considerable difficulty brought about partly by varying diagnostic and aetiological approaches and partly by communicative difficulty at a semantic level.

Alcoholism has been defined in simple terms as a "progressive disease manifested by consistantly undesirable results following the ingestion of alcohol" (A.A. Lit. 1976). This simple definitive approach finds contrast in highly complex discussion papers drawing comment from Robinson (1973) in some air of frustration, "any definition which purported to incorporate the physiological, biochemical, psychological, legal, socialogical, moral, religious nature of the phenomenon, the processes of its development, and likely prognosis, together with its effects upon the individual and society could be nothing other than either totally incomprehensible or of such generality as to bear no meaningful relationship to the empirical world".

The inadequacy of the simple definitive approach is apparent as the disease concept is not readily supported by all authorities (an issue to be taken up later in this thesis) and as there are persons, who suffer consistently undesirable results following the ingestion of alcohol who could not by any other criteria be categorised as alcoholic.

The Hunter Region Community Addiction Service (1975) incorporating the "disease" concept, qualify such as being "characterised by the deviant use of alcohol and resulting in disturbance of thought, feeling and behaviour". This definition could also be fraught with false affirmations if used literally in a diagnostic setting; a use the authors undoubtedly would resist without further qualification and thus begin approaching the problems cited by Robinson (1973).

Keller (1972) in a paper designed to clarify the concept of alcoholism as a disease by identifying the main criteria, insists that it is loss of control in refraining from the first drink not after starting to drink as Jellinek (1952) would have. Jellinek claims that "as soon as a small quantity of alcohol enters the organism a demand for more alcohol is set up which is felt as a physical demand.... the loss of control is effective after the individual has started drinking". Keller (1972) argues that it would be difficult to see how there would be any alcoholics if they could control whether they would drink on any occasion.

Keller (1972) accepts the disease concept incorporating an addiction to alcohol and while recognising that not every first drink by an alcoholic leads to an uncontrolled drinking bout suggests that "at some time under the impulsion of a cue or stimulus which may well be outside his conscious awareness, he will drink". For Keller, alcoholism is an addiction to the drug ethanol; the prime symptom being loss of control, both in choosing to drink and choosing to continue.

Attempts to overcome the inclusion of many and varied

factors in a definition has found authors resorting to classification systems or sliding scales based on presenting symptomatic behaviours. In terms of classification systems, that contained in the classical work "The Disease Concept of Alcoholism" (Jellinek, 1960), is the most widely referred to. The author proposed that alcoholism can be seen as comprising five basic syndromes, ranging from those with purely psychological reliance on alcohol to relieve bodily or emotional pain to bout drinkers or dipsomaniacs. With regard to the sliding scale or stage approach, the tendency is to view the drinking pattern as a continuous process with application to all persons given the right conditions ranging from relief drinking to chronic alcoholism approximating Jellinek's description of dipsomania, with many minor syndromes in between.

Because it contains most of the agreed upon definitive criteria, though by no means all of them, the definition of the World Health Organisation (1951) appears attractive. "Alcoholics are those excessive drinkers whose dependance on alcohol has attained such a degree that they show a noticeable mental disturbance or an interference with their mental and bodily health, their interpersonal relations and their smooth social and economic functioning or who show the prodromal signs of such development". While almost every concept in the above definition is open to qualification and question, particularly that in the last clause (an issue to be taken up later in this thesis;) the basic implied meanings, apparent to the lay reader, present the statement as an acceptable working definition of the alcoholic. To go further in terms

of detailed qualification, the enquirer would have to get involved in the areas of aetiology and diagnostic criteria. Before considering these further matters, it would seem appropriate to review what appears to be in the literature an unclear area surrounding the "disease" concept of alcoholism to the point of open controversy. Clarification of this issue will have far-reaching implications for selecting the patient, treatment approach, staff selection and treatment goals; outcome evaluation techniques would be expected to vary correspondingly.

The idea of alcoholism as a disease is not a recent innovation but a concept appearing in the literature since reportedly being first used by Dr. Benjamin Rush in 1875. Support for the concept ranges from those who would see alcoholism as an affliction in the same sense as heart disease or cancer, to those who view the disease as part of the family of addictions or compulsive neuroses.

Variations on the theme also range from those who adopt the illness or disease model as a convenient and useful treatment analogy, to those who reject this model entirely and assess the concept as not only hindering treatment but aiding the progressive decline of the excessive drinker.

O'Briant et. al. (1973) endorse the disease model by implication and inference, and compare alcoholism by comparative morbidity statistics to heart disease and cancer. They go on to suggest that the condition is similar to leprosy and venereal disease, complaining that medical officers fail to record alcoholism on death certificates, as a primary or even secondary cause of death. Davis (1976) uses a similar

approach, drawing comparisons between morbidity statistics of cardiovascular diseases and alcoholism. From such analogies one could be led to believe that alcoholism was either the result of some form of organic or genetic deficiency, or infectious malady. The analogy fails for want of empirical evidence.

Such analogies and statistical comparisons seem only to confuse what little understanding of the problem exists. It is difficult to see why O'Briant et. al. (1973), introduce the analogy, as a later statement by the same authors clearly support the alternative learning model based on social and psychological factors which, when controlled and manipulated, provide a more positive prognosis. They write, "The problem of alcohol misuse does not reside merely within the individual alone. It exists somewhere in the complex relationships between persons and their social contexts.... we suggest that social dimensions are more than influences and are in fact the most important constituents of the alcohol abuse problem".

Alcoholics Anonymous define a disease as "any deviation from a state of health and more specifically, a definite marked process having a characteristic train of symptoms. It may affect the whole body or any of its parts and its aetiology, pathology and prognosis may or may not be known". They firmly support the disease model, viewing the condition as approximating the above definition by its symptomatic behaviourial presentations. Hershon (1974) soundly rejects this notion claiming that alcoholism "was not demonstrated to be directly due to any physical process recognisable as a

disease and that as a behaviour it was subject to personal control. The conclusion must therefore be that the drinking behaviour of alcoholics does not conform to the proper notions of a disease and it should not be so designated".

The area of personal control appears central to the disease model, controversy with Keller (1972) on the one hand claiming that it is the loss of control that presents the condition as a disease, and researchers such as Cohen et. al. (1973) claiming that, under experimental conditions, controlled drinking by alcoholics over extended periods of free access was possible.

Drewery (1974) suggests that the medical approach may be an approach with grave limitations, with alcoholism viewed as a disease that cannot be cured and only in a minority of cases controlled; and that acceptance by the patient that he is an alcoholic is a prerequisite of his treatment. Further, in almost all cases the goal of treatment is abstinence.

The illness approach is said to be adopted with a view to making it more likely that patients will present for treatment as early as possible in their sickness by reducing guilt and defensiveness. It is also just as likely to operate in the reverse manner in that patients may resist admitting to an incurable disease until the last minute, by which time most of the obvious social motivators have been lost. Such resistance may be compounded by the potential patient's knowledge that the treatment offered is to deprive him of the very substance he craves. Even when he does present for treatment, he appears to be faced with an insidious double bind which Drewery describes: "If the patient is sick he is

not responsible for his drinking but unless he can be persuaded to take responsibility for his behaviour he will never be able to abstain". Robinson (1973) warns that to exhort the alcoholic to control his behaviour may quite reasonably bring the response that he cannot do so, for he is sick.

It can be argued that dependence is as real and important a phenomenon as the hysterical symptom. Dependence on or addiction to alcohol, as a relapsing disorder, fits more neatly into at least a psychological health disorder incorporating a demonstrable susceptibility to personal control under certain appropriate conditions as Glatt (1973) indicates. Such conditions would appear to be highly individualistic and upon investigation to be correlated with the patient's aetiology.

The classification or stage approaches depend on often vague and subjective judgements as to the individual placement in a classification, or at one or another level of the suggested progressive decline into alcoholism indicated by the stage model. It is unclear as to when one passes from social drinking to problem drinking to the clear classification of alcoholism.

Attempts to formalize such judgements force diagnostician to deal with behaviourial symptoms which have sociological correlates. This endeavour in itself produces academic riddles of apparently as much productive worth as "chicken and egg" disputes, for aetiologists find themselves identifying the same factors as symptomatologists.

Edwards (1975) discusses three of the main aetiological explanations of alcoholism: analytic, learning theory model and physiological. Under the analytic model alcoholism is variously interpreted as a manifestation of oral dependence, latent homosexuality, and a subconscious drive toward self-destruction.

Antagonists of the psychodynamic viewpoint argue that alcoholism can no longer be seen purely in terms of intrapsychic dynamics with work by Steinglass (1976) suggesting that family emotional homeostasis seems to perpetuate the drinking and it is this behaviour which must be changed if the drinking is to be controlled.

The learning theory model nominates alcohol and its pleasant effects as its own immediate reward in addition to reducing states of anxiety, tension and guilt. The model fails in its own simplicity to explain why some, in fact most, who drink and are anxious, tense and guilty, do not progressively decline into alcoholics.

The physiological theory of alcohol dependence, while drawing on the ample evidence of a withdrawal syndrome following large ingestion of alcohol as its main support, has failed as yet to provide convincing empirical evidence that an irreversible metabolic condition occurs which will inevitably lead to the pathological excesses of the alcoholic.

The indisputable fact is that despite twenty five years or more of research into alcoholism little is known as to why some persons become alcoholics and other do not (Criteria Committee, National Council on Alcoholism, 1972).

The most promising research approach of recent times is that which endeavours to identify "at risk" populations by use of the more objective personality inventories such as the M. M. P. I. (Hathaway and McKinley, 1967). Such approaches persistently yield typical indications of feelings of guilt, remorse, inadequacy, depression, hostility, self-pity, etc. in the alcoholic, with equally typical defensive patterns of excessive denial, projection, rationalization and overcompensation. However, the profile is not acceptable to all alcohologists and Glatt (1969) describes such a picture as "deceptive", preferring to label the alcoholic as simply emotionally immature.

Vague though the specifications of the learning model are, the development of alcoholism as an addiction or dependence would appear to be the product of a complex interaction of personality, social and cultural factors. However, as Kalb (1975) points out in citing work by Chafetz et. al. (1970), Clark (1966) and Cahalan (1973), "the presumed relationship between the numerous prognostic indicators have no sound empirical basis". Cahalan (1973) questions seriously that heavy drinking necessarily grows worse in the progressive deterioration curve suggested by Jellinek (1960).

Without a clear aetiological pattern, despite a possible acceptable definition and recognition of the problem of alcoholism, medical intervention should be secondary rather than primary, i.e. it should deal with symptom bearers and vacate the area of prevention until the cause or causes of the problem are determined. This appears to be the only rational

role of medicine apart from continued aetiological research. To suggest ways and means of avoiding alcoholism implies knowledge which has not yet been attained.

Despite the problems of definition and aetiology the empirical fact remains: Alcoholism, as a major identifiable problem, exists in ever-increasing and alarming proportions in almost every modern westernized civilization.

Extent of Alcoholism as a Problem.

Most authors writing on alcoholism incorporate at least one or two paragraphs covering the estimated extent of the problem in their own and other communities. For the main the estimates lack two basic types of information:-

1. a clear definitive statement of those included in the described population and
2. supportive empirical evidence.

Leaving aside descriptive figures for countries outside Australia, though the above criticism can be levelled at many of the international studies, the available descriptive statements inferring the extent of alcoholism and related diseases and problems can be grouped under three categories:-

1. Unsubstantiated;
2. Disputed among authors and
3. Documented estimates.

The first is worth comment only by way of illustration and covers statements made in, presumably attempts to arouse emotive concern, e.g. "One person in fifteen who drinks is an alcoholic" (A.A. Lit. 1976); "Each alcoholic directly affects the lives and mental health of five other people". (C.A.S. Lit. 1975).

The former statement is also indicative of areas where apparent dispute or confusion arises. Category 2:- A.A.'s figure of one in fifteen in relation to the Australian population is in contrast with other estimates: ranging from two in one hundred (Davis 1976), five in one hundred (Everingham 1975), seven in one hundred (C.A.S. Lit. 1975). This second category information extends into the areas of absolute numbers of increasing annual consumption rates per head of population and annual costs to the community. For example, the total number of alcoholics in Australia ranges from 258,000 (Davis 1976) to 980,000 (C.A.S. Lit. 1976). Costs to the community are seen by A.A. as being in the vicinity of one hundred million dollars per year; the Australian Minister for Health views the annual bill at ten times that figure (Everingham 1975). There appears to be no hard convincing evidence in support of either of these estimates. Consumption rates are stated by Davis (1976) to be escalating at the rate of five per cent, compared with the C.A.S. (1975) estimate of ten per cent who also indicate that the rate doubled in the last twenty years. The Health Minister declares only a thirty per cent increase in the same period.

In order not to add further confusion to the scene, though recognizing an increasing consumption rate coupled with an increasing awareness of the problem of alcoholism and its associated distresses and costs, it is preferable to adhere to descriptive empirical data and to relate such data to the specific population under study.

With this reservation made, the figures by any estimate are still alarming, with 5,026 persons admitted to N.S.W. Psychiatric Hospitals in the twelve month period 1973/4 diagnosed as alcoholic. A further 706 persons were diagnosed as alcoholic psychosis, giving a total 24.35% of all psychiatric admissions. The figures are proportionately higher for the Newcastle Psychiatric Admission Centre where the 932 persons admitted in the same period diagnosed alcoholic, represented 41.15% of all admissions (N.S.W. Health Commission Stats., 1973/4).

Australian annual consumption of beer per head is 130 litres, with wine and spirits consumption at 10 and 2 litres respectively. Converting all consumption on an ethanol content basis to beer, and relating this to the adult population (over 17 years) raises the annual consumption rate to 454 litres per head of population (Davis 1976). The situation would appear not to be as straightforward as this: work done by Norman (1974) found that 24% of 12 - 14 year olds and 50% of 15 - 18 year olds, sometimes or often got drunk in Australia.

For beer, the alcoholic beverage of choice within the Australian population, production has almost doubled between 1962 (242 million gallons) and 1974 (418 million gallons). In the same period the population rose from 10.5 million to 13 million, according to the Australian Year Book (1974).

Given that daily consumption of ethanol in excess of eighty grams is regarded as a level at which there is a significantly high risk of physical, mental and social complication (Hetzel 1975) and that daily consumption levels in

excess of 120 grams almost certainly shorten life and causes tissue damage (Schmidt and Popha 1975), increases in consumption continuing at the rates reported above would predict illnesses of frightening proportions by 1996. Studies of drinking habits among the young as cited previously suggest that the population is well on the way to unenviable goals.

CHAPTER TWO - DIAGNOSTIC AND RESEARCH CRITERIA.

Chapter One, recognizing alcoholism as a social problem of increasingly alarming proportions, briefly identified the major difficulties of definition and aetiology. This chapter discusses some treatment approaches and evaluation prior to examining a new approach: ALCONFRONTATION.

Before proceeding with such a discussion, identification and formalization of diagnostic procedure is necessary. Given the variation of opinion discussed in chapter one, diagnostic criteria also vary, though common themes pervade the differing approaches with more consistency.

Alcoholics Anonymous describe a prodromal phase in their literature in behaviouristic terms as the pursuit of pleasant experiences more and more frequently. Three phases of progressive decline accompanied by observable behavioural deviance follow.

Phase one is typified by periods of amnesia; drinking with the express purpose to allay fears and restore confidence; gulping toward intoxication rather than drinking; elements of evasiveness (sneaking drinks, arriving at parties partly intoxicated, etc.); personal awareness of abnormal drinking patterns with feelings of guilt, insecurity and defensiveness. A.A. claim that positive prognosis is as high as eighty per cent if the individual presents for treatment at this "early" stage.

Phase two assigned as "crucial", presents mainly similar categories to phase one, though of a more extreme nature, with the additional symptoms of loss of sexual potency, tremulousness, nausea and malnourishment. At this stage the patient

is beginning to experience alcohol-related strife, such as job loss, legal and social complications, etc.

Phase three is presented as the chronic stage, with less than twenty five per cent possibility of a positive prognosis. The patient is said to seek the company of social inferiors; will drink anything; has impairment of thinking; goes on prolonged benders and begins to show signs of secondary alcohol-related illnesses.

Edwards (1967), qualifying his diagnostic approach, suggests that the "syndrome is not an all or none phenomenon". He then outlines symptoms, though differing in terminology, which equate broadly with the A.A. phases (subjective experience that drinking cannot be controlled; amnesia; withdrawal symptoms; craving; beverage choice; and alcohol-related strife of social, physical, legal and economic consequence).

The Criteria Committee of the National Council on Alcoholism (1972) present a uniform and systematic attempt to regulate diagnostic criteria. This approach is used later to ensure clear diagnosis for inclusion in the sample under study. The Committee comments that its efforts were to "ascertain the nature of the disease....from a cluster of symptoms.... to provide early detection and provide uniform nomenclature.....to prevent over-diagnosis and to....identify individuals at multiple levels of dependency". Outcome of the Comittee's deliberations from data assembled established two separate "tracks". Track one deals with the physiological and clinical areas, while track two, because of their behavioural manifestations, covers the areas of psychological and attitudinal criteria. These symptomatic presentations were further classified into early, middle and late

manifestations on the basis of loose agreement that the dependence was a progressive condition. Diagnostic weights were assigned each of the presenting symptoms. A level 1 weighting indicated a clear diagnosis of alcoholism. Level 2 indicated high probability and strong suspicion. Level 3 weighting was suspicious and perhaps indicated potentiality, though other supportive evidence seemed necessary. It was considered sufficient for the diagnosis of alcoholism, that one or more of the level one weightings be determined and several of the minor weightings, in both tracks one and two, to be identified.

The Committee emphasised the need for simultaneous diagnoses to be made of psychiatric and physical disorders. Detail of the diagnostic tracks and their relevant stages is to be found in Appendix (E) of this study.

With regard to treatment, there would appear to be considerable variation among therapists in programme content and approach. Some treatment approaches recruit only those with minimum symptom presentation, who have maintained job and family stability, measuring outcome on the basis of improved social stability and moderation in drinking habits. Other treatment settings accept only those admitting complete helplessness with regard to alcohol consumption, measuring treatment outcome on the basis of abstinence, maintaining that adequate social functioning is an inevitable implication of sobriety. Between these two approaches, there are numerous others incorporating varying shades of interaction and utilising a wide variety of therapeutic techniques.

Edwards (1975) makes the point that major reviews of the literature "have largely served to show that claims for the efficacy of specific treatments and treatment regimes have largely outrun the evidence".

The issue of motivating symptom bearers to limited treatment facilities is highlighted by Mann (1973) who maintains that if all the helping professions diverted their efforts to treating alcoholics, there would still be a deficiency in the number of available personnel. However, the question of motivating alcoholics toward treatment goes largely unanswered. To rely on the forceful experience of hitting rock bottom with the admission that life is unmanageable; that is, a reliance on total human suffering to produce motivation, may be counterproductive. To admit to an "incurable disease" and submit to a treatment expressly designed to deprive one of the very drug one craves, delays treatment intervention as Drewery (1974) mentions "to a point where he has lost most of the things which otherwise might have motivated him to moderate drinking". Alternatively, to promote a programme designed for other than the chronic alcoholic and quote high recovery rates, draws the criticism of whether the treated population was correctly diagnosed. To work with skid row populations on present international standards limits realistic goals to those described by Ritson and Hassall (1964) as "to function fairly well in a sheltered environment".

Source of patient (voluntary or otherwise) and diagnostic category of patient, are necessary components of uniformity

in the comparison of treatment approaches. The wide variety of treatments referred to earlier, can be placed under three classifications:-

1. Abstinence based programmes;
2. Recent innovations characterised by behaviourist approaches, drug therapy, etc.;
3. Broad-based "total push" programmes.

The first category, selective to the point of including those admitting helplessness over alcohol, emphasise abstinence as an illness control, rejecting any possibility of moderate drinking as feasible. With the support of other alcoholics, McLelland (1973) argues that the power drive previously utilised in drinking at pathological levels, is socialised in helping others.

Alcoholics Anonymous, being the most widely acknowledged of this category, is not without its critics. Apart from the possible counter productivity of the disease model propagated by A.A. and mentioned earlier in this thesis, other issues arise. The "one drink; one drunk" axiom is questioned on the basis of an undesirable conditioning process which presents an alcoholic's first drink as a sign of treatment failure to all concerned and a triggering mechanism for pathological drinking by the individual. Work by Schaefer (1971) supports the contention that those who had heard and believed that the first drink necessarily led to drunkenness were significantly less able to drink in a socially acceptable manner than those who did not know or believe in that dictum. Drewery (1974) adds that "the abstaining A.A. member may be

functioning in a highly constricted manner, having as it were, substituted an organizational addiction for an alcoholic one....sober, they are as preoccupied with drink as they had been when drinking".

Gaining valid data on those who pursue such programmes is fraught with methodological control problems with protagonists resorting to less than adequate means in promoting their efficacy. Davis (1976) for example, says "that on a statistical level, an A.A. member attending his first meeting has a sixty percent chance of staying sober for some time at least"....a claim that could be made for most programmes dependent on the meaning of the words "some time at least". Davis (1976) also adds weight to Drewery's comments in the claim that length of sobriety is in direct proportion to the number of meetings attended.

The concept of abstinence is incorporated in the majority of treatment approaches on the basis that the risks of a lesser goal are of grave consequences to the majority of alcoholics. This same argument is interpreted by antagonists as being a goal prohibitively high, hence the large number of alcoholics failing to present for treatment.

The second treatment category includes behavioural approaches, preventative educational programmes, various forms of drug therapy, and of recent times, hypnotherapy and acupuncture. Claims for these methods as yet lack supportive evidence from longitudinal studies. Behavioural approaches in the strictest sense of the term, summarised by Litman (1974), present classical conditioning models as theoretically

impressive but empirically unsound and operant conditioning as functional under circumstances where contingencies can be stringently maintained, but falling short of practicability in the open environment. The author does indicate that self regulation procedures appear promising, though work of a research and development nature needs to be undertaken. Contingency variables are incorporated within other treatment models in varying degrees of intensity and centrality.

Education programmes designed to act as a braking influence on drinking patterns or as a total preventative system are, according to Kalb (1975), destined to failure and regarded as mythical in terms of their effectiveness. The author contends that such programmes are based on the invalid premise that awareness of facts about alcohol leads to a change in drinking habits. Kalb (1975) cites experimental and empirical sources in support of his contention.

Ueckler and Salberg's (1971) study cited by Kalb (1975) concluded that "favourable attitudes toward alcoholism, alcohol education and treatment of alcoholism were not markedly strengthened by an alcohol eduction programme (and) raised questions concerning the wisdom of spending many hours of staff time on making alcoholics familiar with current knowledge about alcoholism". However, the question of attitude change following education is still an open one and as part of the overall treatment approach, is included without evidence of negative effect.

The third treatment category alluded to as a "total push" method is represented by programmes offering:

1. A detoxification unit;
2. a medical unit;
3. in and out-patient on-going programmes;
4. supportive after-care....with major treatment efforts residing with the latter two.

To detoxify the alcoholic is in itself not considered a treatment for alcoholism. Such an approach tends to render fit the individual to resume his drinking career and sets up an expensive "revolving door" system of a "recycling" nature perpetuating its own existence. In a total push approach, detoxification is but the first step of an integrated social, physical and psychological interdisciplinary effort. Designed to resocialise the individual, often in a group setting of a residential nature, the importance of long term adequate after-care is stressed.

The treatment during the initial and follow-up stages generally centres on areas highlighted by Fox (1973) as physical restoration; environmental management; orientation and eduction; family, employers and significant others who are utilised for continued reinforcement. A significant part of such a programme is described by Glatt (1972) as "appeals for a new way of life based on faith and suggestion", hence Alcoholics Anonymous plays a major role in total push programmes.

Moderation of alcohol consumption is generally discarded as a possibility in overall treatments, despite experimental work to the contrary (Cohen, Liebson and Faillace 1973 et. al.).

Abstinence however, is not regarded as the sole outcome measure, but rather a judgement based on positive changes in life style. Changes over time are in terms of improvement in social functioning compared with the individual's condition prior to treatment.

Most treatment systems view as important the evaluation of individual therapist effectiveness; identifying the necessary criteria as being non-judgemental, non-moralistic, sympathetic and understanding. "What the different techniques have in common is the description of a patient's personality and the breakdown of old established and long cherished attitudes" Glatt (1972).

CHAPTER THREE - ALCONFRONTATION.

This chapter describes and examines an approach to the drug dependent person, and more particularly, the alcohol dependent person, developed at the Detoxification Unit of the Newcastle Psychiatric Centre in 1974.

Originally known as a "Confrontation method", the approach was developed and utilised in increasingly wider circles and situations until more recently the author published under the title of "Alconfrontation" (O'Neil, 1976).

In general terms, the technique is designed to break though the massive denial of the problem characteristic of the alcoholic and so often preventing the dependent person from seeing what is obvious to the outside observer. Having made this breakthrough, the system claims a relatively high proportion of what the author terms "conversions", where the dependent person chooses to cease using their drug of choice... in the alcoholic's case, alcohol.

For individuals without previous admission to a psychiatric centre presenting for the first time in relation to their drinking habits and exposed to "Alconfrontation", some fifty percent choose to cease using alcohol (C.A.S. Lit. 1975). Furthermore, O'Neil (1976) observes that "even the less common "conversions" among the recycled "Skid Row" group were accepted as routine occurrences".

The basic formulations were developed when the author was involved with the Newcastle Psychiatric Centre, mentioned earlier in this thesis, as having a relatively large intake

of diagnosed alcoholics. The development of the technique and its broader applications in terms of differing dependencies and variety of those who could become confronters, took place at a later stage.

Information which has been published on the model is of a local duplicated type, though one paper of a descriptive nature has appeared (O'Neil, 1976). In addition to the clinical observations mentioned above, with regard to efficacy of the technique, O'Neil (1976) says, "after several hundred alconfrontations over eighteen months, there has not been one case of self destructive or violent behaviour following the application of this technique" (O'Neil, 1976). Whether the author is referring to behaviour triggered by the actual confrontation, or to continued destructive drinking patterns is difficult to discern. Objective research in either case seems desirable, as such has not yet been attempted. This thesis attempts to examine the Alconfrontation approach in a large Psychiatric Centre where a detoxification unit utilizes the technique.

The Alconfrontation approach consists of five basic units, each incorporating subsections with clearly laid down guide-lines in relation to the content and nature of the intervention. The five sections referred to are as follows:-

1. Diagnostic determination (fact finding).
2. Educating the client with relevant information pertaining to alcohol use and misuse.
3. Confrontation with the diagnosis, that the client is suffering from alcohol disease based on findings

from section 1, and made clear to the client through education in section 2.

4. Degradation - of which the goal is to break through the denial by exaggerating the rock bottom feeling, and
5. Referral, where the confronter offers a point of contact acknowledging the unlikelihood that the confrontee will choose to accept the offer. (A video recording of a typical Alconfrontation accompanies this paper: Appendix (A)).

O'Neil (1976) suggests eight advantages of the Alconfrontation approach, with economy of time, energy and emotion first cited. The first of these economies seems apparent, although the latter two could draw argument. The extent of energy and emotion expended, in the degradation phase, could be argued as considerable, dependent on the personality of the confronter and confrontee.

Minimum need for supportive follow-up is the second advantage of the system mentioned. Follow-up supportive programmes are not viewed as an important part of the model.... an issue contrary to findings in the literature and mentioned earlier in this thesis as being a necessary and integral part of the total push methods.

Advantages three and four relate to "characteristic conversions from dependence to independence and a high success rate related to economy" (O'Neil, 1976). Evidence in support of advantages three and four are, at this stage, in terms of clinical observation. Universality of applicability and the

range of health professionals and others able to use the technique are the fifth and sixth positive factors noted by the author. Application of the technique is said to be effective, regardless of the particular dependency, be it alcohol, narcotics, sedatives, analgesics or nicotine. With regard to these substances, it would appear that more is involved in governing behaviour than rational logical facts, as despite government and individual intervention, cigarette and drug use continues at high rates. That a positive contribution is made to the solution of the problem by ensuring that the user does so in full knowledge of the consequences is difficult to argue.

The simplicity of the technique and its "safety" are viewed by the developers as the additional advantages. The author states "that with a few hours of addiction input and roleplay demonstration, the technique can be satisfactorily taught" which is less expensive than years of medical or para-medical tertiary education. The safety feature as an advantage has been commented on above.

O'Neil (1976) indicates that the technique hinges on four main premises which make up a philosophy of approach to the drug dependent person. They are:-

1. Any person can become dependent on a drug. Conversely any person can become independent of a drug.
2. The individual is responsible for his drug use.
3. A drug dependent person can, in some cases, be provoked into deciding to cease the use of the drug.

4. The problem of the drug dependent person is his drug use. The drug problem should be seen as the problem, not simply as a symptom of another underlying problem.

The first premise would appear to contain a covert contingency that given appropriate circumstances, any person can become dependent on a drug; that is, assuming that even the person who sets out to consume alcohol purposefully in a self destructive manner, does so with reason, either conscious or unconscious. This assumption finds support from the author's use of the phrase later in his paper "those who cop out". It is difficult to find reconciliation on this basis with the fourth premise which insists that the dependency should be seen as the problem and not a symptom of other problems, or another underlying problem. This first premise is not inconsistent with the medical model of alcohol as a disease, while the second premise could find argument with such a model. If alcoholism is a disease in the medical sense, it is difficult to see how the sufferer can be held responsible for other than triggering the mechanism that sets off a "bout" of disease symptoms (a drinking bender). Keller (1972) argues that this personal responsibility is invalid as the loss of control factor is related to whether or not the first drink should be taken at all and not after the first drink has been taken. Responsibility for drug use is assessed by Keller (1972) as being <u>the</u> problem to be tackled and not as O'Neil would have, an assumed premise on which a treatment programme can then function.

The third premise is based on clinical observation, without impirical evidence. In many ways, this provocation appears similar to a general medical practitioner's stern warnings, a clergyman's fire - and - brimstone appeal or the aversive therapy of the behaviourist. Questions as to who can be provoked to conversion and who can do the provoking, are in need of examination and suspected by this author to be contingent on personality variables.

The fourth premise appears to conflict with later statements in the Alconfrontation published article. Even if the strife related to excessive and dependent use of alcohol is seen to be a result of, and not the cause of, pathological drinking. Use of the phrase "cop out" infers an avoidance behaviour. Compromise of these apparently conflicting attitudes could perhaps be arrived at by adopting Mello's (1968) suggestion that in the first instance, drinking behaviour was the result of some avoidance, maybe long since forgotten or at least confused in present aetilogical explanation with present drinking behaviours and the resultant strife, for all intents and purposes, viewed as THE problem.

The stated goals of Alconfrontation are simplistic in nature and designed to "leave the denial - broken drug abuser with two alternatives". (O'Neil, 1976).

1. To continue use in the full knowledge that control has been lost and that progressive strife is inevitable, or
2. To cease completely all use of the drug.

The first goal centres on the words "full knowledge". Undoubtedly the majority of alcoholics, particularly those in the latter stages of alcoholic decline, have been confronted with their abnormal drinking habits and associated strife on many previous occasions by those having concern for them. It is assumed that these confrontations have met with denial, while the "Alconfrontation" occurs following the degradation stage designed to break through this denial barrier. Implicit in this aim is that a decision on the part of the alcoholic to continue drinking is also a termination point for the confronter. No further contact or follow-up programme is stipulated in the Alconfrontation model. O'Neil (1976) states "It's essentially a "one-shot" method. There is no ongoing counselling programme involved". In the sense that the confrontation has occurred and a decision by the confrontee has been made, the model is complete.

The second goal is clearly the desired choice sought after by the confronter, as is evident in the introduction to O'Neil's (1976) paper, where the approach's efficacy is determined in terms of the "breakthrough in the massive denial, and the conversions from dependence to independence".

For a model that emphasises personal responsibility; the ability to become independent of a drug and that dependency is in itself the problem and not a symptom of another underlying problem, a credible third choice consistent with the model of controlled social drinking is not offered.

If Keller's (1972) contention that not every drink leads to an uncontrolled drinking bout is accepted, it would

seem consistent with the Alconfrontation philosophy to indicate such a third choice.

O'Neil (1976) suggests specific guidelines for the confronter who, he states, in a locally produced and unpublished paper (C.A.S. Lit. 1975) "should be a significant resource person, who by virtue of his official position, has a formal relationship with the drug dependent person". This definition extends beyond the addiction trained and formal health worker, to include clergy, personnel managers, voluntary and statutory field workers and others.

The guidelines are stipulated to ensure consistency of approach, while the point at which confrontation should occur is counselled by the author to be during withdrawal and not when the person is intoxicated.

The guidelines for Alconfrontation are notable by their unorthodoxy and set the model apart from traditional approaches to the point of controversy. Confronters are urged to remain un-involved, objective and professional. They are to point out the advantages of using alcohol and disadvantages of not using alcohol. Amplifying feelings of abnormality and worthlessness, the use of colloquial terms to describe the client how society sees him, such as a failure; no hoper; bludger; piss pot; weakling; scungy, etc. are encouraged. The confronter is "to accept with comfort the probability of continued use". (O'Neil, 1976).

Section (A) of Alconfrontation is diagnostic in nature covering a variety of fact finding questions, e.g. reason for referral; history of strife; physical symptoms; mental,

domestic, employment, social, financial and legal complications, establishing daily intake of alcohol, etc. Detail associated with each of these subsections appear in Appendix (B).

Following the diagnostic interview the client is made aware of facts related to alcohol and then confronted with the diagnosis. The education section attempts to relate only two facts:-

1. A definition of a "mind bending drug" (psychotropic drug) and
2. Each standard measure of an alcoholic beverage contains an equal amount of ethanol (ten grams).

The effectiveness of this education needs to be considered in relation to research findings cited earlier in this thesis. The timing of such intended learning (during a withdrawal stage) also warrants investigation.

Using data from the diagnostic interview, confrontation with the diagnosis (Section (C) of the Alconfrontation model) develops from the educational foundation of Section (B). If the client uses in excess of one hundred and twenty grams of ethanol daily, he is informed, often with group pressure, that he is suffering from Alcohol Disease. The confronter then uses examples from the client's life to illustrate that alcohol related strife is progressive.

Alternative courses of action are presented to the client as his only choices:-

1. To continue using alcohol in the full knowledge of ongoing and progressive strife, or

2. To cease using it altogether.

The confronter takes no part in the actual decision making and is advised to adopt a blase attitude without care as to the client's decision.

Section (D), "Degradation" is identified by the author as the most contentious, yet most important step in "helping the client break through denial by exaggerating the rock-bottom feeling" (O'Neil, 1976).

Having degraded the person by highlighting the negative aspects of his record, the confronter firstly harangues the client as a "no-hoper", "abnormal", "failure", "second-class citizen" and generally "inferior". He then suggests that of the two courses open to him, the first has already been attempted many times before with as many failures and that the client should "accept the fact that he is stuck with using" (O'Neil, 1976).

The technique ends abruptly with the client being informed that he has no chance of ceasing to use alcohol and, reiterating the two alternatives available, the confronter verbalises his expectation of failure.

O'Neil (1976) indicates "on occasion dramatic conversion occurs....evidenced by a sudden change in demeanour and a sudden decision to cop-out no more....accompanied by a calm certainty of success". He goes onto say "more commonly this decision occurs in the next twenty-four hours often during the sleepless nights in which increasing tension is suddenly replaced by calm".

A support or follow-up system is seen to greatly reduce the value of the confrontation, although a card is offered in the manner, "you can get in touch with me here if you want to, but I don't expect you will" (O'Neil, 1976).

Contrast between the Alconfrontation model and the recommendations of Glatt (1972) when he advises a therapist's most important task during the first interview is to establish a "non-condemning and non-judgemental" attitude demonstrates the unorthodoxy of the technique. Glatt (1972) magnifies even further the difference, asserting "nobody is likely to have much success in treating alcoholics who approaches them with a censoring, moralistic or even ridiculing attitude and in a holier than thou spirit. On the other hand, an approach based on understanding and genuine acceptance....will often go a long way. Alcoholics are very sensitive and on the lookout for real or imagined rejection".

The Alconfrontation technique is not completely isolated in its approach. Davis (1972) utilised a self-confrontation model in alcoholism treatment, while Moore (1971) in a survey of treatment approaches in private psychiatric hospitals found thirty two percent of his population using some form of confrontation approach. Boylin (1975) in describing Gestalt encounter in the treatment of hospitalised alcoholics, centres the encounter on here and now experiences with personal responsibility for behaviour similar to the Alconfrontation model, though along with these other confrontation techniques does not include in its procedure the degradation phase of Alconfrontation.

Kalb (1975) challenges prevention programmes based on the theory that consequences are an effective way to appeal to and produce changes in drinking habits. Granting that such an approach is highly successful in appealing to persons whose behaviour is determined by weighing the consequences of their actions, the author suggests that "unfortunately they (the consequence thinking people) are likely to be the last people who would become alcoholics". This contention finds support in the commonly cited psychological characteristics of alcoholics as being impulsivity, poor ego controls and difficulty in delaying gratification (Force, 1958). Kalb (1975) indicates "the choice to drink is determined and dictated by his felt need at the time and not by consideration of some delayed negative effect in the future".

This thesis attempts to evaluate the Alconfrontation model as a technique applied to a diagnosed male alcoholic sample.