TREATMENT PATTERNS IN DESIGNATED SOCIAL SERVICE AGENCIES IN GREATER LANSING

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AN ABSTRACT OF

A RESEARCH PROJECT

Submitted to
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This was a study to determine the extent of treatment to alcoholics given by social service agencies in the community of Lansing, Michigan. The sample included all of the professional workers from five community agencies. A three part testing instrument was constructed to gather information on priority ranking patterns of treatment categories in own agency and the other agencies in the sample, percentage of treatment categories in the actual caseloads, and estimate of treatability of each category on a five point scale. On the basis of a two-thirds return, conclusions from the data indicated that alcoholism was given the lowest priority ranking, made up less than one per cent of total average caseload and was rated least treatable. There was some evidence that certain agencies in the community were seen as specializing in child, family, or individual treatment.

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REVIEW OF THE LITERATURE

Alcoholism today ranks as the fourth largest public health problem, exceed only by heart disease, cancer and venereal disease. It is estimated that there are five million alcoholics in the United States today.[1]

The range of definitions of alcoholism extends to the number of sources available. For our purposes alcoholism will be defined as the excessive use of alcohol which interferes with the emotional, social, family and economic life of the individual.

From ancient times the excessive use of alcohol has been identified with sin, debauchery and weakness. Public indignation was aroused at what was considered a blatant search for escape and pleasure. This pervasive current of moralism has tended to retard public recognition of the tragedy presented by the problem of the individual alcoholic and his family. During prohibition it was hoped that the problem could be legislated out of existence.

Societal prejudice still weighs heavily about his neck, even though today it is easier for the alcoholic to obtain help for himself. He may be incarcerated, institutionalized or socially ostracized. Some feel that he must suffer hardship and be desperate before being helped.

Others suggest that conversion, the submission of the unconscious, is necessary. Alcoholics Anonymous, which is believed to have the greatest successful treatment rate stresses the expiation of guilt and the conversion factor involving religious commitment.

Not until 1956 did the American Medical Association officially recognize alcoholism as an illness.[2] The studies of Dr. E. J. Jellinek, between 1910 and 1945, accounted in large measure for the increased scientific and medical attention to the problem.[3]

The disease concept of alcoholism still lacks total cultural acceptance, partially because of lingering moralistic attitudes, but also because there appears little objective evidence for such a theory.[4] While few would argue the physiological effects of chronic alcoholism such as cirrhosis of the liver and brain damage, there seems to be no single physical causative factor.

The disease concept of alcoholism while implying medical or physical causative factors has been associated with the theory that alcoholism is the symptom of an underlying personality disturbance. Zwerling[5] suggests that a basic character disorder is at the root of the illness although he admits that the symptomological picture may vary considerably. Otto Fenichel[6] characterizes alcoholics by their "oral and narcissistic premorbid personalities" with strong unconscious homosexual impulses. Others have pointed out that alcoholics may be found among any of the

neurotic or psychotic disorders. There appears to be no definitive personality study which has achieved general recognition and acceptance.

Attempts to define and explain alcoholism have crossed every field from religion to medicine, psychiatry to sociology. Possibly the most positive result of this explosion of theories has been the growing public recognition of alcoholism as a critical social, psychological and medical problem. Many diverse opinions continue to exist and treatment continues to be sporadic, eclectic, and confused.

Social work has not escaped this confusion and the resulting diverse treatment approaches to the problem of alcoholism. Actually little can be stated with reliability concerning the successful treatment of the alcoholic person.[7]

Currently, much of the available treatment is focused upon the chronic alcoholic. It has been suggested, however, by Wellman, Maxwell, and O'Hallaren that the great majority of male alcoholics in the United States never seek treatment and are hidden from recognition because they do not conform to the old stereotype of what the alcoholic is like. They are hidden by their ability to present a fairly normal appearance to personal and social integration.[8] Hunter points out that the alcoholic is resistant to help.[9] Fox states that the alcoholic fails to seek treatment because of low ego strength. She stresses the relationship between one's ego strengths and ability to accept and cope with

reality.[10] Menninger feels that a progressive reintegration with the environment is necessary for successful treatment.[11]

The social work agencies, as such, have not been conspicuously successful with the alcoholic clients and, as a result do not welcome them for service. According to Krimmel and Falkey,[12] prominent among reasons for this is the strongly entrenched notion that, without exception, alcoholic clients require long months and years of treatment. Nearly as strong is the feeling that the alcoholic will remain indefinitely, clutter up the caseload and exclude from service other clients whose prognosis is more favorable. Reluctance by professionals to treat them is directly related to the alcoholic being viewed as a low prestige client, according to Morris.[13]

Some social workers,[14] as well as members of the medical profession,[15] feel that complete abstinence is necessary before treatment can be initiated. Cork[16] feels it is necessary for the social work profession to recognize the social problems incurred as a result of over indulgence. When these needs have been met, it is then possible to deal with the deeper psychological problems.

Bailey and Fuchs feel that social workers traditionally have been reluctant to involve themselves in treatment relationships with the alcoholic, who they have regarded as unreliable and unrewarding clients. Most social workers learn little about alcoholism and their attitudes have been

generally pessimistic. Their study, in which 429 NASW members participated, indicated that Alcoholics Anonymous is considered to be the most favorable treatment source. No more than 30 per cent of the respondents considered the alcoholics prognosis good with any method of treatment. Social casework was rated as a good treatment method by 22.1 per cent of the social workers. Bailey and Fuchs concluded that there is a relationship between pessimism and frustration of these social workers and their tendency to view alcoholism as a symptom rather than as a disease. They also concluded that those helping persons whose goals are oriented toward the resolution of underlying problems only may thus be failing to observe the principle of meeting the client where he is, and resolving environmental difficulties.[17]

Karen Horney's holistic theory states that the individual and his envornoment are mutually influenced and influencing. Nathan Ackerman emphasizes a holistic approach to treatment of the total family unit.[18]

Ruth Fox,[19] Landy,[20] and Thelma Whalen[21] have pointed up the importance of dealing with family interaction as an essential in treatment of individuals with alcoholism. Bailey[22] stresses the need for workers to deal directly with reality problems rather than minimizing them in favor of the underlying psychological conflicts.

METHOD

Our review of the literature revealed considerable variance of opinions concerning approaches to treatment of alcoholism. It also revealed that social work has not been notably successful in treating alcoholics. This survey was designed to determine the extent of service to alcoholics in the social work agencies in Lansing, Michigan, a medium size city representative of other Midwestern cities of similar size. It was decided to analyse the treatment patterns of agencies offering primarily social work service to see if there were any significant differences between the pattern of treatment for the alcoholic and other identified problem treatment categories.

In our study, we included five agencies designated as primarily offering social work service, such as individual, conjoint, family and group therapy. We excluded those agencies whose caseloads are defined by law or whose policy excludes the alcoholic. The agencies involved were Family Service, Catholic Social Service, Ingham County Comprehensive Mental Health Clinic,* and the Lansing Mental Health Clinic, both Adult and Child Divisions.**

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*Ingham County Comprehensive Mental Health Clinic will be referred to as the All Purpose Clinic.

**The Adult Division of the Lansing Mental Health Clinic will be referred to as the Adult Mental Health Clinic; the Child Division as the Child Guidance Clinic.

Treatment pattern, as it is used in our study, includes per cent of identified problem in worker's caseload, priority ranking of problem treated at agency and worker's perception of treatability. Significant differences in treatment will be in terms of relative per cent treated, position in priority ranking, and how treatable the alcoholic is perceived to be in relation to other identified problems. Treatable is not to include ease or length of treatment.

The other identified problems in our study are parent-child conflict, personal adjustment, school problems, unwed mothers, foster homes, and acting out adolescents.

We constructed an instrument asking each worker to give priority ranking, from one to eight (one being the highest rank) to each of the identified problems that were treated at his agency and to estimate the per cent of each category in his caseload. Then he was asked to rate the identified problem on a five point scale according to treatability. The scale ranged from one, most treatable, to five, untreatable. Workers were also asked to rank problems as they believed other agencies in the study gave them priority.

We hypothesized that the alcoholic client would rank low on the priority ranking, make up a low per cent of the caseloads, and be rated low on the treatability scale. We also thought agencies would be identified as serving specific treatment categories and that the alcoholic would not be included. We were aware that the categories were

overlapping and would not allow for individualization of the client. To give more flexibility to the instrument, we left one category open and invited comments. We felt that the information requested in the first two questions concerning priority ranking and per cent of the problem treated in the caseload would be governed by the agency intake policy. This would determine what problems are treated and to what degree. Our intent in the third question was aimed toward the workers' own bias and attitudes. Thus, we asked them to disregard length and ease of treatment in their evaluation of the categories (see instrument in the appendix).

The research team distributed thirty-six instruments to the social workers from the designated agencies, and twenty-five were returned. All of the agencies were well represented in the responses, with the exception of the Adult Mental Health Clinic which returned only one of four instruments. The reader should consider this fact when reviewing the results of the study.

All of the questions were not answered by all of the workers. Priority ranking in "own agency" and per cent of each problem category in each caseload was answered in twenty-two cases. The question of treatability was answered by fifteen respondents and priority ranking of the other agencies' treatment patterns received only eight responses. Total community averages were based on computation of total individual responses rather than agency averages. On

occasion, when any single rank was not given we arbitrarily used the lowest rank of eight. The averages were then translated into ranks on the basis of numerical size.

View of Selves

According to these responses, as shown in Table 1, when all workers ranked problems treated in their own agency, alcohol was ranked lowest and it received less than one per cent in the total average of the caseloads in the community. When we changed the total average percentage to a rank order, marital received rank one and personal adjustment, rank two. However, there was little actual difference in per cent given.

TABLE 1.--Average rank on priority of problems served for own and other agencies compared to percentage in case loads.

Problem	Priority Ranks			
	Own Agency Rank N=20	Other Agency Rank N=8	Actual % Rank N=22	Actual % N=22
Marital	1	3	2	22.23
Personal Adjustment	2	1	1	23.23
Parent-Child	3	2	3	17.09
School	4	4.5	4	10.27
Acting Out Adolescent	5	4.5	5	8.23
Foster Homes	6	8	7	3.54
Unwed Mothers	7	6	6	5.82
Alcoholics	8	7	8	.77

This data shows that alcoholics were given the lowest priority rank in treatment and made up the smallest percentage in the caseloads.

There were, of course, some differences among individual ranks and among agencies. Tables are included showing the differences (see Tables 2, 3, 4, and 5).

Table 2 shows average priority rankings of each agency and total average rank for all agencies. Alcoholism was viewed lowest by all agencies except the Adult Mental Health Clinic which ranked alcoholism fifth.

TABLE 2.--Priority ranking of problems as seen within own agencies and total community average rank.

Problems	Average Rank by Agency					
	*FSA N=5	CGC N=7	AMH N=1	APC N=1	CSS N=6	Total N=20
Marital	1	4	2	1	1	1
Personal Adjustment	3.5	3	1	2	2	2
Parent-Child	3.5	1	6	4	3	3
School	7	2	4	3	5.5	4
Acting Out Adolescents	5	5	3	5	5.5	5
Foster Homes	6	7	7	8	7	6
Unwed Mothers	2	6	8	8	4	7
Alcoholics	8	8	5	8	8	8

*FSA=Family Service Agency; CGC=Child Guidance Clinic; AMH=Adult Mental Health; APC=All Purpose Clinic; CSS=Catholic Social Service.

Table 3 gives average per cent of problem categories treated in each agency and total community averages. In the total community averages, alcoholism represented less than one per cent of the caseloads. No agency average allocated more than two per cent of its caseload to alcoholism. Figure 1 gives a graphic illustration of the total average per cent of caseloads allocated to the treatment categories.

TABLE 3.--Average estimate of percentage of caseload in own agency compared to total community.

Problems	Average Per Cent by Agency					
	APC N=3	FSA N=4	CSS N=8	AMH N=1	CGC N=6	Total Comm.Av.% N=22
Parent Child	21.66	11.5	11.37	.02	28.66	17.09
Personal Adjustment	30.66	26.25	9.12	.80	26.83	23.23
School	9.33	1.75	4.00	.04	25.83	10.27
Marital	18.66	53.75	20.62	.05	8.00	22.23
Unwed Mothers	3.33	2.5	13.37	.01	-	5.82
Foster Homes	.66	-	8.25	-	-	3.54
Acting Out Adolescents	3.66	6.25	6.00	.05	10.33	8.23
Alcoholics	2.00	1.5	.37	.02	-	.77

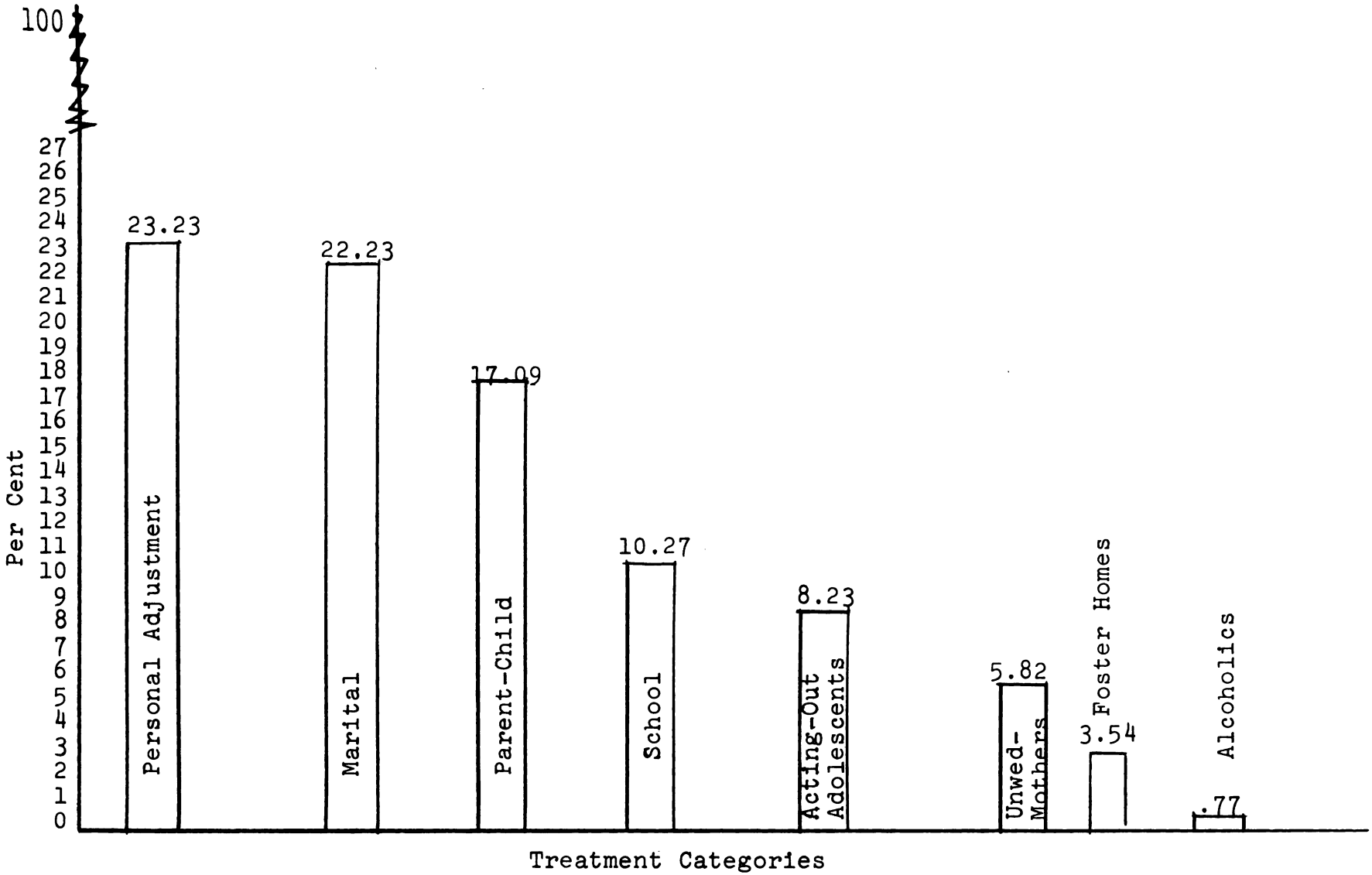

Figure 1.--Average estimate of per cent of caseload for total community.

Table 4 shows average treatability of categories as ranked in the total community. Both foster homes and alcoholism were given the rank of four out of a possible five. We arbitrarily gave the lowest rank of five when no response was given. Since many respondents did not rank the foster home category, the average of the results for foster homes was skewed downwards making it appear that the treatment problems involved in foster home placement are as difficult as those in working with alcoholics which may not be the case. At least two factors operated to account for non-response; one agency did not do foster home placements, and there was some misunderstanding by the workers about what was meant by the category

TABLE 4.--Average treatability ratings of problems as perceived by agency staffs.

Problems	FSA N=5	APC N=2	CGC N=5	CSS N=2	AMH N=1	Average Rating
Parent-Child	2	3	2	2	2	2
Personal Adjustment	2	4	2	3	2	3
School	2	2	3	4	2	3
Marital	2	2	3	4	2	3
Foster Homes	4	5	4	4	5	4
Unwed Mothers	3	4	4	2	2	3
Acting Out Adolescents	3	4	3	4	3	3
Alcoholics	4	5	4	5	4	4

View of Others

Table 5 shows the total average ranking of categories in agencies other than the respondent's own. The averages included only Family Service, Child Guidance Clinic, and Catholic Social Service workers, because data was not given on this part of the instrument by workers from the Adult Mental Health Clinic or the All Purpose Clinic. When the Adult Mental Health Clinic was viewed by workers in the three agencies, alcoholism was seen as receiving an average rank of four. In the All Purpose Clinic, it received an average rank of six. In Family Service and Catholic Social Service, alcoholism received a rank of seven and in the Child Guidance Clinic, a rank of eight.

TABLE 5. Average priority ranking of problems treated in each agency as seen by other agency workers.

Problems	AMH	APC	CGC	FSA	CSS
Marital	2	2	5	1	1
Personal Adjustment	1	1	4	2	3
Parent-Child	3	3	1	3	2
School	7	5	2	4	6
Acting Out Adolescents	5	4	3	5	7
Foster Homes	8	8	7	6	5
Unwed Mothers	6	7	6	8	4
Alcoholics	4	6	8	7	8

We expected agencies to be seen as specializing in certain kinds of problems and that none of the agencies would be seen as specializing in alcoholism. When looking at the top priority given each agency, the ranking pattern indicated that the Child Guidance Clinic was seen as specializing in children's problems; the Adult Mental Health Clinic and the All Purpose Clinic in individual problems; and Family Service and Catholic Social Service in family problems.

The workers in the agencies giving top priority to family problems gave alcoholism the lowest rank for their own agencies, and at the same time, a relatively high rank for agencies whose top priority was given to individual problems. A possible interpretation may be that alcoholism is viewed as an individual treatment problem, not a family problem.

When agencies viewed treatment priorities of the Adult Mental Health Clinic and the All Purpose Clinic they all gave top priority to personal adjustment. This choice tends to substantiate the traditional approach in which these agencies were viewed as focusing upon individual problems. These two agencies were also seen as giving middle range ranks of four and six, respectively to alcoholism, possibly implying that alcoholism is seen as a personal adjustment problem.

When Family Service and Catholic Social Service ranked the priority of treatment at the Child Guidance Clinic, the first two ranks were assigned to parent-child

and school problem categories. This data tends to support the traditional function of child guidance clinics. Alcoholism was given the eighth rank as one would expect with the clinic's focus on the child.

Family Service as viewed by Catholic Social Service and the Child Guidance Clinic workers gives top priority to marital problems. This may be a reflection of their specialization with families. The fact that alcoholism received a low rank of seven may suggest that the workers in these agencies do not view alcoholism as a family problem.

Catholic Social Service appears similar to Family Service based upon other workers' views of this agency. Marital problems were given top priority in the two agencies, with alcoholism given an even lower ranking of eight at Catholic Social Service.

Spearman correlations revealed that three of the five agencies had a high correlation between what they treated and what others saw them as treating. They were the All Purpose Clinic (.828; $p<.01$), Catholic Social Service (.868; $p<.01$), and the Adult Mental Health Clinic (.714; $p<.05$).

When agencies viewed themselves, there appeared to be a high correlation between the priority ranking of problems and the per cent of problem in caseloads in three of the five agencies. The correlations were .821; $p<.05$ at the All Purpose Clinic, .893; $p<.01$ at the Child Guidance Clinic, and .996; $p<.01$ at the Adult Mental Health Clinic.

SUMMARY

In a comparison of the findings from our review of the literature and the findings in our study, we feel there are some implications for in-service training in the area of treatment of alcoholism. According to the literature, psychotherapy alone is not successful. In the N.A.S.W. study, there was a correlation between workers' feelings of pessimism and frustration and their perception of the alcoholic as unreliable, unrewarding and having a poor prognosis.[25] Other factors leading to the failure of social workers to treat alcoholics may be their viewing the alcoholic as a low prestige client, their expectations for immediate abstinence, and their focus on the resolution of underlying pathology. By not considering all aspects of the problem, individual, family, and environmental, workers fail to meet the client where he is.

Many of the authors previously reviewed stress the importance of including the family, its social relationships and influences in the treatment of alcoholism.

Our study showed that alcoholism was consistently given the lowest priority rank, made up an extremely low percentage of caseloads and was rated least treatable. There was some evidence that agencies are seen as specializing in treatment categories (child, individual, and family) and

that alcoholism tends to be seen as an individual treatment problem rather than a family treatment problem with its social ramifications. Although a study by the U.S. Department of Health, Education and Welfare, in 1960 pointed out the presence of over 200,000 alcoholics in Michigan,[26] the survey of five Lansing agencies in 1967 indicated that less than one per cent of the total average caseload was allocated to the treatment of alcoholism. It would appear that it might be advantageous to incorporate into in-service training some of the new ideas, theories, and approaches to the total treatment picture for the alcoholic.

Further research might explore the actual demand for treatment by alcoholics, i.e., the number who make some attempt to obtain treatment at social service agencies. Other research might profitably explore workers' understanding and knowledge of the problem of alcoholism, and general approach to treatment of alcoholics.

FOOTNOTES

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22. Bailey and Fuchs, pp. 14-19.

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APPENDIX

This is a study to determine the referral and treatment patterns of the local social service agencies.

I. Instructions
   A. Circle the name of your agency.
   B. Give priority ranking to the social problems you treat in your agency.
   C. Give priority ranking to the social problems that are applicable for treatment at the other social agencies.
   D. Please rank from one to ten with one being the highest on the scale.

	All Purpose Clinic	Family Service	Catholic Soc. Service	Adult Mental Health	Child Guidance
Parent-child conflict					
Personal adjustment					
School problems					
Marital					
Un-wed mothers					
Foster homes					
Acing out adolescent					
Alcoholism					
Other (Specify)					

I. Estimate the percentage of your caseload made up by the following social problems:

Parent Child Conflict _____

Personal adjustment _____

School problems _____

Marital _____

Un-wed mothers _____

Foster homes _____

Acting out adolescent _____

Alcoholism _____

Other (Specify) _____

II. In your professional opinion indicate the degree of treatability of each of the problems, without regard to ease or length of treatment.

	Most Treatable				Un Treatable
Parent child conflict	1	2	3	4	5
Personal adjustment	1	2	3	4	5
School problems	1	2	3	4	5
Marital	1	2	3	4	5
Un-wed mothers	1	2	3	4	5
Foster homes	1	2	3	4	5
Acting out adolescent	1	2	3	4	5
Alcoholism	1	2	3	4	5