ALCOHOLISM KNOWLEDGE
IN
FOUR HELPING PROFESSIONS

by

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IN

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CHAPTER I

INTRODUCTION

How do those who work professionally with alcoholics really feel about this prime health problem?

To this, as to many other questions arising from the mist-shrouded relationship of alcoholic beverages to man, there is no simple answer. Only very recently, with the recognition of alcoholism as a treatable illness, has there been a partial scattering of the mists of emotionality, controversy, apprehension and misunderstanding which have typified traditional views of the problem.

We are all familiar with the common stereotype of the alcoholic as a "skid-row bum", capable only of receiving a sort of quasi-acceptance composed of mingled pity and ridicule. Only during the past three decades has alcoholism come to be considered a major mental health problem---one of the most important to come to public attention in recent years. Because of this very newness of recognition a myriad of problems, symptomatic of concepts in transition, are still very much with us.

In the past the law punished the alcoholic for his anti-social behavior, and the church preached at his immorality; at the same time medicine treated his symptoms and prescribed abstinence. Today there is a growing emphasis on seeing alcoholism in terms of the individual's underlying personality disorder, as well as social and cultural influences. Accumulating knowledge in the behavioral sciences has much to offer in this area.

Research on the psychological and social aspects of alcoholism include studies of patients' personality structure, and socio-economic background studies of the relationship of alcoholism to absenteeism in industry, prevalence of the illness, the alcoholic family, drinking customs,

and treatment facilities. Recently interest has been aroused in evaluating alcoholism treatment and educational programs, particularly on the state level.

More specifically, some studies have been conducted of community attitudes toward and knowledge of alcoholism. However, to the writer's knowledge, no comprehensive study has ever been done on knowledge and attitudes of members of the "helping" professions.

Recognition of alcoholism as a legitimate health problem has led logically and inevitably to the emergence of "therapists" or "treaters," largely within the fields of medicine, nursing, social work and the clergy. The therapist, by sheer weight of training, is not exempt from the same stereotypes and attitudes which plague the public at large. Yet, members of all these professions are brought into intimate contact with problem drinkers by the very nature of their work. The role they play may be a decisive factor in determining whether the individual alcoholic's battle is won or lost. Because of the impact of these four professions upon the victims of alcoholism, knowledge of actual attitudes and practices among their members should prove valuable.

The individual worker---be he social worker, physician, nurse, or clergyman---is limited in the way he helps those who seek him by the way he perceives the problem. This study, then, is not an attempt to determine why members of the professions think as they do, but rather to gain specific data from one community on how the professional worker sees the problem before him, how alcoholics are being treated and what needs are met and unmet in relation to community resources.

What can be done to help alcoholics? Bacon offers the following statement of rehabilitation goals:

> "The return of the individual---more acceptable to himself, increasingly independent by not using alcohol---to the community to which he can be an acceptable member."[1]

While similarities in goal and approach exist within the four professions, so do differences. Let us take a brief look at both.

Religious approaches have no doubt helped many addictive drinkers to achieve the desired permanent abstinence. Their impact is perhaps

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[1] Sheldon D. Bacon, The Administration of Alcoholism Rehabilitation Programs, (New Haven, Hillhouse Press, 1949).

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evaluating [illegible]
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fargreater than usually suspected; the approaches of the Salvation Army and rescue groups have been particularly valuable. No doubt pastoral counselling is commonly practiced, either with the family or with the problem drinker himself. In most cases the drinker is reticent toward seeking this type of help. However, some approaches in this area have been effective in many cases. The minister is, thus, in a critical position. He has a close relationship with individual families and is often in a position to refer the alcoholic to an agency or to other treatment sources.

Social workers, through the variety of settings in which they practice, cannot help coming into contact with the alcoholic client. The care of this patient often poses a serious problem for casework agencies. He is all-demanding and his often unacceptable behavior makes for difficult interview situations. The fact remains that many casework agencies find themselves heavily loaded with this type of client, or with his family, and with ensuing financial and emotional problems.

Medical care is an essential in dealing with the alcoholic. His physical condition may be the immediate cause for recognition of his problem by a treater. Physically, he may be exhausted, undernourished, nauseated, and unable to eat or sleep. He may suffer from tremors. At the same time he is plagued, more than likely, by feelings of remorse, guilt, self-pity, and any combination of other emotional reactions to his home life. Advances in drugs and in the field of endocrinology have provided many new resources for the medical doctor. Antibuse and other drugs have been used to help the patient lose his desire to drink. The conditioned reflex method is used quite often as a means of building up an aversion to alcoholic beverages to the point that the person becomes nauseated at their very sight, smell, or taste. The responsibility of the medical doctor goes beyond diagnosis or drug administration, however. Through talking with the alcoholic the doctor can often help him express pent-up feelings and help him to reach a point where referral is possible.

Finally, the nurse is in a position to observe the behavior of the alcoholic, particularly the hospitalized one, closely. Public Health nurses play an important role in recognizing the problem and are able to

make referrals to agencies and other sources of help. The understanding shown by a hospital nurse can be a vital factor in the patient's progress. His need for acceptance and gratification of wants play an important part in treatment. The nurse is not only in a position to aid in this process, but by her own awareness can help diagnose the problem in the first place.

With the recognition of alcoholism as a public health problem has come the development, in many states, of specialized programs aimed directly at the problem. The modern trend in state programs began in 1945 with the passage of an act by the Connecticut legislature authorizing a state program on alcoholism. By 1952, twenty-seven states (including Michigan) and the District of Columbia had passed laws creating boards of alcoholism or similar commissions.

Programs vary greatly. Some are concerned with research and education, others with the establishment and operation of facilities for care, treatment and rehabilitation. Some states carry on only one phase; others attempt an over-all approach.

In Michigan the concern has been with stimulating local facilities by establishment of treatment and educational programs within the community. Matching funds have been provided and professional guidance has been given for the establishment of these facilities on a community basis. Specific alcoholism treatment and educational programs on the local level are new. There has been little research to determine their effectiveness. In addition, very little is known about communities where programs have not yet been established, or where procedures are now developing for their establishment. This is the case in Lansing, Michigan, where a committee has been studying the problem under the auspices of the Community Services Council for some two-and-one-half years.

Lansing is a community of some 240,000 residents, including the closely outlying areas. Since it is the state capitol, a large amount of employment is offered by state government, in addition to Michigan State University. The greatest single source of employment is the automotive industry, as Lansing is the home of one of the larger automobile manufacturing companies.

Many residents of the community are new migrants, having arrived since World War II from the more southern states to work in automobile plants and related industries.

The Community Services Council which serves as the focus for recognition of community problems, fathered the Greater Lansing Committee on Alcoholism. This committee, at the time this project was undertaken, was contemplating establishment of an Alcoholism Center. Such a center would provide mainly an educational and informational service channeling alcoholics through existing resources; treatment facilities are presently provided on a limited basis within one local hospital. The Greater Lansing Committee on Alcoholism, in cooperation with the Michigan State Board of Alcoholism, sponsored this project.

One of the major concerns in developing a program such as that proposed by the Greater Lansing Committee on Alcoholism is determination of need. This necessitates some means of determining, first of all, the scope of the problem; and secondly, what is now being done about it. Numerous statistical devices such as the Jellinek formula,[2] have been used to arrive at scope, but as in all areas of this rapidly growing field of study, that established as fact is soon out-moded by two new hypotheses. This formula is based on the number of deaths from cirrhosis of the liver, as an estimate of the number of alcoholics with and without complications.

Applying the Jellinek formula to the Lansing area, a figure of 5,000-plus is arrived at for scope of the problem.[3] The Michigan State Board of Alcoholism currently estimates alcoholics in the state at a quarter million.

Scope is one aspect of determining need. The second is learning how adequately need is presently being met. The alcoholic seeking help is faced with many alternative sources. The most commonly accepted and widely known is Alcoholics Anonymous.

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[2] Community Studies Inc. Alcoholism Survey, State of Kansas, (Kansas City Mo., Community Studies Inc., 1954), Publication 61, p. 36

[3] IBID

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There is little doubt that AA has been one of the most important groups in rehabilitating the afflicted drinker. The World Health Organization Sub-Committee on Alcoholism said of AA, "the many physicians who treat alcoholics consider AA the most hopeful social development which is taking place in the handling of this disorder."[4] The essential philosophy is religious in that the group holds that an abstinent alcoholic is probably most capable of helping another alcoholic to abstain. The alcoholic's best hope for remaining abstinent lies in helping others to achieve the same state. According to one of the founders of AA, the essentials are: "Honesty with oneself and other people, the kind of giving that demands no return, and prayer."[5]

The general philosophy of the Michigan State Board of Alcoholism is that the eventual answer to the alcoholism problem does not lie in creation of new and independent treatment services, but rather in the adaption of existing resources. It is at this point that survey research becomes a useful tool.

Preceding adaption of existing resources is the need to learn how existing resources view the problem. Therefore, it was with the following goals in mind that this study of the attitudes of four professional groups were undertaken:

1. To determine the professionals' understanding of what constitutes an alcoholic.
2. To determine the professionals' interest in this problem in relation to other problems presented by their clientele.
3. To ascertain the involvement of professionals in working with the alcoholic---the number treated, type of referrals, and estimated success.
4. Finally, to gain opinions on the type of resources needed within the community to meet the needs of the problem drinker.

These four areas constitute the major study focus. The study was limited to four professions for practical reasons of time and manageability, however, the four chosen are vital to the treatment process.

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[4] United Nations, World Health Organization, Report of Alcoholism Sub-Committee. pp. 15-16, "Cited by" Bacon, in Alcohol, Science and Society (New Haven, Eillhouse Press, 1952), p. 463.

[5] IBID

CHAPTER II

HISTORY AND BACKGROUND

History shows alcoholic beverages have been used since ancient times and among many different cultures. In the days of the Bible, Amos, Hosea, and Isaiah condemned alcoholic excesses. Hundreds of years later Calvin, Luther, and Wesley preached total abstinence.

In the 17th century secular laws concerning the use of alcohol appeared. The first important English statute was placed on the law books in 1606. For drunkeness the fine was five shillings or six hours in the stocks. This first law, surviving 250 years, served as the basis for colonial law in America. Although alcoholism was seen as a problem having medical implications very early in history, it was not until the 19th century that the basis for our present understanding was laid.

The use of alcoholic beverages has been widely recognized as a dangerous custom, and many attempts have been made to control or abolish its use. Horton describes these attempts this way.

> We know, for instance, that a good many of the higher civilizations of the past have fought against alcoholic beverages and tried to control or prohibit them. We know that in China, at various times; in India, in Mesopotania, and among the Incas, and the Aztecs---the high civilizations of the Americas---attempts were made either to prohibit alcoholic beverages entirely or to control their use, and these attempts invariably failed. In other words, the use of alcoholic beverages as a custom prevailed in the fact of definite, organized, and consciously directed opposition. At one point, the Hindus went probably further than any others in attempting to make the manufacture, transportation, sales, barter or use of alcoholic beverages a capital offense. But this severe law apparently had as little success at stopping the development or continuation of this custom as any of the others."[6]

Why has the use of alcohol been so wide spread and so persistent in spite of recognition of the dangers of its use? Jellinek offers the following explanation:

> "No doubt the complexity of modern society, and the increasing specialization, competition, class segregation, and individualization of interest, tends to produce restrictions and frustrations which cause increasing tension and anxiety

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[6] Donald Horton, "The Functions of Alcohol Primitive Societies" in Alcohol, Science, and Society, (New Haven, 1945), pp. 153-155.

> is not enough; people feel a need for individual release, and they drink alcoholic beverages with friends or family or alone to attain it."[7]

Of course people in modern society use alcoholic beverages as a refreshment, to comply with social custom, and for "prestige purposes." But in both modern and primitive societies the use of alcoholic beverages in excess causes problems, both for the individual drinker and for the society.

Popular understanding of alcoholism is a mixture of many things--among them folklore, misinformation, and defensive rationalization. In an effort to up-grade public understanding, state educational and treatment agencies have distributed tremendous amounts of information---pamphlets, newspaper and magazine articles, television and radio programs. However, we must recognize that mere dissemination of information does not change attitudes, particularly in regard to health problems. Factual data are fundamental to the learning process, but they must have significance for the learner if they are to be incorporated into behavior patterns.

Certain stigmas have developed making it particularly difficult to conceive of this phenomenon as a treatable illness. The voluntary oral use of a liquid is seldom considered the same type of problem as other physical and mental illnesses of a less self-inflicted nature. If we accept alcoholism as a human illness, as we must, the greatest difference lies not in the illness itself, but in the way the individual perceives the problem and mobilizes his or her resources to solve it.

In reviewing the literature on this subject, a double-pronged approach seems most appropriate. First will be an outline of the findings of studies which bear directly upon this project. Secondly, we shall review the literature found in one professional journal for each of the four professions, during the last three years, as it relates to the practioner's role in the alcoholism treatment process.

In 1954, the Kansas Commission on Alcoholism contacted Community Studies Inc. to conduct a comprehensive survey of alcoholism in the state.[8] This study was divided into two areas: Alcoholism--General and Historical Background, and Alcoholism in the State of Kansas.

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[7] Jellinek, E. M., "The Problems of Alcohol," in Alcohol, Science, and Society, pp. 18-19; Horton op. cit.

[8] Community Studies Inc. Alcoholism Survey, State of Kansas, Publication 61, (Kansas City, Mo, 1954).

> is not enough [illegible]
> relief, and they drink [illegible] with
> friends or family [illegible]

Of course people in modern society also drink [illegible] of a refreshment, to comply with [illegible]. But in both eastern and primitive societies the use of alcoholic beverages in excess causes problems, both for the individual drinker and for his society.

Popular and ethnic myths of alcoholism are a mixture of many things, among them folklore, misinformation, and [illegible] misinformation. In an effort to up-grade public understanding, state alcoholism and treatment agencies have distributed tremendous masses of informational pamphlets, newspaper and magazine articles, television and radio programs. However, we must recognize that mere dissemination of information does not change attitudes, particularly in regard to health problems. Factual data are fundamental to the learning process, but they must have significance for the learner if they are to be incorporated into behavior patterns.

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One section of this study deals with physicians and alcoholism. A questionnaire was mailed to 1,715 physicians in Kansas. Data were requested on number of alcoholics treated, types of treatment, resources for referral, where they referred their alcoholic patients, and prognosis. Physicians were also requested to state their opinions as to the best type of treatment facilities and methods of financing such care. A 40% return resulted. Only 30% of the physicians reporting stated that they had treated no alcoholics during the past year. Fifty per cent reported having treated from one to five alcoholics.

In one New York state county a three year educational program for physicians was conducted. Block outlined it this way:

> "The program consisted of panel discussions, lectures, forums on alcoholism, clinics at the hospital, and a continuing distribution of descriptive literature being made available to the medical profession."[9]

At the end of the three year period, a survey was made of the 1,050 physicians in the county. Three hundred forty-five questionnaires were returned. It is estimated that about 668, or about two-thirds of the total number of physicians ever came in contact with an alcoholic patient. To the question, "Do you feel that since 1948 there has been an increased understanding on the part of the general public toward the problem of alcoholism?", seventy-six per cent of the 345 returns answered "Yes;" "No," was the answer given by fifteen per cent of the respondents.

Many attempts have been made to determine the scope of alcoholism and its relationship to present treatment facilities. One study was conducted by the Alcoholism Research Foundation of Toronto, Ontario.[10] This survey attempted to go into the scope of the problem within a particular county; classifications were offered as to the differences in alcoholism in terms of the addict, chronic drinker, and problem drinker.

The most significant piece of research, for purposes of this study, is that recently carried out by McCarthy for the Connecticut Commission on Alcoholism.[11] This study of educational facilities and attitudes focused on

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[9] M. A. Block, "The Physician and Alcoholism," American Practit. Dig. (Vol. 4, 1953) pp. 694-699.

[10] Alcoholism Research Foundation, Alcoholism in Ontario, a Survey of an Ontario County (Toronto, Ontario, 1953).

[11] McCarthy, Clinical Practice and Community Education on Alcoholism A research report on the program of the Connecticut Commission on Alcoholism. (New Haven, June, 1955), Connecticut Commission on Alcoholism.

[illegible]

the following two questions: (1) What are the existing beliefs and understandings of selected samples from Connecticut communities regarding the nature of alcoholism and the availability and type of treatment resources? (2) How can the Commission on Alcoholism sharpen its educational efforts?

The study used an individual interview of approximately 30 minutes in length. The first sample was drawn from the general population in six communities, the second sample was designed to consist of the members of the following professional disciplines in the same communities: judges and probation officers, social workers, physicians, clergymen, industrial nurses, public health nurses. The rationale behind the selection of these groups what that their professional duties placed them in a position to make referrals of alcoholics to treatment centers. The purpose of this portion of the education survey was to determine patterns of beliefs, attitudes and behaviors toward alcoholics among the selected professional groups.

In summarizing conclusions, McCarthy pointed out:

> While there are levels of sophistication in all groups, the social workers generally expressed a high degree of awareness of contemporary thinking about alcoholism, more consistantly than other professions. Most informants accept alcoholism as an illness not genetically transmitted, but differ regarding causation, treatability, and appropriate treatment approaches.[12]

These two findings have a significant bearing upon the present study.

An attempt was made to gain some picture of the interest shown by the social work, nursing, medical, and ministerial professions as reflected through journal articles. The following publications were reviewed for the past three years, (Jan., 1957-1959): Journal of the American Medical Association, American Journal of Nursing, Social Casework, and Christian Century. No attempt will be made to summarize all the articles on this subject, but to present a general picture of the amount and content of research reports in order that some reflection may be obtained as to the interest shown by the profession.

The Journal of the American Medical Society shows an increasing concern with this subject, as measured by the greater frequency of alcoholism articles in recent years. In each volume a report is presented by the Committee on Alcoholis of the American Medical Society. This report pulls together information on treatment methods, primarily a number of institutes conducted during the year on a cooperative basis with the state medical

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[12] IBID

societies. These institutes were conducted at annual meetings of the state societies and the purpose was stated as being "to educate the physician, particularly the general practioner, in the treatment of patients suffering from alcoholism."[13] This report makes a strong point of the fact that the local or state medical society must request an alcoholism institute before it can be brought into the community. Some references appear in the AMA Journal section entitled, "Queries and Minor Notes." This is a series of question and answer articles where the reader writes in a specific question. In one case, a physician asked "What is a definition and what are the symptoms and signs of alcoholism?" In this case the World Health Organization definition was given.[14] Beyond this, material on treatment methods form the bulk of writing in the AMA Journal particularly in regard to drug therapy.

The American Journal of Nursing very clearly points out the trend that is taking place in regard to professional interest in alcoholism. The 1957 volume has one listing in the bibliography for alcoholism, where the 1959 volume has a listing of seven articles. One article that appears to be representative is that in the 1957 volume entitled, "Helping the Alcoholic Patient," [15] This article covers the nurses role in the treatment process. The nurse in the following settings is discussed:

1. In hospitals, here the article points out that the "these people need nursing care that includes more than just treatment of the injury for which they are often confined."

2. In the home, here the public health nurse is given some clues as to recognizing symptoms of problem drinking.

3. In industry. Here some instructions for the industrial nurse in regard to conducting programs in health education and developing rapport with the worker who comes in on Monday morning with a serious headache. This article very coherently points out that nurses in all settings should know about the agencies in the community, not only AA, but also treatment facilities as referral resources.

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[13] Journal American Medical Society, "Report of AMA Committee on Alcoholism," (October, 1959) p. 1053.

[14] Definitions are cited in Chapter II, Methodology C.

[15] Mary Louise Brown, "Helping the Alcoholic Patient," American Journal of Nursing, 1957, Vol. 57, p. 312.

activities. [illegible] study groups [illegible] provisions, particularly [illegible] suffering from mental illness.[13] [illegible] fact that the [illegible] legislate before it [illegible] appear in the [illegible] annual [illegible] Thus in a degree of [illegible] in a [illegible] definition and [illegible] case the court [illegible][14] [illegible] material [illegible] particularly [illegible].

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[15] [illegible]

Difficulties were encountered in obtaining any clear picture of what is being printed in ministerial publications in regard to this problem. The magazine, "Christian Century," was used because of its broad circulation throughout the larger denominations. Only four articles were found to appear in the three-year sample of this publication. These articles in this writers' opinion were far from being representative of present thinking about the problem. More were concerned with the wet-dry issue than with the methods of working with the excessive drinker. This is pointed out very clearly in the following excerpt from the article by William D. Wayne:

> "We must face the fact that one great contribution that law can make to the control of alcoholism is the limitation of taverns and bars which serve alcohol by the drink. These places have their own special drinking patterns which cannot but lead to alcoholism. Worse than the old fashion saloon because of the increasing number of women, who frequent it--the dimly lit 'tavern' thrives by encouraging an atmosphere of unreality."[16]

By far the most extensive coverage to alcoholism treatment is provided in Social Casework. Here again, a certain increase in number of articles is shown within the more recent years; however, going back for the past six to eight years there appears to be at least some coverage in each volume. The following two articles indicate the tone and type of material presented.

A psychiatric social worker in the Philadelphia Counselling Center on Alcoholism points out some of the problems in responding to the emotional needs of the alcoholic. He states that too little is understood about recognizing emotional needs of the alcoholic. Alcoholism is described as a character disorder in which the alcoholism is systematic of deep-seated emotional disturbances. The author states:

> "The alcoholic's need differ from those of the so-called average person in intensity rather than in kind. The alcoholic gives direct expression to his feeling by acting them out rather than verbalizing them."[17]

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[16] Wayne D. Williams, Christian Century, Volumn 75, Part II, (November, 1958), p 1264.

[17] Anne C. Wenneis, Social Casework, "Responding to the Emotional Needs of the Alcoholic," April, 1957, p. 169.

Descriptive of the scene viewed in reclining may please if
what is being purveyed is commercial pleasure is more to this
purpose. The reclining climber, who was once leaning of its
broad expectation thoroughout the larger mountaineering. Only four
crevices were found to appear in the steep-but origin of the protractor.
These already is this writing' opinions were the first national representative
of persons climbing among the pursuit. It is more concerned with the sec-
ory issue when the sunrise or motives with the cooperative mediator.
This is pointed out very strongly in the following excerpt from the article
by MILLIGAN. He says:

> The most free to look that one great confusion
> that we do not to the climber's opinion is
> the climber in the hill. Climb please have their over
> around by this hill. Climb please have their over
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By far the most far-flung use [illegible] is signified as engaging in pursuits
in Capital Investing. Here again, in [illegible] mountain' activities
is shown within this more recent [illegible] activity. Climb rope for the pas-
to eight years there already to be at [illegible] in each village in each nature.
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> A particular second worker in the Alaskan Climbing Center to
> mountains pulls a new line of the problem to [illegible] the equipment
> needs of the climbers. It seems that [illegible] is mountaineering about
> recognizing eventual model of the early [illegible] is demanded an
> a climbing mountain [illegible] is a [illegible] of single-moved
> mountain [illegible]. (5) [illegible]

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16 Wayne C. Milligan, "[illegible] Is Number One," [illegible]
(January 1, [illegible]).

17 Mike C. Mountain, "[illegible] Climbing Is Number One," [illegible]
of the Alpine Club, [illegible].

The author describes how this can affect intake and how the client tests the worker and the worker's attitudes in becoming involved with the patient. The article further explains that:

> "The worker must be on guard lest he react as do family members when the patient is drinking. One feels very much in the middle of life situations, where more often than in work with other clients, one's own emotions and responses must be dealt with on a conscious level."[18]

Gene Sapir has some very pertinent things to say for this study in terms of alcoholism education.[19] The author points out that the main impact of treatment efforts should be on the public's attitude toward, and thinking about, alcohol and alcoholism. The author states that this is equally important in that segment of the public which has professional training and skill in the handling of personal and social problems. This is very much in line with the thesis upon which this study is based. The author goes on to state:

> "What the social worker himself thinks and feels about alcohol and alcoholics has great importance since he plays a vital part in situations involving the alcoholic."[20]

The thinking of Mrs. Sapir, as director of psychiatric social services for the Connecticut Commission on Alcoholism, points out the necessity of a special concern in the alcoholic as basic to the treatment process.

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[18] IBID

[19] Gene D. Sapir, Social Casework "The Alcoholic as an Agency Client," Vol. 38, July, 1957, p. 355

[20] IBID

CHAPTER III

METHODOLOGY

Early in this study it was recognized that if research findings were to be of value to the community, it would be necessary to secure the involvement of community leaders in developing the study focus and in implementing the findings; therefore, this study developed along lines similar to a research project conducted by a Council research staff member working with a lay-advisory group. The researcher's relationship to the Alcoholism Committee might be outlined in four steps, from which process the focus of the study emerged. Those four steps were as follows:

1. Development of the initial research focus, the sampling of those professionals who work most closely with the alcoholic. This came about through discussion with the executive director of the Michigan State Board of Alcoholism.

2. Presentation of the research problem, as then conceived, to the Lansing Committee on Alcoholism. After two years of functioning in this area, committee members were beginning to push for an action program. After the original focus of the study was outlined to this committee, rough draft copies of a proposed questionnaire were distributed to members as a means of stimulating reaction.

3. Appointment of Alcoholism Committee members to serve as a study advisory committee. These members were chosen because of their involvement in the professions under study. Their suggestions, handled largely through individual interviews, helped to shape the thinking of the research worker as the study design progressed.

4. Preparation of a revised study design and budget for the Michigan State Board of Alcoholism, since funds were granted by this board to cover costs of the study.

5. Preparation of questionnaire drafts and review with the committee members. Numerous drafts were prepared of the questionnaire with pre-testing taking place with individuals who were practicing in the four professions. The purpose being to provide in one questionnaire information that would be intelligible to four disciplines.

[illegible]

[illegible]

[illegible]

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[illegible]

[illegible]

[illegible]

6. Development of contacts with the various professional societies concerned.

As the result of interaction between committee members and the researcher, seven basic hypotheses were developed, falling roughly into three areas of concern. They were as follows:

I. About What Constitutes Alcoholism

A. Both within and between the four professions, significant differences exist in regard to understanding of the nature of alcoholism, and the type of treatment resources beneficial.

B. A conflict or ambivalence exists between respondents' theoretical knowledge of the nature of alcoholism and attitudes affecting actual referral and treatment practices.

II. About Treatment and Community Resources

A. The four professions studied are presently attempting to care for but a small portion of those who need help.

B. Referral of the alcoholic is not effectively handled.

C. The major community need is not new treatment facilities, but information and education to assist the professional in providing help and the alcoholic in seeking it.

III. About the Four Helping Professions

A. The worker's knowledge and interest in alcoholism as a treatable illness is basic to treatment success.

B. The most crucial need in providing services for the alcoholic is education of those now in a position to offer treatment.

In view of expense and difficulty in interviewing the number of respondents needed, it was decided that a self-administred structured questionnaire would be most effective. In a questionnaire of this type, it is possible to ask a large number of questions that can discriminate between people's knowledge of the subject with each question geared to a specific area. The combination of various responses for consistencies and inconsistencies then provided the basis for tables and generalizations.

C. [illegible]

[illegible]

[illegible]

I. [illegible]

A. [illegible]

B. [illegible]

II. [illegible]

A. [illegible]

B. [illegible]

C. [illegible]

III. [illegible]

A. [illegible]

B. [illegible]

[illegible] structured

[illegible]

Terminology became a serious problem in questionnaire construction, particularly from two standpoints. First, the questionnaire was being given to four different disciplines; therefore, a word such as "treatment" could have a different connotation for the psychiatrist, for instance, than for the minister. The term "alcoholism" itself posed a serious problem in terms of definition.

The word "alcoholism" has never been successfully defined. However, it is necessary to provide some type of bench mark against which to evaluate how different professions look upon the problem. Various definitions have been offered, many distinguishing between degrees of affliction, such as symptomatic drinking, addictive drinking, and alcoholism involving chronic disease or psychic deterioration. The World Health Organization has offered the following definition:

> "Any form of drinking, which in its extent, goes beyond the traditional and customary 'dietary' use or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behavior and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physio-pathological and metabolic influences."[21]

For the use of this research, a somewhat more effective definition is offered by the Ontario Research Foundation:

> "A person who habitually indulges in alcoholic beverages beyond the limits of the 'normal drinker.' Though he is still in control of his drinking, it has reached such a proportion that it is beginning to be a matter of concern to his family, employers, friends, or associates. Alcoholic beverages constitute a regular and considerable item in his budget. In the latter stages of problem drinking, work and family relationships usually begin to deteriorate."[22]

The real key to success of the study appeared to be the legitimation which it received. Committee members were useful in developing contacts for the researcher within their own profession. In addition it was

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[21] United Nations, World Health Organization, Expert Committee on Mental Health Report of the Alcoholism Sub-Committee, Technical Report Series No. 42, (Genevia, 1951), p. 5.

[22] Alcoholism Research Foundation, "Alcoholism in Ontario, A Survey of Ontario County" (Toronto, Ontario, 1953).

The drinking [illegible] particularly [illegible] given to [illegible] could have [illegible] than for [illegible] problem in terms of [illegible].

The word alcoholism has [illegible]. It is necessary to provide some type of [illegible] to evaluate how different [illegible] have been offered, [illegible] distinguishing [illegible] degrees of affliction, and as symptoms the drinking, [illegible] chronic disease or physical [illegible] has offered the following definition:

> "Any form of drinking which in its extent goes beyond the traditional and customary 'dietary' use or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behavior and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physiopathological and metabolic influences."[21]

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> "A person who habitually indulges in alcoholic beverages beyond the bounds of [illegible]. Though he is still in control of his drinking, it has reached such a proportion that it is [illegible] to his family, [illegible] constitute a [illegible] in this category. In the earlier stages of [illegible]."[22]

The real key to success of the study appeared to be the [illegible] which it required. [illegible] were useful in developing contacts for the researcher within their own [illegible]. In addition, it was

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[21] [illegible]

[22] [illegible]

possible to receive the sanction of the four professional organizations. Approval was gained, for instance, from the president of the Ingham County Medical Society and a cover letter was prepared by him. News releases appeared in the monthly newsletter prepared by the society. Announcements of the forthcoming questionnaire were made at medical society meetings. It was felt that this tie-in with the society was essential to successful return of questionnaires. The questionnaire itself was identified with the Community Services Council and the Lansing Committee on Alcoholism, but not with the research worker.

In the case of the ministerial group, contacts were developed through the Lansing Area Council of Churches. Here, again, notice of the coming questionnaire and the need for returns was handled through the ministerial association's newsletter and a cover letter was prepared by the director.

The Social Work group posed a serious question in terms of who constituted the profession and who should be sampled. It was decided that both trained social workers and practitioners without full graduate training were necessary if this group of helping personnel was to be fully represented.

As no accurate mailing list was available of all professional and non-professional workers employed in the community, the mailed questionnaire was not used in this case. The Social Work Club did prove to be a group apparently well-balanced in types of agencies represented and the training of individual members. Questionnaires were administered at the February monthly meeting of the club. Some seventy members were in attendance. This sample covered various agency settings such as the Bureau of Social Aid, Court workers, Family Service Agency, clinics and others. No doubt the findings of this group would have been considerably different if the sample had been limited to those holding membership in the National Association of Social Workers.

In the case of the nursing group, once more, special problems were encountered. First of all, there are a large number of nurses in the community who are not professionally employed at this time. Nursing could be generally categorized in three types of employment: hospital nurse, the largest group and the most significant in terms of relationship with the alcoholic patient; office nurses and other specialized areas of the practice; public health nurses.

It was decided to limit the sample to registered nurses. The questionnaire was administered at a meeting of the District Nurses Association. A small sample was received from this meeting as attendance was low. The sample was primarily in the area of public health nursing. In order to enlarge the sample, arrangements were made to sample the staff of one large hospital.

Differences in administration of the questionnaire had some effect upon the detail and thought which went into answering the questions. It was found that questionnaires administered at group meetings were not so adequately completed as those returned by mail. Group administered questionnaires tended to have a larger number of no-answers for fill-in or open-ended questions.

Mimeographing and mailing of the questionnaires, assistance was given by the Volunteer Bureau of the Community Services Council. In addition, tabulation of the questionnaire was facilitated by the use of IBM facilities at Michigan State University's Tabulation Center. Some hand coding was completed by volunteers.

The following table outlines the response by profession.

TABLE 1

SIZE OF SAMPLE BY PROFESSIONAL GROUPS

Profession	Number Employed in Community	Tabulated Returns	Per cent of Total Profession
Clergy*	267	83	31%
Nurses**	300	90	30%
Physicians[1]			
Medical Doctors	105	63	34%
Osteopaths'	35	34	97%
Social Workers**	200	67	34%

[1]Total returns for all physicians is 97, or 49% of those employed in community.

*Mailed Questionnaire

**Group Administered Questionnaire

[1]

*

**

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Replies were received from 337 respondents, as shown in Table One. Not all respondents replied to all questions. This fact in itself not only poses a problem in tabulation, but suggests a certain ambivalence or uncertainty of knowledge in this subject matter. The open-ended, fill-in type questions show a preponderence of no answers. Findings in some cases are based on little over fifty per cent of the total sample; however, when this situation occurs possible explanations will be given for the large percentage of no answers.

Knowledge of What Constitutes Alcoholism

Each of the respondents was asked to define the nature of alcoholism, as he understood it. This was done in two ways. First, an open-ended, fill-in type of question: "From your understanding, how does one become an alcoholic?" permitted the respondent to characterize alcoholism in his own words. The second, asked for a "Yes" or "No" answer to the following statement: "Alcoholism is an illness characterized by underlying emotional problems."

The responses to the open-ended question could be grouped, depending on their emphasis, into three major catagories. They are: those stressing psychological reasons, those stressing alcohol itself as the essential factor in causation, and those stressing environmental factors. There were additional miscellaneous replies that did not fall into any clear-cut category.

FINDING: ONE HUNDRED AND EIGHTEEN OR 43% OF ALL RESPONDENTS TO THIS QUESTION VIEWED ALCOHOLISM AS CAUSED PRIMARILY BY PSYCHOLOGICAL PROBLEMS.

TABLE 2

DISTRIBUTION OF MAJOR CAUSATIVE FACTORS

Causes of Alcoholism	Respondents Choosing Cause Number	%
Primarily mental or psychogenic	118	43
Primarily alcohol	100	37
Outgrowth of environment	12	4
Other	42	16

A large portion of the responses in the "other" grouping of Table 2 included some recognition of psychological factors in causation as one of numerous factors rather than as the major cause.

A small number of respondents, mostly in the ministerial group, replied in terms of what might be categorized as moral or ethical causes of alcoholism.

The Connecticut Study by McCarthy, as discussed earlier (page 9), asked the question: "How does one become an alcoholic?" Fifty per cent of the respondents in the general population sample explained alcoholism in terms of psychological factors. This cannot be considered as a fair comparison with the 43% in this study as the tabulation here was in terms of those who saw psychological factors as the major causation.

There were, however, significant differences among the professions in the extent to which they stressed psychological factors. Table 3 indicates that physicians had a larger proportion of responses in this category than any of the other groups, whereas the ministers were substantially below the average for all respondents in stressing psychological factors. Instead, ministers more than any other group saw alcohol as the essential element in alcoholism.

TABLE 3

RELATIONSHIP BETWEEN PROFESSION

AND

UNDERSTANDING OF CAUSATION

Cause	Physicians No.	%	Ministers No.	%	Nurses No.	%	Social Workers No.	%
Primarily mental or psychogenic	37	53	19	28	35	45	27	47
Primarily alcohol	19	27	33	49	29	38	19	33
Primarily out-growth of environment	4	6	3	4	4	5	1	2
Other	10	14	13	19	9	12	10	18
Total	70	100	68	100	77	100	57	100

The replies to this question were not entirely consistent with another question designed to elicit similar information. Instead of being open-ended, this question asked for a "Yes" or "No" response to the statement: "Alcoholism is an illness characterized by underlying emotional problems." Eighty-eight per cent of the respondents to this question answered "Yes". Almost all the respondents thus recognised alcoholism as being associated with emotional problems, but only forty-three per cent of them indicated, without question that they saw psychological factors as the most essential element in alcoholism.

A possible explanation of this inconsistency is that the "Yes" answer to the emotional problems question represents a stereotyped response, reflecting a degree of public sophistication that has grown up in this area and which leads people to give at least partial awareness to the notion of emotional problems; but that the more deeply ingrained beliefs and attitudes were actually reflected in the responses to the open-ended question.

In the design of the questionnaire, it was assumed that a person's estimate of the extent or incidence of alcoholism might be a useful clue in determining his concept of the illness. Respondents were therefore asked to state how many people in the Greater Lansing area they thought were alcoholic at this time. The following suggestions as to magnitude were offered: 200; 2,000; 4,000; 6,000; 8,000; 10,000; and 20,000. The area population was listed as 240,000. Table 4 shows the distribution of responses.

TABLE 4

ESTIMATE OF NUMBER OF ALCOHOLICS IN LANSING AREA
BY
EACH PROFESSION

Estimate No. of alcoholics in Lansing	Number of Professionals Making Estimates							
	Physicians		Clergy		Nurses		Social Workers	
	No.	%	No.	%	No.	%	No.	%
200-3,000	29	30	7	8	24	27	3	5
4,000-8,000	25	26	37	45	34	38	37	55
10,000-20,000	25	26	18	22	21	23	19	28
No Answer	18	18	21	25	11	12	8	12
Total	97	100	83	100	90	100	67	100

There is striking simularity in the responses for all four professions. Fifty-three per cent of the ministers, 56% of the physicians, 60% of the social workers, and 65% of the nurses estimate the number of alcoholics to be less than 8,000.

The Jellinick Formula estimates the number of alcoholics in the Lansing area to be between 5,000 and 6,000. As no respondent could be expected to have an exact knowledge of the number in the community, the range of 4,000 to 8,000 as shown in the Table above would seem to be a good estimate for the number of alcoholics in the Lansing area.

[illegible]

TABLE I

[illegible]

[illegible]

[illegible]	Number of Professionals Holding Certificates							
	[illegible]		[illegible]		[illegible]		[illegible]	
[illegible]	No.	%	No.	%	No.	%	No.	%
2500-3,000	69	70	7	8	24	27	3	4
3,000-5,000	89	86	11	10	[illegible]		17	15
10,000-20,000	60	7	14	25	21	23	19	45
No Answer	16	17	23	28	11	12	5	12
Total	37	100	45	100	90	100	47	100

[illegible]

[illegible]

A serious problem is encountered in attempting to define what an alcoholic is. In designing this question, it was felt that what the person views the number of alcoholics to be would be one measure of how he defines alcoholism. To some, the alcoholic is a person who drinks regardless of amount or effect on the individual. Most commonly accepted definitions include some reference to a person's conflicts with his family life and his employment as a basis for suggesting that the person is either in the process of becoming an alcoholic or has reached that stage.

One first reaction to the question of scope might be that the ministers tend to view the number of alcoholics as higher than other groups, however, this is not true. Many ministers did check 20,000 and more as the number of alcoholics in the community. This would tend to show that the ministers see alcoholism and social drinking as synonymous, however, averaging the responses of all the ministers together, this profession seems to show a realistic understanding of the scope of the problem. The response of the Social Work group is very similar to that of the ministerial profession. However, if any generalizations might be made upon the basis of the table, it would seem that the criterion of scope in itself does not provide a meaningful measure of alcoholism knowledge. It is very possible that one might take this measure together with the measure listed in Table 2, Causation, and be able to arrive at some generalization as to the professional's understanding of what constitutes alcoholism.

FINDING: SIGNIFICANT DIFFERENCES EXIST BETWEEN PROFESSIONALS IN THEIR VIEW OF THE NUMBER OF ALCOHOLICS THAT CAN BE HELPED.

TABLE 5

ESTIMATES BY PROFESSIONAL GROUPS OF PERCENTAGE OF ALCOHOLICS WHO CAN BE HELPED

Per cent of Profession	Estimated Per Cent Who Can Be Helped: 50% or more	Estimated Per Cent Who Can Be Helped: less than 50%	Per Cent of Professionals Not Answering
Physician	43	50	7
Clergy	58	31	11
Nurse	53	40	7
Social Work	36	58	6

This table can be considered a third measure of the individual's conception of what constitutes alcoholism. There are significant differences between professionals in regard to estimates they make of the number of alcoholics that can be helped. In this question, "Help" was not defined, but it would probably be perceived by the professional in terms of the help which he has to offer. In response to an earlier question, ninety-eight per cent of all of the respondents stated that they either agreed or strongly agreed that alcoholics can be helped. Six, or 1.5%, stated that they did not feel alcoholics could be helped; however, as we can see from Table 5 the professions differed in regard to the degree of success which they thought could be achieved.

Nineteen per cent of the physicians were very skeptical about help for the alcoholic, whereas another 11% of the same profession were optimistic feeling that from 75-100% of the alcoholics can be helped--the largest group falling within the middle range of 25-74% success.

The clergy tends to be somewhat more optimistic about help for the alcoholic than do the other three professions. By far the largest group

Adjectives	13	20	7
Clergy	9	1	12
Nurse	11	—	7
Doctor's wife	3	—	4

felt that 50-74% could be helped. The responses from the nursing group are very similar to the clergy. Social Workers appears to be somewhat more conservative than the other three professions in terms of per cent that can be helped.

Although 90% of the respondents to this questionnaire stated that they agreed that alcoholics can be helped, there was no consistency among them in regard to the per cent alcoholics who they thought could be helped. About 9% were unwilling to commit themselves on the per cent that can be helped.

METHOD OF TREATMENT AND REFERRAL

FINDING: ALL FOUR PROFESSIONS RATE ALCOHOLICS ANONYMOUS AS THE MOST EFFECTIVE METHOD IN HELPING THE ALCOHOLIC. PSYCHOTHERAPY IS CONSIDERED THE SECOND MOST IMPORTANT METHOD, WITH THE EXCEPTION OF MINISTERS WHO RANK PASTORAL COUNSELLING SECOND TO AA.

TABLE 6

METHOD OF HELPING ALCOHOLIC CONSIDERED EFFECTIVE
BY
EACH PROFESSION

Method	Physician %	Clergy %	Nurse %	Social Worker %
AA	91	87	87	96
Psychotherapy	75	54	73	58
Medical Care	44	37	43	49
Case Work	22	27	30	57
Pastoral Counselling	33	39	27	36
Institutional Care	46	39	27	36

The treatment methods in the above table are not mutually exclusive categories. The respondents were asked to check the method, or combination of methods, they felt to be effective in helping the alcoholic. In terms of method considered most effective, there seems to be mutual agreement on Alcoholics Anonymous. There is no real way of knowing how many of these respondents viewed AA alone or AA in combination with other methods; however, as a general observation based on the authors tabulation of this question, there were very few professionals that did not check at least one response in addition to AA. The one common tie that runs through almost all responses is AA plus one or more other treatment methods.

The second most commonly accepted method is that of psychotherapy. The term psychotherapy was not defined in the questionnaire and was probably viewed differently by each profession; for example, the physicians probably viewed psychotherapy as being carried out only by the psychiatrist, whereas the social worker may have viewed psychotherapy as a method which he is using. Only 54% of the ministers checked psychotherapy, while 75% checked pastoral counselling. It might be assumed on the basis of this finding that the minister is less apt to call for psychiatric assistance in working with the alcoholic than are the other three professions.

The most striking difference pointed out in this table is the difference in regard to medical care, casework treatment, and pastorial counselling among the four professions. Physicians ranked medical care as the third highest treatment method, whereas the clergy ranked medical care fifth. Therefore, the observation can be offered that doctors consider medical care to be more effective in helping the alcoholic than do ministers; but less effective than the ranking given by nurses and social workers. Seventy five per cent of the ministers checked pastoral counselling as a treatment method and thereby ranking this second, even above psychotherapy, whereas the doctors ranked pastoral counselling fifth, nurses ranked it third, and the social workers ranked ministerial counselling last. This points out some significant differences in emphasis among the four groups which might cause difficulties in making referrals.

The social workers ranked psychotherapy and casework almost equally. This in itself is an interesting observation and might suggest that the individual who feels casework to be effective also feels psychotherapy to be an effective method. However, the ministers, the nurses, and the physicians seem to have very little regard for the validity of case work as a treatment method. Both physicians and clergy ranked this method sixth or last in terms of effectiveness, and the nurses giving it a ranking of five, next to last.

The nursing group offers two important observations here. First, the nurses and doctors view medical care similarly. Secondly, the nurses seem to put more stress upon pastoral counselling than do the doctors or social workers. Institutional care is a method closely involving the nursing profession, but the nurses rank this as least effective.

FINDING: THE MAJORITY OF THOSE WORKING WITH THE ALCOHOLIC CLIENT CARE FOR LESS THAN FIVE ALCOHOLICS PER YEAR.

TABLE 7

Profession	Mean Number Cared For
Physician	4.4
Clergy	4.3
Nurse	4.4
Social Work	4.0

The arithmetic mean in the above table is not based on the total number answering the question, but those who state they have attempted to care for one or more alcoholics in the past year. This question was worded: "How many alcoholics have you attempted to care for in the past year?" and tabulated as grouped data. The groupings were: 1-5, 6-10, 11-15, and over 15. The mean number of alcoholics cared for during the year, based upon all respondents to the questionnaire, falls slightly under two.

This would tend to show that the amount of contact which one professional has with this particular problem in a given year is very small. Whether this is due to the worker's inability to recognize the problem or a reflection of the small number of alcoholics seeking help, it is impossible to say.

The social worker [illegible]
This is itself [illegible]
individuals who would [illegible]
be an effective [illegible]
physicians seem to have very little [illegible]
as a therapeutic method. [illegible]
or last in terms of effectiveness, [illegible]
five, next to last.

The nursing group [illegible]
the nurses [illegible]
seem to [illegible]
actual work [illegible]
production, [illegible]

Finally [illegible]
[illegible]

Table 7

Profession	Effectiveness Rating
Physicians	[illegible]
Clergy	[illegible]
Nurses	[illegible]
Social Work	[illegible]

The arithmetic mean for the above [illegible]
number of answers [illegible]
care for one or more [illegible]
whether [illegible]
years" and tabulated [illegible]
and over 15. [illegible]
based upon all respondents [illegible]

This would seem [illegible]
[illegible]
[illegible]
[illegible]
[illegible]

In terms of extreme values, it might be observed that in the social work group one respondent stated that he had cared for 650 alcoholics in the past year; and one respondent in the ministerial group stated that he had cared for 200. As can be seen from these responses, the meaning for the word "care" has different connotation for different respondents. The type of care provided by an organization, such as the Salvation Army, might involve little more than providing a meal and over-night quarters; whereas, the type of help provided by a caseworker or psychiatrist could involve hundreds of hours. Also, in terms of extreme values it might be pointed out that one physician estimated that he had cared for fifty alcoholics in the past year and four physicians estimated that they had cared for eighteen to twenty-five.

In breaking the medical profession into three groups, osteopaths, general practioners, and specialists, we find there is no significant difference between osteopaths and other general practioners in number cared for. The medical specialists average somewhat higher in number cared for than other physicians. Alcoholism is generally considered a problem most commonly seen by the general practioner, however, in terms of average number of alcoholics cared for, this is not true for this sample of the medical group.

TABLE 8

TOTAL NUMBER OF REFERRALS MADE

BY

EACH PROFESSION DURING PAST YEAR

Profession	Number of Alcoholic Referrals made during past year	Per Cent of Professionals Making No Referrals or not Answering Question
Physician	203	50
Clergy	97	63
Nurse	60	86
Social Worker	95	64

In terms of relative volume it only just exceeds that of a medium sized [illegible]

Table 8

[illegible]

[illegible]

Production	[illegible]	[illegible]
Digestion	[illegible]	[illegible]
Clothing	[illegible]	[illegible]
Income	[illegible]	[illegible]
Direct taxes	[illegible]	[illegible]

The most striking thing about Table 9 is the large percentage of each profession that either did not answer the question or stated they had made no alcoholic referrals during the past year. This was an open-ended question stating: "How many alcoholics have you attempted to refer to other resources during the past year?" This table further substantiates the assumption that only a small group within each profession is actively involved in helping the alcoholic.

No doubt the very practice of referral differs greatly with the profession. To the doctors it is possible that many of the 208 referrals listed involved little more than the physician suggesting to the patient that he see a specialist, attend an AA meeting, or go to the Family Service Agency. In such cases, no contact being made with the agency to which the individual is being referred.

However, referral as handled by a qualified social worker would tend to involve more work with the client in helping him to recognize the need for referral and some contact with the agency receiving the referral. It is impossible to determine how many of the alcoholic referrals shown in Table 9 were successful. This would no doubt be a much smaller figure than shown above. The next question to be asked about referral practices is, who uses what resources.

FINDING: SIGNIFICANT DIFFERENCES EXIST BETWEEN THE FOUR PROFESSIONS IN REGARD TO THE TYPE OF REFERRAL MADE.

TABLE 9

REFERRAL RESOURCES USED BY MEMBERS OF THE FOUR PROFESSIONS

Referral Resource	Number of Members of Profession Using Resource				
	Physician	Clergy	Nurse	Social Worker	Total
AA	23	24	9	17	73
Social Work Agency	7	4	1	9	21
Physician	4	5	1	5	15
Minister	4		1	4	9
Hospital	10	2	1	4	17
Psychiatrist	23	2	2	6	33
Alcoholism Clinic	3	2	1	4	10
No answer	47	52	79	40	218

The next ... (Table 9) ... the percentage of each profession ... that they had made no alcoholic referrals during the past year. There was an open-ended question ... to refer to other resources during the past year ... substantiates the assumption that only a small group within each profession is actively involved in helping the alcoholic.

No doubt the very practice of referral differs greatly with the profession. To the doctors it is possible that many of the referrals listed involved little more than the physician suggesting to the patient that he see a specialist, attend an AA meeting, or go to the Family Service Agency. In such cases, no contact being made with the agency to which the individual is being referred.

However, referral as handled by a qualified social worker would tend to involve more work with the client in helping him to recognize the need for referral and some contact with the agency receiving the referral. It is impossible to determine how many of the alcoholic referrals shown in Table 9 were successful. This would no doubt be a much smaller figure than shown above. The next question to be asked about referral practices is, who uses what resources.

FINDING: SIGNIFICANT DIFFERENCES EXIST BETWEEN THE FOUR PROFESSIONS IN REGARD TO THE TYPE OF REFERRAL MADE.

TABLE 9

REFERRAL RESOURCES USED BY MEMBERS OF THE FOUR PROFESSIONS

Referral Resource	Number of Members of the Professions Giving Referral				
	Physician	Clergy	Nurse	Social Worker	Total
AA	27	24	4	17	72
Social Work Agency	7	4	1	[illegible]	21
Physician	4	5	1	5	15
Minister	4		1	4	9
Hospital	10	2	1	4	17
Psychiatrist	[illegible]	2	[illegible]	[illegible]	[illegible]
Alcoholism Clinic	3	2	1	4	10
No answer	17	22	[illegible]	[illegible]	[illegible]

The three most common resources of referral in ranking order are: Alcoholics Anonymous--73 referrals; psychiatrists--33 referrals; social work agency--21 referrals. The number of professionals using Alcoholics Anonymous would seem to be in line with the earlier discussion, presented in Table 5, where between 87 and 96% of the respondents considered AA to be an effective method of treatment; however, the number of respondents using the psychiatrist and the social worker is high in terms of the findings of Table 6. By far the largest number of references to the psychiatrist were made by the physicians. It is significant to note that twenty-three physicians listed both AA and psychiatrist as a resource. It is impossible to determine whether these were the same practioners although it would appear that many medical practioners consider a combination of AA and psychiatric help to be an effective treatment method.

The ministerial group shows very few referrals made to any source other than Alcoholics Anonymous. Whether the reason for this is the ministers lack of knowledge of community resources of the strong belief of this group in AA, it is not possible to determine. An important observation in the ministerial group may be made in terms of the number of referrals made to ministers. Only nine respondents stated they had made a referral to a minister, this being the smallest number of referrals made to any of the professions or agencies listed. Ministers report working with a large number of alcoholics; however, it would appear that most of the alcoholics come to them directly and not from a referral.

The largest number of referrals made by social workers other than AA were those made to social work agencies. As shown in the above table, nine social workers signified they made referrals to social work agencies, out of twenty-one for the total sample. Social workers also tended to use physicians and psychiatrists frequently. A total of eleven social workers listed referrals were made to physicians.

The nursing group shows very few referrals made. The largest number being Alcoholics Anonymous, beyond this very little contact with any other referral resources. This table also points out the number of referrals made to alcoholism clinics. These being places outside of the Lansing community; such as, Brighton Hospital and Alcoholism Treatment facilities in Grand Rapids, and other neighboring communities.

FINDING: WORK WITH ALCOHOLICS IS GENERALLY RATED AS DIFFICULT IN COMPARISON WITH WORK WITH OTHER CLIENTS.

TABLE 10

RATING OF WORK WITH ALCOHOLICS

Rating	Physicians No.	%	Clergy No.	%	Nurses No.	%	Social Workers No.	%
Not too difficult	6	6	3	4	4	6	4	6
Average	9	9	12	15	18	20	4	6
Difficult	58	60	60	72	34	38	35	52
Impossible to help	7	7	1	1	0	0	3	5
No answer	17	18	7	8	33	36	21	32
Total	97		83		90		67	

The above table is in response to the following question: "How do you rate working with alcoholics in comparison to other problems presented by your clientele?" As can be observed, a consistently large group in each profession states that their work with alcoholics is more difficult than other clients. This is somewhat lower in terms of the nursing group; only 38% rate work with the alcoholics as difficult, whereas 60% of the physicians and 72% of the clergy rated this as difficult. However, it might be observed that the nursing group comes in contact with a small number of alcoholics as presented in the earlier tables and as reflected in the large number of no answers to the above question.

The rating entitled, "Impossible to help" was checked by some physicians and social workers. The largest per cent being with the physicians. In correlating this table with an earlier question entitled, "What per cent success would you estimate," it was found that the percentage of success estimated by physicians was consistent with the difficulty that the physicians expressed in this table. The large number of no answers to this question, would tend to point out difficulty in answering. This

difficulty could very well be due to inexperience in working with alcoholics, or even more important the respondents uncertainty in offering an opinion on the subject.

FINDING: FOR EACH PROFESSIONAL GROUP, THERE IS A DIRECT RELATIONSHIP BETWEEN CONTACT WITH ALCOHOLICS AND THOSE SEEING COUNSELLING AS PART OF THEIR JOB.

TABLE 11

PROFESSIONALS WHO HAVE CONTACT WITH ALCOHOLICS

COMPARED WITH THOSE

WHO SEE COUNSELLING AS PART OF THEIR JOB

No. Contact and Counselling	Physicians No.	%	Clergy No.	%	Nurses No.	%	Social Worker No.	%	Total Number
Number who have contact with alcoholic.	75	77	75	90	56	62	45	67	251
Number who see Counselling as part of job.	64	66	81	98	41	46	41	61	227

Ninety per cent of the ministers signified that they come in contact with alcoholics and particularly all the ministers, ninety-eight per cent say that they see counselling as part of their job. The physicians, nurses, and social workers all show a lower per cent contact with the alcoholic and less involvement in counselling as part of their job. It is interesting to note that of the nursing group only 46% see counselling as part of their job, but 62% stated that they come in contact with the alcoholic. On the basis of this finding, it might be assumed that further education would be helpful in terms of helping the nurse use referral resources as her job may not involve direct counselling.

In all four professions, the per cent who come in contact with the alcoholic is surprisingly high; particularly when this is considered in terms of the number who signify they have treated or cared for alcoholics within the past year.

FINDING: A SIGNIFICANTLY LARGE PERCENTAGE IN EACH PROFESSION CONSIDERED ALCOHOLISM KNOWLEDGE IN THE GENERAL PUBLIC AND THEIR PROFESSION TO BE INCREASING.

TABLE 12

PER CENT WHO STATE KNOWLEDGE OF ALCOHOLISM HAS INCREASED IN THE PAST TEN YEARS AND IS IMPORTANCE IN MY PROFESSION

Profession	Alcoholism Knowledge has Increased in the General Public %	Is Important in My Profession %
Physician	89	87
Clergy	76	87
Nurses	89	91
Social Worker	91	90
Average	87	88

As reported earlier in the review of the literature, a survey in one New York County of physicians showed that 76% answered "Yes" to the question: "Do you feel that since 1940 there has been an increased understanding on the part of the general public toward the problem of alcoholism." The above table shows that 89% of the physicians in the Lansing area report that alcoholism knowledge in the general public has increased.

The second part of this table was drawn from the following question: "In your opinion is the need for education of members of your profession important, not too important, not needed at all?" As shown in the above table 87 to 90%, or an average of 88%, of all those responding to this question felt that education was important within their profession. The high percentages shown in response to this question would seem to point out that the respondents felt the desire for further knowledge about the nature of alcoholism and how to work with the alcoholic client.

Some Observations on Community Needs

When asked the question: "Are the current resources in Lansing adequate, not too adequate, inadequate," 52% of those responding to this question stated, "No." All four professions agreed that the two most important needs were:

1. An information, counselling, and referral center.
2. An alcoholism treatment center.

The physicians group reversed the above order and ranked the treatment center as being more important than an information and educational center. In response to an open-ended question asking the respondent what action he felt the Lansing Committee on Alcoholism should take, by far the largest response, totaling some 90% stated the greatest need was education. Education was defined in many different terms from education to prohibit drinking, to detailed descriptions of community educational programs. However, this is quite significant in terms of the purpose for which this study was set up. The purpose being to first determine if the current resources in Lansing were adequately meeting the needs of alcoholics. Secondly, what the knowledge of the professionals was; and third, what type of resources would be needed. The response of the four professions studied in this questionnaire offers validity to present trends in alcoholism education. That is efforts be geared toward helping the alcoholic seek treatment, and helping the professional to better equip himself to provide treatment.

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2. [illegible] [illegible] [illegible].

Important notes are:

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Most [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

FINDING: PROFESSIONALS BECOME INFORMED OF COMMUNITY ACTIVITIES THROUGH DIFFERENT MEDIA.

TABLE 13

KNOWLEDGE OF LANSING ALCOHOLISM COMMITTEE

AND

SOURCE OF KNOWLEDGE

Profession	Number Who Have Previously Heard of Committee	Source of Knowledge of Committee
Physician	55	Professional Meeting Newspaper
Clergy	32	Community Services Council Professional Meetings
Nurses	35	Professional Meetings Newspaper
Social Worker	53	Community Services Council Newspaper

The above table points out that the social workers and doctors appear to be better informed about the Lansing Committee on Alcoholism than do nurses and clergy. As the Lansing Committee on Alcoholism is a project of the Community Services Council, it might be expected that social workers would be somewhat more informed; however, it is encouraging to note that physicians show a significant involvement to have been familiar with the committee's existence. The clergy group shows a surprisingly low amount of awareness of the committee's existence.

In terms of how knowledge is gained, it appears that the most important sources are Community Services Council publications, meetings, and professional meetings. Next most important media would be the newspaper. The doctors seemed to be the best informed through their professional meetings. The medical nursing groups show the same ranking, however, the clergy and the social workers both list Community Services Council as the first source of knowledge and professional meetings as the second source.

Profession	Number who have [illegible]	[illegible]
Physician	35	Professional Worker
Clergy	34	Generally Considered Member of Professional Class
Nurses	30	Professional Worker & Counselor
Social Worker	35	Generally Considered a Member of Profession

The above table points out that the social workers and doctors appear to be better informed about the Learning Disabilities or Alcoholism than do nurses and clergy. As the Learning Disability or Alcoholism is a problem of the Community Services Council, it might be argued that social workers would be somewhat more informed; however, in examining to note that physicians show a significant involvement to Learn Their Cellular with a committee's existence. The clergy group shows a surprisingly low amount of awareness of the committee's existence.

In terms of how knowledge is gained, it appears that the most significant sources are Community Services Council publications, Practicing [illegible] meetings. Next most important source is clinical [illegible]. It is [illegible] observed to be that [illegible] [illegible] [illegible]. The medical workers would [illegible] [illegible] [illegible] knowledge and [illegible] [illegible] [illegible].

CHAPTER V

GENERALIZATIONS AND CONCLUSIONS

Alcoholism has been shown to be a problem not new to man, but only recently recognized as an illness.

Popular understanding of alcoholism is a mixture of many things---folklore, misinformation, and defensive rationalization. Professional understanding reflects the popular understanding but is hopefully enhanced by experience in working with those afflicted by the illness, reading current literature on the subject, and by education.

This study has been concerned with determining alcoholism knowledge and interest possessed by the members of four helping professions. More specifically, focus has been as follows:

1. To determine some measure of the respondent's understanding of what constitutes alcoholism.

2. To determine the respondent's interest in this problem.

3. To ascertain respondent's involvement in working with the alcoholic client or patient.

4. To gain information on the types of resources needed within the community to meet this problem.

The following summary is an attempt to draw together the basic assumptions of the study with the findings and to come up with some generalizations and conclusions in regard to each of the four areas.

Understanding of Professional Groups As To What Constitutes Alcoholism

It was assumed that both within and among the four professions significant differences exist in regard to the nature of alcoholism and the type of resources considered beneficial. Three measures were used to evaluate the respondents' understanding of alcoholism. These were: causation, scope, and understanding of how and by whom the alcoholic can be helped.

Most respondents generally accept alcoholism as an illness caused by psychological factors. However, forty-nine percent of the ministers felt that alcohol was the primary causitive factor. In general, social workers and physicians possess a higher degree of sophistication on this subject in terms of current thinking than other professions; however, within each profession significant differences exist in regard to knowledge of causation, treatment, and resources needed. A high degree of consistency was shown in regard to the use of Alcoholics Anonymous as the most effective treatment resource.

It was hypothesized that a consistent relationship did not exist between the respondent's knowledge of the nature of the illness and the respondents' beliefs and attitudes about treatment. Between 87 and 96% of the respondents offered Alcoholics Anonymous as a method for helping the alcoholic. The number suggesting psychotherapy, medical care, casework, or other types of treatment were all ~~covered~~ lower. The most commonly accepted causation was that alcoholism is an illness characterized by underlying emotional problems. Eighty-eight percent of the respondents offered this opinion. There would thus seem to be a contradiction between concept of causation and method of treatment, or at least a lack of confidence that professional psychological help is entirely effective with alcoholics, although the problem may be psychologically rooted.

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Professional Interest and Involvement in Working with the Alcoholic

It was hypothesized that the four professions studied are attempting to care for but a small portion of those in need of help. Although no generalizations can be given as to the total number of alcoholics being treated or cared for in the community, it can be assumed on the basis of this sample that the mean number of alcoholics seen by the four professions is less than four per year. The average number of alcoholics helped based upon the total sample of 344 respondents would fall under two per worker. It has been pointed out that according to the Jellinek formula, the Lansing area has between five and six thousand individuals suffering from this problem. Although the average number of alcoholics treated per worker is two, this does not provide a very accurate picture. In actuality there is a small core group within each profession treating alcoholics while the remaining members of the profession have little or no contact with this client.

It was also hypothesized that the referral of the alcoholic client is not effectively handled. The data in this study were not adequate to permit as thorough an analysis as might have been wished of this question. It was found that the methods of helping the alcoholic vary greatly with each profession. Physicians, ministers, and social workers each rate the method they provide higher than the other two helping professions. An exception to this would be the case of the nursing group. It was found that in each profession the number of alcoholics treated seemed to parallel closely the number of referrals made.

Information on Community Resources

A further assumption was made that the need in the Lansing community was not for new treatment facilities, but for information and education to assist the alcoholic in seeking help and the professional in providing help. It has not been possible in the focus of this study to analysize the existing network of agency services and to determine where gaps may exist. An area of further research could very well be to determine the reasons why the alcoholic is not seeking treatment from these sources. It was found

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that 92% of the respondents to the question: "Are the current resources in Lansing adequate?" stated "No." These respondents went on to state that the major needs in the community were as follows:

1. An Information, Counselling, and Referral Center
2. An Alcoholism Treatment Center

This is an important observation in terms of the thesis upon which this study was established. The major need is for community and professional education. This need was recognized by a large per cent of those presently working in the four helping professions.

It seems on the basis of this study that those who are working closely with the alcoholic have a higher degree of knowledge of the problem and of community needs, than do the professionals who are not working with any alcoholics. Within each profession wide differences exist in terms of the individual's involvement in the problem of alcoholism. It might be assumed on this basis, that there are parallel differences in the individual professional's interest in working with the alcoholic. A small core group exists in each profession that is vitally interested in alcoholism and actively treating and referring the alcoholic patient or client.

In terms of community education, it was found that the media most successful vary with the profession. The most influential means of communication of the activities of the Lansing Committee on Alcoholism are professional meetings, Community Services Council meetings and literature, and newspaper articles. Thirty-two to fifty-five per cent of the respondents had previously heard of the Lansing Committee and were aware of its functioning. No doubt the establishment of an Alcoholism Information Center would greatly increase the individual's awareness of this problem and of the facilities for treatment.

Implications for the Community

This study has attempted a two-fold purpose:

1. Some general information on professional knowledge of alcoholism.
2. Specific data on community needs

It is clear from this study that members of the four helping professions---social workers, doctors, nurses, and clergy---recognize the need for further

greatly increase the individual's awareness of his problem and of the facilities in their area.

[illegible]

This study has also led to the following recommendations:

1. [illegible]
   [illegible]

2. [illegible]

It is clear from this study that [illegible] social workers, doctors, [illegible] the [illegible] the [illegible]

information and education on alcoholism as an illness, and on treatment resources available. The recommendation can then be offered that an Alcoholism Information and Referral Center be established for the purpose of organizing and stimulating interest among the general public and among members of the helping professions, in working with alcoholics. This would involve working not only with those professions studied in this project, but also with educators, lawyers, law-enforcement groups, industry, and the general population in order to help them become aware of the problems presented by this illness and the resources available for treatment.

Implications for Further Research

This study and the study by McCarthy, referred to previously, are but beginning efforts to analyize the knowledge and attitudes of groups in regard to alcoholism. Further research might be conducted in terms of a more detailed analysis of one profession in more than one community. Other studies might direct the same kinds of questions to the general public.

Should an Alcoholism Information Center be established, it would be appropriate to conduct a follow-up study sometime in the future in order to evaluate the effect of such a center on the attitudes of professional groups.

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APPENDIX

1-3

Lansing Committee on Alcoholism
Community Services Council
QUESTIONNAIRE*

Your cooperation is asked in filling out the enclosed questionnaire in an effort to gain certain information about Alcoholism knowledge among major treatment and referral professions. This questionnaire is being given to physicians, judges, police officers, clergy, nurses, and social workers in the Lansing area. Please do not sign your name.

4-5 **Profession:**

____ Physician. . . . . .Speciality _____
____ Clergy . . . . . .Denomination _____
____ Nurse. . . . . .Speciality _____
____ Social Worker. . . . .Type of Employment _____
Education, M.S.W. ___1. Yes ___2. No

____ Police officer
____ Lawyer or Judge
____ Other, Specify _____

6. **How long have you practiced or been employed in this profession in the Lansing area?**

____ 1. **Less than one year**
____ 2. **One to three years**
____ 3. **More than three, but less than seven years**
____ 4. **Seven years or more**

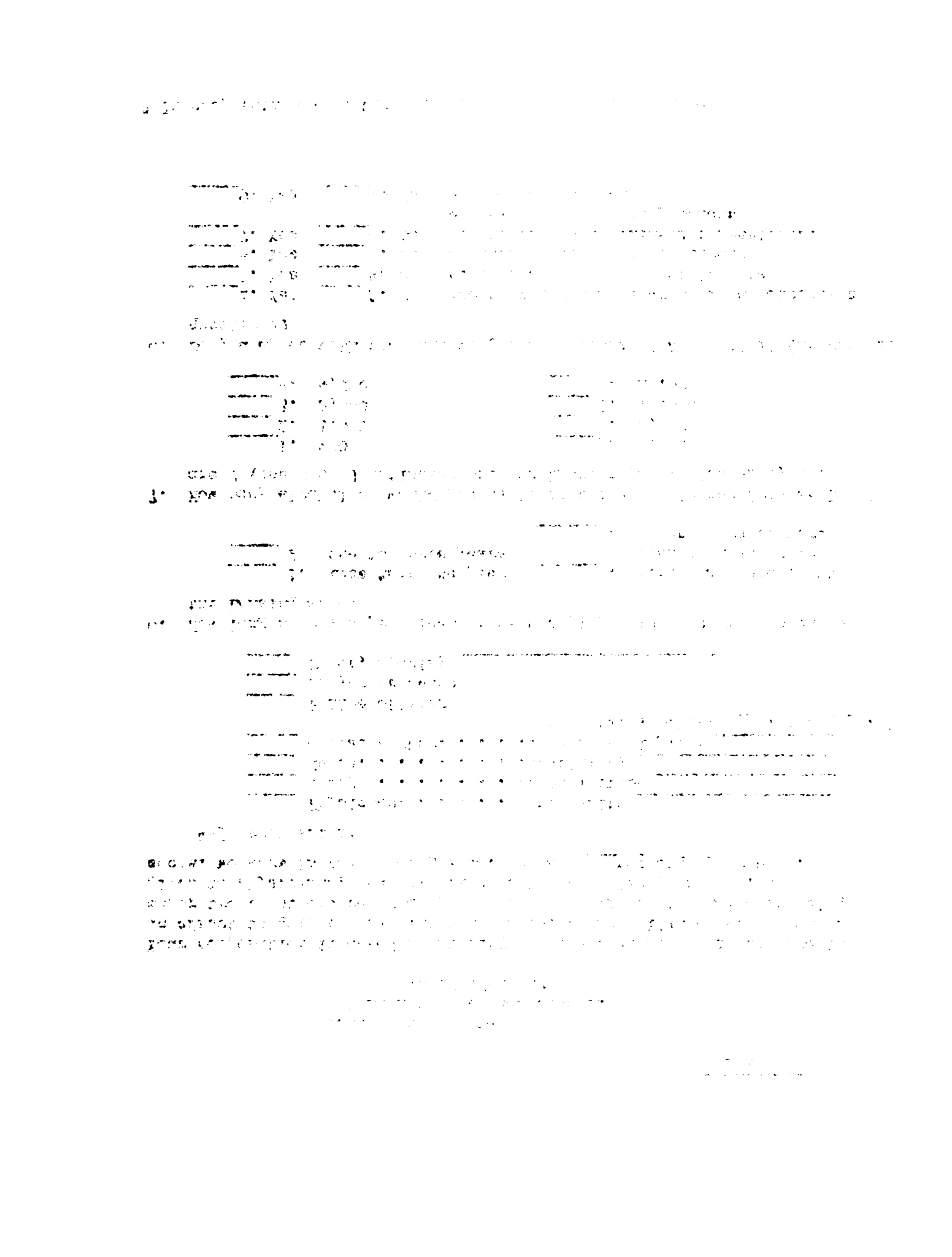
7. **How many alcoholics would you estimate there are in the Greater Lansing area? (check one) Estimated Greater Lansing population--240,000.**

____ 1. **200**
____ 2. 1,000
____ 3. 2,000
____ 4. 4,000
____ 5. 6,000
____ 6. 8,000
____ 7. 10,000
____ 8. 20,000

8. **Do you agree with the following descriptions of Alcoholism? (answer all questions)**

____1. **Yes**	____2. **No**	**The person who gets drunk is an alcoholic**
____3. **Yes**	____4. **No**	**Alcoholism is a physical illness**
____5. **Yes**	____6. **No**	**Alcoholism is a mental illness**
____7. **Yes**	____8. **No**	**Alcoholism is an illness characterized by underlying emotional problems**
____9. **Yes**	____10. **No**	**Alcoholism is a sin**

* In cooperation with the Michigan State Board of Alcoholism



9. In general, do you agree that alcoholics can be helped?

_____1. Strongly agree
_____2. Agree
_____3. Disagree
_____4. Strongly disagree

10. (a) What proportion of alcoholics do you think can be helped? (check one of the following areas)

_____1. 0-24
_____2. 25-49
_____3. 50-74
_____4. 75-100

11. From your understanding, how does one become an alcoholic?

12. Check the method or combination of methods that you feel to be most effective in helping the alcoholic, (check more than one if combination).

_____1. AA
_____2. Report to law enforcement agencies
_____3. Psychotherapy
_____4. Medical care
_____5. Casework treatment
_____6. Pastoral counseling
_____7. Institutional care
_____8. Others, specify _____

Do you feel that there has been an increased understanding, in the past ten years, on the part of:

13. The general public toward the problem of Alcoholism?

_____1. Yes
_____2. No

14. Your profession toward the problem of Alcoholism?

_____1. Yes
_____2. No

15. Do you come in contact with alcoholics as part of your professional responsibility?

_____1. Yes
_____2. No

16. In what proportion of your clientele would you estimate Alcoholism to be a problem? (check one of four)

_____1. 0-24%
_____2. 25-49%
_____3. 50-74%
_____4. 75-100%

17. Do you see counseling as part of your job?

_____1. Yes
_____2. No

11. _____

12. _____
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13. _____
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14. _____
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15. _____
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16. _____
_____

17. _____
_____

18. Approximately how many alcoholics have you attempted to care for in the past year? (specify number) _____

19. What proportion of success would you estimate?

_____%

20. Which of the following common hospital methods do you feel to be most effective in treating the alcoholic? (check one or more)

_____1. Antibuse therapy
_____2. Conditional reflex therapy
_____3. Group hypotherapy
_____4. Closed ward milieu
_____ Others, specify

_____

21. Approximately how many alcoholics have you referred to other resources in the past year? _____

22. What were these resources? (name of agency or type of help received)

_____

_____

_____

_____

23. Do you favor further liquor legislation?

_____1. Yes
_____2. No

24. Please rate your work with alcoholics as compared with other problems presented by your clientele.

_____1. Not too difficult
_____2. Average
_____3. Difficult
_____4. Impossible to help

In your opinion, is the need for:

25. Public education on Alcoholism

_____1. Important
_____2. Not too important
_____3. Not needed at all

26. Education of members of your profession

_____1. Important
_____2. Not too important
_____3. Not needed at all

27. Are the current resources in Lansing:

_____1. Adequate
_____2. Not too adequate
_____3. Inadequate

16. [illegible]

17. [illegible]

21. [illegible]

23. [illegible]

24. [illegible]

25. [illegible]

26. [illegible]

27. [illegible]

28. If not adequate, what do you feel is needed in Lansing? (check one or more)

_____1. Information, counseling, and referral center
_____2. Alcoholic treatment center
_____3. Hospital psychiatric center
_____4. Increased activity on part of professional people and existing agencies
_____ Other resources: (specify)

_____

29. Have you previously heard of the Lansing Committee on Alcoholism?

_____1. Yes
_____2. No

30. If yes, describe how you FIRST learned about the committee.

_____1. Newspaper
_____2. Radio, T. V.
_____3. Professional meeting
_____4. Other professionals
_____5. Community Services Council
_____ Other source (specify)

_____

31. Have you any further ideas on what action should be taken by the Lansing Committee on Alcoholism?