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THE SOCIAL WORKER and the ALCOHOLICS ANONYMOUS PROGRAM in a STATE HOSPITAL

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What happens to the patient in a state hospital when he "gets" the A.A. program? What personality modifications take place? What changes in thinking, feeling, and acting? What is the social worker's role when this process is taking place; where does casework fit into the program?

These were some of the questions facing the two trained social workers in a state hospital of 3000 patients. Social workers who have never worked in such a setting may have trouble visualizing the extreme difficulty of following that basic casework concept of individualizing the patient. The alcoholic patient in the state hospital has been the forgotten patient, less individualized than any other grouping. The social worker found herself saying, with others, "just another alcoholic" or "typical alcoholic." We did not say, nor did others, "just another schizophrenic" or "typical involutional." This along with the mounting admission rate (6 to 8 per-cent of total admissions to state hospitals are now said to be alcoholics), plus the high return from trial visit rate, gave us concern.

The social worker is not primarily interested in the elimination of the symptom of alcoholism. An alcoholic patient on a closed ward is soon relieved of this symptom. This superficial symptom-free condition has long proved to be of little significance because despite the good intentions of the patient on release, the availability of alcohol on return to the community resulted in a

rapid return of symptoms. Drinking, whether accompanied by aggressive or withdrawing behavior, had long been a part of the environment of these patients. It should be remembered, too, that since we had no voluntary admissions they all had run the gamut of clergy, doctors, social workers, family friends, and hospitalizations before their relatives took the final step of commitment to a state hospital.

Special study of the group in conjunction with a modified Alcoholics Anonymous experience seemed the answer. Twelve patients no longer considered mentally ill, but with alcoholism as a part of their diagnosis, were chosen and by random selection divided into two groups of four men and two women. Each patient was interviewed before and after by the A.A. man, the social worker, the psychologist, and the psychiatrist, and evaluated according to certain criteria. While no exact determination of the severity of social maladjustment could be made, it should be pointed out that in terms of conflict with the law, the two most difficult patients were in the treatment group.

The treatment group attended fourteen A.A. meetings on a weekly basis; the control group did not. None of the patients had any other active therapy.

At the end of the study when the interviews and tests were repeated, considerable progress in the direction of stability, self-understanding, and ability to handle social situations was observed in the treatment group, with no corresponding growth in the control group. Concrete evidence of change was seen in the fact that two patients in the treatment group were already on trial visit, and an additional patient had been approved but was awaiting final work arrangements before leaving. All the control group patients remained in the hospital.

When social workers and A.A. representatives take over the responsibility of the treatment and planning for the alcoholic patient, it does not mean that we deny the need of these patients for intensive psychiatric attention. We merely recognize the lack in the usual state hospital of sufficient psychiatrists to

undertake individual psychotherapy and to meet the competitive needs of patients with other diagnoses. Our project had the approval and cooperation of the psychiatric personnel. All were ready to discuss steps, plans, etc. One psychiatrist, Dr. Richard Steinbach, was especially interested and he was the active one on the study. As already indicated, no active psychiatric or other therapy was underway at the time of this project. The psychiatrist attended all of the A.A. sessions. As formulated in the over-all plan, he also interviewed the patients at stated intervals as a part of the evaluation of their reactions.

For the workers concerned, he offered some security in the plans we were making.

It should be remembered, however, that one reason the program was undertaken was to evaluate what could be done to hrlp these alcoholic patients for whom staff limitations made any active therapy impossible. We wanted to know whether other resources in the community could be effectively and safely utilized in a situation we all recognized to be far from ideal.

There is nothing unique in the A.A. group working with patients in a state hospital. What was new was the integration of the activities of the A.A. man and the social workers.

We had previous experience with A.A. members who visited patients at the state hospital. These had not all been constructive. On one or two occasions results were definitely undesirable. At other times, their diffuse activity, totally unreleated to other plans being made by the hospital staff, confused the patients and their families.

Not all A.A. members can work with alcoholic patients in a state hospital. Some, being "lay" as far as mental illness is concerned, are too uncomfortable with mental patients to be helpful. Others present problems because of overenthusiasm. They observe the patient's physical well-being and listen to his verbalization about becoming a teetotaler, and immediately they are ready to begin negotiations for trial visits. Entirely incapable of the finer evaluation needed before the staff could grant trial

visits, they found it difficult to accept our judgment. In their identification with the patient's desire for release they often served to reinforce his hostility to an "unreasonable" staff decision.

Still other A.A. members had too many problems of their own to be helpful. They were seeking solutions to their own problems, and the patients, recognizing this, were unresponsive.

The A.A. man primarily responsible for that part of our program was unusual in his interest and skill. He had had psychiatric help in his struggle with his problems. He knew enough to know the limitation of a lay person working with psychiatric patients. He had little curiosity, no need to delve deep in their situations. On the other hand, he did recognize what might be helpful to us to know. He would bring this material to us in our weekly conferences, and we could use it either with patients or with their families.

The conferences between the A.A. man and the social worker served to make certain our focus was correct. We exchanged observations on the patients and sought to plan "next steps" together. Sometimes, for example, the A.A. man felt the patients were ready to seek work, but we would have had reports of unusual tenseness on day passes with the family and so we would agree to delay a bit. Or we might believe that a patient had made greater progress than the A.A. man thought, and together we would reach a decision.

This paper is concerned first with a description of some of the principles of the A.A. philosophy as they affected the patients under study. Second, we have tried to illustrate how these principles were utilized in the casework process.

The A.A. program is based on definite steps, the first of which is that one is powerless over alcohol and that his life has become unmanageable. This is a real hurdle for any alcoholic, but especially for a patient whose pattern has been not to accept this reality.

Joe, for example, had been drinking since the age of sixteen, had a criminal record, had been in six other state hospitals for

alcoholism, had had numerous general hospital admissions with delirum tremens, and yet, according to a reliable informant, when he was being discharged from one of the above institutions and the official urged him not to drink, the patient replied: "A little beer never hurt anybody."

One of the special values of working with the A.A. is that, as the A.A. man said, "An alcoholic cannot fool another alcoholic." Careful observation of the verbal and other activity of each patient was recorded at every meeting. Nevertheless, it is difficult for a social worker to know when this seeming acceptance of the reality of being powerless over alcohol is real. The A.A. man could tell us when this change, acceptance, insight, or whatever term describes the change, had actually taken place. In an effort to learn more, we had frequent discussions with the A.A. representative about this, but it seems to be an intuitive "experiential" thing, difficult to define in usable form for anyone other than an alcoholic, such as all A.A. representatives have been. Further explanation of this might be helpful.

To return to Joe, during the first two meetings he sat looking at the ceiling, although one somehow had the feeling he was listening. By the third meeting the workers were questioning his suitability for the program as it seemed problematical that he could concentrate sufficiently to take in what was being said. This patient, who had been described as shy and unable to socialize, limited his contacts to the workers at these meetings. By the fourth meeting the patient's delightful sense of humor came to the fore; he talked with us about his hobbies; he cleaned up after refreshments. At the fifth meeting the A.A. leader asked for comments, and Joe volunteered that he had read the literature previously distributed and knew liquor was his problem. By the ninth meeting, he was willing to say he could not drink at all. At this time the psychiatrist stated: "This patient is something of an enigma. His peculiar intellectual and/or emotional make-up convinces me that some of the principal parts of the A.A. program escape him entirely. For the first time, however, he understands what an alcoholic is and is convinced that he is one and is

powerless over alcohol." By the time of the eleventh meeting, changes in the patient's thinking, behavior, and speech had been noticed by his family; the patient had been taken off the closed ward.

Mary giggled in a irrelevant fashion at the first meetings, although nowhere else, either in her past social history or within the hospital, had this been a characteristic. At one time, she burst into tears and left the room; at others she seemed entirely removed from the setting, and the observers felt that she could not be getting much from attending the meetings. At the sixth gathering the patient indicated during the social hour that she had gotten many of the implications of the speaker's remarks. By the ninth, she had related his remarks to her own experiences, indicating that his statements were valid. At the twelfth meeting she admitted she could drink, and it was then that relatives also reported a marked lessening of tension when the patient was on leave from the hospital.

John, on the other hand, who had only been acutely alcoholic for five years, and who was disgusted to have been a "drunkard," came by the forth meeting to an understanding of his inability to drink, although his anxiety and inferiority feelings made him uncertain regarding his ability to control this. By the sixth he had been referred for job training, and by the ninth he was leaving the hospital alone on day passes, was able to handle difficulties regarding job getting without too much trouble, and so on.

Purposeful casework activity began at the time this change took place. The social worker, interested in the social implications of this change, could help the patient to enlarge his concept of "unmanageability" in terms of family, children, jobs, and inadequate general social adjustment. To help the patient to this reality, and to have him see himself in relation to actuality as well as to operate within that limitation, was one of the worker's goals. The common expression used to describe the reality of these patients' lives was to say that they had hit rock bottom. Therefore, for the patient to face this reality was often

devastating. Pronounced feelings of inferiority sometimes resulted, and the degree of support the social worker gave at this point varied directly with the patient's ego strength. Our effort was to direct constructively the emotions freed by this "surrender," as Dr. Harry M. Tiebout calls it.

If the A.A. leader and the social worker do not take the next step together the characteristically narcissistic, egotistical nature of the alcoholic's personality will cause difficulty. "Utter disregard for others" was the phrase the A.A. man used frequently. Once the alcoholic has taken the first step, the A.A. urges him on to a positive handling of his previous shortcomings by making amends when possible. This is certainly desirable in view of the above characteristics, but it also presented a problem in casework. For example, Mike had not had a decent job in five years, but he began planning how he could support the family, refurnish the home, buy the children things, etc. The caseworkers role had to do with recognizing the sincerity of the patient's desires, but helping him accept the reality of his need for continued hospitalization. Possible job difficulty was stressed, and repeated reassurance were given that a wife of 20 years would both recognize and appreciate attitudinal changes as much as the tangible evidences which could come later.

The social worker invariably gets involved in the marriage relationship. Some people speak in terms of "alcoholic marriages," and the role of the wife or husband in this recovery program should not be underestimated. As a matter of fact, most of our patient's had to "prove" to the spouse that this time it was going to be different before the marriage partner would enter into the picture. Thus there was limited activity in this direction. Some of the marriages were typically neurotic, and played a real role in the development of the alcoholic pattern. Others were basically sound, and it was to be expected that after a period of continued sobriety outside the hospital the parties would be reconciled. This, the A.A. say, is not unusual in any group. The patient was enabled to see that while the spouse might not have changed, he had, through

the program, and was therefore able to handle situations which had hitherto resulted in a binge. We felt that after a period of A.A. it would be easier to help the patient toward a better balance of the inner and outer factors in this area.

Anxiety is always meaningful to the social worker. Thus it was interesting that in his initial interviews with the patients prior to the beginning of the study, the A.A. man was struck with the fact that these patients were singularly free from expressed anxiety about their actual situations, even as compared with the alcoholic in the community A.A. groups. There are, of course, several possible explanations, but we were particularly alert to changes in this area. An increase in anxiety frequently accomplishes the early stage of response to therapy. On the tests at the end of the study the psychologist, Dr. Doris T. Allen, reported that there were signs of increased anxiety in two patients, no differentiating direction of change in two, and a decrease in one of the treatment-group patients. Anxiety was observed particularly in patients who had "asocial and amoral trends" as a part of their diagnosis or history.

Joan, for example, had been disappearing from home for days at a time for the last five years. She would be found drunk, associating with undesirable men, and venereally infected. Her only reaction would be a "So what - it was fun while it lasted" attitude based on her feeling that she could not control her urge to drink. After the A.A. series Joan said, "I've got a conscience now." Of course this maturation brought new problems which with her youth caused difficulties, but the patient began to feel responsible not only for this aggressive misbehavior but also for willfulness, temper tantrums, pouting, and like, which had previously been tolerated by herself and others as childish. As a relative said, "Joan has grown up in the past six months."

The securing and handling of a job is often a major event in the life of the alcoholic, especially when he has been in a state hospital. Here again, the patient's anxiety was often so great as to inhibit him completely. Sometimes he would come to the office,

apparently ready to with his worker to town for an interview at the Vocational Rehabilitation Bureau, and then become panic-stricken at the thought of strange people and settings. The commotion of activities in town after the relative quiet of the suburban hospital was also upsetting. Sometimes with patients in whom we could anticipate such a reaction, a trip to town with the worker, unrelated to any specific activity, was the first step for the patient.

We did a good deal of preinterview preparation. It was necessary to persuade some patients away from jobs for which they were obviously unfit. The psychologist's vocational studies helped in this. We constantly reassured and supported them in moving toward job interviews, at the same time trying to keep them within the bounds of reality since they had to be ready for disappointment.

We were fortunate in having one worker at the Vocational Rehabilitation Bureau who worked with our patients. We could therefore tell them her name and something of her personality and appearance. This helped to reduce the the strangeness. We often rehearsed the preliminary steps, such as the introductions, the patients responses to initial inquiries about past jobs, etc.

Here again the A.A. man was invaluable. How much easier for the patient if his prospective employer knows about him and accepts him as he is! The A.A. had members in a large number of industries. Often they were in key positions. We, too, had former patients, successfully employed, who helped out.

Rightly or wrongly, our patients were encouraged not to hide the fact of their hospitalization from the prospective employer. The patients knew we would "lay the groundwork" and they seemed to feel better if the employer knew. Otherwise, as one patient said, "It'd always be a sword over my head." Naturally, they were also encouraged to be discreet with co-workers.

One of the most satisfying aspects of the work was the general lack of prejudice against out patients on the part of prospective employers. Of course this reflected somewhat the careful screening characteristic of hospital referrals at the time.

Most of the patients had lost meaningful friends and had become dependent on associates picked up in bars. One patient was not close to anyone within or without her family but operated on a theory of "getting all I can from everyone." The whole A.A. philosophy is one of sharing, giving, and taking of responsibility. This concern for the individual on the part of others in the A.A. program was often the first real experience the patient had had of being valued for himself. Emotional deprivation in childhood, when attention from the family had been more a matter of necessity than of loving concern, was the pattern. Patients often said they could not have comfortable contact with others even in as relaxed and informal a setting as a bowling alley "without a drink under my belt." The security giving features of the A.A. program should not be underestimated by the caseworker, for with the increase in the patient's strengths, her activity can be modified.

The case worker in a state hospital knows that it is very difficult to provide that necessary step in treatment known as new, satisfying experiences, personal and social. In this respect the A.A. group is ideal for patients, for, in the best sense, it is a fellowship group. Everyone is vitally interested in the continued successful treatment (sobriety) of everyone else. There is a common treatment goal and an understanding, acceptance, and tolerance of one another that is of the utmost importance to the patient.

Patients verbalized the meaning of the group many times. On the psychological tests interpersonal relationships had improved in four out of the six patients. This identification with the group could be and was utilized by the worker. The group attachment is a healthier way of meeting the individual's dependency need than the previous ones utilized by the alcoholic patient, who is frequently described as being at the oral level of development. It was interesting that the dependency on the caseworker which was characteristic at the beginning of the program, and continued for a time, took care of itself as identification with the group was substituted.

The patients derived great satisfaction and apparently gained in ego strength in contemplating, and in some cases carrying out,

the twelfth step of the program which is "Carry the message to other alcoholics." The A.A. community groups were also used by the patients to make easier their separation from the hospital when they left on trial visits.

As caseworkers we found working with the A.A. a valuable experience. Despite our real belief in casework values, we had had, as is true of many social workers, a rather discouraging experience with alcoholic patients. Many had histories which would make anything other than continued hospitalization inconceivable. Often these same patients wanted very badly to stop drinking, but our help was ineffective. They had many of the normal feelings for their families, were often highly endowed intellectually, and were usually of a personality make-up that was appealing. The total waste resulting from our inability to help some of these patients was most discouraging. The A.A. brought an entirely different outlook to the situation. They have had a large percentage of success with alcoholics. They were optimistic and enthusiastic about all patients because some of the "worst cases" in the community had successfully followed the program. They had the same belief in the worth of the individual and in the integrity of human personality that is basic to casework. This sharing of fundamental beliefs helped the A.A. representative and the social worker in their mutual program on behalf of the alcoholic.

To the state hospital social workers overwhelmed by the number of patients and the lack of professional staff, the A.A. offers a powerful resource. They can carry a large share of the responsibility for the alcoholic patients if their activity is properly correlated with other plans being formulated with the patient, and if the social workers and A.A. representatives work closely together.

There need be no difficulty with other professional and nonprofessional staff. Many of our apprehensions about possible difficulties were shown to be groundless, and we feel that other state hospital social workers would have the same experience.

As caseworkers we believe we have learned a great deal about the alcoholic character and personality from the A.A. man. In our

opinion this close association with representatives of Alcoholics Anonymous is a real and invaluable experience to any social worker working with the alcoholic client.