

The Alcoholic as an Agency Client

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Facilities for the treatment of alcoholism have multiplied at an amazing rate during the past ten years and many patients have benefited greatly thereby. Those who work in this field continue to be aware, however, that the main therapeutic impact of their treatment efforts must still be on the public's attitudes toward, and thinking about, alcohol and alcoholism - even that segment of the public which has professional training and skill in the handling of personal and social problems.

Social workers in all settings have some contact with the alcoholic, either because he is a patient or a client, or because he is a parent, a child, a sibling of a patient or a client. 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 who is moving either slowly or quickly toward disintegration or destruction, but who may yet be able to respond to forces that could reverse this process.

Examining One's Own Attitudes

The first and most essential thing a social worker who wants to help the alcoholic or his family must do is examine his own heart and mind. He must explore honestly his own attitudes toward alcohol and alcoholics so that he can determine whether or not he must work on himself before he will be able to be helpful to the persons he wishes to serve. It would be well for him to ask himself a few questions, for instance, about how he reacts to a person who is under the influence of alcohol, since frequently he will have to meet and deal with persons who are intoxicated if he is going to be of service to the alcoholic or to his family.

1. Is he disgusted by an intoxicated person because he is often dirty and disheveled and smells of alcohol or of what may be even more unpleasant, paraldehyde?

2. Does an intoxicated person stir his anger because of his loud talk and demanding ways, or his babyish and clinging helplessness, both of which cry out for immediate attention regardless of anyone's convenience?

3. Or does the alcoholic's uninhibited acting-out of impulses, in the worker's presence or toward the worker, set off in the latter flashes of pure fear and consequent hostility, some expression of which he cannot control and about which he is latter going to be ashamed?

In other words, has the worker developed a blind spot toward the whole problem of alcohol because of his strong feeling reactions in relation to the "man in drink?" After all, everyone develops defensive blind spots for certain material that he avoids noticing because he has never achieved a way of coping with it. Such blind spots may effectively nullify the expression of interest one genuinely thinks he has, such as in making needed services available to alcoholics.

Next, let the worker ask himself a question or two about his own use of alcohol, and about how he regards its use by those close to him.

Some of us hate and despise liquor because of the pain and ruin it has brought to someone near and dear to us. Some of us fear it because of a disturbing experience we have had with it ourselves - at a party we may have done something in bad taste which we shudder to remember, or we may have been a bit "high" while driving, with resulting close shaves or even a small accident. Others of us, however, may have guilt feelings based on our own use of alcohol as a pleasure procuring agent for ourselves and our friends - any or all of whom may occasionally teeter on the edge of overindulgence - which strengthen our impulses to avoid the entire subject.

When a person develops such blind spots he is likely to resort to using a well-worn formula which enables him to skirt or dismiss the whole subject he wishes to avoid. A commonly used formula is that a person who drinks too much is just an alcoholic, a "skid row" character, who is disgusting not only because he is shiftless and dirty and almost mindless, but because he prefers to remain in the state he is in, no better than that of a sick animal, sulking in corners. In any case he is not someone to whom casework services should be offered - they would be wasted.

Such thinking, of course, can be challenged, as by inquiring if Miss X, whom the person knows and who has been able to function effectively for years as a social worker, a writer, or a nurse, is a skid row character. This reminder should be sufficient to suggest the alcoholic's need for individual evaluation.

Another such formula is: Alcoholics are psychiatrically sick people needing special services; There is nothing a mere social worker can do for an alcoholic without expert guidance and help. Mere casework would never touch a disturbance so deep in its origins; There is no use in the caseworker's trying to do anything about it. The alcoholic must be referred to a psychiatric clinic, an alcoholism clinic, or Alcoholics Anonymous; he must be sent to a shelter, a mental hospital, or a relative. In any event he must be got out of this office now! Again the need to individualize the problem of the alcoholic is dodged. How can one possibly know what the alcoholic can, or cannot, use in the way of help without experimenting a bit? The social worker may have what some alcoholics needs, right at his fingertips.

Unexpected Results

In the clinics with which I have been associated for the past nine years, the social workers at one time were disturbed about the small amount of casework they were doing with alcoholic patients because these patients remained "in treatment" such a short time that one had no recourse but to write them off as failures. Our approach was the same in all our cases in respect to the attention we gave to the drinking difficulty as an illness, and the help we attempted to give each patient in relation to facing this fact and other difficulties that beset his life. We made an identical approach to each patient regardless of our evaluation of his "motivation for treatment," since we felt that we owed him a full discussion of his problem and of our service, whether or not we ever saw him again. Because most of these contacts took place at a point of acute crisis, each patient could not help sensing that he was being accepted at his worst, when he was most vulnerable. Because, also, the worker would immediately arrange for him to have a brief contact with the physician or psychiatrist for medical help if he was in physical distress (again whether or not the worker thought he would ever return), He could not fail to feel that his sufferings were taken seriously by all members of the clinic staff. Yet in many instances, after one or two

apparently positively-toned contacts with either the social worker or the physician or both, about superficial aspects of his problem, the patient would fail to return.

As the years have passed, we have gained information more or less by accident on a number of such cases which has disturbed us, inasmuch as it has seemed to point up the lack of connection between what is ordinarily thought of as therapy (casework or psychiatric) and the attainment of one of our legitimate and important goals - symptom cure. I am referring to cases in which our contact - social, medical, or psychiatric - seems to have had nothing in it to explain the fact that the patient immediately lost the need to drink, and years later was reported to be still sober as well as firmly convinced that the clinic had "cured" him. Granted that such results do not occur frequently, and that the patient must be particularly receptive to stimuli before these results can be obtained, much remains to be explained.

These unexpected results that I have been mentioning are not at all mysterious to members of Alcoholics Anonymous, who assert that 50 per cent of those who approach the A.A. program with an earnest desire to get rid of their compulsion to drink are able to attain sobriety immediately and to all appearances permanently. The A.A. members are well aware of the part that the group's full acceptance of the new member - of his drinking both in the past and in the present, with all that goes with it - plays in bringing about this result. Although they usually describe what takes place in religious terms, they also describe it in terms of group participation and identification, with special emphasis on identification of the new member with his sponsor. The A.A. experience departs from what I am trying to depict in so far as continued participation in the program, wherein the new member is led step by step to consolidate his own gains through the help he learns to give to other alcoholics, is also felt to be essential.

Helping the Client Mature

Perhaps the experiences in the alcoholism clinics which I have described are similar to what happens in an apparently spontaneous fashion under circumstances that have led to the revival and strengthening of the Alcoholic's sense of personal worth, and of the importance of his own part in the life around him. The

medical social worker who asked me to explain how the alcoholic described in the following paragraphs had suddenly become able to come to a decision to stop drinking and stick to it, had no thought whatever of her own part in preparing him to make this decision, not had the alcoholic himself.

The medical social worker had come to know the patient in the course of her work in a small but progressive general hospital in one of Connecticut's large factory towns. One illness after another and several hospitalizations had occurred in the family of this alcoholic, all during one winter. She had had many office consultations with both the man himself and his wife, and had made many home visits in the course of which she had become genuinely interested in the whole family. She could not avoid facing the fact, however, that although the man worked fairly steadily at a factory job that demanded considerable skill and seemed to be rather a "good sort," fond of his wife and his five children, he spent so much of the family income on liquor that they all lived in a constant state of deprivation, with all the inevitable tension and bitterness. The only thing she was able to do was to work out with the parents as realistically as possible their problems about paying their bills, home care following hospitalization, and the utilization of community resources. When all were again in good health, she closed the case. The man's alcoholism had been discussed, of course, along with the other problems in the family. As is so often the case, the drinker had been ready enough to acknowledge and deplore his behavior, but when Friday night arrived he would still take his pay check to the bar "to be cashed" and then would spend a night drinking with "the boys."

A few months later, however, this particular "boy" stopped in to tell the hospital social worker that he was all through with alcohol. A queer thing had happened. One hot night in July he and his family had been sitting on their porch, sweltering, when his neighbor, a man with a big family and a job similar to his own, whizzed by in his jalopy with all his children on their way to the beach and a nice cool dip. His first reaction was pure envy but his second was, "Why you fool, you work in the same shop as that fellow, your pay is the same, your family is no bigger than his. If you didn't drink you could have a car, too, and take your family to the beach any night you liked." Then and there he had made up his mind to stop drinking for good - and he had. What was puzzling him was that it had all been so simple. He didn't have to drink, so he had stopped. Now he hardly ever thought about it, much less craved it.

All this had happened several years before the story was recounted, and the social worker was certain the man still was not drinking and the family had prospered accordingly. What had actually happened was that this "boy" had, with a little help, become a man, willing to assume his responsibilities, and had discovered that when one is a man he is free to make his own decisions. One may wonder how much the thoughtful, family-centered service given by the medical caseworker had influenced this long-overdue maturation.

The approach to the alcoholic which had value when practiced by the social worker and the physician in the clinic, had the same value in the hands of the hospital social worker, even though the drinking problem was not the focus of the contact in the latter instance. What happened between the medical social worker and the alcoholic could happen in any social work setting, provided the social worker is able to accept and work with the alcoholic as an individual and take full account of the fact that his drinking is a symptom of maladaptation.

Such must have been the initial approach of the family service agency worker who reported his work with a group of "arrested alcoholics" (a term used by members of A.A. to describe their condition). In the course of his work he had been helpful to an alcoholic in relation to a family problem at a time when the alcoholic was struggling to establish his life on a sober basis with the help of A.A. Solving the man's family problem apparently strengthened his ability to use A.A. and, encouraged by the caseworker, he took the lead in forming an A.A. group in his home city. He remained, however, so convinced of the importance to him of the casework help he had received from the family agency that he was able to persuade all new members who seemed to be having knotty family problems to go for help.

Co-operating with Alcoholics Anonymous

The average alcoholic rejects contact with a psychiatrist because of his fears about himself in the light of his own behavior while drinking, and also, perhaps, because of his past emergency commitments to a mental hospital. It seems to me that it is worth while for the caseworker to go to some pains to make his help available to any new A.A. members who appears to need it. If direct psychiatric contact is needed, the caseworker can then prepare both the patient for the psychiatrist, and the psychiatrist for the patient.

Caseworkers should also be familiar with the Al-Anon Family Group movement which was recently launched. The purpose and function of these groups are worth the exploration of social workers who are mindful of the needs of the wives of alcoholics who apply to service agencies in times of crisis. These groups are made up of relatives of alcoholics, and their purpose is to "welcome and give comfort to the families of alcoholics, to give understanding and encouragement to the alcoholic in the home, and to grow spiritually through living by the twelve steps of Alcoholics Anonymous." Meetings are usually held at the same time and in the same building as an A.A. meeting, with the spouse attending the Al-Anon Family Group and the alcoholic the A.A. group.

The wife who is able to use this program herself undergoes a group experience which has therapeutic effects and which in turn is bound to have favorable repercussions on the alcoholic, whether or not he is trying to work on his problem. If he is also attending A.A. meetings, the benefit to him is enhanced. The type of cooperation between a family agency worker and an A.A. group described above could well develop between family agency workers and an Al-Anon Family Group.

It may seem at first glance that opportunities to work with A.A. and with the Al-Anon Family Group would occur so rarely in the practice of most social agencies that discussion of them hardly merits much space in a casework journal. Such opportunities would, however, multiply for any service agency, public or private, once it had seriously attempted to give any type of service to alcoholics. A.A. is now, and Al-Anon Family Groups may soon be, a powerful instrument for giving mass help to alcoholics; it is available in numerous communities where professional services are nonexistent or at best woefully inadequate. In places where professional services do exist, A.A. may be used to supplement these services in a vital way. Specialists in the field are often quite content to help a patient over his alcoholic crisis and then to concentrate on encouraging him to make full use as he can of the A.A. program. Frequently a patient will make this contact anyway, whether or not the treatment agency plans to have him do so. Our main concern in such cases should not be so much with the patient's manifold emotional problems as with supporting the powerful new defense, which he has found in A.A., against the destructive impulses underlying his addiction.

Those who have worked for any length of time in alcoholism treatment programs have come to have fairly clear ideas about who probably will, and who

probably will not, be able to use A.A. constructively. There are, for instance, lone drinkers who would not be able to tolerate a person-to-person relationship with a therapist, but who would feel safe in losing themselves in a large A.A. group to which they could adjust at their own pace and in their own manner. Again, there are many alcoholics who at some time in their lives have enjoyed group participation in gang play or team play, even if only during latency and early adolescence, who can participate fruitfully in A.A. or in individual therapy. For some alcoholics, however, all the talk at A.A. meetings, about past drinking, invokes nothing but an irresistible impulse to drink then and there. Among this group are those with the most deep-rooted and extensive psychopathology.

Working with "arrested alcoholics" presents, of course, some pitfalls for the social worker. After several years of sobriety in A.A., most alcoholics of much potential have achieved a stability that, though tending to rigidity of pattern, is quite genuine. It is easy for the caseworker to slip into expecting too much help from such a person, and to lose sight of the fact that the A.A. member is a person whose problem is alcoholism. This is particularly apt to happen to the worker, whether trained or not, who is working in a setting in which A.A. has been introduced quite frankly in the interests of therapy - as is true in many penal institutions and the alcoholic wards of many mental hospitals. The worker may, for example, have responsibility for supervising meetings within the institution which are conducted by A.A. groups from the "outside." He will thus become acquainted with individual A.A. members and with their histories as told in these meetings and will quite naturally come to depend on certain of these A.A. members for shrewd opinions on what a particular patient really wants to do about his drinking. He will also count on them to sponsor "likely A.A. prospects" in the movement when they leave the institution.

In working with members of A.A., who are by their own definition arrested alcoholics, the worker tends to identify with the person the alcoholic has become through the A.A. program. Such an identification can enrich the worker's understanding of alcoholism, provided it does not lead to his neglecting the alcoholic who is not responsive to the A.A. approach and who quite frankly is far from being able to face his problems. He must resist the temptation to divide all alcoholics into two groups: "good ones" (potential members of A.A. as good therapy candidates) and "bad ones" (all others). The tendency to look upon

well-functioning A.A. members as persons with a special strength and a special dedication may even lead to the unspoken assumption that they are not really addictive drinkers. When the worker assumes this attitude, the alcoholic who cannot use A.A. (or of course formal therapy) feels that he is being rejected as somehow "inferior" and is less responsive to the only approach that has even a small chance of being successful with him - casework.

Services to the A.A. Member

Caseworkers should keep in mind that their services may at some time be needed by the A.A. member, during or after a setback, or when a slip is sensed by him as imminent. If the A.A. member has the feeling that the caseworker conceives of him as a "strong" person in terms of the services the caseworker has asked of him, he will find it that much more difficult to ask for help for himself when he needs it. Thus, the nature and extent of the help expected of the A.A. member should have clearly defined limits which are understood by both the member and the worker, and which are based on a realistic appraisal of the strengths and limitations of the A.A. movement itself.

Certain A.A. members have emerged as extraordinarily able leaders in the movement and inspire general respect for the real contribution they make to it. Apart from the fact that such achievement deserves admiration and respect and that all genuinely "practicing" A.A. members deserve the same acclaim for similar but less spectacular achievements, there is a temptation on the part of many to overestimate the A.A. member. He may try to remind the worker of what he considers to be his true condition by referring to himself as "just a drunk." May this not be in response to his sensing that overpraising him as he is now represents a guilt reaction on the worker's part - an effort to make up for the tendency to avoid him when he was drinking, and evidence of the worker's distaste for, and neglect of, the alcoholics who are not "cured" and who are regarded as a nuisance to the agency? I have heard A.A. members make the comment, "If they think so much of what we have accomplished for ourselves and others, why don't they pay more attention to what we tell them an alcoholic needs - a bed in the hospital at the right time, for instance."

The Role of the Public Agency Worker

I do not in any sense wish to minimize the alcoholic as an agency problem, particularly a public agency problem. The chronic alcoholic who continues to deteriorate both socially and physically inevitably becomes a public charge on the relief rolls, in jail, in a general hospital, or in a mental institution, if he does not die before his time from sheer self-neglect.

The public agency worker cannot help becoming involved with the alcoholic or his family in many of the situations outlined above and can handle this task best when he fully accepts the idea that the chronically deteriorated alcoholic is ill in much the same manner that the ambulatory schizophrenic is ill, despite occasional appearances to the contrary; and that he should expect no more response from the one to being dealt with in a friendly manner than from the other, although this type of handling is always necessary. If the worker is not hoping to "cure" the alcoholic he will not be angry and rejecting, and consequently defensive, if he does not effect a cure. Moreover, he may very occasionally be surprised by the favorable response he gets to routine handling, warmly administered. By and large, however, he can take comfort in the knowledge that he has done all he can, inasmuch as society has found no effective means of meeting the needs of this group. He can, therefore, focus his attention on those alcoholics in his caseload who may be able to use some active type of help, since they are still struggling to regain their equilibrium.

The public welfare worker will have many opportunities to work with alcoholics in the latter category. Not infrequently he will be called upon to give emergency help to the family of an alcoholic who has capped a drinking spree by borrowing to the hilt and has then taken off for parts unknown to continue his drinking. It will be most important to get acquainted with the alcoholic himself when he returns and to encourage him to use whatever local resources are available for help with his problem. Whether he can bring himself to use them at this stage - when he will have the excuse that he must work every minute and double-time if possible, to pay back debts he has accumulated through his "own folly"- will not be as vital as building a relationship of trust between himself and the worker. It was the worker who helped his family when he had failed it; he can now feel supported in his efforts to "make up" for what he did to those dear to him, and can know that this worker is striving both to understand his trouble and to help him too.

All public agencies have medical resources and it is quite conceivable that when the workers themselves become interested in attempting rehabilitative work with alcoholics and their families, a way will be found to utilize them. Even if the alcoholic's drinking episodes only become shorter and less frequent, the medical expenditures involved would be far from wasted. If each application for help during such an episode is treated by the worker as an application for help for the whole family including the drinker, his wife will become better able to think in these terms herself.

Choice of appropriate medical resources will vary from case to case and may range all the way from emergency locked-ward care to a voluntary visit to the office of a physician who is sympathetic to the alcoholic patient's request for help with a hangover that is threatening to lead to renewed drinking. Clinics for the treatment of alcoholics are few, so that other types of service must be developed. Public welfare workers have many practical reasons to experiment along this line since any alleviation of alcohol addiction among their clientele would cut down materially on welfare expenditures for family and individual maintenance, child placement, and general hospital bills for alcoholics suffering from exposure, diseases of malnutrition, and avoidable accidents.

Overcoming the Hazards

How does one avoid the hazards that accompany treatment of the alcoholic? Social workers are all too familiar with the difficulty of formulating a diagnosis in cases of alcoholism, which by its very nature is a psychosocial illness. Moreover, treatment efforts have frequently been ineffective. These unsatisfactory experiences are responsible in large part for the avoidance of the alcoholic or for giving him only minimum service, although the alcoholic as a citizen is clearly entitled to adequate consideration of his needs.

An obvious first step toward learning to overcome these hazards is to become better acquainted with the alcoholic and his problem through examination of the literature on this subject in professional journals. Now that more and more work in this field is being subsidized by state funds, more reports are available on specialized work with alcoholics in the fields of psychiatry, medicine, social work, and sociology. A second step is to make use of the professional staffs of special programs for the treatment of alcoholism, for

consultation on specific problems. In addition, social workers cannot afford to overlook the opportunity of learning about alcoholics from the point of view of the "arrested alcoholic" offered by attendance at A.A. meetings, and from informal discussions with senior A.A. members regarding the problems they face during the various phases of sponsoring a new member.

What can the individual worker in any setting do until the agency's or general hospital's policies include provision for meeting the needs of alcoholics? In many instances, the policies will have to be changed. I believe that the soundest type of policy change grows out of the case-by-case experience of the individual workers who, having become aware of the need for certain services, find new ways of utilizing whatever resources they have within their reach, in the interest of rendering these services. Once the value of a service has been demonstrated, a working policy has in effect been established and pressure for formal policy change will come from within the agency itself. This new policy will form the soundest base possible upon which to build new services to alcoholics, such as brief-treatment wards or convalescent homes, half-way houses, and community work projects. Thus, the public will become convinced that these services are needed, inasmuch as the agency's workers themselves have seen the needs such services are meant to fill and will be able to use them constructively.