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**Alcoholics Anonymous, Alcoholism Counseling,
And
Social Work Treatment.**

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The authors suggest that the misunderstanding by many social workers of the particular values of Alcoholics Anonymous and the skills of alcoholism counselors can involve alcoholic patients themselves in the stress of reconciling different approaches to treatment. They call upon all who treat alcoholics to build mutual trust and cooperation on two assumptions basic to all forms of treatment - that alcoholism is a disease and abstinence is essential to recovery.

Alcoholics Anonymous (AA) is a powerful social movement that embodies certain principles and assumptions about recovery from alcoholism. Although social workers and other professionals often make use of AA as an adjunct to treatment, they do not always incorporate its principles into their work with patients or take the trouble to learn the differences and similarities in the AA and professional approaches. This sometimes forces the patient to cope with stresses of reconciling two basically different helping agents, neither of whom is fully aware of this conflict. Nevertheless, social workers who understand what recovery from the disease of alcoholism entails can learn not only to counsel newly sober alcoholics or those attempting to become sober, but also to work smoothly with AA. They can also use the knowledge and skills of social work to enhance and broaden the recovery effort in important ways.

This article examines the role of alcoholism counselors in treating alcoholics and discusses the value of AA in promoting recovery from alcoholism. It then contrasts both approaches with social work treatment. It analyzes as well what elements of traditional social work interventions can become liabilities in treating the alcoholic patient. The article's purpose is to enable social workers, alcoholism counselors, and members of Alcoholics Anonymous to recognize each other's strengths and what all forms of treatment share and, out of this knowledge, to discover a ground for cooperation and mutual trust in the treatment of alcoholism.

ALCOHOLISM COUNSELING

Alcoholism counseling involves helping an alcoholic through the early stages of sobriety - the period of recovery from the disease of alcoholism - and assisting the person through three changes. The first change is the abandonment of the stance "I am not an alcoholic, it is something else that is wrong" and the replacement of this stance with the recognition "I am an alcoholic, I own the problem." Making this change involves confronting the denial and realizing that the denial is a major defense for any alcoholic (1). The second change requires a shift from the insistence "I can do it all myself" to the acknowledgment of a need for help. In AA language this is the deflation of the person's ego and the acknowledgment that the self is not the ultimate power. In the terminology of role theory, the alcoholic accepts the role of patient, gives up the power struggle with the helping person or group, or perhaps with fate, and becomes willing to be helped.

The third change is one of learning different styles of communication. Alcoholics who are still drinking or are barely sober have trouble relating openly and honestly, partly because of the organic effect of their chemical use and also because of their use of denial as a defense. They have trouble benefiting from counseling without simultaneously learning a different kind of communication and reshaping their expectations of other people. Alcoholics who come for treatment but are angry, afraid, embarrassed, defiant, and denying may want to get sober, but may not know how; nor do they know how to talk about what is wrong. Alcoholics are often so demoralized and guilty that they do not know how to self-disclose in ways that retain some shreds of self-esteem. It usually takes some time before they develop the openness and spontaneity that professionals know to be the best posture for using counseling help. Attempting to help the alcoholic make these changes and move into early sobriety clearly requires that the person doing the counseling be able to exert some influence over the person coming or being sent for help.

The skills and strengths of the alcoholism counselor are different from those of the professional social worker. Alcoholism counselor is a comparatively new role. The role had its origins among recovered alcoholics who, through AA, had gained extensive experience in helping fellow alcoholics. Although the experience of recovery from alcoholism is not the sole basis for competence in alcoholism counseling, alcoholism counselors have traditionally used their own recovery experiences in their work with alcoholics. This use of oneself as a role model by the recovered alcoholism counselor has been only part of the skills offered by those who choose to use it and who have not always received the recognition or remuneration they deserved. Counselors are now banding together to improve their recognition, skills, and pay scales.

A concomitant development is that people with counseling experience or degrees in other fields such as drug abuse, education, and vocational rehabilitation have begun to receive training in alcoholism counseling. These people, as well as social workers, need to develop an understanding of the experience of alcoholism and of the dynamics and resources of recovery from it,

which have been important to this treatment effort. Organizations of alcoholism counselors are developing criteria for credentialing. There is also a national association of Alcoholism Counselors, and a National Commission for the Credentialing of Alcoholism Counselors was recently formed with sponsorship from the National Institute on Alcoholism and Alcohol Abuse. In May 1978, a master's program at Johns Hopkins University became the first such program to gain accreditation (2).

An alcoholism counselor who is a recovered alcoholic and is skilled in sharing his or her own experience with the disease is able to establish a realm of mutuality with alcoholic patients. The capacity to say to the alcoholic patient, "I used to do the same thing," at once allays guilt and offers hope. If the counselor chooses to share his or her own drinking history, this sharing can be part of the alcoholism counselor's first contact with the new patient, an action that serves several functions. The new patient discovers similarities between his or her own experience and that of the counselor who, as a seemingly comfortable yet acknowledged alcoholic, makes the diagnosis more acceptable. In AA terms, the newcomer can identify. This offering by the counselor of his or her own experience rather than demanding the details of the client's history accommodates the alcoholic's difficulty in self-expression. This approach makes the alcoholic more comfortable and creates a context in which trust and mutuality can develop.

By contrast, a professional brings an ability to empathize and to meet the patient where the patient is, but usually retains more distance than an alcoholism counselor and "explores" more and shares less. A beginning alcoholism counselor may focus on the alcoholism almost exclusively, whereas a social worker new to the field usually looks for an underlying pathology and seeks to determine what recent stresses might have initiated the patient's current episodes of drinking. The social worker also seeks to understand the patient as a person in his or her social context. The social worker is ordinarily able to use a greater variety of approaches and interventions than the counselor; the approaches of the counselors are more specifically designed for the treatment of alcoholism. The counselor who is a recovered alcoholic knows something about alcoholism from personal experience with recovery and is able to serve as a role model, but is likely to need to learn more about counseling and about professional codes and responsibilities to gain greater security as a treating person. As one successful director of a halfway house explained, "My experience in AA qualified me for one thing only - keeping me sober. The rest I had to learn elsewhere."

Social workers often need to learn about alcoholism as a disease and to understand what recovery is like. Having acquired this knowledge, social workers may find that they have to make certain adaptations in the treatment skills of social work in order to influence the alcoholic to begin the necessary changes. In the initial encounters with an alcoholic, for example, the social worker's cautious exploratory process may prove less effective than the counselor's more directive stance.

Obstacles for Social Workers

An encounter with an alcoholic can easily make a beginning social worker feel helpless. With alcoholics, the social worker's well learned skills in exploration and diagnosis do not evoke the same positive response and feeling of being understood as in nonalcoholic patients. New social workers may feel that the patients do not like them, do not really want help, or drink because they are infantile and impulsive. As stated in the Littlejohn reports, professionals can do alcoholism counseling, but it has to be learned and does not come automatically in the course of the usual professional training (3).

Since social workers in many health and welfare agencies are strategically located to be extremely helpful to alcoholics and to families affected by alcoholism, it will be useful to enumerate the problems social workers have in adapting their techniques to the treatment of alcoholism (4).

1. Because alcoholism is such a pervasive social problem and social workers see it constantly in the hospitals, clinics, and welfare and family agencies where they practice, it is easy to assume that social work education must surely include whatever training is relevant to the treatment of alcoholism. The curricula of most schools of social work contain very little on alcoholism, however, and the worker is not attuned to the need to reach for the extensive knowledge base on alcoholism. This is true even of workers who might reach for the specialized knowledge of kidney disease, for example, or of spinal cord injuries in which the need for knowledge outside the social worker's area of expertise is more apparent.

2. The social worker's psychoanalytically oriented approach can be an obstacle in the treatment of alcoholism unless it is adapted to the special needs of the alcoholic. If the worker regards alcohol abuse as a symptom and begins to search for underlying causes, both the patient and the social worker may be distracted from the urgent and immediate need to find a means of recovery.

3. The expectation of social worker's and other professionals that the patient will be able to elucidate the problem if asked the right questions is also a problem in treating alcoholics. The alcoholic's massive denial defeats that expectation and forces the social worker to know and explain what alcoholism is like rather than look for the explanation from the patient. If social workers or other counseling personnel do not have their own recovery experience to draw on, they need to do their homework. They need to learn about the physical, psychological, and emotional aspects of the disease. They also need to have a sense of what recovery is like - perhaps through attendance at AA meetings and listening to recovered alcoholics - so that they can take responsibility for describing to the alcoholic patient what the illness is like and what the patient's situation is. With this knowledge the social worker can encourage the patient to identify with what is being described and need not struggle to evoke this information from a denying patient. Since the alcoholic, at least on some level, does

not want to hear the truth and would like to find a good reason to discount the worker's recommendation, it is especially important that the worker be secure in the knowledge of alcoholism.

4. Some of the traditional social work skills in environmental manipulation may be counterproductive in work with alcoholics if the practitioner's timing or focus is incorrect (5). Recovering alcoholics who are trying to learn to take better care of themselves or who need to obtain more comfortable living arrangements to enhance sobriety may seek help in finding adequate housing or in making use of the welfare system. Such assistance is often invaluable in attaining the objectives of treatment, but to fix up the system so that an active alcoholic can drink more comfortably and therefore get sicker will not be useful and may even oil the revolving door. Better housing alone never got anyone sober. A sober alcoholic can take an active role in getting better housing.

5. Social workers, since they are good at finding and supporting strengths and coping abilities, are easily drawn into the alcoholic's power struggle with the bottle. Alcoholics commonly externalize their problem by placing it in the bottle. They then fight the bottle, a war which cannot be permanently won in those terms because when the battle is won and the triumph disappears, the victory has to be renewed by renewing the struggle, that is, by drinking again (6). In taking this struggle at face value, the social worker may attempt to join forces with the alcoholic in the fight against "demon Rum." Patient and social worker are then likely to go to defeat together. What needs to be supported instead is the patient's interest in real recovery and in finding ways to sustain it.

Changing Systems

A variety of interventions into the internal and external systems that support the alcoholic's drinking may be of value to the social worker's efforts to help. Some interventions, for example, involve helping the alcoholic reposition himself or herself in relation to his or her problem and the world. Just such a repositioning is inherent in the first two steps of the AA approach:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity (7).

Bateson analyzed these two steps in "The Cybernetics of 'Self': A Theory of Alcoholism":

Implicit in the combination of these two steps is an extraordinary - and I believe correct - idea: the experience of defeat not only serves to convince the alcoholic that change is necessary; it is the first step in that change. To be defeated by the bottle and know it is the first "spiritual experience." The myth of self-power is thereby broken by the demonstration of a greater power...

Philosophically viewed, the first step is not a surrender; it

is really a change in epistemology, a change in how to know about the personality in the world (8).

The change is toward a knowledge of the interdependence of man and nature rather than a persistence of the view that man is master of all.

Another way to help the alcoholic make a change in his or her system of relating to the bottle is to refine the problem for him or her and in so doing, since he or she is the one involved in the drinking, to redefine the self. A most familiar way of doing this is by means of the disease concept of alcoholism. Instead of continuing to view oneself as a weakling or moral leper who harms one's family and others by willfulness, the alcoholic can now understand him - or herself as a person with an illness. This shift instructs the alcoholic that he or she must learn about self-concept and alcoholism as a disease and then work out a different adaptation; it also implies that he or she is worthy of attention and concern of health and mental health professionals. The alcoholic comes to recognize that although he or she is not held responsible for becoming alcoholic - since one is not responsible for contracting an illness - he or she does carry the responsibility for cooperating with the treatment and making the effort to recover. The disease concept does not exempt the alcoholic from the need for responsible actions, but it does redirect that action.

Many alcoholics find it difficult to believe that alcoholism is a disease. They say such things as, "For a long time I didn't think it was really true. I thought that people were just being kind instead of condemning, but that was a relief, too." Nevertheless, the disease concept not only offers hope, greater dignity, and positive professional attention, it also tells what to do to recover - listen and learn, follow instructions, and be dependent in a positive way. This approach is consistent with the philosophy of AA: both assert that the alcoholism within the person and "the problem" are one and the same - "I am an alcoholic."

Another redefinition of the problem that can be extremely helpful is the view of alcoholism as a family disease. Understanding the alcoholic's family as part of a system that includes the patient's problem is consistent with the view of AA's companion group for families, Al-Anon. Since all the members of the alcoholic's family have important parts in a self-perpetuating closed system, an intervention at any point in the system exerts pressure for change on the other persons. A spouse's successful effort to "do something for myself" - in Al-Anon terms, "detach with love" - rather than continue daily absorption in the problem frequently brings pressure for change on the alcoholic also. Social workers, of course, are particularly sensitive to working with families and can often be helpful in this kind of redefinition. They are often also able to bring about changes in the way health, welfare, and other systems relate to the alcoholic and his or her family. Social workers who bring an ecosystems perspective to their work have an advantage in dealing with this multifaceted problem.

Understanding AA's Role

Although designing and carrying out systems-type interventions could well be an area in the treatment of alcoholism in which social workers could develop special expertise, there is another area of the alcoholic's life that most social workers need to understand better - the role of Alcoholics Anonymous in the recovery process and the alcoholic's continuing relationship to AA. Although many alcoholism counselors are often either awed by or underrated the value of professional training, they often have a more sophisticated appreciation of the values, limitations, and difficulties involved in the use of AA than do social workers. Alcoholism counselors may have their own experience with AA to draw on. Even if they do not, they have often attended and participated in many different AA meetings and, in addition, may be acquainted with many recovered alcoholics. Attending open AA meetings and meeting recovered alcoholics as peers, rather than just as patients, are experiences that are also open to professionals. However, this kind of personal acquaintance is still relatively rare among social workers who are not in the alcoholism field.

Since AA is a self-help organization that no one runs or speaks for, it can be difficult, without attending a number of AA meetings, to appreciate the tremendous variety in the meetings, the personalities involved, and the myriad ways people use AA's help (9). Reading about AA is no substitute for knowing it and its members, and a single visit to a single AA or Al-Anon group no more leads to thorough understanding than would attendance at a single lecture be a substitute for a well-designed course. Social workers who do take the trouble to acquaint themselves with recovery through AA will be unlikely to regard attendance at AA meetings as merely a substitute for alcohol or as an intrusion into the patient's otherwise normal life.

Because alcoholism pervades many areas of the patient's life - and that of his or her family as well - the switch to sober life can cause great personal and social stress. Because the alcoholic needs to give up the chemical abuse before the problem connected with that radical change can be worked through, newly sober alcoholics are highly vulnerable. They are emotionally labile and are often flooded with anxiety. This early state of sobriety is sometimes compared to acute grief and mourning and sometimes to convalescence from a serious illness. Both comparisons have validity, but it may be that neither is totally accurate. However, as in mourning and convalescence, newly sober alcoholics have the best chance of getting through the shaky period successfully if they are surrounded and supported by caring people who understand what is being experienced and have the interest and patience to see them through it. For the newly sober alcoholic, AA is a powerful provider of many hours of this caring and support, and often of practical advice as well. Some of the AA slogans that some professionals find so offensive, such as "Easy does it," "First things first," "Let go and let God," are especially valuable in the early period of sobriety. They are appreciated by the recovering alcoholics whose own experience validates the various aspects of the AA program.

Alcoholism counselors may also be more aware than inexperienced professionals of the predictable changes that take place in the newly recovered alcoholic's relationship to AA as the period of sobriety lengthens. For example, some recovered alcoholics touch base with AA only occasionally. Others make one group their home group and attend meetings, although they involve themselves in other activities as well. Some continue to organize their social lives exclusively around AA. Moreover, the variety of AA groups in a metropolitan area like New York is as great as the variety in the population itself. Some are open to all; some are only open to theatre people, medical professionals, the hearing impaired, gay, or Spanish, or for young people or airline pilots. The groups are located in various parts of the city, and their meetings are held at all hours of the day and night. Open meetings welcome nonalcoholics; closed meetings are for alcoholics only.

There have been many interesting attempts to explain AA and its antecedents (10). The difficulty in explaining just how AA works may in part be a testimony to its versatility and to the many different kinds of people who find value in it. The universal element may be the decision of the alcoholic from no matter what walk of life to cope with a life-threatening problem by an affirmation - by "owning it" and by taking responsibility for it at the same time: "My name is-----, and I am an alcoholic." Since this decision makes the alcoholic a nondrinker in a drinking society and, consequently, now a social deviant, the availability of peer group support offering the experience of in-group status and belonging takes on considerable importance. Participants in AA share their experience, strength, and hope, not just their problems, and this is an approach that is generally more characteristic of self-help groups than of professional treatment. It also helps to explain why many maintain a life-long affiliation with AA. AA's integrity is based partly on its twelve traditions, which are generally less well known than the twelve steps (11).

Through the traditions, AA maintains clarity of purpose and independence. It remains unaffiliated with other causes and refuses outside funding. Of special interest is AA's fifth tradition, which states that "each group has but one primary purpose - to carry its message to the alcoholic who still suffers." A reason for this singleness of purpose, the tradition explains, "is the great paradox of AA that we know we can seldom keep the precious gift of sobriety unless we give it away." Thus members of AA work with other newly available alcoholics not just for the sake of that person, but for themselves and their own sobriety. This relieves the newcomer of the terrible burden of gratitude. Alcoholism counselors who are members of AA depart from this principle by taking on a professional role in relation to their patients, but they are still in a good position to help their patients use AA by virtue of their own experience with it. Once social workers understand AA's values and variety, they also can support their patients' appropriate use of the organization and thus enhance their own ways of being useful to the recovering patient.

Summary

AA, alcoholism counselors, and social workers all have important roles to play in helping alcoholics and their families, whether the person is still drinking, in early sobriety, or maintaining sobriety and getting help with other problems. Each helping source offers different strengths and assets to alcoholics and their families, and ideally all three should be available in accordance with the individual needs of the alcoholic and his or her family. Of great importance is a commitment on the part of both the alcoholism counselor and the social worker to understand each other's ways and to develop mutual respect and trust. There are two basic assumptions to be made: one, that alcoholism is a disease and, two, that abstinence from alcohol and other mood-altering drugs is necessary to recovery. These assumptions are consistent with the principles of AA, and they offer a starting point for agreement and collaboration among treatment personnel. Agreement on these assumptions can also free the alcoholic from conflicting views among his or her helpers.

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Notes and References

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