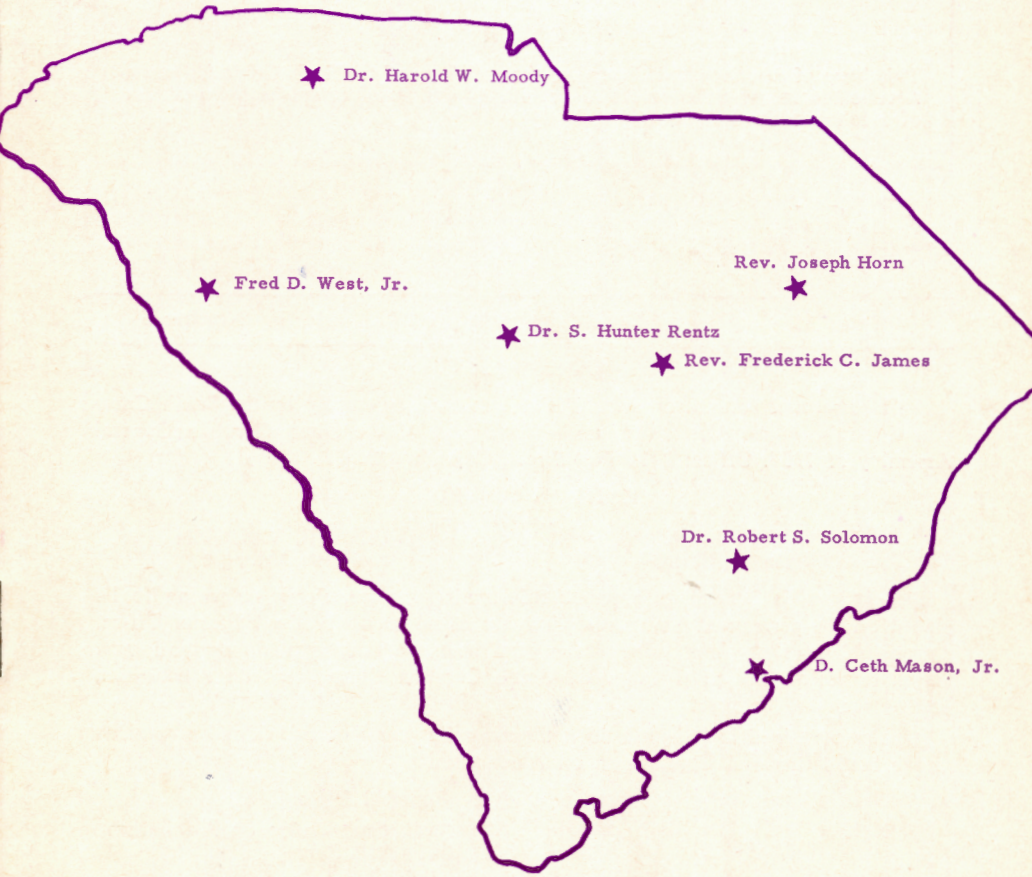
Lifelines

A BIMONTHLY JOURNAL ON ALCOHOLISM

PUBLISHED BY THE SOUTH CAROLINA COMMISSION ON ALCOHOLISM

SEPTEMBER-OCTOBER, 1969



IN THIS ISSUE

COVER

This issue of *Lifelines* is dedicated to the members of the S. C. Commission on Alcoholism in appreciation for their interest and involvement in the problem of alcoholism in the State.

Lifelines . . .

Volume 11 **September-October, 1969** **Number 5**

Columbia, S. C.

An Educational Journal on Alcoholism. Published bimonthly by the South Carolina Commission on Alcoholism, under enactment of the South Carolina General Assembly of 1957. Office: 2414 Bull Street, Columbia, S. C.

EARL W. GRIFFITH
Editor

VIVIAN C. JACKSON
Associate Editor

BEVERLY E. VAUGHN
Circulation Manager

This Journal is printed as a public information service. Persons desiring to be placed on the permanent free mailing list are asked to notify the Editorial Office. Articles of news or other value are invited with the understanding that all such material becomes the property of the South Carolina Commission on Alcoholism, and no fees will be paid.

Articles contained in *Lifelines* do not necessarily represent the views or opinions of the South Carolina Commission on Alcoholism.

Write: Editorial Office

S. C. Commission on Alcoholism
2414 Bull Street
Columbia, S. C. 29201

SECOND CLASS POSTAGE PAID AT COLUMBIA, S. C.

PROGRAM DOINGS

south carolina and the nation
a roundup of alcoholism news

FILM REVIEW
by
James A. Neal
Educational Representative, SCCA

What Time Is It Now?
Gargano Productions
16mm, sound, color, 30 minutes

"WHEN in life is one old enough to begin drinking?" This is the question the film, *What Time Is It Now?* very dramatically and disturbingly asks.

In South Carolina the majority of adults drink beverage alcohol at some time; yet, adults are shocked when the adolescents say, "You drink, why can't we?". And are dumbfounded when, with a dusty Bible in one hand and a Scotch and soda in the other, the kids do not understand the adult answer, "Because . . .".

Without falling into overt preachment, *What Time Is It Now?,* provides evidence why for most adolescents the time to drink is . . . not yet.

The real value of this film is that it can provide the catalyst to stimulate a fruitful exchange between adults and adolescents on this equally important question. The participants, however, must take the responsibility for providing a meaningful agenda for this exchange.

In the final analysis, it is the adolescent who must decide whether to drink and, if so, when to begin. The law is not the answer because we can not legislate wisdom; but we can endow wisdom and this endowment must come from adults who are willing to open the channels of dialogue with the adolescents in their community.

For some adolescents the time to drink may be now . . .

For some the time may be never . . .
For others the time may be . . . not yet . . .

What time is it in your community?

JAN

This film is available on request from the loan library of the South Carolina Commission on Alcoholism.

Editor's Note:

The above film was shown to the patients at Palmetto Center, Florence, S. C. and the editorial staff felt the following comments would be of interest.

" *'What Time Is It Now'* was a new film presented to us at religious discussion on Tuesday. Reactions to the film were, to say the least, overwhelming and varied. Some saw rebellion, many saw independence, identification, experience, and we all saw ourselves.

"The film centered on teenage drinking, and there certainly was rebellion. The teenagers had to rebel against society and their parents to find independence. We all agreed that this initial rebellion led to experimentation with alcohol. The experimentation with just beer led to stronger drinking, finally to escape, and, ultimately, to trouble. That is the inevitable progression of alcohol. The group could see in these teenagers themselves some years ago seeking identification, independence, and acceptance. Many of these teenagers were seeking the answer to *'Who Am I'* and many of us here still seek the same answer. Alcohol was not the answer we once thought it was.

(Continued on Page 13)

SOUTH CAROLINA

COMMISSION ON ALCOHOLISM

Seated, Mr. Mason, Chairman. L. to R., Mr. West, Dr. Rentz and Dr. Moody. Absent are Dr. Solomon and Rev. Horn.

D. C. Mason, Jr., Chairman

Mr. Mason is a native of Ridgeville, S. C. and was educated in the Summerton schools. He was appointed to the Commission October 27, 1960, has served as vice-chairman and was appointed as chairman by Gov. McNair in January, 1968.

He was in the appliance business in Sumter and traveled extensively through several states for various appliance firms. He also served in the Merchant Marines. He became manager of Installment Finance Corporation in Charleston in 1956 and is now president and manager of this corporation.

Mr. Mason has been working with alcoholics for approximately 21 years. He is a graduate of the Southeastern School of Alcohol Studies, a member of the executive board of the Trident Council on Alcoholism, and is chairman of the Charleston Council on Alcoholism.

He is married, has one daughter and two grandchildren.

Dr. Robert S. Solomon

Dr. Solomon is a native of Bristol, Tenn., graduated from Emory and Henry College and received his medical degree from Emory Medical School. He was appointed to the Commission on December 5, 1967.

He has held office in many civic clubs including Berkeley County Medical Society, Berkeley County Council on Alcoholism, S. C. Medical Association and its Committee on Alcohol and Drug Addiction and is currently Chairman of the Trident Council on Alcoholism.

Dr. Solomon is in the general practice of medicine in Moncks Corner, S. C.

Dr. S. Hunter Rentz

Dr. Rentz is a native of Columbia and graduated from the University of South Carolina and the Medical College of South Carolina. He has been in the general practice of medicine since 1958, following rotating internship at Columbia Hospital. Dr. Rentz was appointed to the Commission on January 5, 1968.

He is a graduate of the Southeastern School of Alcohol Studies and attended special post-graduate training in alcoholism at the University of Utah. He was co-founder and first president of the Mid-Carolina Council on Alcoholism, a member of the S. C. Medical Association's Committee on Alcoholism and Drug Abuse, and chosen as Jaycees Man of the Year in 1967 for both Columbia and South Carolina.

Dr. Rentz is married to the former Mariam Lewis of Hemingway, S. C. and has two children.

Dr. Harold C. Moody

Dr. Moody graduated from LaSierra College, Arlington, Calif., and received his medical degree from Loma Linda, Loma Linda, Calif. He was appointed to the Commission on October 19, 1966.

He is a member of the American Medical Association, Southern Medical Society, S. C. Medical Association, Spartanburg County Medical Society and Board of Directors, S. C. Chapter of the American Academy of General Practice. He is also a member of the Spartanburg Council on Alcoholism and Committee on Alcohol and Drug Abuse of the S. C. Medical Association.

Dr. Moody is in the private practice of medicine and serves as Chief of Staff of Spartanburg General Hospital.

Rev. Frederick C. James

Rev. James is a native of Prosperity, S. C. and received degreees from Allen University and Howard University, Washington, D. C. He was appointed to the Commission September 18, 1968.

He is 1st Vice-president of S. C. Christian Action Council; National Consultant to Commission on Social Action, A.M.E. Church, Life Member of NAACP; president of Sumter Branch, NAACP; vice-chairman of Sumter County Economic Opportunity Corporation, vice-chairman of Sumter Citizens Advisory Committee, founder of The Mt. Pisgah Apartments, Inc. Housing Project; and a member of Sumter Housing Authority; S. C. Division, American Cancer Society; Alpha Phi Alpha Fraternity; S. C. Task Force for Community Uplift; Committee on Racial Justice, National Council of Churches; Social Education and Action Section, National Council of Churches. He is also a 33° Mason, Prince Hall Affiliation.

Rev. James is pastor of Mt. Pisgah A.M.E. Church, Sumter, S. C.

Rev. Joseph C. Horn, III

Rev. Horn is a native of New Orleans and was reared in Bessemer, Alabama. He received an A.B. degree from Birmingham-South College and a B.D. from The Virginia Theological Seminary. He has served Episcopal congregations in Baldwin County, Ala.; and was Rector of St. Paul's Episcopal Church, Selma, Ala. Since 1955 Rev. Horn has been Rector of St. John's Episcopal Church, Florence, S. C. He was appointed to the Commission on December 15, 1967.

Rev. Horn has served as President of the Florence County Mental Health Association and on the Board of Directors of the S. C. Mental Health Association. He has served as a member of the Advisory Board of the Darlington-Florence Mental Health Clinic. Gov. Russell appointed Rev. Horn to the Governor's Advisory Group on Mental Health Planning and he served as chairman of the Group on Alcohol and Drug Addiction.

(Continued on Page 15)

PERSONALITY GROWTH: KEY TO THE VOCATIONAL REHABILITATION OF THE CHRONIC ALCOHOLIC

By

Edward F. Mau

"THE alcoholic never had it so good," was overheard recently at an alcoholism seminar. While general agreement to this blanket statement prevailed, it is also true that the revolving door is slowly closing to the alcoholic who is not coming to terms with his problem.

Service to chronic alcoholics, with optimal help for the client and optimal use of the agency, is now offered in the southeastern counties of the Commonwealth of Pennsylvania by the Bureau of Vocational Rehabilitation.

Historically, the chronic alcoholic was neglected by the helping agencies for a number of reasons. No one agency had the patience or the empathy to take on the sick and suffering alcoholic. He was irresponsible. He did not keep appointments. He was cunning. His case was hopeless. He was defiant, stubborn, self-indulgent; he was intractable. (Thus the *raison d'etre* of the fellowship of Alcoholics Anonymous: "I came to AA because there was no place else to go.") He was certainly not feasible for service from vocational rehabilitation because there was substantially less than a reasonable expectation that he would ever return to productive employment.

Now the alcoholic has lots of places to go before he needs to try Alcoholics Anonymous. At the beginning, however, help was slow in coming, even after the American Medical Society went on record in 1956 with the declaration that alcoholism is a disease. Medical practitioners simply did not treat alcoholics. Vocational rehabilitation administrators were unsure whether to require three days or three years as a requirement of sobriety as a condition of eligibility.

Suddenly the pendulum began to swing away from "not one cent for the alcoholic" to a squandering of millions to dry him up in the name of rehabilitation. With an abundance of dollars to spend and with the opening of two new alcoholic treatment centers in our area, we proceeded to purchase services on an

in-patient basis in order to rehabilitate our entire chronic alcoholic population.

But we found it wasn't that simple. Follow-up visits revealed that the alcoholic returned to his old way of life following 30 to 120 days of in-patient alcoholism treatment and sooner or later resumed drinking. With an average of $1,500 invested in each client with less than a five percent success ratio, we were appalled at the astronomical cost of $30,000 to rehabilitate an alcoholic. This is a prohibitive figure even when compared with the cost of rehabilitating a stroke victim.

What was wrong? It became clear that drying up an alcoholic cannot be equated with rehabilitating an alcoholic. Drying up is a process not requiring the participation of the client. It is done to the client. Rehabilitation, on the other hand, implies involvement of the whole person. It is done by the client.

A reconsideration of the role of the vocational rehabilitation counselor, at this time, clearly indicated our need to shore up our initial screening process. While we continued to welcome all referrals, we began to insist upon a manifestation of a positive commitment, on the part of the client, to a life of sobriety before accepting him in status # 16 or #18 and encumbering funds in his behalf. Unless the alcoholic makes a commitment to this reality, he has little chance for the personality growth so necessary to permanent sobriety. It is not, therefore, a responsible use of agency funds to provide for treatment including full maintenance and therapy on an in-patient basis until the client begins to live this new way of life. Although it has been argued that this drying-out process is an incubation period out of which might hatch a recovered alcoholic, the cost is too great, the vocational objective too far removed, and client's motivation toward recovery is too highly questionable for acceptance by the vocational rehabilitation counselor.

Fortunate is the alcoholic whose state of residence is Pennsylvania. Through the Department of Welfare, medical assistance up to 60 days is provided the medically indigent. Now, with an opportunity to enjoy physical restoration induced by a proper diet, ample rest, vitamin and drug therapy, and fresh air and sunshine, the chronic alcoholic obtains physical relief from the disease for, perhaps, the first time in his life.

Mr. Mau is a Rehabilitation Counselor with the State Board of Vocational Rehabilitation, Rosemont, Pennsylvania.

Additionally, the local facilities treating alcoholism offer group therapy that leads to a marathon group experience for selected clients on the basis of their motivation and emotional stability. During this experience, the alcoholic discovers that he is not alone, that he is not unloved, that his situation is not hopeless. He learns too, however, that he must surrender his old way of life in favor of a new commitment. This is not easy. It is a willingness to face life without a chemical crutch, and it requires a major personality change. If, however, the client is able to move through this final barrier, and many do with the help of a skilled therapist, he becomes a highly suitable candidate for vocational rehabilitation service. A reliable measure of emotional growth, at this time, is a demonstration to himself and to others that he has gained the capacity to carry suffering and to sustain pain without sedation. If the rehabilitation counselor is sensitive to this climax in the life of the alcoholic, this commitment to sobriety, at least on a day-to-day basis, he can wave his money wand and produce a miracle. He can help a loser become a winner. From the debilitated, toothless, hopeless, chronic alcoholic; unwanted and unloved, emerges a new man. Confident, physically restored, smiling and hopeful; serenely aware of his need for and his capacity to love, the overall change in the chronic alco-

(Continued on Page 13)

THE TEENAGER AND ALCOHOL EDUCATION

By

Gerald Globetti, Ph.D.
Associate Professor of Sociology
Mississippi State University

Introduction

TEACHING about alcohol is, by legal mandate, a prescribed part of the public school curriculum in each of the states.[1] But because of personal feelings, parent-student attitudes, and community pressures, many superintendents and teachers have been reluctant to include alcohol instruction in their schools.

However, the young person lives in a society where drinking is a pervasive and acceptable social custom. Consequently, only the rare teenager does not experiment with intoxicants in the process of growing up.[2] In this experimentation he is often exposed to some very dangerous uses of alcohol which proper education might prevent. There are, therefore, many good reasons why teenagers should understand the complexities of alcohol intake before they leave high school. An adolescent's or child's reaction to the use of intoxicating beverages should not be left to chance alone.

Unfortunately, there has been a lack of systematic research about the type and source of alcohol instruction offered in our schools.[3] Moreover, and most importantly, studies of the attitudes of young people toward such instructional programs are virtually untouched. For this reason it is relevant to report and interpret here the findings of a survey concerned with one group of high school students' perception of alcohol education. This research involved a random sample of 528 students enrolled in the high schools of two Mississippi communities. Three major areas were studied. First, the students were asked to report their exposure to what they recognized as alcohol education. They were then asked to indicate something of what they had learned about beverage alcohol as well as their opinions regarding the teaching about it. Finally, an examination was made of the students' imagery of the alcoholic and alcoholism. The inception

of this study grew out of the recognition that a significant number of the states' teenagers were using alcohol, some indiscriminately without control and normal propriety.[4]

Findings

The data showed that the students were eager to learn about alcohol and felt there was a need for instruction regarding it in their schools. Approximately 9 in 10 replied that they should have an opportunity to learn more about the nature of alcohol and its use.

When asked what they wanted to know about intoxicants, two dominant themes emerged: 41 percent said that young people should be taught to realize the dysfunctional aspects of drinking; whereas, 36 percent indicated that teenagers should be presented the objective facts, with the purpose of letting them make their own decision about whether or not to drink.

The findings suggest, therefore, little reason to doubt the adolescent's motivation to learn about intoxicants. However, they also point out that young people, like adults, have a variety of interests in the subject of alcohol use. Subsequently, educators should realize that an initial assessment of the student's attitude toward drinking and his pattern of alcohol intake is an almost mandatory prerequisite to effective instruction.

Despite their desire to learn more about alcohol, it was found that the students were actually receiving little formal, organized information regarding it. In both school systems there was a lack of any meaningful, articulate program of alcohol instruction. Most school officials felt that the school had little responsibility in this area and that this form of instruction should be a function of the home or the church.

However, more than half of the students replied that they never discussed *any* aspect of drinking with their parents, which suggests that many parents are also reluctant to accept the responsibility of teaching their children about the use of alcohol. This finding was further demonstrated by an accompanying survey among parents which showed that only 11 percent felt that the child should be taught about alcohol *only* in the home and church. Approximately 9 in 10 felt that the school was the logical place for such instruction.[5] To be effective it appears that both the home and the school must realize that they have a part to play in alcohol instruction. No single agency alone is adequate for the task. Effective alcohol education seems to be, of necessity, a community responsibility.[6]

On the basis of a simple questionnaire survey, it may be presumptuous to evaluate the quality of the information transmitted to the students by their parents or its long range influence. However, a significant number of the respondents who discussed drinking and alcohol use with their parents said that the information given emphasized the evil nature of alcohol to the neglect of objective, scientific data. Those who were exposed to some type of formal church instruction also made a similar statement about its content. This grossly oversimplifies alcohol's complex nature and fails to impart constructive attitudes by which a child can make a wise decision regarding its use or non-use. Most alcohol educators stress that programs should not evoke fear or employ a strategy of terror in teaching about alcohol. These types of pseudo-educational practices may only implant an admiration for intoxicated behavior since the adolescent is often intrigued by forbidden pleasures and fascinated by danger, with little concern for its consequences.

Further analysis revealed that in the absence of instruction about alcohol in the home and school, the students relied on informal discussion with their age peers. Of those questioned, 7 in 10 said the use of intoxicants was a major topic of conversation with their friends. One can hardly fail to draw a parallel between alcohol education and sex education in this respect. In the absence of proper instruction concerning vital teen-

age problems, the young person must depend on inadequate information from his contemporaries. Little wonder that many are unable to make a wise, constructive decision about the use or the non-use of intoxicants.

Questions also were asked concerning from whom a teenager would seek objective information regarding alcohol. More than half of the students said they would use reference materials from such agencies as Alcoholics Anonymous and the public library. School as a source was not mentioned and only 2 percent indicated the church. When asked to what person they would turn, most of the respondents replied, "parents." Only 5 percent mentioned a school official or minister.

Moreover, the students said they would seek advice from a particular adult concerning drinking only if he were understanding and trustworthy. This finding illustrates that the subject of drinking is a sensitive topic for teenagers and that adults must avoid any inclination to ridicule or to be unsympathetic toward a young person's desire to learn more about alcohol.

One long range goal of most alcohol education efforts is to assist in removing the stigma associated with alcoholism and to create a therapeutic milieu conducive to the rehabilitation of its victims. The imagery of the alcoholic was studied and reflected that in the main, the students were fairly sophisticated in their thinking about this illness. For example, a majority of the respondents attributed alcoholism to personal problems and personality disorders. Yet, approximately 29 percent felt that the malady was caused by the overindulgence of alcohol use. Information was also elicited regarding the students' feelings toward the individual alcoholic and the public responsibility in his recovery. Forty-one percent answered that their feeling was one of sympathy and understanding, while 17 percent and 6 percent, respectively, felt disgust toward the alcoholic or were indifferent to him. A number of the students were somewhat unsure in their attitude in that 34 percent responded that they did not know their feeling about the person addicted to alcohol. The majority of the students, namely 6 in 10, stated that the public had a responsibility in establishing treatment centers for the alcoholic. Furthermore, there was a general consensus that community agencies and organizations had a proper role to play in educating the layman about this illness. These data taken together suggest that the students want to know more about alcoholism. This finding is understandable in the light that a significant number of the students had an alcoholic within their close interacting groups. Nearly one-fourth were related to an alcoholic while one-fifth knew friends of the family who were suffering from this condition. Consequently, they were being exposed to the tragedies of abusive drinking. They, therefore, should be provided with some information on how to cope with the problem.

Conclusion and Implications

This analysis has provided several important pieces of information which are pertinent to the implementation of an alcohol education program within the school system of two Mississippi communities. However, it should be cautioned that this paper was a simple descriptive study and make no reference to any personal, social, or cultural factors which may be correlated with a young person's attitude concerning instruction about alcohol. Obviously, such cross-tabulations would have provided much more understanding than the few statistics reported in this paper. Yet, some apparent implications and impressions for teachers, parents, and action workers in the field of alcohol education can be recorded.

This study shows that the high school student wants to learn more about alcohol and its use. However, few are receiving such information and the quality of that transmitted is questionable. The family, school, and church have

been lax in their concern in this area.

The use of alcohol is entrenched within the teenage subculture and many young people are experimenting with it. Yet, if an adolescent wishes to discuss drinking, he must, in most cases, turn to his age peers. As a result, he is not provided with adequate guidelines by which he can make a wise decision about alcohol, nor is he receiving information that can aid him in recognizing the dangers of its abuse.

The adolescent's relation to intoxicants should be governed by adults or other agencies of restraint and not by the normative prescriptions of his friends. The young person needs to be taught that alcohol is a powerful agent which, if used, must be used with control and propriety.

Adults should realize that, to teenagers, the use of intoxicants is a sensitive topic. If one seeks his advice about drinking, he should be understanding, rather than condemning and unsympathetic. The adolescent is passing through a crisis period, demanding all the patience and understanding an adult can muster. It is only within this frame of feeling that the subject of drinking should be interpreted to the young person. This suggests that perhaps how we teach is more important than what we teach. The instructor needs the personal qualities of emotional maturity and should be sensitive to the needs of young people. He must like young people and should be liked by them.

Schools have a major obligation to instruct about alcohol. This is especially true if they accept the responsibility of interpreting the society in which their students will function as adults. Drinking is a recognized part of American society, and, as a result, most teenagers will probably use alcohol sometime in their adult years.

Accordingly, the school should transmit to the child a more constructive, sounder attitude toward drinking. Education received in school is more organized and planned than other types of informal reaching to which he is exposed. Few parents are properly equipped to instruct effectively about alcohol. For example, an accompanying study of adults in the two communities, many of them parents of high school students, revealed that upwards of 9 in 10 had never participated in any discussion groups, study groups or seminars on alcohol or alcoholism. When asked about their major source of information about these topics, 43 percent mentioned the communication media such as television, radio, and popular magazines. Twenty percent answered that they had no source of information about these subjects, while 15 percent indicated their primary source originated from their first hand experience with alcohol or from personal contact with friends or neighbors who drink.[7] The quality of the data imparted through these channels is obviously open to question. The information an individual receives through the communication media during his leisure hours is not systematic or well planned. In most cases, attention is directed toward the e x t r e m e manifestations of excessive drinking which, consequently, excludes a great deal about intoxicants and their use. Moreover, much of the material one sees on television or hears from the radio is simply designed to persuade the individual to purchase alcoholic beverages and is hardly worthy to be labeled as a source of information. Also, direct personal experience with persons who imbibe does not necessarily facilitate an understanding of the problems of alcohol. Unhappy associations with an alcoholic or an excessive drinker, for example, may lead to a narrow bias regarding alcohol use which can vitiate the more objective educational approach.[8]

In conclusion, therefore, as one studies consecutively the reports of numerous workshops on alcohol education over the years, he senses that many of the problems faced by action workers in this area are similar from community to

(Continued on Page 12)

SOUTHEASTERN SCHOOL OF ALCOHOL STUDIES '69

Ninety-seven students and six faculty members from South Carolina attended the Southeastern School of Alcohol Studies at the University of Georgia in August of this year. The South Carolina delegation again was the largest of any state group ever to attend the School in its nine-year history.

Among those in attendance were:

L. J. Allen, Columbia; L. T. Andrews, Aiken; C. F. Beach, Walterboro; Lonnie Belt, Columbia; B. B. Berry, St. George; D. L. Bilberry, Clemson; W. F. Bishop, Jr., Kingstree; B. J. Bolender, Jr., Aiken; Leigh Bolender, Aiken; W. E. Bowie, Columbia; K. A. Breeding, Conway; Mary Brodie, Columbia; T. L. Buckner, Columbia; and W. C. Busch, Aiken.

Also: C. M. Camlin, Jr., Columbia; R. B. Campbell, Marion; M. H. Carroll. Jr., Rock Hill; A. C. Clark, Columbia; B. L. Cunningham, Seneca; F. H. Duncan, Columbia; Lois Duncan, Greenville; M. J. Edge, Columbia; T. B. Edmonds, Spartanburg; Dubose Fant, Greenville; W. B. Fitch, Aiken; Helen Gibson, Florence; Susan Grasso, Spartanburg; and T. B. Greneker, Jr., Edgefield.

Also: T. C. Hadwin, Jr., Columbia; LaNelle Harrison, Manning; R. E. Hatchell, Jr., Charleston; B. E. Heatherly, St. Stephen; Mary Henry, Columbia; D. H. Herbertson, Camden; J. W. Hewell, Simpsonville; R. M. Holliday, Florence; R. L. Howell, Bennettsville; C. H. Huguley, Jr., Columbia; Lloyd Isman, Sumter; Vivian Jackson, Columbia; J. P. Jarvis, Jr., Columbia; and L. J. Johnson, Columbia.

Also: Roy Jones, Sumter; Catherine Kimrey, Columbia; Nancy Kitchings, Hopkins; Dorothy Langley, Columbia; W. D. Leitner, Columbia; Marilyn Lesser, Florence; Glenda Livingston, Greenville; Rean Livingston, Cayce; C. L. McCord, Manning; T. R. McCreight, Pawleys Island; Estelle McGraw, Chesnee; R. H. McKenney, Greenville; K. R. McLennan, Camden; and R. E. Maher, Columbia.

In addition: W. C. Marrett, Columbia; G. N. Martin, III, Columbia; Jean May, Charleston; Grace Mitchell, Ninety Six: Geraldine Moore, Bonneau; Grady Moore, Bonneau; G. B. Mullis, Sumter; C. G. Nations, Pickens; J. A. Neal, Columbia; C. A. Otero, Columbia; J. W. Pearson, Conway; J. M. Pitts, Travelers Rest; H. W. Polk, Rock Hill; C. L. Poole, Lake View; and Mrs. C. L. Poole, Lake View.

Also: E. R. Quattlebaum, Hemingway; J. A. Ratteree, West Columbia; E. C. Ridgell, Florence; W. R. Roberts, Anderson; R. K. Rutledge, Sumter; K. F. Sandiford, Columbia; G. F. Schott, Columbia; T. R. Scott, Columbia; J. L. Setzler, Clinton; J. L. Smith, Anderson: J. P. Solomon, Columbia; B. E. Stafford, Travelers Rest; J. H. Templeton, Columbia; and O. H. Timmerman, Columbia.

Also: H. B. Tollison, Jr., Anderson; Helene Townsend, Columbia; Marjorie Twelkemeier, Columbia; Beverly Vaughn, Columbia; J. T. Walker, Florence; W. O. Weathers, Greenville; Geneva Wilkins, Columbia; R. Y. Winters, Jr., Graniteville; D. H. Wyatt, Columbia; W. L. Yates, Central; and C. L. Young, Florence.

(Continued from Page 9)

community. The principal roadblocks to the development of alcohol education includes such things as the heavy and enervating emotional freight, which alcohol use bears in this society, the lack of time in the school program, the lack of qualified teachers and materials, the conflicting and often acrimonious debates about what should be taught and how it should be taught and so on.[9]

Yet educators have no cause to doubt the teenagers' motivation to learn about alcohol. They are keenly interested in the chemistry, the physiology, the psychology and the sociology of its use, as well as the mental and emotional turmoil created by excessive drinking.

We have been negligent in providing proper education on alcohol. There is an abundance of data on this subject, and it is time that responsible adults make it accessible to our young people.

FOOTNOTES

[1] *Frances Tood,* Teaching About Alcohol *(New York: McGraw-Hill Book Company, 1964), pp. 4-5.*

[2] *For a summary of teenage drinking see: George L. Maddox, "Adolescence and Alcohol", in* Alcohol Education for Classroom and Community, *Raymond G. McCarthy, ed., (New York: McGraw-Hill Book Company, 1964), pp. 32-47.*

[3] *Arthur V. Linden, "What Is Being Done About Alcohol Education?,"* The Journal of School Health, *27: 291-302.*

[4] *For example, see: Gerald Globetti and Gerald O. Windham, "The Social Adjustment of High School Students and the Use of Beverage Alcohol,"* Sociology and Social Research, *51: 148-157, January, 1967; Gerald Globetti, "The Social Adjustment of High School Students and Problem Drinking"* Journal of Alcohol Education, *12: 21-29, Fall, 1967; Gerald Globetti, "A Comparative Study of White and Negro Teenage Drinking in Two Mississippi Communities,"* Phylon, *28: 131-138, Summer, 1967.*

[5] *Gerald Globetti,* Attitudes Toward Education About Alcohol and Alcoholism Among Community Members in Clarksdale, Mississippi *(State College: Mississippi State University College of Arts and Sciences, So.-An. Series, No. 7, June 1967); Gerald Globetti and Walter H. Bennett,* Attitudes Toward Alcohol Education Among Community Members in Tupelo, Mississippi, *(State College: Mississippi State University College of Arts and Sciences, So.-An. Series No. 5, April, 1967).*

[6] *George L. Maddox, "Drinking in High School: An Interpretative Summary,"* Association for the Advancement of Instruction About Alcohol and Narcotics, *5: 11, November, 1958.*

[7] *Gerald Globetti and Walter H. Bennett, pp. 8-10.*

[8] *Giorgio Lolli,* Social Drinking *(New York: Collier Books, 1960), p. 273.*

[9] *George L. Maddox, "Alcohol Education: Clues From Research" Taken from* Proceedings of Conference on Alcohol Education *(Washington, D. C., U. S. Department of Health, Education and Welfare, March 29, 1966), pp. 20-24.*

Children of social drinking parents are likely to become social drinkers themselves. The children of active social drinkers usually learn the attitudes, the rituals, the methods of preparing drinks, and all the other aspects of the cult before they leave home.

John F. Taylor—LISTEN, April 1969

Thinking of others first and caring about other people is a sign of maturity. Maturity is taking on responsibility, realizing its consequences, and who it will affect. It's when a person can look outside himself.

Fran Garten, Miss American Teenager — 1969, — LISTEN, May 1969

(Continued from Page 5)

holic is miraculous.

The most common and tangible needs of the chronic alcoholic are eye glasses and dental restoration. Hearing aids, eye surgery, hernia repair, and correction of ingrown toenails are not uncommon needs in the rehabilitation of the whole man. Assistance with union dues, placement equipment, refresher courses in driver training can be provided. Vocational training that has been provided to clients with less than a year of total abstinence has resulted in failure in one hundred percent of the cases. It appears that a training situation is fraught with more pressure than the recently recovered alcoholic can stand. Aptitude testing, occupational information, job counseling, and selective placement prove to be of optimal benefit to the client who may have been absent from the labor force for as long as 5 years.

Continuing personal adjustment training, group therapy, or residence in a half-way house in the community are vitally important factors that usually determine the success or failure of the entire treatment program. These latter arrangements permit the client to get a firmer grip on his newly acquired pattern of living, to strengthen his personality growth, and, most of all, to become involved again in realistic and meaningful personal relationships.

In summary, vocational rehabilitation funds are unwisely used on in-patient alcoholism treatment of those chronic alcoholics who are constitutionally incapable of meaningful involvement with others, those who do not want to change from their pattern of self-destruction, and those who cannot bear to become honest with themselves and others. Selective acceptance of those chronic alcoholics who demonstrate a capacity and motivation for personality fulfillment can lead to a highly successful rate of rehabilitation closures at a nominal cost per client. A vocational rehabilitation counselor learns through experience and instinct when the chronic alcoholic is ready for his help, when he is beginning to find a satisfying substitute for the bottle, when he has finally become sick and tired of being sick and tired. In the parlance of Alcoholics Anonymous this phenomenon is called a spiritual awakening.

To be realistic, it is only at this moment when the chronic alcoholic has turned the corner that his acceptance as an eligible candidate for vocational rehabilitation services can be justified. Having gained eligibility, there is almost no limit to the quantity and quality of services that can be provided in the vocational rehabilitation of the chronic alcoholic as he makes his way back home, to family, to job, and to his rightful place in the community.

(Continued from Page 1)

"As the film progressed and we saw in the children the innocence of youth growing and reaching out past that first innocent kiss in the park to the beer with the crowd, to the first drink of liquor at the party, to the birth of the unwanted child, to the arrest in the park of the young girl who didn't get away, to the arrest of the boys after their bulldozer crushed the car, we could truly see ourselves not many years ago.

"The question was asked as to how God could possibly be working in these teenagers. The girl who was arrested might now see what alcohol can really do. This might be the experience to prove to these two young boys that drinking does not create but only destroys. The mere fact that this film exists is proof of God at work.

" '*What Time Is It Now*' was of infinite help to us as alcoholics, and should

(Continued on Inside Back Page)

2 IN 3 IMBIBE

TWO persons in every three (64 per cent) say they use alcoholic beverages, only a percentage point under the result for 1966 when a 20-year high was reached.

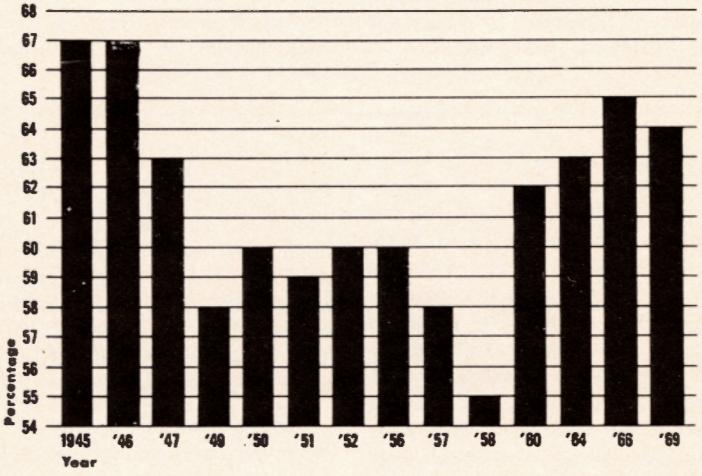
The latest figure is 6 points higher than in 1939, when the Gallup drinking audit was started. The proportion of male drinkers has changed very little over this 30-year period, but the proportion of female drinkers has climbed dramatically. Among men the percentage has increased from 70 per cent to 72 per cent, among women from 45 per cent to 57 per cent.

To obtain the latest results, interviews were conducted with adults in over 300 localities across the nation. The following question has been put to representative samples of the U. S. adult population regularly since 1939:

Do you have occasion to use alcoholic beverages such as liquor, wine, or beer, or are you a total abstainer?

The reader should bear in mind that this question measures only the *number* of drinkers in the population and not necessarily the quantity of beverages consumed. The results therefore should not be projected to the *volume* of beverage sales for any year.

Here are the results of the latest Gallup Poll audit of drinking and the national trend since 1945:



Age, Income Are Major Factors

A greater proportion of young persons, those in their twenties, are apt to be drinkers than are older persons.

Income is also a big factor. More than eight in ten (83 per cent) of persons whose family income is $15,000 or more say they have occasion to use alcoholic beverages. The proportion who drink falls off steadily in relation to income level, with a majority (54 per cent) being abstainers in the under $5,000 income group.

Major differences are also found in terms of religion, education, occupation, and region, as seen in the following table:

1969 Audit of Drinkers By Groups

	Use Alcoholic Beverages %
NATIONAL	64
Men	72
Women	57
21-29 years	80
30-49 years	69
50 years & older	53
$15,000 & over income	83
$10,000-$14,999	78
$7,000-$9,999	72
$5,000-$6,999	61
Under $5,000	46
East	77
Midwest	64
South	43
West	75
Professional & business	74
Clerical & sales	68
Manual laborers	66
Farmers	48
College-trained	74
High School	66
Grade School	51
Protestants	56
Catholics	82

Drinking Among College Students

The proportion of drinkers among college students far exceeds the proportion who drink among the adult population as a whole, but compares closely with the college-trained segment of the general public.

Three in four college students (75 per cent) say they drink, 80 per cent of men and 68 per cent of coeds. Many more seniors (79 per cent) imbibe than freshmen (67 per cent).

Students whose parents earn upwards of $15,000 a year are more apt to drink (84 per cent) than are those whose parents earn under $15,000.

(Continued from Page 3)

Fred C. West, Jr.

Mr. West is a native of Brooks, Ga., and moved to Abbeville, S. C. at an early age. He attended The Citadel and the U. S. Naval Academy. Gov. McNair appointed him to the Commission December 7, 1967.

He is a Mason and Shriner, initiated formation of Abbeville County Development Board and has served as president and member of the executive committee. He is a deacon in the First Baptist Church and has served on the Abbeville County School District 60 Board of Trustees, having been chairman for several years. He has held several offices in the S. C. Press Association and is a former vice president of the S. C. School Boards Association. He is also a Director for the S. C. State Chamber of Commerce.

Mr. West became editor of The Press and Banner, Abbeville, in 1947. He is married and has four children.

Treatment Digest

DETOXICATION FACILITIES FOR ALCOHOLICS

MANY hospitals have traditionally refused to admit alcoholics, either because they were assumed to be obstreperous patients or because proper facilities were not available and the already overburdened staff was inadequately trained in the treatment of alcoholism. In other words, alcoholics were considered simply too much trouble. Alcoholics in a state of acute intoxication were thought to be especially troublesome, not only because they required emergency care, but also because the staff often objected to taking care of them.

Recently, however, attitudes and treatment facilities have been changing. Not only are many general hospitals now accepting alcoholics as patients, but they are also establishing separate detoxication units. In Baltimore, for example, the Acute Alcoholic Detoxication unit has been established at Provident Hospital. In addition to providing medical care for alcoholics, it is intended to serve as a place where interns, residents, nurses and other medical personnel can learn the symptoms and treatment of acute alcohol intoxication. In Michigan the Alcoholism Treatment Center at St. Jospeh's Hospital, Mt. Clemens, encompasses both detoxication and long-range treatment with particular emphasis on educational group therapy and rehabilitation of the alcoholic after he is "dried out" and ambulatory. As of 1967, some 2350 patients had been treated at the Center. In Arizona the Franklin Hospital in Phoenix was licensed solely for the care of alcoholics (both men and women), and provides an intensive-care facility for treating acute intoxication. Normal stay at the hospital is 5 days, but some patients remain as long as 3 weeks. The hospital hopes to establish cooperation with other hospitals in the area where the detoxified alcoholic could be transferred for long-term rehabilitation.

St. Mary's Detoxication Center in St. Louis, Missouri, was established for the treatment of chronic drunkenness offenders. The 78-year-old structure which houses the new Center was scheduled to be closed down due to lack of patients and the migration of medical personnel to more modern hospitals in the area. The St. Louis Police Department, however, had better plans for the hospital: with the aid of a government grant, it attempted, as an alternative to imprisonment, a new approach to managing and caring for the drunkenness offender who for so long has plagued the police departments and courts.

At the 30-bed Center, men and women who have been arrested for public drunkenness are examined for bodily damage or disease and given a tranquilizer to induce sleep. Once ambulatory, patients are transferred to the "self-care" unit, where they are responsible for their own housekeeping and clothing. During this time high-protein diets and mineral supplements rebuild the patient physically, while social workers and the sisters, who maintain the hospital, boost his morale. Essential to the success of the program is the companionship and personal warmth provided by the sisters. In the first 6 months of the Center's operation, of the 350 patients admitted, only 90 have returned, strongly suggesting that chronic drunkenness offenders can be

helped. Sister Eugene Marie concludes from her experience at the Center, "We have found that the alcoholic responds to proper medication and dedicated care. He is really no different from the diabetic who can't live with his diabetic regimen. Why then cannot the alcoholic be admitted to the general hospital?"

—J. Siegrist

References

Byrne, R. J. Detoxication; an emerging apostolate. Hosp. Progr. 48:86-89, 1967.

Farber, R. E. Alcoholic Detoxication Unit at Provident Hospital. Maryland St. med. J. 16 (No. 6):100-101, 1967.

Gray, W. An alcohol treatment program; Alcoholism Treatment Center, Macomb County, Michigan. Marriage 49:22-30, 1967.

Franklin Hospital expands its services for treatment of alcoholics. Arizona Med. 24:1205, 1967.

DEPENDENCY CONFLICTS IN ALCOHOLICS AND THEIR IMPLICATIONS FOR TREATMENT

IN a multitude of psychological studies, alcoholic men have been described as predominantly dependent persons who resent this label so strongly that they feel compelled to overcompensate in the opposite direction. Excessive drinking becomes a symbol of excessive masculinity. While intoxicated, they are able to castigate their employers, wives, children, and associates. In order to perpetuate this facade of independence, alcohol becomes increasingly important and the addictive pattern is eventually established.

In two recent studies, this problem has been examined and evaluated. H. T. Blane and W. R. Meyers of the Alcohol Clinic of the Massachusetts General Hospital studied 99 lower-class alcoholic men who participated in a psychotherapeutic program stressing the constructive use of dependency needs. Each patient was rated as either dependent or counter-dependent (i.e., nondependent) in outward behavior, and two hypotheses were tested; that overly dependent alcoholics would establish a therapeutic relationship more easily and stay in treatment longer than the counter-dependent.

The findings bore out the hypothesis: 60% of the overly dependent versus 15% of the counter-dependent met five or more self-initiated therapy appointments; 27% versus 3% stayed in treatment for long periods.

More recently J. I. Hurwitz and D. Lelos from the Counsultation Center for Alcoholism at N. Y. University Medical Center studied alcoholic employees of long standing, who had been reported by their supervisors for repeated on-the-job drinking problems. Regular attendance at the clinic was a prerequisite of continued employment, hence their cooperation was virtually assured.

Various levels of their personality function were studied, and these non-help-seeking alcoholics proved to be highly conflicted people, 80% presenting a public facade (as well as a conscious self-image) of masculine dominance and strength. Two-thirds, however, consciously yearned for a passive and dependent role in life. In the words of Hurwitz and Lelos: "Since they can neither accept nor publicly display these dependency wishes, they experience a severe dependency conflict. Over half experience a strong underlying hostility which very few, when sober, can acknowledge and none can externalize. The hostility is thus bottled up during sobriety and uncorked only during intoxication."

The conclusions drawn from these studies are not optimistic. Help rejectors do not remain long in treatment and therefore have a poor prognosis; they tend to maintain their customary modes of adjustment with minimal likelihood

of change. Since they lack motivation to seek help with their drinking problem, some type of constructive coercion seems necessary to get them into an appropriate rehabilitation program and keep them there long enough to develop a voluntary desire to be helped. Since few of them have accepted a dependent role in life, a coercive company policy with respect to rehabilitation seems both justified and promising.

— S. S. Jordy

References

Blane, H. T. and Meyers, W. R. Behavioral dependence and length of stay in psychotherapy among alcoholics. Quart. J. Stud. Alc. 24:503-510, 1963.

Hurwitz, J. I. and Lelos, D. A multilevel interpersonal profile of employed alcoholics. Quart. J. Stud. Alc. 29:64-76, 1968.

THE DILEMMA OF THE ALCOHOLIC MARRIAGE

IN a renewed attempt to help the family adjust to the idiosyncrasies of the alcoholic member, Al-Anon has recently published a book which focuses primarily on a relatively unexplored area, i.e., the problem of sexual readjustment in the postdrinking phase. Even though the alcoholic's total recovery depends on numerous social factors other than sexual stability, Al-Anon feels that the importance of this single and often neglected factor demands open discussion. The book is intended primarily for the wife of the alcoholic but it can also apply to the husband of an alcoholic.

What Al-Anon calls the dilemma of the alcoholic marraige is the result of mutual misunderstanding in the days following abstinence. The alcoholic, after experiencing the so-called "pink-cloud" elation, suddenly realizes that abstinence is not a cure-all. Brutally confronted with the reality that not all his problems stem from alcohol, he can find great solace in an understanding wife. But she too is equally unprepared. In marriages in which there was little sexual rapport during the drinking years, the wife expects a loving, more responsive husband to reemerge after years of coldness, only to be nonplused about his continued lack of responsiveness. In both cases, a discrepancy has arisen between what each partner has learned and what he really understands about the nature of alcoholism. Al-Anon like Alcoholics Anonymous feels that alcoholism and sexual maladjustment often have a common psychological basis and to arrest the drinking is not to solve all the problems.

If an alcoholic marriage is to be saved, much of the basic relationship must be modified. The case studies presented show alcoholics to be often weak, dependent persons who seek stronger, more domineering women. During the drinking years, the household responsibilities fall on the wife and she is a mother rather than a wife to her husband. Once abstinent, however, the husband is bewildered about his identity: he no longer wants to be dominated, but feels guilty about how he has mistreated his wife during his drinking years. Al-Anon feels that this situation should be "talked out" and if the couple had meaningful sexual relations before the heavy drinking began, they can regain them through introspection and courtesy.

If the nonalcoholic wife was not formerly an Al-Anon member, she should definitely join at this point. Structured on the same Twelve Steps and Twelve Traditions as A.A., Al-Anon teaches that nonalcoholic relative to pay more than lip service to the conception of alcoholism as a disease rather than a state of moral degeneracy. Once the wife understands the first step—that she is powerless over her husband's drinking—she can only look within to improve herself. She then can achieve a similar personality

change as her husband did upon attaining sobriety. Many times, also, it is not the husband alone who has caused sexual maladjustment; often the wife has refused him sexually to punish him for his excessive drinking. She should now reexamine her role as a "mother" and modify it to fit better with her husband's new role as a man without interests and duties, who is "more than just a husband." She should take daily "personal inventories" and carefully evaluate her behavior (by means of checklists provided), paying particular attention to how she approaches her husband before and after work, how she dresses, how she allots her time, and how she cares for her children. Self-giving is the key and many personal sacrifices are asked of the nonalcoholic spouse.

Al-Anon is quick to point out that there is no "magic solution to all problems" and it is essential that the wife realize this. During the drinking years, Al-Anon offers the wife answers to immediate difficulties and the problem of sexual maladjustment is relegated to lesser importance. Once abstinence is attained, however, the sexual relationship assumes a new meaning and a well-informed and understanding wife will ease the husband's readjustment.

—J. Simonds

References

Al-Anon Family Group Headquarters, Inc. The dilemma of the alcoholic marriage. 65 pp. New York; 1967.

MULTIDISCIPLINARY TREATMENT OF ALCOHOLISM

ALTHOUGH alcoholism is both cause and result of various psychological, physiological, social, cultural and economic difficulties, much treatment effort has been centered around one or another specialized discipline or, in some cases, has merely involved "drying out" and sending the patient home again. Since the alcoholic has a variety of problems which need to be solved, a wide array of disciplines should be utilized. And because each alcoholic has a unique combination of circumstances attending his illness, treatment suited to the individual needs of the patient is necessary.

Such individualized therapy involves deciding who receives which treatment. Dr. Ruth Fox of New York has suggested that treatment be based on psychiatric classifications of patients, i.e., psychotics may need prolonged hospitalization, neurotics may need psychotherapy or psychoanalysis and the immature alcoholic may require extended supportive therapy. Dr. Richard Brothman of New York Medical College, in his critical evaluation of Dr. Fox's paper, states that a psychiatric classification is not enough, especially if one is describing a multidisciplinary approach, as Dr. Fox purportedly does. He proposes, instead, a broader classification based on social functioning (interpersonal relationships involved in family, work, friends, leisure) and physical functioning, as well as psychological components. In this way, various disciplines are brought into play, including medicine, psychiatry, nursing, social casework, community organization and research. The degree to which each discipline is utilized will be determined by each patient's needs.

The multidisciplinary approach can be viewed in two ways: one is that the alcoholic is treated by numerous agencies and specialists, each concentrating on his own area of concern. The second way involves coordinating all disciplines into a cooperative whole, either through one comprehensive agency or through community-wide c o o p e r a t i o n. Both approaches accept the alcoholic as a multi-

problem person, but they differ in the way they handle these problems.

Essentially, Dr. Fox's suggestions follow the first approach. She discusses the role of various treatment modalities, such as disulfiram, psychodrama, psychoanalysis, group therapy, L.S.D., aversion therapy, hypnosis, clergy and family support and Alcoholics Anonymous, in the management of the alcoholic. An important—and interesting—qualification which Dr. Fox makes is that the success of this type of treatment is based on whether the alcoholics are "well-motivated middle- and upper-income patients . . . who will pursue (the program) faithfully for one or two years. . . ." With this stipulation, success is almost guaranteed. Dr. Brotman suggests that more emphasis be placed on the totality of the alcoholic's life, including support from the patient's employer, friends, family and welfare agencies. Even the most extensive medical and psychiatric treatment will fail, says Dr. Brotman, if upon release from treatment the alcoholic is faced with the same social problems he had before.

The second approach is exemplified by the work of W. J. O'Connor and D. W. Morgan at the Sunset Park Alcoholic Clinic in Brooklyn, N. Y. The clinic, set up in 1962 by the Downstate Medical Center, is a neighborhood health center which comprised total treatment of the alcoholic within a single setting. Of the 1500 patients seen at the Clinic since it opened in 1962, many have voluntarily sought treatment; others are referred by various agencies, organizations or professionals.

Initially, the alcoholic is interviewed by the psychiatric social worker, who obtains a complete social and drinking history. The patient is then examined by the internist, who prescribes medication and thereafter acts as the primary therapist in handling medical, psychological and social aspects of the patient's problem. A nutritionist evaluates the dietary deficiencies of the patient and prescribes corrective measures. The patient is informed of available A.A. facilities. The psychiatric social worker obtains the spouse's view of the problem and what assistance she thinks the clinic can render. Central to the program are the monthly staff meetings conducted to coordinate and review treatment methods. Consultations between staff members and the patient focus on his real-life problems rather than his underlying psychological difficulties which have no practical value for the patient himself. The total resources of the community are also being organized to help treat the patients and alleviate the impact of alcoholism on their families.

This method, then, involves the total patient; no aspect of his problem is left unexplored and every effort is made within this single agency to rebuild the alcoholic into a viable and functioning individual.

Rehabilitation of the alcoholic in his psychological, physical and social functioning is the goal of a multidisciplinary approach or treatment. Because the whole of the alcoholic's problem is greater than the sum of its component parts, the therapists' concern is with the total patient and with the interdependence of various aspects of his life. Both treatment approaches described are valuable, but coordination of disciplines is facilitated by having them function within a single agency rather than a community-wide interagency setting.

— J. Siegrist

References

Brotman, R. Total treatment. Int. J. Psychiat. 5:45-46, 1968.

Fox, R. A multidisciplinary approach to the treatment of alcoholism. Int. J. Psychiat. 5:34-44, 1968.

O'Connor, WP. J. and Morgan, D. W. Multidisciplinary treatment of alcoholism; a consultation program for team coordination. Quart. J. Stud. Alc. 29:903-908, 1968.

(Continued from Page 13)

be a wonderful film to show young people the dangers of alcohol. This film should be kept at the Center. The interest created by this film has not been equalled by any other yet shown.

"To those who saw the film *'What Time Is It Now'* only one question remains: Is it sunset, or is today the first day of my life?"

NEVER LIVED OR DIED

He was a very cautious man, who never romped or played,

He never smoked, he never drank, nor ever kissed a maid,

And when he up and passed away, insurance was denied,

For since he hadn't ever lived, they claimed he never died.

CENTER TO IN ROCK HILL

The York County Council on Alcoholism will open an Information and Referral Center on November 1st on the 4th floor of the C & S Bank Building in Rock Hill. They will occupy a three-room suite and initially will be open on Fridays and Saturdays, using voluntary help. The formal dedication is planned for January 9th.

A working conference on alcoholism, sponsored by the York County Mental Health Association and the S. C. Commission on Alcoholism, was held in Rock Hill in November, 1968, and the York County Council on Alcoholism was formed as a result a month later. The officers of the Council are: M. H. Carroll, Jr., President; Ted Henry, Vice President; Caroline Lewis, Secretary; and Jim Honeycutt, Treasurer.

DIRECTORY OF SERVICES

A DIRECTORY of community resources is being prepared by the Commission staff and will be available for distribution shortly. The directory, by including information and referral centers, local councils, local commissions on alcoholism, mental health centers, Vocational Rehabilitation offices, educational material, in-patient treatment centers, AA groups, etc., located in South Carolina, will be of great assistance to those working with alcoholism and alcohol-related problems. This will be printed in a pocket size for convenience and supplementary pages will be mailed as changes occur. As yet, the cost has not been determined but will be priced slightly above actual printing cost. If you are interested in ordering a copy of this directory, please return the information below and we will be happy to furnish you with more details when available.

South Carolina Commission on Alcoholism
2414 Bull Street
Columbia, South Carolina 29201

Please advise when directory of services will be available and actual cost of same.

Name _____

Address _____ Zip _____

Employer or Agency _____

EDUCATION AND INFORMATION SERVICES

LIFELINES—bimonthly magazine which makes available articles on alcoholism and related subjects to those working in the fields of treatment and prevention and to those personally concerned with the problem. Published and distributed without charge.

FILMS—The Columbia office maintains a library of the best films available in the field of alcoholism. They are loaned free to interested organizations and groups. Write or call for list and description of films.

PAMPHLETS—Many educational and informative pamphlets are available dealing with every aspect of alcohol and alcoholism.

SPEAKERS—Members of the Commission and staff are available for personal talks before civic, religious and professional groups.

LIBRARY—Reference books by leading authorities in alcoholism may be had on a loan basis from the office in Columbia.

CONSULTANT SERVICE—Community Councils and state organizations are encouraged to use our facilities in establishing and operating their programs on alcohol education and alcoholism treatment.

EXHIBITS—Exhibits on alcoholism for meetings, conventions, fairs, etc., are available.

EDUCATION—Courses of instruction and seminars are conducted for student groups, organizations, and other agencies interested in or working with alcoholism and alcoholics.

S. C. COMMISSION ON ALCOHOLISM
2414 Bull Street
Columbia, S. C. 29201
Phone 758-2521