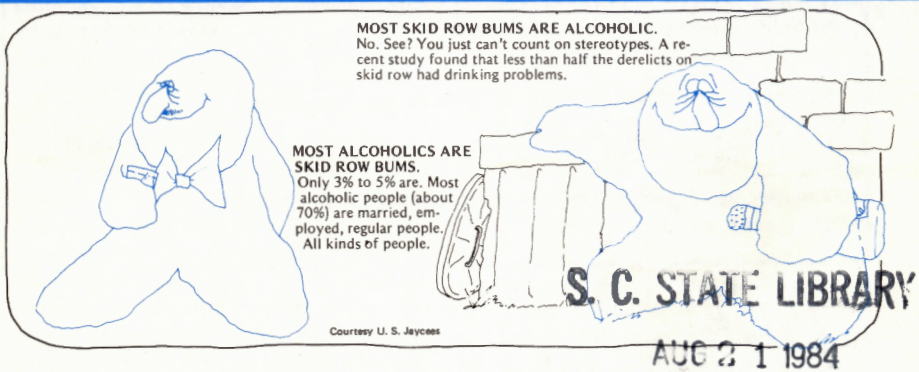
JANUARY-FEBRUARY, 1975

Lifelines

A BIMONTHLY JOURNAL

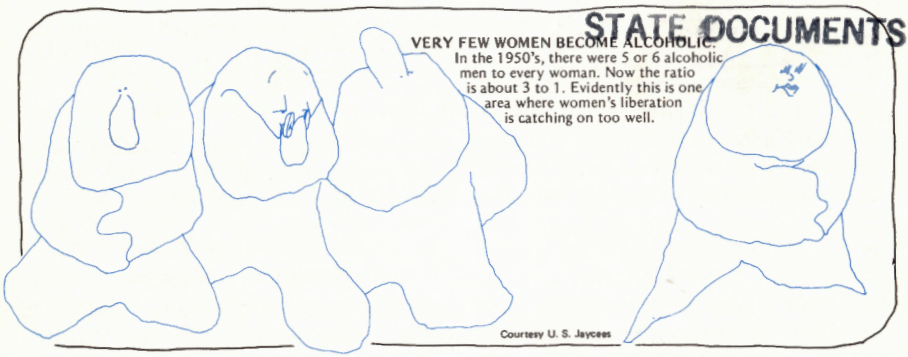
Published by The South Carolina Commission on Alcohol and Drug Abuse



MOST SKID ROW BUMS ARE ALCOHOLIC.
No. See? You just can't count on stereotypes. A recent study found that less than half the derelicts on skid row had drinking problems.

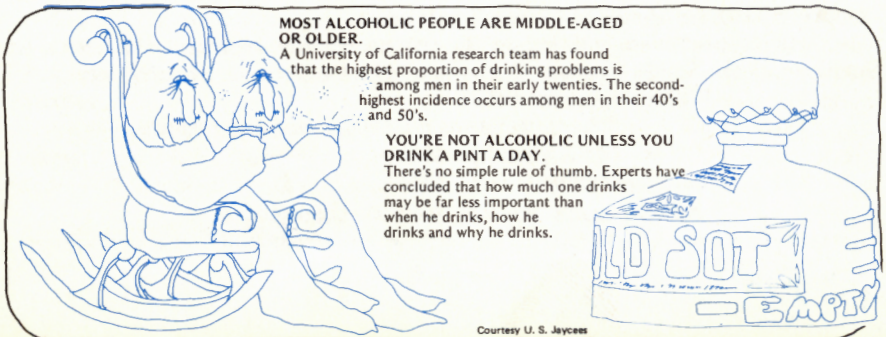
MOST ALCOHOLICS ARE SKID ROW BUMS.
Only 3% to 5% are. Most alcoholic people (about 70%) are married, employed, regular people. All kinds of people.

Courtesy U. S. Jaycees



VERY FEW WOMEN BECOME ALCOHOLIC.
In the 1950's, there were 5 or 6 alcoholic men to every woman. Now the ratio is about 3 to 1. Evidently this is one area where women's liberation is catching on too well.

Courtesy U. S. Jaycees



MOST ALCOHOLIC PEOPLE ARE MIDDLE-AGED OR OLDER.
A University of California research team has found that the highest proportion of drinking problems is among men in their early twenties. The second-highest incidence occurs among men in their 40's and 50's.

YOU'RE NOT ALCOHOLIC UNLESS YOU DRINK A PINT A DAY.
There's no simple rule of thumb. Experts have concluded that how much one drinks may be far less important than when he drinks, how he drinks and why he drinks.

Courtesy U. S. Jaycees

IN THIS ISSUE

Lifelines . .

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Columbia, S. C.

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JOY NOCITO ALBER
Editor

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Circulation Manager

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PROGRAM DOINGS

south carolina and the nation a roundup of alcohol and drug abuse news

Prevention Program Planning Guide

Lena Stevenson has issued the first *South Carolina State Alcohol Abuse Prevention Program Planning Guide.* Lena is the state prevention coordinator, and expresses the hope that the guide will be useful to local program personnel. For copies write Ms. Stevenson at SCCADA.

Community Services Seminar Planned

The next Community Services Seminar, presented by the Division of Training and the Division of Community Treatment Services, SCCADA, will be held at Camp Bethelwoods in York County. Dates for the Seminar are February 18 and 19. Specific information about registration, cost, sleeping arrangements will be forthcoming. Three workshops are planned: an experiential workshop on grantsmanship, a seminar on female alcoholism, and a program on approaches to prevention with special emphasis upon the recently developed South Carolina alcoholism prevention plan.

National Alcoholism Forum

The National Alcoholism Forum will be held at the Marc Plaza hotel, Milwaukee, Wisconsin, on April 27 - May 2, 1975. The latest developments in the field of alcoholism will be presented by leading authorities in lecture and workshop format. For further information write Ms. Sarah Pierce, National Alcoholism Forum Coordinator, National Council on Alcoholism, Inc., 2 Park Avenue, New York, New York 10016.

Rutger's Summer School of Alcohol Studies

Pre-registration is now being accepted for the Rutger's Summer School of Alcohol Studies. Initial reservations should be made as soon as possible, and confirmed by March 31. The minimum criteria for admission to the school will remain essentially the same: (1) having professional qualifications or (2) being employed in some alcohol problems area AT THE TIME OF APPLICATION, and (3) at least two years continued sobriety in the case of a "recovered alcoholic." Total costs are $500 for room, board and tuition. For further information contact Miss Linda J. Allen, Secretary, Summer School of Alcohol Studies, Rutgers University, New Brunswick, New Jersey 08903, or phone (201) 932-2190.

Survey of Drug Abuse Treatment Techniques

Metcor, Inc. is conducting a survey of "innovative drug abuse treatment techniques" for the National Institute on Drug Abuse. The inquiry will identify programs which are utilizing innovative treatment approaches as well as provide a complete survey of relevant treatment literature. The final report will describe and assess problems and potentials in the use of techniques such as acupuncture, contingency contracting, biofeedback, transcendental meditation, and electrosleep. Innovative approaches to treating special populations, such as psychotic addicts and addicted neonates, are of particular interest.

Metcor is now in the process of identifying innovative programs which would be appropriate for site visits. Program Directors or other professionals who wish to identify unique programs suitable for this study should

(Continued on Page 18)

THE TEN YEAR WAR AGAINST SMOKING

BATTLE weariness engulfs the professionals who waged the longest and costliest mass media campaign in the annals of health education. From the opening salvo by the Surgeon General in 1964 to this date, cigarette sales have forged ahead. In 1973 the American people spent $585 *billion* for cigarettes . . . compared with $555 million for government cancer research and $26 million for cancer society research.

As the professional soldiers in the war against smoking devise new strategies and re-group their forces for the next ten years, independent bands of guerrillas (often led by ex-smokers) are engaging in battlefield tactics of confrontation in place of persuasion, and legislation in place of leaflets.

"The broadest assault on smoking by a single state in the history of the U.S." is the claim of the originator of "D-Day" in Minnesota on October 7th. An ex-smoker with an evangelical sense of mission has set a goal of 85,000 converts which includes getting employers to request pledge cards from their employees. A trial run in one town even had "guards" in front of the cigarette counter at the drug store.

A Maryland housewife has organized a grassroots group by the name of GASP (Group Against Smokers' Pollution) which now has chapters throughout the country. Lawmakers reacting to the militancy are introducing anti-smoking legislation at city, county and state-wide levels. In Rochester, New York the GASP group pushed hard to get restaurants and departments stores to put up no-smoking signs, and members talked of possible boycotts against holdouts.

Under pressure from another group, ASH (Action on Smoking and Health), formed by consumer advocate John F. Banzhaf, airlines have set aside no-smoking sections. Still another group, the Citizens Information Committee, has worked for a bill to prohibit motorists from smoking while driving.

It's time for objective thought. Smoking like drinking fulfills a profound need, offering pleasure and release from stress. Just as prohibition failed in the 1920's so other efforts to mandate behavior will prove counter-productive. The blunt fact is that 54,000,000 people smoke as a way of life.

An opposition is forming, made up of smokers who wield power in major corporations, in key posts in network television, in the highest circles of government. Smokers resent the portrait of themselves as second-class citizens reckless of their own health and that of ohers.

Health professionals should resist any campaign to restrict smokers through legislation, to stigmatize smokers as negligent persons. The smoker needs sympathetic help, not abuse.

(Continued on Page 8)

Reprinted from the October, 1974, issue of Communications for Health, P.O.B. 67, Fresh Meadows, New York 11365.

TOBACCO

CONFESSIONS OF AN EX-USER

IN WHICH A BOTHERSOME DRY TICKLE CHANGES INTO BLATANT REALITY. GRIPS AT YOUR SOLAR PLEXUS. A FOURTH ATTEMPT AT QUITTING.

By
Nancy Gray

I DON'T remember when I decided that 13 years was the age to start, but somehow I must have made that decision because on my 13th birthday, I lit my first cigarette feeling fully justified that I had waited the prescribed time. All we ever heard bad about cigarettes back then in the 50's was that they stunted your growth. No one, of course, believed it, all of us having uncles who smoked towering over six feet. We felt they just told us that because they didn't want us to grow up. We knew they preferred us as children because we were easier to control. Back then, and in a lot of ways now also, we equated adulthood with smoking and that's precisely the reason we started.

It was also very important to be good at smoking and to achieve at least a pack a day. We all practiced in front of mirrors. We never got the tip wet (filters were rare then), never held it in the middle of our mouths, always to one side. I got so good I could hold it in my mouth while talking, squinting my eye so the smoke wouldn't irritate. By the time I reached a pack a day (hard to do when one has to spend five hours in school where no smoking is allowed), my parents had lost any authority over me. After all, I reasoned, who are they to tell me. We are all adults now, we all smoke. It is my conclusion that no matter what people say, most of them started smoking to achieve adult status and that's the pity of it. Now we've learned it can cause cancer, heart disease, emphysema and who knows what else. That's a whole lot more than we bargained for when all we wanted to do was grow up.

This is my fourth attempt to quit smoking. I think I'll make it this time. For one thing, I can't remember how long it's been since I quit. (In the past, I used to know to the hour.) I have since concluded that counting the days is a mistake. In order to succeed, I've decided I must understand that it is irrelevant how long it's been. I can only stop smoking once. I can pause, rest, cut down many times, but only stop once. If I am counting the days, then quitting is a continuing thing, not something already accomplished. If I have truly stopped smoking and someone offers me a cigarette, I'd say "No

Nancy Gray is Secretary-Treasurer of the **Do It Now Foundation.** *This article is reprinted with permission from Vol. 4, No. 1 of* **Street Drug Survival, A Do It Now publication.** *Further information may be obtained by writing the foundation at Post Office Box 5115, Phoenix, Arizona 85010.*

thanks, I don't smoke." Otherwise I'd say, "Not now, maybe later."

Two years ago in Colorado I had bronchitis. It was a month of that most horrible of throat things, the unreachable dry tickle. I couldn't do two cigarettes a day without coughing till my eyes teared. When I was finally well, I tried to quit the third time. My husband and I decided to try the buddy system developed by Alcoholics Anonymous. Working together, we "paused" for about six weeks. Then he had to go out of town on a job for three months. That took care of that for both of us.

Now some people say you can't half-way it. I don't agree. I think it must be harder for someone who does two packs a day to quit than someone who does two or three packs a week. I am convinced one can work out a program of gradual withdrawal so that when one takes the final plunge, it's not so severe. I am reinforced in this belief by an interview I saw of Katharine Hepburn in which she related how she quit smoking by cutting down day by day. It was a deliberate, disciplined effort on her part and it worked.

After the Colorado failure, I never quite reached a pack a day. I noticed (and I'm sure all you smokers out there know the feeling) that if I did over a pack a day, my throat would burn and I would burn and I would wake up the following morning feeling like my fat mother was sitting on my chest. Now who wants to feel like that for an eye-opener? To what purpose—you can't even get high on the stuff.

I decided to cut down little by little. Every day, I'd add 15 minutes or more to the time I waited for my first cigarette of the morning. I would not allow myself more than one smoke per hour. In just three or four months I got down to three or four packs a week. Hours would go by without even a craving. I remained at that level for over a year. Now even the Cancer Society would be happy with that. I was pretty satisfied with it myself, but not my husband. He had quit by himself some months before and like some reformed crusader, he badgered. My daughter badgered. "I mind if you smoke," she'd nag.

Oh, I heard all the arguments . . . all the latest statistics from the cancer and heart people. They would appeal to my intelligence, my sense of logic, my love for them, anything they could use. It was getting more and more difficult standing my ground knowing full well I was wrong. Moreover, and what I couldn't admit to them, my throat never really stopped hurting since that time I was sick in Colorado. I dared not tell them that it was always sore, that I was beginning to be afraid myself. A throat is not supposed to hurt constantly, I know that for sure.

I think of myself as practical, logical and realistic. "What" I would ask myself, do I get from smoking? It doesn't speed me up, slow me down or improve my appetite. (I am quite skinny and always working on gaining weight.) It doesn't bring me down or even get me high as a kite. The worst chemical on the whole drug scene has a better record on that score. Yet, I would think about quitting and a cold, deadly feeling would emerge right around the area of my solar plexus. I'm sure you know it; a tight fist grabbing at you, forcing you to back down.

Until recently, I believed that if I could figure out the reason for that feeling of fear, the psychological basis for my smoking would become clear and I would thereby be cured. I still don't have the answer to that one. My throat couldn't wait. I knew the time had come to stop now and if I had

(Continued on Page 8)

THE PATIENT PROFILE SYSTEM —OR HOW A PHARMACIST CAN HELP CONTROL DRUG ABUSE

L. D. Milne, Ph.D.

THE abuse or misuse of legal drugs is one of South Carolina's major problems. No one can dispute the fact that alcohol leads the list of abused drugs, but the public has yet to realize that the medically-prescribed tranquilizers, sedatives, and stimulants are probably our second major problem. When you consider that the above-mentioned drugs are often used in combination with alcohol, the dangers associated with each becomes greatly magnified.

During the summer of 1973, the Resource Planning Corporation, under the direction of Dr. Carl Chambers, studied, in depth, the misuse of legal drugs in this state. Some of his results were shocking. (Base population 1.8 million over age 14)

— Minor Tranquilizers
  - 131,180 (7.1%) South Carolinians are regular users of minor tranquilizers.
  - 31% of the 131,180 do not use the drug exactly as prescribed.
  - 5% admit to obtaining all or part of their tranquilizers **without** a legal prescription.

— Sedatives
  - 6% of the base population admit to having used barbiturates or other sedatives in the last six months.

Dr. Milne is an Associate Professor of Medicinal Chemistry at the College of Pharmacy, University of South Carolina, Columbia, South Carolina. Besides his usual pharmacy courses, his teaching load includes courses in drug education and psychology. He serves as a consultant to the South Carolina Joint Legislative Narcotics and Controlled Substances Study Committee, to the South Carolina Methadone Maintenance Council, to the Columbia Urban Service Center, and to the Richland County Pre-Trial Intervention Project. He is also co-author of the State Plan for Drug Abuse Prevention. Recently, he was appointed by the Governor of South Carolina as a member of the South Carolina Commission on Alcohol and Drug Abuse, and as a Member at Large of the South Carolina Drug Media Advisory Committee. He is in frequent demand as a speaker who is an authority on the alcohol and drug problem in South Carolina.

- 53,450 regular users of barbiturates are "at risk"; i.e., may soon need some sort of treatment.
- 6,000 of the "at risk" group admit to obtaining all or part of their barbiturates **without** a legal prescription.

Although the above statistics are only a small part of Chambers' study, I think it indicates the extent of the problem in South Carolina and should alert those professionals, working in the area of alcohol and drug abuse, to a problem that the general public has yet to identify.

The day to day control of legally prescribed medication actually falls on the shoulders of two groups: the physicians and the pharmacists!

When one considers that over 55% of the population see more than one physician, one can see that it would be very difficult for the physician to stay abreast of all the drugs which each of their patients are taking and especially if the patient refuses to be completely honest.

On the other hand, over 85% of the population patronize the same drug store or pharmacy. Consequently, it would only stand to reason that the pharmacist would be the logical person to monitor the drug usage of his patients.

Many pharmacists have indeed accepted this responsibility. More and more drug stores have initiated a "Patient Profile System." What is a Patient Profile System (PPS)? Quite simply, it is a personal drug record of each patient.

A drug profile card contains all the vital health information concerning a patient's allergies, sensitivities and chronic ailments which may significantly alter drug therapy. Thus, the pharmacist is in a position to prevent the dispensing of any drug which would be counter indicated. The pharmacist can also monitor patient adherence to prescribed dosage schedules as would be indicated by late or early refill requests. The pharmacist can also prevent duplication of therapy or drug overlap when a patient is seeing more than one physician.

Although the Patient Profile System was developed to guarantee better health care, it has proven to be a deterrent to the abuse of legal drugs. Obviously, the ability of the pharmacist to catch early refill requests is important. If a patient can be identified early, the chance of successful treatment is greatly enhanced.

The following case history is an example of how the Patient Profile System can be helpful in curbing illegal attempts to obtain drugs.

A 31-year-old female presented a prescription for Ritalin^{Rx} (a CNS stimulant). The pharmacist, who two days before had begun a PPS, checked her profile card and found that she had received a prescription for the same drug from a different physician the day before. Further investigation showed that the patient had been getting Ritalin^{Rx} frequently, but had always managed to make sure a different pharmacist was on duty (The pharmacy employed four pharmacists.) when she presented her prescription. The appropriate law enforcement officials were informed and the person was arrested and charged with obtaining controlled drugs by fraud.

As mentioned earlier, the PPS is not intended to curb the abuse of legal drugs, but instead is a pharmacist's way of safe-guarding his patient's health through drug monitoring.

Does the pharmacy which you patronize have a Patient Profile System? If not, ask "Why?"!

SCSHP SURVEYS SERVICES IN HOSPITALS

by Max D. Ray, Pharm. D.

THE S. C. SOCIETY of Hospital Pharmacists recently undertook a documentation of pharmacy services offered in hospitals throughout the state.

The Society hopes to serve as a clearinghouse of such information, so that other hospital pharmacists considering the implementation of new services or the expansion of existing ones can be made aware of where other such services are in effect in the state.

Questionnaires were mailed to all South Carolina hospitals which are shown in the current *AHA Guide* to have a pharmacy service. So far, 21 responses have been received, one of which indicated that none of the services being surveyed were being offered. The other respondents indicated a variety of services available in their respective hospitals. These are tabulated in the accompanying table.

The key to the specific services surveyed is as follows:

1—unit dose dispensing
2—IV admixtures service
3—patient profiles
4—computer utilization
5—technician training program
6—pharmacy newsletter
7—drug information service
8—in-service education program
9—manufacturing program
10—quality control facilities
11—clinical services

In some cases, respondents indicated that a particular service was only partially implemented. In several cases accompanying explanatory comments were made.

It appears from this incomplete survey that hospital pharmacists in South Carolina are offering some rather extensive services, comparable to or better than those offered in other sections of the country.

Any reader wishing more complete information on the results of the survey may contact Max D. Ray, Dept. of Pharmaceutical Services, Medical University Hospital, 80 Barre Street, Charleston, S. C. 29401.

Hospital	*Services offered*
Aiken County Hospital, Aiken	5, 7, 8
Anderson Memorial Hospital, Anderson	1, 2, 3, 4, 5, 6, 8, 11
Cherokee County Memorial Hospital, Gaffney	1
Conway Hospital, Conway	4

Max D. Ray, SCSHP, president elect, is associate professor and chief, Division of Clinical Pharmacy at the Medical University Hospital and the MUSC College of Pharmacy.

This article appeared in Vol. 13, No. 8 of the **Palmetto Pharmacist** *and is reprinted with permission.*

Crafts-Farrow State Hospital,
Columbia 4, 7, 11
Mary Black Hospital,
Spartanburg 1, 3, 8
Medical University Hospital,
Charleston
1, 2, 3, 6, 7, 8, 9, 10, 11
Midlands Center,
Columbia 1, 3
Moncrief Army Hospital,
Fort Jackson 2, 4, 5, 6, 7, 8, 9, 10
Naval Hospital,
Beaufort 2, 5, 9
Orangeburg Regional Hospital,
Orangeburg 1, 2, 3, 6, 7, 11
Richland Memorial Hospital,
Columbia 2, 3, 5, 6, 7, 8, 9, 11
St. Francis Xavier Hospital,
Charleston 4
Self Memorial Hospital,
Greenwood 4, 5, 6, 8
Spartanburg General Hospital,
Spartanburg 2, 3, 4, 5, 6, 8
Tuomey Hospital,
Sumter 3, 6, 8
USAF Hospital, Myrtle Beach
AFB 5, 6,
USAF Regional Hospital,
Shaw AFB 1, 2, 3, 5, 6
Williamston Hospital,
Williamston 3, 6, 11
York General Hospital,
Rock Hill 1, 2, 5, 7

"Quitting" — *Continued*

time later, I could ponder on the why's of it. Anyway, I had to admit to myself the only probable reason I was a smoker is I started at 13 to be a grown-up. I am inundated with proof of my adulthood now, responsibilities, motherhood, etc. I truly don't need cigarettes to assure myself that I am no longer a child.

Now I do not smoke. I need two hours less sleep per night and wake up as refreshed as I did when I was a kid. I hop out of bed ready to go even after staying up late the night before. They say things taste and smell better, I'm not really sure. I do know that I have more energy than I've had in years and that's the part I like best.

I am asking every smoker who has never tried to quit, who has never spent a few days without a cigarette since he or she started smoking, to try it. If you've been smoking a year or twenty years without a break, try it. I am not asking you to quit, only to try to do without it for a few days Feel the withdrawal symptoms, (they're impossible to describe). Notice how the desire for a cigarette creeps up on you when you least expect it. Introduce yourself to the fist clutching at your solar plexus. Then, after the few days have passed light one up.

Remember the first cigarette you ever smoked? You probably got dizzy, sick in the stomach, felt a little weak. Remember? Well, after a few days without a cigarette, as soon as you light one up that old experience comes back just like the first time. And that's what cigarettes do daily. They must be some kind of downer. They repress you, make you dizzy and sick and we all get used to it, so we don't even notice anymore. We accept ourselves that way. We forget it's the cigarette that is doing it to us.

Ten Year War — *Continued*

The revolt against seat belts is evidence of a backlash in reaction to government regulation. Over a million 1974 cars were "fixed" by their owners to make the mandatory interlock system inoperative. Reflecting the wrath of their constituents, the House of Representatives recently joined the revolt by voting 337 to 49 to do away with mandatory interlocks on cars.

Health educators should be wary of imposed solutions to matters of personal motivation and deep-seated psychological needs. Much more effort has to be given to the individual. Mass media draw attention to problems but the job of behavior change can only be accomplished in the small group.

RATIONALE AND CLASSIFICATION OF ALCOHOLISM TREATMENT DRINKING OUTCOMES PART II

by
E. Mansell Pattison, M.D.

V. CASE STUDIES OF A MULTI-VARIATE TREATMENT MODEL

The beginning of this paper presented a multi-variate model to conceptualize treatment. In this section, I will briefly summarize data from a recent project in which we compared the relationships between four different alcoholic populations, who received treatment at four different treatment facilities, who achieved four different outcomes. (78)

The four facilities were respectively: 1) an aversion-conditioning hospital (abbreviated ACH), 2) an alcoholism outpatient clinic (OPC), 3) an alcoholism half-way house (HWH) 4) and an alcoholism policework farm (PWF).

In Figure 2. I have listed a *differential assessment of disability* for each area of Life Health for each of the four populations. As can be seen, each of the four populations at the time of admission, were quite different in terms of their profile of differential disability. In the same figure I have listed the *degree of expected change.* Note that again we have four different profiles of expected change. The ACH population are "high bottom" alcoholics. They have little disability in most areas, and hence have little need for improvement in most areas, and will show modest evidence of changes in their life as a result of treatment. The major change to be expected is in their drinking. The OPC population has more disability and will show more improvement and change in their total Life Health. The HWH population has severe disability in almost every area, but they also have a high potential for rehabilitation. These are the classic alcoholics whose lives have been disintegrated by alcoholism. They will show the most dramatic improvement and change. While the PWF population are the skid-row "low bottom" alcoholics. They too have great dysfunction in all areas of Life Health.

Dr. Pattison is Associate Professor and Vice-Chairman of the Department of Psychiatry and Human Behavior, University of California, Irvine, and Deputy Director, Training and Manpower Development Division, Orange County Department of Mental Health, Santa Ana, California. *This paper was read at the First International Medical Conference on Alcoholism, London, England, September, 1973. Part I was printed in the November-December, 1974, Issue of* **Lifelines**. *The second, and last, installment is reprinted here with permission. References will be supplied upon request.*

Figure 2.

Differential Treatment Goal Profiles for Four Alcoholic Groups

Facility:	Aversion Hospital		Outpatient Clinic		Halfway House		Police Farm	
Target Health Area:	Disability on Admission	Predicted degree Improvement	Disability on Admission	Predicted degree Improvement	Disability on Admission	Predicted degree Improvement	Disability on Admission	Predicted degree Improvement
Drinking	4	4	4	4	4	4	4	2
Interpersonal	1	1	2	2	4	4	4	1
Emotional	1	1	3	3	4	4	4	1
Vocational	0	0	1	1	4	4	4	1
Physical	1	1	0	0	2	2	4	3

Disability Ratings are on a scale of 0-4, with 0 = no disability, and 4 — highest disability.

Degree of Improvement Ratings are on a scale of 0-4, with 0 = no improvement, 4 — greatest degree of improvement.

But unlike the HWH population, they have little potential for rehabilitation. Hence we can predict little improvement or change. This chart illustrates the necessity to carefully describe the precise disabilities for each sub-population of alcoholics, and also the need to describe the degree of potential improvement that can be expected.

In Figure 3. I have listed the possible drinking goals for each of the four populations. As will be discussed below, several drinking goals may be possible for each of the four popuations. There is too little data yet, to really form any generalizations. However, I offer this chart as preliminary frame of reference against which we can make empirical evaluations. However, I believe the time is now ripe to define specific drinking goals with specific populations, and assess what drinking goals are most viable for which populations. Further, such research should serve to focus treatment methodologies more explicitly toward specific Life Health treatment area goals, as well as toward specific drinking sub-set goals.

The following vignettes illustrate the pre-existent differences between alcoholic sub-populations, their life coping styles, their definitional model of alcoholism, their goals of treatment, and their different combinations of dysfunction. These relationships are summarized in Figure 4.

It should be stated clearly, that these case examples from these four populations are *not* intended to be taken as definitive population characteristics. There are no doubt degrees of overlap between alcoholic populations. Nor does this group of four populations cover the possible variety of populations and treatment methods. However, I do hope that this oversimplified schemata drawn from one study, will *illustrate* the conceptual frame of reference that may enable us to evaluate alcoholism treatment with more rigor.

A. THE AVERSION-CONDITIONING HOSPITAL

This population has the highest education (college), has achieved the highest socio-economic status, has maintained intact marriages, has the healthiest interpersonal and vocational health scores. These are all indicators of capacity for successful social competence. MMPI data indicate a constellation of personality traits requisite for social skills, for they are oriented toward social acceptance, externalization of problems, somatization of anxiety. In other words, these people are able to successfully keep life conflict outside themselves, or at least out of conscious conflict. They seek a treatment program that will restore flagging social sanctions, and they turn to appropriate social resources.

This population of alcoholics is relatively "less sick," hence have less need for, or room for, improvement in total lif rehabilitation. Alcoholism for them is still seen as an external problem. Alcoholism has not severly disrupted their social and vocational life. If these people feel that they have reached their most desperate point, that level is not nearly as low as for alcoholics at the other facilities. These are "high bottom" alcoholics. Further, being socially sensitive they may seek treatment earlier in their career of alcoholism before disintegration has occurred, with more social and vocational pressures present to push them into treatment. Although they have been drinking as long as the alcoholics at other facilities, they appear to have more capacity to defend against overt alcoholism.

For this population alcoholism is a disease, a medical problem akin to heart trouble or a broken leg, not a re-

Figure 3.

Possible Differential Drinking Goals for Four Alcoholic Groups

Facility:	Aversion Hospital	Outpatient Clinic	Halfway House	Police Farm
Drinking Goal:				
Abstinent	Primary X	X	Primary X	Problematic X
Social*	—	—	—	—
Attenuated	Problematic X	Problematic X	Problematic X	Primary X
Controlled	X?	X?	X?	
Normal		Primary X		

X Primary: goal most like to be achieved in terms of treatment offered.
X Problematic: goal that may be achieved but is unlikely or difficult to attain because of the psychosocial problems of that alcoholic group.
X?: goal that may be achievable, but sufficient data not yet available.
*: social drinking sub-set is listed here only to indicate that it is vacuous goal that has no operational meaning.

Figure 4.

Conceptual Differences Between Four Alcoholic Groups

Facility:	Aversion Hospital	Outpatient Clinic	Halfway House	Police Farm
Definition of alcoholism	medical allergy	neurotic symptom	life problem	secondary nuisance
Treatment goals:	abstinence	emotional restructure	new life style	stay dry and sober
Treatment methods:	aversion conditioning	psychotherapy	group socialization milieu	sheltered structured living
Ego Coping Style	Denial, Suppression, Social Desire, and "Boiler Plate"	Secondary Defenses, Neurotic Defenses, and "Sieve"	Primary Dysfunctions "Collapsed"	Primitive, "Under-developed"

flection of personal conflict. The medical view of alcoholism is a psychodynamic and sociodynamic stance that allows them to maintain their characteristic life style.

The facility in turn reflects the needs and perceptions of this population. The population is "high class" and the treatment is "high priced." The medical orientation of the hospital conveys the message that medical personnel will "do something" to the person to rid him of the unpleasant affliction—alcoholism. The aversion treatment philosophy allows the subjects to maintain their image of adequate, successful individuals. Further, this facility does little in the way of social and vocational rehabilitation, since little is needed in this area. Nor does it provide much psychological treatment. Overtly, this facility does not define alcoholism as a psychological problem. Yet the facility would probably be less successful if it did attempt psychological treatment, for such would challenge the major defense systems of this population.

B. THE ALCOHOLISM OUTPATIENT CLINIC

This population provides evidence of less social competence. They have a high school education, have more middle class jobs, have married but experienced more divorces, have intermediate interpersonal and vocational health scores. The MMPI data indicate a capacity for moderate defenses against anxiety, but not sufficient to prevent breakthrough of anger, depression, and feelings of inadequacy and passivity. This population experiences conflict while still maintaining a reasonable degree of social competence. They are still socially sensitive and look to socially respectable resources, however, they are more negativistic and pessimistic.

They see alcoholism as a personal problem, yet fear that it will overwhelm their lives more than it has. The definition of alcoholism as an expression of neurotic conflict is an apt summation of their personal experience of being alcoholic. In this population there is less need to maintain status by using a medical rationalization like the Aversion Hospital alcoholics do. Yet alcoholism is disrupting their lives and hence undercuts their capacity to deny that alcoholism is a personal problem.

The outpatient clinic is the most eclectic of the facilities. It has a physician and nurse to manage withdrawal symptoms. Disulfiram and psychotropic drugs are prescribed, and patients are informed of and encouraged to attend Alcoholics Anonymous. Yet the main modality is psychotherapy. Treatment is addressed to the personal conflicts that cause the patient to abuse alcohol, and to deal with the consequences of drinking in order to provide insight and strengthen ego adaptive skills. These alcoholics do not seek dramatic life rehabilitation, but they cannot afford to "close over" and deny the personal nature of their alcoholism. This facility does not provide shelter and life maintenance, for this population still can maintain social competence. Nor does this facility focus on abstinence as its treatment goal, since the supposition is that symptomatic alcoholism will disappear with the resolution of life conflict. This is a feasible treatment approach for this population. In contrast, abstinence must be a treatment goal for the Aversion Hospital alcoholics since life conflict is maintained outside awareness; whereas in the subsequent two facilities to be discussed abstinence is required because they lack sufficient social competence to go ahead with the business of living

life while simultaneously coping with their drinking style—abstinence for them is a precursor to rehabilitation.

C. THE ALCOHOLISM HALF-WAY HOUSE

This population demonstrates the effects of diminished social competence. They have only partial high school education, have held laboring and technical jobs, have mostly suffered marital disintegration, and have less healthy interpersonal and vocational health scores. Their MMPI data show characterological traits of inability to cope adequately with conflict and stress. They seek succorance, anger is repressed in the service of getting others to help them, and manipulation of others to provide for them becomes a major coping style in their lives. They experience a breakdown of coping mechanisms and turn to others, the clergy, institutions, to rehabilitate them.

These are the "low bottom" alcoholics. They possessed enough social competence to achieve a degree of successful social adaptation before alcoholism caught up with them. But they have suffered huge steps downward from their previous jobs and family relationships. Although not on skid row they are close to it. Alcoholism for this population is not an isolated affliction, but a major disruption of their entire life. The use of the medical model of alcoholism is not a defense this population can use. Even if they stopped drinking immediately they would still face immense problems of social and vocational rehabilitation. Neither can they employ the model of alcoholism as a neurosis, for alcoholism is a total life problem, not just a neurotic affliction. Further the psychological "set" of this population would not fit them for the usual methods of middle class psychotherapy, for they are faced with the real-life exigencies of just existing. Alcoholism is a problem of life, a need to start over, a spiritual renewal, a destruction of the self which means that a new style of life adaptation must be carved out.

The half-way house facility reflects the definitions and needs of this population. There is heavy reliance on Alcoholics Anonymous philosophy, including the need to surrender one's previous life style, to start over, to begin to live one day at a time, the quasi-religious conversion to becoming a new man. The A. A. philosophy emphasizes the need to change one's whole orientation toward life and towards oneself, and this matches very well the fact that alcoholism has destroyed their lives and a major reconstruction of a pattern of living is needed. Similarly, the program does not emphasize denial, nor strengthening of ego skills to dispatch neurosis. Rather it starts by providing nurturance, gratification of daily needs and desires, it sets limits and defines behavior—very necessary for persons with limited ego strength. The facility provides a setting for re-socialization, and only secondarily is psychological enquiry made. This is social rehabilitation, followed by vocational rehabilitation.

D. THE POLICE FARM WORK CENTER

This population lies at the lowest end of the social competence scale. These men are the socially inept. They only completed grade school, have held transient laboring jobs, have usually never married. Their interpersonal and vocational health scores are the unhealthiest. Their MMPI data reveal a lack of capacity to cope with stress. They show little capacity to deal with internal conflict save via direct action. Hence, they show psycho-

pathic qualities, non-conformity, overt hostility, yet despair and depression. There is little strength in themselves which they can call upon, hence they can only look to external agencies and personnel to cope with life. Alcoholism is for them just another piece of problematic behavior with which they cannot cope. They see little difference between treatment methods or facilities. They have no hope that life can be different. Their only goal is to achieve some respite in life by living in an institution that will provide them with support and nurturance that they cannot give themselves. They will pass from one institution to the next. Within an institution that provides necessary supports they can function, outside a supportive institution they cannot.

The facility provides a program that in actuality meets the immediate needs of this population, although the treatment goals of the facility may be more ambitious than appropriate. The subjects live in the work farm for 60 days isolated from society and from liquor. The subjects are provided with guided and supervised living experiences, and some realistic work experience is provided. It is the type of facility, were it a long term domiciliary, that might provide a sheltered living base where this population might function at a modest level of self-care. The facility makes no major effort at gradual social re-entry, it does not provide significant psychological counseling. It may perceive these areas as desirable additions to the program, but these additions would doubtless be of little value to the recipients. In contrast to the Half-Way House alcoholics where the problem was "re-socialization," the problem here is "primary socialization," which would also require significant augmentation of basic psychological coping skills, basic vocational training, and entry into society. The facility provides a short term "drying out" and a brief surcease from the buffeting rounds of skid-row life, which may be the appropriate level of intervention for this population.

SUMMARY

This paper has described the development of a multi-variate model for the treatment of alcoholism. This model assumes an interaction between different populations of alcoholics, who may receive different treatments, that may produce different treatment outcomes. Outcome goals of treatment have been broken down into five areas of Life Health: Drinking Health, Emotional Health, Interpersonal Health, Vocational Health, and Physical Health. The Drinking Health Variable was divided into five sub-sets: abstinence, social, attenuated, controlled, and normal drinking. The relationship between the sub-sets of drinking outcomes and the other four areas of Life Health were examined. There is a low correlation between the drinking variable sub-sets and other Life Health variables in outcome studies. There is a clear need to describe the degree of disability in each area of Life Health, to specify the areas of Life Health to which specific treatment should be addressed, to define the expected degree of improvement that can be expected, and then to develop specific treatment methods for each target area where improvement is to be sought. This preliminary model provides a conceptual frame of reference within which to frame further empirical studies to refine the predictions and categories presented here.

THE SECOND SPECIAL REPORT ON ALCOHOL AND HEALTH

2nd Special Report Updates Alcohol Knowledge

THE Second Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health, Education, and Welfare, released to the public this past summer, "marks a significant step forward in our understanding of the use and misuse of alcohol," according to HEW Secretary Caspar W. Weinberger. In submitting the report to Congress, the Secretary called for developing "more effective tools for preventing alcoholism and for constructively coping with this health and social problem." The Report, subtitled, "New Knowledge," was prepared by a 38-member task force of authorities in the alcoholism field headed by Dr. Morris E. Chafetz, Director of the National Institute on Alcohol Abuse and Alcoholism.

In introductory remarks, Secretary Weinberger and Dr. Chafetz called attention to the rising use of alcohol by young people, the need for an expanded role by private enterprise in the national effort to curb alcohol abuse, and steps being taken by the Federal Government to encourage third-party payments for alcoholism treatment.

Dr. Chafetz said the document is not intended to supplant the First Special Report on Alcohol and Health, published in 1971, but to supplement it. "The Second Report," he said, "reflects the knowledge gained for the battle against the misuse of alcohol since the inception of the National Institute on Alcohol Abuse and Alcoholism." He noted that while the Second Report is "an authoritative guide to understanding what scientists and scholars are studying and reporting at this time," about alcohol, "it is not an authoritative guide for solving moral issues which belong in the realm of personal decision."

The Report contains a long list of recommendations and findings. The recommendations ask:

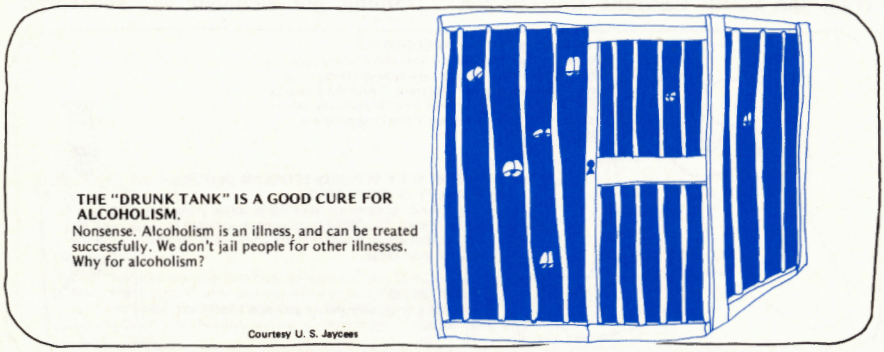
- That the growing store of knowledge about alcohol and alcoholism be made more readily available for use by specialists and the public.
- That educational resources for professionals and schools be expanded and developed.
- That efforts be redoubled to decriminalize public intoxication and to provide community care for offenders, instead of jail.
- That the new laws protecting the privacy and confidentiality of all citizens with drinking problems be strictly and immediately enforced.
- That efforts be accelerated to provide quality care for alcoholism in Spanish-speaking Americans, Indians and other native Americans, and young black men, and that prevention programs be introduced for these groups.
- That greater stress be given to providing treatment and prevention programs aimed at the drinking driver.
- That the values of early identification and treatment programs in

business and industry be generally recognized throughout the country.

- That quality and comprehensive care be extended to alcoholic people through coverage under health and disability benefits and the establishment of standards for care.
- That new and revised policies and guidelines governing the distribution and sale of alcoholic beverages be developed.
- That efforts be made to intensify the study of the relation of alcohol use to cancer, heart disease, liver disorders, pregnancy and fetal health, aging, longevity and mortality, and brain function as it relates to the addictive process.
- That it be recognized that the multiplicity and extent of alcohol-related problems cannot be the exclusive responsibility of the Federal Government.
- That a new national concensus concerning what constitutes responsible use and nonuse of alcoholic beverages be formulated and articulated.

Findings presented in the Second Report include:

- Alcoholism and alcohol abuse continue to occur at high rates in America.
- Drinking among American youth has been increasing and is now almost universal.
- American attitudes toward drinking are marked by ignorance, ambivalence, confusion, and dissent.
- The economic cost associated with misuse of alcohol is estimated at $25 billion annually.
- The alcohol control system is "chaotic" and may contribute to the public's ambivalence toward drinking.
- Excessive alcohol use, especially when combined with tobacco, has been implicated to the development of certain cancers.
- Heavy drinking by an alcoholic mother during pregnancy can harm her offspring.
- Current research gives promise of resolving the problem of cause in liver cirrhosis and may contribute to more effective treatment and prevention.
- Moderate consumption of alcohol is generally not harmful, and may have beneficial effects in some cases, such as in the elderly.
- The nonexcessive use of alcohol does not appear to adversely affect the overall mortality rate or the mortality from coronary heart disease. In fact, the mortality of moderate drinkers is lower than that of abstainers and ex-drinkers.
- Among questions requiring intensive research are how alcohol intoxicates and how alcohol addiction develops.



- Alcoholism is a treatable illness; treatment should vary according to the needs of the individuals.
- Lack of a national concensus on what constitutes responsible use of alcohol is hampering early identification and treatment of alcoholism.
- The accessibility and quality of alcoholism treatment services are improving, but are still seriously short of the need. Most treatment services are designed for late-stage alcoholism and fail to meet the needs of those in an early stage of the illness.
- Proper and efficient utilization of resources can improve alcoholism treatment. This requires an expansion of the role of the private and voluntary sectors of society.
- Occupational programs can be especially effective in achieving earlier identification of alcohol problems and have the highest rates of recovery.
- Third-party coverage of alcoholism treatment costs is essential to providing adequate care.

Reprinted from NIAAA information and feature service, October 20, 1974.

Program Doings — *Continued*

do so in letter form. Please address all correspondence or inquiries to Dr. Peter G. Bourne, Metcor, Inc., 2000 P. Street, N.W., Suite 505, Washington, D. C. 20037.

Library Additions

The following books are available from the South Carolina Commission on Alcohol and Drug Abuse lending library. Contact Ms. Crystal Springs Coates for further information.

Peoplemaking, by Virginia Satir

Written in a lively down to earth style, this book is useful to both the layman and professional. It is primarily concerned with the family, its health, welfare, and survival. The book's points are presented in human terms, relying on the use of simple language, anecdotes, case histories, and a series of "communication" games and exercises.

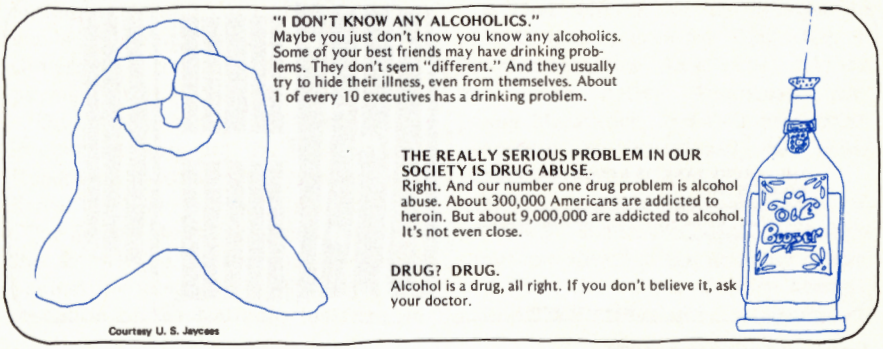
From Social Drinking to Alcoholism, by Jorge Valles, M.D.

Basing his conclusions on medical facts born of his extensive experience with victims of alcoholism, Dr. Valles pinpoints what he considers the heart of the problem: the cause of alcoholism is alcohol.

He attempts to substantiate this theory by a dispassionate exploration of evidence and to corroborate it by a meticulous pursuit of facts in keeping with traditional medical research and practice.

The Para-Professional in the Treatment of Alcoholism (A New Professional), edited by George E. Staub and Leona Kent.

This multiply authored book covers a wide range of philosophies and policies related to working with and as a para-professional in the field of alcoholism. Such subjects as in-service training, non-alcoholic vs. "recovered"



personnel, and the role of the administrator are covered as well as the role of the para-professional in various settings such as poverty communities, medical settings and out-patient clinics.

Crisis Intervention in the Community, by Richard K. McGee

This book is written for professional, para-professional, and volunteer workers in community mental health centers, for crisis intervention program managers and personnel, and for students of community psychology, mental health, clinical psychology, and other fields of sociological and behavioral study involving crisis intervention theory and program development.

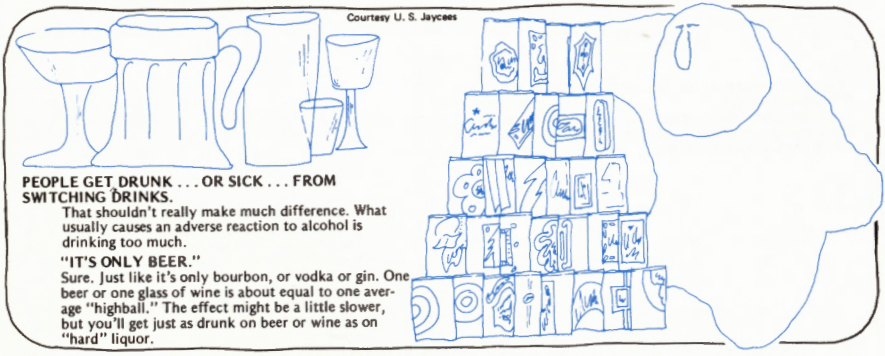
A comprehensive study of crisis intervention delivery systems, it presents realistic, practical guidelines for translating the principles of community mental health and community psychology programming into a service delivery system, and shows how to apply these concepts to program evaluation. It also describes innovative philosophies and methods for developing a comprehensive crisis service, with emphasis on the value of using volunteers and paraprofessional personnel for maximum benefit to the community at large.

Monographs available from SAODAP

A number of monographs are available from SAODAP. Items of interest are the *Central Intake Manual* which is designed to assist communities with multiple drug programs to establish Central Intake Units; the *Guide to Urine Testing for Drugs of Abuse* which provides non-chemists with an explanation of urine screening methodology; the *Vietnam Drug User Returns,* an overall picture of Vietnam drug users returning to the U.S. and continuing to use drugs; *Unique Identification System,* designed to facilitate cooperation among programs in controlling diversion with reference to multiple registration and *Media and Drug Abuse Messages,* which describes some of the issues and problems encountered in production and dissemination of drug abuse prevention messages for more effective methods in the field of drug abuse communication. Each of the above monographs may be obtained at no charge while the supply lasts by writing to: Special Action Office for Drug Abuse Prevention, 726 Jackson Place, N.W., Washington, D. C. 20506.

Labor-Management Journal

The National Council on Alcoholism Labor-Management Services Department produces a bi-monthly comprehensive publication called the *Labor-Management Journal on Alcoholism* which is winning wide acceptance among union and business leaders. Base subscriptions are $18 each and



additional multiple rate subscriptions are $6 each. An examination copy will be sent free of charge upon request. Contact the National Council on Alcoholism, 2 Park Avenue, New York, New York 10016.

Quarter Journal of Studies on Alcohol changes format.

In order to expand the coverage of scientific and scholarly literature, make current bibliography and abstracts available sooner, publish more original articles and reduce the lag time between receipt and publication of accepted articles, the *Quarterly Journal of Studies on Alcohol*, published since 1939, will become a monthly publication in 1975. The new format, to be titled *Journal of Studies on Alcohol*, will be available at $25 annually from *Journal of Studies on Alcohol*, Rutgers University, New Brunswick, New Jersey 08903.

Newspaper campaign available.

A series of 52 newspaper articles on alcoholism with permission from the author, Cecil Carle, to publish in your area as an integral part of your public information campaign will be available soon. The articles comprise a specific newspaper campaign designed to help (1) the problem drinker and his family identify alcoholism, (2) find answers to how the disease of alcoholism is arrested, and (3) alert your community to the critical nature of alcoholism. These articles may be obtained at a cost of $2.00 per volume of 52 articles. Send a check to the Alcoholism Council of Greater Los Angeles, 2001 Beverly Boulevard, Los Angeles, California 90057.

PALMETTO CENTER PLANS TRAINING PROGRAM

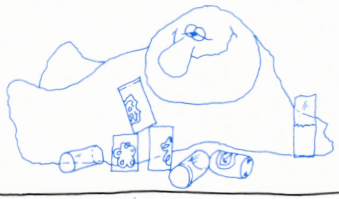
A ONE-WEEK program to provide a training experience to mold functional community interagency alcoholism service teams has been planned by the Palmetto Center. The program is designed for individuals currently employed in the fields of public health, mental health, vocational rehabilitation, social services, corrections, education and alcohol addiction. In addition community teams may include representatives from local resources including industry, military, the ministry and law enforcement. For detailed information and applications contact Training Coordinator, Post Office Box 1567, Florence, S. C. 29501 (Telephone: /803/ 662-9378).

The Government are very keen on amassing statistics. They collect them, add them, raise them to the nth power, take the cube root and prepare wonderful diagrams. But you must never forget that every one of these figures comes in the first instance from the village watchman, who just puts down what he damn pleases.

Sir Josiah Stamp
INLAND REVENUE DEPARTMENT
(England) 1896-1919

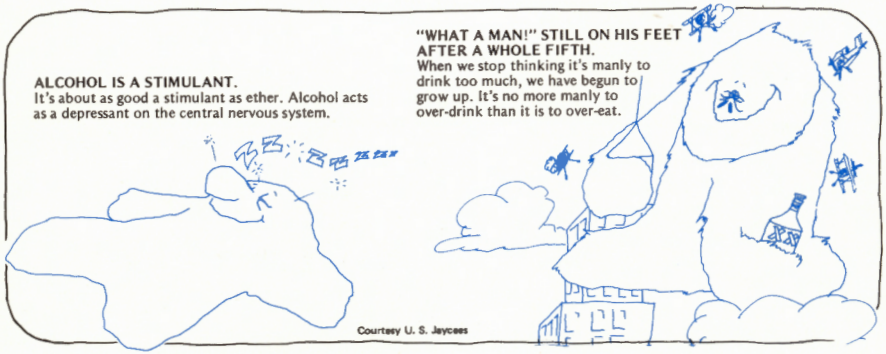
Courtesy U. S. Jaycees

"YA GOTTA HAND IT TO JOE. HE CAN REALLY HOLD HIS LIQUOR."
Don't envy Joe. Often the guy who can hold so much is developing a "tolerance" for alcohol. And tolerance can be a polite word for need.



"I DRIVE BETTER AFTER A FEW DRINKS."
In most states, the legal definition of "driving under the influence" is a blood alcohol level of 0.10%. But scientific tests have proved that even professional drivers' abilities diminish sharply at levels as low as 0.03% to 0.05% . . . just a few drinks. Not only that, but judgment is affected, too. So people think they're driving better than ever while they're really driving worse.

COMPENDIUM FOR 1974



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